

19 Appendices

Appendix 1—Consultation and Liaison

The development of the proposals and processes outlined in this document have been undertaken with industry support and advice. The Department has had regular liaison with metropolitan Networks, country hospitals and the Victorian Healthcare Association on matters relating to casemix development. Refinement of the AR-DRG Version 4.1 weights has been through the consultants KPMG and after discussions with representatives of the Casemix Clinical Sub-Committee. Major consultative groups have included the following in addition to industry specific consultations:

- The Victorian Casemix Clinical Committee, chaired by Associate Professor John Wilson, has provided substantial advice and support in the development of general policy initiatives, classification and implementation issues.
- The Victorian Ambulatory Classification System (VACS) Clinical Panel chaired by Dr Peter Greenberg, has provided substantial advice and has overseen the assignment of hospital clinics.
- The Emergency Services Categorisation and Funding Taskforce has reviewed the emergency categorisation for 2000–01.
- The Rehabilitation Monitoring and Review Committee provides advice on the development and implementation of the new rehabilitation classification and funding system.
- The Advisory Committee on Access to Elective Surgery, chaired by A/Professor Colin Russell, provides advice on the elective component of the Hospital Access Program and monitors public hospital waiting lists.
- The Ministerial Taskforce on Trauma and Emergency Services provided advice to Government on a best practice state-wide trauma system model responsive to the identified needs of critically ill trauma patients.
- A Trauma System Implementation Reference Group and a monitoring group will guide the implementation of the new co-ordinated Statewide Trauma Service.
- The Renal Reference Group consists primarily of practising clinicians. It monitors on an ongoing basis growth, pricing mechanisms and technical developments in this modality.
- The Industry Finance Committee provides a forum to discuss and resolve industry wide financial issues including directions for purchasing policy.
- The Tax Reform Industry Working Group provides a forum to discuss issues and seek advice arising from the Commonwealth Government's introduction of FBT and GST legislation.
- The Clinical Costing Standards Committee (CCSC) comprises hospital clinical costing and finance managers and develops clinical costing standards.
- A review of Positron Emission Tomography (PET) was undertaken. This included the establishment of an Advisory Group comprising the providers of PET Services and also involved consultation with rural and metropolitan hospitals and regions.
- The Victorian Cystic Fibrosis Expert Advisory Committee will be established in June 2000 to provide advice on mechanisms to improve coordination between service providers; enhance quality of care and improve access to expertise in all aspects of cystic fibrosis.
- The BreastCare Advisory Committee, chaired by Mrs Lyn Swinburne, has provided expert advice to the Breast Care Coordination Unit on the implementation of the Breast Disease Service Redevelopment Strategy and its associated programs and initiatives.
- The Acute Health Clinical Indicator Steering Committee is advising the Department on the development, implementation and reporting of performance indicators.

- The Victorian Advisory Committee on Casemix Data Integrity examines data issues related to casemix funding and includes departmental and industry representation.
- The Victorian Hospital Patient Register Reference Committee comprises representatives from clinical groups, consumer advocacy, and technical and health information professionals. It examines the technical feasibility, use and service management value of establishing a state-wide register of Victorian public hospital clients.
- The Critical Care Interhospital Transfer Monitoring and Advisory Group assists in the ongoing development of the critical care interhospital transfer component of the Hospital Access Program.
- The Steering Committee for the project to develop and trial a model for the monitoring of patient satisfaction in Victorian hospitals has provided advice to the Department on future directions and methodology for obtaining feedback from patients on their experiences of care.
- The Chest Pain Evaluation Area Working Party assists with the implementation of the Chest Pain Evaluation Area pilot. It includes representatives from the Department and the three pilot hospitals.
- The Discharge Strategy Expert Advisory Group includes hospital, community and consumer representatives and provides the Department with guidance on the implementation of the Effective Discharge Strategy.
- The Hospital in the Home Advisory Committee, provided advice on the HITH Program.
- The Victorian Hospitals Organ Donation Project is a joint project of the Australian and New Zealand Intensive Care Society and the Department. It provides advice on the organ donation audit and family survey.
- The Expert Working Group on Surveillance of Nosocomial Infections has been reviewing currently available surveillance systems and advising on minimum data sets and possible performance indicators.
- External assessors have provided expert advice and referees reports on projects and programs submitted for the Quality Improvement Program and projects funded as part of the quality improvement Funding for the Maternity Services Program.
- The Post Acute Care Resource Allocation Model Project Steering Committee provided advice to the Department on the development of a new resource allocation model for the Post Acute Care Program to be implemented in 2000–01.
- The Health Promotion in Emergency Departments Steering Committee oversees the development and implementation of a pilot project funding health promotion activities in seven Melbourne suburban emergency departments.
- The Bed Management Working Group, largely comprising hospital management from metropolitan hospitals with major emergency departments, has assisted the Department with the development of the Winter Emergency Demand Strategy.
- The Neonatal Services Advisory Committee was established in 2000 and is chaired by Dr Andrew Perrignon. It advises the Department on the development of neonatal services and comprises members from neonatal nursing and medical staff, rural and metropolitan hospitals.

