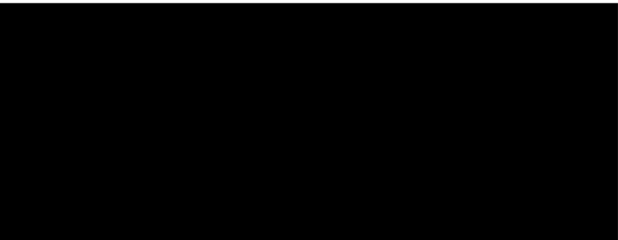
IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

ATTACHMENT FD-5 TO STATEMENT OF FRANCES MARIE DIVER



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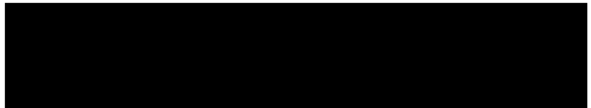

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Attachment FD-5

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Department of Health

health

Victorian health policy and funding guidelines 2014–15

State Government Victoria

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Victorian health policy and funding guidelines 2014–15

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Ministers' foreword

Victoria's health system continues to lead the nation in providing responsive, integrated and innovative healthcare options. The Victorian Government has a clear plan to meet the challenge of a growing population and increased demand for service and provide quality healthcare for all Victorians. The Government also recognises that improving patient access to health services is fundamental to Victorians' quality of life.

The 2014–15 State Budget delivers total funding of $15 billion to the Victorian health system and over the next four years will provide an additional:

- $1.4 billion to support hospitals
- $190 million to boost elective surgery
- $156 million to better support Victorians with mental illness or drug and alcohol addiction
- $60 million to enhance access to health services during peak winter demand

Central to meeting this commitment to the health of all Victorians are specific funding measures that will boost the capacity of essential hospital services including critical care, maternity services and emergency departments across the system. Emergency departments will also receive increased funding to better identify, respond and intervene early in instances of family violence and sexual assault. Health service capacity will also be increased in order to improve patient access during periods of peak demand including over the winter months.

Elective surgery capacity will receive a boost in order to meet increasing levels of demand and ensure that more patients are treated sooner. The Victorian Government is also increasing funding to meet growth in demand for ambulance services, as well as expanding the Victorian Patient Transport Assistance Scheme to enhance access to health services for rural and regional Victorians.

Advice from the Health Innovation Reform Council will continue to support the effective efficient delivery and management of quality health services and the reform of the public health system. The health system will also respond to changes in demand by improving bariatric patient care through service consolidation and access to services by increasing the number of bariatric procedures undertaken. There will also be a boost to alcohol and drug services, including expansion of drug treatment services to support more effective education and treatment responses. The Government is also supporting health services to respond to clinical and non-clinical violence and aggression by patients, staff and visitors. The Government has legislation before the Parliament to ensure emergency workers are protected (Sentencing Amendment (Assaults on Emergency Workers) Bill 2014).

A significant change for the coming year is the introduction of Victoria's new *Mental Health Act 2014*. The new legislation is a key element in the government's mental health reform agenda and places individuals and families at the centre of mental health treatment and care. Funding has been committed to the implementation of key mental health initiatives and to growing mental health services including new Prevention and Recovery Care units and continued housing support for people with a mental illness through the Doorways project.

In the coming financial year, the Victorian Government will support capital projects and infrastructure improvements including state-of-the-art cardiac services at Sunshine Hospital, Latrobe Regional Hospital redevelopment, Boort Hospital redevelopment, expansion of Healesville Hospital and expansion of the Austin Hospital short stay unit.

Funding will also support the replacement of critical engineering infrastructure in hospitals, such as lifts, boilers and electrical equipment, and will continue the replacement of medical equipment in metropolitan and rural health services.

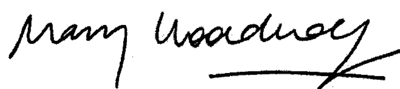
In the community, there will be a new Barwon Health North facility and a new building for Moyne Community Health Service in Port Fairy. There will also be increased support for older people through the Home and Community Care (HACC) program to assist them to remain living in their homes for longer. Victorians with diabetes will be supported to manage their conditions with free access to insulin syringes and pen needles through the National Diabetes Syringe Scheme (NDSS).

This year, the Commonwealth Budget had a significant impact on finalising health service budgets. In particular, the National Partnership Agreement on Improving Public Hospital Services was not renewed beyond 30 June 2014 and the Commonwealth foreshadowed changes to its funding arrangements from 2017 onwards.

Despite these complications, Victorian health service budgets will increase significantly in 2014–15. The net positive result is a consequence of a strong State Budget outcome, which included increased funding for winter demand and additional competitive elective surgery. This additional State funding also allowed Victoria to attract growth funding from the Commonwealth.

The Victorian Government will continue to vigorously pursue the best interests of Victorian health services in its negotiations with the Commonwealth.

Hon David Davis MP
Minister for Health
Minister for Ageing



Hon Mary Wooldridge MP
Minister for Mental Health

Acronyms and abbreviations

ABF	activity based funding
ACAS	Aged Care Assessment Service
ACS	Australian Coding Standard
ACSQHC	Australian Commission on Safety and Quality in Health Care
ADA	Australian Dental Association
AHPACC	Aboriginal Health Promotion and Chronic Care
ALOS	average length of stay
AN-SNAP	Australian National Subacute and Non-Acute Patient Classification
AR-DRG	Australian Refined Diagnosis Related Groups
CDBS	Child Dental Benefits Schedule
CLABSI	central line associated blood stream infection
CMI	Client Management Interface
CMI/ODS	Client Management Interface/Operational Data Store
CPC	community palliative care
CSO	community service organisation
DEECD	Department of Education and Early Childhood Development
DRG	diagnosis related group
DuV	dental unit of value
DWAU	dental weighted activity unit
DVA	Department of Veterans' Affairs
FOBT	faecal occult blood test
GEM	Geriatric Evaluation and Management
GLBTI	Gay, Lesbian, Bisexual, Transgender and Intersex
HACC	Home and Community Care
HARP	Hospital Admission Risk Program
HDSS	health data standards and systems
HIP	health independence program
HITH	Hospital in the Home
i-SNAC	interim-subacute and non-acute classification
ICSP	Individualised Client Support Packages
ICU	intensive care unit
IHCS	Integrated Hepatitis C Service
IHPA	Independent Hospital Pricing Authority
KMS	Koori Maternity Services
LOP	length of phase
MICA	Mobile Intensive Care Ambulance
MHCSS	mental health community support services
MPS	Multi-Purpose Service

NAESG	Non-Admitted Emergency Services Grant
NBCSP	National Bowel Cancer Screening Program
NDSS	National Diabetes Syringe Scheme
NEAT	National Emergency Access Target
NEC	national efficient cost
NEST	National Elective Surgery Target
NEP	national efficient price
NETS	Newborn Emergency Transfer Service
NHS	National Health Service (United Kingdom)
NHT	nursing home type
NIV	non-invasive ventilatory
NPA	national partnership agreement
NSQHS	National Safety and Quality Health Service
NWAU	national weighted activity unit
PAS	performance assessment score
PARC	Prevention and recovery care
PCP	Primary Care Partnership
PDI	The Peter Doherty Institute for Infection and Immunity
PRISM	Program Report for Integrated Service Monitoring
PSRACS	public sector residential aged care service
SACS	subacute ambulatory care services
SLA	Statistical Local Area
SoP	Statement(s) of Priority
SRHS	Small Rural Health Service
TAC	Transport Accident Commission
TB	tuberculosis
TCP	transition care program
VADS	Victorian Ambulance Data Set
VAED	Victorian Admitted Episodes Dataset
VALP	Victorian Artificial Limb Program
VEMD	Victorian Emergency Minimum Dataset
VIC-DRG	Victorian-modified Diagnosis Related Group
VINAH	Victorian Integrated Non-Admitted Health
VHIA	Victorian Hospitals Industrial Association
VPCS	Victorian Product Catalogue System
VRSS	Victorian Respiratory Support Service
VWA	Victorian WorkCover Authority
WAU	weighted activity unit
WBD	weighted bed day
WIES	weighted inlier equivalent separation
WOt	weighted occupancy target

Part 1: Overview, key changes and new initiatives

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1.1 Overview

The Victorian Government is responsible for ensuring a wide range of health services are delivered to the Victorian community. The Department of Health plans, develops policy, funds and regulates health service providers and activities that promote and protect the health of Victorians. Through the department, the government funds more than 500 organisations to provide various health services to Victorians including:

- acute and subacute healthcare delivered through public hospitals and in community settings
- mental health and alcohol and other drugs services delivered through public hospitals and community service organisations (CSOs)
- residential and community care for older people, support and assistance to enable people to function independently in their own homes, positive ageing programs, and healthy and active living
- health promotion and protection through emergency management, public health and related preventative services, education and regulation
- emergency transport and ambulance services through Ambulance Victoria.

The *Victorian health policy and funding guidelines* (the guidelines) represent the system-wide terms and conditions (for funding, administrative and clinical policy) of funding for government-funded healthcare organisations.

The guidelines reflect the government and department's role as a system manager and underpin the contracts at an organisational-level (Statements of Priorities (SoPs) and service agreements). They set out the requirements that funded organisations must comply with in addition to their contractual and statutory obligations, outline activity that is required in order to receive funding, and detail expectations of administrative and clinical conduct.

The guidelines are relevant for all funded organisations including health services, community service organisations (CSOs), and other funded organisations such as Ambulance Victoria.

The Victorian health system continues to evolve as it works towards the aims of the *Victorian Health Priorities Framework 2012–2022*. This year the guidelines are presented in four parts. The 2014–15 guidelines separate the pricing and funding models from the administrative and clinical conditions of funding. The aim here is to improve the clarity and accessibility of the guidelines. The structure of the guidelines is also designed to enable CSOs to locate relevant information throughout the document.

Part 1: Overview, key changes and new initiatives provides an overview of the accountability framework for funded organisations and introduces the most significant developments in funding, policy, government priorities and service delivery for the coming year.

Part 2: Pricing and funding arrangements for Victoria's health system details the pricing and funding arrangements for public hospital services and for all other outputs provided by the department.

In order to receive funding from the Victorian Government, all funded organisations must comply with standards and policies that ensure the delivery of safe, high-quality services and responsible financial management. **Part 3: Conditions of funding** details the relevant standards and policies that may apply.

Tables detailing the modelled budgets for 2014–15 are included in **Part 4: Funding and activity levels**. Activity tables detail the 2014–15 targets for a range of programs across the health system.

In addition to these guidelines, funded organisations are expected to comply with all relevant policy documents and guidelines. A list of key policies and guidelines can be found at <www.health.vic.gov.au/pfg>.

Hospital Circulars provide updates on changes that affect health services during the year. These are available at <www.health.vic.gov.au/hospitalcirculars/index>.

Funded organisations should always refer to the *Policy and funding guidelines* website for the most recent version of the guidelines, as items may be updated throughout the year.

Where these guidelines refer to a statute, regulation or contract, the reference and information provided 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 or the Secretary to the Department of Health, the legislative, regulatory and contractual obligations will take precedence. Each funded organisation should refer to the relevant statute, regulation or contract in order to ascertain all the details of its legal obligations. If any funded organisation has any question in relation to its legal obligations it should seek independent legal advice.

A note on terminology

The term 'funded organisations' 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,* with 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, which are not health services.

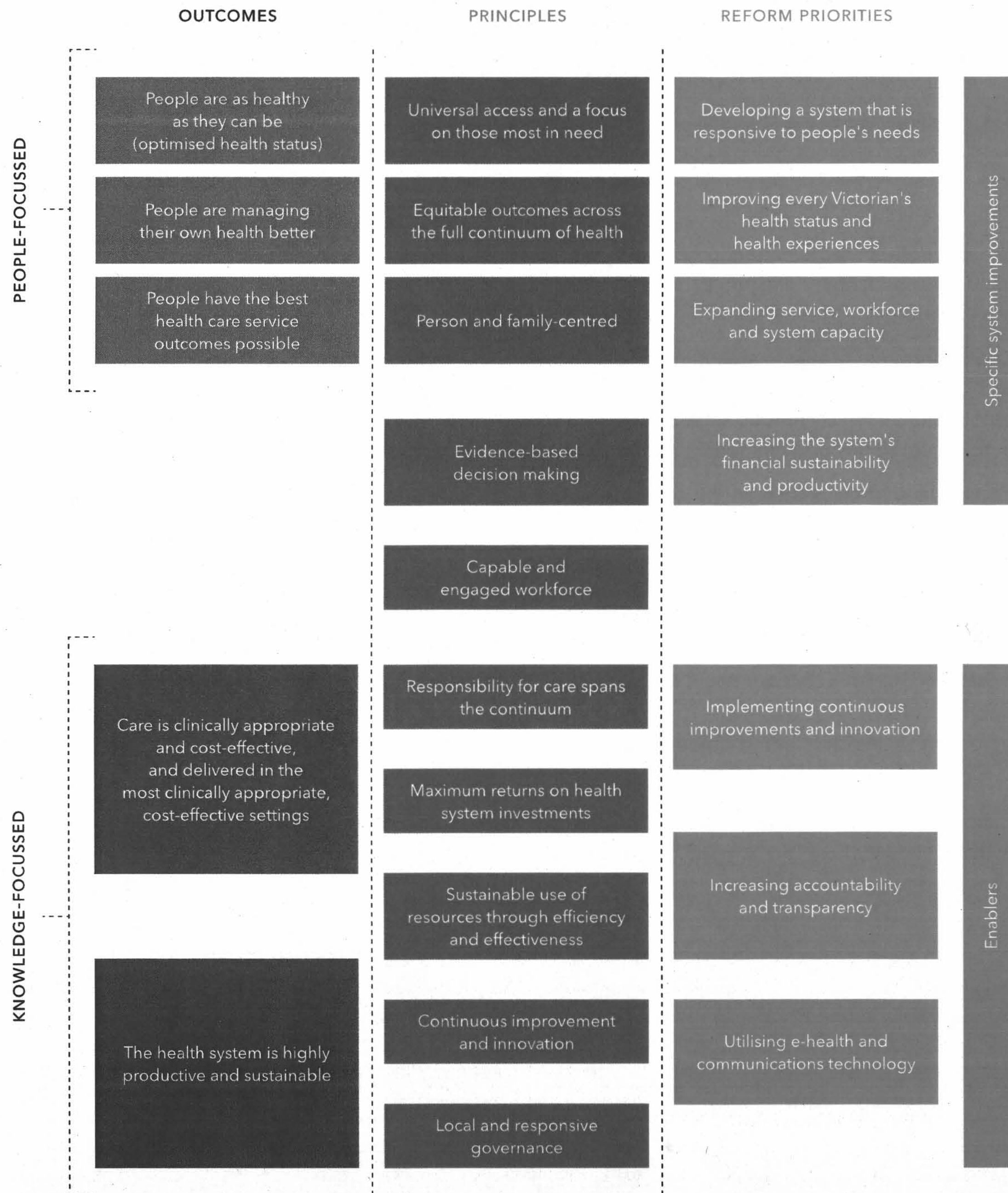
These guidelines are also relevant for Ambulance Victoria, Dental Health Services Victoria, Health Purchasing Victoria and the Victorian Institute of Forensic Mental Health. The guidelines specify where aspects of the guidelines are relevant for these organisations.

1.2 Victorian Health Priorities Framework

The *Victorian Health Priorities Framework 2012–2022* underpins the *Metropolitan Health Plan 2012* and the *Rural and Regional Health Plan 2012*. The *Victorian Health Priorities Framework* sets out the following five key outcomes the health system should strive to achieve by 2022 (Figure 1.1):

- People are as healthy as they can be (optimal health status).
- People are managing their own health better.
- People enjoy the best possible healthcare service outcomes.
- Care is clinically effective, cost-effective and delivered in the most clinically and cost-effective service settings.
- The health system is highly productive and health services are cost-effective and affordable.

Figure 1.1: ***Victorian Health Priorities Framework 2012–2022***



The *Victorian Health Priorities Framework* establishes the key outcomes, attributes and improvement priorities for the healthcare system. It provides a framework for planning and delivering an innovative, informed and effective healthcare system that is responsive to people's needs, now and in the future.

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1.3 Accountability framework

1.3.1 Policy and funding guidelines

These guidelines act as system-wide terms and conditions (for funding and administrative policy) of funding for government-funded organisations. The guidelines reflect the government and department's role as a system manager. They underpin the contracts at an organisational-level (SoPs and service agreements).

The guidelines are relevant for all funded organisations including health services (public health services, denominational hospitals, public hospitals and multipurpose services), CSOs and other funded organisations, such as Ambulance Victoria.

The department monitors all funded organisations' performance to ensure that funds are directed to appropriate services and that the government's objectives for the health system are achieved. Data and reports submitted by funded organisations form part of the accountability requirements, help the department to perform its monitoring role and contribute to planning and policy development.

Part 2 of these guidelines details the pricing and funding arrangements and Part 3 details the state and national policy, legal, reporting and operational obligations of funded organisations.

In general terms, funded organisations are expected to:

- deliver the volume of services for which departmental funding is provided
- deliver quality services consistent with prescribed standards and guidelines
- deliver services that are accessible, inclusive and responsive to the diversity of the Victorian community
- provide agreed data and reporting to meet accountability and planning requirements
- work with the department to develop new approaches to service delivery.

Funded organisations should refer to their SoP, health service agreement or service agreement for any specific conditions of funding and performance requirements.

1.3.2 Statement of Priorities

All health services (including Dental Health Services Victoria), Ambulance Victoria and the Victorian Institute of Forensic Mental Health (Forensicare) agree to a SoP, which is the key service delivery and accountability agreement between the government and health services. The SoP outlines the key performance expectations, targets and funding for the year as well as government service priorities.

SoPs are an explicit requirement under the *Health Services Act 1988* for public health services and represent the service agreement requirements under the Act for public hospitals. The SoP for Ambulance Victoria is a requirement of the *Ambulance Services Act 1986*. The SoP for the Forensicare is a requirement of the *Mental Health Act 2014.*

SoPs are agreed annually between the Minister for Health and board chairs of major public health services and Ambulance Victoria. For sub-regional and local health services and small rural health services, SoPs are agreed between the Secretary to the department and board chairs. For the Forensicare the SoP is agreed annually between the Minister for Mental Health and the board chair.

SoPs are available online at <www.health.vic.gov.au/hospitals/sops.htm>.

1.3.3 Health service and Ambulance Victoria performance monitoring framework

The *Victorian health service performance monitoring framework* describes the mechanisms the department uses to formally monitor the performance of health services and Ambulance Victoria. Health service strategic priorities for the forthcoming year are agreed as part of the annual SoP, or, where relevant, the service agreement process.

There are two key elements of the framework: the performance assessment score (PAS) and the monitoring level. The PAS provides an overall performance score for each health service based on a composite of agreed operational and financial and quality targets in the SoP. The department uses the PAS and a range of other risk factors to determine the level of monitoring required for individual health services.

In 2014–15 the performance monitoring framework will incorporate a number of new and extended directions for high performance. Changes to the framework are described in Part 1, section 1.5.1 'Health service performance measures'.

1.3.4 Community service organisations: accountability and service agreements

The department funds more than 500 CSOs to provide a wide range of health programs to individuals and the community. Thirty-two CSOs are registered community health services for the purposes of delivering state-funded community and dental health services as well as other services. These services include ageing programs; aged and home care; primary, community and dental health; mental health; public health; and alcohol and drug services. CSOs include non-government organisations, local government authorities and other not-for-profit community organisations and consortiums.

The department administers funding to CSOs through standard service agreements, which are aligned to the Victorian Government's *Common funding agreement*. The service agreements detail the primary obligations, objectives, responsibilities and accountabilities for delivering services. These agreements are the main contract management tool between the department and CSOs, and govern the funding conditions for delivering services.

These guidelines provide contextual information to support the service agreements. CSOs that enter into service agreements with the department are required to comply with relevant obligations in these guidelines.

1.3.5 Multi-Purpose Service tripartite agreements

The Multi-Purpose Service (MPS) Program is a joint initiative of the Commonwealth and the state government that aims to deliver flexible and integrated health and aged care services for small rural communities. An MPS is generally established when the local population is not large enough to support separate services (such as a hospital, a residential aged care service and Home and Community Care (HACC) services), and where there is limited access to essential health and aged care services.

The MPS applies the combined Commonwealth and state funding flexibly across acute, aged care, HACC and primary health services. This arrangement offers more choices specific to the needs of the local community and provides staff with flexibility about where they work across a range of services.

Victoria's seven MPSs operate under a tripartite payment and service agreement between the Commonwealth Department of Social Services, the Victorian Department of Health and each MPS. Agreements can be for a maximum of three years. They summarise services to be provided and details of state and Commonwealth funding and reporting requirements, including an annual activity statement and standard program reporting requirements, which align with reporting requirements for all other Victorian health services.

In accordance with agreement stipulations, MPSs are required to have a current and comprehensive service plan informed by service area health status data and extensive community consultation.

1.3.6 Notification obligations

1.3.6.1 Issues of public concern

The Health Services Act specifies the functions of health service boards and chief executive officers. Included in these functions is the requirement for boards to ensure that the Minister for Health and the Secretary to the department are advised about significant board decisions and are promptly informed about any issues of public concern or risks that affect or may affect the public health service (Health Services Act s. 65S(2)(i)). The Act also requires chief executive officers to inform the board, the Secretary and the Minister without delay of any significant issues of public concern or significant risks affecting the health service (Health Services Act s. 65XB(1)(h)).

1.3.6.2 Changes to range or scope of services

Before health services undertake a significant change in the range or scope of services, the planning implications of such a move must be discussed with the department.

Metropolitan health services should contact their department performance lead, and rural services should contact the relevant regional officer. The department must provide explicit approval before a health service may significantly alter its services.

Health services receiving small rural health service funding are exempt from this arrangement and should refer to the small rural health services guide at <www.health.vic.gov.au/ruralhealth>.

1.3.6.3 Exceptional events

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

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

See Part 2, section 2.17 'Prior-year adjustment: activity based funding reconciliation' for more details about exceptional circumstances and recall.

1.4 Budget highlights

The 2014–15 Victorian State Budget builds on previous investments and service reforms, and continues the transition to a more sustainable and innovative system that puts patients first. Investments will not only boost capacity, they will also ensure that all Victorians continue to have access to high-quality treatment and services, irrespective of where they live or their socioeconomic background.

Table 1.1 details funding by output categories provided by the 2014–15 Victorian State Budget for the department. A summary of health service modelled budgets for 2014–15 is provided at Appendix 1.1: 'Summary of modelled budgets 2014–15'.

The 2014–15 State Budget provides $14.95 billion recurrent funding for health, mental health and aged care services. This investment will enable the health system to treat the increasing number of patients and maintain delivery of high-quality services. Funding to deliver preventative health, early intervention programs and community-based care will drive efficiency by leveraging the full scope of the health and mental health systems.

Table 1.1: Victorian State Budget details – health

Output group	2013–14 Budget ($m)	2014–15 Budget ($m)	Percentage increase 2013–14 to 2014–15 [(a)(b)]
Acute health services[(c)]	9,836.0	10,275.3	4.5
Ambulance services[(d)]	661.9	696.5	5.2
Mental health[(e)]	1,203.2	1,260.6	4.8
Ageing, aged and home care[(f)]	1,216.1	1,203.7	–1.0
Primary, community and dental health[(g)]	420.9	462.3	9.8
Small rural services	534.0	560.2	4.9
Public health[(h)]	319.3	328.8	3.0
Drug services	153.5	165.1	7.6
Total	**14,344.9**	**14,952.5**	**4.2**

Source: 2014–15 Victorian Budget Paper No. 3, p. 133

Notes:

(a) The movement in the Department of Health's 2014–15 Budget compared with the 2013–14 Budget are primarily due to:

- *funding provided for government policy commitments including the full-year effect of initiative funding announced in previous years Budgets*
- *output price increases arising from price escalation for anticipated cost increases*
- *output price increases for depreciation and capital asset charge costs associated with the approved asset investment program for 2014–15*
- *output price decreases arising from government savings announced in the* 2013–14 Budget Update *and the full-year effect of efficiencies announced in previous years Budgets*
- *changes to Commonwealth funding across a number of programs.*

(b) The higher 2014–15 Budget reflects funding for implementing policy initiatives announced in the previous and current Budgets.

(c) The higher 2014–15 Budget reflects the impact of the social and community services pay equity case and funding for implementing policy initiatives announced the previous and current Budgets and increased contributions from membership. The 2013–14 expected outcome reflects a decrease in Commonwealth funding for the Expanding Early Psychosis Prevention and Intervention Centre Models and changes in carryover.

(d) The lower 2014–15 Budget reflects changes to Residents and Nursing Home contributions and the impact of previously announced changes.

(e) 2014–15 Budget reflects increase in funding for implementation of policy initiatives announced in this Budget and the impact of the social and community services pay equity case, along with changes to Commonwealth funding.

(f) 2014–15 Budget reflects adjustments to the National Partnership Agreement on Essential Vaccines.

(g) 2014–15 budget reflects increase in funding for implementation of policy initiatives announced in this budget and the impact of the social and community services pay equity case, along with changes to Commonwealth funding.

(h) 2014–15 budget reflects adjustments to the National Partnership Agreement on Essential Vaccines.

Health infrastructure is critical to delivering healthcare services, and assists in driving innovation in healthcare. The 2014–15 Victorian State Budget includes new capital projects that have a total estimated investment of $223 million. In total, the department's 2014–15 capital program comprises new and existing capital projects totalling $4.5 billion.

1.4.1 Output initiatives

The 2014–15 Victorian State Budget committed $331 million in 2014–15 ($1.2 billion over four years) to new output initiatives that will grow and strengthen the health, mental health and aged care sectors, and contribute towards the reform objectives outlined in *the Victorian Health Priorities Framework 2012–2022.*

1.4.1.1 Acute hospital and ambulance services

An additional $297 million in 2014–15 ($1 billion over four years) has been provided for acute health and ambulance services output initiatives. This investment is jointly funded by the Commonwealth Government under the *National health reform agreement*, and includes:

- $179 million ($745 million over four years) for Victorian health services to respond to growing patient demand for services, ensuring more patients will receive the services they need. This funding will provide additional emergency department presentations and admissions, chemotherapy, dialysis/radiation treatments and maternity admissions. In addition, a pilot funding model for heart, lung and heart–lung transplants will be implemented with Alfred Health. This initiative will provide greater flexibility in funding arrangements to accommodate variability in transplant activity levels.
- $60 million in 2014–15 to boost health service capacity during the winter months in metropolitan and regional health centres. This initiative will improve access to services when there is a significant increase in demand.
- $45 million ($190 million over four years) in additional funding for the Elective Surgery Program, which will be allocated on a competitive basis to drive efficiencies in elective surgery, meet increasing levels of demand and treat more Victorian elective surgery patients sooner.
- $6.6 million in 2014–15 to meet the growth in demand for ambulance services.
- $3.3 million ($14 million over four years) for the Victorian Patient Transport Assistance Scheme, providing financial assistance for more Victorians living in rural communities who need to travel significant distances to access specialised care, and to increase the travel and accommodation subsidies so they are in line with cost growth.
- $1.8 million ($8 million over four years) to improve bariatric patient care in Victoria's health system. The initiative improves access to services by consolidating and increasing the number of bariatric procedures undertaken each year. For the 2014–15 financial year, $1.8 million will be allocated to fund 200 additional bariatric surgery procedures. This initiative will build on the existing bariatric surgery programs at Alfred Health, Austin Health and Western District Health Service. In 2014–15 these health services will establish formal collaborative partnerships to provide high-quality and consistent care to patients receiving bariatric procedures across Victoria.
- $500,000 over two years for emergency departments to develop quality protocols, tools and data collection to better identify, respond to and intervene early in instances of family violence and sexual assault.

1.4.1.2 Mental health and alcohol and drug services

The 2014–15 State Budget provides $23 million in 2014–15 ($129 million over four years) for the following mental health and alcohol and drug service initiatives:

- $8.7 million ($69.3 million over four years) to develop and implement a series of programs and initiatives designed to provide targeted services and support for complex and long-stay patients. This includes $15.1 million over four years for Mental Health and Police Response funding. This initiative is partly funded by the Commonwealth Government under the *National health reform agreement.*

- $5.1 million ($21 million over four years) to open three new 10-bed prevention and recovery care (PARC) services (providing 30 new mental health beds in total. The services will operate in two metropolitan locations and one rural location to ensure Victorians with mental illnesses receive appropriate subacute care.
- $1 million ($4.2 million over four years) to continue the Innovative Housing program operated by Mental Illness Fellowship Victoria. This program supports people with mental illness to secure and maintain private rental accommodation, engage with employment opportunities and develop daily living skills.
- $8.2 million ($34 million over four years) to boost treatment and early intervention services across the state in response to the growth in crystal methamphetamine (or 'ice') and other drug use.

1.4.1.3 Ageing, aged and home care

The 2014–15 State Budget commits $5.0 million in 2014–15 ($21 million over four years) in additional funding to the HACC program.

This program provides support to older Victorians and people with a disability to enable them to remain living in their homes for longer. Support services provided includes care assessments, home nursing and allied health services. The additional funding will enable HACC services to be provided to 300,000 eligible Victorians in 2014–15.

From July 2015, HACC services for Victorians aged 65 years and older will be delivered by the Commonwealth Government.

1.4.1.4 Primary, community, public and dental health

New funding of $3.6 million ($16 million over four years) has been committed to continue and build on the following community-based care and support services:

- $1.0 million in 2014–15 ($5.5 million over four years) to continue the National Diabetes Syringe Scheme (NDSS). The NDSS provides Victorians with type 2 diabetes with free access to insulin syringes and pen needles, enabling them to manage their conditions on a daily basis and improve their health and safety.
- $2.5 million ($10 million over four years) to improve health outcomes for at risk pregnant women and their babies. This program provides ongoing funding for targeted support, including home visits and community support, for at-risk pregnant women and their babies. This includes antenatal and postnatal care programs, peer support, health education and appropriate referrals to medical specialists.
- $200,000 in 2014–15 for ANZAC centenary 'lest we forget' grants, which will be provided to cemetery trusts to commemorate the valued contribution and sacrifice of ANZAC soldiers who fought and died in World War I.

1.4.2 Asset initiatives

Table 1.2: Funding for asset initiatives

Initiative	Description	Funding
Austin Short Stay Unit (Heidelberg)	Expansion of the short stay unit at the Austin Hospital will deliver an additional 12 beds in a new facility. This additional capacity will improve patient flow through the emergency department for patients with an expected length of stay of less than 24 hours. Additional funds of $1.2 million has been committed from the Engineering Infrastructure Replacement Program announced in 2013–14 and 2014–15, and an additional $1.6 million contribution from the Austin Hospital, bringing the total cost of the project to $11.5 million.	$8.7 million

Initiative	Description	Funding
Barwon Health – North (Geelong)	The new Barwon Health North facility in Geelong's north will provide an innovative and integrated community-based services model. This will provide access to expanded services and minimise avoidable presentations and admissions at Geelong Hospital through the development of an urgent care centre and collocation of general practitioner services. In addition, this will present opportunities for co-investment from a range of healthcare providers.	$28.1 million
Boort Hospital redevelopment (Boort)	The Boort Hospital redevelopment will provide a new integrated 32-bed facility. The revised configuration will offer improved amenity for patients and staff and ensure the range of services delivered by Boort District Health continues to meet the needs of the community.	$14.0 million
Community residential alcohol and drug withdrawal service for mothers with babies	A residential independent living unit will be established for mothers withdrawing from drug and alcohol dependencies, with access to a collocated alcohol and drug centre providing day withdrawal programs.	$4.0 million
Engineering infrastructure replacement	This initiative enables the systematic replacement of highest priority at-risk essential engineering services infrastructure to reduce risks to patients and staff. It supports the continued effective delivery of acute clinical services across Victorian metropolitan and rural public hospitals.	$25.0 million
Increasing critical care capacity (statewide)	This investment will deliver 14 additional intensive care or neonatal intensive care beds, as well as upgraded and suitably equipped retrieval services in public hospitals. This will support acute health services across the state.	$4.0 million
Latrobe Regional Hospital redevelopment – stage 2A (Latrobe)	The government will expand and enhance the facilities at Latrobe Regional Hospital facilities including construction of a new emergency department, 12 short-stay beds, a new acute 30-bed ward, two day endoscopy rooms, a catheterisation laboratory, a new main entry and admissions area, a new medical records facility and new public parking.	$73.0 million
Major expansion for Healesville Hospital (Healesville)	Funding is provided to expand the upgrade of Healesville Hospital to better meet the health service needs of the Yarra Ranges community by boosting general surgical, endoscopy and gynaecological services. The expansion will deliver a new operating theatre and renal dialysis unit, as well as an expansion of the community health centre and new consulting suites.	$4.6 million
Medical equipment replacement	The replacement of highest at-risk medical equipment in acute public hospitals will continue to be undertaken on a priority basis. This will enable health services to reduce risk to patients and staff and improve service availability. This initiative helps integrate modern technology by providing up-to-date replacement medical equipment that sustains acute clinical services essential for delivering responsive and appropriate services across Victorian metropolitan and rural public hospitals.	$35.0 million
Moyne Community Health Service (Moyne)	A new community health building will be constructed in Port Fairy, enhancing the quality and amenity of services provided through the Moyne Community Health Service. The new facility will allow the health service to respond to local priorities and maintain and enhance its service delivery capacity across a range of primary health services.	$3.0 million
Prevention and recovery care services – Mildura and Warrnambool (non-metro various)	Two new PARC services will be constructed to increase the range and number of mental health services in regional Victoria. A 10-bed facility with an outpatient zone will be built in Mildura and an eight-bed facility with two additional day places will be built in Warrnambool.	$8.6 million
Transition support units (statewide)	Two 10-bed transitional step-down care units will be constructed, establishing a new service model for clients receiving long-term clinical mental health support. This will improve outcomes for people with severe mental illness by ensuring they gain access to the right treatment in the right environment.	$14.9 million

1.4.3 Boosting elective surgery capacity

The 2013–14 Victorian State Budget committed $420.7 million over four years to be distributed on a competitive basis to drive efficiencies in elective surgery, meet increasing levels of demand and treat more Victorian elective surgery patients sooner. For 2013–14, $101.3 million was allocated and $103.8 million has been allocated for 2014–15.

The 2014–15 Victorian State Budget committed an additional $190.1 million over four years to boost elective surgery capacity, with $45.4 million allocated for 2014–15.

The total amount of funding available for allocation through competitive processes in 2014–15 is $149.2 million. The objectives of the elective surgery initiatives are to:

- maximise the value of Victorian Government funding for elective surgery public patients over the long term
- drive efficiencies and innovation in elective surgery to improve access and maximise the number of public patients treated
- encourage partnerships between the public and private sector for delivering public elective surgery.

For 2014–15, Competitive Elective Surgery Initiative funding will be allocated to health services across the following pools:

- $80 million to rollover the $77 million public pool from 2013–14
- $24 million to rollover and grow the $15 million public private pool from 2013–14
- $45 million for a new 'Boosting Elective Surgery' pool.

1.5 Service performance

Continuous improvement requires systems to be in place to collect, link, analyse, benchmark and report safety and quality data within and across health settings. Armed with this information or 'business intelligence', clinicians, consumers and policy makers can more effectively use this knowledge and evidence in decision making.

The government is committed to further developing public reporting of health service performance, outcomes and consumer experience. This includes ensuring that reporting measures are fit for purpose and, where appropriate, consistent across jurisdictions.

1.5.1 Health service performance measures

In 2014–15 the department will introduce new directions for health service performance monitoring. *High-performing health services: the Victorian health services performance monitoring framework 2014–15* will replace the *Victorian health service performance monitoring framework 2013–14*, and describe new directions for performance monitoring in quality and safety, patient experience, organisational culture, clinical outcomes and system support, as well as providing a vision for high performance.

In line with these directions, the 2014–15 performance monitoring framework will also incorporate new indicators into the PAS, Part B of the SoP and the *Performance report for integrated system management.*

The 2014–15 performance monitoring framework sets out the business rules for monitoring performance in Victorian health services and Ambulance Victoria, and is available at <www.health.vic.gov.au/hospital-performance>.

1.5.2 Quality benchmarking

The department provides health services with comparative data so they can compare and benchmark their performance on a variety of quality measures. Using this information is an important component of improving the quality of healthcare.

Quarterly benchmarking reports based on the Core Hospital-Based Outcome Indicators specified by the Australian Commission on Safety and Quality in Health Care are provided to health services via the department's Program Report for Integrated Service Monitoring (PRISM) reporting tool.

In 2014 the department is also trialling the use of Quality Investigator, an interactive tool developed by Doctor Foster Intelligence. The tool supports the activities of a quality benchmarking group of 14 Victorian health services and enables them to compare and investigate their performance in areas related to length of stay, mortality and readmissions. The participating Health Services are: Alfred Health, Austin Health, Barwon Health, Ballarat Health Services, Bendigo Health, Eastern Health, Goulburn Valley Health, Latrobe Regional Hospital, Melbourne Health, Monash Health, Northern Health, Peninsula Health, St Vincent's Health and Western Health.

The department has also provided funding for the four largest tertiary health services (Alfred Health, Austin Health, Melbourne Health, Monash Health) to participate in the Doctor Foster Intelligence Global Comparators program. Membership of Global Comparators enables them to benchmark themselves against, and learn from, peer hospitals throughout the United States, United Kingdom and Europe.

1.5.3 Performance monitoring for community service organisations

The *Performance monitoring framework for funded agencies* operates across the Department of Human Services, the Department of Education and Early Childhood Development (DEECD) and the Department of Health. The framework has been in place since 2005, providing an overarching set of policies and guidelines to support departmental staff in monitoring funded agencies.

Funded agencies are commonly non-government organisations delivering aged care, community and dental health services. Health services such as hospitals and ambulance services are not included. The department is currently reviewing the framework in conjunction with the other participating departments. Sector consultation will form part of this review.

1.6 System improvements and innovation

1.6.1 Commission for Hospital Improvement

The Commission for Hospital Improvement supports the health sector to deliver better healthcare and patient outcomes in Victoria by building leadership capability, driving best practice and innovation, and facilitating communication and collaboration.

During 2014–15 the commission will:

- continue to work collaboratively with program areas to support a range of redesign initiatives including efficiency through redesign focusing of pharmacy supply chain logistics (health services funded as part of the Redesigning Health Care Program will provide reports on progress and outcomes from the improvement work they undertake)
- expand the Junior Doctors in Redesign program and support a pilot Allied Health in Redesign program
- work collaboratively with health services and program areas to facilitate a range of leadership initiatives in 2014–15 including access to leadership programs
- co-host the 3rd APAC Forum in Melbourne in September 2014 in conjunction with Ko Awatea, New Zealand, with support from the Institute for Healthcare Improvement
- run a number of the specialty clinical networks, including the Victorian cardiac clinical network, the emergency care improvement and innovation clinical network, the renal health clinical network, the stroke clinical network, the paediatric clinical network, and the maternity and newborn clinical network.

1.6.1.1 Clinical networks

Victoria is committed to the ongoing development and improvement of the health system to support and optimise the health and wellbeing of all Victorians. Clinical networks are a key mechanism for engaging and harnessing clinical leadership to promote system and quality improvement. They also support collaboration across health services to drive innovation in research and clinical practice.

Clinical networks bring together health professionals, consumers, carers, peak bodies and other stakeholder organisations to provide leadership for clinical service development across the full spectrum of care.

Victoria has clinical networks in the specialty areas of cardiac, emergency care, maternity and newborn, palliative care, paediatric, renal, stroke and cancer. In addition an intensive care network will be established in 2014-15.

Table 1.3 lists each of the networks and summarises the focus of work for 2014–15.

Table 1.3: Clinical networks 2014–15

Clinical network	Focus in 2014-15
The Cardiac Clinical Network	The Network will continue to implement the key priorities in *Heart Health* ($21.9 million over four years was allocated in 2013–14), with a focus on delivering more flexible models of rehabilitation for cardiac (and stroke) patients, improving the management of heart failure across the care continuum and improving access to cardiology advice and cardiac surgical services. It also aims to support the implementation of pre-hospital thrombolysis.
The Stroke Clinical Network	The Network will continue to implement the *Stroke* component of the *Heart Disease and Stroke* initiative. This will include initiatives to address clinical variation identified by the Australian Stroke Clinical Registry and improve access to stroke unit care and stroke thrombolysis. Other programs aim to improve regional access to specialist services, and implement innovative models of rehabilitation for stroke (and cardiac) patients.

Clinical network	Focus in 2014-15
The Renal Health Clinical Network	The Network will continue to implement *Renal directions – Better services and improved kidney health for Victorians*. The Network will provide support for home-based therapies including home dialysis and functioning kidney transplantation and work with primary care sector to improve early detection and management of chronic kidney disease.
The Paediatric Clinical Network	The Network will work to improve coordination of and access to paediatric services, for example, telehealth to improve regional access to specialist care. It will also drive improvements in clinical standards and models of care to reduce inappropriate variation in clinical practice.
The Emergency Care Improvement and Innovation Clinical Network	The Network will continue to implement evidence based practice improvement projects in Emergency Departments; for example, paediatric care in management of fever, sedation and pain. It will also develop programs to improve investigation of chest pain in Aboriginal patients and provide support for implementation of the National Safety and Quality Health Service Standards.
The Maternity and Newborn Clinical Network	The Network will promote and evaluate the Victorian care of obese pregnant women and weight management in pregnancy guidelines. The Network will advise and collaborate on development of Safe Infant Sleeping guidelines and continue to update the neonatal e-handbook.
The Palliative Care Clinical Network	The Network will continue to implement *Strengthening Palliative Care: Policy and Strategic Directions 2011-2015*, including reviewing palliative care clinical policies and referral guidelines to specialist palliative care providers. It will also improve access for Aboriginal people to culturally appropriate palliative care and oversee the Victorian End-of-Life Care Pathways Co-ordinating Program.
The Cancer Clinical Network	The Network will align the work of the ICS and Cancer Centres, including supporting the development of Regional Cancer Centres and improving referral pathways. It will also continue to establish programs in the areas of supportive care, survivorship and the patient experience of care.
The Intensive Care Network	To be established during 2014–15.

1.6.2 Health Innovation and Reform Council

The Health Innovation and Reform Council is an advisory body established in line with the provisions set out in the *Health Services Amendment (Health Innovation and Reform Council) Act 2011*.

The council's role is to provide advice to the Minister for Health and the departmental Secretary on how best to effectively and efficiently deliver and manage quality health services and on the continuing reform of the public health system.

In addition to responding to specific requests from the Minister for advice, the council provides advice on the implementation and ongoing review of the *Victorian health priorities framework*. The council has established the Standing Committee on Health Quality, Safety and Outcomes to consider and provide advice on specific issues of quality, safety and clinical outcomes in the Victorian healthcare system.

On the basis of advice provided by HIRC, the government and department will implement a number of projects in 2014–15:

Readmissions – Improving Heart Failure Outcomes

In partnership with Heart Foundation Victoria, Readmissions – Improving Heart Failure Outcomes is a project designed to improve outcomes for people leaving hospital following an admission for heart failure.

Quality Use of Medicines

In partnership with the Pharmacy Guild, the government and department will work to improve medication management in community settings, specifically to work with consumers to support them to manage their medications more effectively.

Pricing for Quality

HIRC provided advice about financial incentives and disincentives for performance in areas of quality, safety, and outcome. In 2014–15 the Pricing for Quality scheme will be introduced (see Part 1, section 1.8.5 'Pricing for quality' for detail).

HIRC will continue to advise on several projects, including:

Health Outcomes and Wellbeing Framework

In 2014–15 there will be focus on the development and implementation of relevant outcome measures. These measures, along with existing measures of outcome, will be used to populate the Health Outcomes Framework and will provide information about the performance of the healthcare system in relation to its ability to deliver improvements in outcome.

Improving Consumer Choice in Mental Health

HIRC will provide advice on the barriers and enablers to consumer choice in mental health. The HIRC is working with a group of system leaders including consumers, carers, and clinicians to consider the issues and develop a possible approach to enhancing consumer choice.

More information can be found at the Health Innovation and Reform Council website <www.health.vic.gov.au/hirc>.

1.6.3 Mental Health Act implementation

The *Mental Health Act 2014* will commence on 1 July 2014. The legislation will introduce supported decision making, increase safeguards to rights and encourage recovery-oriented service delivery and innovation. Health services must comply with the new Act.

The department will provide recurrent funding of $5.84 million from 2014–15 to support health services to meet the new and changed requirements of the legislation.

To provide additional transition support, the department will also fund specified grants totalling $1.1 million to extend the appointment of health service Mental Health Act implementation project officers until 31 October 2014.

1.6.4 Hand hygiene

During 2014–15 health services will be invited to participate in a range of strategies to improve hand hygiene culture in Victorian hospitals. The department is working with Hand Hygiene Australia to pilot and implement an electronic toolkit to improve the efficiency of hand hygiene auditing and increase capacity across the sector. Combined with this pilot will be the implementation of a statewide auditing validation exercise and the introduction of an organisation-wide hand hygiene self-assessment tool that broadens the focus beyond compliance auditing to a more comprehensive oversight of hand hygiene awareness and engagement across the organisation.

1.6.5 Telehealth

The *Victorian Health Priorities Framework 2012–2022: Rural and Regional Health Plan* identified the potential to use telehealth as part of a coordinated, integrated and sustainable service model to support improved service access, provide optimal care to patients and support health service staff to deliver healthcare.

Telehealth can be a cost effective, real-time and convenient alternative to the more traditional face-to-face way of providing healthcare, professional advice and education. It can help to remove many of the barriers currently experienced by health consumers and professionals, such as distance, time and cost, which can prevent or delay the delivery of timely and appropriate healthcare services and educational support.

The department has established a telehealth unit to identify synergies and opportunities for leverage from projects, as well as ensuring that the projects reflect the overall objectives of the government and department.

In 2014-15 the telehealth unit has six strategic priorities:

- informing investment
- enabling technology
- supporting consumers and health professionals
- supporting good practice and planning
- ensuring good governance
- supporting innovation

In 2014-15, the telehealth unit will publish critical success factors for successful telehealth implementation and will also develop information around medico-legal issues associated with delivering services via telehealth. The department is funding a number of initiatives to promote the sustainable uptake of telehealth in Victorian public health services that leverages off existing investment in a coordinated way.

The objectives are to:

- improve patient outcomes
- drive greater efficiency in the way health care is delivered
- support the delivery of the quality health care across the state and
- make telehealth a viable alternate to the way some health care is traditionally delivered.
- Further details around telehealth is available on the new telehealth website <health.vic.gov.au/telehealth>.

1.6.6 Ageing, aged care and supported residential services

1.6.6.1 Public residential aged care reforms

The department will assist health services in metropolitan Melbourne to reallocate a number of public sector residential aged care service (PSRACS) places to non-government providers, in line with the 2012 Budget Update initiative, *Growing non-government provision of aged care beds*.

The department will continue supporting other health services operating PSRACS through a range of system improvement initiatives designed to support sustainable service delivery for the provision of safe, high quality care.

The department has commissioned the Victorian Healthcare Association to lead a sector-directed program of activities aimed at supporting PSRACS providers to implement key strategic, financial and operational changes associated with the Commonwealth's aged care regulatory and funding changes effective 1 July 2014. The department will also provide advice to rural services in their implementation of minor capital grants, to support alignment with the Commonwealth's *Significant refurbishment* guidelines. This aims to ensure that minor capital investments are directed towards upgrades that contribute to the availability of increased accommodation supplements.

The department will assist PSRACS through resources and training support to optimise the linkages between resident assessment, care and the funding received through the Aged Care Funding Instrument. It will also provide advice to rural services in their implementation of Service Development Program projects to improve sustainable business operations.

1.6.6.2 Seniors programs and participation initiatives

In 2014–15 the Victorian Government will implement a range of initiatives to improve the lives of Victoria's older people. These will include releasing the *Seniors participation action plan* prepared by the

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Commissioner and Ministerial Advisory Committee for Senior Victorians and implementing Victorian Tech Savvy Seniors – a Seniors Card age-friendly partnership with Telstra. This partnership will deliver information technology training in libraries using training resources developed specifically for older people. The government has provided funds via the Victorian Public Library Network for a program of free technology training sessions for seniors in public libraries.

Telstra and the Seniors Card program will support a pilot iPad lending library for seniors at the Yarra Plenty Regional Library Service. Library members who are also Seniors Card holders will be able to borrow an iPad to use at home and attend a training course in the library, which will be supplemented by in-home training tools.

The government will continue to support Seniors Card age-friendly shopping precincts in partnership with local governments and traders associations.

1.6.7 Acute and subacute services

1.6.7.1 Cardiac and stroke services

Health services will be required to implement the policy document *Heart health – improved services and better outcomes for Victorians* released in January 2014 and the government's 2013–14 commitment of $21.9 million over four years to improve access to treatment for heart disease and stroke, especially in rural and regional Victoria.

Key actions include:

- rapid access to urgent blood-clot-dissolving drugs (thrombolysis) pre-hospital for people experiencing a heart attack in rural and remote areas of Victoria
- improved access to specialist advice for rural and regional clinicians to manage suspected cardiac and stroke patients
- improved triage and referral pathways to streamline access to specialist cardiac surgical services
- new or strengthened models of care to improve management and support for people with chronic heart failure
- improved cardiac and stroke recovery through new or strengthened models of care for community rehabilitation
- statewide performance monitoring for cardiac and stroke interventions and outcomes measurement.

1.6.7.2 Emergency department care

Implementing the recommendations from the 2013 Ambulance Transfer Taskforce report will be a key focus in 2014–15. The report outlines a whole-of-system approach to improve ambulance patient transfers into emergency departments. These include developing a standardised clinical handover protocol for transferring ambulance patients, introducing two new time stamps for patient transfer time into the Victorian Emergency Minimum Dataset (VEMD) and introducing ambulance arrivals boards in major hospitals.

Hospital service improvement initiatives that: optimise alternatives to hospital admission; ensure definitive treatment is provided as early as possible; and use evidence to reduce variation in care, optimise acute patient flow and enhance overall system coordination.

1.6.7.3 State trauma system

Critically ill patients with multiple injuries require a multidisciplinary, coordinated and integrated system of trauma care. The Victorian State Trauma System's staged levels of care ensure that trauma patients receive appropriate definitive management.

Adult major trauma services are provided by The Alfred and the Royal Melbourne Hospital and the paediatric major trauma service is provided by the Royal Children's Hospital.

- The major trauma services will continue to receive specified funding to provide definitive care to most of the state's major trauma caseload (either through primary triage or secondary transfer) and to deliver leadership and support to the broader system.

A review of the major trauma guidelines (including the major trauma triage and inter-hospital guidelines and the specialist major trauma guidelines) commenced in 2013–14 and revised guidelines will be released in 2014–15. This review will ensure the guidelines are consistent with best available evidence.

A statewide trauma education program for clinical staff is being developed to support clinical staff who provide early care for major trauma patients outside of a major trauma service. The key program elements are a statewide web-based learning management system incorporating electronic learning modules and a trauma literature warehouse.

Further information regarding the system and its funding is available at <www.health.vic.gov.au/trauma>.

1.6.7.4 Maternity and neonatal services

In 2014–15 there will be a focus on maternity services (antenatal clinics) meeting the implementation requirements of the *Specialist clinics in Victorian public hospitals access policy* (2013) to ensure women have timely and equitable access to services.

The department (in collaboration with DEECD) is revising guidelines to enhance continuity of care between hospitals and maternal and child health services.

There will be ongoing attention on enhancing the sustainability of rural maternity and neonatal services through regional and sub-regional approaches to planning. This will be supported by the Victorian Government's commitments to improve rural obstetrics data, support rural midwifery and provide postgraduate training for specialist rural general practitioners.

The department will continue to work with stakeholders to explore new models of care for maternity and neonatal services. This will include expanding publicly funded home birthing provided by public hospitals.

The neonatal service system will also be expanded, with five additional neonatal intensive care unit cots being added in 2014–15. The department will also explore opportunities to enhance the capability of selected special care nurseries.

