Department of Health and Human Services
policy and funding guidelines 2017

Volume 2: Health operations 2017–18

Chapter 2: Funding arrangements for Victoria’s health system
## Contents

**CHAPTER 2: FUNDING ARRANGEMENTS FOR VICTORIA’S HEALTH SYSTEM**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction to Chapter 2</strong></td>
<td>78</td>
</tr>
<tr>
<td><strong>2.1 Acute inpatient services (WIES)</strong></td>
<td>79</td>
</tr>
<tr>
<td>2.1.1 Admission policy</td>
<td>79</td>
</tr>
<tr>
<td>2.1.2 Classification, counting and costing</td>
<td>80</td>
</tr>
<tr>
<td>2.1.3 Basic WIES cost weights</td>
<td>82</td>
</tr>
<tr>
<td>2.1.4 Development of WIES24 cost weights</td>
<td>83</td>
</tr>
<tr>
<td>2.1.5 Pricing</td>
<td>85</td>
</tr>
<tr>
<td>2.1.6 Pricing for quality</td>
<td>86</td>
</tr>
<tr>
<td>2.1.7 Transport supplement to health services</td>
<td>86</td>
</tr>
<tr>
<td>2.1.8 Interpreter supplement to health services</td>
<td>86</td>
</tr>
<tr>
<td>2.1.9 Hospital in the Home</td>
<td>87</td>
</tr>
<tr>
<td>2.1.10 HealthLinks: Chronic Care</td>
<td>87</td>
</tr>
<tr>
<td><strong>2.2 Acute specialist services</strong></td>
<td>92</td>
</tr>
<tr>
<td>2.2.1 Emergency department</td>
<td>92</td>
</tr>
<tr>
<td>2.2.2 Hepatitis C</td>
<td>93</td>
</tr>
<tr>
<td>2.2.3 Renal services</td>
<td>93</td>
</tr>
<tr>
<td>2.2.4 Radiotherapy</td>
<td>95</td>
</tr>
<tr>
<td>2.2.5 Perinatal autopsy service</td>
<td>96</td>
</tr>
<tr>
<td>2.2.6 Organ and tissue donation</td>
<td>97</td>
</tr>
<tr>
<td>2.2.7 Blood products supply funding</td>
<td>97</td>
</tr>
<tr>
<td>2.2.8 Blood products funding</td>
<td>98</td>
</tr>
<tr>
<td>2.2.9 Genetics program</td>
<td>98</td>
</tr>
<tr>
<td>2.2.10 Pharmaceuticals</td>
<td>99</td>
</tr>
<tr>
<td>2.2.11 Total parenteral nutrition</td>
<td>100</td>
</tr>
<tr>
<td>2.2.12 Home enteral nutrition</td>
<td>100</td>
</tr>
<tr>
<td><strong>2.3 Subacute inpatient services (Subacute WIES)</strong></td>
<td>101</td>
</tr>
<tr>
<td>2.3.1 Admission policy</td>
<td>101</td>
</tr>
<tr>
<td>2.3.2 Classification, counting and costing</td>
<td>101</td>
</tr>
<tr>
<td>2.3.3 Pricing</td>
<td>105</td>
</tr>
<tr>
<td>2.3.4 Adjustments</td>
<td>105</td>
</tr>
<tr>
<td><strong>2.4 Acute Specialist Clinics (Weighted Ambulatory Service Event)</strong></td>
<td>106</td>
</tr>
<tr>
<td>2.4.1 Admission policy</td>
<td>106</td>
</tr>
<tr>
<td>2.4.2 Classification, counting and costing</td>
<td>106</td>
</tr>
<tr>
<td>2.4.3 Pricing</td>
<td>107</td>
</tr>
<tr>
<td>2.4.4 Adjustments</td>
<td>107</td>
</tr>
<tr>
<td>2.4.5 Exclusions</td>
<td>108</td>
</tr>
<tr>
<td><strong>2.5 Subacute non-admitted services</strong></td>
<td>109</td>
</tr>
<tr>
<td>2.5.1 Health Independence Program and community palliative care</td>
<td>109</td>
</tr>
</tbody>
</table>
2.15 Teaching, training and research .................................................. 135
2.15.1 Training and development grants ............................................. 135

2.16 Replacement of critical medical equipment and engineering infrastructure .......... 138
2.16.1 Funding .................................................................................. 138

2.17 National Health Reform Agreement funding arrangements .................................. 139
2.17.1 National activity-based funding arrangements ........................................ 139
2.17.2 The pricing framework for Australian public hospitals: activity-based .................. 141
2.17.3 The pricing framework for Australian public hospitals: block-funded based ........... 141

2.18 Prior year adjustment: activity-based funding reconciliation ................................ 143
2.18.1 Victorian funding recall policy .................................................................. 143
2.18.2 Funding for throughput above target ....................................................... 146
2.18.3 Prior-year adjustment of commonwealth contribution .................................... 147
2.18.4 Hospital activity, WIES and Subacute WIES reports ........................................ 147

2.19 Health service compensable and ineligible patients ........................................... 148
2.19.1 Funding for interstate patients .................................................................. 148
2.19.2 Medicare-ineligible patients and international patients seeking health services ........ 148
2.19.3 Compensable patients ........................................................................ 150

List of figures

List of tables

Acronyms and abbreviations
Chapter 2: Funding arrangements for Victoria’s health system
Introduction to Chapter 2

Chapter 2 of Volume 2: Health operations 2017–18 details the funding arrangements for funding the broad range of services delivered in the Victorian health system. It details the mechanisms used to fund organisations and the rules about how these prices apply. The funding models vary across the activities depending on the nature of the service to be delivered. This chapter also explains the commonwealth–state funding arrangements that affect funded organisations.

These guidelines articulate the performance and financial framework within which State Government-funded health sector entities operate. They are a reference for funded organisations regarding the parameters that they are expected to work to and within, in order to achieve the outcomes expected by the Victorian Government.

The guidelines are divided into five chapters:

- Chapter 1 sets out the key changes and initiatives in 2017–18
- Chapter 2 focuses on the financial framework for providing funding
- Chapter 3 outlines all the prices and associated cost weights that support the overall financial framework
- Chapter 4 outlines the conditions and expectations of that funding
- Chapter 5 includes the modelled budgets for organisations that receive more than $1 million in health funding.

Items may be updated throughout the year. Funded organisations should always refer to the policy and funding guidelines website for the most recent version of the documents and guidelines.

Where these guidelines refer to a statute, Regulation or contract, the reference and information provided in these guidelines is descriptive only. In the case of any inconsistencies or ambiguities between these guidelines and any legislation, Regulations and contractual obligations with the State of Victoria acting through the Department of Health and Human Services (‘the department’) or the Secretary to the department, the legislative, regulatory and contractual obligations will take precedence.

A note on terminology

The term ‘funded organisations’ in Volume 2 and all subsequent chapters relates to all entities that receive departmental funding to deliver services. Aspects of these guidelines referring to funded organisations are applicable to all department-funded entities.

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

The term ‘community service organisations’ (CSOs) refers to registered community health centres, local government authorities and non-government organisations that are not health services.

These guidelines are also relevant for Ambulance Victoria, Health Purchasing Victoria, Ramsay Health Care and the Victorian Institute of Forensic Mental Health. The guidelines specify where aspects of the guidelines are relevant for these organisations.
2.1 Acute inpatient services (WIES)

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

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

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

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


In 2017–18 the unit of measure for acute admitted casemix-adjusted throughput will be known as WIES24.

2.1.1 Admission policy

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

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

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

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

- whether the person has health insurance
- the person’s financial status or place of residence
- whether the person intends to elect or elects to be treated as a public or private patient
- a person’s status as a Medicare-ineligible asylum seeker (refer to Hospital Circulars 27/2005 and 29/2008).
As part of their admission practices, health services will:

- Ensure that an eligible person, at the time of admission or as soon as practicable thereafter, elects or confirms in writing whether they wish to be treated as a public patient or a private patient and that this election process conforms to the National Standards for Public Hospitals Admitted Patient Election Processes.
- Ensure that any ineligible person is appropriately identified as such in the VAED.
- Report admitted Medicare-ineligible asylum seekers to the VAED with the account class code MF – Ineligible Asylum Seeker (see Hospital Circular 27/2005).
- Make every effort to verify the place of residence of interstate patients.
- Ensure that all patients admitted to hospital are asked whether they are of Aboriginal or Torres Strait Islander background. (Identifying Indigenous status is a mandatory data item to be reported by hospitals to the VAED. Aboriginal and Torres Strait Islander patients identified on the VAED will be funded at a 30 per cent loading to the nominated WIES payment for 2017–18.)

The general guidelines for admission are as follows:

- The criteria for admission must reflect the intended level of treatment that the patient is to receive. The criterion under which each patient is admitted does not have an impact on casemix funding.
- Hospitals are responsible for ensuring that appropriate procedures and records are maintained to facilitate accurate reporting, and to justify the admission. The list of criteria for admission in the definition is complete – there are no other criteria for admission.
- Under these criteria, the fact that a procedure is undertaken in a procedure room does not, in itself, justify admission.
- The criterion for admission is determined at the point of admission and does not change, even if the patient’s circumstances change. See the Victorian Admitted Episode Dataset: Criteria for Reporting policy for more information at <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems>. There are nine criteria for admission (six for admitted patients and three for required reporting to VAED). Supporting information, including examples, are provided in the factsheet available at <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vaed>.

For changes to the policy in 2017–18, please refer to Chapter 1, Section 1.9.1 ‘Revisions to the Victorian Admitted Episode Dataset: Criteria for Reporting’.

2.1.2 Classification, counting and costing

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

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

2.1.2.1 Classifying patients

Diagnosis-related groups

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

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

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

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

The AR-DRG classification is continuously updated nationally, with AR-DRG version 8.0 (AR-DRG8.0) being the latest available version at the time of the WIES24 formulation. Victoria will use AR-DRG8.0 for funding purposes in 2017–18.

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

### 2.1.2.2 Counting patients

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

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

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

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

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


### 2.1.2.3 Costing patients

Victorian public hospitals are required to report costs for all funded activity. They are expected to maintain activity and costing systems as part of good hospital management practice. The department currently maintains health cost data collections for both admitted and non-admitted activity that span a range of healthcare settings. The data collections include:

• admitted acute and subacute care
• geriatric evaluation and management (GEM)
• palliative care and rehabilitation
• specialist clinic encounters
• home-based service delivery
• emergency department activity.
Methods of costing include patient costing (bottom-up costing) and cost modelling (top-down costing). Patient costing allocates costs directly to individual patient episodes using service volumes (for example, actual tests and minutes in theatre) and minimises assumptions used to allocate costs, thereby achieving more accurate cost allocation at an individual patient level. By contrast, cost modelling allocates the same costs to all patient episodes using formulas and assumptions, thereby achieving a less accurate cost allocation. All hospitals cost-model to some extent, but hospitals can differ widely in the extent to which they model.

In Victoria, operational expenditure costs (direct and indirect) are allocated, capital and depreciation costs are excluded (not allocated), and all allocated costs must reconcile with the general ledger.

The department conducts annual collections of cost data from all metropolitan, major rural and some small rural public hospitals. Costs are reported by cost categories such as salary and wages, medical supplies or drugs for each area (for example, ward, pathology, emergency) of expenditure.

2.1.3 Basic WIES cost weights

2.1.3.1 Weighted inlier equivalent separation (WIES)

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

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

2.1.3.2 Inliers and outliers

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

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

To minimise the relative financial risk for hospitals, the concept of ‘inliers’ (or usual patients) and ‘outliers’ was introduced. Under the Victorian acute-inpatient cost-weight model, an average patient stay for most DRGs is in the range given by the average length of stay (ALOS) multiplied and divided by three (L3H3 boundary policy). This range is called the ‘inlier’ and the boundary points of the range are called ‘high’ or ‘low’. Cases outside the inlier range are called low outliers (for a short LOS) or high outliers (for a long LOS). If the patient’s LOS falls within the inlier range, the episode will attract the standard inlier WIES payment for that DRG. For a minority of DRGs that are clinically heterogeneous and contain high-cost cases, the inlier range is given by the ALOS multiplied and divided by 2/3 (L2/3H3/2 boundary policy). For some DRGs, separate cost weights are developed for same-day and multi-day patients to ensure that multi-day cost weights are not diluted by high-volume, low-cost, same-day patients. Similarly, for other DRGs, separate cost weights are developed for cases with a LOS of one day to ensure that multi-day cost weights are not diluted by high-volume, low-cost, same-day and overnight patients.

If the patient stays longer than the inlier, the hospital will receive an additional payment for every day over the inlier range.
In most DRGs, the costs per day decrease with a longer LOS; in others the costs can remain the same. To account for this, the daily payment level beyond the inlier range can be altered to suit the DRG patient profile. Payment rates are set at 80 per cent of the average daily inlier cost for medical patients and 70 per cent of the average inlier daily cost (excluding theatre and prosthesis costs) for surgical patients. The total value of the WIES is based on the sum of cost weights for the inlier and outlier components of the stay (if appropriate).

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

For 2017–18 (WIES24), boundary points have been informed by trends in ALOS within the VAED over the period from 1 July 2011 to 28 February 2017.

2.1.3.3 WIES co-payments

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

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

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

Details and technical specifications of all current WIES co-payments are in Chapter 3, Appendix 3.1 ‘Calculating WIES24 for individual patients’. These co-payments include the following procedures and patients:

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

To improve outcomes for Aboriginal and Torres Strait patients, hospitals who receive WIES co-payments are required to complete the Aboriginal Health and Wellbeing Improving Care for Aboriginal Patients Continuous Quality Improvement tool.

2.1.4 Hospital in the Home

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

2.1.4 Development of WIES24 cost weights

2.1.4.1 WIES24 cost weights

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

As mentioned, in 2017–18 the unit of measure for acute-admitted, casemix-adjusted throughput will be known as WIES24. WIES24 cost weights have been developed using 2015–16 acute-admitted cost data as reported by Victorian public hospitals to the annual Victorian Cost Data Collection. WIES24 cost weights are scaled to equal the number of WIES23 reported by public hospitals for the latest 12 months of measured activity available at the time of WIES24 formulation (1 March 2016 to 28 February 2017).

The following changes from the WIES23 (2016–17) funding model have been introduced for WIES24 (2017–18):

- Inclusion of new cost weights for patients that are admitted to and subsequently discharged from short-stay observation units (viz. short-stay cost weights). This modification consists of two new columns in the WIES24 cost weight table, namely a column that indicates DRG eligibility for the short-stay cost weight and a column that contains the short-stay cost weight (see Chapter 3, Appendix 3.2: ‘Definition of WIES24 variables’).
- Inclusion of a new Victorian modification of AR-DRG8.0 for patients receiving endoscopic clot retrieval services. This modification will regroup patients from within the adjacent AR-DRG8.0 of B02 Cranial Procedures to the new VIC-DRG8.0 of B02Y Endoscopic Clot Retrieval.
- Inclusion of a new Victorian modification of AR-DRG8.0 where 44 specific tenth edition ICD-10-AM diagnosis codes, when not coded as the principal diagnosis, will be omitted for the purpose of grouping to VIC-DRG8.0 (see Chapter 3, Appendix 3.1.2: ‘Victorian AR-DRG modifications’).
- Adjustment for the anticipated impact on DRG grouping arising from 1 July 2017 when hospitals begin coding in the tenth edition of ICD-10-AM. It is estimated that the adoption of the tenth edition of ICD-10-AM coding will impact most on DRG grouping (and hence WIES allocation) of episodes with a principal diagnosis code for abnormal findings on diagnostic imaging of uterus (R93.51).
- Revision of the thalassaemia co-payment to maintain alignment with the latest available reported costs.

The diagnosis-related group cost weights to be applied in 2017–18 are listed in Chapter 3, section 3.3.1 ‘WIES24 Victorian cost weights’. The table in this section shows the boundary points, co-payments and the ALOS for inliers used to determine high outlier per diem cost weights.

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

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

Detailed instructions about calculating the WIES for individual patients is at Chapter 3, Appendix 3.1: ‘Calculating WIES24 for individual patients’.

The definitions of WIES24 variables are in Chapter 3, Appendix 3.2: ‘Definition of WIES24 variables’.

2.1.4.2 WIES24 eligibility

The majority of patients in hospital will be allocated a WIES24 price weight. However, as in previous years, WIES cannot be calculated for incomplete or uncoded episodes. Further, WIES is not necessarily an appropriate measure of resource use for many non-acute patients.
WIES cost weights are sometimes allocated to some patient episodes that are ineligible for casemix funding. WIES from these episodes will need to be excluded when comparing health service activity against targets during 2017–18.

Eligible patients might be entitled to base WIES payments and WIES co-payments. Base WIES payments are made according to the formula which models the average costs for patients in each VIC-DRG8.0. WIES co-payments are made to cover the higher costs of care provided to some special types of patients.

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

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

- private hospital separations
- incomplete or uncoded episodes, or episodes coded to a problem VIC-DRG8.0 (zero weight) including Ungroupable (960Z), Unacceptable Principal Diagnosis (961Z) and Neonatal Diagnosis Not Consistent W Age/Weight (963Z)
- episodes with an account class on separation of Newborn – Unqualified, not birth episode (NT), Victorian WorkCover Authority (WC), Ineligible non-Australian residents – not exempted from fees (XX), Armed Services (AS), Common Law Recoveries (CL), Other compensable (OO) and Seamen (SS)
- episodes where the contract role is B (service provider hospital)
- episodes from hospitals not eligible for WIES funding
- episodes with DRG L42Z unless the episode is reported by St Vincent's Health, Ballarat Health Services, Bendigo Health, Barwon Health, Goulburn Valley Health, The Royal Children's Hospital, Mildura Base Hospital, Western Health or Mercy Health (Werribee campus only)
- episodes that have been coded as follows – this activity has been funded through specified grants:
  - include an electroconvulsive therapy code [9334100–9334199]
  - care type 4 (Acute)
  - separated from The Royal Melbourne Hospital (campus code 1334)
  - funding arrangement 2 (Hub and Spoke)
  - contract/spoke identifier in (0010, 0011 and 0012).

2.1.5 Pricing

The standard WIES24 price is established in terms of the general budget and takes into account other forms of funding. It is not the same as the average cost per WIES.

WIES24 prices can be found in Chapter 3, section 3.1 ‘Price tables’.

The funding provided to any patient or all patients can be calculated by multiplying WIES24 by the price.

2.1.5.1 Peer group prices

The 2016–17 peer groups have been maintained for 2017–18. The two peer groups are:

- metropolitan and regional – this group is unchanged from 2016–17
- subregional and local – this group is unchanged from 2016–17.

The WIES peer groups for 2017–18 are outlined in Chapter 3, section 3.2 ‘Peer groups for WIES purposes’. Note that these peer groups only relate to the price for acute hospital activity and are for recall and throughput policy purposes.
2.1.5.2 Normative pricing

In 2017–18, as a continuation of efficient pricing, the WIES23 cost weights for the following VIC-DRG8.0s are based on the median (rather than average) prosthesis costs:

- I03A Hip Replacement with Catastrophic CC
- I03B Hip Replacement without Catastrophic CC
- I04A Knee Replacement with Catastrophic or Severe CC
- I04B Knee Replacement without Catastrophic or Severe CC.