Appendix 2—VicRehab: Weighted Units Specification

Calculation of Rehabilitation Weighted Units

The following describes the steps involved in calculating the rehabilitation weight score for patients:

- 1) Allocate the patient to a CRAFT category
- 2) Determine the patient's length of stay (LOS)
- 3) Determine whether the patient is a low outlier, inlier or high outlier and look up the appropriate weights in the weights table in *Section C*. It may be necessary to multiply a daily weight by the number of days.

1. Allocating the patient to a CRAFT Category

CRAFT categories are based upon the patient's clinical program and in some cases admission Barthel score. Technical instructions are given in Box 1.

Box 1

Clinical Sub Program

10, 31 to 39

Admission Barthel < 60

CRAFT category = Stroke/Neuro Low Barthel

Admission Barthel ≥ 60

CRAFT category = Stroke/Neuro High Barthel

81 to 84

Admission Barthel < 60

CRAFT category = Ortho Fracture Low Barthel

Admission Barthel ≥ 60

CRAFT category = Ortho Fracture High Barthel

85, 86

Admission Barthel < 60

CRAFT category = Ortho Replace Hip/Knee Low Barthel

Admission Barthel > 59 and < 80

CRAFT category = Ortho Replace Hip/Knee Medium Barthel

Admission Barthel ≥ 80

CRAFT category = Ortho Replace Hip/Knee High Barthel

89

Admission Barthel < 60

CRAFT category = Other Ortho Low Barthel

Admission Barthel ≥ 60

CRAFT category = Other Ortho High Barthel

90, 101, 109

CRAFT category = Cardio/Pulmonary

61 to 69, 71 to 79, 120, 132-133, 140, 150

Admission Barthel < 60

CRAFT category = Other Rehabilitation Low Barthel

Admission Barthel ≥ 60

CRAFT category = Other Rehabilitation High Barthel

2. Determining length of stay

Use the LOS field as reported to the VAED.

3. Calculating the Stay Status and appropriate weights score

A patient is a sameday if admitted and separated on the sameday. Samedays patients are identified within the VAED by 'Y' in the sameday field.

A patient is a short stay if the stay is overnight and 1 to 3 days. Low outlier patients are those where the length of stay is 4 days or more and less than the low boundary.

A patient is an inlier if their stay is equal to or more than the inlier low boundary and less than or equal to the inlier high boundary. A high outlier patient is one whose stay is longer than the inlier high boundary.

Refer to *VicRehab Units: 2000–01 Rehabilitation Weights* in Section C for appropriate weight. Details for calculating the stay status and calculating the rehabilitation score for each status are given in Box 2. These scores can then be added to give the total number of Rehabilitation Weighted Units for the Hospital. Refer to *Rehabilitation Weighted Units Specification* for descriptions of the variables in Box 2.

Box 2

Calculating stay status and appropriate Rehabilitation Weighted Unit score

LOS = 1 and Sameday = 'Y'
Stay Status = **Sameday**
Rehabilitation score = **SD**

LOS = 1 and Sameday = 'N'
Stay Status = **Short Stay**
Rehabilitation score = **SS**

LOS = 2 or LOS = 3
Stay Status = **Short Stay**
Rehabilitation score = **SS**

LOS = ≥ 4 and LOS < LIB
Stay Status = **LOW OUTLIER**
Rehabilitation score = **LO_PD**

LOS \geq LIB and LOS \leq HIB
Stay Status = **INLIER**
Rehabilitation score = **MD_IN**

LOS > HIB
Stay Status = **HIGH OUTLIER**
Rehabilitation score = **MD_IN + ((LOS - HIB) x HO_PD)**

Rehabilitation Weighted Units Specification and Technical Definitions

Variables in columns shown within the table *VicRehab Units: 2000–01 Rehabilitation Weights* in Section C are outlined and described below. Each column in the weights table has been given a label below to assist in calculating the Rehabilitation Score, e.g. SD = Sameday Weight.