The Koori Maternity Services (KMS) program, which is currently provided in 11 Aboriginal community-controlled health organisations and three public hospitals, will benefit from new statewide guidelines. The guidelines will enhance the delivery of the KMS program and strengthen the clinical governance arrangements and relationships between hospital and community-based services.

The Victorian Government is funding the Royal Women's Hospital over three years to develop and pilot a statewide parenting kit to provide evidence-based and consistent clinical information and advice on pregnancy, parenting and early childhood development. To complement this, the department will develop consumer information on the Victorian maternity and neonatal service system.

1.6.7.5 Renal health – kidney care

In conjunction with the Renal Health Clinical Network, the department will continue to support the implementation of *Renal directions — Better services and improved kidney health for Victorians.*

- In 2014–15 specific projects will focus on strategies to deliver:
- increased patient independence and improved health outcomes through continuing support for home dialysis as the first option for dialysis
- improved coordination of care through the development of consistent patient pathways for chronic kidney disease, kidney transplantation, dialysis and supportive patient care
- improved capacity in primary care to recognise and manage the early signs of kidney disease
- continue structural reform of services.

1.6.7.6 Advance care planning implementation strategy

Advance care planning: have the conversation – a strategy for Victorian health services 2014–2018 aims to increase opportunities for people to develop advance care plans and for these plans to be activated in health services. The strategy provides practical information to help health services implement advance care planning and sets key measures in four priority areas. In 2014–15 health services are expected to implement formal advance care planning structures and processes, including establishing a system for preparing and/or receiving and documenting advance care plans in partnership with a patient's carer/substitute decision-maker.

1.6.7.7 Clinical Leadership Group on the Care of Older People in Hospital

In 2014–15 the Clinical Leadership Group on the Care of Older People in Hospital will be undertaking projects to identify and develop evidence-based best practice clinical tools and resources. The focus for these projects is the specific care needs of older people in hospital. They will also support health services to meet the National Safety and Quality Health Service (NSQHS) Standards and aim to:

- improve partnerships with consumers by involving older people in decisions about their care
- recognise and respond to clinical deterioration in older people
- identify and respond to older people at risk of harm
- improving medications safety for older people in hospital.

The projects more specifically will look at:

- addressing misconceptions about involving older people in decisions and enabling older people to be engaged in their care
- involving patients and their carers through a focus on structured communication processes such as interdisciplinary clinical rounds
- identifying acute care needs of the less urgent older person presenting to the emergency department
- risk screening and assessment for avoiding preventable harm for older people in hospital
- minimising the risk of harm from malnutrition for older people in hospital
- discharge summary medication information – is this meeting the needs of older people?
- medication regimes for older patients with complex medical issues – the Parkinson's Passport
- optimising the use and safe prescribing of medications for older people in hospital

Best care for older people everywhere – the toolkit is the resource that supports this work plan.

1.6.7.8 Credentialling and scope of clinical practice

The *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services policy* applies to all senior medical staff (including dentists) and eligible midwives appointed to a Victorian health service.

In 2013–14 the department undertook a review of the policy's implementation and the *Partnering for performance* framework. The department will be working with senior doctors and health services to implement the findings of the review in 2014–15.

Further information is available at <www.health.vic.gov.au/clinicalengagement/credentialling>.

1.6.7.9 Perinatal autopsy service

In 2014–15 the Perinatal Autopsy Service will move to a centralised model, with a lead health service providing administrative and clinical leadership under an integrated governance arrangement.

Where there is uncertainty about the cause of death, the value of perinatal or infant autopsy and pathological examination of the placenta should be communicated and offered to parents (refer to Part 2, section 2.2.7 'Perinatal autopsy services'). This information also assists the Consultative Council on Perinatal Mortality and Morbidity to undertake its functions.

1.6.8 Specialist clinics access

The department released the *Specialist clinics in Victorian public hospitals access policy* in May 2013. During 2014–15 the department will continue to work with the sector to implement the policy. The policy and an accompanying implementation guide can be accessed on the department's specialist clinics program website at <www.health.vic.gov.au/outpatients/policy>.

The policy provides business rules and associated timeframes for specialist clinic processes, with key areas covered including: referral management; clinical prioritisation; managing waiting lists; appointment scheduling and booking; patient flow and care coordination; discharge; and performance monitoring.

The policy applies to the 26 health services currently in scope to report specialist clinics data through the Victorian Integrated Non-Admitted Health (VINAH) minimum dataset and are listed in Table 1.4. Health services are responsible for ensuring compliance with the policy by developing appropriate implementation processes. Health services are expected to comply with the policy by 1 July 2015.

Table 1.4: Health services in scope for the *Specialist clinics in Victorian public hospitals: access policy*

Health service	
Albury Wodonga Health	Monash Health
Alfred Health	Northeast Health Wangaratta
Austin Health	Northern Health
Ballarat Health Services	Peninsula Health
Barwon Health	Peter MacCallum Cancer Centre
Bendigo Health Care Group	South West Healthcare
Central Gippsland Health Service	St Vincent's Health
Eastern Health	The Royal Children's Hospital
Goulburn Valley Health	The Royal Victorian Eye and Ear Hospital
Latrobe Regional Hospital	The Royal Women's Hospital
Melbourne Health	West Gippsland Healthcare Group
Mercy Public Hospital Inc.	Western Health
Mildura Base Hospital	Wimmera Health Care Group

The department encourages all other health services providing specialist clinic services to work towards meeting the objectives and principles of the policy.

1.6.9 Ambulance services

In 2014–15 the department is supporting initiatives aimed at improving ambulance patient transfer times into emergency departments to free up ambulance resources for emergency response in the community and to improve the patient experience. New initiatives consider a whole-of-system approach to optimising ambulance distribution across health services and the readiness of hospitals to assume responsibility and provide the most appropriate clinical care for patients arriving by ambulance

As part of the government's plan for improving cardiac services for all Victorians, Ambulance Victoria is expanding the Mobile Intensive Care Ambulance (MICA)-based service that provides pre-hospital administration of thrombolytic (clot-dissolving) drugs for patients experiencing heart attacks. This is particularly relevant in areas of Victoria where timely access to health-service-delivered therapy is not available.

The service began in the Gippsland Region and will be progressively expanded to other rural regions including Hume, Loddon Mallee, Grampians and Barwon-South Western during 2014–15. All rural and

regional MICA paramedics and MICA Air Ambulance paramedics will be trained to administer thrombolytic therapy to people experiencing a heart attack by June 2017.

The Non-Emergency Patient Transport Regulations 2005 are being reviewed to reflect the new Mental Health Act, which will be implemented on 1 July 2014. The sector has been advised of these proposed changes and updates will be provided as the revision progresses.

During 2014–15 the department will continue to consider a range of potential reforms to the non-emergency transport sector to improve this sector's efficiency and patients' experiences. This will include looking at current funding models, delivery modes and the scope of this sector. Consultation will occur with key stakeholders and some reforms may be piloted during 2014–15. See Part 1, section 1.8.3 'Ambulance Victoria'.

During 2014–15 the department will also update the *Non-emergency patient transport clinical practice protocols* to capture changes in clinical practice that have occurred since the protocols were first implemented. This will help realise greater efficiencies in the sector.

1.6.10 Community health services

In order to consolidate the initiatives of recent years and further strengthen community health services, the following initiatives will be progressed in 2014–15:

- The newly developed Community Health Integrated Program guidelines will be rolled out into the sector, providing guidance on service design and program delivery. This includes supplementary guidelines on service delivery in the priority areas of child health and refugee and asylum seeker health and managing chronic disease.
- Community health indicators, designed to support continuous quality improvement in program delivery, will be trialled in partnership with community health services.
- Ongoing improvements in funding accountability will be implemented, building on recent improvements to the Community Health Minimum Dataset.
- Work will begin on a consolidated performance monitoring framework for funded providers of community health services.

1.6.10.1 The Health Literacy Response Framework Project

Deakin University, Monash University and the Victorian Department of Health (HACC, Community Health Program and Health Independence Program) are working together on a research project through an Australian Research Council Linkage Grant. The purpose of the project is to develop a response framework that helps health and community services to identify and respond appropriately to the health literacy needs of their local populations.

The aims of the project are to improve health outcomes and reduce health inequalities for people with long-term conditions through:

- building an understanding of the health literacy of individuals
- developing service provider responses tailored to different health literacy needs
- building system-wide capacity to build the community's health literacy.

In 2014–15 the project will focus on developing and testing interventions that respond to local health literacy needs.

1.6.11 New consumer participation and experience policy

The *'Doing it with us not for us': Strategic direction 2010–13* policy and the *Cultural responsiveness framework* were reviewed in 2013–14.

In 2014–15 the department, in partnership with Health Services, consumers and carers, will be using the policy and framework evaluation findings to develop:

- a new policy to lead consumer, carer and community participation across the Victorian health system and enhance responsiveness to our diverse community members
- a specific policy component to guide health literacy improvement and the development of consumer health information
- tools and resources to help health services partner with consumers, carers and the community to improve the quality and safety of healthcare.

1.6.12 Patient experience: Victorian Healthcare Experience Survey

Establishing a new measurement and public reporting process under the Victorian Healthcare Experience Survey will include moving from a general patient satisfaction questionnaire to one more focused on patient experience. This approach will identify areas where the patient experience can be improved and what aspects of care are enhancing person- and family-centred care. The survey results will provide health services with actionable results.

The surveys are based on the United Kingdom's National Health Service's (NHS) survey and includes some questions from the American National Research Corporation. The surveys include the new Australian national core common set of patient experience questions. For the first time the department will include paediatric and parent/carer questionnaires for inpatients and emergency department service users.

Four new patient experience surveys are being developed for the following cohorts:

- Community health service clients (primarily non-general practitioner primary healthcare clients) will be surveyed using a tool based on the NHS primary care survey
- Specialist clinic patient experience data will be collected using a tool based on the NHS adult outpatient survey and the Picker Europe paediatric and parent/carer outpatient survey
- Public residential aged care residents and carers will be surveyed using a tool developed from the NHS primary care survey and Australian patient experience surveys.

These four new surveys will be developed with the community and services during 2014–15.

All surveys are being developed with funded agencies, consumer and carer working groups. They are being cognitively tested with consumers (and where appropriate carers), piloted through a sample of the appropriate funded agencies and will include verbatim comments thematically streamed from survey respondents.

1.6.13 Meeting the needs of Victoria's diverse populations

To be responsive to people's needs, the department is:

- developing men's health strategic directions to provide guidance on how to improve health system responses to men's needs
- reviewing its *Language services policy*, which provides guidance about ensuring effective communication between health service providers and people who speak no or little English, or whose first language is Auslan (Australian Sign Language)
- developing a refugee and asylum seeker health action plan that will define the long-term strategic vision for how the health system can best meet the health and wellbeing needs of refugees and asylum seekers
- developing a health and wellbeing plan for the gay, lesbian, bisexual, transgender and intersex (GLBTI) community based on a community consultation process and the advice of the GLBTI Health and Wellbeing Ministerial Advisory Committee 2013–14.

Further information is available at <www.health.vic.gov.au/diversity>.

1.6.14 Tuberculosis Control Program

The department is relocating the Tuberculosis (TB) Control Program to Melbourne Health, where it will be renamed the Victorian Tuberculosis Program. This will involve transferring 12 public health nurses who provide case management to people with active TB to ensure adherence with treatment, as well as contact-tracing and screening to determine any spread of infection. Melbourne Health was selected through a competitive process and will provide the program according to the Victorian TB procedure manual and the TB protocol. The department has developed performance measures for Melbourne Health, which are identified in the Victorian TB Control Program service objectives and scope document.

1.6.15 Implementation of changes to the *Assisted Reproductive Treatment Act 2008*

Changes to the *Assisted Reproductive Treatment Act 2008* are due to begin from 2014. The main purpose of the changes is to enable people conceived from gametes (an egg or sperm) donated before 1 July 1988 to obtain identifying information about their donor where available and with the consent of the donor. Other purposes of the changes include securing access to and preserving donor treatment records and increasing the availability of counselling and support services to a wide array of donor conception stakeholders. Implementation will primarily be managed within existing resources with additional recurrent funding to the Victorian Assisted Reproductive Treatment Authority to meet the new and changed requirements.

1.6.16 Private Health Care Facilities Bill 2014

The Private Health Care Facilities Bill 2014 is proposed to replace Part 4 of the Health Services Act. The main purpose of the change is to provide a regulatory framework to continue to register and regulate private healthcare facilities and create new powers to better enable a risk-based approach to be implemented while reducing red tape and modernising and streamlining provisions. This will provide a regulatory framework that is sufficiently flexible to be able to respond to future health service innovations and complement national quality assurance schemes. These changes are proposed to commence in early 2015.

1.7 The pricing and funding framework for Victorian health services

1.7.1 Pricing and funding framework

Victoria has a long-established system of devolved governance for healthcare delivery. The Victorian Government sets the broad policy objectives for the health system and determines the funding models and performance expectations. A network of arm's-length health services then delivers services within those parameters. Devolved governance allows health services to meet local needs, recognising that a solution in one place may not be the most effective solution in another environment.

Since the introduction of the casemix funding model in 1993, Victoria has been a national leader in the development of activity-based funding for public hospital services. Over the past 20 years, applying innovative funding approaches and models of care has enabled Victorian public hospitals to deliver high-quality, effective and efficient services to the Victorian community.

Over recent years the Victorian Government has continued to implement reforms and make adjustments to improve Victoria's funding model and approach. This had been in the context of establishing a national activity-based funding model for the purposes of calculating the Commonwealth contribution to the states. The national model emulates the Victorian framework in both its devolved structure for delivery and its methodology for allocating funding based on activity.

The Victorian funding model also acknowledges that not all activities are suitable for an activity-based funding approach, including where activities tend to have relatively high fixed costs and where they are not readily classifiable. In addition, activity-based funding is not always the best way to drive integrated care across organisational boundaries. The Victorian model provides for a variety of funding mechanisms, including grants for specific purposes, activities not suitable for activity-based funding, and to promote quality and other objectives.

Victoria utilises the national system as a mechanism for determining the Commonwealth's funding contribution to Victoria rather than the pricing system under which all funding flows to health services.

This approach seeks to provide budget stability and predictability for Victorian health services, which is necessary because it enables health services to manage the risk of fluctuations in the price paid for delivering services. Victoria will continue to price activity-based services according to its own policy priorities and will continue to explore potential reforms to the funding model, such as capitation.

As and when components of the national pricing model are suitable for adoption, particularly those relating to non-admitted, subacute and mental health service activity, Victoria could adopt or adapt them as part of its pricing framework.

Under the 2014–15 Victorian approach:

- activity targets and prices will be set according to the existing Victorian funding models, which are supported by current information and financial systems
- in-scope activity targets will be converted into the equivalent National Weighted Activity Units (NWAU); funding will be flowed to health services through the National Funding Pool according to those targets
- health services will report activity and monitor revenue using the existing Victorian funding models.

Victoria's obligations under the *National health reform agreement* to pay hospitals according to the national model will continue to be met by converting Victoria's activity targets into NWAUs and flowing funding through the National Funding Pool according to these targets.

1.7.2 Commonwealth funding

Funding for public health is a combined Commonwealth and State responsibility. However, the Commonwealth Government has implemented successive and substantial cuts to funding for the Victorian health system since 2012–13.

In 2012–13 the Commonwealth Government reduced funding to Victorian health services by $107 million. The Commonwealth reduction in health service funding was announced after Victorian health service budgets were set and took effect in November, with an immediate impact on health service budgets. The Commonwealth Government's decision to return funding of $107 million to Victorian health services was a one-off Commonwealth payment, leaving an ongoing Commonwealth shortfall in promised funding of $368 million over the next three years.

Similarly and in addition, in 2013–14 the Commonwealth Government reduced National Health Reform funding to states and territories, including by $283 million to Victorian health services over the period 2014–15 to 2016–17. In the 2014–15 Commonwealth Budget, the Commonwealth Government made downwards adjustments to National Health Reform funding, resulting in a reduction in funding to Victoria of $20 million in 2014–15 and $440 million from 2015–16 to 2017–18.

The 2014–15 Commonwealth Budget includes savings of $1.8 billion over four years from 2014–15 by ceasing the funding guarantees under the *National health reform agreement* 2011, and revising Commonwealth public hospital funding arrangements from 1 July 2017. From July 2014 to June 2017, NHRA funding will be linked to the level of services delivered by public hospitals as provided under the NHRA. During this period, each state's entitlement will be directly linked to the growth in public hospital activity provided in that jurisdiction. The Commonwealth Government has announced that from 2014–15 the funding guarantees under the agreement will cease.

The Commonwealth Government has also announced the Commonwealth's decision to not renew the national partnership for operational funding for 326 subacute beds generated under the *National partnership agreement on improving public hospital services*, with an estimated ongoing impact of $100 million per year.

In addition, the Commonwealth Government is reprioritising funding of $1.5 billion over five years from the Aged Care Workforce Supplement and will increase aged care subsidies for home and residential care providers and relevant community programs, plus a viability supplement to eligible residential aged care providers. The Commonwealth Government will also aim to achieve savings of $652.7 million over four years by ceasing Payroll Tax Supplement payments to currently eligible residential aged care providers from 1 January 2015.

The Commonwealth Government has also announced the Commonwealth's decision to not renew the national partnership for operational funding for 326 subacute beds generated under the *National partnership agreement on improving public hospital services*, with an estimated ongoing impact of around $100 million per year. However, the Victorian Government has been able to replace this funding so that Victorians continue to benefit from investments in subacute health services.

1.8 Funding reforms 2014–15

Ongoing funding reform is required to achieve longer term sustainability and adapt to new challenges. Each year funding models are reformed and updated to improve the functioning of the health system. In 2013–14 there was progressive implementation of a nationally consistent approach to activity-based funding for acute admitted services, emergency department services and non-admitted patient services from 1 July 2012, which was extended to cover in-scope admitted mental health and subacute services on 1 July 2013.

The 2014–15 Commonwealth Budget included a number of significant changes to Commonwealth funding of health and Commonwealth–State relations more broadly. While the changes will result in cost shifting to the states in the short and longer term, more broadly the Commonwealth Government's announcements, if fully implemented, would herald the most significant change to the Australian healthcare sector in decades.

The timetable for implementing national activity-based funding has been driven by the Commonwealth Government's growth funding methodology, rather than the feasibility of producing mature models for extending activity-based funding to emergency departments, non-admitted and subacute care, and mental health services. This has resulted in the Independent Hospital Pricing Authority (IHPA) developing a national funding model been based on costing, classification and data systems that have serious gaps, and are therefore not yet fit for the purpose of supporting a national funding system, which will enable states to effectively manage their public hospital systems.

As discussed above, in line with the Victorian framework for pricing and funding health services, Victoria will maintain a Victorian funding system that adopts appropriate elements of the national approach within current Victorian funding models. Changes will continue to be made to Victorian funding models in 2014–15 to improve their functionality.

In addition to the funding reforms outlined below, in 2014–15 a number of regular updates, including rebasings, have been made to account for the most recent cost and activity data. Changes include updates to WIES21 cost weights, interim subacute non-acute classification (i-SNAC) cost weights and the non-admitted emergency services grant. See Part 2 of these guidelines for details.

1.8.1 Marginal WIES pricing

The recall and throughput policies for acute and subacute admitted services have been revised for 2014–15. The changes to the policies aim to:

- simplify the throughput and recall rates for acute admitted services
- encourage activity above target, where it is cost-effective for health services to do so and up to a capped amount, by paying a higher weighted inlier equivalent separation (WIES) price for activity delivered over target than has traditionally been the case
- discourage under-activity by recalling a higher proportion of the WIES price for activity delivered under target.

The following changes from the 2013–14 acute admitted recall and throughput rates have been introduced this year:

- adjustments to the ranges of activity below target and the corresponding rate at which recall is applied for acute admitted services (there are now two ranges and two corresponding rates for recall)
- an adjustment to the range of activity above target and the corresponding rate at which activity over target is paid (a higher WIES price will be paid for acute admitted activity up to three per cent over target).

1.8.2 WIES peer groups

Historically the Victorian health funding model has utilised different WIES prices for different types of hospitals (peer groups). Under the 2013–14 model, there are four peer groups with prices that vary significantly and do not necessarily reflect the cost of delivering admitted services across the different peer groups or promote the most efficient and effective outcomes.

In order to reduce the variance across peer groups in 2014–15, the number of WIES groups has been reduced from four to three by consolidating the regional and subregional peer groups into a regional and rural peer group. The price difference has also been reduced between the major provider, outer metropolitan and regional peer groups.

The realignment of peer groups is consistent with 2012–13 changes to progress towards reducing the number of peer groups and considers the net change of incorporating specified grants into price. Details of the new peer groups are set out in Part 2, **section 2.1.3** 'Pricing' and **Part 2, section 2.19 'Peer groups for activity based funding purposes'**.

1.8.3 Ambulance Victoria

New funding model and fee schedule for Ambulance Victoria began from 1 July 2014.

The new funding model is premised on the key principles of full cost recovery and a user-pay model and:

- establishes a sustainable basis on which to fund ambulance services in Victoria
- stabilises Ambulance Victoria's financial position in the short and long term
- ensures there is clarity regarding the services each funder is purchasing from Ambulance Victoria.

The new funding model and fee schedule will provide a stable basis on which a range of reforms to improve the efficiency and effectiveness of ambulance services in Victoria can be accelerated.

The department will monitor the impact of the new model on health services during 2014–15 and the model will be reviewed after 12 months of implementation.

1.8.4 Normative pricing

WIES cost weights represent a relative measure of resource use for each episode of care in a Diagnosis Related Group (DRG), and 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.

Under the current system, cost weights are based on the average cost of delivering services. An alternative approach is to base cost weights on the efficient cost of delivering services. As a trial of this approach, in 2014–15 the costs weights for hip and knee replacements are based on the (lower) median prosthesis cost rather than the (higher) average prosthesis cost. There is evidence that more expensive hip and knee prostheses do not necessarily provide better patient outcomes. This is also consistent with the Grattan Institute's recent review of hospital costs. See Part 2, section 2.1.3 **'Pricing'**.

1.8.5 Pricing for quality

For 2014–15 Victoria will implement a 'pricing for quality' scheme, providing an opportunity to link funding allocations to discrete performance measures that demonstrate a health service's success in reducing preventable harm and improving the quality of care. The scheme will focus on a small suite of indicators that have:

- a strong evidence base and clinical consensus on the characteristics of best practice
- high impact – that is, variation in practice, a gap between best evidence and current practice, high volumes of significant impact
- availability and quality of data.

Victoria will adopt a positive reinforcement approach through rewarding desirable actions. The scheme will focus on the following clinical areas in the first instance:

- eliminate intensive care unit (ICU) central line associated blood stream infection rate per financial year
- accreditation outcomes against the NSQHS standards where developmental actions were assessed by accrediting agencies to have been 'met with merit'.

The scheme will enable Victoria to establish a system that is sustainable and drives performance while minimising the cost for Victorians and avoiding an additional reporting burden for health services.

The introduction of pricing for quality focuses on transparent reinforcement and is a mechanism by which services can stimulate improved performance at the individual, the professional group and the organisational level that culminate in better patient outcomes.

The scheme will be closely monitored in 2014–15 and the department will continue to develop additional measures for future consideration.

1.8.6 Specified grant consolidation

The following changes to sector-wide specified grants will occur in 2014–15:

- The "T and D research" and "ACHA teaching and research" specified grants will be consolidated into the relevant WIES peer group price for 2014-15. These training and development grants were introduced to recognise the costs of teaching and training activities of health services. As teaching and training activities form part of the core business of Victorian health services these costs will now be factored into the price of delivering health services.
- The Blood Matters grant for funding transfusion nurse and transfusion trainer roles will be incorporated into the WIES price. The grant provides for specialist roles in health services to improve blood transfusion practice, reduce the risk of adverse outcomes associated with blood transfusions and assist health services to meet obligations under the relevant national and industry standards. Following the successful trial program, this is now considered a service that should be part of base funding and health services are expected to continue to deliver the service.
- From 2014-15, palliative care funding for hospital consultancy, previously included in WIES price, has been adjusted to align with the relevant WIES prices for major provider and outer metro and large regional peer groups.

1.8.7 Non-admitted radiotherapy and allied health

The non-admitted patient radiotherapy funding model has previously incorporated a premium for associated department costs, including allied health services provided to radiotherapy patients.

In 2014–15 an amount of $1.7 million will be moved from the non-admitted radiotherapy budget and will be paid to radiotherapy hub hospitals for allied health service events as defined under the IHPA Tier 2 non-admitted services definitions manual.

The non-admitted radiotherapy price per weighted activity unit will be discounted to effect this change and overall funding will remain neutral.

1.8.8 Blood funding

In 2014–15 Victoria will introduce the initial stages of blood funding reform by commencing the process towards devolved blood budgets to health services. Blood and blood products are currently provided free of charge to public hospitals in Victoria and the budget is centrally held and managed.

To improve awareness among public hospitals of the costs of blood processing and procurement, the department in 2014–15 will provide health services with a Statement of Advice, which will summarise the costs of blood used by public hospitals in the previous period.

In 2015–16 it will also introduce financial accountability for blood use by devolving funding responsibility to public hospitals.

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

1.8.9 Updates to the admitted mental health model: towards an activity-based model

Changes to the Weighted Occupancy target (WOt) model in 2014–15 have been guided by discussions with health services that identified specific implementation issues with the current model. In recognition of the changes being made to the model and the need for further monitoring and analysis, funding will again not be adjusted for under performance in 2014–15.

Performance against the WOt was monitored during 2013–14. This information was used to establish minimum occupancy thresholds for WOt1 in 2014–15 to assist health services with monitoring performance.

Prior to 2014–15, and unlike acute health, mental health funding provided by the Department of Veterans' Affairs (DVA) (see Part 2, section 2.18.3 'Compensable patients') for inpatient services historically has been embedded in price. The WOt allocation provided to each health service in 2014–15 has been split to separately identify the WOt funded by the DVA. This split has been determined using 2012–13 validated bed day data accepted by the DVA as being eligible for funding. A premium payment will be paid for eligible DVA patients, but this will now be determined on the basis of DVA WOts allocated.

In 2014–15 the existing adult cohort (aged 18–64 years) has been split into two cohorts – 18–25 and 26–64 – so there are now four cohorts.

During discussions services have raised the need for the model to reflect the difference between those patients requiring low-dependency care and those requiring high-dependency care (such as in a high dependency unit, Psychiatric Assessment and Planning Unit patients or specialling).

While the department is not yet able to match costing data consistently with patient data associated with high-dependency care, additional WOts will be allocated to health services with high-dependency capacity.

The department is planning to trial mapping this type of care with a number of services during 2014–15 using the Client Management Interface/Operational Data Store (CMI/ODS) to better inform cost weights next year. It will set up the trial using CMI for a three-month block in the first part of 2015 to test ways of capturing this data.

1.8.10 Home and Community Care: transition to the Commonwealth Government

In May 2013, as part of the agreement to implement the National Disability Insurance Scheme from July 2019, the Victorian and Commonwealth governments agreed that the full funding and administration responsibility for Victorian HACC services for people aged 65 years and over (and 50 years and over for Aboriginal and Torres Strait Islander people) would transition to the Commonwealth from July 2015. The Victorian Government will continue to fund and manage services for people aged under 65.

Business as usual arrangements will continue until 30 June 2015, with the Victorian Government responsible for administering the HACC program in Victoria. The directions for the HACC program in Victoria for this period will continue to be as described in the HACC triennial plan 2012–15. The triennial plan is consistent with the *Victorian Health Priorities Framework*. It proposes a continuing focus on implementing the active service model, responding to people with diverse needs, and improved assessment and care planning.

During 2014–15 the Victorian Department of Health and Commonwealth Department of Social Services will be working with providers to identify resources targeted to people aged 65 and over (50 and over for Aboriginal and Torres Strait Islander people). When the resources are transferred to the Commonwealth from 30 June 2015, affected providers will be offered a service agreement under the new Commonwealth Home Support Programme to take effect from 1 July 2015.

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1.9 Data and reporting changes

1.9.1 Revisions to the *Victorian hospital admission policy*

The *Victorian hospital admission policy* has been revised for 2014–15 to reflect the following:

- It has been clarified that Criterion for Admission Type C requires special circumstances to be documented in the patient's medical record. The fact that the hospital is an exclusive provider of a service does not in itself justify admitting the patient.
- The guidelines for reporting non-admitted radiotherapy have been removed. The *National health reform agreement* is clear that patients cannot be reported as being in two places at one time. This information is, therefore, no longer required in the policy.
- 'Criteria for Admission Type R Restorative Care; Off Site' has been removed because this care type was discontinued from 1 July 2015. See the Health data standards and systems (HDSS) website for more details related to this change at <www.health.vic.gov.au/hdss/annualchanges/proposals-specifications>.
- Health services sought clarification regarding the eligibility of newborns for admission when their care had been fully provided by the Newborn Emergency Transfer Service (NETS). The policy has been amended to state that newborns cared for by NETS must still be reported to the Victorian Admitted Episodes Dataset as Unqualified Newborns.
- Examples to clarify the intent of the Criteria for Admission have been included in response to specific queries received during the year.

The revised admission policy is in effect as of 1 July 2014. The policy and the procedure code lists can be downloaded at <www.health.vic.gov.au/hdss>.

1.9.2 Data collection changes

The following forms have been discontinued:

- Subacute Ambulatory Care Services and Post Acute Care (S2_305)
- BBV/STI Non-admitted Services (S2_116A)
- BBV/STI Non-admitted and Aboriginal Liaison Services (S2_116AK)
- Non-admitted Drug Treatment Services (S2_116D)
- Aboriginal Liaison Services (S2_116K).

A new AIMS form has been introduced to collect further information on urgent care centres at 10 applicable health services. The purpose of the new collection is to better understand urgent care centres with a view to using urgency disposition groups in the future.

1.9.2.1 Victorian Emergency Minimum Dataset

Two new time points will be collected in the VEMD: ambulance at destination date/time and ambulance handover complete date/time. Ambulance paramedics and hospital staff have a shared responsibility for collecting and recording the time points.

1.9.2.2 Victorian Ambulance Data Set

In 2014–15 the department will, for the first time, implement a unit-record minimum dataset for ambulance services provided by Ambulance Victoria, which will be referred to as the Victorian Ambulance Data Set (VADS). VADS builds upon existing data-sharing between the department and Ambulance Victoria and will provide essential data to increase transparency and accountability, enhance forecasting and improve modelling with respect to the use of and demand for Ambulance Victoria's services.

1.9.2.3 Non-admitted subacute model counting

The counting unit for HIPs and community palliative care will change from 'service events' to 'contacts' in 2014–15. This will reduce the complexity of counting and remove distortions in clinical practice that can be created by service events.

Health services will have activity targets subject to recall expressed as contacts. See Part 2, section 2.17.1 'Victorian funding recall policy' for more detail.

Community palliative care providers will have a shadow contact target that will not be subject to recall.

1.9.3 Health service environmental management planning and reporting

In 2014–15 the department will begin implementing a new online environmental data management system to help health services drive performance improvements in resource management and reduce duplicative reporting requirements. All health services will be required to use the new system once it is operational. More detail is outlined in Part 3, **section 3.7.4 'Health service environmental management planning and reporting'**.

1.9.4 Victorian WorkCover Authority

In 2014–15 the department will continue to increase dialogue and engagement with the Victorian WorkCover Authority (VWA) in relation to Occupational Health and Safety risk in public hospitals. The Auditor General concluded in a December 2013 audit report that significant OHS risks exist across the public hospital system.

The department will collaborate with VWA to incorporate sector-wide findings on OHS risk into its performance monitoring framework and discussions with health services.

A copy of the Auditor General's report can be downloaded at
<www.audit.vic.gov.au/publications/20131128-OHS-in-Hospitals/20131128-OHS-in-Hospitals.html>

Appendix 1.1: Summary of modelled budgets 2014–15

Table 1.5: Summary of modelled budgets 2013–14 and 2014–15

	2013–14 expenditure budget							2014–15 expenditure budget						
	Acute and subacute health services	Mental health	Drug services	Ageing, aged & home care	Primary community & dental health	Public health	Total	Acute and subacute health services	Mental health	Drug services	Ageing, aged & home care	Primary community & dental health	Public health	Total
Provider type	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Health services	7,129,091	783,318	25,911	197,261	49,912	29,034	**8,214,527**	7,513,909	805,294	33,449	201,079	52,035	29,285	**8,635,050**
Small rural health services	200,622	332	-	57,089	11,469	-	**269,513**	205,712	258	-	58,020	11,651	-	**275,642**
Registered community health centres	5,655	13,148	19,923	83,644	78,683	1,819	**202,871**	5,904	24,278	23,306	94,780	88,125	2,250	**238,643**
Local government authorities	-	86	46	240,999	1,695	13,918	**256,745**	-	8	113	246,837	2,234	15,643	**264,834**
Non-government providers	52,208	86,717	63,097	248,761	28,651	121,244	**600,678**	52,354	89,792	74,443	254,157	30,888	123,712	**625,345**
Health consortium	-	-	-	87	-	80	**167**	-	-	-	89	-	80	**169**
Other organisations*	398,858	42,417	-	679	171,533	545	**614,031**	426,044	43,104	-	695	174,216	664	**644,723**
Total	7,786,434	926,018	108,976	828,520	341,943	166,640	10,158,531	8,203,923	962,733	131,311	855,656	359,150	171,634	10,684,408

* *Includes the budget for ambulance services*

Part 2: Pricing and funding arrangements for Victoria's health system

Introduction to Part 2

Part 2 of these guidelines details the pricing and funding arrangements for funding the broad range of services delivered in the Victorian health system. It details the mechanisms used to fund organisations, including the prices organisations face 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 part also explains the Commonwealth–state funding arrangements that affect funded organisations.

These guidelines are a functional document that articulates 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, as well as the funding linked to various services, in order to achieve the expected outcomes of the Victorian Government.

While Part 1 details new funding and initiatives, this Part of the guidelines focuses on the overall financial framework. Part 3 outlines the conditions and expectations of that funding and Part 4 of these guidelines 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 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 or the Secretary to the Department of Health, the legislative, regulatory and contractual obligations will take precedence.

A note on terminology

The term 'funded organisations' 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,* with 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, which are not health services.

These guidelines are also relevant for Ambulance Victoria, Dental Health Services Victoria, Health Purchasing Victoria 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.

For more information on the casemix funding model, please refer to the department's activity based funding (ABF) website at <www.health.vic.gov.au/abf/history>.

In 2014–15 the unit of measure for acute admitted casemix-adjusted throughput will be known as WIES21.

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 times of treatment. Generally, admitted patients are treated in wards and non-admitted patients in specialist clinics. The criteria for admission are provided in the *Victorian hospital admission policy*, available online at <www.health.vic.gov.au/hdss>.

The *Victorian hospital admission 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 (ED) 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 Criteria for Admission outlined in the policy.

Patients not meeting one of these criteria are non-admitted patients and 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 2014–15.

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 hospital admission policy fact sheet* for more information at <www.health.vic.gov.au/hdss/vaed>. 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 fact sheet available at <www.health.vic.gov.au/hdss/vaed>.

For changes to the policy in 2014–15, please refer to Part 1, section 1.9.1 'Revisions to the *Victorian hospital admission policy*'.

2.1.2 Classification, counting, 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 (DRG))
- counting patients treated (administrative health data collections)
- costing patients treated (hospital cost data collections).

2.1.2.1 Classifying patients

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 7.0 (AR-DRG7.0) the latest, released in the first half of 2013. Victoria will use AR-DRG7.0 for funding purposes in 2014–15.

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.

Weighted inlier equivalent separation

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 level 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.

Inliers and outliers

If all separations within a DRG 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 a 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 an 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 2014–15 (WIES21), boundary points have been informed by trends in ALOS within the VAED over the period from 1 July 2008 to 28 February 2014.

WIES21 cost weights

Cost weights represent a relative measure of resource use for each episode of care in a DRG, and 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 2014–15 the unit of measure for acute-admitted, casemix-adjusted throughput will be known as WIES21. WIES21 cost weights have been developed using 2012–13 acute-admitted cost data as reported by Victorian public hospitals to the annual Victorian Cost Data Collection. WIES21 cost weights are scaled to equal the number of WIES20 reported by public hospitals for the latest 12 months of measured activity available at the time of WIES21 formulation (1 March 2013 to 28 February 2014).

The following changes from the 2013–14 funding model (WIES20) have been introduced this year:

- implementation of the AR-DRG 7.0 classification (AR-DRG 7.0 includes more than 60 additional DRGs compared with AR-DRG 6.0x; many of these new DRGs are sameday DRGs which Victoria already uses within the WIES funding model; AR-DRG 7.0 also includes changes such as splitting the newborn DRGs using gestational age, capturing combined ventilation support for neonates and regrouping of bariatric procedures)
- for patients that are admitted from an emergency department (ED), the reported cost of care provided in the ED is bundled into the admitted episode
- the cost (risk) of medical indemnity insurance is now based on actual costs reported by health services across all clinical specialties (DRGs)
- cost weights for hip and knee replacements (AR-DRG 7.0s I03A, I03B, I04A and I04B) are based on an efficient (median) prosthesis cost rather than the average prosthesis cost
- a new cochlear prosthetic device co-payment is introduced for bilateral cochlear implantations (AR-DRG 7.0 D01Z Cochlear Implant)
- cost-weight adjustments are applied for AR-DRG 7.0 Y01Z Ventilation for Burns and Severe Full Thickness Burns to capture increased costs associated with cultured epithelial autografts.

DRG cost weights to be applied in 2014–15 are listed at Part 2, section 2.21 'Cost weight tables'. 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 adjust for 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 Part 2, Appendix 2.1: 'Calculating WIES21 for individual patients'.

The definitions of WIES21 variables are at Part 2, Appendix 2.2: 'Definition of WIES21 variables'.

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, ED 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.

Further information on the VAED can be found at <www.health.vic.gov.au/hdss/vaed>.

WIES21 eligibility

The majority of patients in hospital will be allocated a WIES21 price weight. However, as in previous years, WIES cannot be calculated for incomplete or un-coded 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 2014–15.

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-DRG 7.0. 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 a care type of '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-DRG7.0 (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), Seamen(SS)
- episodes funded through a Competitive Elective Surgery Funding Initiative (specified program identifier of 06). This activity is funded through the competitive elective surgery public private pool.
- episodes where the contract role is B (service provider hospital)
- episodes from hospitals not eligible for WIES funding
- episodes that have been coded as follows as this activity has been funded through specified grants
  - include an electroconvulsive therapy code [9334100–9334199] and
  - care type 4 (Acute) and

- separated from Royal Melbourne Hospital (campus code 1334) and
- funding arrangement 2 (Hub & Spoke) and
- contract/spoke identifier in (0010, 0011, 0012).

2.1.2.3 Costing patients

Victorian public hospitals are required to report costs for all funded activity, and 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, including admitted acute and subacute care (geriatric evaluation and management (GEM), palliative care and rehabilitation), specialist clinic encounters, home-based service delivery and ED 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 (ward, pathology, emergency, etc.) of expenditure.

2.1.3 Pricing

The standard WIES21 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.

WIES21 prices can be found in Part 2, section 2.20 'Price tables'.

The funding provided to any patient or all patients can be calculated by multiplying WIES21 by the price.

2.1.3.1 Peer group prices

In order to reduce the price variance across peer groups, the number of WIES groups has been reduced from four to three in 2014–15 and the price difference between groups reduced. The three peer groups are:

- **Major provider**: this group is unchanged from 2013-14
- **Outer metro and large regional**: this group is unchanged from 2013-14
- **Regional and rural**: this group combines the *Regional and large sub-regional* and *Sub-regional and local* from 2013-14

The WIES peer groups for 2014–15 are outlined in Part 2, 2.19 'Peer groups for activity based funding purposes'. Note that these peer groups only relate to the price for acute hospital activity and for recall and throughput policy purposes.

2.1.3.2 Normative pricing

In 2014–15, as a trial of efficient pricing, the WIES21 cost weights for the following VIC-DRG7.0s 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

2.1.4 Adjustments and 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.

Co-payments and loadings are made for the following procedures and patients. Details and technical specifications of all WIES co-payments are at Part 2, Appendix 2.1: 'Calculating WIES21 for individual patients'.

2.1.4.1 Mechanical ventilation

A mechanical ventilation WIES co-payment is made where a patient is admitted to a specific health service (see Part 2, Appendix 2.1, section A2.1.3.1 'Mechanical ventilation'), has had more than six hours of continuous mechanical ventilation and is allocated to a VIC-DRG7.0 that is eligible for a mechanical ventilation co-payment.

Base WIES payments for high outliers are reduced when a patient receives daily mechanical ventilation co-payments. To make this reduction it is necessary to record the number of days receiving mechanical ventilation co-payments.

2.1.4.2 Thalassaemia

Thalassaemia is a genetic disorder that affects the production of haemoglobin, the oxygen-carrying protein in red blood cells.

A co-payment is made in recognition of the higher costs for treating patients with Thalassaemia for other diagnoses. Thalassaemia co-payments are made to patients with any ICD–10-AM diagnosis code of D56.x or D57.2 who are allocated to an eligible VIC-DRG7.0.

2.1.4.3 AAA stent

AAA stent co-payments are made to patients undergoing an endoluminal repair of an aortic aneurysm as indicated by any ACHI 8th edition procedure code of 33116-00 and who are allocated to an eligible VIC-DRG7.0.

2.1.4.4 ASD closure device

ASD co-payments are made to patients receiving an atrial septal defect closure device as indicated by the presence of any ACHI 8th edition procedure code of 38742-00 and who are allocated to an eligible VIC-DRG7.0.

2.1.4.5 Cochlear prosthetic device

Cochlear co-payments are made to patients receiving a bilateral cochlear implantation in the one (same) episode (indicated by the multiple occurrence of ICD–10-AM 8th edition procedure code 41617-00 within the one episode) and who are allocated to an eligible VIC-DRG7.0

2.1.4.6 Indigenous

A 30 per cent WIES loading is paid to health services for treating Aboriginal and Torres Strait Islander patients in recognition of their higher costs of care.

2.1.5 Pricing for quality

In 2014–15 Victoria will introduce a limited 'pricing for quality' model for public health services. The department proposes to allocate additional funding to services that achieve:

- a zero ICU central line associated blood stream infection (CLABSI) rate per quarter
- accreditation outcomes against the National Safety and Quality Health Service Standards where developmental actions have been met with merit.

Note payments against the accreditation criterion will be back-dated to ensure equity across all services that have been accredited against the national standards from 1 January 2013 onwards.

The agreed methodology for determining the ICU CLABSI rate is defined in the relevant Statement of Priorities (SoP) business rule. Data for this measure will be reported to the department by the Victorian Healthcare Associated Infection Surveillance Coordinating Centre.

The funding model will be closely monitored in 2014–15 and the department will continue to develop additional measures for future consideration.

2.2 Acute specialist services

2.2.1 Emergency department

The Non-Admitted Emergency Services Grant (NAESG) is distributed to 39 Victorian hospitals that provide 24-hour emergency services. All other health services receive non-admitted patient grants to cover both emergency and outpatient services.

Episodes where the patient's entire care is provided in the ED are not considered for admission, irrespective of whether a criterion for admission is met. The NAESG grant and WIES activity targets were both adjusted in 2012–13 to take account of this.

The NAESG model does not fund EDs in their entirety. Other relevant funding includes: WIES payments for patients who receive treatment in the ED and are subsequently admitted to a ward; specified grants; and training and development funding.

The funding model is composed of two parts: a 24-hour availability component and an activity component. Updates have been made to the distribution of the base grant for 2014–15. In 2014–15 distribution of the grant will be based on 2012–13 Victorian Emergency Minimum Dataset and VAED data from the most recent full financial year.

In the 2014–15 model, 50 per cent of the base grant has been distributed based on the availability component and 50 per cent based on the activity component. This has resulted in the redistribution of some legacy grants that were based on other factors. Adjustments made in 2012–13 related to the elimination of ED only admissions have not been redistributed.

Growth funding and indexation have been applied to the grant in 2014–15.

2.2.1.1 Availability component

The availability component is allocated according to each health service's share of the total non-same-day emergency WIES for the 39 health services that receive the grant. In 2014–15 the availability component is based on each health service's share of the total non-same-day emergency WIES in 2012–13.

Whilst the funding for ED patients subsequently admitted to a ward occurs through WIES, there is recognition that there is a cost of having ED resources available 24/7 irrespective of the actual level of activity undertaken by the health service. The availability component of the NAESG aims to provide health services with a reimbursement based on the level of staffing estimated to be required based on a proxy measure for the complexity. This measure of complexity is based on the health service's share of total non-same day emergency WIES. The rationale is that these patients with a longer length of stay (overnight and greater) are more complex which is subsequently reflected in the extended length of stay.

This measure also avoids differences in admission practices for same-day emergency patients and does not provide any strong incentives for admitting same-day patients.

This component is referred to as the availability component, but it does not represent the fixed or minimum costs of operating a 24-hour ED.

2.2.1.2 Activity component

Health services are allocated a share of activity funding in proportion to their share of total weighted estimated emergency presentations.

The 2014–15 triage weights for the activity component are calculated based on the state-wide triage percentages reported in 2012–13. Individual health service percentages are not used so as to not incentivise individual hospitals changing triaging practices. The triage percentages are further adjusted by applying a factor of 5 weighting to triage 1 decreasing to a factor of 1 for triage 5 to derive the 2014–

15 triage weights. Pre-planned ED visits are further discounted by 50 per cent. A loading for Aboriginal and Torres Strait Islander patients is also applied.

In addition, presentations where the patient left at their own risk, or left after receiving clinical advice regarding treatment options or after referral to a collocated general practitioner clinic, are excluded from the funding model.

Triage category 6 cases (dead on arrival) are funded through the grant to fund hospitals assistance in certification services for the Coroner's Office. In 2014–15 the allocation of funding for each health service is based on their share of triage category 6 presentations in 2012–13.

The 2014–15 triage weights are calculated as follows:

Table 2.1: Activity weighting 2014–15

Triage	1	2	3	4	5
State wide %	0.005	0.097	0.335	0.464	0.099
Weight	5	4	3	2	1
Triage weight	0.023	0.387	1.004	0.928	0.099

Health services are then allocated a proportion of the amount available for the activity component according to their proportion of the total weighted activity (as estimated). It is important to remember that the amount allocated is a fixed grant, and not a case payment. It is, however, subject to annual review.

2.2.1.3 Loadings

A 30 per cent loading is applied to the weighted activity for treating Aboriginal and Torres Strait Islander patients in recognition of their higher costs.

2.2.2 Hospital in the Home

Hospital in the Home (HITH) patients must fulfil the criteria for admission as per the department's *Victorian hospital admission policy*. 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 inpatient acute care.

The policy is available at <www.health.vic.gov.au/hdss/vaed>.

HITH separations and beddays are now included in the *Program report for integrated service monitoring* 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 ward-based care.

2.2.3 Specialist clinics

Funding for specialist clinics will be based on existing funding levels, with adjustments for indexation and growth funding. The department will monitor activity levels to ensure effort is maintained. Activity levels, counted by the number of service events, will be derived from data provided through AIMS.

2.2.4 Hepatitis C

The Integrated Hepatitis C Service (IHCS) is funded recurrently under the Specialist Clinics (non-Department of Veterans' Affairs (DVA)) grant to 10 hospitals, and under the Hepatitis C Service (non-hospital) grant to two community health centres. For the hospitals with IHCS, activity is reported through AIMS as per other specialist clinics. For the community health centres with IHCS, activity is reported through SAMS to the community health minimum dataset.

2.2.5 Renal services

2.2.5.1 Facility dialysis

For routine haemodialysis within a health facility the funding model consists of 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 managing 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.

Health services *providing* dialysis are then required to make a payment of $189 per L61Z dialysis separation to their specialist hub to cover:

- haemodialysis consumables
- equipment maintenance and servicing
- medical care, review and 24-hour on-call service, including emergency
- other specialist renal coordination and services.

The payment is consistent across health services and includes two components – one for consumables and equipment costs and the other for specialist support costs. The payment is to be made based on expected activity levels, in line with the health service payment schedule, and it is essential that this payment is made in a timely manner.

Adjustments in payments to reflect actual activity should occur at least twice a year, with the detailed process to be negotiated between health services.

Where satellite facilities have patients from more than one specialist hub service the payment will be made to the specialist hub providing the consumables. The specialist hub will then pass on the specialist support component to the appropriate service under existing cross-charging practices.

During 2014–15 there will be a review of the funding arrangements, including consideration of changing protocols so that the WIES component funds standard or routine haemodialysis pathology testing for facility-based patients. The agency providing dialysis may then be responsible for ordering and paying for pathology tests, in accordance with a testing schedule endorsed by the Renal Health Clinical Network. Further details, including the testing schedule, are available from <www.health.vic.gov.au/renalhealth>.

There is no defined loading or co-payment for dialysis within the WIES payment for non-L61Z admitted episodes. The funding arrangement detailed above is not applicable for these episodes.

Renal activity and WIES are incorporated within total agency public and private WIES activity targets so are subject to the standard health service recall policy. This excludes small rural health services (SRHS), which continue to be funded to actual activity.

2.2.5.2 Home dialysis

Home dialysis is funded as an annual grant of $53,269 per patient for 2014–15.

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

- home peritoneal dialysis – $768 per patient per annum
- home haemodialysis – $2,024 per patient per annum.

Home-based dialysis must be reported as non-admitted clinic activity using AIMS. In future years patient-level reporting of home activity will be required, so health services should consider how this could be achieved using existing reporting systems.

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

For further information refer to the department's website at <www.health.vic.gov.au/renalhealth>.

2.2.6 Radiotherapy

The department funds admitted and non-admitted radiotherapy services provided by health services. Admitted patients are funded under WIES and non-admitted patients are funded under the non-admitted patient radiotherapy funding model, where the various components of a course of radiotherapy are allocated cost weights developed for non-admitted services.

The health services (including their satellite services) that are funded under the non-admitted patient radiotherapy funding model are Alfred Health, Austin Health, Barwon Health and Peter MacCallum Cancer Centre.

In 2014–15 funding for non-admitted radiotherapy services will comprise:

- a DVA premium (where applicable) above the combined the variable and associated department cost payment (health services will bill Medicare on behalf of the specialist using the appropriate CMBS item and they will be paid directly by Medicare on DVA's behalf)
- a variable payment per Weighted Activity Unit (WAU) up to set targets for public, DVA and private patient categories. Costs for associated department services are included in this payment and must be provided to all patients as required. Associated department services include patient accommodation, patient transport, patient education, staff transport, staff education, staff accommodation, pharmacy and radiology.

The radiotherapy budget is therefore calculated as follows:
(Target non-DVA WAUs × price per WAU) plus (target DVA WAUs × price per WAU × 1.21)

The WAU price in 2014–15 is $228. The DVA premium is 21 per cent.

The non-admitted patient radiotherapy funding model has previously incorporated a premium for associated department costs, including allied health services provided to radiotherapy patients.

In 2014–15 an amount of $1.7 million will be moved from the non-admitted radiotherapy budget and will be paid to radiotherapy hub hospitals for allied health service events as defined under the Independent Hospital Pricing Authority (IHPA) tier 2 non-admitted services definitions manual.

The non-admitted radiotherapy price per WAU will be discounted to effect this change and overall funding will remain neutral.

Health services will continue to be able to retain 100 per cent of revenue generated from all other sources.

Non-admitted radiotherapy activity and funding will not be included for the purposes of *National health reform agreement* funding. Future funding for non–admitted radiotherapy continues to be under review and is subject to ongoing discussion with the Commonwealth regarding inclusion of non-admitted radiotherapy within ABF.

Current year WAU targets and health service information are available on the radiotherapy website at <www.health.vic.gov.au/radiotherapy/activity>.

2.2.7 Perinatal autopsy services

The Perinatal Autopsy Service is fully funded for parents who require this service. Services are provided at an agreed rate by pathology services within Victoria undertaking perinatal autopsies.

Where there is uncertainty about the cause of death, the value of perinatal or infant autopsy and pathological examination of the placenta should be communicated and offered to parents.