2.1.6 Pricing for quality

In 2017–18, Victoria will introduce a pricing mechanism for sentinel events. The Victorian model will involve not paying for an episode containing an avoidable sentinel event.

Health services are required to report sentinel events (see list below) to the Sentinel Event Program coordinated by Safer Care Victoria. Safer Care Victoria will analyse every sentinel event to determine if it was avoidable. If the event is determined to be avoidable, a health service will not receive payment for the entire episode.

2.1.6.1 Sentinel events list

- Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.
- Suicide in an inpatient unit.
- Retained instruments or other material after surgery requiring re-operation or further surgical procedure.
- Intravascular gas embolism resulting in death or neurological damage.
- Haemolytic blood transfusion reaction resulting from ABO incompatibility.
- Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.
- Maternal death or serious morbidity associated with labour or delivery.
- Infant discharged to the wrong family.
- Other catastrophic: Incident severity rating one (ISR1).

2.1.7 Transport supplement to health services

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

In 2016–17 health services that had transport costs (as a proportion of total funding) amounting to twice the state average (1.45 per cent), were considered eligible for additional funding. Health services deemed to be eligible received funding equal to 75 per cent of their costs above the threshold.

In 2017–18 the department will reduce the eligible threshold to 1.4 per cent to be considered eligible for additional funding. Health services deemed to be eligible under the revised rate will receive funding equal to 80 per cent of their costs above the threshold, up from the existing 75 per cent.

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

2.1.8 Interpreter supplement to health services

Effective communication is essential for high-quality healthcare. Departmental policy requires health services to provide professional interpreting and translating services for people who speak limited or no English when making significant health decisions.
The current funding approach of including all interpreter services funding in WIES is not aligned with the distribution of total costs associated with providing interpreter services.

The department will continue to provide a funding supplement for those services with significantly higher than average costs for the provision of interpreter services in 2017–18.

Health services with reported 2016–17 interpreter costs that exceed 0.2 per cent of their total funding will receive additional funding from the department in 2017–18 (excluding Dental Health Service Victoria). Health services deemed to be eligible, will receive funding equal to 75 per cent of the reported costs above the 0.2 per cent of total funding threshold.

2.1.9 Hospital in the Home

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


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

2.1.10 HealthLinks: Chronic Care

HealthLinks: Chronic Care (HLCC) reflects the department’s commitment to public hospital funding reform and the objective of delivering person-centred and integrated care.

HLCC is based on a recognition that people with chronic and complex health needs are often frequent users of hospital inpatient services, and that current funding models may be a barrier to care that best meets the longer-term needs of this patient group.

The challenge has been to create a more suitable funding approach that promotes alternative service models for this patient cohort, while ensuring costs are within existing budget parameters across the system.

Under HLCC, health services will be given the flexibility to use projected inpatient activity-based WIES funding to design care around the needs of these patients. This will enable the provision of more comprehensive and integrated health services, delivered in different settings by a range of providers.

Over time, it is anticipated that patients with chronic and complex needs will be more accurately identified and provided with targeted active management, thus reducing unplanned hospitalisations and improving patient outcomes.

2.1.10.1 HealthLinks: Chronic Care implementation

HealthLinks: Chronic Care commenced in 2016–17 and ten health services were invited to participate. Implementation is staggered according to health service readiness. The trial enables each health service to design an appropriate model of care based on the characteristics of the patient cohort and to align with the service’s strategic and operational objectives and design.

Health services participating in the trial have greater flexibility in how they use projected inpatient activity-based WIES funding for HLCC enrolled patients.

Funding is converted into a capitation-based HLCC grant and will be used to:
• cover all future acute inpatient admissions for the enrolled patient cohort
• invest in alternative services that may prevent, or help plan for, some of the predicted inpatient admissions.

HealthLinks: Chronic Care is designed to be budget neutral. That is, there is no new HLCC funding stream as the trial is funded from the current WIES funding pool.

2.1.10.2 Eligible patient cohort
The department has developed a model that is able to identify HLCC eligible patients (see Table 2.1).

Patients with a score of 9+ based on the most recent 12 months of VAED/VEMD data will constitute the HLCC eligible pool. It is predicted that more than 30 per cent of eligible patients will be admitted three or more times over the next year.

The department encourages health services to identify the HLCC eligible group based on the department’s eligibility criteria. The department will support health services by using the VAED and VEMD to circulate an updated monthly listing of HLCC eligible patients. This list will be provided within three weeks of the VAED/VEMD data submission deadline.

Table 2.1: Parameters of the HealthLinks: Chronic Care scoring algorithm

<table>
<thead>
<tr>
<th>Variable</th>
<th>Parameters</th>
<th>Assigned score</th>
<th>Maximum score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient age group</td>
<td>30–39 vs 18–29</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>40–49 vs 18–29</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>50–59 vs 18–29</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>60–69 vs 18–29</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>70–79 vs 18–29</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>80+ vs 18–29</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Number of unplanned admission in the 183 days or less</td>
<td>1 vs 0</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 vs 0</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>3 vs 0</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4+ vs 0</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>ED visits (separations) in the previous 90 days</td>
<td>1+ vs 0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Acute inpatient separation that includes a selected condition in the last 6 months (183 days or less)</td>
<td>Symptom/sign of digestive system ( T_{diag1} = R10x–19x )</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Asthma ( T_{diag1} = J45x–46x ) or ( J82x )</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kidney disease ( T_{diag1} = I12x, N00x–N19x, I131–32, I139 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes ( T_{diag1} = E10x–14x )</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Disorder of pancreas ( T_{diag1} = K85x–86x )</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>COPD ( T_{diag1} = J40x–44x )</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-infective enteritis and colitis ( T_{diag1} = K50x–52x )</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>
### Variable Parameters

<table>
<thead>
<tr>
<th>Variable</th>
<th>Parameters</th>
<th>Assigned score</th>
<th>Maximum score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatoid arthritis</td>
<td>Tdiag1 = M05x–06x, M45x, M080</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cirrhosis/alcoholic hepatitis</td>
<td>Tdiag1 = K701, K703, K746</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking status</td>
<td>Current/ex-smoker last month vs non-smoker</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Tobacco dependent vs non-smoker</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Patient residence</td>
<td>Aged care vs other</td>
<td>-3</td>
<td>-3</td>
</tr>
</tbody>
</table>

Notes: 1) Diagnosis codes exclude the period (‘.’); and 2) TDiag1 represents the principal diagnosis.

#### 2.1.10.3 HealthLinks: Chronic Care enrolment

All patients eligible for HLCC must be enrolled in the program at the time of their first unplanned admission to a health service that is participating in the HLCC trial. This is recorded in the VAED using Funding Arrangement = 9 HealthLinks program.

Following the commencement of HLCC, additional patients will become eligible for HLCC (in response to an unplanned admission) and can be enrolled in the program. This must be recorded in the corresponding dataset.

In 2017–18, if enrolled patients use less than the forecast average WIES of 2.2 per patient in their first year of enrolment, these funds will not be recalled.

The HLCC algorithm excludes:

- episodes that are not funded with the department’s resources
- patients and/or their episodes of care that are predicted to be high cost and/or not preventable
- patients cared for under specialist statewide programs.

These exclusions are based on the previous 12 months of VAED data and are listed in Table 2.2.

There will be a small proportion of patients (approximately eight per cent a year) who will die,¹ or become ineligible for HLCC. Where a HLCC eligible patient becomes ineligible, the health service will receive the HLCC allocated funding for that month. The episode that results in HLCC ineligibility and all subsequent episodes of care will revert back to activity-based (WIES) funding and will not count against HLCC guaranteed capitation funding. This will result in the exclusion of a suite of high cost episodes (for example, chemotherapy and trauma).

Patients who are enrolled in HLCC, and subsequently become ineligible, cannot be re-enrolled in HLCC for 12 months from the time that they became ineligible.

Funding for palliative care, subacute non admitted and ambulatory care (that is, non-WIES funded) services will remain intact. These services are available to all patients in the HLCC eligible pool within existing non-WIES health service activity targets.

---

¹ The HLCC modelling is based on patient deaths that occur within Victorian health services (i.e. the Victorian and National Death Indexes have not been linked to the HLCC modelling). In this version of HLCC, patients that do not die within a health service and do not meet any of the other exclusion criteria will continue to be funded under the HLCC program. Death Index data may be included in future HLCC models.
Table 2.2: Parameters defining HLCC ineligibility (exclusions)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episodes excluded from consideration for the (enrolment) trigger admission and subsequent WIES utilisation</td>
<td></td>
</tr>
<tr>
<td>Private hospitals</td>
<td>Private hospital VAED file</td>
</tr>
<tr>
<td>Compensable patients – TAC/DVA/WorkCover</td>
<td>Patient type = S or V&lt;br&gt;Account class = JN, JP, V-, W-, T-, A-, S-, C-, O-</td>
</tr>
<tr>
<td>Medicare ineligible</td>
<td>Patient type = X&lt;br&gt;Account class = ME, MF, XX, XN</td>
</tr>
<tr>
<td>Renal dialysis</td>
<td>ARDRG = 'L61x' or 'L68x'</td>
</tr>
<tr>
<td><strong>Patient level exclusions</strong></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>Age ≤17 years in any episode in the previous 12 months</td>
</tr>
<tr>
<td>Maternity</td>
<td>ARDRG = O0x, O6x</td>
</tr>
<tr>
<td>Cancer</td>
<td>ARDRG = J62, R62–R64, Q60–Q62, R60, R61&lt;br&gt;or TDiag(x) = Cxx, D0x, D37–D48</td>
</tr>
<tr>
<td>Palliative care</td>
<td>Caretype = 8 or TDiag(x) = Z515</td>
</tr>
<tr>
<td>Trauma patients: Acquired Brain Injury (ABI) Burns</td>
<td>Injury and poisoning as principal diagnosis = S00–T98 with ≥1 hour of mechanical ventilation&lt;br&gt;ARDRG = Wxx or Y00 to Y62</td>
</tr>
<tr>
<td>Mental health interventions</td>
<td>Caretype = 5&lt;br&gt;ARDRG = B63–64, U40, U60–68, V60–64</td>
</tr>
<tr>
<td>Human Immunodeficiency Virus (HIV)</td>
<td>TDiag(x) = B20–B24</td>
</tr>
<tr>
<td>Poliomyelitis</td>
<td>TDiag(x) = A80x</td>
</tr>
<tr>
<td>Victorian respiratory support service (VRSS)</td>
<td>ARDRG = A06</td>
</tr>
<tr>
<td>Spinal cord injury (SCI)</td>
<td>ARDRG = B60–B61</td>
</tr>
<tr>
<td>Cystic fibrosis (CF)</td>
<td>TDiag(x) = E84x or ARDRG = E60</td>
</tr>
<tr>
<td>Thalassaemia</td>
<td>TDiag(x) = D560–D569 or TDiag(x) = D572</td>
</tr>
<tr>
<td>Transplant patients</td>
<td>ARDRG = A01, A03, A05, A07, A08 or A09</td>
</tr>
<tr>
<td>Rehabilitation in acute care</td>
<td>TDiag(x) with Care type ‘0’ or ‘4’</td>
</tr>
<tr>
<td>Inpatient death</td>
<td>Sepsmode = ‘D’</td>
</tr>
</tbody>
</table>

2.1.10.4 HealthLinks: Chronic Care intervention cohort

Participating health services may choose (and are encouraged) to focus interventions on a subset of the total HLCC enrolled cohort. This will not impact the funding calculation, which will be based on the projected activity-based WIES payments for the predicted average number of enrolled patients.

This will enable health services to test and refine patient selection processes and determine whether a focus on a particular cohort can be effective in reducing inpatient care for that group of patients.

Patients who do not receive any intervention and receive usual care are included in the funding calculation. All inpatient services delivered to these patients will be funded from the specified grant. These patients are expected to use variable proportions of the predicted number of WIES allocated to them in the funding pool over the period of the trial.
2.1.10.5 HealthLinks: Chronic Care funding pool

The conversion to the HLCC grant in the first enrolment year will be set at the forecast average WIES utilisation for the average number of enrolled patients for the period April 2015 to March 2016. This will be paid pro-rata monthly; even if health services focus their interventions on a subset of the total HLCC enrolled cohort. This will be a ‘WIES conversion’ and there will be no adjustments to cash flow.

In 2017–18 the WIES conversion has been set at 2.2 WIES per patient for the first year of a patient’s enrolment in HealthLinks: Chronic Care. Funding will be part of the monthly cash flow provided by the department and will be identifiable as a separate grant line.

If a HLCC eligible patient is admitted for acute care, the funding to cover the delivery of these services will be assigned to the HLCC funding source and flagged in the VAED as HLCC. Where a HLCC eligible patient becomes ineligible, the health service will receive the HLCC allocated funding for that month.

Both the episode that results in HLCC ineligibility and all subsequent episodes of care will be funded using the activity-based (WIES) model and will not count against HLCC guaranteed capitation funding. This will result in the exclusion of a suite of high cost episodes (for example, chemotherapy and trauma).

Palliative care, subacute non-admitted and ambulatory care (non-WIES) funding will remain intact. These services are available to all patients in the HLCC eligible pool within existing non-WIES health service activity targets. If enrolled patients use less than the forecast average WIES of 2.2 per patient in their first year of enrolment, these funds will not be recalled.

The department will regularly monitor the actual number of enrolled patients and the WIES utilisation at each health service. In the event that the average number of HLCC enrolled patients significantly differs from the actual number of enrolled patients, the department will discuss the way forward with the health service.

2.1.10.6 HealthLinks: Chronic Care evaluation

The department has contracted the Commonwealth Scientific and Industrial Research Organisation (CSIRO) to work with the department on a co-sponsored evaluation of HealthLinks: Chronic Care.

The HLCC evaluation will involve the analysis of the department’s data sets including historical and prospective patient-level data. It will also include a survey of HLCC-enrolled patients on their health, wellbeing and healthcare experiences. Patient information will be collected through surveys at the time of their enrolment in HLCC, and at 6 months and 12 months following enrolment.

Participating health services will be required to participate in the evaluation and support evaluation data collection processes. Health services that focus the intervention on specific cohorts of HLCC-enrolled patients must ensure that information about the focus of their intervention is provided to the evaluators to ensure that this is reflected in the evaluation findings.

The HealthLinks: Chronic Care evaluation will also include focus group interviews conducted with HLCC clinicians across participating health services to identify the impact of HLCC implementation on the workforce.
2.2 Acute specialist services

2.2.1 Emergency department

In Victoria, 39 hospitals are funded to provide 24-hour emergency services. Patients who attend these emergency departments can either be admitted to hospital or may be discharged after they receive care in the emergency department. The funding approach for emergency department activity mirrors this patient flow through two streams of funding.

Funding for activity that occurs in the emergency department for patients who are subsequently admitted as inpatients is provided through the inpatient price, which includes allowances for the cost of the emergency department care.

Funding for patients who are not admitted, but who receive care in the emergency department only, is provided via the Non-Admitted Emergency Services Grant (NAESG). The NAESG comprises two parts: an availability component and an activity component.

In 2015–16 the department commenced reforms to better align the non-admitted and admitted acute funding pools to reflect the activity that is being reported. This shift saw some funds being transferred between the non-admitted emergency department activity grant into the admitted funding mechanism.

In 2017–18, the department will continue with this funding reform and maintain this split funding approach for the different patient pathways (admitted or non-admitted). Improving the specificity of the two funding streams will provide a clearer signal to health services about the efficient level of resources required for admitted and non-admitted emergency care.

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

2.2.1.1 Non-Admitted Emergency Services Grant availability component

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

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

2.2.1.2 Non-Admitted Emergency Services Grant activity component

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

The split between the availability and activity pools (80:20) within the 2017–18 NAESG is consistent with the split used in the 2016–17 model.

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

In 2017–18 the department aligned the total funding for the NAESG with the total reported costs (indexed to 2017–18 price levels with modelled growth added).

In 2016–17, a proportion of the residual funding has been added to the inpatient funding pool to be distributed using the WIES model. This change has improved the specificity of the two funding streams by providing funding for each type (admitted or non-admitted) of emergency department patient. In 2017–18, no residual funding has been moved into the inpatient funding pool and no additional funding has
been added to the funding pool where there has been no observed increased in non-admitted activity directly related to the NAESG grant.

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

Following the realignment of the Non-Admitted Emergency Services Grant (NAESG) and the incorporation of a portion of funding into the WIES funding in 2016–17, some health services did not receive the same amount of funding as that received in 2015–16. To provide budget stability for health services, a specified grant (positive or negative) has been retained, but adjusted to partly reflect the changes observed in the NAESG grant between years. This approach will be continued in 2017–18.

2.2.2 Hepatitis C

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

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

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

Work commenced in 2015–16 to identify best practice for the IHCS in the context of new generation treatments for hepatitis C. Integrated Hepatitis C Service providers will be advised of new performance requirements relating to measuring increases in hepatitis C treatment for 2017–18.

2.2.3 Renal services

2.2.3.1 Facility dialysis

The funding model for routine haemodialysis within a health facility has two components:

• An admitted patient component (WIES) paid to the dialysis service provider for all direct costs for separations allocated to L61Z (the payment provides for consumables and general specialist support costs).

• A non-admitted component paid to specialist services only, for non-admitted clinical consultations relating to the management of chronic kidney and end-stage kidney disease. Clinic activity includes medical, nursing and allied health. These clinics must be registered with the department and the activity reported through AIMS.

Victorian public sector renal services are delivered through a two tiered ‘hub and spoke’ service model. There are currently 11 tertiary centres or ‘hubs’ which have responsibility for the overall management of their satellites. While all hub services have a role in providing pre and post-transplant care, five hub services actually perform kidney transplantation.

There are 75 public satellite dialysis services (‘spokes’) currently operating, which are responsible for providing haemodialysis services and day-to-day, non-acute patient haemodialysis care.

Health services providing dialysis have been required to make a mandatory payment, comprising two components, per L61Z dialysis separation to their specialist hub to cover:

• Equipment and consumables which includes:
  – haemodialysis consumables
  – provision of equipment
  – equipment maintenance and servicing
  – renal water testing.
Funding arrangements for Victoria’s health system

• Specialist services which includes:
  – medical care
  – review and 24-hour on-call service (including emergency)
  – pathology
  – other specialist renal coordination and services.

Pathology tests will continue to be paid by the satellite provider in 2017–18 as per the 2016–17 change.

Health Purchasing Victoria has negotiated a set of prices for dialysis equipment and consumables for all health services. The department is providing greater flexibility for satellites to access the lower prices by removing the mandated arrangement with a specific hub. Satellite providers now have the opportunity to purchase equipment and consumables using the negotiated prices from suppliers. This option is only available:

• to satellites at the expiry of their current contract with the hub
• upon expiry of the hub’s contract with a supplier that includes the satellite's activity
• where there is no contract in place.

Once existing contracts expire the options for satellites are to:

• make no change and purchase through the current affiliated hub at an agreed price
• arrange for another hub to provide these goods and services at an agreed price
• purchase the goods and services directly from the supplier without any hub involvement, at the Health Purchasing Victoria negotiated price.

Whilst the intent of this policy and funding change is to enable satellites to benefit from access to Health Purchasing Victoria, satellites must ensure that the ongoing specialist clinical governance of the dialysis unit by their hub includes the oversight of equipment and consumable purchasing.