Definition of CRAFT Categories

CRAFT	<p>Short Stay /Overnight (1 - 3 days) Stroke/Neurological LB < 60 Stroke/Neurological HB ≥ 60 Orthopaedic Fracture LB < 60 Orthopaedic Fracture HB ≥ 60 Orthopaedic Replace Hip/Knee LB < 60 Orthopaedic Replace Hip/Knee MB 60 - 79 Orthopaedic Replace Hip/Knee HB ≥ 80 Other Orthopaedic LB < 60 Other Orthopaedic HB ≥ 60 Cardio/Pulmonary Other Rehabilitation LB < 60 Other Rehabilitation HB ≥ 60</p>	<p>For 1999–2000, twelve of the sixteen CRAFT categories will be used to fund Level 2 rehabilitation units with twenty beds or more. A separate category is provided for short stay patients (overnight stays of 1 to 3 days). Separate weights are provided for these thirteen funding categories. (See Section C).</p> <p>LB means a low admission Barthel score of up to 59. HB means a high admission Barthel score of 60 or over (or for Orthopaedic Replace Hip/Knee, 80 or more). MB means a medium admission Barthel score of 60 to 79.</p>
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Technical Definition of Variables (See VicRehab Units: 2000–01 Rehabilitation Weights in Section C)

Low Inlier Boundary	Inlier Boundaries Low LIB	The low length of stay boundary for inliers. Patients with a length of stay of more than 3 days and less than the low boundary are classed as low outliers. The low boundary point is set at the Average Length Of Stay for the category less 4 days. Boundaries are truncated to the nearest whole number. The estimated average length of stay is calculated from the 1997-98 VIMD data.
High Inlier Boundary	Inlier Boundaries High HIB	The high length of stay boundary for inliers. Patients with a length of stay greater than the high boundary are classed as high outliers. The high boundary point is set at the Average Length Of Stay for the category plus 4 days. Boundaries are rounded to the nearest whole number. The estimated average length of stay is calculated from the 1997-98 VIMD data.
Same day	Same Day Weight SD	<p>The Rehabilitation Weighted Unit allocated to patients who are admitted and separated on the same day. The weight is derived as:</p> <p>* Inlier Weight ÷ Low Inlier Boundary</p> <p>The factor of 0.7 is in recognition that sameday stays do not incur overnight resource costs.</p>
Short Stay	Short Stay Weight SS	The Rehabilitation Weighted Unit allocated to patient overnight stays from 1 to 3 days.
Multi-day per diem low outlier weight	Low Outlier Per Diem LO_PD	<p>The per diem Rehabilitation Weighted Unit value allocated to patients who have a length of stay of at least four days and less than the low boundary. The weight is derived as:</p> <p style="text-align: center;">Inlier Weight ÷ Low Boundary</p> <p>The total Rehabilitation Weighted Unit value is calculated by multiplying the low outlier multi-day weight by the patient's length of stay.</p>
Multi day Inlier weight	Inlier weight MD_IN	Inliers are patients whose length of stay falls on or between the low and high boundary. This weight is calculated based on the weights derived from the average cost of inliers in the CRAFT category as reported in the 1998 Victorian Cost Weights Study.

<p>Multi-day per diem high outlier weight</p>	<p>High Outlier Per Diem HO_PD</p>	<p>The per diem Rehabilitation Weighted Unit value allocated to patients whose length of stay is in excess of the high boundary. This is derived from: $0.9 * \text{Inlier Weight} \div \text{average length of stay}$ <p>The factor of 0.9 is in recognition that the days at the end of a patients stay are less resource intensive than days at the beginning of a patients stay.</p> <p>The total Rehabilitation Weighted Unit value for high outliers is calculated by multiplying the high outlier multi-day weight by the number of days the patient stays beyond the high boundary and adding to the inlier weight:</p> $\text{Inlier weight} + (\text{LOS} - \text{high boundary}) * \text{high outlier per diem}$ </p>
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Appendix 3—Hospital Access Program

In 2000-01 the Hospital Access Program (HAP) will work in conjunction with other Government initiatives such as the Emergency Demand Strategy to measure, report on and enhance access to the key areas of elective surgery, emergency and critical care services. The HAP makes \$30 million available to health services for meeting performance targets, with \$13 million allocated to both emergency services and elective surgery and \$4 million to critical care.