The information obtained through the Perinatal Autopsy Service assists the Consultative Council on Obstetric and Paediatric Mortality and Morbidity to provide expert advice on maternal and perinatal outcomes.

To access the Perinatal Autopsy Service, the attending doctor should (after obtaining consent) contact the closest hospital pathology department with specialist expertise in perinatal pathology and arrange with a funeral director to transport the infant and the placenta.

More details are available at <www.health.vic.gov.au/ccopmm/about/perinatal>.

2.2.8 Organ and tissue donation

The Australian Organ and Tissue Donation Authority, in partnership with the department, funds the operational costs of the DonateLife in Victoria organ donation organisation and the employment of clinical staff dedicated to organ donation. Health service medical directors and senior nurses of organ and tissue donation will be based in a number of metropolitan and regional health services. The Australian Organ and Tissue Donation Authority also provides additional support funding for health services for some of the extra costs associated with organ donation.

Further details regarding organ and tissue donation are available at <www.health.vic.gov.au/organdonation>.

2.2.9 Blood 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 2014–15. This supply plan has been negotiated between the government, the National Blood Authority and the Blood Service. Victoria's contribution in 2014–15 will be over $99 million.

In 2014–15 Victoria will begin the process towards blood supply funding reform. See Part 1, section 1.8.8 'Blood funding' for details.

Access to blood and blood products will be guided by the *Blood and blood products charter*, which is being implemented with health providers nationally in 2014–15. The National Stewardship Expectations for the Supply of Blood and Blood Products is at <www.nba.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 <www.health.vic.gov.au/blood>.

Subcutaneous immunoglobulin is available through the supply plan to health services for agreed uses. Further information on access is available at <www.health.vic.gov.au/hospitalcirculars/circ13/circ1013>.

Normal immunoglobulin will be subject to new national governance arrangements. Further information is available at <www.nba.gov.au>.

There is an ongoing commitment to safe transfusion practice in health services through the Blood Matters Program.

Further details regarding blood and blood products are available at <www.health.vic.gov.au/blood>.

2.2.10 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 four metropolitan hubs:

- the Parkville hub – the Victorian Clinical Genetics Services at the Royal Children's Hospital, the Royal Melbourne Hospital and the Royal Women's Hospital
- the southern hub – Monash Medical Centre
- the northern hub – Austin Hospital and Mercy Hospital for Women
- the Peter MacCallum Cancer Centre.
- There is also periodic clinical outreach to other metropolitan, regional and rural centres.

The department provides funding for public genetic testing to selected specialist providers (Victorian Clinical Genetics Services, the Royal Melbourne Hospital, the Peter MacCallum Cancer Centre, the Victorian Cancer Cytogenetics Service at St Vincent's Hospital and the Victorian Thalassaemia Laboratory Service at Monash Medical Centre). Public genetic testing is provided either in-house or through subcontracting to other and/or interstate or overseas laboratories. If a genetic test is not available in Victoria, it may be sent interstate or overseas.

Recurrent funding for genetic services will remain as a specified grant. Activity will be shadowed in 2014–15 as part of the transition of genetic outpatient clinics to tier 2 non-admitted service clinics under ABF. Clinic activity will be reported through AIMS.

Further information on genetic services in Victoria is available at <www.health.vic.gov.au/genetics>.

2.2.11 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.

2.2.11.1 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.

Further details on pharmaceutical reforms are available at <www.health.vic.gov.au/pbsreform>.

2.2.11.2 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 services.

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 paid on actual usage, less a patient co-payment, via claims submitted to Medicare Australia. Further information about the Highly Specialised Drugs Program, is available at <www.health.vic.gov.au/hsdp>.

2.3 Subacute inpatient services (i-SNAC)

2.3.1 Admission policy

Please refer to the admission policy under Part 2, section 2.1.1 'Admission policy'.

2.3.2 Classification, counting, costing

Victoria will continue to move towards an episodic funding model for admitted subacute activity. As in 2013–14, in 2014–15 subacute and non-acute admitted activity will be funded using the Interim Subacute and Non-Acute Classification (i-SNAC) funding model. The model classifies patients according to their care type and class. Each class has a weight. Multiplying a patient's bed day by the appropriate class weight produces a weighted bed day (WBD). Each WBD is funded based on the relevant public/private i-SNAC price.

2.3.2.1 Classifying patients

i-SNAC is a per-diem-based model to distribute funding for inpatient palliative care, rehabilitation, GEM and maintenance care.

The i-SNAC model calculates a WBD as its final product. The calculation includes:

- 17 weighted classes, with each class weight based on Victorian expenditure data and classes aligned with patient attributes
- four classes for palliative care (based on phase of care)
- 11 classes for rehabilitation (based on impairment)
- one class for GEM (based on care type)
- one class for maintenance (based on care type)
- two types of loadings
- one loading for indigenous status (based on self-reported Aboriginal or Torres Strait Islander status)
- three loadings for remoteness, in lieu of peer pricing, (based on the postcode of the patient's usual accommodation).

In 2014–15 i-SNAC class weights have been updated to reflect updated cost data. Compared with 2013–14, the updates result in a relative increase in the weights for high-complexity palliative care and a relative decrease in the rehabilitation weights. Allocations of WBDs have been adjusted to reflect changes in the mix of activity conducted by health services.

Care types are consistent with the service expectations and levels detailed in Part 2, section 2.22 'Subacute service capability framework levels and health services alignment 2014–15'. Local health services delineated as level 2 (and Swan Hill) in the *Subacute capability framework* will provide and report maintenance care type only. In 2014–15 seven rural health services will be funded and able to report on maintenance care. These services are Swan Hill District Health, East Grampians Health Service, Kyabram and District Hospital, Maryborough District Health Service, Gippsland Southern Health Service, Stawell Regional Health and Western District Health Service (Penshurst campus only).

Health services are expected to manage nursing home type (NHT) patients using other funded activity streams, such as transition care program (TCP). Therefore NHT activity is not funded by the department.

Current nursing home-type arrangements for DVA, private and compensable patients remain.

2.3.2.2 Counting patients

Subacute admitted services are counted based on WBDs. 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. In 2014–15 eligible Victorian health services will report 'maintenance care' as a care type in the VAED and will no longer report code R1 or R2.

The following episodes are not eligible for i-SNAC 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), S* (Seamen) or J* (Prisoners)
- episodes where the contract role is B (service provider hospital).

2.3.2.3 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.

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.

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.

A reduction in the intensity of acute care does not trigger a change to a subacute care type if the patient is not receiving care that meets the definition of a subacute care type. It is therefore essential that any care type change reflects a clear change in the primary clinical purpose or treatment goal of the care provided. All care type changes must be clearly documented.

The national definitions are outlined below. The National Minimum Dataset definitions can be found at the 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 an 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

GEM 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.

GEM is always:

- managed by a clinician with special expertise in GEM
- 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, that covers the physical, psychological, emotional, social and spiritual needs of the patient and their negotiated goals.

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.

2.3.2.4 Care type changing

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.

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 ensure that the ward clerk (or staff member responsible for updating the Patient Administration System) is informed of the care type decision.

During an admission or stay the primary clinical purpose or treatment goal of care may change. When this occurs, the care type also changes. It is essential that any change in care type is supported by documentation reflecting the change in purpose and goal of care.

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, or
- clearly documented in the patient's medical record and approved by the hospital's director of clinical services or delegated officer.

2.3.2.5 Costing patients

It is expected that health services maintain and report subacute costing data, as for acute costing data, and as detailed in Part 2, section 2.1.2.3 'Costing patients'.

2.3.3 Pricing

A standard WBD price is not the same as the average cost per WBD. The standard WBD price is established as part of the general budget setting process and takes into account other forms of funding. The public WBD is discounted to determine the private WBD price.

See Part 2, section 2.20 'Price tables'.

2.3.4 Adjustments

Subacute WBDs are adjusted for loadings for indigenous and rural patients. The loadings are:

- indigenous status – 30 per cent
- outer regional – eight per cent
- remote – 15 per cent
- very remote – 24 per cent.

Please note that the loadings are assigned and follow the patient regardless of the location of the health service.

2.3.5 Health Independence Program and Community Palliative Care

In 2014–15 non-admitted subacute programs and services will remain block-funded. The Health Independence Program (HIP) and Community Palliative Care (CPC) will be block-funded and receive an associated activity target. Individual activity targets will be issued for the different HIP streams (post-acute care, subacute ambulatory care services (SACS), the Hospital Admission Risk Program (HARP) and Residential in Reach) with an aggregated HIP target. Services that do not meet the overall HIP target are subject to recall.

The targets for CPC will be considered as shadow targets for 2014–15, with funding not subject to recall.

Non-admitted targets by health service and program type are at Part 4, section 4.2.5 'Non-admitted subacute contact targets 2014–15'.

2.3.5.1 A 'contact' as the new unit of count

In 2014–15 the unit of count for HIP and the CPC activity will be the 'contact', which is reported in the Victorian Integrated Non-Admitted Health (VINAH) archive. In the 2013–14 financial year, Service Events were introduced as the unit of activity count for non-admitted subacute services. The complexity and disadvantages of measuring non-admitted subacute activity in SEs became clear as the 2013–14 year progressed. The move to counting non-admitted contacts is being introduced in 2014–15 to:

- adopt a standard measure of count to be used across all elements of HIP
- use a simple measure readily understood by health services when used to describe activity levels
- not have disincentives to providing multidisciplinary interactions or same-day appointments for clients
- allows interactions with carers to be counted (for palliative care) towards activity targets, in recognition of the importance of carers to client outcomes.

The definition of a contact for activity counting purposes will differ between HIP and CPC.

Health Independence Program

The unit of count for HIP will be the 'direct non-admitted contact'. 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 ED (13)
- contact inpatient flag of outpatient/non-admitted present.

A note on counting and costing

- The overall funding provided in conjunction with the activity target provides the funds required to complete all elements of care delivery. For example, while only direct non-admitted contacts are counted in HIP, it is expected that these would have been accompanied by time spent completing indirect and administrative tasks. Likewise, while contacts with admitted patients and ED patients cannot count towards target, it is expected that HIP services will still have contact with patients in these settings. The foundation principle is that services are being funded to complete all relevant aspects of service delivery, but only a specific portion of this activity needs to be counted.

Community Palliative Care

The unit of count for CPC will be the 'contact'. All contacts (both direct and indirect) will count, where the contact account class is either MP, MA or DVA (VX). Including indirect contacts recognises the consultancy role of CPC providers.

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

2.3.5.2 Reporting of activity

- Contacts will be reported through VINAH as per the standard VINAH reporting requirements.
- The AIMS S11 form will continue to be required to report SEs for Commonwealth reporting processes.
- No AIMS S2_305 reporting is required – the AIMS S2_305 reporting requirements ceased at the end of the 2013–14 financial year.

In the first instance, non-admitted subacute care programs/services are required to submit data to both VINAH and the AIMS S11 form for activity to count towards the target. VINAH is the preferred data collection. Non-admitted subacute care programs/services that reliably submit VINAH data for all subacute program streams will be able to cease providing AIMS data once agreement has been reached with the department.

The department requires services to continue to report in VINAH program streams for activity undertaken in HIP. Health services are expected to maintain sustained effort across all HIP services.

In 2014–15 the activity level of each CPC provider will not be subject to funding recall or additional payments.

In 2014–15 the department will work with health services to monitor the level of activity for all HIP service delivery components in recognition that targets for some components (for example, Residential in Reach) require ongoing refinement.

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2.4 Subacute non-admitted

2.4.1 Victorian Artificial Limb Program

Victorian Artificial Limb Program (VALP) funding will continue to be provided as a block grant to health services as a non-admitted subacute service. VALP 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 VALP in 2014–15 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 2014–15.

Please note that in 2014–15 recall will not apply to VALP activity.

2.4.2 Victorian Respiratory Support Service

Victorian Respiratory Support Service (VRSS) funding will continue to be provided as a block grant to health services as a non-admitted subacute service. VRSS services are required to report SEs as a non-admitted subacute service through the AIMS S11 form.

Please note that in 2014–15 recall will not apply to VRSS activity.

2.4.3 Palliative care consultancy services

Funding for hospital palliative care consultancy has been provided as part of the price paid for acute inpatient activity since 2013–14. In 2014–15 there is no separate funding line for this program.

There is no activity target for hospital palliative care consultancy activity in 2014–15.

Funding for regional palliative care consultancy teams is provided as a block grant in 2014–15. There is no activity target for regional palliative care consultancy activity in 2014–15.

Funding for statewide palliative care consultancy teams is provided as a block grant in 2014–15. Statewide consultancy services include the Victorian Paediatric Palliative Care Consultancy Program, Very Special Kids and the Australian Centre for Grief and Bereavement.

There is no activity target for statewide palliative care consultancy teams in 2014–15.

Recall does not apply to specified grants for palliative care consultancy services in 2014–15.

2.4.4 Day hospice

Funding for day hospice services will continue to be a block grant in 2014–15.

Hospice providers are required to submit their activity information using the S11 form in AIMS. Recall will not apply.

2.5 National programs

2.5.1 Nationally funded centres

The objectives of the Nationally Funded Centres (NFC) Program are to ensure there is optimal access within Australia 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 NFC services will be funded in advance based on the estimated activity and NFC determined cost per procedure, and then adjusted after the financial year to reflect actual activity. The health services that provide NFC services are Alfred Health, The Royal Children's Hospital, Monash Health and St Vincent's Hospital.

2.5.2 Transition Care Program

The TCP is jointly funded by the Commonwealth, state and territory governments through joint per diem contributions. The flexible care places used in the TCP are legislated by the *Aged Care Act 1997* and the Aged Care Principles made under the Act. The *Transition Care Program guidelines 2011* govern the program.

Commonwealth Government subsidies are provided directly to health services by Medicare Australia 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 Australia for payment.

Commonwealth Government subsidies are paid for up to 12 weeks (with an option for a six-week extension) for each client, up to the maximum number of approved TCP places at each health service.

The Victorian Government subsidy in 2014–15 is $147 per client per day for bed based places, and $51 per client per day for home based places (see Part 2, section 2.20 'Price tables').

The Commonwealth Government subsidy component in 2014-15 consists of the basic rate of $190.86 and the dementia and veterans' supplement equivalent of $3.82 per occupied place per day and is applicable to both home and bed based places.

Where a TCP client stay exceeds the specified timeframe, the department will consider providing health services with further financial support. To access this additional funding, health services must notify and provide a quarterly report to the department of any potential discharge challenges.

Where a person is occupying a bed-based place, the department will provide payment of the combined state and Commonwealth subsidies. Where a person is occupying a home-based place, payment will be based on actual costs incurred (up to a maximum of the full home-based TCP payment rate). The department will then make a payment in arrears based on the actual separated activity beyond 18 weeks.

Data will be monitored to contain the risk for both health services and the department. If costs appear unsustainable, the department will review the way these cases are managed. Any modifications to the approach will be discussed with health services in advance of any change.

Daily care fees for TCP 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 may be 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 TCP is subject to recall for under performance as outlined in the recall policy detailed in these guidelines.

2.6 Ambulance Victoria

The Victorian Government funds free clinically necessary transport for Community Service Obligation patients – primarily pensioners and health care card holders (refer to the department's website for a full listing of eligible patients). 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 transport costs. The government is committed to helping Victorians struggling with rising living costs and ensuring they have access to life saving ambulance services when required, without concern for cost. As a result, the government has invested $242 million to make ambulance membership more affordable for all Victorians and from July 2011 membership costs were halved. MSS fees rise by 2.5 per cent in 2014–15 so a single 12 month membership is $41.30 and a family 12 month membership is $82.62.

Ambulance Victoria also receives fees from a number of third parties that have responsibility for particular patient cohorts including:

- the DVA for eligible veterans
- the Transport Accident Commission (TAC) for eligible Victorians involved in a transport accident
- the Victorian WorkCover Authority (VWA) for eligible Victorians involved in a workplace accident
- private healthcare facilities (for the first time in 2014–15)
- general patients who are not eligible under any of the other criteria and do not have a membership subscription.

From 1 July 2014 the government is implementing a new funding model and fee schedule for Ambulance Victoria based on the key principles of full cost recovery and a user-pays model. The new funding model was designed to address a number of significant deficiencies in the previous funding model including:

- fees did not reflect the actual cost of delivering the service – some fees were less than the actual cost of delivery and other fees were more
- funders were charged different fees even when they were purchasing the same service
- there were inequities in the fees charged between metropolitan and regional and rural patients
- some services provided were not charged for at all and were funded by cross-subsidisation from other service lines (or products)
- the Victorian Government was the only funder of depreciation to replace Ambulance Victoria's current asset base even though this was a cost of service delivery
- at times, it was difficult for funders to understand what they were purchasing.

The new funding model will stabilise Ambulance Victoria's financial position in the short and long term and provide a robust platform on which reforms to continually improve its efficiency and effectiveness can be accelerated.

2.6.1 New funding model and fee schedule

Ambulance Victoria's fees for each of its service lines are now 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.

Fees for these services have been simplified and are transparent, with all payers paying the same for each service:

- emergency road: a single flat fee for metro of $1,115 and a single flat fee for regional and rural of $1,645
- non-emergency road (stretcher): a single flat fee for metro of $301 and a single flat fee for regional and rural of $509

- non-emergency road (clinic car): a single flat fee of $99
- treat not transport (an ambulance attends but does not transport): a single flat fee of $481
- 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 $1,977)
- rotary: 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 $9,946).

Price tables are included at Part 2, section 2.20.3 'Ambulance'.

A number of additional services provided through Ambulance Victoria will be funded directly or are included as loading in the above costs such as the Adult Retrieval Service.

Under the funding model, each funder will pay its fair share of the fixed costs of operating fixed wing and rotary services based on respective utilisation. For administrative ease in 2014–15, for health services the department will collect the fixed cost fee from health services to pay Ambulance Victoria.

The implementation of a new funding model and fee schedule for Ambulance Victoria in 2014–15 has meant that Ambulance Victoria's budget for 2014–15 varies considerably to previous years. This is because Ambulance Victoria's new model fundamentally differs to its previous funding model – making valid comparison of budgets between years difficult.

In addition to the funding provided directly to Ambulance Victoria, the government also provides funding to Victoria's health services for the inter-hospital transfer of patients (for example, the transfer of patients between health services and/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.

Revised guidelines that set out the payment responsibility for patient transports in Victoria will be released in 2014 to reflect the new funding model and fee schedule.

Compensation to health services for 2014–15

The department will provide compensation for 2014–15 to neutralise the impact of moving to full cost recovery for Ambulance Victoria's services. The department will compensate health services where costs, based on expected utilisation, are estimated to be higher under the new model. This compensation will be at the department's standard compensation rate in the first year of compensation at 90 per cent. The department will also recall 90 per cent of the difference for those health services where the estimated costs are lower than what the health service previously paid.

During 2014–15, the department will closely monitor and review the impacts of the new funding model on health services. Compensation beyond the first transitional year of the model will be considered during 2014–15 to ensure that any implications of the funding model can be taken into account.

2.7 Mental health inpatients

The transition to an ABF model began in 2013–14 by introducing patient-centred pricing using a 'shadow' weighted occupancy approach for non-specialist inpatient services (acute adult, aged, child and adolescent). This included introducing a single unit price for non-specialist acute beds and some specialist acute beds with each bed type determining the Weighted Occupancy target (Wot) set for each health service.

Activity based funding in mental health acute settings are based on patient days weighted for certain patient characteristics rather than by service type (adult, aged, child & adolescent and youth). It is a patient centred pricing model. Each patient day is referred to as a WOt and is calculated using different cost weights for each age cohort and adjusted for indigenous status and whether the patient is being treated in a rural health service. WOts are allocated to health services based on actual bed-day capacity and adjusted for expected age-cohort occupancy.

The basic WOt model will continue in 2014–15, with some improvements. In the WOt model, each patient day earns a WOt. The amount of WOts earned for each patient day is weighted based on patient characteristics. In 2014–15 health services receive funding based on actual capacity adjusted for expected occupancy for each age cohort. Actual occupancy will continue to be monitored in 2014–15; no recall or payments for overactivity apply.

2.7.1 Admission policy

All health services that provide funded mental health hospital beds are required to provide access when needed. At times, people may require access to beds or mental health services (including mental health community support services) from outside of the mental health catchment where they would normally reside. While it is the department's expectation that services will be provided locally where possible, all funded mental health services are required to meet the treatment and care needs of people with a severe mental illness who require it. Health services and mental health community support services are expected to participate in processes that streamline and provide better integration of mental healthcare. Health services are not permitted to restrict access to people with a severe mental illness from outside their catchment who require this level of care without prior discussion with the department.

2.7.2 Classification, counting, costing

2.7.2.1 Classifying patients

In 2014–15 there are four different WOt weights based on age cohort. The weights are based on cost data. The new 18–25 cohort has been developed to recognise youth service activity within the adult cohort. This has been supported by costing data that indicates that costs for this particular cohort are much higher, on average, than the 26–64 years cohort.

Table 2.2: Mental health non-admitted grant structure for 2014–15

Age cohorts WOt weightings			
0–17 years	18–25 years	26–64 years	65+ years
1.1078	1.0470	0.8885	0.9790

2.7.2.2 Counting patients

Low-dependency care

All mental health patients are funded on the same basis weighted for the different patient characteristics.

High-dependency care

High-dependency patient days are likely to be more costly to deliver than low-dependency patient days. However, current cost data is not sufficient to inform appropriate high-dependency weights for WOt classifications.

As an interim measure to account for additional high-dependency costs, services have been allocated additional WOts based on an assessment of available capacity to deliver high-dependency care.

The approach taken this year means that health services allocate additional resources to support those patients requiring high-dependency care through high-dependency WOt allocations. High-dependency WOt allocations are based on a range of factors, including a health services capacity for psychiatric assessment and planning units, high dependency units or specialling (1:1, 1:2 Nursing care for example).

In 2014–15 the department will set up a trial using the Client Management Interface for a three-month block in the first part of 2015 to test ways of capturing cost data on high-dependency care. This will inform cost weights for 2015–16.

Department of Veterans' Affairs' patients

DVA WOts have been determined using 2012–13 bed day data and expected DVA revenue for 2014–15. A premium payment for eligible DVA patients will also be provided but this will be determined on the basis of DVA WOts allocated. Premium payments for unexpended 2014–15 DVA WOts will be subject to recall.

Occupancy thresholds

Occupancy thresholds will be used to monitor health service performance in expending WOt allocations. This refers to the minimum amount of WOt activity expected by the department, based on existing models of care for each age cohort and past expenditure. In 2014–15 funding will not be adjusted for under-performance.

Table 2.3: Mental health non-admitted grant structure for 2014–15

Occupancy thresholds			
0–17 years	18–25 years	26–64 years	65+ years
55 per cent	92 per cent	92 per cent	90 per cent

2.7.2.3 Costing patients

Data submitted by health services to the Victorian Cost Data Collection has been used to determine appropriate weightings for 2014–15.

2.7.3 Pricing

The standard WOt price is not necessarily the same as the average cost per WOt. The WOt price is established as part of the general budget setting process and takes into account other forms of funding. In 2014–15 each WOt will be funded at $632 per unit.

2.7.4 Adjustments

Aboriginal and Torres Strait Islander patients attract a loading of 30 per cent in recognition of their higher costs of care when determining WOt expenditure. This is based on the loading for acute and subacute services. A loading is also applied for services delivered in a rural setting.

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2.8 Mental health non-admitted

Victoria's non-admitted mental healthcare encompasses specialist outpatient clinic services, mental health community support services (MHCSS) and non-admitted bed-based treatment services (Prevention and recovery care (PARC) and community care unit).

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 2014–15.

Community-based services will continue to be funded on a specified grant basis. The department has consolidated 26 of these grants into two specified grants, which will continue to be paid as a block grant in 2014–15. The revised grant structure can be found in Table 2.4.

Table 2.4: Mental health non-admitted grant structure for 2014–15

2013–14 grant description	2014–15 grant description
Academic Positions	MH Academic chairs and positions
Evaluation Academics	
Mental Health – Academics	
Occupational Therapy Academic	
Psychology Academics	
Rehabilitation Academics	
Social Work Academics	
Aged Training Co-ordinator	MH Training and Development
Mental Health – Training – Aged Persons – Training EBA Position	
Mental Health – Training & Development	
MH – Rural Workforce Initiative	
MH T&D – CLIPP – Adult	
MH T&D – Cluster Project & Infrastructure	
MH T&D – GP Share Care	
MH T&D – Nurses EBA	
MH T&D – Psychiatric Academic – Adult	
MH T&D – Registrars – Adult	
MH T&D – Registrars – Aged	
MH T&D – Registrars – CAMHS	
MH T&D – Research & Development – CAMHS	
MH T&D – Services	
MH T&D – Staff – Adult	
MH T&D – Staff – Adult, Aged and CAMHS	
MH T&D – Staff – Aged	
MH T&D – Staff – CAMHS	
MH T&D – Women's Health Consultant – Adult	
MH T&D – Statewide Transcultural Service VPTU	MH Statewide Transcultural Service VPTU
MH T&D – Training to Victoria Police	MH Training to Victoria Police
Redesign Demonstration Project	Child & Youth pilot program

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.

The full-year effect of the SACS pay equity outcomes has been rolled into the PARC price in 2014–15.

To support the reform of the MHCSS, formerly known as the Psychiatric Disability Rehabilitation and Support Services program, the department has developed a new funding model for some key activities.

Key to the reform is the introduction of Individualised Client Support Packages (ICSP). This involves remodelling home-based outreach support, day programs, care coordination, aged intensive support and special client packages funding streams into a single flexible funding stream to be implemented from 1 August 2014.

ICSPs will be funded on the basis of a standard, single-price unit to be known as a Client Support Unit. A Client Support Unit is based on the average efficient total hourly costs.

The funding model also includes youth residential rehabilitation based on a bed day rate, and new catchment-based intake assessment and planning functions, which are block funded.

2.8.1.1 Performance targets

Funding for MHCSS activities is output-based, and statewide targets are set out in Victorian State Budget Paper No 3. Funded organisations should use the Funded Agency Channel to determine their targets for MHCSS activities and note these represent the minimum deliverables expected for the funding provided. In monitoring performance against these targets, the department will take into account issues associated with the transition to new service delivery arrangements. See Part 3, section 3.2.2 'Mental health services' for more details.

2.8.1.2 National Disability Insurance Agency

The Victorian Government is working closely with the National Disability Insurance Agency to support the trial site in the Barwon area. The trial site commenced 1 July 2013.

The Victorian Government committed $1.5 million in MHCSS funding (in kind) for 2013–14 and will contribute $5.4 million from July 2014.

2.8.1.3 Mental health outputs and outcomes

In 2010–11 the department established formal service hours targets for community activity. Service hours are the same as contact hours, except that group sessions for registered clients are measured from a clinician perspective (that is, in clinician hours). This is achieved by dividing the recorded group session duration by the number of registered clients, and multiplying by the number of clinicians delivering the session. The department undertook modelling in 2010–11 in order to determine an appropriate funding rate per service hour, and subsequently indexed this figure each year.

A new funding rate of $354 per service hour, to be used in setting targets, has been determined. Targets for 2014–15 are provided in Part 4, section 4.2.6 'Mental health ambulatory, inpatient and residential targets'.

2.9 Alcohol and other drug services

The Victorian alcohol and drug service system is being redeveloped in two stages. The first stage of redevelopment commenced in the second half of 2013 with the recommissioning of adult non-residential treatment services. New funding and delivery arrangements for these alcohol and drug treatment services will begin on 1 September 2014.

Key changes being brought about through recommissioning include:

- a clearer area-based set of delivery responsibilities for 16 catchments across Victoria
- the creation of a centralised intake and assessment function in each catchment
- three broad streams of funded activity – counselling, withdrawal (non-residential) and care and recovery coordination.

To support the recommissioning process, a new funding model has been introduced. The model aims to offer service providers the flexibility required to respond innovatively and efficiently to the changing needs of alcohol and drug clients and their families as well as providing clear and simpler accountability.

Funding for adult non-treatment services will be provided on the basis of a Drug Treatment Activity Unit across five new activities:

- care and recovery coordination
- counselling
- intake and assessment
- non-residential withdrawal
- catchment-based planning.

Adult residential and youth services will be recommissioned separately at a later stage and will continue to be funded on an episode basis. Output measures for AOD services are outlined in Table 2.5.

Table 2.5: Alcohol and drug services outputs

Measure or indicator	Unit	Government target
Average working days between screening of client and commencement of community-based drug treatment	Number of days	3
Average working days between screening of client and commencement of residential drug treatment	Number of days	6

2.9.1.1 Performance management framework

Victorian alcohol and drug service system reform brings a renewed focus on outcomes-focused performance monitoring. This will be supported by a new performance management framework for state-funded alcohol and drug treatment services scheduled for a phased implementation beginning in late 2014. See Part 3, section 3.2.3 '**Alcohol and other drug services**' for more detail.

2.9.1.2 Pharmacotherapy reform

Pharmacotherapy reforms form an important component of the broader reforms to drug treatment services that are currently being progressed across this state. Recurrent investment of $11 million over four years will help deliver real improvements across this important part of the system.

Five new pharmacotherapy area-based networks are currently being established across Victoria to enhance and support community-based pharmacotherapy services. The new networks will ensure that an integrated, coordinated and accessible pharmacotherapy system is available for people addicted to drugs, and will improve pathways between specialist and primary care, more effectively linking clients with other health, community and human services. Once established, the new networks will have access

to additional funding for addiction medicine specialists to assist local pharmacotherapy providers to deal with more complex patients. As a result, this important specialist capacity will be available much more widely across Victoria to respond to local needs. A boost to training for health professionals is also included as part of this reform.

2.10 Ageing, aged and home care services

Ageing, aged and home care unit prices are provided at Part 2, section 2.20.4 'Ageing, aged and home care'.

2.10.1 Aged care assessment services

The timely delivery of high-quality comprehensive assessments for all people needing access to health and aged care services continues to be the key focus of Victorian aged care assessment services (ACAS) in 2014–15. ACAS projects will support this emphasis through:

- maintaining the ACAS locum bank of trained assessors who can be deployed in areas of high demand or where staff take planned or unplanned leave
- all ACAS members completing national training
- promoting greater uptake of mobile computing to streamline business processes and reduce double handling of information.

Ongoing evaluation of the program is provided by the Lincoln Centre for Research on Ageing.

Victoria is currently negotiating with the Commonwealth Government to extend an agreement that gives Victoria responsibility for managing and operating ACAS for another two years (to 30 June 2016). The Commonwealth is seeking Victoria's agreement to develop a transition plan to enable the ACAS to use the My Aged Care ICT operating system during this period.

The department will discuss the development of the transition plan with health services to identify any issues for health services in ACAS migrating to the My Aged Care system.

2.10.2 Home and Community Care

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

In May 2013, as part of the agreement to implement the National Disability Insurance Scheme from July 2016, the Victorian and Commonwealth governments agreed that the full funding and administrative responsibility for Victorian HACC services for people aged 65 years and over (and 50 years and over for Aboriginal and Torres Strait Islander people) would transition to the Commonwealth from July 2015. The Victorian Government will continue to fund and manage services for people aged under 65.

The Commonwealth and Victorian governments also agreed to work together to retain the benefits of the Victorian HACC system, including stability in the service delivery platform and the role of local government as a funder, planner and deliverer of services. Means of achieving this objective are currently being negotiated between the department and the Commonwealth Department of Social Services.

Joint consultations across all Victorian regions about the transfer and how the benefits of the Victorian system can be retained occurred during February and March 2014. See <www.health.vic.gov.au/hacc/transition> for further information.

Business as usual will continue until 30 June 2015, with the Victorian Government responsible for administering the HACC program in Victoria. The directions for the HACC program in Victoria for this period will continue as described in the *HACC triennial plan 2012–15*. The triennial plan is aligned with the *Victorian Health Priorities Framework 2012–2022*. It proposes a continuing focus on implementing the active service model, responding to people with diverse needs, and improved assessment and care planning.

Approximately 470 organisations, including local councils, will continue to receive funding for a range of services including domestic assistance, personal care, nursing, allied health and social support. Funding for 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.

The fees policy for HACC services can be found at <www.health.vic.gov.au/pch/service_providers/fees>.

During 2014–15 the Victorian Department of Health and Commonwealth Department of Social Services will be working with providers to identify services and resources targeted to people aged 65 and over (50 and over for Aboriginal and Torres Strait Islander people). These resources will then be transferred to the Commonwealth effective 1 July 2015. Affected providers will be offered a service agreement under the new Commonwealth Home Support Programme, which is also scheduled to be in place from 1 July 2015.

Recurrent funds may be recalled from service providers, see Part 2, section 2.17.1 'Victorian funding recall policy' for details.

2.10.3 Supported residential services and accommodation support

In 2014–15 a range of community service organisations will continue to 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 residents of those services (through the Supporting Accommodation for Vulnerable Victorians Initiative)
- the health and wellbeing of pension-level supported residential services residents, and help secure stable tenancies for people who are homeless or at risk of homelessness.

2.10.3.1 Personal Alert Victoria

The contract with Peninsula Health for Personal Alert Victoria concludes on 14 September 2015. The program will be re-tendered for a new contract to be in place on 15 September 2015.

2.10.4 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 meet set targets for resident occupancy.

In 2014–15 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

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- a review indicates failure to optimise service provision for those requiring residential care.

Where an organisation wishes to vary the number of operational places, it must notify its departmental regional program and services advisers of its plans prior to implementing any change. It can also obtain information and advice about this program/policy.

The department will also 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 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 Rural health

2.11.1 Small rural health services

In 2014–15 SRHSs will continue to be funded nationally through block grants.

The SRHS funding model applies to 43 SRHS that deliver public admitted acute services, inclusive of the seven multipurpose services.

The block-funded model gives organisations more flexibility to determine service mix and models of care. It also provides more opportunities to be active in planning and managing health service delivery to meet local needs, to involve the community and to be active in collaborative planning and service delivery arrangements with neighbouring health service providers.

The funding is organised according to the following outputs:

- small rural services acute health
- small rural services aged care
- small rural services HACC
- small rural services primary health.

The description of SRHS outputs and activities are provided in Part 2, section 2.23 'Outputs and activities tables' (Table 2.24: Small rural health services – outputs and activities). As for other health services, SRHSs are required to deliver services consistent with the requirements outlined in the relevant program sections in these Guidelines.

2.11.2 Contract negotiations with visiting medical officers

Visiting medical officers (VMO) remain a dominant feature of rural health services, which largely rely on the local general practitioner workforce to meet their operational needs.

VMOs operate under contractual arrangements with the health service. Health services are obliged to ensure that contracts between hospitals and VMOs are current, adequately documented and transparent about services to be delivered rates and are clear about conditions of payment. 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 (the VHIA) or from legal advisors.

A standard contract has been developed by the Australian Medical Association Victoria and the VHIA in consultation with the Rural Doctors Association of Victoria and identifies the need to stipulate:

- services and activities required of the VMO
- dispute resolution, termination and renewal processes
- insurance arrangements
- right of audit by the hospital
- rules regarding billing, such as those concerning public, DVA and private patients
- payment rates.

As part of the contract, it is also imperative to define the VMO's employment status. Multiple factors contribute to the legal determination of whether a person is an independent contractor or an employee. It is essential for health services to determine whether a VMO is an independent contractor or an employee who is entitled to benefits, including sick and long service leave and redundancy, which independent contractors cannot claim. A determination that a VMO is an employee of the health services carries a substantial risk to health services.

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Contracts should also establish a process to ensure the VMO is effectively performing against the contract and the services being purchased are provided to expected standards. This can be facilitated through developing performance measures in the VMO contracts and annual performance reviews.

In establishing contractual arrangements with VMOs, it is also imperative that health services consider whether the independent contractor model is the best option for the service in obtaining medical services and meeting patient needs.

2.11.3 Rural Enhancement Program Grant

The Rural Enhancement Program Grant has been provided to rural health services since 2007 to support VMOs who participate in a dedicated 24-hour on-call roster for emergency presentations.

The Rural Enhancement Program provides for a minimum level of daily on-call payment. The program is block-funded and annually indexed. The Rural Enhancement Program will continue to be paid to approved health services that block-fund through the SRHS funding model, and to a number of bush nursing hospitals.

For local health services funded through the WIES funding model, the Rural Enhancement Program Grant was one of a number of grants rolled into WIES price in 2012–13. The value of the grant remains in the funding allocation and health services should continue to pay VMOs the full value of the Rural Enhancement Program.

2.11.4 Funding for Rural Health Alliance membership

The department will no longer be providing cash advances to health services to facilitate payment of the annual contributions made by health services to fund Rural Health Alliance membership.

It will be the responsibility of health services to work with their respective alliance to establish an agreed payment schedule and ensure membership contributions can be met.

2.12 Primary, community and dental health

2.12.1 Primary health services

2.12.1.1 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 and community nursing. 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.

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 and/or health outcomes
- the development of service models that are appropriate for 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 (28021, 28048, 28062, 28063, 28064, 28066, 28081, 28085, 28086) appropriately and refer to relevant initiative guidelines.

Additional support for specific populations groups is also provided through:

- the Refugee Nurse Program, which aims to increase refugee an asylum seeker access to primary health services and assist newly arrived communities to improve their health and wellbeing
- Pregnancy, Resilience and Antenatal Material Support, which 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.

Agencies receiving specific initiative funding are required to demonstrate through their reporting that funds are targeted to meet the aims of the initiative (refer to Part 3, section 3.12.9 '**Primary, community, public and dental health data reporting requirements**').

The *Fees policy for primary health programs* was previously titled the *Community health fees policy*. It is now the combined *Home and Community Care (HACC) and primary health programs fees policy*.

Further information about the Victorian HACC fees policy is available at:
<www.health.vic.gov.au/pch/service_providers/fees>.

2.12.1.2 Health Conditions Peer Support Grants Program

The annual Health Conditions Peer Support Grants Program (2011–15) aims to support and strengthen the work of peer support self-help groups and organisations in recognition of the significant benefits of

peer support programs to people with a chronic condition and their carers. Peer support helps decrease the overall burden of disease by encouraging improved health outcomes for members, including advocacy and self-management.

The program has three bands of grants:

- Band 1: up to $5,000 per annum (the former health self-help grants), which contributes to the running costs of peer support groups and are advertised every two years
- Band 2: between $5,000 and $50,000 per annum to an organisation to undertake a range of health-condition-specific peer support activities
- Band 3: between $50,000 and $100,000 per annum to an organisation to provide a range of peer support modes and to develop pathways and build capacity in providing health-condition-specific peer support across the health sector.

Note: For the four years 2011–12 to 2014–15, an annual funding round invites applications for Band 2 and Band 3 grants.

2.12.1.3 Primary Care Partnerships

The Primary Care Partnership (PCP) Program Logic 2013–17 guides PCP activity over a four-year period. It aims to strengthen collaboration and integration across sectors in order to:

- maximise health and wellbeing outcomes
- promote health equity
- avoid unnecessary hospital presentations and admissions.

PCP action from 2013 to 2017 covers the three integral domains of: early intervention and integrated care; consumer and community empowerment; and prevention. Strategies, accountability indicators and enablers are detailed in the Program Logic to guide activity under each of the three domains.

This work will necessarily involve strategic partnerships including with public and private health services, local government, Medicare Locals and other organisations across the health and human services sectors.

2.12.2 Dental health

The Dental Health Program funding model is activity based and the activity measure is a completed course of care. The funding unit is a dental unit of value (DuV).

Victoria signed the *National partnership agreement on treating more public dental patients* (the NPA) in May 2013. The NPA provides up to $85.4 million to treat approximately 110,000 people. All activity under the agreement is to be delivered by March 2015 and is additional to current levels of activity.

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

To simplify funding and accountability arrangements for agencies, a single approach to all Dental Health Program funding was introduced from 1 July 2013, with all targets expressed in DWAUs.

Funding is aligned to DWAUs to ensure that NPA activity targets are met. During the life of the NPA consideration will be given to the most appropriate funding model. Initial findings from the first two years of the Dental Health Program Funding Model, including the use of DuVs, will inform this consideration.

2.12.2.1 Participation in Commonwealth initiatives

The Commonwealth Child Dental Benefits Schedule (CDBS) took effect on 1 January 2014 and provides up to $1,000 in dental benefits over two years for children aged two to 17 in families eligible for Family Tax Benefit A. The Commonwealth estimates the CDBS will provide Victoria with up to $668 million for approximately 800,000 eligible children over six years. The CDBS is available to private and public

dental providers. Public sector agencies will initially only have access to the scheme until the end of 2014 and are encouraged to participate.

A second NPA for adult public dental services, which will build on the current *NPA on treating more public dental patients*, has been deferred from 1 July 2014 until 1 July 2015. Negotiations between the Commonwealth and jurisdictions are yet to begin.

2.12.2.2 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: <www.health.vic.gov.au/dentistry/key-policies>.

2.12.3 Aboriginal health

The department aims to make a significant and measurable impact on improving the length and quality of the lives of Aboriginal Victorians in this decade, in partnership with the Aboriginal community and stakeholders.

The government's objectives are to:

- close the gap in life expectancy for Aboriginal people living in Victoria
- reduce the differences in infant mortality rates, morbidity and low birthweights between the general population and Aboriginal people
- improve access to services and outcomes for Aboriginal people.

2.12.3.1 Key priorities

The six key priorities of *Koolin Balit: Victorian Government strategic directions for Aboriginal health 2012–2022* are:

- a healthy start to life
- a healthy childhood
- a healthy transition to adulthood
- caring for older people
- addressing risk factors
- managing illness better with effective health services.

Koolin Balit builds on the *Victorian Health Priorities Framework 2012–2022*. Broader, whole-of-government strategies are outlined in the *Victorian Aboriginal affairs framework 2013–2018.*

2.12.3.2 Koolin Balit statewide action plan

The statewide action plan covers the period from 2013 to 2015, outlining the detail of what the Victorian Department of Health and other relevant departments and partners will do to achieve the aims of the *Koolin Balit*.

The action plan includes clear measures and milestones to implement and achieve within each of the aims set out in the *Koolin Balit* 10-year strategy.

The key actions for the next three years are:

- reducing the rate of Aboriginal perinatal mortality
- increasing the proportion of Aboriginal children participating in maternal and child health visits

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- reducing smoking take-up among Aboriginal teenagers
- reducing the number of Aboriginal adults who are current smokers
- helping older Aboriginal people access information, support and services to maximise their health and wellbeing
- improving access to primary, acute and mental health services.

2.12.3.3 Aboriginal Health Promotion and Chronic Care partnership

The Aboriginal Health Promotion and Chronic Care (AHPACC) partnership initiative supports Aboriginal community-controlled health organisations and community health services to work in partnership to develop and deliver local services and programs that prevent and manage the high prevalence of chronic disease within Aboriginal communities.

More than 20 organisations receive ongoing (recurrent) funding to deliver AHPACC as partnerships or consortiums within Victoria. The way in which AHPACC is implemented is dependent on local planning and community needs.

The overall intended outcome for AHPACC is to improve the length and quality of the lives of Aboriginal people in Victoria by ensuring:

- services more closely meet community needs
- more Aboriginal Victorians access comprehensive primary healthcare
- improved health literacy
- a positive impact on the social determinants of Aboriginal health.

For further information, contact your local regional office of the Department of Health. Contact details for all regional offices are available at <www.health.vic.gov.au/contact>.

2.13 Public health

2.13.1 Health promotion and prevention

The department will continue to fund a range of health promotion and prevention initiatives to prevent illness and improve the health and wellbeing of Victorians. A number of these initiatives are described below.

2.13.1.1 Healthy Together Victoria

Organisations that receive funding to deliver Healthy Together Victoria contribute to achieving the following *National partnership agreement on preventive health* performance benchmarks:

- the proportion of Victorians at an unhealthy weight remaining within five per cent of the 2009 baseline by 2016, and returning to the 2009 baseline by 2018
- the mean number of daily serves of fruit and vegetables to increase by 0.2 and 0.5 respectively by 2016, and by 0.6 and 1.5 respectively by 2018
- a five per cent increase in the proportion of children doing 60 minutes and adults doing 30 minutes of moderate physical activity daily by 2016, and a 15 per cent increase by 2018
- a two per cent reduction by 2011 from the 2007 national baseline in the proportion of adults smoking daily, and a 3.5 per cent reduction by 2013.

Harmful alcohol use is also a focus.

Measurement of performance benchmarks is through the Victorian Population Health Survey. Data collection and reporting requirements, performance targets, service standards and guidelines for the Prevention System Initiatives activity are provided in the relevant sections of these guidelines.

2.13.1.2 National Bowel Cancer Screening Program designated provider model

The National Bowel Cancer Screening Program (NBCSP) is an initiative of the Commonwealth Government. It is a population health initiative aimed at 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 (FOBT) in the privacy of their own home and then to mail it to a pathology laboratory for analysis.

Victoria has established a designated provider model to ensure timely access to colonoscopy in public health services for NBCSP participants. There are 19 designated providers.

To be admitted to a designated health service provider for a colonoscopy under the NBCSP, with or without gastroscopy, a patient must have been referred for the procedure due to a positive FOBT as a result of being invited to the NBCSP. Other patients admitted for a procedure to investigate a positive FOBT, 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 in order to receive additional WIES funding.

It is expected that most episodes will be grouped to AR-DRGs G48C Colonoscopy, Sameday or G46C Complex Endoscopy, Sameday. A small number of episodes may group to other DRGs where the patient has required an overnight stay or other circumstances have arisen. The department may ask hospitals to confirm episodes with unusual DRGs to ensure the coding is correct and/or that the patient was a participant in the NBCSP.

NBCSP activity is included in total PP WIES reporting throughout the year and contributes to a health services performance of PP WIES compared to target for performance reporting. As NBCSP activity is provided in addition to the funding provided for other activity, and as it is paid to actual activity, it is not part of PP WIES for the determination of recall and throughput.

Further information can be obtained by contacting the department's Screening and Cancer Prevention team.

2.13.1.3 Sexual health and viral hepatitis

The Sexual Health and Viral Hepatitis section of the Department of Health responds to the needs of those affected communities experiencing high prevalence rates of HIV, viral hepatitis and sexually transmitted infections.

A wide range of agencies are funded to provide peer-based care and support, clinical care, health promotion and workforce training – and to increase our knowledge base through research and evaluation.

All funded agencies are required to develop work plans in consultation with the department. Six-monthly reporting and face-to-face meetings have been instigated to discuss progress against deliverables and to fine tune work in response to emerging issues and needs.

2.13.1.4 Tobacco control

A number of organisations are provided funding for a range of activities to contribute to reducing smoking prevalence in Victoria, and to reducing the harms caused by smoking. Funding is allocated via *Funding and service agreements*, which contain performance benchmarks. Organisations are required to report to the department on these benchmarks on a regular basis.

2.13.1.5 Life! Helping you prevent diabetes, heart disease and stroke Program (Life! 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. It also includes social marketing to increase community awareness of the importance of physical activity and dietary habits to reduce the risks of diabetes and cardiovascular disease. Associated activities include evaluation and continuous quality improvement of the program as part of the prevention system in Victoria.

Targets 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.

2.13.2 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 aims. This work aims to reduce the risk of current and emerging infectious diseases in Victoria through implementing patient-focused and population-focused control strategies based on surveillance and risk assessment.

Environmental Health works to prevent ill health arising from environmental factors, to respond to major threats to public health and promote the health and wellbeing of the Victorian community.

Food safety and regulatory activities are aimed at protecting the community from food-related harm and the harmful effects of pesticides, to support public health through strategic regulatory policy analysis and development, and to influence thinking, policy and programs, to achieve a healthier community.

2.13.2.1 Chief Health Officer

The Victorian Government's Chief Health Officer undertakes a variety of statutory functions under the health and food Acts, and 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 documents accessible on the Chief Health Officer's website at <www.health.vic.gov.au/chiefhealthofficer>.

2.13.2.2 The Peter Doherty Institute

The Victorian Government will contribute $55 million to building The Peter Doherty Institute for Infection and Immunity (PDI) in the Parkville Precinct. The PDI will be a purpose-built facility that will integrate microbiology research with leading public health laboratories to strengthen capabilities in infectious diseases and immunology.

The PDI 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 PDI will bring together six organisations into a new state-of-the-art facility and aims to:

- develop strong working partnerships between two iconic Victorian organisations – the university 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.

2.14 Teaching, training and research

2.14.1 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. It comprises four streams of funding:

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

2.14.1.1 People in Health

The People in Health initiative has been established to support, strengthen and expand the health workforce to meet the challenges of Victoria's ageing and growing population. It includes a $238 million investment to train and educate the state's future doctors, nurses, midwifes and allied health professionals.

The People in Health initiative will ensure ongoing and integrated investment to develop a sustainable Victorian health workforce through strong leadership and partnerships across government, health services, the education sector and professional bodies.

Further information can be accessed at <www.health.vic.gov.au/peopleinhealth>.

2.14.1.2 Research grants

Administration of operational infrastructure support for biomedical research institutes is the responsibility of the Department of State Development, Business and Innovation. However, the Department of Health maintains a strong involvement with a wide range of programs that relate to medical research.

2.14.1.3 Professional-entry and student placements

Payments to health services for professional-entry student placements are based exclusively on their proportion of total (weighted) clinical placement activity for students enrolled in a professional-entry course of study in medicine, nursing (registered and enrolled), midwifery or allied health (including allied health assistance). Through the People in Health initiative, $194 million is being invested to support increased capacity for, and the quality of, professional-entry clinical training over the four years to 2016–17 (equivalent to a 45 per cent increase in funding compared with the previous four years). In 2014–15 the grant is $44.7 million.

Following a stakeholder consultation process through the Teaching and Training Funding Industry Advisory Group, changes to the allocation methodology and eligibility have been made to improve the efficiency, equity and accountability of the subsidy.

Further information regarding eligibility, definitions and reporting requirements is available at Part 3, section 3.12.11 'Workforce data reporting requirements' and can be accessed at <health.vic.gov.au/workforce/learning/professional.htm>.

The department also provides 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.

2.14.1.4 Transition to practice – graduate funding

Graduate funding provides payments to health services to contribute to the cost of supervision and on-the-job training in the first year for new nursing, midwifery and allied health graduates, and the first two years for medical graduates. Some allied health students undertaking professional practice placements are also supported through this stream.

For further details regarding this funding stream refer to <www.health.vic.gov.au/workforce>.

Graduates – allied health

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

The number and breadth of allied health professions supported during 2013–14 will include the following professions: physiotherapy, clinical psychology, speech, occupational therapy, social work, dietetics podiatry, orthoptics, audiology, optometry, exercise physiology and orthotics and prosthetics.

Under the ABF model, health services will need to report on allied health graduate activity in order to receive a subsidy. They will also be required to provide evidence of delivering either a formal structured new graduate supervision program or equivalent.

Graduates – medical

This grant provides subsidies for prevocational positions for postgraduate years 1 and 2. Positions have been targeted to areas and disciplines of high need. Clinical training has also been supported in an expanded range of settings, such as general practices and areas within health services that traditionally have not been used for clinical training of early medical graduates.

Graduates – nursing and midwifery

Funding under the graduate stream for nurses and midwives is a subsidy for health services to provide formal graduate programs for new graduates of Bachelor of Nursing, Bachelor of Midwifery, double degrees (nursing/midwifery) and masters' degrees, leading to initial registration as a nurse.

The training and development grant for nursing and midwifery is allocated on the basis of each health service's activity as a percentage of the total grant funds from 2014–15. To provide certainty to smaller sites and to recognise the additional costs associated with providing programs to small numbers of participants, health services with 10 FTE places or fewer will be assured funding for those places.

Funding adjustments will be made on the basis of actual data on graduates for 2015 (provided by health services in January to February) rather than projections as occurred previously.

The grant allocation is a simple, transparent and equitable funding model that supports smaller services – especially rural – to provide graduate employment opportunities with more certainty regarding levels of funding support.

Details of the funding model, eligibility and reporting requirements for graduate programs are set out in the specific program guidelines available on the Nursing in Victoria website at <www.health.vic.gov.au/nursing/graduate>.

The department has undertaken the development of a monitoring and evaluation framework for graduate programs (nursing and midwifery) in Victoria to improve the quality of programs and the evaluation methodology currently in place within health services. Evaluation outcomes will help inform future guidelines for training and development grants.