The department expects that satellites discuss any proposed change to the purchasing of equipment and consumables with their affiliated hub to ensure clinical oversight of patients is maintained, and that Victorian renal patients continue to receive safe, high-quality renal services.

Existing arrangements for provision of the specialist component or clinical oversight from an affiliated hub service will not change if a satellite chooses to purchase equipment and consumables through a non-affiliated hub service.

In 2017–18 the mandatory payment schedule for satellites within a contracted arrangement is:

• $110 to cover equipment and consumables
• $78 to cover specialist services (excluding pathology testing).

The payment is consistent across health services and is based on expected activity levels, in line with the health service payment schedule. It is essential that this payment is made in a timely manner. Payment adjustments to reflect actual activity should occur at least twice a year, with the detailed process negotiated between health services.

Where satellite facilities have patients from more than one specialist hub service, the specialist support component of the mandatory payment will be made to the specialist hub with clinical oversight of the satellite provider. The specialist hub will then pass on the specialist support component to the appropriate service under existing cross-charging practices.

Renal activity and WIES are incorporated within the total agency public and private WIES activity targets. As such, they are subject to the standard health service recall policy. This excludes small rural health services (SRHS), which continue to be funded to actual activity. In 2017–18 small rural health services targets have been adjusted based on the average actual activity over the last three years. Small rural health services will continue to have renal activity paid to actual via recall adjustments at the end of the financial year.
2.2.3.2 Home dialysis

Home dialysis is funded as an annual grant of $55,702 per patient in 2017–18.

Home dialysis payments include the following patient payments to be administered by the hub services:

- home peritoneal dialysis – $791 per patient per annum
- home haemodialysis – $2,085 per patient per annum.

In 2017–18, home-based dialysis must be reported as a non-admitted clinic activity using AIMS. Patient-level reporting of home dialysis activity will be required in future years; health services should consider how this might be achieved using existing reporting systems.

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


2.2.4 Radiotherapy

There are twelve sites at which public radiotherapy services are provided in Victoria, across metropolitan and regional campuses.

2.2.4.1 Funding

Patients who are admitted to hospital during their radiotherapy are funded under WIES for that component of their care. The majority of radiotherapy patients (~90 per cent) however, are ambulatory and are funded under the non-admitted patient radiotherapy funding model. Under this model, the various components of a course of radiotherapy are weighted and aggregated for each course of care.

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

In 2017–18 funding for non-admitted radiotherapy services will continue to comprise:

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

The WAU price can be found in Chapter 3, section 3.1 ‘Price tables’.

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

Radiotherapy activity data for funding was transitioned in 2016–17 from reporting in the AIMS Form S8 to the Victorian Radiotherapy Minimum Dataset. This unified dataset will be the key source of radiotherapy data for funding and service planning from 2017–18. Consultations will continue to be collected via the AIMS S8 and S10 in 2017–18. Services are now only required to report consultations relating to radiotherapy in the revised S8 form.

2.2.4.2 Shared-care

In addition to funding through the non-admitted radiotherapy funding model and contract arrangements at Warrnambool and Albury-Wodonga, the department also provides funding to eligible public health services that have entered into shared-care contracts with local private radiotherapy operators. Under these arrangements cancer patients receiving care as public patients can access local radiotherapy in coordination with their public hospital care. Health services who currently receive funding for
radiotherapy shared-care are Western Health (Footscray Hospital), Northern Health, Peninsula Health (Frankston Hospital) and Monash Health (Casey Hospital).

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


### 2.2.4.3 Quality

**Statewide Knowledge Based Learning Project**

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

The project will continue to develop models across new tumour streams in 2017–18.

**Assessment against the National Radiation Oncology Practice Standards**

During 2016–17 all Victorian public radiotherapy providers assessed their services against the National Standards using the Self Audit Tool. The tool is used as part of their internal quality management protocols. The results of the assessment has been integrated into the annual performance discussions with the department.

**Quality metrics data**

The department will continue to provide services with data analyses from the VRMDS to inform ongoing service improvements. In 2017–18 this will include analyses around mortality and morbidity, pathways of care and waiting times.

### 2.2.5 Perinatal autopsy service

Since 2016–17 all public health services are expected to use the Victorian Perinatal Autopsy Service (VPAS). VPAS commenced in January 2016 under the administration of The Royal Women’s Hospital, and provides perinatal autopsies, associated investigations and advice about perinatal deaths. The service is a collaboration of the three level 6 maternity services. Private health services are also encouraged to use VPAS (refer to Chapter 1, section 1.7.13.10 ‘Perinatal autopsy service’).

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

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

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

During 2017–18 the service will:

- Provide advice to Victorian health services, pathologists or clinicians regarding perinatal death investigation.
- Provide perinatal autopsies and associated investigations for all perinatal deaths from 20 weeks gestation.
• Provide perinatal autopsies and associated investigations for deaths less than 20 weeks gestation at the discretion of the three pathology departments associated with the VPAS (according to clinical need).

• Provide opportunities for health service providers to participate in multi-disciplinary clinical education relating to quality perinatal autopsy investigations, referral processes and family bereavement.

• Provide value for money transport arrangements.

The service is available to private health services and pathology laboratories, which are encouraged to use this service for all perinatal deaths.

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

2.2.6 Organ and tissue donation

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


2.2.7 Blood products supply funding

Funding of the Victorian blood and blood products supply will continue as per the National Blood Agreement (2003) using the commonwealth–state funding model of 63–37 per cent, respectively. In compliance with the supply and funding arrangements in the agreement, sufficient volumes of blood and blood products will be available to public and private Victorian health services in 2017–18. This supply plan has been negotiated between the government, the National Blood Authority and the Blood Service. Victoria’s contribution in 2017–18 will be about $105 million.

In 2017–18 the Victoria Government will continue the blood supply funding reform.

Access to blood and blood products will be guided by the Blood and blood products charter, which continues to be implemented with health providers nationally in 2017–18. The National Stewardship Expectations for the Supply of Blood and Blood Products is available at <www.blood.gov.au>.

Intravenous immunoglobulin is made available through the supply plan to health services for uses that have been agreed according to the Criteria for the clinical use of intravenous immunoglobulin in Australia. Intravenous immunoglobulin is also available for direct purchase by health services for uses that have not been included in the criteria due to a lack of sufficient evidence of efficacy as demonstrated by the literature or specialist clinical consensus. Further information is available at <https://www.blood.gov.au/intravenous-ig>.

Subcutaneous immunoglobulin is available to health services through the supply plan for agreed uses. The department is funding a number of hospitals to transition some patients being treated with intravenous immunoglobulin to at home self-administered subcutaneous immunoglobulin. Further information on access is available at <https://www2.health.vic.gov.au/about/news-and-events/hospitalcirculars/circ1013>.

Normal immunoglobulin is subject to national governance arrangements. Further information is available at <www.blood.gov.au>. 
There is an ongoing commitment to safe transfusion practice in health services through the Blood Matters Program.


2.2.8 Blood products funding

In 2017–18 Victoria will further progress blood products funding reform by continuing the process commenced in 2014–15 towards devolved blood budgets to health services.

Blood and blood products have historically been provided free-of-charge to public hospitals in Victoria and the budget centrally held and managed. In 2017–18 the department will continue to transition towards financial accountability for blood use by devolving funding responsibility to selected public hospitals that are major users.

If a health service’s total blood and blood product utilisation is greater than the adjusted virtual budget, then the health service will not be eligible for any incentive payment. The department will cover the entire over utilisation through its payment to the National Blood Authority. If a health service’s total blood and blood product utilisation is less than the adjusted virtual blood budget, then the health service will be eligible for an incentive payment.

The department, in conjunction with health services, will monitor this devolution of funding responsibility, to inform future blood and blood product funding policy.

2.2.9 Genetics program

Public genetic services in Victoria provide a range of clinical and laboratory genetic services. Services are provided in outpatient settings with hospital ward consultations provided as needed.

Entry to public genetic services is usually by referral from a general practitioner or medical specialist, but self-referral may occur. Public clinical genetic services are located at three metropolitan hubs:

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

There is also periodic clinical outreach to other metropolitan, regional and rural centres.

Public genetic testing is provided either in-house by the clinical provider or purchased from another Victorian laboratory. If a genetic test is not available in Victoria, it may be sent to an interstate or overseas laboratory.

In 2017–18 the Victorian Government allocated an additional $8.3 million over four years for children and adults with rare diseases and undiagnosed conditions. This will facilitate a clinical diagnosis, thus avoiding the costly and lengthy diagnostic odyssey that many patients currently undergo.

This funding will support access to clinical genetic consultations, genetic counselling and genomic sequencing currently not funded under Medicare. The clinical care will be provided through the metropolitan hubs, including to regional and rural Victoria through outreach clinics; genomic sequencing will be provided by accredited laboratories.

Clinic activity will be reported through AIMS.

2.2.10 Pharmaceuticals

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

2.2.10.1 Pharmaceutical reform

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

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


2.2.10.2 Highly Specialised Drugs Program

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

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

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

The prescribing doctor must be affiliated with the specialised hospital unit. Health services are reimbursed for the medicine supplied, less a patient co-payment, via claims submitted to Medicare Australia. Further information about the Highly Specialised Drugs Program is available at https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/pharmaceuticals/highly-specialised-drug-program.

2.2.10.3 Direct acting antiviral hepatitis C treatments

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

2.2.11 Total parenteral nutrition

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

Service targets were introduced in 2016–17, based on the latest 12 months of activity. In 2017–18 these service targets have been updated based on the latest 12 months of activity. A recall/throughput adjustment will be applied at the full rate at the end of 2017–18 for health services whose activity is below or over target.

2.2.12 Home enteral nutrition

Service targets were introduced in 2016–17, based on the latest 12 months of activity. In 2017–18 these service targets have been updated based on the latest 12 months of activity. A recall/throughput adjustment will be applied at the full rate at the end of 2017–18 for health services whose activity is below or over target.
2.3 Subacute inpatient services (Subacute WIES)

2.3.1 Admission policy

Please refer to the admission policy under Chapter 2, section 2.1.1 ‘Admission policy’.

2.3.2 Classification, counting and costing


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

The AN-SNAP classification was developed as a casemix classification for subacute and non-acute care patients in a national study conducted by the Centre for Health Service Development, University of Wollongong in 1997. The report of the study is available at <http://ahsri.uow.edu.au/Publications/pre2001_pubs/snapstudy1997.pdf>.

AN-SNAP is a casemix classification that includes four subacute care types (rehabilitation, palliative care, geriatric evaluation and management and psychogeriatric care) and one non-acute care type (maintenance care). AN-SNAP classifies subacute and non-acute patient care provided in inpatient, outpatient and community settings. Patients are classified on the basis of setting, care type, phase of care, assessment of functional impairments, age and other measures.

In December 2013, the Centre for Health Service Development, University of Wollongong was commissioned by the Independent Hospital Pricing Authority to develop version 4 of the AN-SNAP classification which comprises 130 classes. The admitted branch of the classification contains 83 classes for subacute overnight episodes/phases, six for subacute same-day admissions and six for non-acute episodes and explains 55 per cent of the variation in cost. The non-admitted branch of AN-SNAP V4 comprises 35 classes but will not be used to fund non-admitted subacute in 2017–18.

The key changes of AN-SNAP V4 are:

- A change in the description of the two major branches from ‘overnight’ and ‘ambulatory’ to ‘admitted’ and ‘non-admitted’.
- A change in the order of the care type sub-branches within the admitted and non-admitted branches to improve consistency with national definitions.
- The introduction of four character alpha numeric code for AN-SNAP V4 classes.
- The introduction of paediatric classes for the palliative care, rehabilitation and non-acute care types.
- The inclusion of six same-day admitted classes (one each for rehabilitation, palliative care, psychogeriatrics, geriatric evaluation and management, paediatric rehabilitation and paediatric palliative care) in the admitted branches.
- The removal of ‘assessment only’ classes from the classification.
- The removal of the bereavement class from admitted and non-admitted palliative care branches.
- Minor refinement to the positioning of age and clinical splits in the admitted branches.
- The introduction of delirium and dementia diagnoses as variables in the admitted geriatric evaluation and management classes.
- The removal of non-admitted non-acute (maintenance) classes.

Although same-day admissions are not funded through Subacute WIES.
• The removal of the Functional Independence Measure (FIM™) cognitive sub-scale from the admitted geriatric evaluation and management branch and from the non-admitted branches.
• The removal of single discipline classes from the non-admitted.

AN-SNAP technical specifications can be found in Chapter 3, Appendix 3.3 ‘Australian National Subacute and Non-acute Patient Classification technical specifications’.

Note that all geriatric evaluation and management episodes are required to submit a complete FIM™ score, including the cognitive sub-scale, when reporting into the VAED. AN-SNAP technical specifications can be found in Chapter 3, Appendix 3.3 ‘Australian National Subacute and Non-acute Patient Classification technical specifications’.

There will be one type of loading applied to the Subacute WIES model:
• Indigenous status (based on self-reported Aboriginal or Torres Strait Islander status).

In 2017–18 Subacute WIES cost weights have been rebased to reflect updated cost data.

All metropolitan, regional and sub-regional health services are delineated to provide rehabilitation and GEM services through the Subacute capability framework. Local health services delineated as level 2 (and Swan Hill) will provide and report maintenance care. The framework can be found at <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/subacute-planning>. Targets for these health services can be found in Chapter 5, ‘Table 5.15: Admitted subacute and non-acute targets (Subacute WIES2) 2017–18’.

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

A Program Identifier for Specialist Acquired Brain Injury (ABI) Rehabilitation Service (code 09) is to be reported for patients in the two designated specialist ABI rehabilitation services located at Caulfield Hospital, Alfred Health and the Royal Talbot Rehabilitation Centre, Austin Health.

Each AN-SNAP class (subacute and non-acute care types) has a number of classification elements. The classifications are outlined in Chapter 4, section 4.12.4 ‘Subacute data reporting requirements’.

2.3.2.1 Care type

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

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

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

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

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

The national care type definitions are outlined below. The National Minimum Dataset definitions can be found at the metadata online registry (METeOR) online registry at <www.aihw.gov.au>.
Rehabilitation
Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating in rehabilitation.

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

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

Geriatric evaluation and management is always:
• managed by a clinician with special expertise in geriatric evaluation and management
• evidenced by an individualised multidisciplinary management plan that is documented in the patient’s medical record, which includes negotiated goals within indicative timeframes and documented assessment of functional ability.

Palliative care
Palliative care is care in which the primary clinical purpose or treatment goal is optimising quality of life for a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.

Palliative care is always:
• managed or informed by a clinician with specialised expertise in palliative care
• evidenced by an individualised multidisciplinary assessment and management plan that is documented in the patient’s medical record; it covers the physical, psychological, emotional, social and spiritual needs of the patient and their negotiated goals.

The National Standards for Providing Quality Palliative Care define the patient, their carer and family as the unit of care. The needs of carers and families should be addressed in the patient’s management plan. The plan should outline the negotiated goals of care evidenced by a collaborative approach with the patient and/or their family.

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

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

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

Only one care type can be assigned at a time. In cases where a patient is receiving multiple types of care, the care type that best describes the primary clinical purpose or treatment goal should be assigned. It is essential that any change in care type is supported by documentation reflecting the change in purpose and goal of care. Care type changes must be reported in accordance with VAED business rules.
The care type is assigned by the clinician responsible for managing the care, based on clinical judgements as to the primary clinical purpose of the care provided and, for subacute care types, the specialised expertise of the clinician who will be responsible for managing the care.

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

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

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

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

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

### 2.3.2.3 Counting patients

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

Funding for subacute admitted services is based on episodes for eligible care types (see Chapter 3, Appendix 3.4 ‘Calculating Subacute WIES for individual patients’). The following episodes are not eligible for Subacute WIES funding:

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

#### Counting and reporting geriatric evaluation and management activity

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

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

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

It is expected that health services maintain and report subacute costing data, as for acute costing data. The requirements are outlined in Chapter 2, section 2.1.2.3 ‘Costing patients’.

2.3.3 Pricing

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

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

See Chapter 3, section 3.1 ‘Price tables’.

2.3.4 Adjustments

Subacute WIES is adjusted for the loading for Indigenous patients. The loading for Indigenous status is 30 per cent.
2.4 Acute Specialist Clinics (Weighted Ambulatory Service Event)

2.4.1 Admission policy

Please refer to the admission policy under Chapter 2, section 2.1.1 ‘Admission policy’.

Only acute non-admitted services that are not funded by another Victorian funding model are eligible to be funded under the acute non-admitted specialist clinics Weighted Ambulatory Service Event (WASE) funding model.

2.4.2 Classification, counting and costing

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

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

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

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

Classification rules exist to guide the decision making regarding which Tier 2 class a clinic should be classified to. The Independent Hospital Pricing Authority has developed a suite of two reference documents to assist with the consistent allocation of non-admitted services to a Tier 2 class:

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


Tier 2 technical specifications can be found in Chapter 3, Appendix 3.6 ‘Weighted Ambulatory Service Event technical specifications’.

2.4.2.1 Counting patients

The Weighted Ambulatory Service Event (WASE) model is based on the ‘service event’ unit of count.

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

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

Care provided to two or more patients by the same service provider(s) at the same time can also be referred to as a group session when the patients within the group receive the same service. One service event is recorded for each patient who attends a group session regardless of the number of healthcare providers present, where the definition of a non-admitted patient service event is met.

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

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

Further Tier 2 technical specifications can be found in Chapter 3, Appendix 3.6 ‘Weighted Ambulatory Service Event technical specifications’.


### 2.4.2.2 Costing patients

It is expected that health services maintain and report subacute costing data, as they would for acute costing data. For details see Chapter 2, section 2.1.2.3 ‘Costing patients’.

### 2.4.3 Pricing

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

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

See Chapter 3, section 3.1 ‘Price tables’.

### 2.4.4 Adjustments

Acute non-admitted specialist clinics are adjusted for the loading for review patients. The adjustment for review patients is -20 per cent.

A new service event is defined as a patient seeing a specialist for the first time in an episode. A patient can have more than one new service event in the same episode if the patient receives care from multiple specialists. There can only be one new service event per speciality in the one episode.

A review service event is defined as a second or subsequent service event in the same clinic for the continuing management or treatment of the same condition. If a patient sees a clinician for a second or subsequent time but a new episode has been opened (and the previous episode closed), the service event will be recorded as new, rather than review.

Tier 2 technical specifications can be found in Chapter 3, Appendix 3.6 ‘Weighted Ambulatory Service Event technical specifications’.
### 2.4.5 Exclusions

The majority of non-admitted acute patient service events reported to the AIMS S10 data collection, will be allocated a Weighted Ambulatory Service Event cost weight. However, a cost weight will not be allocated for Tier 2 clinics that are funded by another Victorian Funding model. Excluded Tier 2 clinics are shown in Table 2.3.