Eligibility

Hospitals participating in the HAP are determined as follows:

- Emergency services hospitals are Group A or B hospitals with 24 hour emergency departments which have provided more than 4200 emergency WIES7 during 1999–2000.
- Critical care hospitals are metropolitan hospitals with a Level 2 or 3 intensive care unit and/or a Level 2, 3 or 4 Cardiac Care service.
- Elective surgery hospitals are those reporting through ESIS. Non reporting elective surgery hospitals receive reduced HAP payments which are not tied to meeting targets.

Participating hospitals are listed at the end of this section.

Performance Expectations

Good performance in elective, emergency and critical care services is crucial to a sound public hospital system. In 1999-2000, a number of issues were identified which provide direction to the Government's approach to these services in 2000-2001. These issues are integrated bed management, seasonal bed management, and system wide performance.

The importance of integrated bed management has been highlighted in preparations for winter 2000, through the Winter Emergency Demand Strategy. Hospitals should consider the inter-relationship between performance in elective, emergency and critical care services and work to achieve the best outcome across these areas. A number of hospitals have already reviewed bed management practices, and all hospitals should be considering the best methods of ensuring optimal usage of beds.

Hospitals also need to examine the seasonal fluctuations in demand for emergency, elective and critical care services, to plan for increasing emergency demand in winter and to take advantage of non-winter months to more uniformly schedule elective surgery.

It is important for hospitals to consider how their own performance contributes to performance at a system level for all indicators. In particular, this should occur for those indicators which have an overall system impact, such as ambulance bypass and interhospital transfers.

Indicators, Targets and Bonus Reductions

As outlined in the main body of this document, a number of new indicators have been introduced across the three component areas, including a number specifically related to Government policy commitments.

In addition, a standardised approach to target setting has been adopted, replacing targets individually negotiated with hospitals. This will enable measurement and reporting of hospital

performance against common targets, as the Department moves to increased public reporting of performance, and will simplify bonus recall arrangements.

The structure for bonus reductions has been revised to encourage greater attention to bed management and system performance, as well as to maintain a strong focus on those indicators related to the care of seriously ill patients.

The changes to bonus reductions against specific indicators is summarised as follows:

Emergency Services

- Reductions applied to admission block are calculated differently and the reduction is no longer capped at 60 per cent. This reflects the Government's concern that performance in emergency services improves and its funding injection to enable this to occur.
- The bonus reduction for triage category 2 emergency patients needing to be seen in 10 minutes has increased as these are urgent patients. Indicators and targets for triage category 4 & 5 patients have been included in the Program but no bonus reduction applies when targets are not met for this financial year.
- Length of stay in the emergency department will be monitored this year, and an indicator measuring those patients spending over 24 hours in the emergency department prior to admission will be introduced. No bonus reductions will apply to these indicators this year.

Elective Surgery

- Targets and bonus reductions applying to existing elective surgery indicators, with the exception of category 2 patients, remain unchanged. Treating all Category 1 patients in 30 days remains critical and this is reflected in the high bonus reduction where the target is not achieved. While bonus reductions for performance against the remaining indicators is less, waiting list management to treat patients in order of need and in the minimum possible time clearly enhances patient care and is a priority of the Government.
- A new indicator measuring hospital initiated postponements of elective surgery has also been introduced. Performance against this indicator will be closely monitored during 2000–01 but no bonus reductions apply this year.

Critical Care

- An additional indicator measuring the number of intensive care beds open in metropolitan Melbourne hospitals, has been added. Intensive care bed state has been monitored for some time by the Office of the Coordinator of Emergency and Critical Care Services. It will continue to be monitored with no bonus reductions applying this financial year, but will be publicly reported.

The indicators, targets and bonus reductions for not meeting targets are summarised in the following table.

More detailed information can be found in HAP Business Rules, which will be provided separately. This will also include bonus reduction and target information for data quality and timeliness, which will also be in operation in 2000–01.