2.14.1.5 Postgraduate nursing and midwifery funding

A single stream for postgraduate nursing and midwifery programs is now in place for postgraduate nursing and midwifery studies that lead to an award classification of graduate certificate, graduate diploma or master's-level studies. Eligible postgraduate education programs must include a requirement for supervised clinical support.

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

Funding is allocated on the basis of each health service's activity as a percentage of total grant funds. To provide certainty to smaller sites, health services with 10 FTE places or fewer will be assured of funding for those places.

A single grant for this activity reflects that, irrespective of the area of postgraduate study and/or employment arrangements, the clinical and professional supervision required (and therefore costs to provide it to students) are similar.

Clinical placement model midwifery studies are not eligible for this stream of the training and development grant. Instead they are eligible for a professional-entry student placement subsidy.

Details of eligibility and reporting requirements for postgraduate nursing and midwifery funding are set out in the specific program guidelines available on the Nursing in Victoria website at <www.health.vic.gov.au/nursing/furthering/training>.

2.14.1.6 Rates and additional conditions of funding

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 the academic year, and depends on adequate reconciliation of all funded places where requested.

If programs or training positions include a period of rotating placements, participating funded organisations are required to ensure that the host organisation receives a 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 funded level, the training and development grant will be adjusted to reflect actual performance.

The programs should conform to the most recent versions of guidelines (where available) for medical and allied health graduates, including guidelines and standards set by the Australian Health Practitioner Regulation Agency. Graduate nurse and midwife programs as well as postgraduate nurse and midwife programs must meet the criteria set out in the relevant guidelines available on the Nursing in Victoria website.

The guidelines are available at <www.health.vic.gov.au/nursing/furthering/training>.

Training and development grant rates in 2014–15 are listed in Table 2.6.

Table 2.6: Training and development grant rates in 2014–15

Training and development grant	Rate per EFT ($)
Medical postgraduate Year 1	35,020
Medical postgraduate Year 2	38,307
Graduate program (nursing and midwifery)	17,455
Postgraduate nursing and midwifery education	17,455
Pharmacy trainees	29,349
Medical radiation interns	28,012
Medical biophysics placements	17,343
Medical laboratory science placements	17,343
Physiotherapists graduates	Variable depending on demand
Occupational therapists graduates	Variable depending on demand
Speech therapy graduates	Variable depending on demand
Podiatry graduates	Variable depending on demand
Clinical psychology graduates	Variable depending on demand
Dietetics graduates	Variable depending on demand
Social work graduates	Variable depending on demand
Orthoptics graduates	Variable depending on demand
Audiology graduates	Variable depending on demand
Optometry graduates	Variable depending on demand
Exercise physiology graduates	Variable depending on demand
Orthotics and prosthetics graduates	Variable depending on demand

* *Currently the training and development grant rate for the graduate program (nursing and midwifery) and postgraduate nursing and midwifery education is under review. Once available the revised grant rate will be published on the Nursing in Victoria website at <www.health.vic.gov.au/nursing/training>.*

2.15 Replacement of critical medical equipment and engineering infrastructure

The Medical Equipment Replacement and Engineering Infrastructure Replacement programs are directed at sustaining assets essential for delivering responsive and appropriate acute clinical services across Victorian public health services. They enable systematic replacement of highest priority at-risk medical equipment and engineering services infrastructure.

These two programs support health services to manage risk and maintain patient safety, occupational health and safety and service availability and continuity by replacing assets in a planned manner, prior to failure.

Each program is delivered through two funding streams:

- A department-managed, centralised fund is used to qualify, assess and invest in high-value, highest system-wide risk mitigation and management in medical equipment and engineering infrastructure replacements.
- Specific-purpose capital grants devolve appropriate financial responsibility and decision-making flexibility to health services.

Managing the two programs in a consistent 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. It devolves appropriate responsibility for decisions on asset replacement to health services and promotes transparency and responsive prioritisation of funding allocation. The initiative responds to these and other challenges identified over time by the Victorian Auditor-General's Office and the Victorian Healthcare Association.

The programs promote and rely on effective asset management from health services to achieve their service delivery objectives:

- Specific-purpose capital grants provide health services with funds to manage in-scope, priority, at-risk critical assets.
- Health services are expected to actively plan, and in some cases to set aside funds, to stage or fund their prioritised replacements over years, to ensure that these grants can deliver best outcomes for the health service in their at-risk medical equipment and engineering infrastructure replacements.

Conditions of funding apply, including basic asset management plans (see Part 3, section 3.7 '**Asset and environmental management**'). For further information about the programs visit <www.health.vic.gov.au/med-equip>.

2.15.1 Funding

A total of $60 million in 2014–15 will be provided for the Medical Equipment Replacement and Engineering Infrastructure Replacement programs: $35 million for the Medical Equipment Replacement Program; and $25 million for the Engineering Infrastructure Replacement Program. The funding will be allocated as follows:

- 50 per cent from each program will be managed and centrally awarded by the department for high-value high-risk replacements. This includes funding for services delivering statewide public health programs and services.
- 50 per cent from each program will be managed by health services, via specific-purpose capital grants.

These specific-purpose capital grants are structured as follows:

- Grants are allocated to metropolitan, regional, sub-regional and local health services with acute services, for high at-risk replacements.
- Grant calculations are built up from sub-components for medical equipment and engineering infrastructure, which are based on a number of factors including activity and floor space (the latter relates to infrastructure), with adjustments to take account of recent major capital development.
- SRHSs with acute services receive a block capital grant.
- Assets not owned by the state that are part of a private–public partnership arrangement, or are not used for services for public patients are excluded from the basis of grant award.

Funding provided to health services through the programs can only be spent on projects/items that are within the specified scope of each program.

2.16 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*, which has provided joint funding for public hospital services since 1 July 2012. The *National health reform agreement* outlines 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.

The 2014–15 Commonwealth Budget announced the Commonwealth Government's intention to fund jurisdictions on the basis of population and CPI from 2017–18 onwards. This is a significant departure from activity based funding and, therefore, the future of the *National health reform agreement* is unclear. The Commonwealth Budget also announced the removal of state funding guarantees from 2014–15. Nonetheless, for the next three years, the Commonwealth Government will continue to pay a contribution to activity funding to health services.

2.16.1 National activity based funding arrangements

The *National health reform agreement* established a new framework for funding public hospital services under a national approach to ABF.

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, EDs, subacute, non-admitted care, in-scope mental health and block-funded services.

The national model recognises that ABF may not always be practicable and that some services will need to be funded on a block-grant basis. Under current arrangements, SRHSs and teaching, training and research outputs will continue to be funded nationally through block grants.

However, as this new national system is still being implemented and refined, Victoria will retain its existing pricing and funding models for 2014–15. This approach aims to provide budget stability and predictability for Victorian health services, and will continue to be used until there is clarity about the ongoing national funding model, particularly given the changes to the *National health reform agreement*.

Under the national ABF model, activity is funded by the Commonwealth Government with reference to the National Efficient Price (NEP) determination published by 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, ED presentations or non-admitted service events, weighted for clinical complexity.

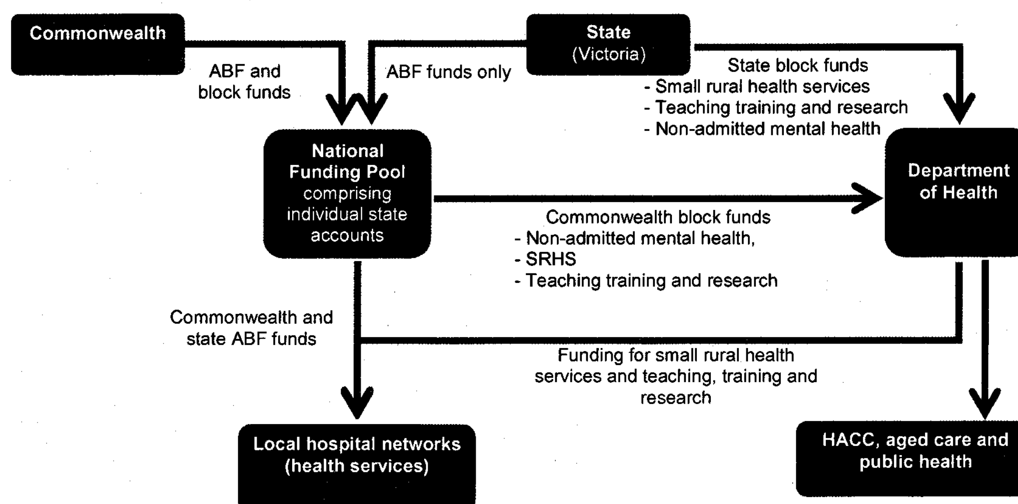
NWAU targets will be included in health services' SoPs Part D, in addition to WIES targets (Part C).

In 2014–15 the NEP has been set at $5,007 per NWAU(14). 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 ABF 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 SoPs. The Victorian Government will continue to manage block-funded payments, including SRHS, 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



2.16.2 The pricing framework for Australian public hospital services: activity based

In 2014–15 in-scope public hospital services that will be funded through the *National health reform agreement* are:

- all acute admitted patient services, including HITH
- all ED services
- all admitted subacute services
- all admitted mental health services
- non-admitted acute and non-admitted subacute patient services.

In 2014–15:

- the national activity unit will be known as NWAU(14)
- the NEP is set by IHPA at $5,007. Costing information used to determine the NEP was drawn from the 2011–12 National Hospital Cost Data Collection (Round 16).

The national model uses a number of classification systems to express the relative cost weights in terms of NWAUs for each 'group' of ABF services. The national classification systems used to group patients for each ABF service are:

- *admitted patient services:* AR-DRG Version 7.0
- ED services: Urgency Related Groups Version 1.4 (for recognised EDs at levels 3B–6) and Urgency Disposition Groups Version 1.3 (for recognised EDs at levels 1–3A)
- *non-admitted patient services:* tier 2 Outpatient Clinics Definitions Version 3.0.
- *admitted mental health patient services:* modified version of AR-DRG Version 7.0
- *admitted subacute patient services:* Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) Version 3.

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In 2014–15 health services' total funding will continued to be determined based on activity volumes and prices according to the Victorian funding models, such as WIES and i-SNAC. 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. The technical specifications of the national ABF model are detailed in the IHPA's 2014–15 National Efficient Price Determination and is available on the IHPA website at: <www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/funding>

2.16.3 The pricing framework for Australian public hospital services: block funded

The national model includes recognition that ABF may not always be practicable and that some services will need to be funded on a block-grant basis. Under current arrangements SRHS will continue to be funded through block grants. In addition to SRHS, teaching training and research, non-admitted mental health, home enteral nutrition, total parental nutrition and home ventilation services would also be block in 2014–15.

The government provides advice to the IHPA on which services meet the criteria to be block funded. Services currently funded through the SRHS model will continue to be block funded. Those currently receiving output funding through the casemix model will be subject to ABF 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 & research, non-admitted mental health, home enteral nutrition, total parental nutrition and home ventilation services in November 2014 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 NEC Determination for 2014–15 that applies to block-funded services.

In 2014–15 the NEC is $5.725 million. This represents the average cost of a block-funded hospital. The NEC was determined using the average in-scope expenditure data for 2011–12 reported to the National Public Hospital Establishment Database of $5.003 million indexed at 4.6 per cent per annum (based on national cost data) to account for price and activity growth over the three years.

For more information on this and for categorisation of SRHS refer to the NEC information available at <www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/national-efficient-cost-determination-lp>

2.17 Prior-year adjustment: activity based funding reconciliation

The department allocates funding according to 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 the financial year according to the policies set out in this section.

2.17.1 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 2.7.

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

In 2014–15, public / private WIES and i-SNAC will be recalled based on new rates, detailed in Table 2.7. The marginal WIES policy changes simplify the throughput and recall rates. The new rates aim 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.

DVA and TAC activity will continue to be funded to actual activity.

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.

SRHS are exempt from the recall policy for acute, subacute and primary health. Recall applies to renal, HACC, ACAS 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)
- GEM
- palliative care.

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

In 2014–15, recall will apply to all HIP non-admitted activity. Recall will apply to the total HIP activity target. Funding recall will not be automatically applied to CPC.

Recall will also apply for non-acute services (maintenance care and the TCP). Maintenance care and TCP recall will be calculated separately and will not be included in the subacute wrap.

Funding recall applies for the state component of TCP, with recall for TCP wrapped between bed-based and home-based.

A recall policy also applies to HACC and ACAS services as outlined in Table 2.7. Funded organisations should note that significant underperformance in any activity should be discussed with the department in a timely manner.

NFC activity will continue to be funded to actual activity.

An overview of the calculation process for recall can be found at Appendix 2.4:Calculating funding recall.

Table 2.7: Victorian funding recall rates 2014–15

Service	Funding recall policy	
Acute admitted services Subacute admitted services (wrap includes GEM, rehabilitation and palliative care) Non-acute admitted services (maintenance care)	0–3 per cent below target	50 per cent of relevant public rate / wrap value
	> 3 per cent below target	Full public rate
Nationally funded centres	Full recall of under-activity at the NFC determined cost per procedure.	
Small rural health services	Recall applies to renal, HACC, ACAS and residential aged care services. No recall applies for acute, subacute and primary health.	
Mental health admitted inpatient services	The department may recall funds associated with funded beds, which remain unopened or have been temporarily closed. Recall will depend on statewide priorities and the need for funding redistribution to achieve these priorities as defined by the department. Premium payments for unexpended 2014–15 DVA WOts will be subject to recall.	
Non-admitted emergency services	Non-admitted emergency services are currently not subject to recall.	
Acute non-admitted services	Funding recall will not be automatically applied to acute non-admitted services. When determining whether recall applies, the department will consider maintenance of effort in relation to service events.	
Subacute non-admitted services	Funding recall will be applied to subacute non-admitted services. When determining whether recall applies, the department will take into account activity against the total HIP target.	
	0–5 per cent below target	No recall
	> 5 per cent below target	The department may recall at the full HIP rate for the amount that is beyond the five per cent underperformance.
Transition Care Program (bed-based and home-based wrapped)	0–5 per cent below target	No recall
	> 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.
Dialysis services	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 end of year, before the recall is applied. Home dialysis activity under target will be subject to full recall.	
Non-admitted radiotherapy	Funding will be recalled at the full rate for performance below target.	
Integrated cancer services	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.	
Primary health funding approach	0–5 per cent below target	No recall
	> 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.
	Further information on the primary health funding approach recall policy is available at <www.health.vic.gov.au/pch/service_providers/funding>.	

Service	Funding recall policy	
BreastScreen Victoria services	0–3 per cent below target	No recall
	3–5 per cent below target	Recall at 50 per cent of relevant rate
	> 5 per cent below target	Recall at full rate
ACAS	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.	
HACC	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.	
Diabetes prevention	Program funding recalled per participant target not met.	
Residential aged care	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.	

Exceptional events

There may be circumstances (including industrial action and natural disasters) beyond the reasonable control of health service management that may 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 so 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.

2.17.2 Funding for throughput above target

Funding for health service throughput above target will be based on a proportion of the funding rate (see Table 2.8).

DVA and TAC will continue to be funded to actual activity, and will therefore attract additional funding for throughout above target.

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)
- GEM
- palliative care.

Significant under- or over-activity in any stream should be discussed with the department. Maintenance care, TCP and NHT activity and non-admitted services are not included in the subacute wrap.

There is no funding for any over-activity for non-acute care (TCP, maintenance or NHT).

Table 2.8: Funding for throughput above target

Service	Funding for throughput above target
Acute admitted services Subacute services (GEM, rehabilitation and palliative care combined) Non-acute admitted services (maintenance care)	50 per cent of relevant public rate / wrap value for activity up to three above target. Any activity above three per cent will not attract additional funds.
Nationally funded centres	Full payment of over-activity at the NFC determined cost per procedure.
Dialysis services	Admitted dialysis activity is incorporated within the total health service acute admitted activity. Payment from dialysis provider to specialist service (hub) should be adjusted to actual by end of year. Home dialysis activity over target will be paid to actual activity.

2.17.3 Prior-year adjustment of Commonwealth contribution

The National Health Funding Body is required to complete a six-monthly reconciliation against NWAU targets for each Local Hospital Network in Victoria. At the time of writing, this reconciliation process is yet to be determined by the administrator for either 2013–14 or 2014–15.

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.

2.17.4 Hospital activity, WIES and i-SNAC reports

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

Further information, including the report specifications, are available on the health data standards and systems (HDSS) website <www.health.vic.gov.au/hdss/reffiles/reporting>.

2.18 Health service compensable and ineligible patients

2.18.1 Funding for interstate patients

The *National health reform agreement* allows jurisdictions to enter into agreements to adjust 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 *National health reform agreement*. 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.

2.18.2 Medicare-ineligible patients

Health services can charge Medicare-ineligible patients for the full cost of their treatment. Health services are able to determine the level of fees chargeable, and fees should be set to achieve full cost recovery. The department provides a guide to fees for ineligible patients to assist health services with fee setting. Suggested fees are published in the *Fees manual* at <www.health.vic.gov.au/feesman>.

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 02/2011 for more information.
- Visitors from a country that has a reciprocal healthcare agreement with Australia are eligible for medically necessary treatment. Refer to Hospital Circular 23/2009 for more information.

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 ED regardless of their eligibility status. Medicare-ineligible patients are expected to pay for these services.
- Health services may provide advice to Medicare-ineligible patients about alternative options for treatment if a patient has been triaged 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.
- 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 first health service.
- Fees charged to Medicare-ineligible patients are at the discretion of individual health services. Fees should be set to achieve full cost recovery.

- Health services are encouraged to obtain an assurance of payment from all Medicare-ineligible patients prior to treating them.
- 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.
- 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.

2.18.3 Compensable patients

2.18.3.1 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 DVA 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, DVA unique identifier, date of birth and sex. Final payment will only be authorised after the veteran's eligibility has been confirmed by DVA.

Eligible veterans will not be covered under the DVA arrangement if they:

- do not elect to be treated as a DVA patient
- elect to be treated as a public patient
- are another category of compensable patient, such as a TAC or VWA patient
- elect to use their private health insurance.

Health services will need to retrospectively reclassify patients as public patients in the event that the DVA 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 DVA 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 DVA patients.

Funding arrangements

The Commonwealth Government has signalled its intent to implement a uniform national purchasing arrangement from 1 July 2015 for public hospital services provided to eligible veterans. This will ensure future arrangements are consistent across all states and territories with the important goals of price equity and simplified administration.

These arrangements would form part of a new three-year agreement commencing on 1 July 2014, with the shift to the new framework occurring on 1 July 2015 for a two-year period ending on 30 June 2017. The nationally consistent approach would then form the basis for negotiations of arrangements from 1 July 2017 onwards.

The arrangements for 1 July 2014 will be negotiated over the coming months but, at the time of writing, no formal discussions have been held. The Commonwealth Government will continue the 2013–14 payment arrangements for Quarter 1 2014–15 and these arrangements will be updated once negotiations are progressed.

Funding arrangements for DVA patients are detailed in Table 2.9. Throughput-based services will continue to attract a premium for eligible veterans, and payment will be made on a reconcilable basis.

Table 2.9: Funding arrangements for DVA patients

Service	Funding arrangements
Emergency department attendances	Emergency department services are funded via a block grant, which incorporates funding for all patient costs. There will be no separate billing of medical and diagnostic costs.
Specialist clinic services	• Specialist clinic services are funded via a block grant. Veteran patients may access all services, and funding and reporting arrangements mirror those for public patients.
Admitted patient services	Funding for the following services is based on throughput and attracts a premium: • acute: health services receive WIES throughput payments from the department • subacute: categories for funding are palliative care, rehabilitation, GEM and maintenance care, and mirror funding and reporting arrangements for public patients • Victorian Maintenance Dialysis Program • admitted mental health services.
Non-admitted services	• HIP: DVA contributes to the block funding provided by the department. Veteran patients may access all services, and funding and reporting arrangements mirror those for public patients. • Non-admitted radiotherapy: weighted activity units (WAU) are funded on a throughput basis. The DVA rate does not include funding for medical costs, and clinicians may charge an MBS rate consistent with processes for admitted activity.
DVA non-specialist mental health acute care	A premium payment for 2014–15 will be made to health services based on the number of DVA WOts allocated. Premium payments for unspent 2014–15 DVA WOts will be subject to recall.
Transition Care Program	The TCP is available to all members of the Australian community, including veterans. However, DVA will only fund the patient contribution for veterans who are former prisoners of war. Further details are available on the DVA website at <www.dva.gov.au>.

Payments

Payment for DVA patients requires an exact match of submitted veteran data with DVA eligibility requirements. Veteran throughput is uncapped, and a premium is payable for all eligible DVA patients including numbers in excess of the target estimates. Where health services do not achieve the DVA target estimate, any funding previously cash flowed will be recalled at the full DVA rate. It is imperative that health services ensure their own records and reporting to the department are complete, comprehensive and timely. DVA funding cannot be substituted for other services for non-veterans.

Additional requirements

Health services should note that:

- The DVA 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 and/or telephone services at the facility.
- The DVA agreement prohibits subcontracting of DVA patient services to a private hospital or facility. If a bed is not available for a DVA patient, the patient is to be formally discharged and transferred to the private hospital. Subcontracting for transition care is exempt from this requirement. Health services will not be paid separately by DVA for eligible veterans in transition care (see Table 2.9).
- Specific requirements apply for long-stay patients. Under the current DVA health service arrangement with Victoria, if the hospitalisation of an eligible veteran is likely to exceed a continuous period of 35 days in any care type other than NHT and palliative care, DVA 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 forwarded to:

  Public Hospital Contract Manager
  c/o Department of Veterans' Affairs
  300 La Trobe Street
  Melbourne VIC 3000

  or
- in the case of SRHS, the beneficiary is reclassified to a NHT patient and the changed status and payment adjusted accordingly.

- If an admitted veteran's LOS is longer than 35 days and the health service has not forwarded an acute care certificate to DVA, reimbursement will be made at the NHT patient payment rate. Veterans who are reclassified to NHT patients can be charged a patient contribution, in line with the provisions of the Health Insurance Act.

2.18.3.2 Transport Accident Commission patients

Eligibility

Patients are required to complete and sign a 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 health services, the TAC and the department address these errors.

Funding arrangements

Funding arrangements for TAC patients are detailed in Table 2.10. TAC rates may be viewed at <www.health.vic.gov.au/feesman>.

Table 2.10: Funding arrangements for TAC patients

Service	Funding arrangements
Emergency department attendances	Health services charge the TAC directly at a flat rate per attendance for patients treated in the ED only
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
Non-admitted services	Health services should bill the TAC directly at the rates set out in the *Fees manual*

Payments

The department will continue to provide health services with WIES throughput and trauma-specific payments for TAC patients.

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 2014–15 based on throughput previously reported in the VAED.

The department will 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 (refer to Hospital Circular 4/2008). 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 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 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 information is entered accuracy 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, department and the TAC.

If a claim is not accepted by TAC, either:

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

Any resulting health service funding adjustments will be undertaken through the prior year's adjustment process.

Additional information

More detailed information on TAC 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.

2.18.3.3 Victorian WorkCover patients

VWA patients treated in Victorian health services are directly funded by VWA insurers. This process will continue in 2014–15 at the rates agreed between the VWA and the department on behalf of health services.

Patients treated in an ED only will continue to be directly billed to VWA at a flat rate per attendance. This rate will apply to all ED attendances (in lieu of the previously charged facility fee).

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>.

2.18.3.4 Prisoners

Admitted activity for prisoners will continue to be WIES funded at the private patient rate in 2014–15, and ED presentations should continue to be billed to the Department of Justice through existing processes. The department will work with the Department of Justice to develop a new funding model for implementation from 2015–16.

2.18.3.5 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 the full cost recovery. Recommended fees are outlined in the department's *Fees manual* available at <www.health.vic.gov.au/feesman>.

2.19 Peer groups for activity based funding purposes

Table 2.11: Peer groups for activity based funding purposes

Health service	Peer group
Alfred Health	Major provider
Austin Health	Major provider
Barwon Health	Major provider
Melbourne Health	Major provider
Mercy Public Hospital Inc.	Major provider
Monash Health	Major provider
Peter MacCallum Cancer Centre	Major provider
St Vincent's Hospital (Melbourne) Limited	Major provider
The Royal Children's Hospital	Major provider
The Royal Victorian Eye and Ear Hospital	Major provider
The Royal Women's Hospital	Major provider
Ballarat Health Services	Outer metro and large regional
Bendigo Health Care Group	Outer metro and large regional
Eastern Health	Outer metro and large regional
Latrobe Regional Hospital	Outer metro and large regional
Northern Health	Outer metro and large regional
Peninsula Health	Outer metro and large regional
Western Health	Outer metro and large regional
Albury Wodonga Health	Regional and rural
Bairnsdale Regional Health Service	Regional and rural
Bass Coast Regional Health	Regional and rural
Benalla Health	Regional and rural
Castlemaine Health	Regional and rural
Central Gippsland Health Service	Regional and rural
Colac Area Health	Regional and rural
Djerriwarrh Health Services	Regional and rural
East Grampians Health Service	Regional and rural
Echuca Regional Health	Regional and rural
Gippsland Southern Health Service	Regional and rural
Goulburn Valley Health	Regional and rural
Kyabram and District Health Services	Regional and rural
Maryborough District Health Service	Regional and rural
Mildura Base Hospital	Regional and rural
Northeast Health Wangaratta	Regional and rural

Health service	Peer group
Portland District Health	Regional and rural
Stawell Regional Health	Regional and rural
South West Healthcare	Regional and rural
Swan Hill District Health	Regional and rural
West Gippsland Health Care Group	Regional and rural
Western District Health Service	Regional and rural
Wimmera Health Care Group	Regional and rural

Note: From 2014-15 the previous Regional and large sub-regional peer group and Sub-regional and local peer group have been combined to create the Regional and rural peer group.

2.20 Price tables

2.20.1 Acute and subacute

Table 2.12: Price table: acute and subacute services 2014–15

Payment	All health services $	Major provider $	Outer metro and large regional $	Regional and rural $
Acute inpatients				
Public WIES21	–	4,385	4,459	4,678
Private WIES21	–	3333	3390	3,555
TAC WIES21	–	3,931	3,998	3,840
DVA WIES21	–	4,483	4,558	4,782
Subacute				
Admitted – Public	480	–	–	–
Admitted – Private	446	–	–	–
Admitted – DVA	581	–	–	–
Transition Care Program bed places (per diem rate)	147	–	–	–
Transition Care Program home places (per diem rate)	51	–	–	–
Non-admitted patients				
Radiotherapy per WAU	228	–	–	–

2.20.2 Mental health and drug services

Table 2.13: Mental health – bed day rates applicable to clinical bed-based services 2014–15

Output	Service element	Funded unit	2014–15 Metro Unit Price ($)	2014–15 Rural Unit Price ($)
Clinical care	**Admitted**			
	Acute care	WOt	632	632
	Acute Care Specialist – Level 2	Available Bed Day	743	746
	Extended Care Adult	Available Bed Day	538	541
	Non-admitted			
	Community Care Unit	Available Bed Day	370	373
	Adult PARC	Available Bed Day	451	451
	Youth PARC	Available Bed Day	538	538
	Aged Persons Nursing Home Supplement	Available Bed Day	96	96
	Aged Persons Hostel Supplement	Available Bed Day	85	85

Notes

1. The bed day rates are based on 100 per cent availability of the funded beds, regardless of actual occupancy.

Table 2.14: Mental Health Community Support Services unit prices

Service element		Funded unit	2014–15 Unit Price ($)
Mental Health Community Support Services recommissioned activities.[1]	Individualised Client Support Packages	Client Support Unit	80.01
	Community Intake Assessment Function	Block Grant	313,770
	Catchment Based Planning Function	Block Grant	50,203
	Youth Residential Rehabilitation – 24hr	Bed Day	192.45
	Youth Residential Rehabilitation – Non 24hr	Bed Day	165.25
Aged intensive support		Client	7,516
Care Coordination		Block grant	
Home based outreach support[2]	Standard (T3)	Client contact hour	113.86
	Moderate (T6)	Client contact hour	113.86
	Intensive (T30)	Client contact hour	56.93
Mutual Support and Self Help (MSSH)[3]	Standalone (high availability)	Weighted block grant	202,780
	Standalone (low availability)	Weighted block grant	Varies
	Individual support referral and advocacy	Client contact hour	35.10
	Information development and dissemination	Block grant	-
	MSSH group support	Contact hour (group)	92.87
	Groups education and training	Contact Hour (group)	316.44
	Volunteer coordination	Hour	40.66

Service element		Funded unit	2014–15 Unit Price ($)
Planned Respite	In home	Client contact hour	31.70
	Community	Client contact hour	31.70
	Residential	Client contact hour	31.70
Psychosocial Day Programs	Drop in	Client contact hour	17.57
	High cost integrated	Client contact hour	88.83
	Standard integrated	Client contact hour	36.80
	Specialist	Client contact hour	32.46
Residential Rehabilitation	Support	Client contact hour	98.45
	24 hour	Available bed day	171.22
	Non 24 hour	Available bed day	136.88
Special Client Packages		Block grant	
Supported Accommodation	24 hour On-site small facilities (0–11 beds)	Available bed day	132.84
	24 hour On-site small facilities (> 11 beds)	Available bed day	46.50
	Non 24 hour On-site Cluster (0–11 beds)	Available bed day	86.69
	Non 24 hour On-site Cluster (> 11 beds)	Available bed day	64.45
	Non 24 hour On-site Other facilities (>11 beds)	Available bed day	86.69

Notes

1. *These activities and prices are effective from 1 August 2014*
2. *Standalone MSSH statewide specialist (high availability) receives a 50 per cent discount of the standard price.*
3. *The Home Based Outreach (T30) rate is half the HBOS (T3&T6) rate $54.44 because matched hours of direct and indirect service is not assumed. This program is still being evaluated.*

Table 2.15: Drug services – unit prices

Service element		Funded unit	2014–15 Unit Price ($)
Drug Treatment Services recommissioned activities.[1]	Care and Recovery Coordination	DTAU	668.92
	Counselling	DTAU	668.92
	Intake and Assessment	DTAU	668.92
	Non-Residential Withdrawal	DTAU	668.92
	Catchment-Based Planning	Block Grant	49,858
Alcohol & Drug Supported Accommodation	Alcohol & Drug Supported Accommodation – Metro	Episodes of care	5,190
	Alcohol & Drug Supported Accommodation – Rural	Episodes of care	6,920
Counseling Consultancy and Continuing Care	Counsel Consult & Continuing Care	Episodes of care	931.79
	Extended Hours Capacity	Episodes of care	1,165
	Youth CCCC	Episodes of care	931.79
Home-based withdrawal		Episodes of care	1,567

Service element		Funded unit	2014–15 Unit Price ($)
ACCO Services – Drug Services	Koori Community A & D Resource Centre – Model 1	Episodes of care	636.41
	Koori Community A & D Resource Centre – Model 2	Episodes of care	1,966
	Koori Community A & D Resource Centre – Model 3	Episodes of care	1,966
	Koori Community Alcohol and Drug Worker	Block grant	1,747
Koori Community Alcohol and Drug Worker	Koori Community Alcohol and Drug Worker	episodes of care	1,747
Forensic Adult Residential Rehabilitation	Forensic Adult Residential Rehab	episodes of care	14,101
	Forensic Alcohol Drug Supptd Accom Metro	episodes of care	5,190
Forensic Counselling Consultancy Cont Care	Forensic Counsel Consult & Cont Care	episodes of care	931.79
Forensic Koori Community A and D Worker	Koori Community Alcohol & Drug Worker	episodes of care	1,747
Forensic Youth Residential Drug Withdrawal	Forensic Youth Resid Drug Withdrawal	episodes of care	8,695
Mobile Overdose Response	Mobile Overdose Response Service (MORS)	Episodes of care	6,100
Outpatient Withdrawal	Outpatient Withdrawal	Episodes of care	510.11
Peer Support		Episodes of care	585.15
Residential Drug Withdrawal	Residential Drug Withdrawal - 12 Beds	Episodes of care	2,726
	Residential Drug Withdrawal - 4 Beds	Episodes of care	8,279
	Residential Drug Withdrawal - 6 Beds	Episodes of care	4,055
Residential Rehabilitation	Adult Residential Rehabilitation	Episodes of care	14,101
Rural Withdrawal		Episodes of care	1,567
	Specialist Pharmacotherapy Service	Episodes of care	2,828
Women's Alcohol & Drug Supported Accommodation	Rural Women's Alcohol & Accommodation	Episodes of care	6,920
	Women's Alcohol & Drug Supported Accommodation	Episodes of care	5,190
Youth Alcohol & Drug Supported Accommodation	Metro	Episodes of care	5,160
	Rural	Episodes of care	6,920
Youth Outreach		Episodes of care	1,544
Youth Residential Drug Withdrawal		Episodes of care	8,696

Notes

1. *These activities and prices are effective from 1 September 2014*

2.20.3 Ambulance

Table 2.16: Price table: ambulance 2014–15

Program area	Service		Funded unit	2014–15 estimated unit price ($)
Ambulance services	Emergency road*	Metro	Case	1,115
		Non-metro	Case	1,645
	Non-emergency road	Metro – stretcher	Case	301
		Non-metro – stretcher	Case	509
		Clinic car	Case	99
	Treat not transport	Statewide (ambulance attendance without transport)	Case	481
	Air	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)	Case	1,977 variable charge
		Rotary (reflecting the cost of service delivery, these fees include a fixed and variable charge. The fixed charge is based on respective usage by payers)	Case	9,946 variable charge

Note:

* *Incorporates a loading for Adult Retrieval Victoria*

The classification of emergency or non-emergency is not relevant for air transport fees. The type of transport – rotary or fixed-wing – determines the fee.

Reflecting the cost of service delivery, the fixed-wing service fee includes a fixed and variable charge. For general patients this is combined in the one variable fee – charged per transport. For the remaining users, this is spilt between a fixed charge (due 1 July 2014) and a variable charge invoiced per transport.

Reflecting the cost of service delivery, the rotary fee includes a fixed and variable charge. General patients only incur the variable charge.

Air transport fees do not include any road leg associated with the air transport. Road legs are billed separately, as per the fees above.

2.20.4 Ageing, aged and home care

Table 2.17: Ageing, aged and home care output group – unit prices

Program area	Service		Funded unit	2014–15 estimated unit price ($)
Aged support services	Supporting accommodation for vulnerable Victorians	Cluster plans	Plans	5,819
		Expenditure plans (KPOM)	Plans	10,994
HACC primary health, community care and support	HACC linkages packages	HACC – linkages packages	Packages	14,832
	HACC domestic assistance	HACC – domestic assistance	Hours	32.05
	HACC respite	HACC – respite	Hours	33.09
	HACC planned activity group – core	Planned activity group – core	Hours	13.02
	HACC planned activity group – high	Planned activity group – high	Hours	18.34
	HACC volunteer coordination	Hours of coordinator time	Hours	37.98
	HACC allied health	Counselling	Hours	97.28
		Dietetics	Hours	97.28
		HACC – allied health	Hours	97.28
		Occupational therapy	Hours	97.28
		Physiotherapy	Hours	97.28
		Podiatry	Hours	97.28
		Speech therapy	Hours	97.28
	HACC delivered meals	HACC – delivered meals	Meals	3.23
	HACC property maintenance	HACC – property maintenance	Hours	46.60
	RDNS HACC allied health	Counselling	Hours	71.38
		Dietetics	Hours	71.38
		Occupational therapy	Hours	71.38
		Physiotherapy	Hours	71.38
		Podiatry	Hours	71.38
		RDNS – HACC – allied health	Hours	71.38
		Speech therapy	Hours	71.38
	HACC nursing	HACC nursing (KPOM)	Hours	89.15
		RDNS Top-up	Hours	12.72
	HACC access and support	HACC access and support	Hours	65.50
	HACC Assessment	Short term case management	Hours	89.15
		Unit-priced hours of HACC assessment (KPOM)	Hours	89.15
	HACC personal care	HACC – personal care	Hours	36.61
		RDNS top-up	Hours	33.42

Program area	Service		Funded unit	2014–15 estimated unit price ($)
	ACCO services – aged and home care	HACC – allied health	Hours	97.28
		HACC – counselling	Hours	97.28
		HACC access and support	Hours	65.50
		HACC – delivered meals	Meals	3.23
		HACC – domestic assistance	Hours	32.05
		HACC – nursing	Hours	89.15
		HACC – occupational therapy	Hours	97.28
		HACC – personal care	Hours	36.61
		HACC – physiotherapy	Hours	97.28
		HACC – planned activity group / core	Hours	13.02
		HACC – podiatry	Hours	97.28
		HACC – property maintenance	Hours	46.60
		HACC – respite	Hours	33.09
		HACC – volunteer coordination	Hours	37.98
		Planned activity group – high	Hours	18.34
		HACC assessment (KPOM)	Hours	89.15
		HACC Assessment - Care Planning	Hours	89.15
Residential aged care*	Public Sector Residential Aged Care Supplement	HSUA 1 EBA – hostel	Bed day	5.73
		High care supplement	Bed day	61.88
		Public sector residential aged care supplement**	Bed day	12.50
	Residential Aged Care Complex Care Supplement	Nursing home complex care supplement	Bed day	37.54
	Rural Small High Care Supplement	21–30 places	Bed day	6.26
		11–20 places	Bed day	7.51
		1–10 places	Bed day	10.01

* *Annual funding is generally calculated as follows:*

Number of operational places × 365.25 days per year × 99 per cent occupancy factor × relevant unit price. Places that are not operational (for a time-limited period or ongoing), or used for any other purpose, will not attract state government PSRACS supplements.

** *This price is determined by the Commonwealth Department of Health and Ageing at the beginning of each financial year. The 2014–15 price was not available at time of publication so the figure is an estimate and may differ from the figure to be published by the Commonwealth. The current public sector residential aged care supplement is available online at <www.health.gov.au/internet/main/publishing.nsf/Content/ageing-subs-supp-current.htm>.*

2.20.5 Primary, community and dental health output group

Table 2.18 Primary, community and dental health output group – unit prices

Program Area	Service		Funded unit	2014–15 estimated unit price ($)
Community Health Care	FARREP	FARREP – Direct Care	Hours	98.33
	IHSHY	IHSHY – Counselling/Casework	Hours	98.33
		IHSHY – Nursing	Hours	89.10
	Womens Health	Womens Health – Counselling | Casework	Hours	98.33
	Family Planning	Family Planning – Counselling | Casework	Hours	98.33
		Family Planning – Nursing	Hours	89.10
	Aboriginal Services and Support	Case Coordination	Hours	98.33
	Integrated Chronic Disease Management	Integrated Chronic Disease	Hours	98.33
		Nursing	Hours	89.10
	Diabetes Self Management	Community Health Diabetes Self Management	Hours	98.33
	Refugee Health Nurses	Refugee Health Nursing	Hours	89.10
	Healthy Mothers Healthy Babies	Allied Health	Hours	98.33
		Nursing	Hours	89.10
	Community Health	Allied Health	Hours	98.33
		Nursing	Hours	89.10

2.21 Cost weight tables

2.21.1 i-SNAC class weights

Interim – Subacute and Non-Acute Classification (i-SNAC)				
Care type	**Class**	**Class weight**	**VAED data element**	**Codes**
Palliative care	Stable	1.011	• Phase of care on admission • Phase of care on phase change	1
	Unstable	1.372		2
	Deteriorating	1.488		3
	Terminal	1.825		4
Rehabilitation	Stroke	1.332	• Impairment	01x
	Brain dysfunction	1.730		02x
	Neurological	1.325		03x
	Spinal cord	2.514		04x
	Amputation	1.333		05x
	Pain	1.260		07x
	Orthopaedics	1.239		08x
	Cardiac	1.266		09x
	Burns	1.227		11x
	Major multiple trauma	1.728		14x
	Other	1.188		06x,10x, 12x,13x, 15x, 16x
Geriatric evaluation and management	GEM	1.188	• Care type	9
Maintenance	Maintenance	0.865	• Care type	MC

2.21.2 WIES21 Victorian Cost Weights 2014–15

WIES21 2014–15 Victorian cost weights

Victorian Modified AR-DRG 7.0x

Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
A01Z	Liver Transplant	D		8	77	23.0		5.1691	6.6004	2.5049	26.6393	0.3621	0.2897
A03Z	Lung or Heart-Lung Transplant	4		11	102	29.9		4.1788	5.0861	1.6496	23.2319	0.3621	0.2897
A05Z	Heart Transplant	4		19	179	46.4		5.5889	6.5818	1.8812	42.3249	0.3621	0.2897
A06A	Tracheostomy W Ventilation >=96hrs W Catastrophic CC	4		28	63	41.2		2.0296	2.5050	0.9167	28.1729	0.3621	0.2897
A06B	Ventilation >=96hrs and OR Proc (W/O Tracheostomy or W/O Cat CC)	4		15	36	24.2		2.4928	2.9954	0.9383	17.0700	0.3621	0.2897
A06C	Tracheostomy W/O Ventilation >=96hrs, or Ventilation >=96hrs W/O OR Proc	4		11	25	16.6		1.1711	1.5741	0.7328	9.6353	0.3621	0.2897
A07A	Allogeneic Bone Marrow Transplant, Age <17	4		60	137	103.9		1.9715	2.4200	0.8822	55.3504	0.3621	0.2897
A07B	Allogeneic Bone Marrow Transplant, Age >=17	D		15	34	26.6		0.4645	0.8854	0.7857	12.6703	0.3328	0.2663
A08A	Autologous Bone Marrow Transplant W Catastrophic CC	D		13	31	20.0		0.3376	0.6220	0.5250	7.4468	0.2592	0.2073
A08B	Autologous Bone Marrow Transplant W/O Catastrophic CC	D		3	8	5.5		0.4789	0.9578	0.6385	2.8734	0.3621	0.2897
A09A	Kidney Transplant, Age <17 or W Catastrophic CC	D		3	30	10.4		2.1609	3.1793	1.3579	7.2531	0.3621	0.2897
A09B	Kidney Transplant, Age >=17 W/O Catastrophic CC	D		2	21	7.0		2.3405	3.5573	1.2168	5.9908	0.3621	0.2897

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
A10Z	Insertion of Ventricular Assist Device	4		57	129	87.0		15.7125	16.3813	1.3141	91.2856	0.3621	0.2897
A11A	Insertion of Implantable Spinal Infusion Device W Catastrophic CC	D		16	37	28.0		8.3841	8.6713	0.5384	17.2855	0.2297	0.1838
A11B	Insertion of Implantable Spinal Infusion Device W/O Catastrophic CC	D		1	14	2.5		4.1716	4.7671	0.0000	4.7671	0.3335	0.2668
A12Z	Insertion of Neurostimulator Device	D		0	5	1.9		5.4049	5.4049	0.0000	5.4049	0.3581	0.2865
A40A	ECMO W Tracheostomy	4		32	73	50.1		6.9908	7.6338	1.2458	47.4979	0.3621	0.2897
A40B	ECMO W/O Tracheostomy	4		13	30	19.2		4.2083	4.9550	1.3786	22.8766	0.3621	0.2897
B01A	Ventricular Shunt Revision W Catastrophic or Severe CC	D		2	23	5.8		1.3949	1.9039	0.5090	2.9219	0.2450	0.1960
B01B	Ventricular Shunt Revision W/O Catastrophic or Severe CC	D		1	10	3.4		1.3819	2.0010	0.0000	2.0010	0.2535	0.2028
B02A	Cranial Proc W Cerebral Haemorrhage W Cat CC	D		5	50	17.6		2.5466	3.5157	1.5507	11.2691	0.3621	0.2897
B02B	Cranial Procs W/O Cerebral Haem W Cat CC or (W Cerebral Haem W Sev CC)	D		3	33	11.3		2.7225	3.5767	1.1390	6.9935	0.3162	0.2529
B02C	Cranial Procs W/O Cerebral Haem W Sev CC or W/O Cat/Sev CC	D		1	16	5.3		2.3160	3.4102	0.0000	3.4102	0.2914	0.2331
B03A	Spinal Procedures W Catastrophic or Severe CC	D		2	22	6.7		2.1761	2.7252	0.5491	3.8235	0.2282	0.1826

WIES21 2014–15 Victorian cost weights

Victorian Modified AR-DRG 7.0x

Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
B03B	Spinal Procedures W/O Catastrophic or Severe CC	D		0	9	2.8		2.2036	2.2036	0.0000	2.2036	0.2593	0.2074
B04A	Extracranial Vascular Procedures W Catastrophic CC	D		3	30	9.4		1.5216	1.9974	0.6344	3.9005	0.2133	0.1706
B04B	Extracranial Vascular Procedures W/O Catastrophic CC	D		1	11	3.5		1.5747	2.1878	0.0000	2.1878	0.2436	0.1949
B05Z	Carpal Tunnel Release	D		0	3	1.0		0.3850	0.3850	0.0000	0.3850	0.0931	0.0745
B06A	Procs for Cerebral Palsy, Muscular Dystrophy, Neuropathy W Cat or Sev CC	D		3	35	11.2		1.4834	2.0734	0.7866	4.4331	0.2218	0.1774
B06B	Procs for Cerebral Palsy, Muscular Dystrophy, Neuropathy W/O Cat or Sev CC	D		0	7	1.8		1.7036	1.7036	0.0000	1.7036	0.3202	0.2561
B06C	Procs for Cerebral Palsy, Muscular Dystrophy, Neuropathy, Sameday	D		0	3	1.0		0.5656	0.5656	0.0000	0.5656	0.1161	0.0928
B07A	Cranial or Peripheral Nerve and Other Nervous System Procedures W CC	D		2	19	6.1		1.0572	1.5419	0.4847	2.5113	0.2219	0.1775
B07B	Cranial or Peripheral Nerve and Other Nervous System Procedures W/O CC	D		0	5	1.6	Same day	0.5068	1.0503	0.0000	1.0503	0.2398	0.1918
B40Z	Plasmapheresis W Neurological Disease, Sameday	D		0	3	1.0		0.1535	0.1535	0.0000	0.1535	0.1228	0.0982
B41Z	Telemetric EEG Monitoring	D		2	7	4.0		0.3032	0.5983	0.2950	1.1883	0.2338	0.1871

WIES21 2014–15 Victorian cost weights														
Victorian Modified AR-DRG 7.0x														
Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
B42A	Nervous System Disorders W Ventilator Support W Catastrophic CC	D		3	33	11.9		0.8053	1.5832	1.0373	4.6951	0.3146	0.2517
B42B	Nervous System Disorders W Ventilator Support W/O Catastrophic CC	D		1	12	3.3		1.0908	2.1584	0.0000	2.1584	0.3621	0.2897
B60A	Acute Paraplegia/Quadriplegia W or W/O OR Procs W Catastrophic CC	D		20	45	28.5		0.2658	0.5317	0.5051	10.6332	0.2985	0.2388
B60B	Acute Paraplegia/Quadriplegia W or W/O OR Procs W/O Catastrophic CC	D		3	8	4.7		0.3128	0.6255	0.4170	1.8765	0.3217	0.2574
B61A	Spinal Cord Conditions W or W/O OR Procedures W Catastrophic or Severe CC	D		7	17	10.8		0.3317	0.6635	0.5687	4.6444	0.3441	0.2753
B61B	Spinal Cord Conditions W or W/O OR Procedures W/O Catastrophic or Severe CC	D		2	5	3.3		0.4813	0.9625	0.4813	1.9251	0.3621	0.2897
B62Z	Apheresis	D		0	3	1.0		0.3398	0.3398	0.0000	0.3398	0.2676	0.2140
B63Z	Dementia and Other Chronic Disturbances of Cerebral Function	D		2	22	7.7		0.3969	0.7939	0.3969	1.5878	0.1652	0.1322
B64A	Delirium W Catastrophic CC	D		2	25	8.6		0.4794	0.9589	0.4794	1.9177	0.1780	0.1424
B64B	Delirium W/O Catastrophic CC	D		1	13	3.8	Same day	0.2851	0.9761	0.0000	0.9761	0.2074	0.1659
B65A	Cerebral Palsy	D		4	42	15.2		0.4392	0.8784	0.6588	3.5136	0.1847	0.1477
B65B	Cerebral Palsy, Sameday	D		0	3	1.0		0.2529	0.2529	0.0000	0.2529	0.2023	0.1619

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
B66A	Nervous System Neoplasm W Radiotherapy	D		2	18	6.6		0.4387	0.8773	0.4387	1.7546	0.2117	0.1694
B66B	Nervous System Neoplasm W/O Radiotherapy W Catastrophic or Severe CC	D		2	18	6.6		0.4387	0.8773	0.4387	1.7546	0.2117	0.1694
B66C	Nervous System Neoplasm W/O Radiotherapy W/O Catastrophic or Severe CC	D		1	10	3.0	Same day	0.3176	1.0110	0.0000	1.0110	0.2696	0.2157
B67A	Degenerative Nervous System Disorders W Catastrophic or Severe CC	D		2	25	8.2		0.5106	1.0213	0.5106	2.0425	0.1984	0.1587
B67B	Degenerative Nervous System Disorders W/O Catastrophic or Severe CC	D		1	16	4.8	One day	0.4478	0.4478	0.0000	1.2695	0.2102	0.1682
B67C	Degenerative Nervous System Disorders, Sameday	D		0	3	1.0		0.1040	0.1040	0.0000	0.1040	0.0931	0.0745
B68A	Multiple Sclerosis and Cerebellar Ataxia W CC	D		1	16	4.5		0.6621	1.3242	0.0000	1.3242	0.2329	0.1863
B68B	Multiple Sclerosis and Cerebellar Ataxia W/O CC	D		0	3	1.1		0.2023	0.2023	0.0000	0.2023	0.1528	0.1223
B69A	TIA and Precerebral Occlusion W Catastrophic or Severe CC	D		1	10	3.2		0.4698	0.9397	0.0000	0.9397	0.2385	0.1908
B69B	TIA and Precerebral Occlusion W/O Catastrophic or Severe CC	D		0	5	1.7	Same day	0.3117	0.5890	0.0000	0.5890	0.2751	0.2201
B70A	Stroke & Other Cerebrovascular Disorders W Catastrophic CC	D		3	33	10.9		0.4458	0.8917	0.5944	2.6750	0.1970	0.1576

WIES21 2014–15 Victorian cost weights														
Victorian Modified AR-DRG 7.0x														
Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
B70B	Stroke & Other Cerebrovascular Disorders W Severe CC	D		1	15	4.7		0.6812	1.3625	0.0000	1.3625	0.2297	0.1837
B70C	Stroke & Other Cerebrovascular Disorders W/O Catastrophic or Severe CC	D		1	10	3.4	Same day	0.3797	1.0506	0.0000	1.0506	0.2489	0.1991
B70D	Stroke & Other Cerebrovascular Disorders, Died/Trans Acute Facility <5 Days	D		0	7	2.2		0.8333	0.8333	0.0000	0.8333	0.3013	0.2410
B71A	Cranial and Peripheral Nerve Disorders W CC	D		2	22	7.0	One day	0.4959	0.4959	0.6190	1.7260	0.1983	0.1587
B71B	Cranial and Peripheral Nerve Disorders W/O CC	D		1	10	3.1		0.4444	0.8887	0.0000	0.8887	0.2259	0.1807
B71C	Cranial and Peripheral Nerve Disorders, Sameday	D		0	3	1.0		0.1306	0.1306	0.0000	0.1306	0.1045	0.0836
B72A	Nervous System Infection Except Viral Meningitis W Cat or Sev CC	D		3	34	12.1		0.5704	1.1408	0.7605	3.4223	0.2261	0.1809
B72B	Nervous System Infection Except Viral Meningitis W/O Cat or Sev CC	D		2	21	6.5	One day	0.2816	0.2816	0.7307	1.7431	0.2140	0.1712
B73Z	Viral Meningitis	D		0	7	2.3		0.7114	0.7114	0.0000	0.7114	0.2513	0.2011
B74A	Nontraumatic Stupor and Coma W Catastrophic or Severe CC	D		1	11	2.9		0.4429	0.8859	0.0000	0.8859	0.2423	0.1938