#### Table 2.3: Tier 2 groups excluded from WASE1

<table>
<thead>
<tr>
<th>Tier 2 clinic v4.1</th>
<th>Description</th>
<th>Note/relevant funding model</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.10</td>
<td>Renal Dialysis – Hospital Delivered</td>
<td>Weighted Inlier Equivalent Separation</td>
</tr>
<tr>
<td>10.12</td>
<td>Radiation Oncology (Treatment)</td>
<td>Radiotherapy Weighted Activity Unit</td>
</tr>
<tr>
<td>10.15</td>
<td>Renal Dialysis – Haemodialysis – Home Delivered</td>
<td>Home renal dialysis</td>
</tr>
<tr>
<td>10.16</td>
<td>Renal Dialysis – Peritoneal Dialysis – Home Delivered</td>
<td>Home renal dialysis</td>
</tr>
<tr>
<td>10.17</td>
<td>Total Parenteral Nutrition – Home Delivered</td>
<td>Total Parenteral Nutrition (TPN)</td>
</tr>
<tr>
<td>10.18</td>
<td>Enteral Nutrition – Home Delivered</td>
<td>Home Enteral Nutrition (HEN)</td>
</tr>
<tr>
<td>10.19</td>
<td>Home Ventilation</td>
<td>Victorian Respiratory Support Service, Family Choice Program</td>
</tr>
<tr>
<td>10.20</td>
<td>Radiotherapy (simulation and planning)</td>
<td>Radiotherapy Weighted Activity Unit</td>
</tr>
<tr>
<td>20.06</td>
<td>General Practice and Primary Care</td>
<td>Commonwealth program</td>
</tr>
<tr>
<td>20.08</td>
<td>Genetics</td>
<td>Genetic Clinical Activity/Genetic Counselling and Information/Genetic Testing/Screening</td>
</tr>
<tr>
<td>20.43</td>
<td>Radiation Oncology (Consultation)</td>
<td>Radiotherapy Weighted Activity Unit</td>
</tr>
<tr>
<td>30.01</td>
<td>General Imaging</td>
<td>Out of scope</td>
</tr>
<tr>
<td>30.02</td>
<td>Medical Resonance Imaging (MRI)</td>
<td>Out of scope</td>
</tr>
<tr>
<td>30.03</td>
<td>Computerised Tomography (CT)</td>
<td>Out of scope</td>
</tr>
<tr>
<td>30.04</td>
<td>Nuclear Medicine</td>
<td>Out of scope</td>
</tr>
<tr>
<td>30.05</td>
<td>Pathology (Microbiology, Haematology, Biochemistry)</td>
<td>Out of scope</td>
</tr>
<tr>
<td>30.06</td>
<td>Positron Emission Tomography (PET)</td>
<td>Out of scope</td>
</tr>
<tr>
<td>30.07</td>
<td>Mammography Screening</td>
<td>Out of scope</td>
</tr>
<tr>
<td>30.08</td>
<td>Clinical Measurement</td>
<td>Out of scope</td>
</tr>
<tr>
<td>40.02</td>
<td>Aged Care Assessment</td>
<td>Commonwealth program</td>
</tr>
<tr>
<td>40.08</td>
<td>Primary Health Care</td>
<td>Commonwealth program</td>
</tr>
<tr>
<td>40.27</td>
<td>Family Planning</td>
<td>Family Planning</td>
</tr>
<tr>
<td>40.33</td>
<td>General Counselling</td>
<td>Commonwealth program</td>
</tr>
<tr>
<td>40.34</td>
<td>Specialist Mental Health</td>
<td>Non-admitted mental health</td>
</tr>
</tbody>
</table>
2.5 Subacute non-admitted services

2.5.1 Health Independence Program and community palliative care

In 2017–18 non-admitted subacute programs and services under the Health Independence Program and community palliative care will remain block-funded. These programs will receive an associated activity target (health services will receive an aggregate Health Independence Program activity target).

Services that do not meet the overall Health Independence Program target are subject to recall. Community palliative care targets for 2017–18 are not subject to recall.

Non-admitted targets by health service and program type can be found in Chapter 5, section 5.2.7 ‘Health Independence Program contact targets 2017–18’ and Chapter 5, section 5.2.8 ‘Community palliative care contact targets 2017–18’.

Community palliative care

Our growing and ageing population, combined with the prevalence of chronic progressive disease and people’s preferences about care, is increasing demand for Victoria’s palliative care services and challenging existing service delivery models.

The Victorian Budget 2017–18 allocated non-admitted palliative care growth funding of $6.2 million. This investment will improve access to specialist palliative care advice and enable services to deliver person-centred care according to the person’s preferences, values and goals. It will provide home-based care that is coordinated and responsive to people’s end-of-life and palliative care needs, including improved carer support.

This investment also aims to increase the proportion of home-based deaths for those who choose to die at home, and improve clinical outcomes including pain/symptom management and carer/family support. It will deliver more effective and efficient healthcare outside acute hospital settings. This will reduce unnecessary emergency presentations and acute hospital admissions for community palliative care clients, thereby freeing up hospitals to better respond to acute care demand.

2.5.1.1 Counting unit

In 2017–18 the counting unit for Health Independence Program and community palliative care activity will continue to be a ‘contact’, which is reported in the VINAH dataset. The definition of a Health Independence Program and community palliative care contact is defined in the VINAH business rules.

Health Independence Program

The Health Independence Program counting unit will be ‘direct non-admitted contacts’. Contacts where all of the following VINAH characteristics are met will count as contacts:

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

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

Work will continue to review the Health Independence Program price and service stream weights to
better reflect stream costs over 2017–18. Further work to improve the Health Independence Program
classification data, including potential VINAH refinements for 2018–19 will also continue.

Community palliative care

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

2.5.1.2 Reporting of activity

The Victorian Integrated Non-Admitted Health dataset is the data collection on which recall will be based.

In 2017–18 the activity level of each community palliative care provider will not be subject to funding
recall or additional payments.

It is expected that health services maintain and report non-admitted subacute costing data as detailed in
Chapter 2, section 2.1.2.3 ‘Costing patients’.

2.5.2 Victorian Artificial Limb Program

Funding for the Victorian Artificial Limb Program will continue to be provided as a block grant to health
services as a non-admitted subacute service. Victorian Artificial Limb Program services are required to
report service events as a non-admitted subacute service through the AIMS S11 form. Services expected
to provide artificial limbs under the Victorian Artificial Limb Program in 2017–18 are: The Royal Children’s
Hospital, Peninsula Health, Melbourne Health, Alfred Health, Barwon Health, Ballarat Health Services,
Austin Health, St Vincent’s Health, Latrobe Regional Hospital, Bendigo Health and South West
Healthcare.

To monitor maintenance of effort, the pre-existing annual activity statement regarding limbs and repairs,
including expenditure, will also be required for 2017–18.

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

Recall will not apply to Victorian Artificial Limb Program activity in 2017–18.

2.5.3 Victorian Respiratory Support Service

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

Recall will not apply to Victorian Respiratory Support Service activity in 2017–18.

2.5.4 Palliative care consultancy services

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

Consultancy services provide advice and support to treating teams in hospitals and in the community.
Consultancy services also provide direct clinical care, assessment and advice for clients and carers with
complex needs. This means that the treating team can maintain care of the person with a life-limiting
illness and address their pain, symptoms and psychological, social and spiritual concerns. Consultancy
services work across acute and subacute services and have an increasing presence in outpatient clinics. Consultancy services assist in coordinating discharge planning with community palliative care services where patients wish to be cared for and/or die at home and transition to other specialist inpatient, subacute or residential locations.

Palliative care consultancy services provide specialist advice and support to services in the community, including community palliative care services and residential facilities, enabling them to meet the very complex needs of clients that otherwise would necessitate admission to hospital.

Consultancy services also provide education and training about palliative care to other clinicians and provide palliative care input to cancer tumour streams and chronic disease management meetings.

Funding for hospital-based palliative care consultancy is part of the price paid for acute inpatient activity. There is no activity target for hospital-based palliative care consultancy activity in 2017–18. Funding for regional palliative care consultancy teams is provided as a block grant in 2017–18. In the majority or regions, this funding includes aged and disability link nurses. This funding is recurrent. There is no activity target for regional palliative care consultancy in 2017–18.

Funding for statewide palliative care consultancy teams is also provided as a block grant in 2017–18. Statewide consultancy services include the Victorian Paediatric Palliative Care Program, Very Special Kids and the Australian Centre for Grief and Bereavement.

Recall does not apply to specified grants for palliative care consultancy services in 2017–18.

2.5.5 Day hospice

Funding for day hospice services has been provided as part of the subacute palliative care non-admitted grant line since 2013–14. Day hospice providers are required to submit activity information using the AIMS S11 form. Recall will not apply for day hospice services in 2017–18.
2.6 National programs

2.6.1 Nationally Funded Centres

The objectives of the Nationally Funded Centres program are to ensure there is optimal access for all Australians to certain high-cost, low-demand, new and emerging technologies. While the program operates nationally, funding for this program is provided by states and territories, not the commonwealth. Health services that provide Nationally Funded Centres services will be funded in advance, based on estimated activity and the Nationally Funded Centres Program-determined cost per procedure. This figure will then be adjusted after the financial year to reflect actual activity. The health services that provide Nationally Funded Centres services are Alfred Health, Austin Health, The Royal Children’s Hospital, Monash Health and St Vincent’s Hospital.

Nationally Funded Centre status for the Norwood procedure and staged surgical palliation for hypoplastic left heart syndrome will cease from 1 July 2017, but will continue to be provided and funded under WIES in 2017–18.

2.6.2 Transition Care Program

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

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

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

The Victorian Government subsidy in 2017–18 is $152 per client per day for bed-based places and $56 per client per day for home-based places (see Chapter 3, section 3.1 ‘Price tables’).

The Commonwealth Government subsidy component in 2017–18 was not available at the time of releasing this report and will be made known to health service Transition Care Program managers once declared. It usually consists of a basic rate and the dementia and veterans’ supplement equivalent per occupied place per day and is applicable to both home and bed-based places.

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

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

The state-funded component of the Transition Care Program is subject to recall for under performance as outlined in the recall policy detailed in these guidelines.
The Commonwealth Government continues to implement its aged care reforms. All Transition Care Program referrals are received via the My Aged Care provider portal. It is imperative that program staff ensure that clients have current approvals to avoid loss of the commonwealth subsidy component for episodes of care. Approvals can be verified with ACAS or online with Medicare.
2.7 Ambulance Victoria

The Victorian Government funds clinically necessary transport for concession patients, primarily pensioners and Health Care Card holders. The government provides this funding to Ambulance Victoria, which is responsible for delivering these transports. Ambulance Victoria’s Membership Subscription Scheme insures patients against Ambulance Victoria ambulance transport costs. The membership subscription scheme fees will be indexed and are due to rise by 2.5 per cent in 2017–18. A single 12-month membership is now $46.00 and a family 12-month membership is $92.05.

Ambulance Victoria also receives fees from a number of third parties that have responsibility for the transport of patients using Ambulance Victoria service including:

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

2.7.1 Fee structure

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

- All payers paying the same for each service (noting that the fixed charge is based on respective usage by payers maintaining the same approach as 2016–17).
- Emergency road: a single flat fee for metropolitan of $1,204 and a single flat fee for regional and rural of $1,776.
- Non-emergency road (stretcher): a single flat fee for metropolitan of $325 and a single flat fee for regional and rural of $549.
- Non-emergency road (clinic car): a single flat fee of $107.
- Treatment without transport (an ambulance attends but does not transport): a single flat fee of $519.
- Fixed-wing: reflecting the cost of service delivery, these fees include a fixed and variable charge (the fixed charge is based on respective usage by payers; the variable charge is $2,134).
- Rotary: the fee structure for air services will be maintained in 2017–18, with fees increased by indexation and, for rotary transports, the increased costs borne under the contract for the new helicopter fleet. The mechanism for payment of the fixed component of the air fees for major users will remain unchanged as an upfront grant, except for institutional payers whose legislative arrangements prevent this. These payers will pay the fixed and variable component per transport. General patients will continue to pay the variable component only, which is $10,737. The department will continue to collect the fixed component fee from health services to pay Ambulance Victoria.

Price tables are included in Chapter 3, section 3.1 ‘Price tables’.

A number of additional services provided through Ambulance Victoria will be funded directly or are included as loading in the above costs. For example, adult retrieval services.
In addition to the funding provided directly to Ambulance Victoria, the government also provides funding to Victoria’s health services for the interhospital transfer of patients (for example, the transfer of patients between health services or between the different campuses of a health service). Health services have discretion as to which patient transport provider they choose to engage to transfer patients – either Ambulance Victoria or from a range of private non-emergency patient transport providers that are licensed by the department. Timely payment for ambulance transports provided through Ambulance Victoria is expected under normal commercial terms.
2.8 Mental health acute admitted

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

In 2017–18, funding for admitted mental health activity will be distributed to health services based on the bed capacity that is available at each health service, with the number of bed days available. Adult, child, aged and specialist bed types will receive the same price regardless of the location of the health service.

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

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

In 2017–18, acute – child and adolescent, adult, aged and specialist care provided by health services that deliver admitted inpatient mental healthcare will be reimbursed based on a single unit price, irrespective of the bed setting or patient characteristics.

The health service target will be based on the health service’s total number of acute – child and adolescent, adult, aged and specialist bed days.

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

The unit price is not intended to reimburse health services for the total cost of providing admitted care, as there are a number of supplementary funding grants. The transition grant and other mental health specified grants contribute to meeting the costs of mental health admitted care (for example, in 2017–18, grants to support allied health and medical workforce on weekends and additional EFT allocated to enhance quality and safe care).

2.8.2 Transition funding

As funding for admitted mental healthcare progresses towards a single price, and to ensure budget stability for health services, a supplementary transition grant (block funding) has been applied in 2017–18. This transition grant will be reviewed during 2017–18.
2.9 Mental health non-admitted

Victoria’s non-admitted mental healthcare encompasses clinical community care and non-admitted bed-based treatment services (prevention and recovery care services, community care units and residential beds).

Clinical community care
Clinical community care consists of a range of community-based clinical services, including bed substitution programs provided to people with a mental illness. As a national mental healthcare model encompassing non-admitted mental health patients is yet to be developed, existing funding arrangements will continue for these services in 2017–18.

2.9.1 Mental health outputs
Targets for the number of service hours to be provided are set per health service and are calculated on the hours of service provided per clinician and adjusted for historical and projected service levels. A funding rate of $396 per service hour has been used in setting ambulatory targets.

Targets for 2017–18 are provided in Chapter 5, section 5.2.14 ‘Mental health ambulatory targets 2017–18’.

Non-admitted bed-based treatment services
The full-year effect of the Social and Community Services union pay equity outcomes has been rolled into the prevention and recovery care price in 2017–18.

2.9.2 Mental health community support services
The Mental Health Community Support Services (MHCSS) program is an integral part of the Victorian Government’s specialist mental health service system.

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

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

These and other selected MHCSS activity types will be delivered within a new outcome-focused accountability framework that has been designed to strengthen agency accountability and transparency for delivering tangible benefits for clients and inform policy and service-level improvement.

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

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

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

In-scope MHCSS programs will fully transition to the National Disability Insurance Scheme by June 2019. In-scope programs include Individualised Client Support Packages, Adult Residential Rehabilitation and selected Supported Accommodation Services.
2.9.3 Performance targets

Funding for Mental Health Community Support Services activities is output-based. Statewide targets are set out in the Victorian State Budget paper No 3. Targets for MHCSS activities are listed in the Funding and Service Agreement and these represent the minimum deliverables expected for the funding provided. See Chapter 4, section 4.2.2 ‘Mental health services’ for more information.

Targets for Individualised Client Support Packages, Adult Residential Rehabilitation and Supported Accommodation Services will be reduced as these activity types progressively transition to the National Disability Insurance Scheme from 1 July 2016 to 30 June 2019.

2.9.4 National Disability Insurance Scheme

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

Victoria’s contribution to the NDIS includes $77 million in Mental Health Community Support Services (MHCSS) funding each year. MHCSS activity types in scope to transition to NDIS include: Individualised Client Support Packages; Adult Residential Rehabilitation Services; and selected Supported Accommodation Services.

The NDIS is being progressively rolled-out across Victoria over a three-year period. Transition has commenced in North-East Melbourne and the Central Highlands areas. The NDIS commenced full scheme in Barwon on 1 July 2016. Victoria will transition to the full scheme by 30 June 2019.

The Victorian Government is working closely with the National Disability Insurance Agency to support a phased implementation of the National Disability Insurance Scheme (NDIS). Victoria will be responsible for quality and safeguards for existing and new providers during the transition period.

There is also a commitment to Aboriginal people with psycho-social disability who are eligible for National Disability Insurance Scheme funding to enable them to choose to purchase services from Aboriginal community-controlled organisations and/or culturally responsive mainstream services. This is supported by the Aboriginal social and emotional wellbeing framework as part of Victoria’s 10-year mental health plan.
2.10 Alcohol and drug services

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

- The majority of adult non-residential services are delivered across defined geographic areas and have been provided on the basis of a drug treatment activity unit since September 2014.
- Adult residential services, Aboriginal and youth-specific services and some out-of-scope non-residential services are funded on the basis of an episode of care.
- Other drug treatment activities such as research, local initiatives and pharmacotherapy programs continue to be funded on the basis of a block grant.

The main mechanism for funding drug prevention and control activities are based on block grants and submissions.

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

2.10.1 Service expansion

In 2017–18 there will be improvements to treatment and support services including:

- Expanded capacity in the treatment system to support those affected by ice, alcohol and other drugs across Victoria. This includes expanding drug treatment and harm reduction services as part of Stage Three of the Ice Action Plan. The new initiatives include:
  - $8.7 million to further increase the number of residential rehabilitation beds. Thirty new beds will be established within existing services, providing a short-term boost to capacity.
  - $17 million to provide better access to treatment services for up to 3,800 parents each year to help them meet court requirements and reunify their families.
  - $9.1 million to provide 960 treatment places for people on community correction orders to receive support and get back on their feet.
  - $12.4 million to expand the support available to people when transitioning into or out of treatment services. A critical time when they are at a higher risk of harm.
  - $4.0 million to strengthen alcohol and other drug treatment data systems.
  - $6 million to expand the current 24/7, 7-day-a-week system of alcohol and drug-specific web and phone-based services and support for at-risk groups.

- Additional service enhancements announced as part of the Victorian Budget 2017–18 included:
  - $14.2 million to expand Aboriginal-specific alcohol and drug services with the creation of new adult and youth Aboriginal AOD worker positions.
  - $17.3 million to increase family violence expertise across mental health and alcohol and other drug services.

- Continued implementation of:
  - Additional residential withdrawal services at local hospitals in three rural regions and through the new Mother and Baby Unit.
  - Expansion in youth services, focusing on building the capacity for services to support vulnerable and at-risk young people experiencing alcohol and drug issues.
  - Training and support to better equip frontline workers to deal with people affected by ice.
  - Therapeutic day rehabilitation programs rolled out in 2015–16 under the Ice Action Plan.
  - Additional treatment services to support drug offenders seen through the expanded Drug Treatment Court.
  - New service models to better meet the needs of Aboriginal community members affected by ice through the Aboriginal Metropolitan Ice Partnerships.
  - Expanded intake and assessment, counselling and residential rehabilitation services through Corrections Growth Funding.
2.11 Ageing, aged and home care services

Ageing, aged and home care unit prices are provided at Chapter 3, section 3.1 ‘Price tables’.

2.11.1 Aged Care Assessment Services

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

Aged Care Assessment Services are jointly funded by the Victorian and Commonwealth Governments to 30 June 2018.

2.11.2 Regional assessment services

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

The department will manage the Home Support Assessment function in Victoria on behalf of the commonwealth for the period 1 July 2016 to 30 June 2019.