	Indicators	Targets	Bonus Reductions
Emergency Services	• Proportion of triage category 1 emergency patients seen immediately	100%	20% per patient
	• Proportion of triage category 2 emergency patients seen within 10 minutes	80%	5% per % point over
	• Proportion of triage category 3 emergency patients treated on time	75%	1% per % point over
	• Proportion of triage category 4 emergency patients treated on time	60%	No reduction
	• Proportion of triage category 5 emergency patients treated on time	60%	No reduction
	• Number of occasions of ambulance bypass	5 per quarter	2% per bypass
	• Proportion of patients admitted to ward in less than 12 hours	95%	#
	• Number of patients staying in the emergency department for longer than 24 hours	To be determined	No reduction
Elective Services	• Length of stay in emergency departments	To be determined	No reduction
	• Proportion of category 1 elective surgery patients treated within 30 days	100%	20% per patient
	• Proportion of category 2 elective surgery patients treated within 90 days	75%	2% per % point over
	• Average waiting time of category 2 elective surgery patients	85 days	2% per % point over (capped at 20%)
	• Average waiting time of category 3 elective surgery patients	300 days	1% per % point over
	• Multiple postponements of elective surgery	To be determined	No reduction
	• Growth in elective surgery waiting list	No growth from Jan 1 '00	1% per % point over
Critical Care Services	• Proportion of intensive care patients transferred because no bed was available	1.7%/3%/7%*	6% per patient
	• Proportion of coronary care patients transferred because no bed was available	4%/7%/8%*	6% per patient
	• Number of intensive care beds open	Demonstrated increase	No reduction
Data Quality and Timeliness	These are included in HAP Business Rules.		

*according to hospital groupings included in HAP Business Rules

Details on the bonus reduction to apply to the number of patients admitted to ward in over 12 hours are contained in the HAP Business Rules.

Allocation and Payment of Bonuses

Bonuses will be paid retrospectively according to hospitals' performance against targets, following receipt of relevant data.

The method of determining the maximum bonus available to each hospital aims to take account of hospitals' level and complexity of workload, which are related to ability to meet targets. Bonus allocations are derived as follows:

- Emergency services—\$13 million is allocated across hospitals according to participating hospitals' relative projected proportion of 1999-2000 multi-day emergency public and private WIES7.
- Critical care—\$4 million is allocated across hospitals according to each hospital's projected proportion of 1999-2000 elective and emergency public and private WIES7.

- Elective surgery—Non ESIS hospitals receive a proportion of \$6.5 million, allocated according to each hospital's relative share of the total state-wide public and private elective surgical WIES7. The remainder of the \$13 million is distributed among ESIS hospitals according to the number of patients on the waiting list and the average WIES7 per patient separation at that hospital.

To maximise the funds from the bonus pool that are channelled into the system, a high proportion of bonus funds retained by the Department when hospitals have not met targets will be reallocated to hospitals that exceed performance requirements. Some funds will also be used to undertake or complete Access Projects, both state-wide projects such as Consistency of Triage in Emergency Departments, and hospital projects for final payments on Hospital Access Development Program projects which are in train.

Elective Surgery	Emergency Services	Critical Care
The Alfred	The Alfred	The Alfred
The Angliss Health Service	The Angliss Health Service	The Angliss Health Service (CCU only)
Austin & Repatriation Medical Centre	Austin & Repatriation Medical Centre	Austin & Repatriation Medical Centre
Ballarat Health Services	Ballarat Health Services	
Barwon Health	Barwon Health	
Bendigo Health Care Group	Bendigo Health Care Group	
Box Hill Hospital	Box Hill Hospital	Box Hill Hospital
Dandenong Hospital	Dandenong Hospital	Dandenong Hospital
Frankston Hospital	Frankston Hospital	Frankston Hospital
Goulburn Valley Health	Goulburn Valley Health	
New Latrobe Regional Hospital	New Latrobe Regional Hospital	
Maroondah Hospital	Maroondah Hospital	Maroondah Hospital
Monash Medical Centre	Monash Medical Centre	Monash Medical Centre
The Northern Hospital	The Northern Hospital	The Northern Hospital
Royal Children's Hospital	Royal Children's Hospital	
Royal Melbourne Hospital	Royal Melbourne Hospital	Royal Melbourne Hospital
The Royal Victorian Eye and Ear Hospital		
Royal Women's Hospital		
Sandringham & District Memorial Hospital	Sandringham & District Memorial Hospital	Sandringham & District Memorial Hospital
St Vincent's Hospital (Melbourne)	St Vincent's Hospital (Melbourne)	St Vincent's Hospital (Melbourne)
Sunshine Hospital		
Wangaratta District Base Hospital		
West Gippsland Healthcare Group		
Western Hospital	Western Hospital	Western Hospital

Appendix 4—Identified Savings