WIES21 2014–15 Victorian cost weights														
Victorian Modified AR-DRG 7.0x														
Code	**Label**	**Mech. Vent Co-payment**	**Other Co-payment**	**Inlier Low**	**Boundary High**	**Average Inlier Stay**	**Same/ One day DRG**	**Same day weight**	**One day weight**	**Multi-day low outlier per diem**	**Inlier weight**	**High outlier per diem**	**HITH outlier per diem**
B74B	Nontraumatic Stupor and Coma W/O Catastrophic or Severe CC	D		0	4	1.3		0.3731	0.3731	0.0000	0.3731	0.2269	0.1815
B75Z	Febrile Convulsions	D		0	3	1.2		0.3525	0.3525	0.0000	0.3525	0.2413	0.1930
B76A	Seizures W Catastrophic or Severe CC	D		1	14	4.0		0.6735	1.3470	0.0000	1.3470	0.2677	0.2142
B76B	Seizures W/O Catastrophic or Severe CC	D		0	6	1.8		0.6484	0.6484	0.0000	0.6484	0.2936	0.2349
B76C	Seizures, Sameday	D		0	3	1.0		0.2426	0.2426	0.0000	0.2426	0.1941	0.1553
B77Z	Headache	D		0	6	1.7	Same day	0.2002	0.5416	0.0000	0.5416	0.2556	0.2045
B78A	Intracranial Injuries W Catastrophic or Severe CC	D		2	23	7.6		0.5317	1.0634	0.5317	2.1267	0.2229	0.1783
B78B	Intracranial Injuries W/O Catastrophic or Severe CC	D		0	8	2.3		0.8276	0.8276	0.0000	0.8276	0.2934	0.2348
B78C	Intracranial Injuries, Died or Transferred to Acute Facility <5 Days	D		0	6	1.9		0.8450	0.8450	0.0000	0.8450	0.3558	0.2846
B79A	Skull Fractures W Catastrophic or Severe CC	D		1	11	3.5		0.6707	1.3415	0.0000	1.3415	0.3066	0.2453
B79B	Skull Fractures W/O Catastrophic or Severe CC	D		0	5	1.4		0.6235	0.6235	0.0000	0.6235	0.3621	0.2897
B80A	Other Head Injuries W Catastrophic or Severe CC	D		1	12	3.1		0.4645	0.9289	0.0000	0.9289	0.2376	0.1901
B80B	Other Head Injuries W/O Catastrophic or Severe CC	D		0	4	1.2	Same day	0.2276	0.4773	0.0000	0.4773	0.3193	0.2554

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
B81A	Other Disorders of the Nervous System W Catastrophic or Severe CC	D		2	20	6.6		0.4060	0.8119	0.4060	1.6238	0.1962	0.1570
B81B	Other Disorders of the Nervous System W/O Catastrophic or Severe CC	D		0	9	2.5	Same day	0.3498	0.7890	0.0000	0.7890	0.2502	0.2002
B82A	Chronic and Unspec Para/Quadriplegia W or W/O OR Proc W Skin Grft/Flap Repair	D		69	156	115.4		0.2060	0.4119	0.4059	28.4222	0.1970	0.1576
B82B	Chronic and Unspec Para/Quadriplegia W or W/O OR Proc W Cat CC	D		10	23	14.8		0.2304	0.4609	0.4148	4.6085	0.2490	0.1992
B82C	Chronic and Unspec Para/Quadriplegia W or W/O OR Proc W/O Cat CC	D		3	8	5.1		0.2988	0.5976	0.3984	1.7927	0.2822	0.2258
C01Z	Procedures for Penetrating Eye Injury	D		0	6	2.0		1.2289	1.2289	0.0000	1.2289	0.2235	0.1788
C02Z	Enucleations and Orbital Procedures	D		0	7	2.3	Same day	0.5408	1.4770	0.0000	1.4770	0.2494	0.1995
C03Z	Retinal Procedures	D		0	3	1.1		0.7531	0.7531	0.0000	0.7531	0.1911	0.1529
C04Z	Major Corneal, Scleral and Conjunctival Procedures	D		0	4	1.3		1.2691	1.2691	0.0000	1.2691	0.1861	0.1489
C05Z	Dacryocystorhinostomy	D		0	3	1.1		0.8954	0.8954	0.0000	0.8954	0.2250	0.1800
C10Z	Strabismus Procedures	D		0	3	1.0		0.7976	0.7976	0.0000	0.7976	0.2115	0.1692
C11Z	Eyelid Procedures	D		0	5	1.4	Same day	0.5368	0.8988	0.0000	0.8988	0.2442	0.1953

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
C12Z	Other Corneal, Scleral and Conjunctival Procedures	D		0	4	1.2		0.5331	0.5331	0.0000	0.5331	0.1066	0.0853
C13Z	Lacrimal Procedures	D		0	3	1.0		0.3472	0.3472	0.0000	0.3472	0.0980	0.0784
C14Z	Other Eye Procedures	D		0	4	1.1		0.3475	0.3475	0.0000	0.3475	0.0931	0.0745
C15Z	Glaucoma and Complex Cataract Procedures	D		0	3	1.1		0.6643	0.6643	0.0000	0.6643	0.1326	0.1061
C16Z	Lens Procedures	D		0	3	1.1	Same day	0.5117	0.6648	0.0000	0.6648	0.1710	0.1368
C60A	Acute and Major Eye Infections W CC	D		2	20	6.2		0.3285	0.6570	0.3285	1.3140	0.1705	0.1364
C60B	Acute and Major Eye Infections W/O CC	D		0	8	2.9		0.5394	0.5394	0.0000	0.5394	0.1512	0.1210
C61A	Neurological and Vascular Disorders of the Eye W CC	D		1	11	3.3		0.4725	0.9450	0.0000	0.9450	0.2302	0.1841
C61B	Neurological and Vascular Disorders of the Eye W/O CC	D		1	11	3.3	One day	0.2208	0.2208	0.0000	0.9283	0.2228	0.1782
C62A	Hyphema and Medically Managed Trauma to the Eye, W CC	D		1	10	3.2	Same day	0.2667	0.9224	0.0000	0.9224	0.2332	0.1865
C62B	Hyphema and Medically Managed Trauma to the Eye W/O CC	D		0	4	1.3	Same day	0.2265	0.4798	0.0000	0.4798	0.2862	0.2290
C63A	Other Disorders of the Eye W CC	D		1	13	3.9	Same day	0.2015	1.0050	0.0000	1.0050	0.2054	0.1643
C63B	Other Disorders of the Eye W/O CC	D		0	6	1.9	Same day	0.2225	0.5658	0.0000	0.5658	0.2339	0.1871
D01Z	Cochlear Implant	D	Bilat	0	3	1.1		7.1565	7.1565	0.0000	7.1565	0.0931	0.0745

WIES21 2014–15 Victorian cost weights

Victorian Modified AR-DRG 7.0x

Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
D02A	Head and Neck Procedures W Microvascular Tissue Transfer or W Cat/Sev CC	D		3	27	9.6		2.3644	2.8957	0.7084	5.0209	0.2324	0.1859
D02B	Head and Neck Procedures W Malignancy or W Mod CC	D		1	9	2.3		1.1921	1.5871	0.0000	1.5871	0.2355	0.1884
D02C	Head and Neck Procedures W/O Malignancy W/O CC	D		0	5	1.5		1.3394	1.3394	0.0000	1.3394	0.2905	0.2324
D03Z	Surgical Repair for Cleft Lip and Palate Disorders	D		0	6	2.1		1.9795	1.9795	0.0000	1.9795	0.3621	0.2897
D04Z	Maxillo Surgery	D		0	5	1.6		1.4504	1.4504	0.0000	1.4504	0.2763	0.2210
D05Z	Parotid Gland Procedures	D		0	7	2.2		1.8394	1.8394	0.0000	1.8394	0.2518	0.2014
D06Z	Sinus and Complex Middle Ear Procedures	D		0	3	1.0		1.0632	1.0632	0.0000	1.0632	0.2814	0.2251
D10Z	Nasal Procedures	D		0	3	1.0		0.7985	0.7985	0.0000	0.7985	0.2180	0.1744
D11Z	Tonsillectomy and/or Adenoidectomy	D		0	3	1.1		0.5480	0.5480	0.0000	0.5480	0.1896	0.1517
D12A	Other Ear, Nose, Mouth and Throat Procedures W CC	D		1	14	3.7	Same day	0.5644	1.7804	0.0000	1.7804	0.2346	0.1877
D12B	Other Ear, Nose, Mouth and Throat Procedures W/O CC	D		0	5	1.3	Same day	0.4644	0.9876	0.0000	0.9876	0.2533	0.2027
D13Z	Myringotomy W Tube Insertion	D		0	3	1.0		0.3172	0.3172	0.0000	0.3172	0.0931	0.0745
D14A	Mouth and Salivary Gland Procedures W CC	D		0	8	2.4		1.3357	1.3357	0.0000	1.3357	0.2620	0.2096
D14B	Mouth and Salivary Gland Procedures W/O CC	D		0	4	1.2		0.6341	0.6341	0.0000	0.6341	0.1633	0.1306
D15Z	Mastoid Procedures	D		0	4	1.1		1.8173	1.8173	0.0000	1.8173	0.3280	0.2624

WIES21 2014–15 Victorian cost weights

Victorian Modified AR-DRG 7.0x

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D40Z	Dental Extractions and Restorations	D		0	3	1.0		0.5128	0.5128	0.0000	0.5128	0.1261	0.1009
D60A	Ear, Nose, Mouth and Throat Malignancy W Catastrophic or Severe CC	D		2	21	6.7		0.4803	0.9606	0.4803	1.9212	0.2308	0.1846
D60B	Ear, Nose, Mouth and Throat Malignancy W/O Catastrophic or Severe CC	D		0	7	1.6		0.7160	0.7160	0.0000	0.7160	0.3517	0.2814
D60C	Ear, Nose, Mouth and Throat Malignancy, Sameday	D		0	3	1.0		0.4200	0.4200	0.0000	0.4200	0.3360	0.2688
D61A	Dysequilibrium W CC	D		1	11	3.3		0.4511	0.9022	0.0000	0.9022	0.2164	0.1731
D61B	Dysequilibrium W/O CC	D		1	10	3.4	One day	0.3507	0.3507	0.0000	0.8935	0.2113	0.1690
D61C	Dysequilibrium, Sameday	D		0	3	1.0		0.1937	0.1937	0.0000	0.1937	0.1550	0.1240
D62A	Epistaxis	D		0	6	1.8		0.5046	0.5046	0.0000	0.5046	0.2197	0.1758
D62B	Epistaxis, Sameday	D		0	3	1.0		0.1797	0.1797	0.0000	0.1797	0.1437	0.1150
D63A	Otitis Media and Upper Respiratory Infections W CC	D		1	9	2.8		0.4421	0.8842	0.0000	0.8842	0.2515	0.2012
D63B	Otitis Media and Upper Respiratory Infections W/O CC	D		0	8	2.7	One day	0.3409	0.3409	0.0000	0.7637	0.2250	0.1800
D63C	Otitis Media and Upper Respiratory Infections, Sameday	D		0	3	1.0		0.1991	0.1991	0.0000	0.1991	0.1593	0.1274
D64Z	Laryngotracheitis and Epiglottitis	D		0	4	1.3	Same day	0.1952	0.5435	0.0000	0.5435	0.3239	0.2591
D65Z	Nasal Trauma and Deformity	D		0	6	1.6	Same day	0.2894	0.6277	0.0000	0.6277	0.3130	0.2504

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
D66A	Other Ear, Nose, Mouth and Throat Disorders W CC	D		1	11	3.0		0.4723	0.9446	0.0000	0.9446	0.2493	0.1994
D66B	Other Ear, Nose, Mouth and Throat Disorders W/O CC	D		0	4	1.3		0.3923	0.3923	0.0000	0.3923	0.2433	0.1946
D66C	Other Ear, Nose, Mouth and Throat Disorders, Sameday	D		0	3	1.0		0.3026	0.3026	0.0000	0.3026	0.2421	0.1937
D67A	Oral and Dental Disorders	D		1	11	3.5	One day	0.4502	0.4502	0.0000	1.0105	0.2325	0.1860
D67B	Oral and Dental Disorders, Sameday	D		0	3	1.0		0.2254	0.2254	0.0000	0.2254	0.1803	0.1443
E01A	Major Chest Procedures W Catastrophic CC	D		3	35	11.5		1.8059	2.4326	0.8356	4.9394	0.2286	0.1829
E01B	Major Chest Procedures W/O Catastrophic CC	D		1	17	6.0		1.8681	2.8393	0.0000	2.8393	0.2284	0.1827
E02A	Other Respiratory System OR Procedures W Catastrophic CC	D		3	29	10.2		0.9516	1.4648	0.6843	3.5177	0.2120	0.1696
E02B	Other Respiratory System OR Procedures W Severe or Moderate CC	D		1	9	2.9	Same day	0.4555	1.5800	0.0000	1.5800	0.2534	0.2027
E02C	Other Respiratory System OR Procedures W/O CC	D		0	4	1.2	Same day	0.4822	0.7668	0.0000	0.7668	0.2525	0.2020
E40A	Respiratory System Disorders W Ventilator Support	D		3	30	9.7		0.7303	1.4466	0.9550	4.3115	0.3527	0.2821
E40B	Respiratory System Disorders W Vent Supp, Died/Trans Acute Facility <5 Days	D		0	7	2.8		2.1164	2.1164	0.0000	2.1164	0.3621	0.2897
E41A	Respiratory System Disorders W Non-Invasive Ventilation W Catastrophic CC	D		3	33	11.0		0.6942	1.3798	0.9141	4.1220	0.2997	0.2398

WIES21 2014–15 Victorian cost weights

Victorian Modified AR-DRG 7.0x

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E41B	Respiratory System Disorders W Non-Invasive Ventilation W/O Catastrophic CC	D		2	19	6.4		0.7330	1.4580	0.7250	2.9079	0.3621	0.2897
E42A	Bronchoscopy W Catastrophic CC	D		4	38	12.6		0.6329	1.0773	0.6666	3.7437	0.2264	0.1811
E42B	Bronchoscopy W/O Catastrophic CC	D		1	16	5.0		0.9651	1.6836	0.0000	1.6836	0.2312	0.1850
E42C	Bronchoscopy, Sameday	D		0	3	1.0		0.3895	0.3895	0.0000	0.3895	0.1357	0.1085
E60A	Cystic Fibrosis W Catastrophic or Severe CC	D		3	36	12.8		0.6182	1.2363	0.8242	3.7090	0.2327	0.1862
E60B	Cystic Fibrosis W/O Catastrophic or Severe CC	D		2	21	10.8		0.8078	1.6155	0.8078	3.2311	0.2386	0.1909
E61A	Pulmonary Embolism W Catastrophic CC	D		2	22	8.2		0.5237	1.0474	0.5237	2.0949	0.2033	0.1627
E61B	Pulmonary Embolism W/O Catastrophic CC	D		1	16	5.5	Same day	0.3621	1.1627	0.0000	1.1627	0.1694	0.1355
E62A	Respiratory Infections/Inflammations W Catastrophic CC	D		2	18	6.5		0.4091	0.8183	0.4091	1.6366	0.2002	0.1601
E62B	Respiratory Infections/Inflammations W Severe or Moderate CC	D		1	13	4.2	One day	0.4125	0.4125	0.0000	1.0790	0.2038	0.1630
E62C	Respiratory Infections/Inflammations W/O CC	D		0	7	2.4	Same day	0.2487	0.6626	0.0000	0.6626	0.2227	0.1782
E63Z	Sleep Apnoea	D		1	16	5.4	One day	0.2695	0.2695	0.0000	0.7402	0.1088	0.0871
E64A	Pulmonary Oedema and Respiratory Failure	D		1	14	3.9		0.6074	1.2148	0.0000	1.2148	0.2473	0.1979

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WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x													
E64B	Pulmonary Oedema and Respiratory Failure, Died/Trans Acute Facility <5 Days	D		0	5	1.5		0.7857	0.7857	0.0000	0.7857	0.3621	0.2897
E65A	Chronic Obstructive Airways Disease W Catastrophic CC	D		1	18	5.7		0.7229	1.4459	0.0000	1.4459	0.2038	0.1631
E65B	Chronic Obstructive Airways Disease W/O Catastrophic CC	D		1	13	4.3	One day	0.3379	0.3379	0.0000	1.0702	0.2008	0.1607
E66A	Major Chest Trauma W Catastrophic CC	D		2	24	8.3		0.6080	1.2160	0.6080	2.4320	0.2351	0.1880
E66B	Major Chest Trauma W Severe or Moderate CC	D		1	10	3.1		0.5175	1.0350	0.0000	1.0350	0.2658	0.2126
E66C	Major Chest Trauma W/O CC	D		0	5	1.6		0.5680	0.5680	0.0000	0.5680	0.2910	0.2328
E67A	Respiratory Signs and Symptoms	D		1	13	4.0		0.5668	1.1336	0.0000	1.1336	0.2255	0.1804
E67B	Respiratory Signs and Symptoms, <2 Days	D		0	3	1.0	Same day	0.2425	0.3816	0.0000	0.3816	0.3053	0.2442
E68A	Pneumothorax W Catastrophic or Severe CC	D		2	18	5.6		0.4435	0.8870	0.4435	1.7740	0.2554	0.2043
E68B	Pneumothorax W/O Catastrophic or Severe CC	D		0	7	2.4		0.7433	0.7433	0.0000	0.7433	0.2476	0.1981
E69A	Bronchitis and Asthma W CC	D		0	7	2.3		0.7693	0.7693	0.0000	0.7693	0.2695	0.2156
E69B	Bronchitis and Asthma W/O CC	D		0	4	1.4	Same day	0.2050	0.4703	0.0000	0.4703	0.2769	0.2215
E70A	Whooping Cough and Acute Bronchiolitis W CC	D		0	8	2.6		0.9749	0.9749	0.0000	0.9749	0.2995	0.2396
E70B	Whooping Cough and Acute Bronchiolitis W/O CC	D		0	8	2.8	One day	0.3490	0.3490	0.0000	0.8961	0.2543	0.2034

WIES21 2014–15 Victorian cost weights **Victorian Modified AR-DRG 7.0x** **Code**	**Label**	**Mech. Vent Co-payment**	**Other Co-payment**	**Inlier Low**	**Boundary High**	**Average Inlier Stay**	**Same/ One day DRG**	**Same day weight**	**One day weight**	**Multi-day low outlier per diem**	**Inlier weight**	**High outlier per diem**	**HITH outlier per diem**
E71A	Respiratory Neoplasms W Catastrophic CC	D		2	21	6.7		0.4408	0.8816	0.4408	1.7632	0.2118	0.1694
E71B	Respiratory Neoplasms W/O Catastrophic CC	D		1	10	2.9		0.4362	0.8725	0.0000	0.8725	0.2374	0.1899
E71C	Respiratory Neoplasms, Sameday	D		0	3	1.0		0.3102	0.3102	0.0000	0.3102	0.2482	0.1986
E72Z	Respiratory Problems Arising from Neonatal Period	D		1	14	2.8	One day	0.2240	0.2240	0.0000	0.6994	0.1993	0.1594
E73A	Pleural Effusion W Catastrophic CC	D		2	23	7.6		0.4886	0.9773	0.4886	1.9546	0.2071	0.1657
E73B	Pleural Effusion W Severe or Moderate CC	D		1	15	5.2	One day	0.3326	0.3326	0.0000	1.4086	0.2169	0.1736
E73C	Pleural Effusion W/O CC	D		1	9	2.9	Same day	0.2440	0.8259	0.0000	0.8259	0.2285	0.1828
E74A	Interstitial Lung Disease W Catastrophic CC	D		2	21	7.5		0.4844	0.9689	0.4844	1.9378	0.2067	0.1654
E74B	Interstitial Lung Disease W Severe or Moderate CC	D		1	12	3.1		0.4479	0.8957	0.0000	0.8957	0.2313	0.1851
E74C	Interstitial Lung Disease W/O CC	D		1	10	2.8	Same day	0.2432	0.7678	0.0000	0.7678	0.2229	0.1783
E75A	Other Respiratory System Disorders W CC	D		1	12	3.8	Same day	0.2888	1.1036	0.0000	1.1036	0.2296	0.1837
E75B	Other Respiratory System Disorders W/O CC	D		0	6	1.8	Same day	0.2076	0.5604	0.0000	0.5604	0.2429	0.1943
E76A	Respiratory Tuberculosis W CC	D		4	42	13.8		0.4143	0.8287	0.6215	3.3147	0.1924	0.1539
E76B	Respiratory Tuberculosis W/O CC	D		1	14	3.3		0.4337	0.8673	0.0000	0.8673	0.2088	0.1671

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
F01A	Implantation or Replacement of AICD, Total System W Catastrophic CC	D		3	33	11.9		3.1577	4.5801	1.8965	10.2696	0.3621	0.2897
F01B	Implantation or Replacement of AICD, Total System W/O Catastrophic CC	D		0	5	1.2		5.4242	5.4242	0.0000	5.4242	0.3621	0.2897
F02Z	Other AICD Procedures	D		1	9	2.3		1.3192	2.1623	0.0000	2.1623	0.3621	0.2897
F03A	Cardiac Valve Procs W CPB Pump W Invasive Cardiac Inves W Cat CC	D		5	48	15.5		2.6334	3.4356	1.2834	9.8525	0.3621	0.2897
F03B	Cardiac Valve Procs W CPB Pump W Invasive Cardiac Inves W/O Cat CC	D		1	13	5.5		4.4258	8.2440	0.0000	8.2440	0.3621	0.2897
F04A	Cardiac Valve Procs W CPB Pump W/O Invasive Cardiac Inves W Cat CC	D		3	34	10.8		3.9320	4.8701	1.2508	8.6226	0.3621	0.2897
F04B	Cardiac Valve Procs W CPB Pump W/O Invasive Cardiac Inves W/O Cat CC	D		2	19	6.8		3.7159	4.6495	0.9337	6.5169	0.3621	0.2897
F05A	Coronary Bypass W Invasive Cardiac Investigation W Catastrophic CC	D		5	47	16.1		2.7069	3.4271	1.1523	9.1886	0.3126	0.2501
F05B	Coronary Bypass W Invasive Cardiac Investigation W/O Catastrophic CC	D		4	37	12.7		2.6655	3.4116	1.1191	7.8881	0.3284	0.2627
F06A	Coronary Bypass W/O Invasive Cardiac Investigation W Catastrophic CC	D		3	30	10.3		2.8223	3.6839	1.1487	7.1301	0.3506	0.2805

WIES21 2014–15 Victorian cost weights

Victorian Modified AR-DRG 7.0x

Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
F06B	Coronary Bypass W/O Invasive Cardiac Investigation W/O Catastrophic CC	D		2	22	7.6		2.9039	3.9039	1.0000	5.9039	0.3621	0.2897
F07A	Other Cardiothoracic/Vascular Procedures W CPB Pump W Catastrophic CC	D		3	29	9.5		4.2078	5.1403	1.2433	8.8701	0.3621	0.2897
F07B	Other Cardiothoracic/Vascular Procedures W CPB Pump W/O Catastrophic CC	D		2	23	5.7		3.0914	3.9690	0.8776	5.7243	0.3621	0.2897
F08A	Major Reconstructive Vascular Procedures W/O CPB Pump W Cat CC	D	AAA	3	32	10.8		2.6299	3.2707	0.8544	5.8340	0.2482	0.1986
F08B	Major Reconstructive Vascular Procedures W/O CPB Pump W/O Cat CC	D	AAA	1	13	4.2		2.4225	3.1515	0.0000	3.1515	0.2428	0.1942
F09A	Other Cardiothoracic Procs W/O CPB Pump W Catastrophic CC	D		2	23	7.1		1.3468	2.2518	0.9050	4.0618	0.3558	0.2847
F09B	Other Cardiothoracic Procs W/O CPB Pump W/O Catastrophic CC	D		0	9	3.3		2.1774	2.1774	0.0000	2.1774	0.3621	0.2897
F09C	Other Cardiothoracic Procs W/O CPB Pump, Died/Trans Acute Facility <5 Days	D		0	5	1.6		2.2898	2.2898	0.0000	2.2898	0.3621	0.2897
F10A	Interventional Coronary Procedures Admitted for AMI W Catastrophic CC	D		1	15	5.2		1.7784	3.2245	0.0000	3.2245	0.3621	0.2897

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x													
Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
F10B	Interventional Coronary Procedures Admitted for AMI W/O Catastrophic CC	D		1	10	3.1		1.3868	2.3885	0.0000	2.3885	0.3621	0.2897
F11A	Amputation, Except Upper Limb and Toe, for Circulatory Disorders W Cat CC	D		7	67	24.1		1.7481	2.1743	0.7307	7.2894	0.1733	0.1387
F11B	Amputation, Except Upper Limb and Toe, for Circulatory Disorders W/O Cat CC	D		4	42	14.3		1.5639	2.0087	0.6671	4.6772	0.1748	0.1398
F12A	Implantation or Replacement of Pacemaker, Total System W Catastrophic CC	D		2	22	7.4		1.3352	2.1417	0.8065	3.7547	0.3064	0.2451
F12B	Implantation or Replacement of Pacemaker, Total System W/O Catastrophic CC	D		0	7	2.1		2.1538	2.1538	0.0000	2.1538	0.3621	0.2897
F13A	Amputation, Upper Limb and Toe, for Circulatory Disorders W Cat or Sev CC	D		4	41	11.8		1.0361	1.4557	0.6293	3.9730	0.1987	0.1589
F13B	Amputation, Upper Limb and Toe, for Circulatory Disorders W/O Cat or Sev CC	D		2	20	6.9		0.7421	1.1002	0.3581	1.8163	0.1444	0.1155
F14A	Vascular Procs, Except Major Reconstruction, W/O CPB Pump W Cat CC	D		2	23	6.8		1.1871	1.7608	0.5737	2.9081	0.2366	0.1893
F14B	Vascular Procs, Except Major Reconstruction, W/O CPB Pump W Sev or Mod CC	D		0	7	1.8		1.2612	1.2612	0.0000	1.2612	0.3381	0.2705

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
F14C	Vascular Procs, Except Major Reconstruction, W/O CPB Pump W/O CC	D		0	5	1.3		1.0625	1.0625	0.0000	1.0625	0.3621	0.2897
F15A	Interventional Coronary Procs, Not Adm for AMI W Stent Implant W Cat/Sev CC	D		0	7	1.8		1.8610	1.8610	0.0000	1.8610	0.3621	0.2897
F15B	Interventional Coronary Procs, Not Adm for AMI W Stent Implant W/O Cat/Sev CC	D		0	4	1.3		1.6465	1.6465	0.0000	1.6465	0.3621	0.2897
F16A	Interventional Coronary Procs, Not Adm for AMI W/O Stent Implant W CC	D		1	10	2.4		1.0586	1.8782	0.0000	1.8782	0.3621	0.2897
F16B	Interventional Coronary Procs, Not Adm for AMI W/O Stent Implant W/O CC	D		0	4	1.2		1.1848	1.1848	0.0000	1.1848	0.3621	0.2897
F17Z	Insertion or Replacement of Pacemaker Generator	D		0	3	1.0		1.2635	1.2635	0.0000	1.2635	0.3621	0.2897
F18A	Other Pacemaker Procedures W CC	D		2	24	7.1		1.2886	1.9702	0.6815	3.3333	0.2699	0.2159
F18B	Other Pacemaker Procedures W/O CC	D		0	5	1.3		1.1911	1.1911	0.0000	1.1911	0.3621	0.2897
F19A	Trans-Vascular Percutaneous Cardiac Intervention, Age >=80 or W CC	D	ASD	1	14	3.2		1.1431	1.7419	0.0000	1.7419	0.2626	0.2101
F19B	Trans-Vascular Percutaneous Cardiac Intervention, Age <80 W/O CC	D	ASD	0	3	1.0		1.7709	1.7709	0.0000	1.7709	0.3621	0.2897
F20Z	Vein Ligation and Stripping	D		0	3	1.0		0.8472	0.8472	0.0000	0.8472	0.2017	0.1613

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
F21A	Other Circulatory System OR Procedures W Catastrophic CC	D		3	32	11.1		0.7100	1.1791	0.6255	3.0555	0.1772	0.1418
F21B	Other Circulatory System OR Procedures W/O Catastrophic CC	D		0	6	1.4		1.4521	1.4521	0.0000	1.4521	0.3621	0.2897
F40A	Circulatory Disorders W Ventilator Support	D		3	34	12.4		0.8146	1.5995	1.0464	4.7388	0.3042	0.2434
F40B	Circulatory Disorders W Ventilator Support, Died/Trans Acute Facility <5 Days	D		0	7	2.3		1.9421	1.9421	0.0000	1.9421	0.3621	0.2897
F41A	Circulatory Dsrds, Adm for AMI W Invasive Cardiac Inves	D		2	19	6.0		0.5963	1.1605	0.5643	2.2890	0.2997	0.2398
F41B	Circulatory Dsrds, Adm for AMI W Invasv Card Inves, Died/Trans Ac Fac <5 Days	D		0	8	2.7		1.2588	1.2588	0.0000	1.2588	0.3621	0.2897
F42A	Circulatory Disorders, Not Adm for AMI W Invasive Cardiac Inves W Cat/Sev CC	D		1	17	5.4		1.0484	2.0437	0.0000	2.0437	0.2929	0.2343
F42B	Circulatory Disordrs, Not Adm for AMI W Invasive Cardiac Inves W/O Cat/Sev CC	D		0	6	1.9		1.3073	1.3073	0.0000	1.3073	0.3621	0.2897
F42C	Circulatory Disordrs, Not Adm for AMI W Invasive Cardiac Inves, Sameday	D		0	3	1.0		0.5741	0.5741	0.0000	0.5741	0.3621	0.2897
F43Z	Circulatory Disorders W Non-Invasive Ventilation	D		3	30	10.7		0.7125	1.4005	0.9174	4.1526	0.3082	0.2465
F60A	Circulatory Dsrd, Adm for AMI W/O Invasive Cardiac Inves	D		1	14	4.4		0.6142	1.2284	0.0000	1.2284	0.2242	0.1794

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
F60B	Circulatory Dsrd, Adm for AMI W/O Invas Card Inves, Died/Trans Ac Fac <5 Days	D		0	6	1.9	Same day	0.5639	1.0160	0.0000	1.0160	0.3621	0.2897
F61A	Infective Endocarditis W Catastrophic CC	D		7	67	25.9		0.4107	0.8214	0.7041	5.7501	0.1779	0.1423
F61B	Infective Endocarditis W/O Catastrophic CC	D		3	32	10.3		0.2881	0.5762	0.3842	1.7287	0.1337	0.1070
F62A	Heart Failure and Shock W Catastrophic CC	D		2	22	7.6		0.4571	0.9143	0.4571	1.8286	0.1925	0.1540
F62B	Heart Failure and Shock W/O Catastrophic CC	D		1	14	4.6	One day	0.3379	0.3379	0.0000	1.1158	0.1959	0.1567
F62C	Heart Failure and Shock, Died or Transferred to Acute Facility <5 Days	D		0	8	2.9	One day	0.3342	0.3342	0.0000	0.9632	0.2676	0.2140
F63A	Venous Thrombosis W Catastrophic or Severe CC	D		1	18	5.9		0.6536	1.3072	0.0000	1.3072	0.1787	0.1430
F63B	Venous Thrombosis W/O Catastrophic or Severe CC	D		1	17	5.9	Same day	0.2246	0.7807	0.0000	0.7807	0.1055	0.0844
F64A	Skin Ulcers in Circulatory Disorders W Catastrophic or Severe CC	D		3	28	8.8	Same day	0.1978	0.6064	0.4043	1.8193	0.1647	0.1317
F64B	Skin Ulcers in Circulatory Disorders W/O Catastrophic or Severe CC	D		1	12	3.6	Same day	0.1767	0.8523	0.0000	0.8523	0.1880	0.1504
F65A	Peripheral Vascular Disorders W Catastrophic or Severe CC	D		1	17	5.1		0.7492	1.4984	0.0000	1.4984	0.2366	0.1892

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
F65B	Peripheral Vascular Disorders W/O Catastrophic or Severe CC	D		0	8	2.2	Same day	0.3626	0.7664	0.0000	0.7664	0.2797	0.2238
F66A	Coronary Atherosclerosis W Catastrophic or Severe CC	D		1	10	2.8		0.4319	0.8638	0.0000	0.8638	0.2448	0.1958
F66B	Coronary Atherosclerosis W/O Catastrophic or Severe CC	D		0	5	1.4	Same day	0.2108	0.4592	0.0000	0.4592	0.2576	0.2061
F67A	Hypertension W Catastrophic or Severe CC	D		1	12	3.7		0.6277	1.2553	0.0000	1.2553	0.2731	0.2185
F67B	Hypertension W/O Catastrophic or Severe CC	D		0	6	1.7	Same day	0.1947	0.5141	0.0000	0.5141	0.2357	0.1886
F68Z	Congenital Heart Disease	D		0	5	1.2		0.4086	0.4086	0.0000	0.4086	0.2661	0.2129
F69A	Valvular Disorders W Catastrophic or Severe CC	D		1	17	4.6		0.6091	1.2183	0.0000	1.2183	0.2128	0.1702
F69B	Valvular Disorders W/O Catastrophic or Severe CC	D		1	10	3.5	One day	0.2626	0.2626	0.0000	0.9994	0.2265	0.1812
F72A	Unstable Angina W Catastrophic or Severe CC	D		1	11	3.2		0.4965	0.9930	0.0000	0.9930	0.2492	0.1994
F72B	Unstable Angina W/O Catastrophic or Severe CC	D		0	6	1.9	Same day	0.2603	0.6631	0.0000	0.6631	0.2812	0.2250
F73A	Syncope and Collapse W Catastrophic or Severe CC	D		1	13	3.9		0.5413	1.0827	0.0000	1.0827	0.2209	0.1767
F73B	Syncope and Collapse W/O Catastrophic or Severe CC	D		1	11	3.5	One day	0.3632	0.3632	0.0000	0.9223	0.2107	0.1686
F73C	Syncope and Collapse, Sameday	D		0	3	1.0		0.2241	0.2241	0.0000	0.2241	0.1793	0.1434
F74A	Chest Pain	D		1	9	3.2		0.4899	0.9799	0.0000	0.9799	0.2487	0.1990

WIES21 2014–15 Victorian cost weights

Victorian Modified AR-DRG 7.0x

Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
F74B	Chest Pain, <2 Days	D		0	3	1.0		0.2297	0.2297	0.0000	0.2297	0.1837	0.1470
F75A	Other Circulatory Disorders W Catastrophic CC	D		2	20	6.8		0.5026	1.0052	0.5026	2.0105	0.2368	0.1895
F75B	Other Circulatory Disorders W Severe or Moderate CC	D		1	14	4.5	One day	0.4132	0.4132	0.0000	1.2829	0.2266	0.1812
F75C	Other Circulatory Disorders W/O CC	D		0	6	1.9	Same day	0.2950	0.6666	0.0000	0.6666	0.2835	0.2268
F76A	Arrhythmia, Cardiac Arrest and Conduction Disorders W Cat or Sev CC	D		1	14	4.4		0.6320	1.2640	0.0000	1.2640	0.2275	0.1820
F76B	Arrhythmia, Cardiac Arrest and Conduction Disorders W/O Cat or Sev CC	D		1	11	3.8	One day	0.4042	0.4042	0.0000	0.9316	0.1977	0.1582
F76C	Arrhythmia, Cardiac Arrest and Conduction Disorders, Sameday	D		0	3	1.0		0.2206	0.2206	0.0000	0.2206	0.1765	0.1412
G01A	Rectal Resection W Catastrophic CC	D		4	39	13.1		2.1143	2.6095	0.7428	5.5808	0.2121	0.1697
G01B	Rectal Resection W/O Catastrophic CC	D		2	20	7.2		2.0875	2.6352	0.5476	3.7304	0.2129	0.1703
G02A	Major Small and Large Bowel Procedures W Catastrophic CC	D		4	39	12.5		1.6630	2.1394	0.7145	4.9975	0.2129	0.1703
G02B	Major Small and Large Bowel Procedures W/O Catastrophic CC	D		1	15	5.0		1.6328	2.3329	0.0000	2.3329	0.1941	0.1553
G03A	Stomach, Oesophageal and Duodenal Procedures W Malignancy or W Cat CC	D		4	39	12.7		2.1239	2.6804	0.8348	6.0194	0.2448	0.1959

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
G03B	Stomach, Oesophageal and Duodenal Procedures W/O Malignancy W Sev or Mod CC	D		1	11	3.5		1.6740	2.3022	0.0000	2.3022	0.2507	0.2006
G03C	Stomach, Oesophageal and Duodenal Procedures W/O Malignancy W/O CC	D		0	7	2.4		1.7317	1.7317	0.0000	1.7317	0.2443	0.1955
G04A	Peritoneal Adhesiolysis W Catastrophic CC	D		3	34	10.9		1.4872	2.0224	0.7136	4.1632	0.2060	0.1648
G04B	Peritoneal Adhesiolysis W Severe or Moderate CC	D		1	14	4.6		1.4175	2.0872	0.0000	2.0872	0.2026	0.1621
G04C	Peritoneal Adhesiolysis W/O CC	D		0	7	2.4		1.3934	1.3934	0.0000	1.3934	0.2235	0.1788
G05A	Minor Small and Large Bowel Procedures W Catastrophic CC	D		3	31	10.1		1.3223	1.6821	0.4798	3.1213	0.1500	0.1200
G05B	Minor Small and Large Bowel Procedures W Severe or Moderate CC	D		1	15	4.3		1.1634	1.6985	0.0000	1.6985	0.1727	0.1381
G05C	Minor Small and Large Bowel Procedures W/O CC	D		0	8	2.8		1.2085	1.2085	0.0000	1.2085	0.1642	0.1314
G06Z	Pyloromyotomy	D		1	12	3.9		1.1133	1.8453	0.0000	1.8453	0.2618	0.2094
G07A	Appendicectomy W Malignancy or Peritonitis or W Catastrophic or Severe CC	D		1	9	3.3		1.0354	1.5622	0.0000	1.5622	0.2229	0.1783
G07B	Appendicectomy W/O Malignancy or Peritonitis W/O Cat or Sev CC	D		0	5	1.8		1.1010	1.1010	0.0000	1.1010	0.2582	0.2065
G10A	Hernia Procedures W CC	D		1	9	2.5		1.0263	1.4087	0.0000	1.4087	0.2108	0.1686
G10B	Hernia Procedures W/O CC	D		0	3	1.1		0.8401	0.8401	0.0000	0.8401	0.2040	0.1632

WIES21 2014–15 Victorian cost weights														
Victorian Modified AR-DRG 7.0x														
Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
G11Z	Anal and Stomal Procedures	D		0	6	1.7	Same day	0.4342	0.8169	0.0000	0.8169	0.1980	0.1584
G12A	Other Digestive System OR Procedures W Catastrophic CC	D		3	30	11.2		1.1715	1.7288	0.7431	3.9581	0.2086	0.1669
G12B	Other Digestive System OR Procedures W Severe or Moderate CC	D		1	13	3.3		0.9236	1.4112	0.0000	1.4112	0.2066	0.1653
G12C	Other Digestive System OR Procedures W/O CC	D		0	6	1.9		0.9817	0.9817	0.0000	0.9817	0.2117	0.1693
G46A	Complex Endoscopy W Catastrophic CC	D		3	28	9.2		0.7605	1.1674	0.5426	2.7954	0.2122	0.1698
G46B	Complex Endoscopy W/O Catastrophic CC	D		1	10	3.2		0.7096	1.1395	0.0000	1.1395	0.2160	0.1728
G46C	Complex Endoscopy, Sameday	D		0	3	1.0		0.3590	0.3590	0.0000	0.3590	0.1059	0.0848
G47A	Gastroscopy W Catastrophic CC	D		2	23	7.6		0.6885	1.1841	0.4955	2.1751	0.2093	0.1674
G47B	Gastroscopy W/O Catastrophic CC	D		0	8	2.4		0.9052	0.9052	0.0000	0.9052	0.2384	0.1907
G47C	Gastroscopy, Sameday	D		0	3	1.0		0.2573	0.2573	0.0000	0.2573	0.0931	0.0745
G48A	Colonoscopy W Catastrophic or Severe CC	D		2	20	7.2		0.6270	1.0697	0.4427	1.9551	0.1966	0.1573
G48B	Colonoscopy W/O Catastrophic or Severe CC	D		0	9	2.4		0.8193	0.8193	0.0000	0.8193	0.2064	0.1651
G48C	Colonoscopy, Sameday	D		0	3	1.0		0.3074	0.3074	0.0000	0.3074	0.0931	0.0745
G60A	Digestive Malignancy W Catastrophic CC	D		2	22	6.7	Same day	0.1955	0.8687	0.4344	1.7374	0.2087	0.1670

WIES21 2014–15 Victorian cost weights														
Victorian Modified AR-DRG 7.0x														
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G60B	Digestive Malignancy W/O Catastrophic CC	D		0	8	2.2	Same day	0.2169	0.5589	0.0000	0.5589	0.2059	0.1647
G61A	Gastrointestinal Haemorrhage W Catastrophic or Severe CC	D		1	11	3.3		0.4673	0.9347	0.0000	0.9347	0.2242	0.1794
G61B	Gastrointestinal Haemorrhage W/O Catastrophic or Severe CC	D		1	9	3.0	One day	0.2906	0.2906	0.0000	0.7484	0.2002	0.1601
G64A	Inflammatory Bowel Disease W CC	D		1	13	4.3	Same day	0.2131	1.1595	0.0000	1.1595	0.2135	0.1708
G64B	Inflammatory Bowel Disease W/O CC	D		0	9	2.8	Same day	0.2724	0.8589	0.0000	0.8589	0.2429	0.1943
G65A	Gastrointestinal Obstruction W Catastrophic or Severe CC	D		1	16	5.5	One day	0.5039	0.5039	0.0000	1.3954	0.2045	0.1636
G65B	Gastrointestinal Obstruction W/O Catastrophic or Severe CC	D		1	10	3.2	One day	0.4170	0.4170	0.0000	0.8295	0.2070	0.1656
G66A	Abdominal Pain and Mesenteric Adenitis	D		0	9	3.0	One day	0.4008	0.4008	0.0000	0.8636	0.2302	0.1842
G66B	Abdominal Pain and Mesenteric Adenitis, Sameday	D		0	3	1.0		0.2300	0.2300	0.0000	0.2300	0.1840	0.1472
G67A	Oesophagitis and Gastroenteritis W Catastrophic or Severe CC	D		1	13	3.8	Same day	0.2439	1.0673	0.0000	1.0673	0.2229	0.1783
G67B	Oesophagitis and Gastroenteritis W/O Catastrophic or Severe CC	D		0	5	1.7	Same day	0.1773	0.5328	0.0000	0.5328	0.2509	0.2008

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
G70A	Other Digestive System Disorders W Catastrophic or Severe CC	D		1	13	4.0		0.5557	1.1115	0.0000	1.1115	0.2211	0.1769
G70B	Other Digestive System Disorders W/O Catastrophic or Severe CC	D		1	10	3.3	One day	0.3873	0.3873	0.0000	0.8669	0.2104	0.1683
G70C	Other Digestive System Disorders, Sameday	D		0	3	1.0		0.2232	0.2232	0.0000	0.2232	0.1786	0.1429
H01A	Pancreas, Liver and Shunt Procedures W Catastrophic CC	D		4	37	12.2		2.5014	3.0653	0.8459	6.4487	0.2598	0.2078
H01B	Pancreas, Liver and Shunt Procedures W/O Catastrophic CC	D		2	19	6.3	One day	0.8353	0.8353	1.3855	3.6063	0.2326	0.1861
H02A	Major Biliary Tract Procedures W Catastrophic CC	D		4	41	14.6		1.4391	1.9540	0.7722	5.0428	0.1977	0.1582
H02B	Major Biliary Tract Procedures W/O Catastrophic CC	D		1	12	3.9		1.2502	1.8489	0.0000	1.8489	0.2166	0.1733
H05A	Hepatobiliary Diagnostic Procedures W Catastrophic CC	D		3	33	10.9		1.4618	2.0466	0.7797	4.3858	0.2258	0.1806
H05B	Hepatobiliary Diagnostic Procedures W/O Catastrophic CC	D		0	5	1.2		0.6361	0.6361	0.0000	0.6361	0.2042	0.1634
H06A	Other Hepatobiliary and Pancreas OR Procedures W Catastrophic CC	D		3	32	13.8		1.0395	1.6891	0.8662	4.2879	0.1977	0.1581
H06B	Other Hepatobiliary and Pancreas OR Procedures W/O Catastrophic CC	D		0	5	1.2		0.8995	0.8995	0.0000	0.8995	0.3621	0.2897

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
H07A	Open Cholecystectomy W Closed CDE or W Catastrophic CC	D		3	31	9.5		1.4543	1.9104	0.6082	3.7349	0.2009	0.1607
H07B	Open Cholecystectomy W/O Closed CDE W/O Catastrophic CC	D		1	13	4.6		1.4199	2.0426	0.0000	2.0426	0.1901	0.1521
H08A	Laparoscopic Cholecystectomy W Closed CDE or W Cat or Sev CC	D		1	12	3.7		1.3198	1.8967	0.0000	1.8967	0.2206	0.1765
H08B	Laparoscopic Cholecystectomy W/O Closed CDE W/O Cat or Sev CC	D		0	5	1.6		1.2152	1.2152	0.0000	1.2152	0.2619	0.2095
H40A	Endoscopic Procedures for Bleeding Oesophageal Varices W Cat CC	D		2	20	7.0		0.9850	1.5858	0.6007	2.7872	0.2755	0.2204
H40B	Endoscopic Procedures for Bleeding Oesophageal Varices W/O Cat CC	D		1	9	2.3		0.5710	0.9214	0.0000	0.9214	0.2415	0.1932
H43A	ERCP Procedures W Catastrophic or Severe CC	D		2	24	8.0		0.9752	1.5316	0.5564	2.6444	0.2222	0.1777
H43B	ERCP Procedures W/O Catastrophic or Severe CC	D		1	10	3.1		0.7369	1.1638	0.0000	1.1638	0.2171	0.1737
H43C	ERCP Procedures, Sameday	D		0	3	1.0		0.5582	0.5582	0.0000	0.5582	0.2024	0.1619
H60A	Cirrhosis and Alcoholic Hepatitis W Catastrophic CC	D		2	23	7.2		0.4970	0.9939	0.4970	1.9879	0.2213	0.1770
H60B	Cirrhosis and Alcoholic Hepatitis, W/O Catastrophic CC	D		1	13	3.6		0.4974	0.9948	0.0000	0.9948	0.2184	0.1747

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
H60C	Cirrhosis and Alcoholic Hepatitis , Sameday	D		0	3	1.0		0.2449	0.2449	0.0000	0.2449	0.1960	0.1568
H61A	Malignancy of Hepatobiliary System and Pancreas W Catastrophic CC	D		2	20	6.8		0.4592	0.9184	0.4592	1.8368	0.2167	0.1734
H61B	Malignancy of Hepatobiliary System and Pancreas W/O Catastrophic CC	D		1	10	3.3	One day	0.4724	0.4724	0.0000	0.8217	0.1986	0.1589
H61C	Malignancy of Hepatobiliary System and Pancreas, Sameday	D		0	3	1.0		0.3025	0.3025	0.0000	0.3025	0.2420	0.1936
H62A	Disorders of Pancreas, Except Malignancy W Catastrophic or Severe CC	D		1	16	5.3		0.7372	1.4744	0.0000	1.4744	0.2205	0.1764
H62B	Disorders of Pancreas, Except Malignancy W/O Catastrophic or Severe CC	D		0	8	2.7	Same day	0.3217	0.7451	0.0000	0.7451	0.2181	0.1745
H63A	Other Disorders of Liver W Catastrophic CC	D		2	22	7.3		0.5702	1.1404	0.5702	2.2809	0.2511	0.2009
H63B	Other Disorders of Liver W/O Catastrophic CC	D		1	11	3.3		0.5061	1.0122	0.0000	1.0122	0.2463	0.1970
H63C	Other Disorders of Liver, Sameday	D		0	3	1.0		0.2748	0.2748	0.0000	0.2748	0.2198	0.1759
H64A	Disorders of the Biliary Tract W CC	D		1	14	4.4		0.6037	1.2074	0.0000	1.2074	0.2178	0.1742
H64B	Disorders of the Biliary Tract W/O CC	D		0	7	2.1		0.6385	0.6385	0.0000	0.6385	0.2402	0.1922

Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x													
H64C	Disorders of the Biliary Tract, Sameday	D		0	3	1.0		0.2711	0.2711	0.0000	0.2711	0.2169	0.1735
I01A	Bilateral and Multiple Major Joint Proc of Lower Limb W Revision or W Cat CC	D		7	67	22.7		3.7826	4.1562	0.6404	8.6388	0.1613	0.1291
I01B	Bilateral and Multiple Major Joint Proc of Lower Limb W/O Revision W/O Cat CC	D		1	17	5.6		4.2327	5.1356	0.0000	5.1356	0.2243	0.1794
I02A	Microvascular Tissue Transfers or (Skin Grafts W Cat or Sev CC), Excl Hand	D		6	58	21.4		3.1617	3.6431	0.8023	8.4566	0.1889	0.1511
I02B	Skin Grafts W/O Cat or Sev CC, Excluding Hand	D		2	26	7.4	One day	0.8526	0.8526	1.2958	3.4442	0.1957	0.1566
I03A	Hip Replacement W Catastrophic CC	D		3	28	9.1		2.1059	2.5025	0.5288	4.0889	0.1832	0.1465
I03B	Hip Replacement W/O Catastrophic CC	D		1	15	4.9		2.9505	3.7019	0.0000	3.7019	0.2132	0.1705
I04A	Knee Replacement W Catastrophic or Severe CC	D		2	18	6.3		2.7003	3.1466	0.4463	4.0392	0.1998	0.1599
I04B	Knee Replacement W/O Catastrophic or Severe CC	D		1	14	4.5		2.8326	3.5500	0.0000	3.5500	0.2217	0.1773
I05A	Other Joint Replacement W Catastrophic or Severe CC	D		2	22	6.6		2.8679	3.3808	0.5129	4.4066	0.2187	0.1750
I05B	Other Joint Replacement W/O Catastrophic or Severe CC	D		0	9	2.9		3.3282	3.3282	0.0000	3.3282	0.3086	0.2468
I06Z	Spinal Fusion for Deformity	D		2	26	8.4		6.9014	8.1530	1.2516	10.6561	0.3621	0.2897
I07Z	Amputation	D		6	54	18.5		1.4177	1.7962	0.6308	5.5811	0.1722	0.1378

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
I08A	Other Hip and Femur Procedures W Catastrophic CC	D		3	29	9.4		1.3529	1.7622	0.5458	3.3997	0.1822	0.1458
I08B	Other Hip and Femur Procedures W/O Catastrophic CC	D		1	14	4.4		1.5238	2.2012	0.0000	2.2012	0.2168	0.1734
I09A	Spinal Fusion W Catastrophic CC	D		3	33	11.3		4.2134	4.9570	0.9915	7.9314	0.2758	0.2206
I09B	Spinal Fusion W/O Catastrophic CC	D		1	13	4.4		3.2935	4.1753	0.0000	4.1753	0.2831	0.2265
I10A	Other Back and Neck Procedures W Catastrophic or Severe CC	D		2	20	6.3		1.5843	2.0722	0.4879	3.0479	0.2160	0.1728
I10B	Other Back and Neck Procedures W/O Catastrophic or Severe CC	D		0	8	2.8		1.8030	1.8030	0.0000	1.8030	0.2387	0.1909
I11Z	Limb Lengthening Procedures	D		1	10	3.4		3.7565	4.4304	0.0000	4.4304	0.2770	0.2216
I12A	Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint W Cat CC	D		6	60	21.2		1.0388	1.4217	0.6382	5.2507	0.1514	0.1211
I12B	Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint W Sev or Mod CC	D		3	34	10.4		0.8712	1.2267	0.4740	2.6487	0.1436	0.1149
I12C	Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint W/O CC	D		3	28	7.9	One day	0.6496	0.6496	0.5567	2.3412	0.1593	0.1275
I13A	Humerus, Tibia, Fibula and Ankle Procedures W CC	D		2	20	6.6		1.5605	2.0237	0.4632	2.9500	0.1955	0.1564