Designated Assessment Services in Victoria will receive commonwealth funding through their Funding and Service Agreement to undertake Home Support Assessment as part of a regional assessment service. The requirements to undertake Home Support Assessment will be detailed in the Funding and Service Agreement and guidelines for Home Support Assessment in Victoria.

Designated assessment services will also continue to provide assessment services for the Victorian Government-funded HACC program for younger people.

2.11.3 Home and Community Care

Targeted to people aged under 65 (and Aboriginal people aged under 50) with disabilities and their carers, the Home and Community Care (HACC) program is funded by the Victorian Government to provide a range of services in the home or in healthcare or community-based agencies. The goal of the program is to allow participants to continue living in their homes and their communities.

In excess of 400 organisations, including local councils, will continue to receive funding to support younger people by providing a range of services including domestic assistance, personal care, nursing, allied health and social support. Funding for the most recurrent services in Victoria is based on a published set of unit prices per hour or other unit of service to determine the output targets for each service provider. Outputs are reported and monitored via the HACC minimum dataset.


Recurrent funds may be recalled from service providers. See Chapter 2, section 2.18.1 ‘Victorian funding recall policy’.

The Victorian and Commonwealth Governments have committed to implement the NDIS from July 2016.
As part of this agreement, the previously jointly funded Home and Community Care program was split from 1 July 2016:

- Services for older Victorians (people aged 65 and over and aged 50 and over for Aboriginal and Torres Strait Islander people) are now directly funded and managed through the Commonwealth Home Support Programme by the Commonwealth Department of Health.
- Services for younger Victorians (people aged under 65 and under 50 for Aboriginal and Torres Strait Islander people) continue to be funded and managed by the department.
- Some HACC clients aged less than 65 will transfer to the National Disability Insurance Scheme as it rolls-out in Victoria.

The commonwealth has committed to a three-year period of stability for funds allocated to services for older people under the Commonwealth Home Support Programme. The Victorian Government has committed to funds stability for services for younger people subject to funds transferring to the NDIS as it is implemented across Victoria. Victoria and the commonwealth have agreed to retain the benefits of the current Victorian HACC system as follows:

- The department will continue to manage the assessment function until 30 June 2019 and will integrate these services to operate in the My Aged Care system (see below).
- Victoria and the Commonwealth Government have developed a jointly resourced Service Development and Change Management Framework that will ensure that service development, planning and change management continue to be coordinated and supported.
- The significant role of local government in Victoria as service planners and developers, funders and service providers for older people will be recognised through a trilateral Statement of Intent with local government represented by the Municipal Association of Victoria and the Commonwealth and Victorian Governments.
- A connected approach to service delivery will continue.

### 2.11.4 Aged support services

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

#### 2.11.4.1 Supported residential services and accommodation support

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

#### 2.11.4.2 Personal Alert Victoria

Personal Alert Victoria is a daily monitoring and emergency response service for frail older people and people with a disability who have high ongoing health and support needs and mostly live alone. Personal Alert Victoria aims to keep clients living independently for as long as possible. More than 27,000 Victorians are assisted by Personal Alert Victoria with a budget of $10.0 million in 2017–18.

Personal Alert Victoria relies on nominated contacts (such as family, friends and neighbours) providing assistance to respond to calls, ensuring public emergency services are utilised effectively.

The Personal Alert Victoria response service is used when people do not have any relatives or other contact people. About 15 per cent of Personal Alert Victoria clients use the Personal Alert Victoria response service ($2.5 million per annum).
2.11.4.3 Support for Carers Program

The Support for Carers Program provides $17.1 million distributed to 49 agencies for services for people in care relationships where other services are not available or where clients are not eligible for other services. Services may include respite, information, advice, counselling and subsidised goods and equipment.

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

2.11.4.4 Victorian Eyecare Service

The Victorian Eyecare Service provides subsidised eyecare and visual aids to people experiencing disadvantage via metropolitan, outreach and rural services. The Victorian Eyecare Service is delivered by the Australian College of Optometry in Melbourne metropolitan regions and private practice optometrists in rural regions. The Victorian Eyecare Service funding is $6.6 million, which delivers 75,800 occasions of service.

2.11.4.5 Dementia services

The Support for Carers Program provides additional support for carers of people with dementia (including young people with dementia) through ten agencies.

Funding to Alzheimer’s Australia (Victoria) for support, counselling, education and training, Dementia Awareness Week activities and commonwealth–state HACC funding for dementia service hubs in regional centres and café style support services totals $2.6 million in 2017–18.

2.11.5 Public sector residential aged care

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

In 2017–18 the department will continue to provide top-up funding to designated PSRACS to support the viability of small rural services, services supporting residents with specialised care needs and additional costs of the public sector workforce. This includes continuation of the unit priced funding approach for high-care and low-care beds in designated services, as introduced in 2011–12.

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

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

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

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

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

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

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

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

**2.11.6 Seniors programs and participation**

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

2.12.1 Small rural health services

Small rural health services (SRHS) will continue to be funded through the existing SRHS funding model as applied in 2016–17 for the 42 SRHS (including the seven multipurpose services) that deliver public admitted acute services in Victoria.

An independent review of the SRHS funding model in 2014–15 found that:

- activity is the dominant driver of the costs incurred
- there is a cost premium for delivering services in rural areas
- there are operational (fixed) costs for staying open regardless of the level of activity delivered.

The department is undertaking a staged implementation of a revised funding model based on this review. The model will maintain organisations’ flexibility to determine service mix and models of care in order to meet local needs, but will increase accountability, transparency and equity.

A detailed implementation plan has been developed and project governance arrangements, including a sector advisory committee, have been established. It is proposed that the funding model will be shadowed in 2017–18.

The description of SRHS outputs and activities are provided in Chapter 3, section 3.5 ‘Output and activity tables’ (see Chapter 3, ‘Table 3.27: Small rural health services 2017–18’). Funding arrangements for public sector residential aged care services are outlined in section Chapter 2, section 2.11.5 ‘Public sector residential aged care’.

2.12.2 Rural and Regional Health Partnerships

Seven Rural and Regional Health Partnerships have been established in rural Victoria to drive quality and safety consistency and enhanced clinical governance support, especially for smaller health services. Funding of $300,000 will be provided to regional health services in 2017–18 to support the coordination and leadership of regionally-established priorities.

In 2016–17, the Rural and Regional Health Partnerships were asked to focus on the relevant recommendations of Targeting zero, the review of hospital quality and safety assurance in Victoria. In particular, clinical governance oversight and support. The partnerships will continue this focus in 2017–18, and also work with Safer Care Victoria and the department to establish consistency in the support mechanisms for clinical governance oversight, as well as a further focus on regional mortality and morbidity committees.

The guidelines for the partnerships will be reviewed in 2017–18. Health services will be asked for feedback on the effectiveness of the partnership approaches.

2.12.3 Small rural health service funding model implementation

The focus for SRHS in 2017–18 will be:

- ensuring that all activity and costing data is recorded and reported accurately
- that the service mix is reflective of community needs.

These factors will improve data integrity to support the move to the new funding model. During 2017–18, SRHS will be provided with their data aggregated as small rural weighted activity units against expected levels, based on their funding received in 2016–17.

In preparation for the new funding model, the department has rolled up a number of existing grants in 2017–18 to better align with the activities delivered. This consolidation of grants will be expanded in 2018–19. The total value of the grants for each health service will remain the same. Please refer to the ‘parameters sheet’ for further information on how grant lines have been consolidated.
Updates on the development of the new funding model will be provided to the sector throughout 2017–18.

2.12.4 Contract negotiations with visiting medical officers

Visiting medical officers operating under contractual arrangements remain a dominant feature of rural health services, which largely rely on the local general practitioner workforce to meet their operational needs.

Health services are obliged to ensure that contracts between hospitals and doctors:

- are current and transparent
- adequately document the services to be delivered
- are clear about the conditions of payment and status of the employee.

It is also imperative to ensure that contracts and associated practices comply with relevant legislation, policies and guidelines. Health services may obtain specific advice relating to contract negotiation from the Victorian Hospitals Industrial Association or from legal advisors.

As part of the contract, it is imperative to define the visiting medical officer’s employment status to determine whether he/she is an independent contractor or an employee. An employee is entitled to benefits which independent contractors cannot claim. Benefits include sick leave, long service leave and redundancy. A determination that a visiting medical officer is an employee of the health service carries a substantial risk to the health service, which should be appropriately mitigated.

Contracts should also establish a process to ensure the visiting medical officer is effectively performing against the contract and that the services being purchased are provided to expected standards.

2.12.5 Rural Enhancement Program Grant

The Rural Enhancement Program Grant has been provided to selected rural health services since 2007. The grant supports general practitioners who participate in a dedicated after-hours on-call roster for emergency presentations.

The rural enhancement program grant was rolled into price in 2012–13 for local health services funded through the WIES funding model. The value of the grant remains in the funding allocation.

The Rural Enhancement Program Grant will continue to be paid to small rural health services and to a number of bush nursing hospitals. Relevant services will be advised as to the value of the grant in 2017–18. These grants have not been consolidated ahead of the introduction of the small rural health service funding model implementation.

2.12.6 Bush nursing centres

As a result of the changes to HACC funding arrangements, bush nursing centres are no longer identified as HACC program funds. In 2016–17 payments were made under the Small Rural-Acute Health-Bush Nursing Centre activity and this will be continued for 2017–18. Bush nursing centres are to maintain their current service profile and provision, and should continue reporting to the HACC minimum datasets by sub-activity. The department will work with bush nursing centres to transition them to reporting via the Community Health minimum datasets, with the intention to start from 1 July 2018.

During 2017–18, the department and Safer Care Victoria will work with bush nursing centres to implement longer-term arrangements that best align with the bush nursing centre service model and government policy and administration. Consideration is being given to an ongoing quality and safety framework, clinical governance and funding model.
2.12.7 Director of Medical Services

The Victorian public healthcare system is predicated upon a medical leader being appointed in the role of Director of Medical Services or Chief Medical Officer for each health service. This role includes leading the development, monitoring and reporting of effective clinical governance systems; giving strategic guidance on service planning issues; and contributing towards the accreditation efforts of a health service.

The department recognises the critical function of this role. It will continue to work with health services in 2017–18 to address a number of issues identified in consultation with the sector, including:

- the limited definition of the position
- the varying role of the position across different models of medical management, particularly in rural and regional health services
- encouraging Rural and Regional Health Partnerships to collaboratively address clinical governance across rural services
- the supply and retention of suitably trained people to the position, particularly within rural and regional health services through participation in the Victorian tailored Associate Fellowship of the Royal Australasian College of Medical Administrators.

Outcomes of this body of work will be communicated to health services as work progresses.
2.13 Primary, community, public and dental health

2.13.1 Primary health services

2.13.1.1 Community health program

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

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

The community health program activities prioritise health services to the following population groups:

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

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

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

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

Additional support for specific population groups is also provided through:

- The Refugee Health Program, which aims to increase refugee and asylum seeker access to primary health services and assist newly arrived communities to improve their health and wellbeing.
- The Healthy Mothers, Healthy Babies Program which provides pregnancy, resilience and antenatal material support. This program aims to improve the health outcomes for pregnant vulnerable women and their babies.
- Early Intervention in Chronic Disease, which aims to assist people with chronic disease to improve their capacity to manage their condition, prevent complications and improve their health and wellbeing.
- The Community Health Nurse in sexual assault multidisciplinary clinics (MDCs) program. This program provides health needs identification, care planning, referral to appropriate services providers and education and awareness raising for victim/survivors of sexual assault.

Agencies receiving specific initiative funding are required to demonstrate that funds are targeted to meet the aims of the initiative. This is achieved through reporting requirements (refer to Chapter 4, section 4.12.9 ‘Primary, community and dental health data reporting requirements’).

The community health fees policy aligns with the Victorian HACC program policy. Further information about the HACC program and fees policy is available at <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/hacc-schedule-of-fees>.
Funding arrangements for Victoria’s health system


2.13.1.2 Health Condition Support Grants Program

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

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

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

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

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

2.13.1.3 Primary Care Partnerships

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

The key objectives for Primary Care Partnerships within their current strategy are:

- maximising health and wellbeing outcomes
- promoting health equity
- avoiding unnecessary hospital presentations and admissions
- improving e-health capability across the sector.

The program logic for Primary Care Partnerships has been extended to June 2018. During the next year, the Primary Care Partnership strategy and program logic will be reviewed to take account of the changing primary care and policy landscape.

2.13.2 Dental health

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

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

2.13.2.1 Participation in commonwealth initiatives

The Child Dental Benefits Schedule is a means-tested benefit scheme (Family Tax Benefit-A) for children aged 2–17 years covering preventative and basic dental treatment.

In December 2016, the commonwealth advised it would continue the Child Dental Benefits Schedule and retain public sector access, extending the scheme to 31 December 2019.
The commonwealth initially announced a reduced biennial cap of $700 per child from 1 January 2017. However, on 8 February 2017, the Commonwealth Minister for Health reinstated the Child Dental Benefits Schedule cap of $1000 per child over two years.

2.13.2.2 Dental Health Program fees policy

Fees for public dental services apply to:

- people aged 18 years and over who are Health Care or pensioner concession card holders or dependants of concession card holders
- children aged from birth to 12 years who are not Health Care or pensioner concession card holders and are not dependants of concession card holders.

Further information on the policy, including a fees schedule and exemptions, is available at <https://www2.health.vic.gov.au/primary-and-community-health/dental-health>.

2.13.2.3 Office of the Victorian Auditor-General audit – access to public dental services

The Victorian Auditor-General tabled the Access to Public Dental Services in Victoria audit in December 2016.

The report recommended:

- changes to current dental services arrangements to increase the relative focus on preventive efforts
- a range of changes to pricing, funding and performance management for State Government-funded dental services.

The department is working closely with Dental Health Services Victoria to progress the implementation of these recommendations.
2.14 Public health

2.14.1 Health promotion and primary prevention

The department invests in a range of activities that aim to reduce the likelihood of developing a disease or disorder. The focus is on environmental and behavioural measures, to eliminate the causes of poor health and wellbeing. Primary prevention aims to prevent problems occurring in the first place by eliminating or reducing underlying causes. This is achieved by controlling the exposure to risk, and promoting factors that protect health, wellbeing, safety and social outcomes. Examples include immunisation, tobacco control legislation, and universal maternal and child health services.

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

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

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

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

The plan also identifies three platforms through which change can be achieved: healthy and sustainable environments, place-based approaches and people-centred approaches. Place-based approaches focus on children’s settings, workplaces and communities to deliver an integrated approach to chronic disease risk factors.

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

The Victorian public health and wellbeing outcomes framework provides a new approach to monitoring and reporting on our collective efforts to improve Victorians health and wellbeing over the long term. It provides a comprehensive set of outcomes, indicators, targets and measures for our major population health and wellbeing priorities and their determinants. Where data is available, the framework also enables an assessment of health and wellbeing inequalities. The first report against the Victorian public health and wellbeing outcomes framework will be produced in 2018. A suite of public health and wellbeing ‘progress measures’ are being developed to assess change towards the achievement of population level changes. ‘Progress measures’ will be identified at state and local levels and a detailed data dictionary has been published.

2.14.1.1 Chronic disease prevention

The Victorian Government funds a range of strategies to reduce the risk factors for chronic disease. It is also delivering new legislation to limit smoking in outdoor dining areas and require large food chain outlets to display kilojoules against food items.

The Achievement Program provides an evidence-based framework to support workplaces, schools and early childhood education and care services to look at health and wellbeing within their organisation. The
framework supports these settings to determine what policy, cultural and environmental changes are needed to improve the health of their workers, students, children and the wider community. The framework is complemented by standards that inform best practice in areas such as healthy eating, physical activity, and mental health and wellbeing. Further information is available on the Achievements Program website <www.achievementprogram.health.vic.gov.au>.

Reducing risk factors for chronic disease through a place-based approach to prevention also includes increasing access to healthy food and drinks in places where people spend their time. The Healthy Choices policy guidelines suite is a framework for improving the provision and promotion of healthier foods and drinks that are available in the community through retail outlets, vending machines and workplace catering. The policy guidelines support the implementation of Healthy Choices in hospitals, health services, sport and recreation centres, workplaces and parks. Many health services are choosing to integrate the Healthy Choices policy guidelines into their retail food service contracts. The Healthy Choices policy guidelines can be found at <https://www2.health.vic.gov.au/public-health/preventive-health/nutrition/healthy-choices-for-retail-outlets-vending-machines-catering>.

The Healthy Choices policy guidelines have been integrated into the funding requirements for local government sport and recreation grants. This includes the 2017–18 Better Indoor Stadiums Fund and the 2018–19 Community Sports Infrastructure Fund in the criteria of the Better Pools category. These application guidelines can be found at <http://www.sport.vic.gov.au/grants-and-funding/our-grants>.

The Healthy Eating Advisory Service (HEAS) provides support for the implementation of the Healthy Choices policy guidelines by providing the skills and knowledge that organisations need to remove sugary drinks and increase healthy food choices. The service is changing the way that Victorian organisations think about food organisation by organisation, sector by sector. Their service is provided free to early childhood education and care services, schools, health services, workplaces, sport and recreation facilities, parks and universities. Further information is available on the Healthy Eating Advisory Service website <http://www.heas.health.vic.gov.au>.

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

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

Results for participants in the Life! program are collected quarterly.

Data collection and reporting requirements and the funding recall policy are provided in the relevant sections of these guidelines (Table 2.4 and Chapter 4, ‘Table 4.13: Public health data collection and reporting requirements’).

2.14.1.3 Hazelwood Mine Fire Inquiry – healthy and strong Latrobe

The department continues to support a strong whole-of-community approach to driving prevention, early detection and more effective management of chronic disease in the Latrobe Valley. It is also a key partner in the whole-of-government partnership with the Latrobe Valley community to build a stronger future for the region.

In 2017–18, over $6.6 million of the government’s $27 million four-year investment in Healthy and Strong Latrobe will support a range of health measures, developed and implemented in collaboration with the community. These measures will improve the health and wellbeing of current and future generations.

The department is working collaboratively with the Latrobe Health Assembly and broader community to develop and test innovative approaches to improve the health and wellbeing of people in Latrobe. In 2017–18, a newly created Health Advocate, will provide independent community-wide leadership and
advice on system and policy issues affecting the health and wellbeing of the community. The Health Advocate will also establish the Latrobe Health Innovation Zone.

The department will work with the community and other government partners to deliver the $85 million investment in sport and recreation infrastructure and programs in the Latrobe Valley and establish a Youth Space in Morwell with investment of $4.3 million over three years.

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

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

The NBCSP is in a period of expansion. In 2017 people aged 50, 54, 55, 58, 60, 64, 68, 70, 72 and 74 will be invited to screen. By 2020 all eligible people aged 50–74 will be invited to screen every two years.

During the NBCSP expansion period, all Victorian public hospitals providing colonoscopy will be allocated a separate NBCSP WIES target. This was previously only available to NBCSP-designated provider health services, but has been expanded to include all public health services providing colonoscopy. This funding is provided in addition to the funding provided for other activity and is paid according to actual activity. The WIES target will be modelled to align with growth resulting from the NBCSP. A PYA process will reconcile NBCSP activity with target. Variation in activity against the NBCSP WIES target will be recalled or paid at full WIES rate. It is not part of public and private WIES for the determination of recall and throughput.

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

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

NBCSP activity will be paid against the health service’s NBCSP WIES target based on actual throughput. Reconciliation for under or over activity will be adjusted at the end of 2017–18.

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


### 2.14.1.5 Sexual health and viral hepatitis

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

A wide range of agencies are funded to provide peer-based care and support, clinical care, health promotion, research, surveillance and workforce training.
All agencies funded for health promotion activities are required to develop annual workplans in consultation with the department. Standard contract management processes apply, including performance output monitoring, regular reporting and face-to-face meetings.

2.14.1.6 Tobacco control

A number of organisations are provided funding for a range of activities to contribute to the reduction of smoking in Victoria, and to reduce the harms caused by smoking. This includes providing education about, and enforcing the Tobacco Act 1987. New reforms will commence on 1 August 2017 to ban smoking in outdoor dining areas and regulate e-cigarettes and shisha tobacco. Funding is allocated via funding and service agreements, which contain performance benchmarks. Organisations are required to regularly report to the department on these benchmarks.


2.14.1.7 Victorian Tuberculosis Program

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

2.14.2 Health protection

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

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

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

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

2.14.2.1 Chief health officer

The Victorian Government’s Chief Health Officer undertakes a variety of statutory functions under a number of Acts. The officer is responsible for:

- developing and implementing strategies to promote and protect public health
- providing advice to the minister and the secretary on matters relating to public health and wellbeing
- publishing a comprehensive report on public health and wellbeing in Victoria on a biennial basis.

The chief health officer acts as the government’s media spokesperson on matters relating to the control of disease and promotion of health as required such as communicable diseases, land/air/water contamination, radiation, food safety, ethics and public health emergencies.

The chief health officer regularly informs Victorians about issues that have the potential to impact on their health and safety. Information is provided via health alerts and advisories and a range of other

2.14.2.2  The Peter Doherty Institute

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

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

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

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

2.15.1 Training and development grants

Training and development grants were introduced into the original casemix formula to recognise the additional costs inherent in the teaching, training and research activities of public health services. The grants aim to support the development of a high-quality future health workforce for Victoria in the areas of:

• research
• professional-entry student placements
• graduate funding
• postgraduate medical, nursing and midwifery funding.

2.15.1.1 Research grants

The department administers the Operational Infrastructure Support program. The Operational Infrastructure Support program provides annual funding to eligible Victorian medical research institutes as a contribution towards the indirect, operational overhead costs of research. The Department of Economic Development, Jobs, Transport and Resources is also involved with programs that relate to medical research.

2.15.1.2 Professional entry and student placements

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

Further information regarding eligibility, definitions and reporting requirements is available at Chapter 4, section 4.12.10 'Workforce data reporting requirements' and can be accessed at https://www2.health.vic.gov.au/health-workforce/education-and-training.

The department also provides separate funding to health services to partly fund a limited number of professional clinical placements, professional development year or industry-based learning positions in hospital pharmacy, medical imaging (radiography), nuclear medicine, radiation therapy, medical biophysics, medical laboratory science and employment model midwifery. These positions are not eligible for the professional-entry student placement subsidy.

2.15.1.3 Transition to practice – (graduate) funding

Allied health, medical (PGY1 and PGY2), nursing and midwifery

Subsidies to health services are provided to contribute to the cost of supervision and on-the-job training in the first year for approved nursing, midwifery and allied health graduate positions, and the first two years for approved medical graduate positions. Some allied health students undertaking professional practice placements are also supported through this stream.

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

Subsidies are approved and allocated on the basis of each health service’s activity as a proportion of total graduate activity. Health services are required to report actual graduate activity each year for the previous calendar year. Funding adjustments are made annually.

For further details regarding this funding stream refer to https://www2.health.vic.gov.au/health-workforce.
2.15.1.4 Postgraduate funding

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

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

For further details regarding this funding stream refer to <https://www2.health.vic.gov.au/health-workforce>.

Medical specialist training

The following programs are available for postgraduate medical specialist training.

*Victorian medical specialist training program*

The Victorian medical specialist training program provides funding in targeted specialties to assist health services to increase the number of medical specialist training positions.

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

*Victorian paediatric training programs*

Victorian paediatric training programs provide subsidies to support a statewide basic paediatric training program. Subsidies ensure that the distribution and rotation of paediatric trainees is aligned with the workforce requirements of outer metropolitan, regional and rural Victoria, and promotes access to local paediatric services across the state.

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

*Basic physician training consortia*

The program provides annual funding to five consortia comprising all Victorian hospitals with accredited physician training positions to: support distribution and management of basic physician trainees; address workforce shortages; and improve the quality of education and training in rural Victoria.

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

Nursing and midwifery

The postgraduate nursing and midwifery funding program provides subsidies, for postgraduate studies that lead to an award classification of Graduate Certificate, Graduate Diploma or Master-level studies.

Eligible postgraduate education programs must include a requirement for supervised clinical support.

Master-level studies that lead to endorsement as a nurse practitioner may be eligible; however, individuals receiving Nurse Practitioner Candidate Support Packages are excluded.

Postgraduate (entry-to-practice) clinical placement model midwifery studies are not eligible for this stream of the training and development grant because they are eligible for a professional-entry student placement subsidy.

2.15.1.5 Transition to practice (graduate) and postgraduate funding rates and additional considerations

The number of funded positions supported by the training and development grant is limited by the total grant pool. Funding for all positions and programs is based on reported activity and depends on appropriate reconciliation of all places.

If programs or training positions include a period of rotating placements, lead organisations are required to ensure that the other host organisation(s) receive a pro rata portion of the grant equal to the length of the rotation. If positions remain unfilled by staff who meet the criteria approved by the department, or if
program activity by the health service is not at the funded level, the training and development grant may be adjusted to reflect actual activity.

The programs should conform to the most recent versions of guidelines (where available), including guidelines and standards set by the Australian Health Practitioner Regulation Agency.

Training and development grant rates in 2017–18 are listed at Chapter 3, section 3.1 ‘Price tables’.
2.16 Replacement of critical medical equipment and engineering infrastructure

The Medical Equipment Replacement program and the Engineering Infrastructure Replacement program are directed at replacing assets essential for delivering acute clinical services. They enable the systematic replacement of the highest priority at-risk medical equipment and engineering services infrastructure.

The Infrastructure Renewal Contribution grant assists health services with the costs of hospital infrastructure.

These three programs support health services to manage risk and maintain patient safety, occupational health and safety, and service availability and continuity by maintaining and replacing assets in a planned manner, prior to failure. The department has adopted a coordinated approach to the allocation and management of funds from these three separate sources.

Managing the programs in a coordinated way also progresses government requirements for longer-term asset planning to be undertaken by both the department and health services. It enables longer-term system-wide planning for replacing high-cost assets, while devolving a level of responsibility for decisions on asset replacement to health services. Effective asset management practices within health services are central to the achievement of their service delivery objectives.

Conditions of funding apply, including basic asset management plans (see Chapter 4, section 4.7 ‘Asset and environmental management’). For further information about the programs visit <https://www2.health.vic.gov.au/hospitals-and-health-services/planning-infrastructure/medical-equipment>.

2.16.1 Funding

In 2017–18, $35 million will be provided for the Medical Equipment Replacement program and $25 million for the Engineering Infrastructure Replacement program. Fifty per cent from each program will be centrally managed and allocated by the department for highest priority at-risk, high-value replacements.

Fifty per cent of the Medical Equipment Replacement program pool will be distributed to major hospitals in 2017–18, based on activity as a specific-purpose capital grant.

Fifty per cent of the Engineering Infrastructure Replacement program pool will also be distributed to metropolitan and regional hospitals based on indicators of activity, size and age as a specific-purpose capital grant.

Replacement priorities for both allocations are to be determined by health services, and expenditure will be acquitted in accordance with the requirements for capital appropriations and reported through the Agency Information Management System – 7B reporting.

The $40 million Infrastructure Renewal Contribution will be distributed to all hospitals including rural and small rural health services.
2.17 National Health Reform Agreement funding arrangements

Health services are required to ensure their operations comply with the obligations of the Victorian Government under various commonwealth–state agreements. These agreements include the National Health Reform Agreement – and the addendum to this Agreement – which has provided joint funding for public hospital services since 1 July 2012. The National Health Reform Agreement outlines the responsibilities for delivering key health services including: public hospital services; general practitioner and primary healthcare; and aged care and disability services. Health services are expected to comply with the business rules contained in the national agreement.

On 1 April 2016, the Council of Australian Governments (COAG) signed a Heads of Agreement which substantially rolls over existing National Health Reform Agreement arrangements from 2017–18 to 2019–20, and commits to:

- Delivering reforms designed to improve health outcomes for patients and decrease avoidable demand for public hospital services.
- Introducing models to integrate quality and safety into hospital funding and pricing and reduce avoidable readmission rates in conjunction with the Australian Commission on Safety and Quality in Health Care and the Independent Hospital Pricing Authority.
- Cooperative development of a longer-term public hospital agreement for COAG consideration before the end of 2018 and commencement by 1 July 2020.

The Heads of Agreement formed the basis of negotiations which led to a time-limited addendum of the National Health Reform Agreement from 1 July 2017 to 30 June 2020. Victoria signed the addendum in April 2017.

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

The addendum does not completely reverse the 2014–15 budget cuts (which included commonwealth savings nationally, ceasing the funding guarantees under the National Health Reform Agreement, moving to block funding indexed by population growth and the Consumer Price Index from July 2017) as the maximum funding Victoria could receive from the commonwealth is still significantly less than what Victoria would have received under the original National Health Reform Agreement, for the same period.

As the addendum is due to expire in 2019–20, negotiations for a new national health agreement are expected to begin shortly. The new agreement will begin in 2020–21.

2.17.1 National activity-based funding arrangements

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

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

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

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

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

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

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

In 2017–18 the NEP has been set at $4,910 per NWAU(17). Details are published in the IHPA’s NEP determination and pricing framework each year. Documents relating to the NEP and NWAUs are available at <www.ihpa.gov.au>.

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

As system managers, the Victorian Government instructs when payments are to be made out of the pool in accordance with the activity levels agreed between the state and each health service in their statement of priorities. The Victorian Government will continue to manage block-funded payments, including small rural health services, teaching, training and research and non-admitted mental health services. Block-funded payments will be paid to health services by the department through the state-managed fund (see Figure 2.1).

**Figure 2.1: Payment flows under national activity-based funding**
2.17.2 The pricing framework for Australian public hospitals: activity-based

In 2017–18 the in-scope public hospital services that will be funded through the National Health Reform Agreement are:

- all acute admitted patient services, including Hospital in the Home
- all emergency department services
- all admitted subacute services
- all admitted mental health services
- non-admitted acute and non-admitted subacute patient services.

In 2017–18:

- The national activity unit will be known as NWAU(17).
- The national efficient price is set by IHPA at $4,910. Costing information used to determine the NEP was drawn from the 2014–15 National Hospital Cost Data Collection (Round 19).

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

- admitted patient services: AR-DRG Version 8.0
- emergency department services: Urgency Related Groups Version 1.4 (for recognised emergency departments at levels 3B–6) and Urgency Disposition Groups Version 1.3 (for recognised emergency departments at levels 1–3A)
- non-admitted patient services: Tier 2 Outpatient Clinics Definitions Version 4.1
- admitted mental health patient services: modified version of AR-DRG Version 8.0
- admitted subacute patient services: Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) Version 4.0.

Health services’ total funding will continue to be determined based on activity volumes and prices according to the Victorian funding models, such as WIES and Subacute WIES in 2017–18. The commonwealth and state contributions to health services, through the national funding pool, will be based on the projected equivalent NWAUs generated by the activity levels as set by the Victorian funding models and will be cash flowed according to a health service NWAU specific rate.


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

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

The government provides advice to the IHPA on which services meet the criteria to be block-funded. Services currently funded through the small rural health services model will continue to be block-funded. Those currently receiving output funding through the casemix model will be subject to activity-based funding and will therefore be paid via the National Health Funding Pool. The government also provides advice to the IHPA on the funding for teaching, training and research and non-admitted mental health in November 2016 in which the IHPA then include as the block amount in its national efficient cost (NEC) determination.

The IHPA has applied these criteria in developing the national costing model and the national efficient cost determination for 2017–18 that applies to block-funded services.
In 2017–18 the national efficient cost is $5.406 million. This represents the average cost of a block-funded hospital. The national efficient cost was determined using the average in-scope expenditure data for 2014–15 reported to the National Public Hospital Establishment Database of $4.710 million indexed at 4.7 per cent per annum (based on national cost data) to account for price and activity growth over the three years.

2.18 Prior year adjustment: activity-based funding reconciliation

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

2.18.1 Victorian funding recall policy

Funding recalls will be triggered by a drop in service activity that is below targeted levels. Recall rates are set out in Table 2.4.

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

In 2017–18, public/private WIES and Subacute WIES will be recalled based on the rates detailed in Table 2.4. The marginal WIES policy aims to maintain minimal levels of funding for under-activity in recognition of fixed costs and variable demand but incentivise efficient service delivery above target where it is cost-effective for health services to do so and up to a capped amount.

Department of Veterans’ Affairs and Transport Accident Commission activity will continue to be funded to actual activity that is approved by the Department of Veterans’ Affairs. Health services are expected to update the VAED for any rejected or denied episodes of care prior to reconciliation. Any denied or rejected records that are not amended will not be paid as either public or Department of Veterans’ Affairs when the 2017–18 Prior Year Adjustment is calculated.

In 2017–18, National Bowel Cancer Screening Program WIES be recalled based on rates detailed in Table 2.4 and continue to be funded to actual activity.

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

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

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

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

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

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

Recall will apply to the total Health Independence Program activity target. Recall will also apply to the Transition Care Program. Transition Care Program recall will be calculated separately and will not be included in the subacute wrap. Funding recall applies for the state component of the Transition Care Program, with recall for the Transition Care Program wrapped between bed-based and home-based.
A recall policy also applies to Home and Community Care and Aged Care and Assessment Services as outlined in Table 2.4. Funded organisations should note that significant underperformance in any activity should be discussed with the department in a timely manner.

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

In 2017–18, recall will apply to all acute admitted specialist clinics activity eligible to be funded under the Weighted Ambulatory Service Event (WASE) funding model. The recall policy differs to the WIES and Subacute WIES approach and will not include a cash adjustment to adjust for the final public and private mix. Instead, the target will be revised based on the existing funding level and end of year observed public and private mix.

An overview of the calculation process for recall can be found at Chapter 3, Appendix 3.9: ‘Calculating funding recall’.

Table 2.4: Victorian funding recall rates 2017–18

<table>
<thead>
<tr>
<th>Service</th>
<th>Funding recall policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute admitted services</td>
<td>• 0–3 per cent below target: 50 per cent of the weighted relevant rate or wrap value.</td>
</tr>
<tr>
<td>Subacute admitted services (wrap includes GEM, rehabilitation and palliative care)</td>
<td>• &gt; 3 per cent below target: 100 per cent of the relevant rate.</td>
</tr>
<tr>
<td>Non-acute admitted services (maintenance care)</td>
<td></td>
</tr>
<tr>
<td>Nationally funded centres (NFC)</td>
<td>Full recall of under-activity at the NFC determined cost per procedure.</td>
</tr>
<tr>
<td>National Bowel Cancer Screening Program</td>
<td>Full recall of under-activity.</td>
</tr>
<tr>
<td>Department of Veterans’ Affairs</td>
<td>Full recall of under-activity.</td>
</tr>
<tr>
<td>• Acute admitted services</td>
<td></td>
</tr>
<tr>
<td>• Subacute admitted services (wrap includes GEM, rehabilitation and palliative care)</td>
<td></td>
</tr>
<tr>
<td>Transport Accident Commission and WorkSafe</td>
<td>Full recall of under-activity.</td>
</tr>
<tr>
<td>• Acute admitted services</td>
<td></td>
</tr>
<tr>
<td>Small rural health services</td>
<td>Recall applies to renal, HACC, ACAS and residential aged care services.</td>
</tr>
<tr>
<td></td>
<td>No recall applies for acute, subacute and primary health.</td>
</tr>
<tr>
<td>Acquired brain injury unit</td>
<td>Full recall of under-activity at the full rate.</td>
</tr>
<tr>
<td>Mental health admitted services</td>
<td>The department may recall funds associated with funded beds, which remain unopened or</td>
</tr>
<tr>
<td></td>
<td>have been temporarily closed. Recall will depend on statewide priorities and the need</td>
</tr>
<tr>
<td></td>
<td>for funding redistribution to achieve these priorities as defined by the department.</td>
</tr>
<tr>
<td>Non-admitted emergency services</td>
<td>Non-admitted emergency services are currently not subject to recall.</td>
</tr>
<tr>
<td>Subacute non-admitted services</td>
<td>Funding recall will be applied to subacute non-admitted services. When determining</td>
</tr>
<tr>
<td></td>
<td>whether recall applies, the department will take into account activity against the</td>
</tr>
<tr>
<td></td>
<td>total HIP target:</td>
</tr>
<tr>
<td></td>
<td>• 0–5 per cent below target: no recall</td>
</tr>
<tr>
<td></td>
<td>• &gt; 5 per cent below target: the department may recall at the full HIP rate for the</td>
</tr>
<tr>
<td></td>
<td>amount that is beyond the five per cent underperformance.</td>
</tr>
<tr>
<td>Service</td>
<td>Funding recall policy</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mental health non-admitted services</td>
<td>• 0–5 per cent below target: no recall.</td>
</tr>
<tr>
<td></td>
<td>• &gt; 5 per cent below target: the department may recall at the relevant rate. The amount subject to recall is that beyond the five per cent underperformance.</td>
</tr>
<tr>
<td>Transition Care Program (bed-based and home-based wrapped)</td>
<td>• 0–5 per cent below target: no recall.</td>
</tr>
<tr>
<td></td>
<td>• &gt; 5 per cent below target: the department may recall at the home bed day rate. The amount subject to recall is that beyond the five per cent underperformance.</td>
</tr>
<tr>
<td>Dialysis services</td>
<td>Admitted dialysis activity is incorporated within the total health service acute admitted activity. Payment from the dialysis provider to the specialist service (hub) should be adjusted to actual by the end of the year, before the recall is applied. Home dialysis activity (determined on a monthly basis) under target will be subject to full recall.</td>
</tr>
<tr>
<td>Non-admitted radiotherapy</td>
<td>Funding will be recalled at the full rate for performance below target.</td>
</tr>
<tr>
<td>Non-admitted specialist clinics</td>
<td>• 0–3 per cent below target: 50 per cent of the weighted relevant rate or wrap value.</td>
</tr>
<tr>
<td></td>
<td>• &gt; 3 per cent below target: No recall for 2017–18 only.</td>
</tr>
<tr>
<td>Integrated cancer services</td>
<td>The department may recall unexpended integrated cancer services funds. Recall will depend on statewide cancer reform priorities and the need for funding redistribution to achieve these priorities as defined by the department.</td>
</tr>
<tr>
<td>Primary health funding approach</td>
<td>• 0–5 per cent below target: no recall.</td>
</tr>
<tr>
<td></td>
<td>• &gt; 5 per cent below target: the department may recall at the full rate. The amount subject to recall is that beyond the five per cent underperformance.</td>
</tr>
<tr>
<td>BreastScreen Victoria services</td>
<td>• 0–3 per cent below target: no recall.</td>
</tr>
<tr>
<td></td>
<td>• 3–5 per cent below target: recall at 50 per cent of relevant rate.</td>
</tr>
<tr>
<td></td>
<td>• &gt; 5 per cent below target: recall at full rate.</td>
</tr>
<tr>
<td></td>
<td>Recall policy is subject to the terms and conditions of BreastScreen Victoria’s Funding and Service Agreement with the department.</td>
</tr>
<tr>
<td>Aged Care Assessment Service (ACAS)</td>
<td>The department recognises that ACAS may find it difficult to meet the exact annual targets for the number of assessments. In the case of sustained underperformance compared with annual targets of more than five per cent for two years or longer, a funding reduction may be applied that corresponds to the level of underperformance.</td>
</tr>
<tr>
<td>Home and Community Care (HACC)</td>
<td>Recurrent funds may be recalled from service providers, including small rural HACC services that achieve less than 95 per cent of funded targets or fail to achieve agreed deliverables for block-funded activities in a timely way.</td>
</tr>
<tr>
<td>Diabetes prevention</td>
<td>Program funding recalled per participant target not met.</td>
</tr>
<tr>
<td>Residential aged care</td>
<td>Recurrent funds may be recalled from service providers, including small rural residential aged care services where they reduce the number of operational places. As funding is calculated on the basis of operational places any reduction will result in a corresponding adjustment to funding.</td>
</tr>
<tr>
<td>Total parenteral nutrition</td>
<td>Total parenteral nutrition activity (determined on a monthly basis) under target will be subject to full recall.</td>
</tr>
<tr>
<td>Home enteral nutrition (HEN)</td>
<td>Recall may apply for health services where reported HEN service events are below the target. Funding may be recalled based on the service events below target.</td>
</tr>
</tbody>
</table>
Exceptional events

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

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

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

2.18.2 Funding for throughput above target

Funding for health service throughput above target will be based on a proportion of the funding rate (see Table 2.5).