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WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x													
I13B	Humerus, Tibia, Fibula and Ankle Procedures W/O CC, Age >=17	D		0	8	2.6		1.6376	1.6376	0.0000	1.6376	0.2332	0.1865
I13C	Humerus, Tibia, Fibula and Ankle Procedures W/O CC, Age <17	D		0	4	1.4		1.1035	1.1035	0.0000	1.1035	0.2927	0.2341
I15Z	Cranio-Facial Surgery	D		1	13	3.9		2.8907	3.8334	0.0000	3.8334	0.3403	0.2722
I16Z	Other Shoulder Procedures	D		0	3	1.2		1.3070	1.3070	0.0000	1.3070	0.3204	0.2563
I17A	Maxillo-Facial Surgery W CC	D		0	8	2.2		2.1660	2.1660	0.0000	2.1660	0.3218	0.2574
I17B	Maxillo-Facial Surgery W/O CC	D		0	5	1.5		1.5090	1.5090	0.0000	1.5090	0.2929	0.2343
I18Z	Other Knee Procedures	D		0	6	1.6	Same day	0.5690	1.0482	0.0000	1.0482	0.2356	0.1885
I19A	Other Elbow and Forearm Procedures W CC	D		1	11	3.3		1.4048	1.9365	0.0000	1.9365	0.2247	0.1798
I19B	Other Elbow and Forearm Procedures W/O CC	D		0	5	1.5		1.3247	1.3247	0.0000	1.3247	0.2658	0.2126
I20Z	Other Foot Procedures	D		0	5	1.5		1.1418	1.1418	0.0000	1.1418	0.2500	0.2000
I21Z	Local Excision and Removal of Internal Fixation Devices of Hip and Femur	D		0	4	1.2		0.8314	0.8314	0.0000	0.8314	0.2091	0.1673
I23Z	Local Excision and Removal of Internal Fixation Devices, Except Hip and Femur	D		0	5	1.3	Same day	0.4407	1.0615	0.0000	1.0615	0.2610	0.2088
I24Z	Arthroscopy	D		0	4	1.1		0.6579	0.6579	0.0000	0.6579	0.1567	0.1253
I25A	Bone and Joint Diagnostic Procedures Including Biopsy W CC	D		2	26	11.3		0.8633	1.5741	0.7107	2.9955	0.1758	0.1407

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I25B	Bone and Joint Diagnostic Procedures Including Biopsy W/O CC	D		0	4	1.1		0.6376	0.6376	0.0000	0.6376	0.2611	0.2089
I27A	Soft Tissue Procedures W Catastrophic or Severe CC	D		2	22	6.6		1.0827	1.5730	0.4902	2.5534	0.2088	0.1671
I27B	Soft Tissue Procedures W/O Catastrophic or Severe CC	D		0	6	1.7		1.0845	1.0845	0.0000	1.0845	0.2454	0.1963
I27C	Soft Tissue Procedures, Sameday	D		0	3	1.0		0.4777	0.4777	0.0000	0.4777	0.1128	0.0902
I28A	Other Musculoskeletal Procedures W CC	D		2	22	7.0		1.0982	1.5948	0.4966	2.5881	0.1986	0.1589
I28B	Other Musculoskeletal Procedures W/O CC	D		0	4	1.3		1.0155	1.0155	0.0000	1.0155	0.2355	0.1884
I29Z	Knee Reconstructions, and Revisions of Reconstructions	D		0	3	1.1		1.4577	1.4577	0.0000	1.4577	0.3621	0.2897
I30Z	Hand Procedures	D		0	5	1.5	Same day	0.5218	0.9793	0.0000	0.9793	0.2276	0.1821
I31A	Revision of Hip Replacement for Infect/Inflam of Joint Prosth or W Cat CC	D		4	43	13.6		3.1930	3.6787	0.7286	6.5931	0.2005	0.1604
I31B	Revision of Hip Replacement not for Infect/Inflam of Joint Prosth W/O Cat CC	D		1	17	6.5		3.3713	4.3594	0.0000	4.3594	0.2116	0.1693
I32A	Revision of Knee Replacement for Infect/Inflam of Joint Prosth or W Cat CC	D		4	43	12.7		3.4043	3.7947	0.5856	6.1371	0.1725	0.1380

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I32B	Revision of Knee Replacement not for Infect/Inflam of Joint Prosth W/O Cat CC	D		1	16	5.0		3.6640	4.5535	0.0000	4.5535	0.2502	0.2002
I40Z	Infusions for Musculoskeletal Disorders, Sameday	D		0	3	1.0		0.2655	0.2655	0.0000	0.2655	0.1728	0.1383
I60Z	Femoral Shaft Fractures	D		0	8	2.9		1.2814	1.2814	0.0000	1.2814	0.3580	0.2864
I61A	Distal Femoral Fractures W CC	D		2	19	7.4		0.4478	0.8957	0.4478	1.7914	0.1937	0.1549
I61B	Distal Femoral Fractures W/O CC	D		1	15	4.0		0.5374	1.0748	0.0000	1.0748	0.2163	0.1730
I63A	Sprains, Strains and Dislocations of Hip, Pelvis and Thigh W CC	D		1	14	4.1		0.5963	1.1925	0.0000	1.1925	0.2348	0.1878
I63B	Sprains, Strains and Dislocations of Hip, Pelvis and Thigh W/O CC	D		0	5	1.6		0.5771	0.5771	0.0000	0.5771	0.2966	0.2373
I64A	Osteomyelitis W Catastrophic or Severe CC	D		4	44	16.7		0.3821	0.7642	0.5731	3.0568	0.1468	0.1175
I64B	Osteomyelitis W/O Catastrophic or Severe CC	D		3	33	9.9		0.3220	0.6441	0.4294	1.9323	0.1565	0.1252
I65A	Musculoskeletal Malignant Neoplasms W Radiotherapy or W Cat CC	D		2	23	8.1		0.5614	1.1229	0.5614	2.2457	0.2205	0.1764
I65B	Musculoskeletal Malignant Neoplasms W/O Radiotherapy W/O Cat CC	D		1	13	3.7		0.6436	1.2873	0.0000	1.2873	0.2781	0.2225
I66A	Inflammatory Musculoskeletal Disorders W Catastrophic or Severe CC	D		2	23	7.5		0.5143	1.0286	0.5143	2.0572	0.2184	0.1747

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I66B	Inflammatory Musculoskeletal Disorders W/O Catastrophic or Severe CC	D		1	11	3.3		0.5344	1.0688	0.0000	1.0688	0.2562	0.2049
I67A	Septic Arthritis W Catastrophic or Severe CC	D		4	41	15.1		0.3612	0.7224	0.5418	2.8897	0.1534	0.1227
I67B	Septic Arthritis W/O Catastrophic or Severe CC	D		3	32	11.8	One day	0.3988	0.3988	0.5035	1.9207	0.1297	0.1038
I68A	Non-surgical Spinal Disorders W CC	D		1	17	5.1		0.6887	1.3774	0.0000	1.3774	0.2156	0.1725
I68B	Non-surgical Spinal Disorders W/O CC	D		1	13	4.0	One day	0.3855	0.3855	0.0000	1.0483	0.2104	0.1683
I69A	Bone Diseases and Arthropathies W Catastrophic or Severe CC	D		2	18	6.3		0.3695	0.7389	0.3695	1.4778	0.1889	0.1511
I69B	Bone Diseases and Arthropathies W/O Catastrophic or Severe CC	D		0	9	2.7		0.7298	0.7298	0.0000	0.7298	0.2169	0.1735
I71A	Other Musculotendinous Disorders W Catastrophic or Severe CC	D		1	16	4.9		0.6445	1.2890	0.0000	1.2890	0.2125	0.1700
I71B	Other Musculotendinous Disorders W/O Catastrophic or Severe CC	D		1	11	3.6	One day	0.3596	0.3596	0.0000	0.9821	0.2153	0.1723
I72A	Specific Musculotendinous Disorders W Catastrophic or Severe CC	D		2	22	7.3		0.4266	0.8532	0.4266	1.7065	0.1865	0.1492
I72B	Specific Musculotendinous Disorders W/O Catastrophic or Severe CC	D		0	9	2.5		0.6230	0.6230	0.0000	0.6230	0.1959	0.1567

Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x													
I73A	Aftercare of Musculoskeletal Implants or Prostheses W Cat or Sev CC	D		3	35	11.5		0.3754	0.7508	0.5005	2.2524	0.1561	0.1249
I73B	Aftercare of Musculoskeletal Implants or Prostheses W/O Cat or Sev CC	D		2	20	4.9		0.2615	0.5231	0.2615	1.0461	0.1694	0.1355
I74A	Injuries to Forearm, Wrist, Hand and Foot W CC	D		1	15	4.1		0.5423	1.0846	0.0000	1.0846	0.2126	0.1701
I74B	Injuries to Forearm, Wrist, Hand and Foot W/O CC	D		0	4	1.2		0.5553	0.5553	0.0000	0.5553	0.3570	0.2856
I75A	Injuries to Shoulder, Arm, Elbow, Knee, Leg and Ankle W CC	D		2	18	6.3		0.3916	0.7832	0.3916	1.5664	0.1989	0.1591
I75B	Injuries to Shoulder, Arm, Elbow, Knee, Leg and Ankle W/O CC	D		1	11	3.6	One day	0.4178	0.4178	0.0000	0.9610	0.2155	0.1724
I76A	Other Musculoskeletal Disorders W Catastrophic or Severe CC	D		1	17	5.4		0.7015	1.4030	0.0000	1.4030	0.2094	0.1675
I76B	Other Musculoskeletal Disorders W/O Catastrophic or Severe CC	D		0	6	1.8		0.6316	0.6316	0.0000	0.6316	0.2805	0.2244
I77A	Fractures of Pelvis W Catastrophic or Severe CC	D		2	22	7.4		0.4271	0.8543	0.4271	1.7086	0.1840	0.1472
I77B	Fractures of Pelvis W/O Catastrophic or Severe CC	D		1	16	4.7	One day	0.4683	0.4683	0.0000	1.1091	0.1878	0.1503
I78A	Fractures of Neck of Femur W Catastrophic or Severe CC	D		2	21	6.4		0.3655	0.7311	0.3655	1.4622	0.1834	0.1467

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
I78B	Fractures of Neck of Femur W/O Catastrophic or Severe CC	D		1	11	3.3		0.3910	0.7820	0.0000	0.7820	0.1898	0.1519
I79A	Pathological Fractures W Catastrophic CC	D		3	31	11.9		0.4361	0.8722	0.5815	2.6166	0.1754	0.1403
I79B	Pathological Fractures W/O Catastrophic CC	D		1	16	5.2		0.6581	1.3161	0.0000	1.3161	0.2008	0.1606
I80Z	Femoral Fractures, Transferred to Acute Facility <2 Days	D		0	3	1.0	Same day	0.2870	0.4044	0.0000	0.4044	0.3235	0.2588
I81Z	Musculoskeletal Injuries, Sameday	D		0	3	1.0		0.2644	0.2644	0.0000	0.2644	0.2115	0.1692
I82Z	Other Sameday Treatment for Musculoskeletal Disorders	D		0	3	1.0		0.2196	0.2196	0.0000	0.2196	0.1756	0.1405
J01A	Microvas Tiss Transf for Skin, Subcut Tiss & Breast Disd W Cat or Sev CC	D		3	34	10.5		3.3096	3.8569	0.7297	6.0461	0.2180	0.1744
J01B	Microvas Tiss Transf for Skin, Subcut Tiss & Breast Disd W/O Cat or Sev CC	D		2	21	7.3		2.7313	3.3212	0.5899	4.5011	0.2270	0.1816
J06A	Major Procedures for Malignant Breast Disorders	D		1	11	3.0		1.1309	1.5905	0.0000	1.5905	0.2176	0.1741
J06B	Major Procedures for Non-Malignant Breast Disorders	D		0	8	2.1		1.3855	1.3855	0.0000	1.3855	0.1918	0.1535
J07A	Minor Procedures for Malignant Breast Disorders	D		0	3	1.1		0.7102	0.7102	0.0000	0.7102	0.2154	0.1723
J07B	Minor Procedures for Non-Malignant Breast Disorders	D		0	3	1.0		0.5681	0.5681	0.0000	0.5681	0.1403	0.1123

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
J08A	Other Skin Grafts and Debridement Procedures W CC	D		2	21	6.6		0.9443	1.3063	0.3620	2.0303	0.1525	0.1220
J08B	Other Skin Grafts and Debridement Procedures W/O CC	D		0	7	1.9		0.9980	0.9980	0.0000	0.9980	0.1947	0.1558
J08C	Other Skin Grafts and Debridement Procedures, Sameday	D		0	3	1.0		0.5204	0.5204	0.0000	0.5204	0.1170	0.0936
J09Z	Perianal and Pilonidal Procedures	D		0	7	1.3		0.6528	0.6528	0.0000	0.6528	0.1623	0.1298
J10Z	Plastic OR Procedures for Skin, Subcutaneous Tissue and Breast Disorders	D		0	7	1.6	Same day	0.4916	1.0837	0.0000	1.0837	0.2088	0.1670
J11Z	Other Skin, Subcutaneous Tissue and Breast Procedures	D		0	8	1.8	Same day	0.3723	0.9239	0.0000	0.9239	0.2063	0.1650
J12A	Lower Limb Procs W Ulcer/Cellulitis W Catastrophic CC	D		5	48	15.8		0.7103	1.0434	0.5329	3.7078	0.1477	0.1181
J12B	Lower Limb Procs W Ulcer/Cellulitis W/O Cat CC W Skin Graft/Flap Repair	D		3	28	10.6		0.8783	1.2290	0.4675	2.6316	0.1394	0.1115
J12C	Lower Limb Procs W Ulcer/Cellulitis W/O Cat CC W/O Skin Graft/Flap Repair	D		2	20	6.1		0.4993	0.8051	0.3058	1.4168	0.1403	0.1122
J13A	Lwr Limb Procs W/O Ulcer/Cellulitis W (Skin Grafts and Sev CC) or W Cat CC	D		3	28	9.6		0.9154	1.2392	0.4317	2.5343	0.1417	0.1133

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
J13B	Lwr Limb Procs W/O Ulcer/Cellulitis W/O (Skin Grafts and Sev CC) W/O Cat CC	D		1	16	5.3	One day	0.6394	0.6394	0.0000	1.5727	0.1492	0.1194
J14Z	Major Breast Reconstructions	D		2	24	9.2		2.7401	3.3570	0.6169	4.5909	0.1882	0.1506
J60A	Skin Ulcers W Catastrophic CC	D		3	29	10.0		0.3573	0.7146	0.4764	2.1438	0.1712	0.1369
J60B	Skin Ulcers W/O Catastrophic CC	D		2	18	6.1		0.2691	0.5382	0.2691	1.0763	0.1405	0.1124
J60C	Skin Ulcers, Sameday	D		0	3	1.0		0.1344	0.1344	0.0000	0.1344	0.1075	0.0860
J62A	Malignant Breast Disorders	D		1	15	3.6		0.5459	1.0918	0.0000	1.0918	0.2407	0.1925
J62B	Malignant Breast Disorders, Sameday	D		0	3	1.0		0.2062	0.2062	0.0000	0.2062	0.1650	0.1320
J63A	Non-Malignant Breast Disorders	D		0	8	2.7		0.6844	0.6844	0.0000	0.6844	0.2036	0.1629
J63B	Non-Malignant Breast Disorders, Sameday	D		0	3	1.0		0.3522	0.3522	0.0000	0.3522	0.2818	0.2254
J64A	Cellulitis W Catastrophic or Severe CC	D		2	19	6.1		0.3427	0.6854	0.3427	1.3707	0.1802	0.1442
J64B	Cellulitis W/O Catastrophic or Severe CC	D		1	13	4.4	One day	0.3557	0.3557	0.0000	0.7702	0.1411	0.1129
J65A	Trauma to Skin Subcutaneous Tissue and Breast W Cat or Sev CC	D		1	15	4.2		0.5992	1.1983	0.0000	1.1983	0.2270	0.1816
J65B	Trauma to Skin Subcutaneous Tissue and Breast W/O Cat or Sev CC	D		0	5	1.4		0.5098	0.5098	0.0000	0.5098	0.2919	0.2335

Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x													
J65C	Trauma to Skin Subcutaneous Tissue and Breast, Sameday	D		0	3	1.0		0.2603	0.2603	0.0000	0.2603	0.2082	0.1666
J67A	Minor Skin Disorders	D		1	13	4.2	One day	0.3602	0.3602	0.0000	1.0742	0.2059	0.1648
J67B	Minor Skin Disorders, Sameday	D		0	3	1.0		0.2425	0.2425	0.0000	0.2425	0.1940	0.1552
J68A	Major Skin Disorders W Catastrophic or Severe CC	D		2	21	6.1		0.3954	0.7909	0.3954	1.5817	0.2089	0.1671
J68B	Major Skin Disorders W/O Catastrophic or Severe CC	D		1	9	3.0		0.4382	0.8765	0.0000	0.8765	0.2336	0.1869
J68C	Major Skin Disorders, Sameday	D		0	3	1.0		0.2776	0.2776	0.0000	0.2776	0.2221	0.1776
J69A	Skin Malignancy W Catastrophic CC	D		2	27	8.1		0.5435	1.0870	0.5435	2.1739	0.2144	0.1715
J69B	Skin Malignancy W/O Catastrophic CC	D		2	21	5.4	One day	0.5142	0.5142	0.3975	1.3277	0.1965	0.1572
J69C	Skin Malignancy, Sameday	D		0	3	1.0		0.2643	0.2643	0.0000	0.2643	0.2115	0.1692
K01A	OR Procedures for Diabetic Complications W Catastrophic CC	D		6	58	21.2		1.0429	1.4420	0.6650	5.4322	0.1579	0.1263
K01B	OR Procedures for Diabetic Complications W/O Catastrophic CC	D		2	26	7.3		0.6980	1.1303	0.4323	1.9949	0.1665	0.1332
K02A	Pituitary Procedures W CC	D		2	23	6.9		1.8124	2.4338	0.6214	3.6766	0.2526	0.2020
K02B	Pituitary Procedures W/O CC	D		1	13	4.9		1.8983	2.8089	0.0000	2.8089	0.2625	0.2100
K03Z	Adrenal Procedures	D		1	10	3.4		1.8818	2.6215	0.0000	2.6215	0.3067	0.2453

WIES21 2014–15 Victorian cost weights

Victorian Modified AR-DRG 7.0x

Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
K05A	Parathyroid Procedures W Catastrophic or Severe CC	D		1	18	5.4		1.6390	2.4861	0.0000	2.4861	0.2203	0.1763
K05B	Parathyroid Procedures W/O Catastrophic or Severe CC	D		0	4	1.3		1.2568	1.2568	0.0000	1.2568	0.3296	0.2637
K06A	Thyroid Procedures W Catastrophic or Severe CC	D		1	10	3.1		1.7036	2.3381	0.0000	2.3381	0.2892	0.2314
K06B	Thyroid Procedures W/O Catastrophic or Severe CC	D		0	5	1.7		1.5273	1.5273	0.0000	1.5273	0.2920	0.2336
K08Z	Thyroglossal Procedures	D		0	4	1.2		0.9340	0.9340	0.0000	0.9340	0.2438	0.1951
K09A	Other Endocrine, Nutritional and Metabolic OR Procs W Catastrophic CC	D		4	40	13.0		0.8867	1.3266	0.6598	3.9659	0.1900	0.1520
K09B	Other Endocrine, Nutritional and Metabolic OR Procs W Severe or Moderate CC	D		1	15	4.5		1.0901	1.7421	0.0000	1.7421	0.2039	0.1631
K09C	Other Endocrine, Nutritional and Metabolic OR Procs W/O CC	D		0	8	2.3		1.2826	1.2826	0.0000	1.2826	0.2781	0.2224
K10A	Revisional and Open Bariatric Procedures W CC	D		3	29	6.5		2.2003	2.6434	0.5908	4.4158	0.2863	0.2290
K10B	Revisional and Open Bariatric Procedures W/O CC	D		0	7	3.5		3.1115	3.1115	0.0000	3.1115	0.2931	0.2345
K11A	Major Laparoscopic Bariatric Procedures W CC	D		1	11	5.7		2.6830	3.5920	0.0000	3.5920	0.2227	0.1782
K11B	Major Laparoscopic Bariatric Procedures W/O CC	D		0	8	4.0		2.9116	2.9116	0.0000	2.9116	0.1892	0.1513
K12Z	Other Bariatric Procedures	D		0	5	1.9		2.4785	2.4785	0.0000	2.4785	0.2922	0.2338

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
K13Z	Plastic OR Procedures for Endocrine, Nutritional and Metabolic Disorders	D		1	10	3.1		1.3033	1.6532	0.0000	1.6532	0.1590	0.1272
K40A	Endoscopic and Investigative Procs for Metabolic Disorders W Cat CC	D		4	43	12.9		0.6754	1.1298	0.6817	3.8568	0.2254	0.1803
K40B	Endoscopic and Investigative Procs for Metabolic Disorders W/O Cat CC	D		1	12	3.9		0.7913	1.3447	0.0000	1.3447	0.2298	0.1838
K40C	Endoscopic and Investigative Procs for Metabolic Disorders, Sameday	D		0	3	1.0		0.3404	0.3404	0.0000	0.3404	0.1183	0.0947
K60A	Diabetes W Catastrophic or Severe CC	D		1	17	4.9		0.7806	1.5611	0.0000	1.5611	0.2560	0.2048
K60B	Diabetes W/O Catastrophic or Severe CC	D		0	8	2.6		0.9297	0.9297	0.0000	0.9297	0.2872	0.2297
K60C	Diabetes Management, Sameday	D		0	3	1.0		0.2389	0.2389	0.0000	0.2389	0.1911	0.1529
K61Z	Severe Nutritional Disturbance	D		2	22	7.1		0.4510	0.9019	0.4510	1.8038	0.2032	0.1626
K62A	Miscellaneous Metabolic Disorders W Catastrophic or Severe CC	D		1	15	4.6		0.6367	1.2735	0.0000	1.2735	0.2224	0.1779
K62B	Miscellaneous Metabolic Disorders W/O Catastrophic or Severe CC	D		0	7	2.1		0.6655	0.6655	0.0000	0.6655	0.2541	0.2033
K62C	Miscellaneous Metabolic Disorders, Sameday	D		0	3	1.0		0.1396	0.1396	0.0000	0.1396	0.1117	0.0894

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
K63A	Inborn Errors of Metabolism W Catastrophic or Severe CC	D		2	21	6.6	One day	0.4351	0.4351	0.8723	2.1796	0.2636	0.2109
K63B	Inborn Errors of Metabolism W/O Catastrophic or Severe CC	D		0	3	1.1		0.2070	0.2070	0.0000	0.2070	0.1569	0.1255
K64A	Endocrine Disorders W Catastrophic or Severe CC	D		1	17	5.8		0.8767	1.7534	0.0000	1.7534	0.2408	0.1926
K64B	Endocrine Disorders W/O Catastrophic or Severe CC	D		0	8	2.6		0.8767	0.8767	0.0000	0.8767	0.2650	0.2120
K64C	Endocrine Disorders, Sameday	D		0	3	1.0		0.2203	0.2203	0.0000	0.2203	0.1762	0.1410
L02A	Operative Insertion of Peritoneal Catheter for Dialysis W Cat or Sev CC	D		2	18	4.7		0.9303	1.4288	0.4985	2.4258	0.2950	0.2360
L02B	Operative Insertion of Peritoneal Catheter for Dialysis W/O Cat or Sev CC	D		0	4	1.2		0.8493	0.8493	0.0000	0.8493	0.2564	0.2051
L03A	Kidney, Ureter and Major Bladder Procedures for Neoplasm W Catastrophic CC	D		3	29	10.0		2.1939	2.7289	0.7134	4.8691	0.2249	0.1799
L03B	Kidney, Ureter and Major Bladder Procedures for Neoplasm W Severe CC	D		1	12	4.2		2.0456	2.7239	0.0000	2.7239	0.2247	0.1797
L03C	Kidney, Ureter and Major Bladder Procedures for Neoplasm W/O Cat or Sev CC	D		1	10	3.2		1.7519	2.3272	0.0000	2.3272	0.2482	0.1986
L04A	Kidney, Ureter and Major Bladder Procedures for Non-Neoplasm W Cat CC	D		3	29	9.6		1.2536	1.7549	0.6683	3.7598	0.2188	0.1750

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L04B	Kidney, Ureter and Major Bladder Procedures for Non-Neoplasm W/O Cat CC	D		0	7	2.1		1.3928	1.3928	0.0000	1.3928	0.2350	0.1880
L04C	Kidney, Ureter & Major Bladder Procedures for Non-Neoplasm, Sameday	D		0	3	1.0		0.6816	0.6816	0.0000	0.6816	0.1409	0.1127
L05A	Transurethral Prostatectomy for Urinary Disorder W Catastrophic or Severe CC	D		1	18	5.0		1.1029	1.6916	0.0000	1.6916	0.1646	0.1317
L05B	Transurethral Prostatectomy for Urinary Disorder W/O Cat or Sev CC	D		0	7	2.1		1.0898	1.0898	0.0000	1.0898	0.1971	0.1577
L06A	Minor Bladder Procedures W Catastrophic or Severe CC	D		2	18	6.5		1.0633	1.4848	0.4214	2.3276	0.1804	0.1443
L06B	Minor Bladder Procedures W/O Catastrophic or Severe CC	D		0	6	1.6		0.7812	0.7812	0.0000	0.7812	0.1789	0.1431
L07A	Other Transurethral Procedures W CC	D		0	8	2.1		0.9760	0.9760	0.0000	0.9760	0.1903	0.1522
L07B	Other Transurethral Procedures W/O CC	D		0	3	1.1		0.6224	0.6224	0.0000	0.6224	0.1708	0.1367
L08A	Urethral Procedures W CC	D		0	6	2.0		1.0663	1.0663	0.0000	1.0663	0.1968	0.1575
L08B	Urethral Procedures W/O CC	D		0	4	1.2		0.6733	0.6733	0.0000	0.6733	0.1722	0.1377
L09A	Other Procedures for Kidney and Urinary Tract Disorders W Cat CC	D		3	31	12.1		0.9961	1.5762	0.7734	3.8962	0.2009	0.1607
L09B	Other Procedures for Kidney and Urinary Tract Disorders W Sev CC	D		0	6	1.4		1.0895	1.0895	0.0000	1.0895	0.2557	0.2046

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
L09C	Other Procedures for Kidney and Urinary Tract Disorders W/O Cat or Sev CC	D		0	3	1.1		0.8453	0.8453	0.0000	0.8453	0.2245	0.1796
L40Z	Ureteroscopy	D		0	4	1.2		0.7043	0.7043	0.0000	0.7043	0.2034	0.1627
L41Z	Cystourethroscopy for Urinary Disorder, Sameday	D		0	3	1.0		0.2254	0.2254	0.0000	0.2254	0.0931	0.0745
L42Z	ESW Lithotripsy	D		0	8	2.7	Same day	0.0000	0.4318	0.0000	0.9364	0.2752	0.2202
L60A	Kidney Failure W Catastrophic CC	D		2	24	8.3		0.5808	1.1617	0.5808	2.3234	0.2244	0.1795
L60B	Kidney Failure W Severe CC	D		1	11	3.3		0.4698	0.9396	0.0000	0.9396	0.2298	0.1838
L60C	Kidney Failure W/O Catastrophic or Severe CC	D		1	12	3.8	One day	0.2345	0.2345	0.0000	1.0676	0.2264	0.1811
L61Z	Haemodialysis	D		0	3	1.0		0.1055	0.1055	0.0000	0.1055	0.1055	0.0844
L62A	Kidney and Urinary Tract Neoplasms W Catastrophic or Severe CC	D		2	20	6.0	One day	0.3149	0.3149	0.7052	1.7432	0.2322	0.1858
L62B	Kidney and Urinary Tract Neoplasms W/O Catastrophic or Severe CC	D		1	15	3.2	One day	0.3799	0.3799	0.0000	1.1543	0.2845	0.2276
L63A	Kidney and Urinary Tract Infections W Catastrophic or Severe CC	D		1	15	4.7		0.6104	1.2209	0.0000	1.2209	0.2070	0.1656
L63B	Kidney and Urinary Tract Infections W/O Catastrophic or Severe CC	D		0	7	2.3	Same day	0.1887	0.6322	0.0000	0.6322	0.2219	0.1775
L64A	Urinary Stones and Obstruction W Catastrophic or Severe CC	D		1	10	2.8		0.5517	1.1034	0.0000	1.1034	0.3148	0.2518

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
L64B	Urinary Stones and Obstruction W/O Catastrophic or Severe CC	D		0	8	2.7	One day	0.4318	0.4318	0.0000	0.9364	0.2752	0.2202
L64C	Urinary Stones and Obstruction, Sameday	D		0	3	1.0		0.2362	0.2362	0.0000	0.2362	0.1890	0.1512
L65A	Kidney and Urinary Tract Signs and Symptoms W Catastrophic or Severe CC	D		1	13	3.6		0.4688	0.9375	0.0000	0.9375	0.2074	0.1659
L65B	Kidney and Urinary Tract Signs and Symptoms W/O Catastrophic or Severe CC	D		0	6	1.9	Same day	0.1830	0.5461	0.0000	0.5461	0.2341	0.1872
L66Z	Urethral Stricture	D		0	4	1.2		0.4731	0.4731	0.0000	0.4731	0.3276	0.2621
L67A	Other Kidney and Urinary Tract Disorders W Catastrophic or Severe CC	D		1	15	4.4		0.6491	1.2981	0.0000	1.2981	0.2337	0.1870
L67B	Other Kidney and Urinary Tract Disorders W/O Catastrophic or Severe CC	D		0	6	1.8		0.6190	0.6190	0.0000	0.6190	0.2690	0.2152
L67C	Other Kidney and Urinary Tract Disorders, Sameday	D		0	3	1.0		0.1592	0.1592	0.0000	0.1592	0.1273	0.1019
L68Z	Peritoneal Dialysis	I		0	3	1.0		0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
M01A	Major Male Pelvic Procedures W Catastrophic or Severe CC	D		1	15	4.8		2.3119	3.1150	0.0000	3.1150	0.2329	0.1864
M01B	Major Male Pelvic Procedures W/O Catastrophic or Severe CC	D		0	8	2.7		2.8086	2.8086	0.0000	2.8086	0.2821	0.2257

WIES21 2014–15 Victorian cost weights

Victorian Modified AR-DRG 7.0x

Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
M02A	Transurethral Prostatectomy for Reproductive System Disorder W Cat/Sev CC	D		1	13	3.8		1.0692	1.5680	0.0000	1.5680	0.1862	0.1490
M02B	Transurethral Prostatectomy for Reproductive System Disorder W/O Cat/Sev CC	D		0	7	2.3		1.1350	1.1350	0.0000	1.1350	0.1967	0.1574
M03Z	Penis Procedures	D		0	3	1.1		0.7416	0.7416	0.0000	0.7416	0.1771	0.1417
M04Z	Testes Procedures	D		0	3	1.0		0.6198	0.6198	0.0000	0.6198	0.1681	0.1345
M05Z	Circumcision	D		0	3	1.0		0.4589	0.4589	0.0000	0.4589	0.0954	0.0763
M06A	Other Male Reproductive System OR Procedures W CC	D		1	14	3.4		2.1856	3.3698	0.0000	3.3698	0.3621	0.2897
M06B	Other Male Reproductive System OR Procedures W/O CC	D		0	5	1.3	Same day	0.7052	3.5761	0.0000	3.5761	0.3621	0.2897
M40Z	Cystourethroscopy for Male Reproductive System Disorder, Sameday	D		0	3	1.0		0.2126	0.2126	0.0000	0.2126	0.0931	0.0745
M60A	Male Reproductive System Malignancy W Catastrophic or Severe CC	D		1	15	4.6		0.6410	1.2821	0.0000	1.2821	0.2206	0.1765
M60B	Male Reproductive System Malignancy W/O Catastrophic or Severe CC	D		0	3	1.0		0.3375	0.3375	0.0000	0.3375	0.2626	0.2101
M61A	Benign Prostatic Hypertrophy W CC	D		1	9	2.9		0.3891	0.7782	0.0000	0.7782	0.2154	0.1723
M61B	Benign Prostatic Hypertrophy W/O CC	D		0	3	1.0		0.3341	0.3341	0.0000	0.3341	0.2562	0.2049

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WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x													
M62A	Male Reproductive System Inflammation W CC	D		1	13	3.9	Same day	0.2339	1.0022	0.0000	1.0022	0.2072	0.1657
M62B	Male Reproductive System Inflammation W/O CC	D		0	7	2.3	Same day	0.2242	0.6259	0.0000	0.6259	0.2135	0.1708
M63Z	Male Sterilisation Procedures	D		0	3	1.0		0.3853	0.3853	0.0000	0.3853	0.3083	0.2466
M64Z	Other Male Reproductive System Disorders	D		0	4	1.1		0.3491	0.3491	0.0000	0.3491	0.2578	0.2062
N01A	Pelvic Evisceration and Radical Vulvectomy W Catastrophic or Severe CC	D		4	42	11.9		1.5039	1.9167	0.6193	4.3939	0.1940	0.1552
N01B	Pelvic Evisceration and Radical Vulvectomy W/O Catastrophic or Severe CC	D		1	11	4.6		1.5329	2.2767	0.0000	2.2767	0.2259	0.1807
N04A	Hysterectomy for Non-Malignancy W Catastrophic or Severe CC	D		1	12	4.1		1.6040	2.2763	0.0000	2.2763	0.2285	0.1828
N04B	Hysterectomy for Non-Malignancy W/O Catastrophic or Severe CC	D		0	8	2.9		1.8725	1.8725	0.0000	1.8725	0.2566	0.2053
N05A	Oophorectomy and Complex Fallopian Tube Procs for Non-Malig W Cat or Sev CC	D		1	10	3.3		1.3349	1.8985	0.0000	1.8985	0.2392	0.1914
N05B	Oophorectomy & Complex Fallopian Tube Procs for Non-Malig W/O Cat or Sev CC	D		0	5	1.7		1.4047	1.4047	0.0000	1.4047	0.2940	0.2352
N06Z	Female Reproductive System Reconstructive Procedures	D		0	6	2.0		1.3364	1.3364	0.0000	1.3364	0.2468	0.1974

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N07A	Other Uterus and Adnexa Procedures for Non-Malignancy	D		0	5	1.7		1.3946	1.3946	0.0000	1.3946	0.3112	0.2490
N07B	Other Uterus and Adnexa Procedures for Non-Malignancy, Sameday	D		0	3	1.0		0.6890	0.6890	0.0000	0.6890	0.1979	0.1583
N08Z	Endoscopic and Laparoscopic Procedures, Female Reproductive System	D		0	5	1.7	Same day	0.6992	1.1695	0.0000	1.1695	0.2802	0.2241
N09Z	Other Vagina, Cervix and Vulva Procedures	D		0	3	1.0		0.4811	0.4811	0.0000	0.4811	0.1375	0.1100
N10Z	Diagnostic Curettage and Diagnostic Hysteroscopy	D		0	3	1.0		0.4334	0.4334	0.0000	0.4334	0.1089	0.0871
N11Z	Other Female Reproductive System OR Procedures	D		1	17	5.4	Same day	0.3779	2.3516	0.0000	2.3516	0.2206	0.1765
N12A	Uterus and Adnexa Procedures for Malignancy W Catastrophic CC	D		2	22	7.1		1.4826	2.0280	0.5454	3.1189	0.2146	0.1717
N12B	Uterus and Adnexa Procedures for Malignancy W/O Catastrophic CC	D		1	10	3.7		1.3854	2.0089	0.0000	2.0089	0.2345	0.1876
N60A	Female Reproductive System Malignancy W Catastrophic CC	D		2	19	7.3		0.4893	0.9787	0.4893	1.9573	0.2157	0.1726
N60B	Female Reproductive System Malignancy W/O Catastrophic CC	D		1	12	4.1	One day	0.3203	0.3203	0.0000	1.2557	0.2456	0.1964
N61Z	Female Reproductive System Infections	D		1	10	3.2	One day	0.3325	0.3325	0.0000	0.9195	0.2307	0.1846

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N62Z	Menstrual and Other Female Reproductive System Disorders	D		0	5	1.6	Same day	0.2626	0.5359	0.0000	0.5359	0.2758	0.2207
O01A	Caesarean Delivery W Catastrophic CC	D		2	21	6.3		1.0796	1.6363	0.5567	2.7497	0.2485	0.1988
O01B	Caesarean Delivery W Severe CC	D		1	13	4.4		1.3279	2.1997	0.0000	2.1997	0.2751	0.2200
O01C	Caesarean Delivery W/O Catastrophic or Severe CC	D		1	11	3.6		1.2068	1.9827	0.0000	1.9827	0.2985	0.2388
O02A	Vaginal Delivery W OR Procedures W Catastrophic or Severe CC	D		1	11	3.7		1.1324	1.9318	0.0000	1.9318	0.3006	0.2405
O02B	Vaginal Delivery W OR Procedures W/O Catastrophic or Severe CC	D		0	8	2.8		1.5099	1.5099	0.0000	1.5099	0.3621	0.2897
O03A	Ectopic Pregnancy W CC	D		0	6	2.3		1.4569	1.4569	0.0000	1.4569	0.3292	0.2634
O03B	Ectopic Pregnancy W/O CC	D		0	4	1.4	Same day	0.2511	1.0103	0.0000	1.0103	0.3218	0.2574
O04A	Postpartum and Post Abortion W OR Procedures W Catastrophic or Severe CC	D		1	16	4.0		1.1734	1.9685	0.0000	1.9685	0.2776	0.2221
O04B	Postpartum and Post Abortion W OR Procedures W/O Catastrophic or Severe CC	D		0	8	2.2		1.0153	1.0153	0.0000	1.0153	0.2409	0.1927
O04C	Postpartum and Post Abortion W OR Procedures, Sameday	D		0	3	1.0		0.4617	0.4617	0.0000	0.4617	0.1337	0.1070
O05Z	Abortion W OR Procedures	D		0	3	1.0		0.4644	0.4644	0.0000	0.4644	0.1269	0.1015

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
O60A	Vaginal Delivery W Catastrophic or Severe CC	D		1	12	3.9	One day	0.7231	0.7231	0.0000	1.5911	0.3256	0.2605
O60B	Vaginal Delivery W/O Catastrophic or Severe CC	D		0	9	2.9	One day	0.7145	0.7145	0.0000	1.2053	0.3360	0.2688
O60C	Vaginal Delivery, Single Uncomplicated	D		0	8	2.6	One day	0.5724	0.5724	0.0000	1.0399	0.3152	0.2522
O61Z	Postpartum and Post Abortion W/O OR Procedures	D		0	7	2.5	Same day	0.2343	0.6189	0.0000	0.6189	0.2020	0.1616
O63Z	Abortion W/O OR Procedures	D		0	4	1.4	Same day	0.1919	0.5911	0.0000	0.5911	0.3493	0.2794
O66A	Antenatal and Other Obstetric Admissions W Catastrophic or Severe CC	D		0	9	2.5		0.6903	0.6903	0.0000	0.6903	0.2207	0.1766
O66B	Antenatal and Other Obstetric Admissions W/O Catastrophic or Severe CC	D		0	5	1.6		0.4408	0.4408	0.0000	0.4408	0.2248	0.1799
O66C	Antenatal and Other Obstetric Admissions, Sameday	D		0	3	1.0		0.1398	0.1398	0.0000	0.1398	0.1118	0.0894
P01Z	Neonate W Significant OR Proc, Died or Transferred to Acute Facility <5 Days	I		0	7	2.4		4.9599	4.9599	0.0000	4.9599	0.3621	0.2897
P02Z	Cardiothoracic and Vascular Procedures for Neonates	I		16	38	22.7		8.3236	9.3607	1.9446	40.4748	0.3621	0.2897
P03A	Neonate, AdmWt 1000-1499g W Significant OR Proc W Multiple Major Problems	I		34	77	53.7		0.4817	0.9566	0.9220	32.3042	0.3621	0.2897

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
P03B	Neonate, AdmWt 1000-1499g W Significant OR Proc W/O Multiple Major Problems	I		22	51	36.5		0.4626	0.9252	0.8832	20.3546	0.3621	0.2897
P04A	Neonate, AdmWt 1500-1999g W Significant OR Proc W Multiple Major Problems	I		23	53	36.0		0.4556	0.8791	0.8103	19.5155	0.3621	0.2897
P04B	Neonate, AdmWt 1500-1999g W Significant OR Proc W/O Multiple Major Problems	I		14	32	21.7		0.5819	1.0205	0.8145	12.4229	0.3621	0.2897
P05A	Neonate, AdmWt 2000-2499g W Significant OR Proc W Multiple Major Problems	I		21	49	33.6		1.3634	1.8815	0.9867	22.6032	0.3621	0.2897
P05B	Neonate, AdmWt 2000-2499g W Significant OR Proc W/O Multiple Major Problems	I		10	24	16.8		0.8684	1.3965	0.9506	10.9029	0.3621	0.2897
P06A	Neonate, AdmWt >=2500g W Significant OR Procedure W Multiple Major Problems	I		17	39	26.1		1.8902	2.4533	1.0600	20.4734	0.3621	0.2897
P06B	Neonate, AdmWt >=2500g W Significant OR Procedure W/O Multiple Major Problems	I		2	24	7.6		1.6927	2.9498	1.2572	5.4641	0.3621	0.2897
P07Z	Neonate, AdmWt <750g W Significant OR Procedure	I		120	272	155.3		0.8415	1.1950	0.7010	85.3182	0.3621	0.2897
P08Z	Neonate, AdmWt 750-999g W Significant OR Procedure	I		64	144	108.0		1.5270	2.1724	1.2705	83.4873	0.3621	0.2897
P60A	Neonate W/O Sig OR Proc, Died or Transferred to Acute Facility <5 Days	I		0	7	2.3		0.9156	0.9156	0.0000	0.9156	0.3621	0.2897

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P60B	Neonate W/O Sig OR Proc, Died or Transferred to Acute Facility Sameday	I		0	3	1.0		0.3320	0.3320	0.0000	0.3320	0.3320	0.2656
P61Z	Neonate, AdmWt <750g W/O Significant OR Procedure	I		56	127	96.2		0.4956	0.9913	0.9736	55.5113	0.3621	0.2897
P62Z	Neonate, AdmWt 750-999g W/O Significant OR Procedure	I		41	94	66.9		0.4394	0.8788	0.8574	36.0303	0.3621	0.2897
P63A	Neonate, AdmWt 1000-1249g W/O Sig OR Proc <32 Completed Wks Gestation	I		20	46	31.6		0.4025	0.8050	0.7647	16.0997	0.3621	0.2897
P63B	Neonate, AdmWt 1000-1249g W/O Sig OR Proc >=32 Completed Wks Gestation	I		8	19	12.1		0.3988	0.7976	0.6979	6.3809	0.3621	0.2897
P64A	Neonate, AdmWt 1250-1499g W/O Sig OR Proc <32 Completed Wks Gestation	I		17	39	27.5		0.3526	0.7051	0.6636	11.9868	0.3621	0.2897
P64B	Neonate, AdmWt 1250-1499g W/O Sig OR Proc >=32 Completed Wks Gestation	I		15	35	27.1		0.3352	0.6704	0.6257	10.0556	0.3621	0.2897
P65A	Neonate, AdmWt 1500-1999g W/O Significant OR Proc W Multiple Major Problems	I		13	31	21.7		0.2122	0.4244	0.3918	5.5176	0.2538	0.2031
P65B	Neonate, AdmWt 1500-1999g W/O Significant OR Proc W Major Problem	I		13	31	22.5		0.1962	0.3924	0.3622	5.1009	0.2270	0.1816
P65C	Neonate, AdmWt 1500-1999g W/O Significant OR Proc W Other Problem	I		12	29	20.6		0.1888	0.3776	0.3461	4.5309	0.2196	0.1757

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P65D	Neonate, AdmWt 1500-1999g W/O Significant OR Proc W/O Problem	I		12	27	18.9		0.1795	0.3590	0.3291	4.3085	0.2285	0.1828
P66A	Neonate, AdmWt 2000-2499g W/O Significant OR Proc W Multiple Major Problems	I		10	23	15.9		0.2012	0.4023	0.3621	4.0233	0.2028	0.1622
P66B	Neonate, AdmWt 2000-2499g W/O Significant OR Proc W Major Problem	I		9	20	13.9		0.1779	0.3557	0.3162	3.2016	0.2531	0.2024
P66C	Neonate, AdmWt 2000-2499g W/O Significant OR Proc W Other Problem	I		7	16	10.9		0.1811	0.3622	0.3105	2.5355	0.2329	0.1863
P66D	Neonate, AdmWt 2000-2499g W/O Significant OR Proc W/O Problem	I		2	19	6.3		0.2946	0.5891	0.2946	1.1783	0.1865	0.1492
P67A	Neonate, AdmWt >=2500g W/O Sig OR Proc <37 Comp Wks Gest W Mult Major Probs	I		4	39	12.7		0.3816	0.7633	0.5724	3.0530	0.2410	0.1928
P67B	Neonate, AdmWt >=2500g W/O Sig OR Proc <37 Comp Wks Gest W Major Problem	I		3	28	10.5		0.3912	0.7825	0.5216	2.3474	0.2674	0.2139
P67C	Neonate, AdmWt >=2500g W/O Sig OR Proc <37 Comp Wks Gest W Other Problem	I		2	25	8.7		0.5043	1.0086	0.5043	2.0172	0.1860	0.1488
P67D	Neonate, AdmWt >=2500g W/O Sig OR Proc <37 Comp Wks Gest W/O Problem	I		1	14	4.6		0.4443	0.8886	0.0000	0.8886	0.1545	0.1236

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P68A	Neonate, AdmWt >=2500g W/O Sig OR Proc >=37 Comp Wks Gest W Mult Major Probs	I		2	24	7.6		0.5007	1.0014	0.5007	2.0028	0.2648	0.2118
P68B	Neonate, AdmWt >=2500g W/O Sig OR Proc >=37 Comp Wks Gest W Major Problem	I		1	15	4.6		0.5571	1.1142	0.0000	1.1142	0.2886	0.2309
P68C	Neonate, AdmWt >=2500g W/O Sig OR Proc >=37 Comp Wks Gest W Other Problem	I		1	12	4.0	One day	0.3129	0.3129	0.0000	0.9702	0.1934	0.1547
P68D	Neonate, AdmWt >=2500g W/O Sig OR Proc >=37 Comp Wks Gest W/O Problem	I		1	10	3.3	One day	0.3090	0.3090	0.0000	0.7108	0.1715	0.1372
Q01A	Splenectomy W Catastrophic or Severe CC	D		2	27	7.6		1.6683	2.3384	0.6702	3.6787	0.2457	0.1966
Q01B	Splenectomy W/O Catastrophic or Severe CC	D		1	11	4.1		1.5109	2.1915	0.0000	2.1915	0.2316	0.1853
Q02A	Blood and Immune System Disorders W Other OR Procedures W Cat or Sev CC	D		3	34	11.0	Same day	0.4901	1.5819	0.7331	3.7813	0.2099	0.1680
Q02B	Blood and Immune System Disorders W Other OR Procedures W/O Cat or Sev CC	D		0	6	1.8	Same day	0.4620	1.1498	0.0000	1.1498	0.2592	0.2074
Q60A	Reticuloendothelial and Immunity Disorders W Catastrophic or Severe CC	D		1	17	5.6		0.9536	1.9072	0.0000	1.9072	0.2726	0.2180
Q60B	Reticuloendothelial and Immunity Disorders W/O Catastrophic or Severe CC	D		0	9	2.9		0.8886	0.8886	0.0000	0.8886	0.2448	0.1959

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
Q60C	Reticuloendothelial and Immunity Disorders, Sameday	D		0	3	1.0		0.1268	0.1268	0.0000	0.1268	0.1015	0.0812
Q61A	Red Blood Cell Disorders W Catastrophic or Severe CC	D	Thal	1	14	4.1		0.5828	1.1656	0.0000	1.1656	0.2290	0.1832
Q61B	Red Blood Cell Disorders W/O Catastrophic or Severe CC	D	Thal	1	10	3.3	One day	0.3785	0.3785	0.0000	0.9432	0.2255	0.1804
Q61C	Red Blood Cell Disorders, Sameday	D	Thal	0	3	1.0		0.1507	0.1507	0.0000	0.1507	0.1205	0.0964
Q62A	Coagulation Disorders	D		1	10	2.7		0.3841	0.7682	0.0000	0.7682	0.2294	0.1835
Q62B	Coagulation Disorders, Sameday	D		0	3	1.0		0.1775	0.1775	0.0000	0.1775	0.1420	0.1136
R01A	Lymphoma and Leukaemia W Major OR Procedures W Catastrophic or Severe CC	D		6	61	17.4		1.8739	2.3821	0.8470	7.4640	0.2449	0.1959
R01B	Lymphoma and Leukaemia W Major OR Procedures W/O Catastrophic or Severe CC	D		1	10	2.0		0.8551	1.2139	0.0000	1.2139	0.2470	0.1976
R02A	Other Neoplastic Disorders W Major OR Procedures W Catastrophic CC	D		4	38	12.7		1.6974	2.0966	0.5987	4.4915	0.1762	0.1409
R02B	Other Neoplastic Disorders W Major OR Procedures W Severe or Moderate CC	D		2	24	6.6		1.6544	2.0671	0.4126	2.8923	0.1757	0.1406
R02C	Other Neoplastic Disorders W Major OR Procedures W/O CC	D		1	17	5.0		1.3296	1.8708	0.0000	1.8708	0.1511	0.1209
R03A	Lymphoma and Leukaemia W Other OR Procedures W Catastrophic or Severe CC	D		5	46	15.8		0.9785	1.5134	0.8558	5.7924	0.2369	0.1895

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
R03B	Lymphoma and Leukaemia W Other OR Procedures W/O Catastrophic or Severe CC	D		1	10	2.9		0.9993	1.5286	0.0000	1.5286	0.2582	0.2066
R03C	Lymphoma and Leukaemia W Other OR Procedures, Sameday	D		0	3	1.0		0.5028	0.5028	0.0000	0.5028	0.1892	0.1513
R04A	Other Neoplastic Disorders W Other OR Procedures W CC	D		2	26	8.6	Same day	0.4562	1.9295	0.6173	3.1640	0.2017	0.1614
R04B	Other Neoplastic Disorders W Other OR Procedures W/O CC	D		0	8	2.0	Same day	0.9897	1.5213	0.0000	1.5213	0.2688	0.2150
R60A	Acute Leukaemia W Catastrophic CC	D		13	30	22.3		0.3055	0.6110	0.5640	7.9432	0.2849	0.2279
R60B	Acute Leukaemia W/O Catastrophic CC	D		1	15	4.9	One day	0.6003	0.6003	0.0000	1.6874	0.2768	0.2214
R60C	Acute Leukaemia, Sameday	D		0	3	1.0		0.2048	0.2048	0.0000	0.2048	0.1639	0.1311
R61A	Lymphoma and Non-Acute Leukaemia W Catastrophic CC	D		3	34	11.1		0.6188	1.2376	0.8251	3.7128	0.2669	0.2135
R61B	Lymphoma and Non-Acute Leukaemia W/O Catastrophic CC	D		1	11	3.5		0.7051	1.4102	0.0000	1.4102	0.3261	0.2609
R61C	Lymphoma and Non-Acute Leukaemia, Sameday	D		0	3	1.0		0.2104	0.2104	0.0000	0.2104	0.1683	0.1347
R62A	Other Neoplastic Disorders W CC	D		1	12	3.3	Same day	0.3395	0.9075	0.0000	0.9075	0.2206	0.1765
R62B	Other Neoplastic Disorders W/O CC	D		1	13	4.3	One day	0.2984	0.2984	0.0000	1.3194	0.2445	0.1956
R63Z	Chemotherapy	D		0	3	1.0	Same day	0.2278	0.0000	0.0000	0.0000	0.0000	0.0000