The Department of Veterans’ Affairs and the Transport Accident Commission will continue to be funded to actual activity and will therefore attract additional funding for throughout above target.

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

Throughput funding for above target will apply for acute non-admitted specialist clinics WASE activity in 2017–18.

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

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

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

There is no funding for any over-activity for non-acute care (Transition Care Program or nursing home activity) or non-admitted Health Independence Program.
Table 2.5: Funding for throughput above target 2017–18

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

2.18.3 Prior-year adjustment of commonwealth contribution

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

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

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

2.18.4 Hospital activity, WIES and Subacute WIES reports

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

2.19 Health service compensable and ineligible patients

2.19.1 Funding for interstate patients

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

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

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

2.19.2 Medicare-ineligible patients and international patients seeking health services

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

Exemptions from charging fees are as follows:

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

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

2.19.2.1 Medicare-ineligible patients principles

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

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

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

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

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

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

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

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

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

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

Health services who are currently providing treatment to international patients who have travelled to Victoria specifically for care may continue to do so from 1 July 2017, with the expectation that board endorsement of this activity should occur by 31 December 2017. Health services can contact the International Health team at the department if they require further advice or assistance in transitioning to these new requirements at <internationalhealth@dhhs.vic.gov.au>.

### 2.19.3 Compensable patients

#### 2.19.3.1 Department of Veterans’ Affairs patients

**Eligibility**

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

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

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

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

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

Experience has shown that those health services that actively develop service quality and marketing plans and employ veteran or patient liaison officers are more likely to retain Department of Veterans’ Affairs patients.

**Admission requirements**

Within two days of admission to hospital, health services should complete a Department of Veterans’ Affairs Hospital Admission Voucher (or form which captures equivalent information) for each admitted
eligible veteran. Health services should ensure that the admission of eligible veterans is in accordance with Victoria’s admission policy and other relevant policies and procedures.

Eligible veterans will continue to be provided public health services on a private patient basis, which entitles them to a minimum of:

- choice of doctor (subject to doctor having rights of private practice)
- shared accommodation
- if medically necessary, private accommodation
- private accommodation, if available, where the patient or their private health insurer agrees to pay the difference between the shared and private accommodation.

Eligible veterans are eligible to access convalescent care or respite care in public health services following an acute or subacute stay without the need for financial authorisation from Department of Veterans’ Affairs.

Pharmaceuticals

Health services should ensure medication reviews (including self-management) are completed prior to discharge by the clinical pharmacist or doctor for patients:

- who require administration of four or more different medications or more than 12 doses of medication daily
- where a change in medication has occurred during the admission
- where anti-coagulant therapy has commenced during the admission.

Medication reviews are to be documented on an appropriate approved form, be available to the patient and care providers on discharge and involve education as a component.

The Veteran Affairs Pharmaceutical Advisory Centre can be contacted on 1800 552 580.

Long stay

If the hospitalisation of an eligible veteran is likely to exceed a continuous period of 35 days in any care type other than nursing home type and palliative care, the Department of Veterans’ Affairs requires that health services ensure the veteran’s status is reviewed and that either:

- A certificate similar to that previously required under s. 3B of the Health Insurance Act 1973 is completed by a medical practitioner and held on the patients file for audit purposes.
- Reclassifies the patient as either maintenance or in the case of small rural health services, the eligible veteran is reclassified to a nursing home type patient and the changed status and payment adjusted accordingly. Where the patient is reclassified, the hospitals should use their best endeavours to ensure the patient is assessed and a discharge plan is developed.

Under the new arrangement, the Acute Care Certificate or equivalent is no longer required to be sent to Department of Veterans’ Affairs.

Nursing home type patients

If eligible veterans are assessed as needing nursing home type or respite care and are at a multi-purpose services (i.e. at facilities that receive commonwealth funding to operate residential care beds) then the health service must attempt to reclassify the patient from a hospital patient to a residential aged care recipient. If there are no residential aged care beds available, the patient should be reclassified as a nursing home type patient and Department of Veterans’ Affairs charged at the nursing home type patient rate. Department of Veterans’ Affairs will not pay for residential aged care under the arrangement.

Health services should collect any co-payment for nursing home type patient from the patient with the exception of Victoria Cross or Prisoners of War recipients. For this group, health services should make a claim directly based on prior approval to Department of Veterans’ Affairs for reimbursement using MBS item number NH05.
**Discharge planning**

Health services will use their best endeavours to demonstrate effective discharge planning for Department of Veterans’ Affairs patients including the regular contribution of a multidisciplinary team, supporting documentation, discharge follow up and communication with care providers and family and carers (with permission from the patient).

Written documentation in the form of a Discharge Plan should be provided to the patient or carer on the day of discharge. Should e-Discharge summaries be available these are to be used. The Department of Veterans’ Affairs may request to see documentation of hospital discharge policies and procedures, as well as copies of the patient and hospital discharge plans. If the patient is enrolled in a Coordinated Veterans’ Care program then the local medical officer or nurse coordinator must also receive a copy of the patient discharge plan (and is involved as appropriate).

Health services should coordinate for a health professional to assess eligible veterans prior to discharge for community nursing, personal care, aids and appliances, home modifications or convalescent care. Any aids, equipment or modifications will be arranged through Department of Veterans’ Affairs services in a timely manner and be available to the patient prior to discharge. Public hospitals must provide a summary of discharge to the original referring doctor and local medical officer at, or within, 48 hours of discharge.

Referrals for community nursing services for Department of Veterans’ Affairs patients may be made to a Victorian or Commonwealth Government-funded program or to a Department of Veterans’ Affairs contracted provider.

To arrange home and personal care services for eligible veterans, health services must contact the National Veterans’ Home Care assessment agency (1300 550 450). Discharge aids and equipment for veteran patients must be provided to facilitate safe discharge for a period of thirty days post discharge. For further information contact the Rehabilitation Appliances Program (RAP) schedule at [www.dva.gov.au](http://www.dva.gov.au) or ring 1300 550 457 (metro) or 1800 550 457 (rural).

**Funding arrangements**

In April 2017, the Commonwealth Government signed an agreement with Victoria which implements a uniform national purchasing arrangement for public hospital services provided to eligible veterans. The commonwealth to state funding arrangements will be based on the national funding model developed by the Independent Hospital Pricing Authority with modifications to reflect the contribution that the Department of Veterans’ Affairs providers to medical practitioners.

Funding arrangements for Victorian public health services will be affected by the new arrangement as the revised agreement significantly reduces the amount of state revenue available for redistribution in 2017–18. The Department of Veterans’ Affairs price will also not index its price paid to the department for each National Weighted Activity Unit paid to Victoria under the national funding model.

Victoria will fund eligible veterans in alignment with the revised commonwealth revenue in 2017–18. Funding for admitted acute and subacute services will continue to be paid to actual throughput based on the Victorian WIES and Subacute WIES funding models. Funding for emergency departments (non-admitted presentations), acute non-admitted and the Health Independence Program will be paid as a block grant and based on the health service’s activity share of total weighted activity.

Funding arrangements for Department of Veterans’ Affairs patients are detailed in Table 2.6. Throughput-based services will continue to attract a premium from the department for eligible veterans in recognition of the cost of treating these patients. Payment will be made on a reconcilable basis.

Payment for interfacility transport (excluding Secondary Aeromedical retrieval) is included in the payment arrangements for services.
Table 2.6: Funding arrangements for Department of Veterans’ Affairs patients

<table>
<thead>
<tr>
<th>Service</th>
<th>Funding arrangements</th>
</tr>
</thead>
</table>
| Admitted patient services     | Funding for the following services is based on throughput and attracts a premium:  
  - acute: health services receive the Department of Veterans’ Affairs WIES throughput payments from the department  
  - subacute: categories for funding are palliative care, rehabilitation, geriatric evaluation and management, and maintenance care, and mirror funding and reporting arrangements for public patients  
  - maintenance  
  - admitted dialysis  
  - admitted mental health services.  
  Hospitals should bill the Department of Veterans’ Affairs separately for medical and diagnostic costs for admitted patients. |
| Emergency department attendances | Emergency department services will receive a block grant that is based on the health service’s proportionate share of the total non-admitted emergency weighted activity. There will be no separate billing of medical and diagnostic costs. Veteran patients who are subsequently admitted will be funded under the WIES model. |
| Acute non-admitted            | Acute non-admitted services will receive a block grant that is based on the health service’s proportionate share of the total acute non-admitted weighted activity. Veteran patients may access all services, and funding and reporting arrangements mirror those for public patients. Where eligible veterans have been privately referred, as a Privately Referred Non-Inpatient (PRNI), to a named specialist and consents to be treated as a private outpatient, DVA will pay separately for specialist consultations and procedures, and associated pathology and radiology services. |
| Subacute non-admitted         | Subacute non-admitted services will receive a block grant that is based on the health service’s proportionate share of the total subacute non-admitted weighted activity. Veteran patients may access all services, and funding and reporting arrangements mirror those for public patients. Where eligible veterans have been privately referred, as a Privately Referred Non-Inpatient (PRNI), to a named specialist and consents to be treated as a private outpatient, DVA will pay separately for specialist consultations and procedures, and associated pathology and radiology services. |
| Non-admitted radiotherapy     | Weighted activity units are funded on a throughput basis. Where eligible veterans have been privately referred, as a Privately Referred Non-Inpatient (PRNI), to a named specialist and consents to be treated as a private outpatient, DVA will pay separately for specialist consultations and procedures, and associated pathology and radiology services. |
| Specialist mental health acute care | Funding for mental health services to eligible Veterans are funded within the total funding provided to services. Veteran patients may access all services, and funding and reporting arrangements mirror those for public patients. |
| Non-specialist mental health acute care | Funding for mental health services to eligible Veterans are funded within the total funding provided to services. Veteran patients may access all services, and funding and reporting arrangements mirror those for public patients. |
| Transition Care Program       | The Transition Care Program is available to all members of the Australian community, including veterans. However, the Department of Veterans’ Affairs will only fund the patient contribution for veterans who are former prisoners of war. Further details are available on the Department of Veterans’ Affairs website at [www.dva.gov.au](http://www.dva.gov.au). |
| Community Health Program      | Community health services should bill the Department of Veterans’ Affairs directly for allied health and nursing services provided under the Community Health Program. |

Payments

Health services should note that:

- In April 2017, the Commonwealth Government signed an agreement with Victoria which implements uniform national purchasing arrangements for public hospital services provided to eligible veterans. The arrangements will be based on the national funding model developed by the Independent Hospital Pricing Authority with modifications to reflect the contribution that the Department of Veterans’ Affairs providers to medical practitioners.
If a claim is not accepted by the Department of Veterans’ Affairs either:

- health services must transmit additional or corrected information to allow the claim to be accepted
- claims should be retrospectively reclassified to reflect the patient’s changed care type or preferences.

In 2017–18, the department will no longer make changes to the VAED for denied or rejected claims after consolidation through the prior year’s adjustment. Health services are required to make changes prior to the consolidation of the VAED, otherwise funding will not be paid at either the DVA or public rate.

The Department of Veterans’ Affairs agreement prohibits organisations from raising any charges directly on an eligible veteran except where provided for under commonwealth legislation. This prohibition does not, however, prevent organisations from charging a cost for providing personal services such as television access or telephone services at the facility.

The Department of Veterans’ Affairs agreement recognises that the provision of treatment to Department of Veterans’ Affairs patients may occasionally be subcontracted to a private hospital or facility. Where that private hospital or facility is contracted to the Department of Veterans’ Affairs, and claims for the service, the Department of Veterans’ Affairs will pay the facility directly through their payment arrangements with Medicare Australia. Under these circumstances, the public hospital cannot also claim payment separately for the treatment provided.

Subcontracting for Transition Care is exempt from this requirement as public hospitals do not directly bill the Department of Veteran’s Affairs for this service (see Table 2.6).

### 2.19.3.2 Transport Accident Commission patients

#### Eligibility

Patients are required to complete and sign a Transport Accident Commission (TAC) claim form before the TAC will accept responsibility for payment. Health services should make themselves aware of the form’s specific requirements. If health services’ data does not exactly match the details a patient has entered on a claim form, there will be significant delays in payment from the TAC while the errors are addressed by health services, the TAC and the department.

#### Funding arrangements

Funding arrangements for TAC patients are detailed in Table 2.7. Transport Accident Commission rates may be viewed at [www.health.vic.gov.au/feesman](http://www.health.vic.gov.au/feesman).

<table>
<thead>
<tr>
<th>Service</th>
<th>Funding arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency department attendances</td>
<td>Health services charge the TAC directly at a flat rate per attendance for patients treated in the emergency department only. Health services should bill the TAC directly for medical and diagnostic costs.</td>
</tr>
</tbody>
</table>
| Admitted patient services   | Acute: Health services receive WIES throughput payments from the department at the TAC-specific rate.  
Rehabilitation: Health services charge the TAC directly at the TAC-specific bed day rate.  
Other admitted services: Health services charge the TAC directly at the public rate.  
Health services should bill the TAC directly for medical and diagnostic costs. |

#### Payments

The department will continue to provide health services payments based on WIES throughput.

Funding for TAC patients is provided to the department by the TAC. This is cash flowed to health services throughout the year and adjusted to actual at year end based on data reconciled with the TAC.
Separate uncapped TAC WIES targets are incorporated into health service budgets for 2017–18 based on the latest available 12 month throughput reported in the VAED.

The department will only pay a rate applicable for all accepted TAC patients matched with TAC records (as reported in the VAED) including numbers in excess of the target. If health services do not achieve the TAC target, any funding that has been cash flowed will be recalled at the full TAC rate. It is imperative that health services ensure their own records are complete, comprehensive and timely.

For the department to receive payment from the TAC, the TAC must accept the claim and issue a claim number. The patient information reported by health services to the department via VAED must match those held by the TAC for each admitted patient separation.

Health services should ensure that their TAC records are updated in the VAED, with TAC remittance advice fed back by the department. This will ensure that updated records are accepted by the TAC and that delays in reconciling activity and payment for records are minimised.

The department will cash flow TAC funding to accepted TAC cases. If a TAC claim is later rejected, the department will automatically fund the claim using public WIES in the prior year adjustment process unless the health service has exceeded its WIES target.

To minimise errors and delays, health services are required to ensure that the information is entered accurately and to proactively identify and resolve errors before sending the data to the TAC or to the department. Errors that are not accurately corrected by health services, such as an incorrect date of birth, continually cycle through both the department and the TAC databases and remain unmatched and consequently unfunded. This requires additional review, reconciliation and problem solving by the health services, the department and the TAC.

If a claim is not accepted by the TAC, either:

- health services must transmit additional or corrected information to allow the claim to be accepted
- claims should be retrospectively reclassified to reflect the patient’s changed care type or preferences.

In 2017–18, the department will no longer make changes to the VAED for denied or rejected claims after consolidation through the prior year’s adjustment. Health services are required to make changes prior to the consolidation of the VAED, otherwise funding will not be paid at either the TAC or public rate.

Additional information

More detailed information on the Transport Accident Commission’s policy, services and funding is available on the TAC website at <www.tac.vic.gov.au/providers/for-health-professionals/hospital-resources/public>.

Agreed amendments to the current services and prices will be documented on the department’s fees and charges website and in the department’s circulars.

2.19.3.3 Victorian WorkCover Authority patients

Victorian WorkCover Authority patients treated in Victorian health services are directly funded by Victorian WorkCover Authority insurers. This process will continue in 2017–18 at the rates agreed between the authority and the department on behalf of health services.

Patients treated in an emergency department only will continue to be directly billed to the Victorian WorkCover Authority at a flat rate per attendance. This rate will apply to all emergency department attendances (in lieu of the previously charged facility fee). Health services should also bill the Victorian WorkCover Authority directly for medical and diagnostic costs.

Further details regarding the current services and prices are set out on the department’s fees and charges website at <www.health.vic.gov.au/feesman>. 
2.19.3.4 Prisoners

Prisoners receiving admitted, emergency department and specialist clinic services in Victorian public hospitals are treated and funded as public patients. The following arrangements apply:

- Acute admitted activity is funded at the public WIES price.
- Admitted subacute services are funded at the public Subacute WIES price.
- Emergency department services are funded through the Non-Admitted Emergency Services Grant, as the prisoner population is included in the calculation of this grant.
- Specialist clinic services are funded through the Acute Specialist Clinics Grant.
- Health services should not bill the Department of Justice and Regulation via primary care providers for these services provided to prisoners.

Health services should ensure they:

- Report all prisoners to the VAED with the account class ‘JP - Prisoner’ or ‘JN - Prisoner Non-Acute’ as relevant and a Medicare Suffix of P-N.
- Record the ‘type of usual accommodation’ data element in the VEMD as ‘prison/remand centre/youth training centre’ and a Medicare Suffix of P-N.
- Report all prisoners to VINAH with the contact account class ‘JP - Prisoner’ and Contact Client Medicare Number of P-N.

Health services are not permitted to raise additional fees or charges for pharmaceuticals or other items described in Chapter 4, section 4.11.4 ‘Health service fees and charges’.

2.19.3.5 Direct billing compensable patients

For compensable patients who are directly billed, the following arrangements are in place:

- armed services – paid by the Department of Defence and billed through Medibank (refer to Hospital Circular 02/2013)
- seamen – paid by private health insurers that cover care for international seafarers
- common law recoveries – paid by a third party where health costs are provided for under a common law damages claim
- other compensables – paid by a third party where health costs are provided for under a public liability claim.

For these patients, health services should directly bill the relevant organisation responsible for payment. Billing rates are as determined by health services and should be set to provide for full cost recovery. Recommended fees are outlined in the department’s Fees manual available at <www.health.vic.gov.au/feesman>.
List of figures

Figure 2.1: Payment flows under national activity-based funding ................................................................. 140

List of tables

Table 2.1: Parameters of the HealthLinks: Chronic Care scoring algorithm .................................................. 88
Table 2.2: Parameters defining HLCC ineligibility (exclusions) ................................................................. 90
Table 2.3: Tier 2 groups excluded from WASE1 ............................................................................................ 108
Table 2.4: Victorian funding recall rates 2017–18 ....................................................................................... 144
Table 2.5: Funding for throughput above target 2017–18 ......................................................................... 147
Table 2.6: Funding arrangements for Department of Veterans’ Affairs patients ..................................... 153
Table 2.7: Funding arrangements for TAC patients ..................................................................................... 154
Funding arrangements for Victoria’s health system

## Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;EP</td>
<td>Aids and Equipment Program</td>
</tr>
<tr>
<td>AAPL</td>
<td>Automatically Admitted Procedure List</td>
</tr>
<tr>
<td>ABF</td>
<td>activity-based funding</td>
</tr>
<tr>
<td>ABN</td>
<td>Australian Business Number</td>
</tr>
<tr>
<td>ABO</td>
<td>blood group system</td>
</tr>
<tr>
<td>ACAS</td>
<td>Aged Care Assessment Service</td>
</tr>
<tr>
<td>ACCO</td>
<td>Aboriginal community-controlled organisations</td>
</tr>
<tr>
<td>ACHA</td>
<td>Assistance with Care and Housing for the Aged</td>
</tr>
<tr>
<td>ACHI</td>
<td>Australian Classification of Health Interventions</td>
</tr>
<tr>
<td>ACS</td>
<td>Australian Coding Standard</td>
</tr>
<tr>
<td>ACSQHC</td>
<td>Australian Commission on Safety and Quality in Health Care</td>
</tr>
<tr>
<td>ADA</td>
<td>Australian Dental Association</td>
</tr>
<tr>
<td>ADIS</td>
<td>Alcohol and Drugs Information System</td>
</tr>
<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>AIMS</td>
<td>Agency Information Management System</td>
</tr>
<tr>
<td>ALOS</td>
<td>average length of stay</td>
</tr>
<tr>
<td>AN-SNAP</td>
<td>Australian National Subacute and Non-Acute Patient</td>
</tr>
<tr>
<td>ANZICS</td>
<td>Australian and New Zealand Intensive Care Society</td>
</tr>
<tr>
<td>AOD</td>
<td>Alcohol and other drugs</td>
</tr>
<tr>
<td>AQL</td>
<td>acceptable quality level</td>
</tr>
<tr>
<td>AR-DRG</td>
<td>Australian Refined Diagnosis Related Groups</td>
</tr>
<tr>
<td>ASD</td>
<td>atrial septal defect</td>
</tr>
<tr>
<td>BBV</td>
<td>blood-borne virus</td>
</tr>
<tr>
<td>BPCLE</td>
<td>Best Practice Clinical Learning Environments</td>
</tr>
<tr>
<td>BPD</td>
<td>Better Patient Dataset</td>
</tr>
<tr>
<td>BPT</td>
<td>Basic physician training</td>
</tr>
<tr>
<td>CCCS</td>
<td>Community Care Common Standards</td>
</tr>
<tr>
<td>CCOPMM</td>
<td>Consultative Council on Obstetric and Paediatric Mortality and Morbidity</td>
</tr>
<tr>
<td>CDBS</td>
<td>Child Dental Benefits Schedule</td>
</tr>
<tr>
<td>CEO</td>
<td>chief executive officer</td>
</tr>
<tr>
<td>CHO</td>
<td>chief health officer</td>
</tr>
<tr>
<td>CKD</td>
<td>chronic kidney pathway</td>
</tr>
<tr>
<td>CLABS1</td>
<td>central line associated blood stream infection</td>
</tr>
<tr>
<td>CMBS</td>
<td>Commonwealth Medicare Benefit Scheme</td>
</tr>
<tr>
<td>CMI</td>
<td>Client Management Interface</td>
</tr>
<tr>
<td>CMIA</td>
<td><em>Crimes (Mental Impairment and Unfitness to be Tried) Act 1997</em> (Review)</td>
</tr>
<tr>
<td>CMI/ODS</td>
<td>Client Management Interface/Operational Data Store</td>
</tr>
<tr>
<td>CNS</td>
<td>Clinical Nurse Specialists</td>
</tr>
<tr>
<td>COPD</td>
<td>chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>CORE</td>
<td>Centre for Outcome and Resource Evaluation</td>
</tr>
<tr>
<td>CPC</td>
<td>community palliative care</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
<td>----------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CSO</td>
<td>community service organisation</td>
</tr>
<tr>
<td>CTN</td>
<td>clinical training networks</td>
</tr>
<tr>
<td>DEECD</td>
<td>Department of Education and Early Childhood Development</td>
</tr>
<tr>
<td>DET</td>
<td>Department of Education and Training</td>
</tr>
<tr>
<td>DFI</td>
<td>Dr Foster Intelligence</td>
</tr>
<tr>
<td>DHHS</td>
<td>Department of Health and Human Services</td>
</tr>
<tr>
<td>DRG</td>
<td>diagnosis-related group</td>
</tr>
<tr>
<td>DTC</td>
<td>day therapy centre</td>
</tr>
<tr>
<td>DuV</td>
<td>dental unit of value</td>
</tr>
<tr>
<td>DWAU</td>
<td>dental weighted activity unit</td>
</tr>
<tr>
<td>EBA</td>
<td>enterprise bargaining agreements</td>
</tr>
<tr>
<td>ECDS</td>
<td>Electronic Communications Devices Scheme</td>
</tr>
<tr>
<td>ECT</td>
<td>electroconvulsive treatment</td>
</tr>
<tr>
<td>ED</td>
<td>emergency department</td>
</tr>
<tr>
<td>eMAP</td>
<td>Electronic Management and Assistance for Primary Care</td>
</tr>
<tr>
<td>ESIS</td>
<td>Elective Surgery Information System</td>
</tr>
<tr>
<td>F1</td>
<td>Financial Data</td>
</tr>
<tr>
<td>FIM</td>
<td>Functional Independence Measure</td>
</tr>
<tr>
<td>FOBT</td>
<td>faecal occult blood test</td>
</tr>
<tr>
<td>FTE</td>
<td>full-time equivalent</td>
</tr>
<tr>
<td>GEM</td>
<td>geriatric evaluation and management</td>
</tr>
<tr>
<td>GST</td>
<td>goods and services tax</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>HAI</td>
<td>healthcare-associated infections</td>
</tr>
<tr>
<td>HARP</td>
<td>Hospital Admission Risk Program</td>
</tr>
<tr>
<td>HDSS</td>
<td>health data standards and systems</td>
</tr>
<tr>
<td>HEN</td>
<td>home enteral nutrition</td>
</tr>
<tr>
<td>HIP</td>
<td>Health Independence Program</td>
</tr>
<tr>
<td>HIRC</td>
<td>Health Innovation and Reform Council</td>
</tr>
<tr>
<td>HITH</td>
<td>Hospital in the Home</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>HPV</td>
<td>Health Purchasing Victoria</td>
</tr>
<tr>
<td>HSMR</td>
<td>Hospital standardised mortality ratios</td>
</tr>
<tr>
<td>ICS</td>
<td>Integrated Cancer Services</td>
</tr>
<tr>
<td>ICT</td>
<td>information communication technology</td>
</tr>
<tr>
<td>ICU</td>
<td>intensive care unit</td>
</tr>
<tr>
<td>IHCS</td>
<td>Integrated Hepatitis C Service</td>
</tr>
<tr>
<td>IHI</td>
<td>Individual healthcare identifiers</td>
</tr>
<tr>
<td>IHPA</td>
<td>Independent Hospital Pricing Authority</td>
</tr>
<tr>
<td>ISCP</td>
<td>Individualised Client Support Packages</td>
</tr>
<tr>
<td>i-SNAC</td>
<td>interim-subacute and non-acute classification</td>
</tr>
<tr>
<td>KMS</td>
<td>Koori Maternity Services</td>
</tr>
<tr>
<td>LGBTI</td>
<td>Lesbian, Gay, Bisexual, Transgender and Intersex</td>
</tr>
<tr>
<td>LOP</td>
<td>length of phase</td>
</tr>
</tbody>
</table>

Volume 2: Health operations 2017–18, Chapter 2

Acronyms and abbreviations
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOS</td>
<td>length of stay</td>
</tr>
<tr>
<td>MDS</td>
<td>Hospital Minimum Payroll and Workforce Employee Dataset</td>
</tr>
<tr>
<td>METeOR</td>
<td>metadata online registry</td>
</tr>
<tr>
<td>MHCC</td>
<td>Mental Health Complaints Commissioner</td>
</tr>
<tr>
<td>MHCSS</td>
<td>mental health community support services</td>
</tr>
<tr>
<td>MHT</td>
<td>Mental Health Tribunal</td>
</tr>
<tr>
<td>MICA</td>
<td>Mobile Intensive Care Ambulance</td>
</tr>
<tr>
<td>MOU</td>
<td>memorandum of understanding</td>
</tr>
<tr>
<td>MPS</td>
<td>multipurpose service</td>
</tr>
<tr>
<td>MSS</td>
<td>Membership Subscription Scheme</td>
</tr>
<tr>
<td>MYEFO</td>
<td>Mid-Year Economic and Fiscal Outlook</td>
</tr>
<tr>
<td>NAESG</td>
<td>Non-Admitted Emergency Services Grant</td>
</tr>
<tr>
<td>NAQAL</td>
<td>Not Automatically Qualified for Admission List</td>
</tr>
<tr>
<td>NATA</td>
<td>National Association of Testing Authorities</td>
</tr>
<tr>
<td>NBCSP</td>
<td>National Bowel Cancer Screening Program</td>
</tr>
<tr>
<td>NDIS</td>
<td>National Disability Insurance Scheme</td>
</tr>
<tr>
<td>NDSS</td>
<td>National Diabetes Syringe Scheme</td>
</tr>
<tr>
<td>NEAT</td>
<td>National Emergency Access Target</td>
</tr>
<tr>
<td>NEC</td>
<td>national efficient cost</td>
</tr>
<tr>
<td>NEHTA</td>
<td>National E-Health Transition Authority</td>
</tr>
<tr>
<td>NEP</td>
<td>national efficient price</td>
</tr>
<tr>
<td>NEPT</td>
<td>non-emergency patient transport</td>
</tr>
<tr>
<td>NETS</td>
<td>Newborn Emergency Transfer Service</td>
</tr>
<tr>
<td>NFC</td>
<td>Nationally Funded Centres</td>
</tr>
<tr>
<td>NGO</td>
<td>non-government organisation</td>
</tr>
<tr>
<td>NHIPPC</td>
<td>National Health Information and Performance Principal Committee</td>
</tr>
<tr>
<td>NHRA</td>
<td>National Health Reform Agreement</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service (United Kingdom)</td>
</tr>
<tr>
<td>NHT</td>
<td>nursing home type</td>
</tr>
<tr>
<td>NPA</td>
<td>national partnership agreement</td>
</tr>
<tr>
<td>NRCP</td>
<td>National Respite for Carers Program</td>
</tr>
<tr>
<td>NSAP</td>
<td>National Standards for Providing Quality Palliative Care</td>
</tr>
<tr>
<td>NSP</td>
<td>Needle and Syringe Program</td>
</tr>
<tr>
<td>NSQHS</td>
<td>National Safety and Quality Health Service</td>
</tr>
<tr>
<td>NWAU</td>
<td>national weighted activity unit</td>
</tr>
<tr>
<td>OCIO</td>
<td>Office of the Chief Information Officer</td>
</tr>
<tr>
<td>OCP</td>
<td>Optimal Care Pathways</td>
</tr>
<tr>
<td>OHS</td>
<td>occupational health and safety</td>
</tr>
<tr>
<td>OHSC</td>
<td>Office of the Health Services Commissioner</td>
</tr>
<tr>
<td>OIS</td>
<td>operational infrastructure support</td>
</tr>
<tr>
<td>PARC</td>
<td>prevention and recovery care</td>
</tr>
<tr>
<td>PAS</td>
<td>performance assessment score</td>
</tr>
<tr>
<td>PCEHR</td>
<td>Personally Controlled Electronic Health Record</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Partnership</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>PDI</td>
<td>Peter Doherty Institute for Infection and Immunity</td>
</tr>
<tr>
<td>PDRSS</td>
<td>Psychiatric Disability Rehabilitation and Support Services</td>
</tr>
<tr>
<td>PRISM</td>
<td>Program Report for Integrated Service Monitoring</td>
</tr>
<tr>
<td>PSRACS</td>
<td>public sector residential aged care service</td>
</tr>
<tr>
<td>PTC</td>
<td>patient treatment coordinator</td>
</tr>
<tr>
<td>QDC</td>
<td>Quarterly Data Collection</td>
</tr>
<tr>
<td>RACs</td>
<td>Royal Australasian College of Surgeons</td>
</tr>
<tr>
<td>REACH</td>
<td>Retrieval and Critical Health</td>
</tr>
<tr>
<td>ROSH</td>
<td>risk of significant harm</td>
</tr>
<tr>
<td>RRAP</td>
<td>Risk Reduction Action Plan</td>
</tr>
<tr>
<td>RRI</td>
<td>Reducing Restrictive Interventions</td>
</tr>
<tr>
<td>RRP</td>
<td>Risk-rated premium</td>
</tr>
<tr>
<td>RUG ADL</td>
<td>Resource Utilisation Group – Activity of Daily Living</td>
</tr>
<tr>
<td>SAMS</td>
<td>Service Agreement Management System</td>
</tr>
<tr>
<td>SAVVI</td>
<td>Supporting Accommodation for Vulnerable Victorians Initiative</td>
</tr>
<tr>
<td>SCTT</td>
<td>service coordination tools template</td>
</tr>
<tr>
<td>SDE</td>
<td>Secure Data Exchange</td>
</tr>
<tr>
<td>SHERP</td>
<td>State health emergency response plan</td>
</tr>
<tr>
<td>SIDS</td>
<td>Sudden infant death syndrome</td>
</tr>
<tr>
<td>SOII</td>
<td>Surgical Outcomes Information Initiative</td>
</tr>
<tr>
<td>SoP</td>
<td>statement(s) of priority</td>
</tr>
<tr>
<td>SRHS</td>
<td>small rural health service</td>
</tr>
<tr>
<td>SRS</td>
<td>supported residential services</td>
</tr>
<tr>
<td>STEMI</td>
<td>ST Elevation Myocardial Infarction</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmissible infections</td>
</tr>
<tr>
<td>SWEP</td>
<td>Statewide Equipment Program</td>
</tr>
<tr>
<td>T&amp;D</td>
<td>training and development</td>
</tr>
<tr>
<td>TAC</td>
<td>Transport Accident Commission</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>TPN</td>
<td>total parenteral nutrition</td>
</tr>
<tr>
<td>UCC</td>
<td>Urgent Care Centre</td>
</tr>
<tr>
<td>VADC</td>
<td>Victorian Alcohol and Drug Collection</td>
</tr>
<tr>
<td>VADS</td>
<td>Victorian Ambulance Data Set</td>
</tr>
<tr>
<td>VAED</td>
<td>Victorian Admitted Episodes Dataset</td>
</tr>
<tr>
<td>VAGO</td>
<td>Victorian Auditor-General’s Office</td>
</tr>
<tr>
<td>VALP</td>
<td>Victorian Artificial Limb Program</td>
</tr>
<tr>
<td>VASM</td>
<td>Victorian Audit of Surgical Mortality</td>
</tr>
<tr>
<td>VCCAMM</td>
<td>Victorian Consultative Council on Anaesthetic Mortality and Morbidity</td>
</tr>
<tr>
<td>VCCN</td>
<td>Victorian Cardiac Clinical Network</td>
</tr>
<tr>
<td>VCDC</td>
<td>Victorian Cost Data Collection</td>
</tr>
<tr>
<td>VCOR</td>
<td>Victorian Cardiac Outcomes Registry</td>
</tr>
<tr>
<td>VCTC</td>
<td>Victorian Clinical Training Council</td>
</tr>
<tr>
<td>VEMD</td>
<td>Victorian Emergency Minimum Dataset</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>VFPMS</td>
<td>Victorian Forensic Paediatric Medical Services</td>
</tr>
<tr>
<td>VGPB</td>
<td>Victorian Government Purchasing Board</td>
</tr>
<tr>
<td>VHES</td>
<td>Victorian Healthcare Experience Survey</td>
</tr>
<tr>
<td>VHIA</td>
<td>Victorian Hospitals Industrial Association</td>
</tr>
<tr>
<td>VHIMS</td>
<td>Victorian <em>health incident management policy</em></td>
</tr>
<tr>
<td>VIC-DRG</td>
<td>Victorian-modified diagnosis related group</td>
</tr>
<tr>
<td>VICNISS</td>
<td>Victorian Healthcare Associated Infection Surveillance System</td>
</tr>
<tr>
<td>VIFM</td>
<td>Victorian Institute of Forensic Mental Health</td>
</tr>
<tr>
<td>VINAH</td>
<td>Victorian Integrated Non-Admitted Health</td>
</tr>
<tr>
<td>VMIA</td>
<td>Victorian Managed Insurance Authority</td>
</tr>
<tr>
<td>VMNCN</td>
<td>Victorian Maternity and Newborn Clinical Network</td>
</tr>
<tr>
<td>VPAS</td>
<td>Victorian Perinatal Autopsy Service</td>
</tr>
<tr>
<td>VPCN</td>
<td>Victorian Paediatric Clinical Network</td>
</tr>
<tr>
<td>VPCS</td>
<td>Victorian Product Catalogue System</td>
</tr>
<tr>
<td>VPD</td>
<td>Victorian Perinatal Data Collection</td>
</tr>
<tr>
<td>VPRS</td>
<td>Victorian Paediatric Rehabilitation Service</td>
</tr>
<tr>
<td>VPTP</td>
<td>Victorian paediatric training program</td>
</tr>
<tr>
<td>VRMD</td>
<td>Victorian Radiotherapy Minimum Dataset</td>
</tr>
<tr>
<td>VRSS</td>
<td>Victorian Respiratory Support Service</td>
</tr>
<tr>
<td>VSCC</td>
<td>Victorian Surgical Consultative Council</td>
</tr>
<tr>
<td>VWA</td>
<td>Victorian WorkCover Authority</td>
</tr>
<tr>
<td>WASE</td>
<td>Weighted Ambulatory Service Event</td>
</tr>
<tr>
<td>WAU</td>
<td>weighted activity unit</td>
</tr>
<tr>
<td>WBD</td>
<td>weighted bed day</td>
</tr>
<tr>
<td>WIES</td>
<td>weighted inlier equivalent separation</td>
</tr>
<tr>
<td>WOT</td>
<td>weighted occupancy target</td>
</tr>
</tbody>
</table>