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
R64Z	Radiotherapy	D		2	23	7.1	Same day	0.8994	1.2821	0.6411	2.5642	0.2893	0.2315
S65A	Human Immunodeficiency Virus W Catastrophic CC	D		5	47	16.5		0.5316	1.0632	0.8505	5.3158	0.2571	0.2057
S65B	Human Immunodeficiency Virus W Severe CC	D		2	21	6.3		0.5095	1.0189	0.5095	2.0378	0.2583	0.2066
S65C	Human Immunodeficiency Virus W/O Catastrophic or Severe CC	D		1	12	4.2		0.7297	1.4594	0.0000	1.4594	0.2789	0.2231
S65D	Human Immunodeficiency Virus, Sameday	D		0	3	1.0		0.2610	0.2610	0.0000	0.2610	0.2088	0.1671
T01A	Infectious and Parasitic Diseases W OR Procedures W Catastrophic CC	D		6	57	20.7		1.1629	1.6331	0.7837	6.3350	0.1909	0.1527
T01B	Infectious and Parasitic Diseases W OR Procedures W Severe or Moderate CC	D		2	22	7.2		0.8056	1.2134	0.4078	2.0290	0.1588	0.1271
T01C	Infectious and Parasitic Diseases W OR Procedures W/O CC	D		1	16	3.5		0.7426	1.1578	0.0000	1.1578	0.1676	0.1341
T40Z	Infectious and Parasitic Diseases W Ventilator Support	D		3	34	10.2		0.8070	1.5572	1.0002	4.5579	0.3523	0.2819
T60A	Septicaemia W Catastrophic CC	D		2	23	7.9		0.6223	1.2447	0.6223	2.4893	0.2534	0.2027
T60B	Septicaemia W/O Catastrophic CC	D		1	15	4.9	One day	0.4200	0.4200	0.0000	1.2612	0.2051	0.1640

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Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
T61A	Postoperative and Post-Traumatic Infections W Catastrophic or Severe CC	D		2	20	6.1		0.3415	0.6830	0.3415	1.3660	0.1801	0.1441
T61B	Postoperative and Post-Traumatic Infections W/O Catastrophic or Severe CC	D		1	15	4.3	One day	0.2828	0.2828	0.0000	0.8809	0.1650	0.1320
T62A	Fever of Unknown Origin W Catastrophic CC	D		1	12	3.3		0.4960	0.9920	0.0000	0.9920	0.2435	0.1948
T62B	Fever of Unknown Origin W/O Catastrophic CC	D		1	9	3.1	One day	0.2958	0.2958	0.0000	0.9589	0.2437	0.1950
T63A	Viral Illnesses W CC	D		1	12	2.9	Same day	0.1956	0.9757	0.0000	0.9757	0.2663	0.2130
T63B	Viral Illnesses W/0 CC	D		0	5	1.6	Same day	0.1692	0.5514	0.0000	0.5514	0.2716	0.2173
T64A	Other Infectious and Parasitic Diseases W Catastrophic CC	D		4	37	12.2		0.4005	0.8011	0.6008	3.2043	0.2102	0.1681
T64B	Other Infectious and Parasitic Diseases W Severe or Moderate CC	D		2	19	5.8		0.3592	0.7184	0.3592	1.4367	0.1976	0.1581
T64C	Other Infectious and Parasitic Diseases W/O CC	D		1	15	3.6	Same day	0.2533	0.9416	0.0000	0.9416	0.2090	0.1672
U40Z	Mental Health Treatment W ECT, Sameday	D		0	3	1.0		0.1502	0.1502	0.0000	0.1502	0.0931	0.0745
U60Z	Mental Health Treatment W/O ECT, Sameday	D		0	3	1.0		0.1881	0.1881	0.0000	0.1881	0.1505	0.1204
U61A	Schizophrenia Disorders, Involuntary Admission	D		1	12	2.6		0.3226	0.6452	0.0000	0.6452	0.1992	0.1593
U61B	Schizophrenia Disorders	D		1	12	2.6		0.3226	0.6452	0.0000	0.6452	0.1992	0.1593

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
U62A	Paranoia & Acute Psyc Disorders, Involuntary Admission W Cat or Sev CC	D		2	27	8.0		0.4963	0.9926	0.4963	1.9852	0.1978	0.1583
U62B	Paranoia & Acute Psyc Disorders W/O Cat or Sev CC	D		1	11	3.4		0.4158	0.8317	0.0000	0.8317	0.1971	0.1577
U63A	Major Affective Disorders Age >=70 or W Catastrophic or Severe CC	D		2	24	7.4		0.4150	0.8300	0.4150	1.6600	0.1789	0.1431
U63B	Major Affective Disorders Age <70 W/O Catastrophic or Severe CC	D		2	19	5.6	One day	0.3491	0.3491	0.5191	1.3774	0.1966	0.1573
U64Z	Other Affective and Somatoform Disorders	D		1	17	4.9	One day	0.3138	0.3138	0.0000	1.1635	0.1891	0.1513
U65Z	Anxiety Disorders	D		1	14	4.1	One day	0.3878	0.3878	0.0000	1.1828	0.2290	0.1832
U66Z	Eating and Obsessive-Compulsive Disorders	D		4	39	14.5		0.4628	0.9257	0.6943	3.7027	0.2042	0.1633
U67Z	Personality Disorders and Acute Reactions	D		0	7	1.8		0.4787	0.4787	0.0000	0.4787	0.2072	0.1657
U68Z	Childhood Mental Disorders	D		1	17	2.9		0.4455	0.8909	0.0000	0.8909	0.2473	0.1978
V60A	Alcohol Intoxication and Withdrawal W CC	D		1	9	2.8		0.4378	0.8756	0.0000	0.8756	0.2511	0.2009
V60B	Alcohol Intoxication and Withdrawal W/O CC	D		0	5	1.4		0.3815	0.3815	0.0000	0.3815	0.2173	0.1738
V61Z	Drug Intoxication and Withdrawal	D		0	8	2.3		0.7018	0.7018	0.0000	0.7018	0.2464	0.1971
V62Z	Alcohol Use and Dependence	D		1	12	3.5		0.5149	1.0298	0.0000	1.0298	0.2326	0.1861
V63Z	Opioid Use and Dependence	D		1	13	3.1		0.4659	0.9318	0.0000	0.9318	0.2396	0.1917

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x													
Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
V64Z	Other Drug Use and Dependence	D		1	9	2.9		0.3786	0.7572	0.0000	0.7572	0.2076	0.1661
V65Z	Treatment for Alcohol Disorders, Sameday	D		0	3	1.0		0.2001	0.2001	0.0000	0.2001	0.1600	0.1280
V66Z	Treatment for Drug Disorders, Sameday	D		0	3	1.0		0.1848	0.1848	0.0000	0.1848	0.1478	0.1183
W01A	Tracheostomy for Multiple Significant Trauma	4		25	57	36.2		4.4023	5.1689	1.4719	41.9671	0.3621	0.2897
W01B	Vent & Cran Procs for Mult Sig Trauma, W/O Trach W (Vent >=96hrs or Cat CC)	4		13	30	19.9		3.6104	4.0873	0.8805	15.5332	0.3621	0.2897
W01C	Vent & Cran Procs for Mult Sig Trauma, W/O Trach W/O Vent >=96hrs W/O Cat CC	D		7	18	11.1		2.5380	3.0510	0.8794	9.2072	0.3621	0.2897
W02A	Hip, Femur & Lower Limb Procs for Multiple Signif Trauma W Cat or Sev CC	D		3	34	11.9		2.6567	3.3241	0.8899	5.9936	0.2365	0.1892
W02B	Hip, Femur & Lower Limb Procs for Multiple Signif Trauma W/O Cat or Sev CC	D		2	23	7.6		2.1181	2.8530	0.7348	4.3226	0.2710	0.2168
W03Z	Abdominal Procedures for Multiple Significant Trauma	D		2	26	9.9		2.3593	3.3523	0.9930	5.3382	0.2803	0.2242
W04A	Multiple Significant Trauma W Other OR Procs W Catastrophic or Severe CC	D		4	37	11.9		2.5243	3.1579	0.9504	6.9594	0.2970	0.2376
W04B	Multiple Significant Trauma W Other OR Procs W/O Catastrophic or Severe CC	D		2	21	6.5		1.7978	2.4611	0.6633	3.7877	0.2868	0.2295

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
W60Z	Multiple Trauma, Died or Transferred to Acute Facility <5 Days	D		0	7	2.2		2.1074	2.1074	0.0000	2.1074	0.3621	0.2897
W61A	Multiple Trauma W/O OR Procedures W Catastrophic or Severe CC	D		2	26	8.7		0.7409	1.4818	0.7409	2.9635	0.2731	0.2185
W61B	Multiple Trauma W/O OR Procedures W/O Catastrophic or Severe CC	D		1	10	3.5		0.7527	1.5055	0.0000	1.5055	0.3486	0.2789
X02A	Microvascular Tiss Transfer or (Skin Graft W Cat/Sev CC) for Injuries to Hand	D		0	7	2.1		1.2585	1.2585	0.0000	1.2585	0.1943	0.1555
X02B	Skin Graft for Injuries to Hand W/O Catastrophic or Severe CC	D		0	3	1.1		0.5739	0.5739	0.0000	0.5739	0.1561	0.1249
X04A	Other Procedures for Injuries to Lower Limb W Catastrophic or Severe CC	D		2	18	5.9		0.8786	1.2192	0.3406	1.9005	0.1604	0.1283
X04B	Other Procedures for Injuries to Lower Limb W/O Catastrophic or Severe CC	D		0	5	1.4		0.7302	0.7302	0.0000	0.7302	0.2040	0.1632
X05A	Other Procedures for Injuries to Hand W CC	D		0	8	2.5		1.0132	1.0132	0.0000	1.0132	0.1807	0.1446
X05B	Other Procedures for Injuries to Hand W/O CC	D		0	3	1.1		0.5024	0.5024	0.0000	0.5024	0.1430	0.1144
X06A	Other Procedures for Other Injuries W Catastrophic or Severe CC	D		2	21	5.9		0.8614	1.2340	0.3726	1.9792	0.1779	0.1423

WIES21 2014–15 Victorian cost weights														
Victorian Modified AR-DRG 7.0x														
Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
X06B	Other Procedures for Other Injuries W/O Catastrophic or Severe CC	D		1	10	2.9	One day	0.5597	0.5597	0.0000	1.1738	0.1839	0.1471
X07A	Skin Graft for Injuries Excl Hand W Microvascular Tiss Trans or W Cat/Sev CC	D		3	33	10.8		1.1279	1.5187	0.5211	3.0821	0.1522	0.1217
X07B	Skin Graft for Injuries Excl Hand W/O Microvascular Tiss Trans W/O Cat/Sev CC	D		1	13	4.3		0.9158	1.4090	0.0000	1.4090	0.1590	0.1272
X40Z	Injuries, Poisoning and Toxic Effects of Drugs W Ventilator Support	D		1	15	4.6		1.2433	2.4749	0.0000	2.4749	0.3621	0.2897
X60A	Injuries W Catastrophic or Severe CC	D		1	13	4.0	Same day	0.2894	0.9991	0.0000	0.9991	0.2016	0.1613
X60B	Injuries W/O Catastrophic or Severe CC	D		0	5	1.5	Same day	0.2443	0.4781	0.0000	0.4781	0.2612	0.2090
X61Z	Allergic Reactions	D		0	4	1.2	Same day	0.1661	0.4295	0.0000	0.4295	0.2842	0.2274
X62A	Poisoning/Toxic Effects of Drugs and Other Substances W Cat or Sev CC	D		1	13	4.1	One day	0.5561	0.5561	0.0000	1.6364	0.3187	0.2550
X62B	Poisoning/Toxic Effects of Drugs and Other Substances W/O Cat or Sev CC	D		0	4	1.4	Same day	0.1916	0.4808	0.0000	0.4808	0.2795	0.2236
X63A	Sequelae of Treatment W Catastrophic or Severe CC	D		1	16	4.4	Same day	0.2680	1.2732	0.0000	1.2732	0.2336	0.1869
X63B	Sequelae of Treatment W/O Catastrophic or Severe CC	D		0	7	1.9	Same day	0.1991	0.6179	0.0000	0.6179	0.2595	0.2076

Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x													
X64A	Other Injuries, Poisonings and Toxic Effects W Catastrophic or Severe CC	D		1	12	3.6	Same day	0.2657	1.3351	0.0000	1.3351	0.2936	0.2349
X64B	Other Injuries, Poisonings and Toxic Effects W/O Catastrophic or Severe CC	D		0	4	1.2	Same day	0.2288	0.4344	0.0000	0.4344	0.2816	0.2253
Y01Z	Vent >=96hrs or Trach for Burns or OR Procs for Severe Full Thickness Burns	4		33	75	57.5		10.4366	10.9031	0.9047	40.7574	0.3621	0.2897
Y02A	Skin Grafts for Other Burns W Catastrophic or Severe CC	D		5	49	18.9		1.5199	1.9821	0.7396	5.6799	0.1716	0.1373
Y02B	Skin Grafts for Other Burns W/O Catastrophic or Severe CC, Emergency	D		4	36	13.9		1.0869	1.4681	0.5718	3.7554	0.1535	0.1228
Y02C	Skin Grafts for Other Burns W/O Catastrophic or Severe CC, Non Emergency	D		0	8	2.0		0.9439	0.9439	0.0000	0.9439	0.1712	0.1370
Y03Z	Other OR Procedures for Other Burns	D		2	24	6.4	One day	0.5413	0.5413	0.6675	1.9190	0.2308	0.1847
Y60Z	Burns, Transferred to Acute Facility <5 Days	D		0	4	1.1		0.4840	0.4840	0.0000	0.4840	0.3585	0.2868
Y61Z	Severe Burns	D		1	9	2.2		0.3850	0.7700	0.0000	0.7700	0.3575	0.2860
Y62A	Other Burns W CC	D		1	18	4.6		0.6802	1.3605	0.0000	1.3605	0.2931	0.2345
Y62B	Other Burns W/O CC	D		0	8	1.9		0.5432	0.5432	0.0000	0.5432	0.2809	0.2247
Y62C	Other Burns, Sameday	D		0	3	1.0		0.1980	0.1980	0.0000	0.1980	0.1980	0.1584
Z01A	Other Contacts W Health Services W OR Procedures	D		1	11	2.5		0.7736	1.0972	0.0000	1.0972	0.2592	0.2074

WIES21 2014–15 Victorian cost weights

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Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
Z01B	Other Contacts W Health Services W OR Procedures, Sameday	D		0	3	1.0		0.4323	0.4323	0.0000	0.4323	0.1497	0.1197
Z40Z	Other Contacts W Health Services W Endoscopy, Sameday	D		0	3	1.0		0.2298	0.2298	0.0000	0.2298	0.0931	0.0745
Z60Z	Rehabilitation	D		4	11	7.1		0.1429	0.2857	0.2143	1.1430	0.1294	0.1035
Z61A	Signs and Symptoms	D		1	16	4.7	One day	0.3937	0.3937	0.0000	1.2072	0.2055	0.1644
Z61B	Signs and Symptoms, Sameday	D		0	3	1.0		0.2209	0.2209	0.0000	0.2209	0.1767	0.1414
Z63A	Other Follow Up After Surgery or Medical Care W Catastrophic CC	D		3	30	9.4		0.3005	0.6010	0.4007	1.8030	0.1910	0.1528
Z63B	Other Follow Up After Surgery or Medical Care W/O Catastrophic CC	D		2	19	5.3	One day	0.2104	0.2104	0.3064	0.8232	0.1563	0.1251
Z64A	Other Factors Influencing Health Status	D		2	21	6.0	One day	0.4442	0.4442	0.3368	1.1178	0.1497	0.1198
Z64B	Other Factors Influencing Health Status, Sameday	D		0	3	1.0		0.2027	0.2027	0.0000	0.2027	0.1622	0.1297
Z65Z	Congenital Anomalies and Problems Arising from Neonatal Period	D		0	6	1.3		0.4242	0.4242	0.0000	0.4242	0.2560	0.2048
Z66Z	Sleep Disorders	D		0	4	1.5		0.4383	0.4383	0.0000	0.4383	0.2284	0.1827
801A	OR Procedures Unrelated to Principal Diagnosis W Catastrophic CC	D		4	43	14.5		1.1620	1.7016	0.8093	4.9387	0.2079	0.1663

WIES21 2014–15 Victorian cost weights Victorian Modified AR-DRG 7.0x Code	Label	Mech. Vent Co-payment	Other Co-payment	Inlier Low	Boundary High	Average Inlier Stay	Same/ One day DRG	Same day weight	One day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
801B	OR Procedures Unrelated to Principal Diagnosis W Severe or Moderate CC	D		1	14	4.4		1.3261	2.1332	0.0000	2.1332	0.2583	0.2067
801C	OR Procedures Unrelated to Principal Diagnosis W/O CC	D		0	4	1.3		0.8127	0.8127	0.0000	0.8127	0.2018	0.1614
960Z	Ungroupable	I		0	0	0.0		0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
961Z	Unacceptable Principal Diagnosis	I		0	0	0.0		0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
963Z	Neonatal Diagnosis Not Consistent W Age/Weight	I		0	0	0.0		0.0000	0.0000	0.0000	0.0000	0.0000	0.0000

2.22 Subacute service capability framework levels and health services alignment 2014–15

Table 2.19: Subacute services – level 4

	Admitted subacute		Health Independence Programs														Non-acute care
Health services	**GEM**	**Rehabilitation**	**Centre-based**	**Home-based**	**CDAMS**	**Continence**	**Fall and Balance**	**Chronic Pain**	**Chronic Wound**	**Movement Disorders**	**Young Adult Transition**	**VPRS**	**HARP**	**HARP HIV**	**PAC**	**RIR**	**Transition Care Program**
Alfred Health	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓			✓	✓
Austin Health	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓		✓	✓	✓
Calvary – Bethlehem	✓		✓	✓													
Eastern Health	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓		✓	✓	✓
Melbourne Health	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓
Mercy Public Hospital Inc. (Werribee)	✓	✓	✓	✓		✓	✓						✓		✓	✓	✓
Monash Health	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Northern Health	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓		✓	✓	✓
Peninsula Health	✓	✓	✓	✓	✓	✓	✓	✓		✓			✓		✓	✓	✓
St Vincent's Health	✓	✓	✓	✓	✓	✓	✓	✓			✓		✓	✓		✓	✓

	Admitted subacute		Health Independence Programs														Non-acute care
Health services	GEM	Rehabilitation	Centre-based	Home-based	CDAMS	Continence	Fall and Balance	Chronic Pain	Chronic Wound	Movement Disorders	Young Adult Transition	VPRS	HARP	HARP HIV	PAC	RIR	Transition Care Program
The Royal Children's Hospital		✓						✓				✓	✓		✓		
Western Health	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓		✓	✓	✓
Albury Wodonga Health	✓	✓	✓	✓	✓	✓	✓	✓					✓		✓		
Ballarat Health Services	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓		✓	✓	✓
Barwon Health	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓
Bendigo Health	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Goulburn Valley Health	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓		✓	✓	✓
Latrobe Regional Hospital	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓		✓	✓	✓

Table 2.20: Subacute services – level 2 and 3

	Admitted subacute		Health Independence Program								Non-acute care	
Health services	GEM	Rehabilitation	Centre-based	Home-based	CDAMS	Continence	Fall and Balance	HARP	PAC	RIR	Maintenance Care	Transition Care Program
Bass Coast Regional Health	✓	✓	✓	✓		✓	✓	✓	✓	✓		
Bairnsdale Regional Health Service	✓	✓	✓	✓		✓	✓	✓	✓	✓		
Castlemaine Health	✓	✓	✓	✓				✓	✓			
Central Gippsland Health Service	✓	✓	✓	✓			✓	✓	✓	✓		
Echuca Regional Health	✓	✓	✓	✓		✓	✓	✓	✓	✓		
Mildura Base Hospital	✓	✓	✓	✓	✓			✓	✓	✓		✓
Northeast Health Wangaratta	✓	✓	✓	✓	✓	✓		✓	✓	✓		
South West Healthcare – Warrnambool	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Swan Hill District Hospital			✓	✓		✓	✓	✓	✓		✓	
Western District Health Service	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
West Gippsland Healthcare Group	✓		✓	✓	✓	✓		✓	✓	✓		
Wimmera Health Care Group	✓	✓	✓	✓		✓	✓	✓	✓	✓		
Benalla & District Memorial Hospital			✓	✓				✓	✓		✓	
Colac Area Health			✓	✓				✓	✓		✓	
Djerriwarrih Health Services			✓	✓								
East Grampians Health Service								✓			✓	
Gippsland Southern Health Service											✓	
Kyabram and District Hospital											✓	
Maryborough District Health Service								✓			✓	
Portland District Hospital			✓	✓				✓	✓		✓	✓
Stawell Regional Health			✓	✓				✓	✓		✓	

Table 2.21: Statewide specialist subacute services – level 5

Service	Health service providers
Neurodegenerative	Calvary Health Care Bethlehem
Paediatric rehabilitation	The Royal Children's Hospital, Monash Children's Hospital
Specialist ABI rehabilitation	Austin Health and Alfred Health
Specialist burns rehabilitation	Alfred Health
Specialist spinal rehabilitation	Austin Health and Alfred Health
Polio	St Vincent's Hospital

Notes:

Current program funding and service provision should be considered in the context of the subacute Service capability framework. *See <www.health.vic.gov.au/subacute/pubs>.*

Tables provide an overview of subacute services expected to be delivered by individual health services in 2014–15.

Only SRHS will be funded for public NHT.

Health services designated to provide specialist statewide (level 5) services will provide all other subacute services as level 4.

Amputee rehabilitation is expected to be provided in all level 4 and above rehabilitation services only.

Cobram District Health, Seymour Health and Yarram and District Health Service are funded to provide home- and centre-based rehabilitation and PAC as level 2. Seymour Health is funded to provide HARP. Mildura Cognitive, Dementia and Memory Services are provided at Sunraysia Community Health, with support from Bendigo Health.

Alfred Health and St Vincent's Health are supported by a PAC service funded at Inner South and North Richmond Community Health Services.

Penshurst campus of Western District Health Service is approved to report maintenance care.

Health services are authorised to operate the TCP in agreement with the department. Where authorised TCP service providers enter into agreement with another hospital in their region to enable local access to TCP, then this hospital is referred to as the partnership site. There are 34 partnerships across the Gippsland, Grampians, Hume and Loddon Mallee regions.

2.23 Outputs and activities tables

Table 2.22: 2014–15 mental health – outputs and activities

Activity no.	Activity name	Activity description
Clinical care		
A range of inpatient, residential and community-based clinical services provided to people with a mental illness and their families so that those experience mental health problems can access timely, high-quality care and support to recover and live successfully in the community.		
15005	Crisis assessment and treatment	24-hour, seven-day-a-week mobile crisis services that provide effective assessment and treatment throughout the community to people in crisis due to a mental illness. This includes assessing the most effective and least restrictive client service options and screening all inpatient bed admissions.
15006	Community care units	Community care units are purpose-built units of up to 20 beds located in community settings with 24-hour staffing. They are designed for adults who require longer term support, on-site clinical services and individualised rehabilitation.
15007	Adult continuing care	A range of community-based services that provide assessment, treatment and additional continuing care and case management for adults with a mental illness.
15008	Adult integrated community service	An integrated range of services that meet the client's treatment needs, ensuring the efficient and effective provision of community-based mental health services.
15012	Acute care – adult	Acute inpatient units provide for the short-term assessment, treatment and management of mentally ill adults aged 15–65. The focus is on interventions designed to reduce symptoms and promote recovery from mental illness.
15014	Secure extended care – adult	Long-term inpatient treatment and support for adults aged 15–65 years who have unremitting and severe symptoms, together with an associated significant disturbance in behaviour that inhibits the client's capacity to live in the community.
15019	Aged persons mental health community teams	Mobile services that provide assessment, treatment, rehabilitation and case management for people with a mental illness primarily over 65 years of age.
15022	Acute care – aged	Inpatient units providing short-term assessment and treatment for older people aged 65 and over with acute symptoms of mental illness who cannot safely be cared for in the community.
15026	Child and adolescent assessment treatment	A range of services including crisis assessment, case management, individual or group therapy, family therapy, parent support and medication-based treatments for children and adolescents experiencing significant psychological distress and/or mental illness. Services support a timely response to referrals, including crises referrals, delivered on an outreach basis, where appropriate.
15028	Intensive youth support	Mobile intensive mental health case management and support to adolescents who display substantial and prolonged psychological disturbance and/or have complex needs that may include challenging, at-risk and suicidal behaviours, and who have been difficult to engage through less-intensive treatment approaches.

Activity no.	Activity name	Activity description
15030	Acute care – specialist statewide	A range of specialist clinical inpatient mental health assessment, treatment or consultancy services that support specific and/or general target groups on a statewide, inter-regional or specific catchment area basis. The focus of these inpatient services is on providing clinical services to people with a mental illness.
15031	Acute care – child and adolescent	Inpatient units provide short-term psychiatric assessment and/or treatment for children and adolescents with a severe psychological disturbance who cannot be effectively assessed or treated in a less-restrictive community-based setting.
15032	Forensic community service	Provides community-based assessment and multidisciplinary treatment services to high-risk clients referred from a range of criminal justice agencies, mental health services and private practitioners. Also provides secondary consultations and specialist training to area mental health services.
15041	Acute care – forensic	Inpatient services for assessing, diagnosing and treating the crisis and acute phases of mentally disturbed offenders referred by the courts, prison system, police and general mental health services.
15049	Aged persons mental health nursing home supplement	Community residential services for aged clients who cannot be managed in the general residential system due to their level of persistent cognitive, emotional or behavioural disturbances. Services include long-term accommodation, ongoing assessment, treatment and care of residents, rehabilitation and respite care.
15054	Training – statewide	All activities associated with training and staff development.
15057	Prevention and recovery care	PARC subacute clinical bed-based treatment services for people with a significant mental health problem requiring pre-crisis or post-acute treatment and support. PARC assists in averting acute inpatient admission and facilitates earlier discharge from inpatient units. It is not a substitute for inpatient admission.
15058	Rural workforce initiative	Funding to be used to access specialist opinion, particularly on aged and child- and adolescent-related issues, and to access professional supervision for senior clinical staff – all of which is unavailable within the area mental health service.
15060	Homeless outreach psychiatric services	Outreach services that provide assessment, treatment, rehabilitation and case management for homeless people with a mental illness. Also includes secondary consultation and support to the homelessness service sector.
15070	Academic positions – health Services	All activities associated with specified academic positions attached to tertiary institutions, regardless of the location of the position.
15071	Training – graduate year training	Funding provided to health services to support nurses and allied health staff participating in specialist mental health graduate-year programs for training, supervision, backfill and subsidy to enable reduced clinical loads during the orientation phase.
15072	Training – adult	All adult mental health service activities associated with training and staff development for Department of Health and funded agency staff.
15073	Training – aged person	All older persons mental health service activities associated with training and staff development for Department of Health and funded agency staff.

Activity no.	Activity name	Activity description
15200	Community specialist statewide services	A range of specialist clinical community mental health assessment, treatment or consultancy services that support specific and/or general target groups on a statewide, inter-regional or specific catchment area basis. The focus of these community services is on providing clinical services to people with a mental illness.
15203	Statewide support – clinical services	A range of services including resourcing to the clinical mental health service system on a statewide, inter-regional or specific-purpose basis.
15250	Aged persons mental health hostel supplement	Hostel-based community residential services for aged clients who cannot be managed in the general residential system due to their level of persistent cognitive, emotional or behavioural disturbances. Services include: long-term accommodation; ongoing assessment, treatment and care of residents; low-level nursing home or hostel care; and rehabilitation and respite care.
15251	Consultation and Liaison	Consultation liaison psychiatry is the diagnosis, treatment and prevention of psychiatric morbidity among physically ill patients who are patients of an acute general hospital. This activity includes providing a psychiatric assessment, consultation, liaison and education services to non-psychiatric health professionals and their clients/patients.
15252	Primary mental health	Primary mental health teams provide short-term treatment, crisis prevention and early intervention in psychosis to people with high-prevalence disorders, especially depression and anxiety. Consultation and liaison, education and training are also provided to primary services. Clinical mental health services provide day-to-day management and clinical support to teams while the strategic management is carried out in partnership with clinical services, community health services, divisions of general practice and mental health community support services.
15255	Short term rehabilitation – forensic	Inpatient services for assessment, diagnosis and treatment that supports rehabilitating offenders with a mental illness referred by the courts, prison system, police and general mental health services.
15262	Prevention and promotion	The development and delivery of mental health promotion and the prevention of mental health problems and disorders.
15264	Consumer participation	Participation of consumers, which may include employing consumer consultants to provide input into service planning, development and evaluation, establishing consumer networks and becoming involved in consumer participation plans for area mental health services.
15265	Ethnic consultants	Strategies that increase the accessibility of mental health services for people from CALD backgrounds, such as the development and implementation of strategic plans for providing culturally sensitive services, and for establishing and maintaining partnerships with ethnic community groups and bilingual health workers.
15267	Research and evaluation	All activities associated with academic appointments, research and evaluation.
15272	Quality incentive strategy	Financial incentives for service quality in adult, aged persons and child and adolescent mental health services. The QIS includes measures of consumer and carer satisfaction, service responsiveness and timeliness of data reporting.
15274	Carer support program	Individualised support for carers of people with a mental illness to respond to, or prevent, a crisis. Includes carer consultation and carer support programs.

Activity no.	Activity name	Activity description
15275	Carer support program – brokerage	The Mental Health Carer Support Fund Brokerage comprises discretionary funds accessed by carers of people with a mental illness receiving treatment from area mental health services and a selection of statewide specialist services. The funds meet some of the direct and indirect costs related to the caring role to promote and sustain a caring relationship.
15300	Conduct disorder program	Services that provide prevention programs for children and young people at risk and clinical services for those with established conduct disorder.
15320	Early psychosis program	Specialist treatment and improved continuity of care services for young people with an emerging disorder, particularly co-existing substance abuse problems.
15321	Koori liaison officers	All activities associated with the mental health Koori liaison positions.
15350	Community specialist statewide services – mother–baby	A range of specialist clinical community mental health assessment, treatment or consultancy services that support mother–baby groups on a statewide, inter-regional or specific catchment area basis. The focus of these community services is on providing clinical services to people with a mental illness.
15351	Community specialist statewide services – eating disorders	A range of specialist clinical community mental health assessment, treatment or consultancy services that support eating disorder groups on a statewide, inter-regional or specific catchment area basis. The focus of these community services is on providing clinical services to people with a mental illness.
15352	Aged persons intensive community treatment	Short-term assessment and treatment for people aged 65 years or older with acute symptoms of a mental illness, delivered in community settings.
15353	Acute care – mother–baby	A range of specialist clinical inpatient mental health assessment, treatment or consultancy services that support mother–baby groups on a statewide, inter-regional or specific catchment area basis. The focus of these inpatient services is on providing clinical services to people with a mental illness.
15354	Acute care – eating disorders	A range of specialist clinical inpatient mental health assessment, treatment or consultancy services that support eating disorder groups on a statewide, inter-regional or specific catchment area basis. The focus of these inpatient services is on providing clinical services to people with a mental illness.
15355	Emergency department crisis assessment	Extended-hours coverage in EDs for mobile crisis services that provide effective assessment and treatment throughout the community to people in crisis due to a mental illness.
15356	Community specialist statewide services – Koori	A range of specialist clinical community mental health assessment, treatment or consultancy services that support Indigenous groups on a statewide, inter-regional or specific catchment area basis. The focus of these community services is on providing clinical services to people with a mental illness.
15357	Community specialist-statewide services – non-government	A range of specialist clinical community mental health assessment, treatment or consultancy services delivered by non-government organisations that support groups on a statewide, inter-regional or specific catchment area basis. The focus of these community services is on providing clinical services to people with a mental illness.
15358	Training – child and adolescent	All child and adolescent mental health service activities associated with training and staff development for departmental and funded agency staff.

Activity no.	Activity name	Activity description
15359	System capacity development – non-government	These are block grants provided for a specified purpose or as a contribution towards a program that assists with developing system capacity. They exclude funding for clinical positions.
15361	Academic positions – other	All activities associated with specified academic positions attached to tertiary institutions, regardless of the location of the position.
15362	Workforce support	Specialist clinical inpatient mental health assessment and short-term admission and treatment services that support neuropsychiatric disorders on a statewide, inter-regional or specific catchment area basis.
15363	Community specialist statewide – neuropsychiatry	A range of specialist clinical community mental health assessment, treatment or consultancy services that support neuropsychiatry groups on a statewide, inter-regional or specific catchment area basis. The focus of these community services is on providing clinical services to people with a mental illness.
15364	Acute care – neuropsychiatry	A range of specialist clinical inpatient mental health assessment, treatment or consultancy services that support neuropsychiatry groups on a statewide, inter-regional or specific catchment area basis. The focus of these inpatient services is on providing clinical services to people with a mental illness.
15365	National Perinatal Depression Initiative	The intention of the plan is to improve early detection of antenatal and postnatal depression and to provide better support and treatment for expectant and new mothers experiencing depression.
15366	Youth suicide prevention	Youth suicide prevention programs aim to reduce suicide among young people aged 10–25 years. Programs provide preventative support, activities and early intervention services to the young person, their family and friends and the broader community.
Mental health community support services		
A range of rehabilitation and support services provided to youth and adults with a psychiatric disability, and their families and carers, so that those experiencing mental health problems can access timely, high-quality care and support to recover and reintegrate into the community.		
15061	Care coordination	Care coordination supports recovery and addresses social exclusion of clients with a severe mental illness and multiple needs by coordinating care and providing practical support to access the range of mental and general health and social support services.
15062	Home-based outreach support – standard	Standard home-based outreach services that provide support to the core MHCSS client group living in their own homes, whether that be rental or privately owned accommodation, or supported accommodation.
15063	Home-based outreach support – moderate	Moderate home-based outreach services that provide support to the core MHCSS client group living in their own homes, whether that be rental or privately owned accommodation, or supported accommodation.
15064	Psychosocial rehabilitation day programs – drop-in	Psychosocial rehabilitation drop-in day programs assist people with a severe psychiatric disability to improve their quality of life by participating in recreational, social, educational and vocational activities.
15065	Psychosocial rehabilitation day programs – standard integrated	Psychosocial rehabilitation standard integrated day programs help people with a severe psychiatric disability to improve their quality of life by participating in recreational, social, educational and vocational activities. Standard integrated day programs provide a combination of both drop-in and structured activities and may be either centre-based or community- or home-based.

Activity no.	Activity name	Activity description
15066	Psychosocial rehabilitation day programs – statewide and specialist	Psychosocial rehabilitation specialist programs help people with a severe psychiatric disability to improve their quality of life by participating in specialist recreational, social, educational and vocational activities. Specialist day programs services can be provided on a regional, inter-regional or statewide basis.
15067	Planned respite – in home	In-home planned respite services help sustain existing relationships between people with a mental illness and their carers by providing a short-term respite at home.
15068	Planned respite – community	Community planned respite services assist in sustaining existing relationships between people with a mental illness and their carers by providing a short-term respite in the community.
15069	Planned respite – residential	Residential planned respite services assist in sustaining existing relationships between people with a mental illness and their carers by providing a short-term respite in a residential situation.
15074	Training –MHCSS	Includes all MHCSS mental health service activities associated with training and staff development of funded agency staff. It also includes training for participants of funded agencies and their carers. It does not include training provided as part of a mutual support and self-help service or as part of a community development function of any MHCSS funded agency.
15075	PDRSS carer support	Psychiatric disability rehabilitation carer support includes those services and programs that have as their primary client the carer of a person with a mental illness, and that do not fit into the components of 'planned respite' or 'mutual support self-help'.
15076	MHCSS centrally funded support	Funded provided by central office for MHCSS services on a specific-purpose grant.
15077	Residential rehabilitation support	Support services provided to residential rehabilitation clients either within the residential service or at another site.
15078	Residential rehabilitation – 24-hour	Residential rehabilitation services staffed on site on a 24-hour basis provide medium- to long-term transitional accommodation with rehabilitation support, prior to the client living in their own accommodation.
15079	Residential rehabilitation – non-24-hour	Residential rehabilitation services staffed on other than an onsite 24-hour basis provide medium- to long-term transitional accommodation with rehabilitation support, prior to the client living in their own accommodation.
15082	Aged intensive support	Intensive home- and centre-based support for people aged 65 years or older.
15086	Special client packages	One-off packages negotiated to support individual clients with exceptional needs. These are negotiated either by the department's head office or regional offices.
15088	PDRSS regional special needs grant	Time-limited funding provided by regions as assistance to agencies to fund participation in local or national events or to support a flexible response to a particular client or clients with high needs. Flexible funding responses to high-needs clients may include minor capital purchases on behalf of the client – for example, furniture.
15090	Psychosocial rehabilitation day programs – high cost Integrated	High-cost integrated day programs provide a combination of both drop-in and structured activities and may be centre-, community- or home-based and comprises the residual funding left at some agencies following allocation of funding to integrated day programs.

Activity no.	Activity name	Activity description
15091	MSSH statewide specialist availability grant	Availability grants are only provided to statewide specialist mutual support self-help (MSSH) organisations. This is a block grant that encompasses two of the five core MSSH activities: individual support, referral and advocacy; and information development and dissemination.
15092	MSSH individual support referral and advocacy	Direct contacts between the service provider and the client for the purpose of information and advice, including referral and one-to-one support. Clients include those with a mental illness, their carers or friends and family members and health professionals.
15093	MSSH information development and dissemination	Costs associated with developing primary reference material. Does not include the dissemination of existing materials developed by other organisations to clients in the course of normal business. Can include website development costs, writing and so on.
15094	MSSH groups support	Facilitated support groups conducted for clients with a mental illness, their carers or friends or family members.
15095	MSSH groups – education and training	This refers to groups conducted to provide training and/or information and education for members of the general public and/or health professionals.
15096	MSSH volunteer coordination	Volunteer coordination refers to those activities associated with recruitment and training/education and support and management of volunteers.
15097	Supported accommodation – 24-hour support model	Staff provide on-site support 24 hours a day, seven days a week. This type of model is generally delivered in a larger facility. Under this model residents normally have their own bedroom but may share bathroom facilities and communal areas such as a lounge and kitchen.
15098	Supported accommodation – non 24-hour support	Support is provided either in a cluster environment on the same site or in units and houses located within close geographic proximity. Support is provided during standard work hours (9 am to 5 pm, Monday to Friday) as well as after-hours, weekend and on-call support.
15099	ACCO services – mental health	Funding for those mental health services provided by Aboriginal community-controlled organisations.
15100	NPA supporting national mental health reform	The *National partnership agreement supporting mental health reform* targets people who are severely mentally ill and who are chronically homeless and provides MHCSS managed community support, clinical treatment and access to accommodation.
15266	Statewide support – MHCSS	A range of specialist clinical community mental health assessment, treatment or consultancy services that support specific and/or general target groups on a statewide, inter-regional or specific catchment area basis. The focus of these community services is on providing clinical services to people with a mental illness.
15451	Home-based outreach support – intensive	Intensive home-based outreach services provide support to a small proportion of complex MHCSS clients who require significant additional contact and indirect service living in their own homes, whether that be rental or privately owned accommodation, or supported accommodation.
15500	Individualised client support packages	Individualised client support packages refers to the range of non-bed-based supports a client receives based on their recovery plan.
15501	Community intake assessment function	The community intake assessment function determines and prioritises client eligibility for MHCSS.

Activity no.	Activity name	Activity description
15502	Catchment-based planning function	The catchment-based planning function enables catchment-based MHCSS providers to develop a common plan identifying service gaps and strategies to address these, improve cross-sector coordination and enable effective participation in service coordination and planning platforms.
15503	Youth residential rehabilitation – 24 hour	Youth residential rehabilitation provides transitional accommodation with rehabilitation support. Support is provided at the facility 24 hours a day, seven days a week.
15504	Youth residential rehabilitation – non-24 hour	Youth Residential Rehabilitation provides transitional accommodation with rehabilitation support. Support is provided at the facility on a non-24-hour basis.

Table 2.23: 2014–15 drug services – outputs and activities

Activity no.	Activity name	Activity description
Drug prevention and control		
Encourages all Victorians to minimise the harmful effects of illicit and licit drugs, including alcohol, by providing a comprehensive range of strategies that focus on enhanced community and professional education, targeted prevention and early intervention, and the use of effective regulation.		
34001	Family counselling	Provides for the delivery of counselling to families with a drug-affected member.
34002	Licensing/regulation	To provide controls over availability of drugs and poisons and treatment of patients with drugs.
34003	Poisons information	Provides information and advice to the public on drugs and poisons, especially following exposure.
34004	Client information and support	To help provide mutual support and information for people with alcohol and drug problems.
34006	Targeted interventions	To deliver initiatives according to targeted needs designed to prevent or reduce hazardous behaviour in relation to substance use.
34009	Alcohol Information – Advice and Interventions	To provide strategic directions and advice to government on alcohol policy, issues and trends and provide information to the Victorian community about alcohol.
34010	Statewide support – drug prevention	A range of services including resourcing to the drug prevention and control service system on a statewide, inter-regional or specific-purpose basis.
34020	Community education	To provide different groups in the community with information about the impacts and consequences of substance use and, in the case of parents, to resource them to inform their children about substance use issues.
34021	Local initiatives	To resource local government and communities to implement prevention and intervention programs and projects designed to support local stakeholders, business, residents and communities.
34070	Needle and syringe program	To make sterile injecting equipment available to injection drug users, promote safe disposal, promote safer injecting practices and provide information, education and referral.
34100	Pharmacotherapy development	Pharmacotherapy development.

Activity no.	Activity name	Activity description
Drug treatment and rehabilitation		
Assists the community and individuals to control and reduce the harmful effects of illicit and licit drugs, including alcohol, in Victoria through providing: community-based services; non-residential and residential treatment services; education and training; and support services.		
34022	Capacity building	To implement projects designed to strengthen the community's ability to respond to alcohol and drug issues.
34023	Professional development	To provide information, training, consultancy, curriculum development and/or training needs analysis for the range of workers dealing with clients with alcohol and drug problems.
34024	Education and training	To provide information, training, consultancy, curriculum and/or training needs analysis for workers dealing with clients with alcohol and drug problems, and/or to provide education to alcohol and drug treatment clients, or prior learning and/or recognition.
34025	Research, service development, evaluation	To develop and enhance high-quality public health research into: drug and alcohol issues including targeted and general population surveys; risk and protective factors; the effects of alcohol and drug use; and evaluating services. This is designed to enable findings to inform policy, planning and practice.
34040	Education (FOCiS)	To provide a drug education program for people requiring it as a condition of their sentence for possessing a small amount of illicit drugs. This is aimed at increasing the likelihood of the person maintaining behaviour that reduces drug-related harm.
34041	Youth day program	To support young people who are currently involved in treatment with youth alcohol and drug treatment service(s) and to complement these services in order to provide a pathway for the client following treatment.
34042	Community offenders advice and treatment	To provide post-sentence assessments and treatment plans for offenders who have received a court-imposed community-based disposition. To provide pre-sentence assessments (in exceptional circumstances) as ordered by the court and treatment plans for offenders whose offending is related to drug use. To provide pre-release assessment and treatment plans on release for prisoners on parole with an alcohol and drug treatment condition and offenders who have received a custody and community treatment order. To purchase appropriate treatment from alcohol and drug agencies for offenders who have received a community-based disposition with an alcohol and drug treatment condition.
34043	Alcohol and drug supported accommodation	To provide support to clients in short-term accommodation who require assistance in controlling their alcohol and drug use.
34044	Ante- and postnatal support	To provide inpatient, outpatient, distance case management and secondary consultation activities. This aimed at minimising the harms of alcohol and drug use to mothers and their children.
34045	Koori community alcohol and drug resource centres	To provide a high level of support to ensure a client satisfactorily and safely reduces their level of alcohol or other drug intoxication. To provide clients with options and linkages to after-care support. To provide the community with education and information about alcohol and drugs.
34046	Youth alcohol and drug supported accommodation	To provide support in short-term accommodation to those who require assistance in controlling their alcohol and drug use.

Activity no.	Activity name	Activity description
34047	Specialist pharmacotherapy program	To provide specialist assessment and treatment for people receiving methadone who have complex medical, psychiatric or psychosocial problems and to provide training and consultancy services for relevant health practitioners.
34048	Outdoor therapy	To coordinate case managed, therapeutic wilderness adventures for young people aged 12–21 years who have alcohol and drug issues, and facilitate wilderness adventure skills in the alcohol and drug sector.
34049	Koori community alcohol and drug worker	To provide a range of culturally appropriate activities targeted to Aboriginal communities involving health promotion, education, information provision and emotional wellbeing. To facilitate harm minimisation for individuals, families and communities related to the impact of alcohol and drug use through providing counselling and group activities. To achieve and maintain behavioural changes in Aboriginal people with alcohol and drug problems.
34050	Adult residential drug withdrawal	To provide a high level of support to ensure a client satisfactorily and safely completes drug withdrawal treatment.
34053	Adult residential rehabilitation	To provide a residential treatment program for clients with serious and entrenched drug misuse to achieve significant reduction in drug-related harm.
34054	Peer support	To provide mutual support and information for people with alcohol and drug problems.
34056	Youth residential drug withdrawal	To provide a short-term drug withdrawal, time out and intensive support residential service for young people aged 12–21 years in a physically and emotionally safe, drug-free environment within a multidisciplinary, psycho-social health framework.
34057	Pharmacotherapy regional outreach	To support and enhance the role of trained general practitioners and dispensers of drug substitute pharmacotherapies in encouraging, recruiting and retaining opiate-dependent people in drug substitution programs.
34058	Parent support program	To provide therapeutic programs for families of drug users that provide support and information about drugs, adolescent development, risk and protective factors and a means of assisting with rehabilitation.
34059	Post-residential workers	To provide linkages support and referral to meet the needs of clients that have recently completed drug withdrawal and other drug treatment.
34060	Intensive community rehabilitation	To provide a residential treatment program for young clients with serious and entrenched drug misuse to achieve significant reduction in drug-related harm.
34061	Mobile drug safety	To provide education on drug safety to drug users and to refer users for treatment and rehabilitation.
34062	Mobile overdose response	To provide counselling, information and support to non-fatal overdose clients and facilitate access to treatment and support services.
34064	Youth home-based withdrawal	To provide a safe and effective drug withdrawal in a home-based setting with medical, pharmacotherapy and supportive care.
34065	Women's alcohol and drug supported accommodation	To provide support to women in short-term accommodation who require assistance in controlling their alcohol and drug use.
34066	Rural withdrawal	To provide a safe and effective drug withdrawal in a rural community setting with medical, pharmacotherapy and supportive care.

Activity no.	Activity name	Activity description
34068	Home-based withdrawal	To provide a safe and effective drug withdrawal in a home-based setting with medical, pharmacotherapy and supportive care.
34069	Homeless and drug dependency capacity building	To provide secondary consultation, health promotion, training and direct support services to strengthen the capacity of Supported Accommodation Assistance Program (SAAP)-funded crisis supported accommodation services to mitigate the effect of various harms caused by drug dependency among their residents.
34071	Youth outreach	To make sterile injecting equipment available for injecting drug users, to promote safe disposal, to promote safer injecting practices and to provide information, education and referral.
34074	Counselling consultancy and continuing care	To provide a range of services and support to clients (adult and/or youth) who need assistance to control their alcohol and drug use.
34075	Outpatient withdrawal	To provide safe and effective drug withdrawal for clients (adult and/or youth) in an outpatient setting with medical, pharmacotherapy and supportive care.
34076	Statewide support – drug treatment and rehabilitation	A range of services, including resourcing to the drug treatment and rehabilitation service system on a statewide, inter-regional or specific-purpose basis.
34077	AOD treatment program special needs funding	Discretionary funds provided to regions for the alcohol and other drug (AOD) treatment program.
34078	ACCO services – drug services	Funding for those drugs services provided by Aboriginal community-controlled organisations.
34079	Koori Youth Alcohol and Drug Healing Service	To provide a residential program for young Aboriginal people to address alcohol and other drug problems by assisting changes in behaviour through a variety of culturally appropriate counselling and educational activities.
34080	Youth residential rehabilitation	To provide a residential treatment program for young clients with serious and entrenched drug misuse by assisting changes in behaviour through a variety of counselling and therapeutic activities.
34081	Workforce education and training	To provide workforce development education, information, training and consultancy for workers dealing with clients with alcohol and drug problems, and/or to provide education to alcohol and drug treatment clients.
34082	HDDP supported accommodation	To provide support to clients in short-term accommodation who require assistance in controlling their alcohol and drug use through the Homeless Drug Dependency Program.
34083	HDDP residential drug withdrawal	To provide a high level of support to ensure a client satisfactorily and safely completes drug withdrawal treatment through the Homeless Drug Dependency Program.
34084	Therapeutic counselling	Therapeutic counselling, consultancy and continuing care to provide a range of interventions that are appropriate to the needs of clients within the spectrum of problematic alcohol and other drug use, to assist change in substance using behaviour.
34200	Forensic education and training (cannabis)	To provide education to clients issued a cannabis caution, agency training, curriculum development and/or training needs analysis for workers.
34201	Forensic alcohol and drug supported accommodation	To provide support to forensic clients in short-term accommodation who require assistance to maintain treatment gains.

Activity no.	Activity name	Activity description
34202	Forensic Koori community alcohol and drug worker	To provide culturally appropriate treatment, support and linkages to forensic clients from Aboriginal communities through a variety of activities involving health promotion, education, information provision and emotional wellbeing. To facilitate harm minimisation for individuals, families and communities relating to the impact of alcohol and drug use, and by providing counselling and group activities. To achieve and maintain behavioural changes in Aboriginal people with alcohol and drug problems.
34203	Forensic adult residential drug withdrawal	To provide a high level of support to ensure adult forensic clients satisfactorily and safely complete community residential drug withdrawal treatment.
34204	Forensic youth residential drug withdrawal	To provide a short-term drug withdrawal, time out and intensive support residential service for young forensic clients aged 12–21 years in a physically and emotionally safe, drug-free environment within a multidisciplinary, psycho-social health framework.
34205	Forensic adult residential rehabilitation	To provide a residential treatment program for adult forensic clients with serious and entrenched drug misuse by assisting changes in behaviour through a variety of counselling and therapeutic activities.
34206	Forensic youth residential rehabilitation	To provide a residential treatment program for young forensic clients with serious and entrenched drug misuse via a variety of counselling and therapeutic activities.
34207	Forensic youth outreach	To provide therapeutic treatment to young forensic clients whose use of drugs causes significant harm.
34208	Forensic counselling consultancy continuing care	To provide therapeutic treatment to forensic clients through a variety of counselling and therapeutic activities.
34209	Forensic Koori youth alcohol and drug healing service	To provide a residential program for young Indigenous forensic clients to address alcohol and other drug problems by assisting changes in behaviour through a variety of culturally appropriate counselling and educational activities.
34210	Youth justice	Brokerage funds to purchase AOD therapeutic treatment for youth justice clients.
34211	Diversion programs	Brokerage funds to purchase AOD therapeutic treatment for pre-arrest/pre-sentence diversion clients.
34212	COATS post sentence	Community Offenders Advice and Treatment Service (COATS) brokerage funds to purchase AOD therapeutic treatment for post-sentence/post-prison clients.
34213	Justice programs	Funds provided via a Department of Health and Department of Justice MOU to purchase AOD therapeutic treatment for clients of justice programs such as the Court Integrated Services Program and programs at the Neighbourhood Justice Centre.
34214	Severe substance dependence treatment withdrawal services	Specified services provided under the *Severe Substance Dependence Treatment Act 2010*, including coordinating client care and individual care planning and ensuring clients are linked into services in their local area that provide appropriate care and support.
34300	Care and recovery coordination	Care and Recovery Coordination facilitates seamless and integrated treatment pathways for complex clients and their families and improves access to other services and support systems in the community through a range of mechanisms including peer support options.

Activity no.	Activity name	Activity description
34301	Counselling	Counselling includes face-to-face, online and telephone treatment and support for individuals and families, including group counselling and day programs. The duration can range from a single session to extended periods of engagement.
34302	Intake and assessment	Intake and Assessment Function delivers standardised, good-practice screening and assessments to identify and prioritise a person's referral and treatment needs. It includes brief interventions where appropriate.
34303	Non-residential withdrawal	Non-residential withdrawal services support people to safely achieve neuroadaptation reversal in conjunction with a medical practitioner. Includes clinical withdrawal assessment, withdrawal treatment and referral and information provision via home-based, outpatient, outreach or hospital-supported modalities.
34304	Catchment-based planning	Catchment-based planning enables catchment-based AOD providers to develop a common plan identifying service gaps and strategies to address these, improve cross-sector coordination and enable effective participation in service coordination and planning platforms.

Table 2.24: Small rural health services – outputs and activities

Output name	Activity no.	Activity name	Activity description
SRHS – acute health	35024	Small rural – flexible health service delivery	A range of health services provided to small rural communities.
	35025	Small rural – TAC – acute health	TAC-funded inpatient services.
	35026	Small rural – DVA – acute health	DVA-funded inpatient services.
	35028	Small rural – acute health service system development and resourcing	Provides funds for workforce, community, service development and IT projects that support SRHSs.
	35051	Acute health – bush nursing hospitals	Suitably qualified people assessing and providing direct care to individuals for the purpose of providing therapeutic intervention, clinical care, practical assistance, support, referral and/or advocacy with the goal of improving quality of life, social function and/or health. Promoting health, independence and wellbeing to prevent illness, injury and disease through screening, risk assessment, immunisation, social marketing / health information, community action for social and environmental change, organisational development, workforce development and resources.
	35052	Small rural – specified services	Provides funding for services and projects as specified in applicable grant descriptions and conditions of funding. Includes specific-purpose activities of both a one-off and recurrent nature.
SRHS – aged care	35010	Small rural – aged support services	A range of health promotion and community service activities that support older Victorians and their carers in small rural communities such as seniors health promotion, aged carer support and respite, dementia services and aged community grants.

Output name	Activity no.	Activity name	Activity description
	35030	Small rural – HACC healthcare and support	A range of services to support frail older people, younger people with disabilities and their carers to remain at home.
	35011	Small rural – residential aged care	Care and support for people in small rural communities who are approved for care and accommodation in residential aged care facilities. This includes the state contribution towards equalising the recurrent funding paid by the Commonwealth as an adjusted subsidy reduction places.
	35042	Small rural – drugs services	Delivery of a range of health and aged care services as per an agreed service profile and business rules.
	35048	Small rural – primary health flexible services	Suitably qualified people assessing and providing direct care to individuals for the purpose of providing therapeutic intervention, clinical care, practical assistance, support, referral and/or advocacy with the goal of improving quality of life, social function and/or health. Promoting health, independence and wellbeing to prevent illness, injury and disease through screening, risk assessment, immunisation, social marketing / health information, community action for social and environmental change, organisational development, workforce development and resources.

Table 2.25: 2014–15 aged and home care – outputs and activities

Output name	Activity no.	Activity name	Activity description
Aged care assessment	13004	ACAS projects	ACAS projects are service development activities designed to improve quality, effectiveness and efficiency of ACAS services.
	13005	ACAS assessment	To ensure that older people and, in some exceptional circumstances younger people with disabilities, have access to services appropriate to meet their support needs. ACAS assessment is an activity that involves conducting a comprehensive assessment.
	13109	ACAS evaluation	Commonwealth-funded Victorian evaluation unit for the aged care assessment program to report on national minimum dataset, Commonwealth and state performance targets.
	13210	ACAS training and development	Statewide training to staff of the aged care assessment services in areas identified as requiring strengthening and development in order to best meet the objective of the ACAS program. This includes training in clinical assessment as well as service access.
Aged support services	13035	Support for carers	Flexible and innovative respite and support in a planned and unplanned way during and outside business hours, inside and outside home, in response to the individual needs of carers and care recipients.
	13053	Victorian eye care services	Low-cost eye care services and visual aids for people living in Victoria who have a pensioner concession card, or have held a health care card for six months or more.
	13067	Aged community grants	This component comprises a number of grants made to community-based organisations in the aged care field.
	13082	Low-cost accommodation support	Housing support for the aged including the Older Persons High Rise Support program, brokerage funding and some EFT of Community Connections are included under this activity area. Specifically, assistance to people with unmet complex needs who are homeless or living in insecure housing.

Output name	Activity no.	Activity name	Activity description
	13083	Aged training and development	This component comprises funding for designated training positions in organisations, specified funding for educational courses and academic chairs and specified funding for other short courses either conducted or provided in-house or externally by organisations.
	13100	Aged research and evaluation	Funding for research that contributes to policy and program development for community and residential aged care services programs that respond to the functional and social needs of frail older people and the needs of their carers. These include community aged care services aimed to optimise independence and to assist frail older people to stay in their own homes and residential care services that provide accommodation and care for those who can no longer be assisted to stay at home. These programs include not only functional assistance but also positive ageing and health and active living strategies aimed at increasing participation, activity and other health-promoting behaviour among older people.
	13103	Language services	Accredited interpreting and translation services by specialist organisations to HACC and aged care services to enhance access to and support service provision for individuals and communities who speak little or no English.
	13155	Dementia services	Counselling, education, support, information and referral services, and policy and service development, to enhance the quality of life of people with dementia, their families and carers.
	13156	Seniors health promotion	Health promotion initiatives and activities to promote health and wellbeing among residents of aged care facilities, supported residential services and older people who live in their own homes.
	13302	SRS supporting accommodation for vulnerable Victorians	This activity funds a number of measures aimed at improving the viability and sustainability of the pension-level SRS sector and improving service responses to residents. Included is facility cost relief assistance for proprietors.
	13303	SAVVI supporting connections	This activity builds the skills of proprietors while supporting better coordination and access to a range of services and supports for high-need residents of targeted pension-level SRS.
HACC primary health, community care and support	13015	HACC linkages packages	Individualised packages of care incorporating assessment, case management and funds to purchase services.
	13023	HACC service development grant	One-off projects (up to six months' duration) to improve quality, effectiveness and efficiency of HACC services and service system. Service provision is not funded under this activity.
	13024	HACC assessment	This activity is described in the *Framework for assessment* in the HACC program (27) and requires the delivery of living-at-home assessments. Living-at-home assessments include home-based holistic assessments of need and service-specific assessments.
	13026	HACC domestic assistance	Assistance with housekeeping tasks such as cleaning, making beds, laundry, shopping, escorting and meal preparation, plus some cyclical tasks such as spring cleaning. Assistance is provided in a manner that promotes skills development, capacity building and independence.
	13027	HACC respite	Support for the care relationship by providing carers of frail older people and people of any age with a disability with a break from their caring responsibilities. Respite can be provided in a care recipient's home or in the community.

Output name	Activity no.	Activity name	Activity description
	13038	HACC service system resourcing	Resources to assist the sector to better meet the needs of all people in the HACC target group and to help clients to gain better access to services.
	13043	HACC flexible service response	Funding to support innovative, developmental approaches to HACC service delivery that cannot be funded under the unit pricing structure.
	13056	HACC planned activity group – core	A planned program of activity to maintain a person's ability to live at home and in the community by maintaining daily living and social skills. The group may meet at a local venue or go on outings and is for clients in the HACC target group with core needs.
	13057	HACC planned activity group – high	Planned program of activity to maintain an individual's ability to live at home and in the community by maintaining daily living and social skills. The group may meet at a local venue or go on outings.
	13063	HACC volunteer coordination	Funding to coordinators to recruit, train and supervise volunteers and to manage volunteer services to clients.
	13096	HACC allied health	Allied health services, including clinical assessment, treatment, therapy or professional advice, that may be provided in the home or at a centre.
	13097	HACC delivered meals	A subsidy for meals delivered to people in the HACC target group at home and or in a local venue.
	13099	HACC property maintenance	Assistance with home maintenance or modification, including maintenance and repair of the client's home, garden or yard to keep it in a safe and habitable condition, and home modification or minor renovations to the client's home to help them cope with a disabling condition.
	13130	HACC volunteer coordination – other	Block funding to cover volunteer reimbursements and some program costs.
	13131	RDNS HACC allied health	Allied health services by RDNS, including clinical assessment, treatment, therapy or professional advice, that may be provided in the home or at a centre.
	13217	HACC minor capital	Minor capital funds to HACC-funded organisations to maintain, refurbish or upgrade infrastructure to help provide HACC services.
	13223	HACC nursing	Professional nursing care, including direct clinical care, clinical assessment, and the provision of education and information.
	13226	HACC personal care	Assistance with daily self-care tasks and other tasks provided in a manner that promotes skills development, capacity building and independence.
	13227	ACCO services – aged and home care	Funding for aged and home care services provided by Aboriginal community-controlled organisations.
	13229	HACC access and support	One-on-one support to HACC-eligible people with complex needs to access a wide range of services.
Residential aged care	13031	Public sector residential aged care supplement	Funds designated places for: • adjusted subsidy reduction supplement – this is the state contribution towards equalising the recurrent funding paid by the Commonwealth as adjusted subsidy reduction places to public sector residential aged care operators • contribution to public sector wage adjustments.
	13059	Residential aged care complex care supplement	Funds designated places to support services targeting people with particularly complex conditions to provide a higher level of specialised care management.

Output name	Activity no.	Activity name	Activity description
	13107	Rural small high care supplement	Funds designated small-sized high-care public sector residential aged care services (up to 30 places) that are located in rural Victoria. There are three levels of supplement paid for services of various sizes: • services with 1–10 high-care places • services with 11–20 high-care places • services with 21–30 high-care places.
	13211	Aged annual provisions – minor works	This activity provides minor capital funds for funded organisations and includes vehicles, minor building modifications and repairs and furniture and equipment expenses.
	13301	Aged quality improvement	To support safety and high-quality care and services in public sector residential aged care facilities through a range of activities, including performance monitoring, workforce development, infrastructure development and social inclusion.
Seniors programs and participation	13352	Victorian Seniors Festival	Events and activities associated with the Victorian Seniors Festival, including grants to local councils, Victorian Senior of the Year activities and festival communications and publicity.
	13354	Elder abuse prevention and response	Implementation of elder abuse prevention and prevention activities, including funding for Seniors Rights Victoria, communications and awareness raising, professional education and agency coordination.
	13355	Seniors community programs	Grant programs for older people in the community.
	13356	Information and lifelong learning	Recurrent funding programs for seniors' information and support, including the U3A growth strategy, Seniors Information Victoria and the Ministerial Advisory Committee.

Table 2.26: 2013–14 public health – outputs and activities

Output name	Activity no.	Activity name	Activity description
Health advancement	16035	Communication. Information. Advice.	To communicate information, via one or more media, to members of the public or other specific external people and groups.
	16308	Injury prevention	To undertake the design, management and evaluation of projects aimed at fostering best practice in injury prevention program planning and delivery.
	16348	Children's obesity	To implement initiatives to increase healthy eating and physical activity among children.
	16349	Obesity – community projects	To implement obesity prevention initiatives in a community and develop activities to increase healthy eating and physical activity.
	16449	Smoking information – advice and interventions	To provide smoking cessation advice/support and to educate the community and stakeholders about tobacco and smoking-related legislative requirements and to enforce the *Tobacco Act 1987*.
	16450	Diabetes prevention	To undertake initiatives aimed at minimising the number of people in the Victorian community with type 2 diabetes.
	16452	Aboriginal health advancement	To undertake policy and program development and promote access to programs and services.

Output name	Activity no.	Activity name	Activity description
	16453	Aboriginal health worker support	To facilitate training and professional development opportunities for Aboriginal health workers employed by mainstream organisations.
	16454	Health promotion initiatives	To develop and support programs that prevent illness and promote wellbeing through using a mix of health promotion interventions and capacity-building strategies across a range of settings.
	16460	Targeted recruitment for screening programs	To undertake a range of activities aimed at improving participation of under-screened and never-screened people in screening programs.
	16461	ACCO services – public health	Funding for those public health services provided by Aboriginal community-controlled organisations.
	16518	Cancer and screening intelligence	To undertake research and analysis activities to inform policy, program development and future directions.
	16462	Prevention system initiatives	To deliver the Victorian prevention system and its components to improve the population health status of Victorians.
Health protection	16037	Immunisation education	To provide educational and promotional resources and programs for immunisation providers as well as parents, adolescents and older people.
	16038	Tuberculosis screening – management	To provide for services and activities related to tuberculosis management in Victoria.
	16042	Infectious disease investigation and response	To investigate sporadic cases or outbreaks of infectious disease and institution of suitable control measures.
	16047	Food system quality improvement	To oversee the State Safe Food System through inter-sectoral linkages with an aim of continuous improvement in system operation through consultation and cooperation.
	16049	Cemetery sector governance	To undertake a range of projects relating to the governance of the cemetery sector.
	16084	Immunisation services	To provide subsidy payments to local governments for childhood immunisation (under six years old) plus associated activities.
	16102	Infectious disease surveillance	To collect, collate and report on data relating to notifiable infectious diseases, as required by legislation.
	16119	School and adult immunisation services	To provide subsidy payments to local governments for immunisation service delivery in secondary schools and for adults.
	16163	Food safety education	To provide education to local government, public and food businesses on food safety.
	16206	Laboratory testing	To provide a range of laboratory tests for infectious diseases (including arbovirus where applicable), including reference functions, advice on microbiological issues and undertaking education and training in relation to laboratory services.
	16234	Public health legislative review	To review public health legislation.
	16373	BBV and STI – clinical services	To provide diagnoses and clinical management of clients in relation to HIV/AIDS and sexual health.
	16377	BBV and STI – surveillance	To collect, collate and report on data relating to notifiable blood-borne viruses (BBVs) or sexually transmitted infections (STIs).

Output name	Activity no.	Activity name	Activity description
	16381	Risk management and emergency response	To investigate, evaluate and respond to environmental health risks, emergencies and/or incidents, and to perform activities that help us to better respond to emergencies.
	16505	BBV and STI – training and development	To provide education and training to the BBV/STI sector, including volunteers and organisation staff, and coordination of information updates.
	16506	BBV and STI – research	To support, commission or undertake research projects related to BBV/STIs in Victoria.
	16507	BBV and STI – laboratory services	To provide laboratory testing services related to BBV/STIs in Victoria.
	16508	BBV and STI – health promotion	To provide for the delivery of BBV/STI health promotion/prevention services to the community or targeted population groups.
	16509	BBV and STI – community-based care and support	To provide for the delivery of community-based care and support to clients, carers and significant others.
	16513	Screening and preventative messages	To undertake a range of activities within the community aimed at enabling people to make positive decisions about their health and wellbeing.
	16514	Screening service development	To undertake specific activities to improve service delivery, capacity and program effectiveness.
	16515	Education and training in screening programs	To undertake a range of education and training activities with program stakeholders to support and enhance delivery of organised screening programs.
	16516	Screening counselling and support	To provide counselling, support and/or clinical care to individuals and families who have, or are at risk of, a disease or condition that has been identified through a screening program.
	16517	Cancer and screening registers	To maintain a register (as prescribed by legislation where applicable) to record data about cancers and screening results for Victorians.
	16519	Screening tests and assessments	To provide screening tests and assessments to the target population of an organised screening program.
Public health development, research and support	16020	Multisite research ethics review	To establish a centralised ethical review system to streamline regulatory processes.
	16034	Languages services	To provide funds for language services (interpreting and/or translating) to assist clients with no or low English language proficiency to access and receive quality services from funded organisations.
	16061	Strategy development and review	To develop, coordinate, evaluate and review statewide strategies addressing priority risk and protective factors.
	16069	Public and professional education and support	To undertake planning, development and project management of information provision, social marketing and community and professional education activities addressing priority risk and protective factors.
	16116	Partnership development	To encourage and participate in the development of partnerships on public health priorities at the local, state and federal government levels.
	16203	Regulation of ART and associated legislation	To provide funding and support of legislation for assisted reproductive technology (ART).

Appendix 2.1: Calculating WIES21 for individual patients

To calculate the WIES funding allocated to a patient you need to:

- determine if the episode is eligible for WIES funding (see Box 2.1)
- calculate VIC-DRG 7.0 by applying Victorian modifications to AR-DRG 7.0 (see Box 2.2)
- calculate any WIES co-payments (see Boxes 2.3a, 2.3b, 2.3c, 2.3d, 2.3e)
- calculate the base WIES allocation using the VIC-DRG7.0 and the patient's LOS adjusted for mechanical ventilation and high outlier days. This can be done using the appropriate weights from the WIES weights table (see Boxes 2.4a, 2.4b, 2.4c)
- apply the Aboriginal and Torres Strait Islander loading if applicable (see Box 2.5)
- add the base WIES payment, any co-payments and Aboriginal and Torres Strait Islander loading (see Box 2.6). The steps are described in detail below with technical specifications provided in boxes.

A2.1.1 WIES21 eligibility

The majority of patients in hospital will be allocated a WIES21 price weight. However, as in previous years, WIES cannot be calculated for incomplete or un-coded 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 2014–15.

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-DRG 7.0. 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.

Box 2.1: Episodes eligible for WIES21 funding

All episodes in the VAED with a care type of:

- 4 – Other care (Acute), including qualified newborns

Except for:

- private hospital separations
- incomplete or uncoded episodes, or episodes coded to a problem VIC-DRG7.0 (zero weight) including VICDRG7.0 960Z (Ungroupable), 961Z (Unacceptable Principal Diagnosis) and 963Z (Neonatal Diagnosis Not Consistent W Age/Weight)
- episodes with an account class on separation of NT (Newborn – Unqualified, not birth episode), WC (Victorian WorkCover Authority), XX (Ineligible non-Australian residents – not exempted from fees), AS (Armed Services), CL (Common Law Recoveries), OO (Other compensable), SS (Seamen)
- episodes with a specified program identifier of 06 (Competitive Elective Surgery Funding Initiative); this activity is funded through the competitive elective surgery public private pool
- episodes where the contract role is B (service provider hospital)
- episodes from hospitals not eligible for WIES funding
- episodes that have been coded as follows as this activity has been funded through specified grants
  - include an electroconvulsive therapy code [9334100-9334199] and
  - care type 4 (Acute) and
  - separated from Royal Melbourne Hospital (campus code 1334) and

– funding arrangement 2 (Hub & Spoke) and
– contract/spoke identifier in (0010, 0011, 0012).

While contracted patients are allocated a WIES score they are not eligible for WIES funding.

A2.1.2 Victorian AR-DRG modifications

In 2014-15 hospitals will assign diagnosis and procedure codes using the 8th edition of the ICD-10-AM classification. For funding purposes, these codes will be grouped using AR-DRG Version 7.0 with no mapping required.

One adjustment will be made to the original AR-DRG 7.0 grouping, utilising the VIC-DRG 7.0 field prior to the calculation of WIES21 for radiotherapy.

Box 2.2: Radiotherapy VIC-DRG 7.0

Australian Coding Standard (ACS) 0229 *Radiotherapy* instructs coders to assign a code for the malignancy as the principal diagnosis in multi-day episodes for radiotherapy. This results in episodes grouping to a wide range of AR-DRG 7.0s. To maintain funding equity, a VIC-DRG7.0 of R64Z Radiotherapy will be assigned for:

(i) non same day non-surgical episodes that include a radiation oncology procedure from ACHI blocks [1786] to [1792], [1794] or [1795] for treatment of a neoplastic condition (i.e. at least one code from the ICD-10-AM range C00-D48), except for episodes with the following adjacent AR-DRG 7.0s: B61; and pre-MDC adjacent AR-DRG 7.0s: A40, B60, B82, S65, W60, and W61;

and for

(ii) same day episodes initially grouped to AR-DRG 7.0 R62B Other Neoplastic Disorders W/O CC that have an ICD-10-AM 8th edition principal diagnosis code of Z51.0 (Radiotherapy session).

A2.1.3 Co-payments

The four types of WIES20 co-payments used in 2013-14 will continue in 2014–15 with the addition of a new cochlear prosthetic device co-payment for bilateral implantations..

A2.1.3.1 Mechanical ventilation

Technical specifications for mechanical ventilation co-payments are provided in Box 2.3a. To be eligible for a mechanical ventilation co-payment the patient must be admitted to specific health services (see Table 2.27), have had more than six hours of continuous mechanical ventilation and be allocated to a VIC-DRG7.0 that is eligible for a mechanical ventilation co-payment. VIC-DRG7.0s are classed as one of the following:

- eligible for daily co-payments of 0.7659 WIES (mv_elig ='D' in the WIES21 weights table)
- eligible for daily co-payments at 0.7659 WIES for ventilated days in excess of four days (96 hours) mechanical ventilation (mv_elig = '4' in the WIES21 weights table)
- ineligible for co-payments (mv_elig = 'I' in the WIES21 weights table).

All patients who are eligible for a mechanical ventilation co-payment receive an additional one-off payment of 0.6980 WIES. This additional WIES payment is to provide health services with the capacity to run at lower levels of ICU occupancy so that ICU beds will be available for periods of peak demand. However, the additional co-payment is subject to health services staffing appropriate numbers of ICU beds.

Mechanical ventilation severity co-payment eligibility

Below is a list of hospitals that are eligible for attracting mechanical ventilation co-payments for ventilated patients in non-neonate eligible DRGs ('D', '4').

Only episodes with the campus codes listed in Table 2.27 may be eligible.

Table 2.27: Health service campus codes

Code	Name	Code	Name
1010	The Alfred	2111	Dandenong Hospital
1021	Bendigo Health	2160	South West Healthcare [Warrnambool]
1031,1032	Austin and Repatriation Medical Centre	2170	Wimmera Health Care Group [Horsham]
1050	Box Hill Hospital	2220	Frankston Hospital
1071	Western District Health Service [Hamilton]	2320	New Mildura
1121	Goulburn Valley [Shepparton]	2440	Latrobe Regional Hospital
1150	Wangaratta	6200	Valley Private Hospital [Mulgrave]
1170	Monash Medical Centre [Clayton]	6400	Knox Private Hospital [Wantirna]
1180	Western Hospital	6470	Freemasons Hospital [East Melbourne]
1191	The Royal Children's Hospital	6490	Epworth Hospital [Richmond]
1210	Maroondah Hospital	6511	Cabrini Malvern
1280	Northern Hospital	6520	St John of God Health Care Ballarat
1334	The Royal Melbourne Hospital	6550	St John of God Health Care Geelong
1390	Sunshine Hospital	6620	St Vincent's Private Hospital [Fitzroy]
1450	St Vincent's Hospital	6770	Melbourne Private Hospital [Parkville]
1550	Peter MacCallum Cancer Centre	6910	Warringal Private Hospital [Heidelberg]
2010	Ballarat Health Services	7350	South Eastern Private Hospital [Noble Park]
2050	Barwon Health [Geelong]	8550	John Fawkner – Moreland Private Hospital
2060	Central Gippsland Health Service	8890	Jessie McPherson Private Hospital [Clayton]

Box 2.3a: Calculating mechanical ventilation co-payments

```
Select mv_elig

case 'D' then
  if (hours on mechanical ventilation > 6) and (ICU hospital)
  then
    adjmvday = round((hours mechanical ventilation +12)/24)
  else
    adjmvday = 0
  mv_copay = adjmvday × 0.7659 + 0.6980
  go to Box 2.3b

case '4' then
  if (hours on mechanical ventilation > 96) and (ICU hospital)
  then
    adjmvday = round((hours mechanical ventilation +12)/24) – 4
  else
    adjmvday = 0
```

WIT.3031.001.0390_R


```
  mv_copay = adjmvday × 0.7659 + 0.6980
  go to Box 2.3b

otherwise do
  adjmvday = 0
  mv_copay = 0
  go to Box 2.3b
```

Base WIES payments for high outliers are reduced when a patient receives daily mechanical ventilation co-payments. To make this reduction it is necessary to record the number of days receiving mechanical ventilation co-payments ('adjmvday' in the technical specifications).

A2.1.3.2 Thalassaemia

Thalassaemia co-payments are made to patients with any ICD–10-AM diagnosis code of D56.x or D57.2 who are allocated to an eligible VIC-DRG7.0 (indicated with a 'Thal.' in the 'Other Co-payment' column in the WIES21 weights table). The WIES21 thalassaemia co-payment is set at 0.2648 WIES per episode. Technical specifications are provided in Box 2.3b.

Box 2.3b: Calculate thalassaemia co-payment

```
If (copay = 'Thal') and record has an ICD–10-AM 8th edition diagnosis of D56.x or D57.2 then
  th_copay = 0.2648
else
  th_copay = 0;
go to Box 2.3c
```

A2.1.3.3 AAA stent

AAA stent co-payments are made to patients undergoing an endoluminal repair of an aortic aneurysm as indicated by any ICD–10-AM 8th edition procedure code of 33116-00 and who are allocated to an eligible VIC-DRG7.0 (indicated with a 'AAA' in the 'Other Co-payments' column in the WIES21 weights table). The WIES21 AAA stent co-payment is set at 3.1421 WIES per episode. Technical specifications are provided in Box 2.3c.

Box 2.3c: Calculate AAA stent co-payment

```
If (copay = 'AAA') and record has an ICD–10-AM 8th edition procedure of 33116-00 then
  AAA_copay = 3.1421
else
  AAA_copay = 0;
go to Box 2.3d
```

A2.1.3.4 ASD closure device

ASD co-payments are made to patients receiving an atrial septal defect closure device as indicated by the presence of any ICD–10-AM 8th edition procedure code of 38742-00 and who are allocated to an eligible VIC-DRG7.0 (indicated with a 'ASD' in the 'Other Co-payments' column in the WIES21 weights table). The WIES21 ASD co-payment is set at 2.4713 WIES per episode. Technical specifications are provided in Box 2.3d.

Box 2.3d: Calculate ASD co-payment

```
If (copay = 'ASD') and record has an ICD–10-AM 8th edition procedure code of 38742-00 then
  ASD_copay = 2.4713
else
  ASD_copay = 0
go to Box 2.3e
```

A2.1.3.5 Cochlear prosthetic device

Cochlear co-payments are made to patients receiving a bilateral cochlear implantation in the one (same) episode (indicated by the multiple occurrence of ICD–10-AM 8th edition procedure code 41617-00 within the one episode) and who are allocated to an eligible VIC-DRG7.0 (indicated with a 'Bilat' in the 'Other Co-payments' column in the WIES21 weights table). The WIES21 cochlear co-payment is set at 5.0544 WIES per episode. Technical specifications are provided in Box 2.3e.

Box 2.3e: Calculate cochlear co-payment

```
If (copay = 'Bilat') and record has

  (Number of times the ICD–10-AM 8th edition procedure code 41617-00 is reported)
  less
  (Number of times the ICD–10-AM 8th edition procedure code 41617-01 is reported)
  = 2

  then bilat_copay = 5.0544
Else
  Bilat_copay = 0
```

A2.1.4 Base WIES21

To calculate a patient's base WIES21 you need to determine:

- the patient's VIC-DRG7.0
- the patient's LOS
- the patient's LOS category (LOS_cat: 'S' or same-day, 'O' or one-day, 'M' or multi-day)
- the number of mechanical ventilation co-payment days ('adjmvday' refer to Box 2.3a)
- the patient's inlier equivalence ('I' or inlier, 'L' or low outlier, 'H' or high outlier).

The patient's LOS and LOS category are derived from the admission date, separation date and leave days. For payment purposes a maximum LOS of five years (1,825 days) is used. This ensures that WIES are not allocated to extreme stays that are likely to represent non-acute care. Technical specifications are provided in Box 2.4a.

Box 2.4a: Determining LOS category and maximum LOS

```
Same day = 'Y' if admission date = separation date
Else same day = 'N'
If (same day = 'Y') then
        LOS_cat = 'S'
        go to Box 2.4b
else if (same day = 'N') and (LOS =1) then
        LOS_cat = 'O'
        go to Box 2.4b
else
        LOS = min(LOS,1825)
        LOS_cat = 'M'
        go to Box 2.4b
```

The patient's inlier funding equivalence is determined by comparing the patient's LOS with the inlier boundaries for the VIC-DRG7.0x to which the patient is allocated. The low and high inlier boundaries are given in the WIES21 weights table. For purposes of reporting, a patient is classified as an inlier based only on LOS. However, the high outlier per diems are adjusted for any mechanical ventilation co-payments. Consequently, some high outliers are paid at the inlier rate (where: [LOS – HB] < adjmvday).

A patient is funded as an inlier when their LOS is greater than or equal to the low inlier boundary and less than or equal to the sum of the high inlier boundary plus any mechanical ventilation co-payment days.

Patients with an LOS less than the low inlier boundary are funded as low outliers. Patients with an LOS greater than the sum of the high inlier boundary and mechanical ventilation co-payment days are funded as high outliers. Technical specifications are provided in Box 2.4b.

Box 2.4b: Calculate inlier funding equivalence

```
If LOS < lb then
        Inlier = 'L'
        go to Box 2.4c

else if LOS > (hb + adjmvday) then
        Inlier = 'H'
        go to Box 2.4c
else
        Inlier = 'I'
        go to Box 2.4c
```

Separate columns occur in the WIES21 weights table for:

- same-day weights
- one-day weights
- multi-day low outlier per diem weight
- multi-day inlier weights
- high outlier per diem weights
- high HITH per diem weights.

The base WIES cost weight for same-day episodes (inlier and low outlier), one-day episodes (inlier and low outliers), and multi-day inliers can be read directly from the WIES21 weights table using the appropriate column and row (VIC-DRG7.0). The base WIES cost weight for multi-day low outliers can be calculated by multiplying the low outlier per diem weight given in the WIES21weights table by the patient's LOS less one day and adding the one-day weight.

The base WIES cost weight for high outliers is obtained by:

- calculating the number of high outlier days (high_days) by subtracting the high boundary and any mechanical ventilation co-payment days (adjmvday – see Box 2.3a) from the LOS
- calculating the number of high outlier days (high_days) that are paid at the discounted HITH rate (hith_days) (this is the minimum of either the number of HITH LOS or high outlier days)
- adding the multi-day inlier weight (md_in), the number of high outlier HITH days (hith_days) by the high HITH per diem weight (hith_pd) and the number of remaining high outlier days (high_days – hith_days) by the high outlier per diem weight (ho_pd).

Technical details are provided in Box 2.4c.

Box 2.4c: Calculate base WIES21

```
Select inlier
  case 'L' do
    select LOS_cat
      case 'S' do
        base_WIES = sd
        go to Box 2.5
      case 'O' do
        base_WIES = od
        go to Box 2.5
      case 'M' do
        base_WIES = od + (LOS – 1) × lo_pd
        go to Box 2.5
  case 'I' do
    select LOS_cat
      case 'S' do
        base_WIES = sd
        go to Box 2.5
                         case 'O' do
        base_WIES = od
        go to Box 2.5
      case 'M' do
        base_WIES = md_in
        go to Box 2.5
  case 'H' do
    if hithLOS = missing then hithLOS = 0
    high_days = max(0, LOS – hb – adjmvday)
    hith_days = min(high_days, hithLOS)
    base_WIES = md_in + (high_days – hith_days) × ho_pd +
      (hith_days × hith_pd)
    go to Box 2.5
```

A2.1.5 Aboriginal and Torres Strait Islander loading

A 30 per cent WIES loading is paid to health services for treating Aboriginal and Torres Strait Islander patients in recognition of their higher costs of care. Technical details are provided in Box 2.5.

Box 2.5: Applying the Aboriginal and Torres Strait Islander loading

```
If Indigenous status in (1,2,3) then do
Aboriginal and Torres Strait Islander_WIES = 0.3*(base_WIES + mv_copay + th_copay + AAA_copay +
ASD_copay + Bilat_copay)

else
ATSI_WIES = 0
go to Box 2.6
```

A2.1.6 Calculating WIES cost weight

The WIES cost weight is calculated by adding base WIES, co-payment WIES and Aboriginal and Torres Strait Islander WIES. Details are provided in Box 2.6.

Box 2.6: Calculating WIES cost weight

```
WIES = base_WIES + mv_copay + th_copay + AAA_copay + ASD_copay + Bilat_copay +
       ATSI _WIES
```

Appendix 2.2: Definition of WIES21 variables

Definitions and descriptions of each variable within the WIES21 formulae are provided in Table 2.28.

Table 2.28: WIES20 variables

Variable	Label	Description
Victorian DRG 7.0	VICDRG7.0	AR-DRG7.0 with Victorian modifications.
Mech. Vent. Co-payment	mv_elig	This describes the way mechanical ventilation severity co-payments are made for the VIC-DRG7.0x. Options are: D: funded if more than six hours of ventilation is provided. Patients attract a one-off payment of 0.6980 WIES plus a daily rate of 0.7659 WIES for patients in hospitals with appropriate ICU facilities. 4: funded for each day of mechanical ventilation after four days. Patients attract a one-off payment of 0.6980 WIES plus a daily rate of 0.7659 WIES for patients in hospitals with appropriate ICU facilities. I: ineligible for mechanical ventilation co-payments.
Other co-payment	copay	Some groups of patients attract additional funds in recognition of their higher costs. Options are: Thal: a co-payment of 0.2648 WIES is made to patients with a reported ICD–10-AM thalassaemia diagnosis code of D56.x or D57.2. (Note: These do not have to be principal diagnoses.) AAA: a co-payment of 3.1421 WIES for patients with the procedure code for the insertion of a stent for endovascular repair of aneurysm of the aorta (AAA stent). ASD: a co-payment of 2.4713 for patients with a procedure code for using an ASD closure device. Bilat: a co-payment of 5.0544 is made to patients with procedure codes for the bilateral implantation of cochlear prosthetic devices within the same (one) episode
Inlier boundary – low	lb	The low LOS boundary for inliers. Patients with an LOS of less than the low boundary are classed as low outliers. For most VIC-DRG7.0s the low boundary has been set at a third of the estimated ALOS for the VIC-DRG7.0. Boundaries are truncated to the nearest whole number.
Inlier boundary – high	hb	The high LOS boundary for inliers. Patients with an LOS greater than the high boundary are classed as high outliers. For most VIC-DRG7.0s the high boundary has been set at three times the estimated ALOS for the VIC-DRG7.0. Boundaries are rounded to the nearest whole number.
Average inlier stay	I_alos	The ALOS (days) for inliers only (based on costed episodes and used to set the high-outlier per diem).
Same-day/one-day DRG		VIC-DRG7.0s marked as 'Same day' have same-day weights based on the costs of same-day patients. VIC-DRG7.0s marked as 'One day' have one-day and same-day weights based on the costs of patients with an LOS of one day. VIC-DRG7.0s with a blank value have same-day and one-day weights derived from the multi-day inlier weight.
Same-day weight	sd	The same-day weight is used to allocate WIES to patients admitted and separated on the same day. Depending on the VIC-DRG7.0, same-day patients may be either low outliers or inliers: **Designated same-day VIC-DRG 7.0s** The same-day weight is based on the costs of same-day patients.

Variable	Label	Description
		Designated one-day VIC-DRG 7.0s The same-day weight is based on the costs of patients with an LOS of one day. **Non-designated VIC-DRG 7.0s with a low boundary of zero days** The same-day weight is set at the multi-day inlier weight. **Non-designated VIC-DRG 7.0s with a low boundary of one day** The same-day weight is based on the average cost of multi-day inliers. For medical DRGs the weight is set at half of the multi-day inlier average cost. For non-medical DRGs the same-day weight is set at 100 per cent of theatre and prosthesis costs plus 50 per cent of the average for other costs. **Non-designated VIC-DRG7.0s with a low boundary of two days or more (low outliers)** The same-day weight is based on the average cost of multi-day inliers. For medical DRGs the same-day weight is set at half of the multi-day inlier average cost divided by the low boundary. For non-medical DRGs the same-day weight is set at 100 per cent of theatre and prosthesis costs plus 50 per cent of the average for other costs divided by the low boundary.
One-day weight	od	The one-day weight is used to allocate WIES to patients with an LOS of one day, but who were not separated on the same day as they were admitted. Depending on the VIC-DRG7.0x, one-day patients may be either low outliers or inliers: **Designated same-day VIC-DRG7.0s** The one-day weight is based on the costs of all inliers excluding same-day patients. If the patient is an inlier they attract the full multi-day inlier weight. For low outliers in medical DRGs the one-day weight is based on the average cost of multi-day inliers divided by the low boundary. For low outliers in non-medical DRGs the one-day weight is based on 100 per cent of the average theatre and prosthesis costs plus the average of other costs divided by the low boundary. **Designated one-day VIC-DRG7.0s** The one-day weight is based on the costs of patients with an LOS of one day. **Non-designated VIC-DRG7.0s with a low boundary of zero or one day** The one-day weight is set at the multi-day inlier weight. **Non-designated VIC-DRG7.0s with a low boundary of two days or more (low outliers)** For medical DRGs the one-day weight is based on the average cost of multi-day inliers divided by the low boundary. For non-medical DRGs the one-day weight is based on 100 per cent of the average theatre and prosthesis cost plus the average of other costs divided by the low boundary.
Multi-day low outlier per diem	lo_pd	The low outlier multi-day per diem weight is used to allocate WIES to low outliers who have an LOS of at least two days. Not all VIC-DRG7.0s have low outliers. No weight is reported in these cases. For most VIC-DRG7.0s the low outlier weight is derived from the average cost of multi-day inliers (excluding costs associated with setting the one-day weight) divided by the low boundary. (Note: a minimum criterion applies.) The base WIES for low outliers is calculated by multiplying the low

Variable	Label	Description
		outlier per diem by the patient's LOS less one day and adding the one-day weight: Low outlier WIES = od + (LOS –1) × lo_pd
Inlier weight	md_in	The inlier multi-day weight is used to allocate WIES to inliers that have an LOS of at least two days. For designated VIC-DRG7.0s, same-day/one-day patients are excluded when deriving the inlier multi-day weight.
High outlier per diem	ho_pd	The high outlier multi-day per diem weight is used to allocate additional WIES for all days of stay in excess of the high boundary after adjusting for any mechanical ventilation co-payment days and hospital in the home days. The high outlier multi-day per diem rate is based on the average cost of inliers (*excluding all* prosthesis and theatre costs for non-medical DRGs only) according to the following formula: ho_pd = high factor × (av. inlier cost less theatre and prosthesis costs for non-medical DRGs only) ÷ i_alos where the high factor is set at 0.7 for surgical VIC-DRG7.0s and 0.8 for medical VIC-DRG7.0s to recognise that days at the end of a patients stay are less resource intensive than days at the beginning of a patients stay. Inlier ALOS (i_alos) is based on costed episodes. A number of variations exist on the general formula: 1) The high factor is set at one or greater for some high-cost VICDRG7.0s 2) Maximum and minimum criteria apply.
HITH outlier per diem	hith_pd	The HITH high outlier multi-day per diem weight is used to allocate additional WIES for all days of stay in excess of the high boundary that can be attributed to HITH. These days can occur at any stage of the patient's treatment, including before the high boundary. For example, suppose a patient stayed seven days in hospital, followed by five days of HITH, but a complication occurred requiring another four days in hospital care and was subsequently allocated to a DRG with a high boundary of 10 days. The patient has an LOS of 16 days resulting in six high days, five of which will be paid at the HITH high outlier multi-day per diem rate and one of which will be paid at the high outlier per diem rate. The HITH high outlier multi-day per diem rate is based on 80 per cent of the high outlier per diem and subject to maximum and minimum criteria.

Appendix 2.3: i-SNAC technical specifications

A2.3.1 Steps to calculating i-SNAC value, weighted bed day value and revenue

The classes in i-SNAC are used with the length of time the patient is in the class to determine the i-SNAC value. Using this value and applying any loadings that are applicable will derive the WBD value. The WBD is then used with one of three prices depending on the account class of the patient to determine the revenue.

Table 2.29 shows the broad steps in the calculation of i-SNAC, WBD and revenue for admitted subacute or non-acute episodes.

Table 2.29: Overview of the steps to calculate i-SNAC, WBD and revenue for subacute and non-acute patient

Step	Product	Actions
1	i-SNAC value	Use the LOS or length of phase (LOP) with the appropriate i-SNAC class weight to calculate the classification weight.
2	WBD value	Use the i-SNAC value and, where applicable, the loadings to determine the WBD value for the episode
3	Revenue	Use the WBD value and multiply by the correct price based on the episode account class.

Table 2.30 shows which VAED data elements are required to calculate an i-SNAC value, WBD value or revenue.

Table 2.30: VAED data elements and calculation purpose

VAED data element	i-SNAC value	WBD value	Revenue
Care type	Describes the arm of i-SNAC being used Describes the GEM and maintenance class	Not required	Not required
Impairment code	Describes the class within the rehabilitation arm of i-SNAC	Not required	Not required
Phase of care on admission Final phase of care Phase of care on phase change	Describes the class within the palliative care arm of i-SNAC	Not required	Not required
Admission date Separation date	Used to calculate the LOS for rehabilitation, GEM and maintenance episodes	Not required	Not required
Admission date Phase of care change date Final phase of care state date Separation date	Used to calculate the LOP for palliative care phases	Not required	Not required
Indigenous status	Not required	Used to determine Indigenous loading	Not required
Postcode	Not required	Used to determine the remoteness loading	Not required
Account class	Not required	Not required	Used to apply the correct price

A2.3.2 Mapping Victorian Admitted Episode Dataset care type to i-SNAC arms

The mapping from the VAED care type variable (for subacute activity) to the i-SNAC arm is shown in Table 2.31.

Table 2.31: Mapping between VAED care type variable and i-SNAC arm

i-SNAC arm	VAED care type code	VAED care type description	Mapping rules
Rehabilitation	2	Designated rehabilitation program/unit: level 1	All records
	6	Designated rehabilitation program/unit: level 2	
	P	Designated paediatric rehabilitation program/unit	
Palliative care	8	Palliative care program	All records
GEM	9	Geriatric evaluation and management program	All records
Maintenance care	MC	Maintenance care	All records

A2.3.3 Determining the i-SNAC value

A2.3.3.1 Palliative care classes and class weights

Palliative care activity is classified into an i-SNAC class based on the patient's phase of care. Palliative care activity is different from the other subacute activity because there can be multiple phases within one episode, with each phase being independently classified. This means that for an episode of care (between admission and separation) there may be multiple phases that each have a different i-SNAC weight. In addition some classes may be repeated in the episode because palliative care phases are not sequential and a patient may move back and forth between phases. The i-SNAC value is calculated by summing each individual phase across the total episode.

The phase of care is recorded at the start of the episode. The palliative care clinical team will review the patient and record phase changes if and when they occur during the episode. Phases are recorded as one of four types:

- stable phase
- unstable phase
- deteriorating phase
- terminal phase.

Table 2.32 shows the VAED codes for the palliative care phases. The VAED has three specific variables for recording phase of care:

- on admission – the first phase
- during the last phase – where there are more than 10 phase changes in the episode
- at each phase change – up to the 10th phase change.

Each variable uses the same code set (Table 2.32).

Table 2.32: The VAED code set used to record a patient's phase of care

VAED code	VAED descriptor
1	Stable phase
2	Unstable phase
3	Deteriorating phase
4	Terminal phase

The phase of care on admission is reported at the time of admission. Up to 10 changes of phase of care can be reported. The VAED requires phase changes to be reported in sequence.

A2.3.3.2 Calculating the length of phase

Palliative care phases provide a clinical indication of the type of care required. The length of phase (LOP) is the date of the phase end minus the date of the phase start. A phase will start and end when the patient's clinical condition changes. If a patient changes phase on the day of discharge, the LOP = 0 because the end date is the same as the start date of that phase. This phase is **not** adjusted up to an LOP = 1.

At present, the number of phase changes reported is limited to 10 phase changes (or 11 phases of care). Less than one per cent of all episodes have more than 11 phases of care. However, if a patient has more than 11 phases the phase of care on admission and the first nine change of phases are calculated based on the LOP (phase end date minus phase start date) for each phase.

The 10th change of phase (which is the 11th phase) is assumed to be the same phase until the final phase. The LOP of the 10th phase is the start date of the final phase minus the start date of the 10th phase.

The final phase of care is calculated as the LOP between the discharge date and start date of the final phase.

A2.3.3.3 Palliative care leave days

Like all subacute care types, when a palliative care patient has leave from the hospital, the length of the episode will be discounted by the number of days the patient is on leave. The VAED does not record the date of the leave days and therefore it is not possible to know the phase the patient was in when they took leave. For palliative care episodes there are two scenarios to determine the appropriate methodology to discount the leave days:

- If the entire episode is undertaken within the one phase and there are no phase changes, the discounting for the leave days will occur at the rate of the phase during the episode.
- If the episode contains two or more different phases, the discounting will occur against the stable phase for the total number of leave days. The stable phase rate is used even if the patient didn't have a stable phase.

Leave days are calculated as the product of the number of days of leave (the number of midnights) and the appropriate phase price weight.

A2.3.3.4 Calculating the i-SNAC value

Once the length of each phase is known, the i-SNAC value is calculated by multiplying the LOP by the appropriate weight. Table 2.33 shows the 2014–15 weights for the palliative care classes.

Table 2.33: Palliative care classes and weights in 2014–15

i-SNAC arm	i-SNAC class	Weight
Palliative care	Stable	1.011
	Unstable	1.372
	Deteriorating	1.488
	Terminal	1.825

Example

A palliative care patient is admitted on 12 December 2014 and classified as 'unstable'. Their status changed to 'Deteriorating' on 17 December 2014. The patient takes leave from 31 December 2014 to 2 January 2015. The patient's phase was reclassified to 'Terminal' on 28 December 2014. The patient died on 10 January 2015.

LOP:

Unstable – Phase start = 12 December; Phase end = 17 December; LOP = 5 days

Deteriorating – Phase start = 17 December; Phase end = 28 December; LOP = 11 days

Terminal – Phase start = 28 December; Phase end = 10 January; LOP = 13 days

Leave days = Leave start = 31 December; Leave end = 2 January; Leave days = 2 days

i-SNAC value:

$(5 \times 1.372) + (11 \times 1.488) + (13 \times 1.825) – (2 \times 1.011) = 6.86 + 16.368 + 23.725 – 2.022 = 44.931$

A2.3.3.5 Rehabilitation classes

Rehabilitation activity is classified in i-SNAC based on the patient's VAED impairment code on admission. Impairment refers to the diagnosis, based on the body system manifesting the reason for rehabilitation.

Impairment codes should be assigned by the treating clinician. Code assignment must be supported by the appropriate ICD–10-AM codes reported in the X5/Y5 Diagnosis/Extra Diagnosis Records.

The patient will be in only one impairment class for their entire episode of care. There are 11 impairment classes in i-SNAC. The mapping in Table 2.34 shows the relationship between the VAED impairment data item and the i-SNAC classes. Six of the VAED impairment code groups have been combined into the 'Other' i-SNAC class.

Table 2.34: Mapping between i-SNAC rehabilitation class and VAED impairment data item

i-SNAC class	VAED impairment description	VAED code	Impairment description
Stroke	Stroke	011	Left body involvement (right brain)
		012	Right body involvement (left brain)
		013	Bilateral involvement
		014	No paresis
		019	Other stroke
Brain dysfunction	Brain dysfunction	0211	Subarachnoid haemorrhage
		0212	Anoxic brain damage
		0213	Other non-traumatic brain dysfunction
		0221	Open injury
		0222	Closed injury
Neurological	Neurological conditions	031	Multiple sclerosis
		032	Parkinsonism
		033	Polyneuropathy
		034	Guillain-Barré syndrome
		035	Cerebral palsy
		038	Neuromuscular disorders (include motor neuron disease)
		039	Other neurological disorders
Spinal cord	Spinal cord dysfunction	04111	Paraplegia, incomplete
		04112	Paraplegia complete
		041211	Quadriplegia incomplete C1–4
		041212	Quadriplegia incomplete C5–8
		041221	Quadriplegia complete C1–4
		041222	Quadriplegia complete C5–8
		0413	Other non-traumatic SCI
		04211	Paraplegia, incomplete
		04212	Paraplegia complete
		042211	Quadriplegia incomplete C1–4
		042212	Quadriplegia incomplete C5–8
		042221	Quadriplegia complete C1–4
		042222	Quadriplegia complete C5–8
		0423	Other traumatic spinal cord dysfunction

i-SNAC class	VAED impairment description	VAED code	Impairment description
Amputation	Amputation of limb	051	Single upper amputation above the elbow
		052	Single upper amputation below the elbow
		053	Single lower amputation above the knee (includes through knee)
		054	Single lower amputation below the knee
		055	Double lower amputation above the knee (includes through knee)
		056	Double lower amputation above/below the knee
		057	Double lower amputation below the knee
		058	Partial foot amputation (includes single/double)
		059	Other amputation
Pain	Pain syndromes	071	Neck pain
		072	Back pain
		073	Extremity pain
		074	Headache (includes migraine)
		075	Multi-site pain
		079	Other pain (includes abdominal/chest wall)
Orthopaedics	Orthopaedic conditions	08111	Fracture of hip, unilateral (includes #NOF)
		08112	Fracture of hip, bilateral (includes #NOF)
		0812	Fracture of shaft of femur (excludes femur involving knee joint)
		0813	Fracture of pelvis
		08141	Fracture of knee (includes patella, femur involving knee joint, tibia or fibula involving knee joint)
		08142	Fracture of lower leg, ankle, foot
		0815	Fracture of upper limb (includes hand, fingers, wrist, forearm, arm, shoulder)
		0816	Fracture of spine (excludes where the major disorder is pain)
		0817	Fracture of multiple sites (multiple bones of same lower limb, both lower limbs, lower with upper limb, lower limb with rib or sternum; excludes with brain injury or with spinal cord injury)
		0819	Other orthopaedic fracture (includes jaw, face, rib, orbit or sites not elsewhere classified)
		08211	Unilateral hip replacement
		08212	Bilateral hip replacement
		08221	Unilateral knee replacement
		08222	Bilateral knee replacement
		08231	Knee and hip replacement same side
		08232	Knee and hip replacement different sides
		0824	Shoulder replacement or repair

i-SNAC class	VAED impairment description	VAED code	Impairment description
		0825	Post spinal surgery (includes nerve root injury (laminectomy, spinal fusion, discectomy; excludes spinal cord injury or caudaequina)
		0826	Other orthopaedic surgery
Cardiac	Cardiac	091	Following recent onset of new cardiac impairment (AMI, heart transplant, cardiac surgery)
		092	Chronic cardiac insufficiency
		093	Heart and heart–lung transplant
Burns	Burns	0110	Burns
Major multiple trauma	Major multiple trauma	0141	Brain and spinal cord injury
		0142	Brain and multiple fracture/amputation
		0143	Spinal cord and multiple fracture/amputation
		0149	Other multiple trauma
Other	Arthritis	061	Rheumatoid
		062	Osteoarthritis
		069	Other arthritis
	Pulmonary	0101	Chronic obstructive pulmonary disease
		0102	Lung transplant
		0109	Other pulmonary
	Congenital deformities	0121	Spina bifida
		0129	Other congenital
	Other disabling impairments	0131	Lymphoedema
		0132	Other disabling impairments
	Developmental disabilities	0151	Developmental disabilities
	Re-conditioning/ restorative	0161	Re-conditioning following surgery
		0162	Re-conditioning following medical illness
		0163	Cancer rehab

A2.3.3.6 Geriatric evaluation and management and maintenance classification

All GEM activity is classified into one class in the i-SNAC model and all maintenance activity is classified into one class. The classification is based on the care type recorded in the VAED for the patient's episode and the health service that admitted the patient. The VAED care types that can be mapped to either the GEM or Maintenance i-SNAC arms is shown in Table 2.35.

Table 2.35: Mapping between VAED care type and GEM and maintenance i-SNAC arms

i-SNAC arm	VAED care type code	VAED care type description	Mapping rules
GEM*	9	Geriatric evaluation and management program	All episodes
Maintenance care*	9	Maintenance care	All episodes

A2.3.3.7 Rehabilitation, GEM and maintenance LOS and leave days

The calculation of an i-SNAC value requires the LOS of the patient in the class to be multiplied by the class weight. The LOS is effectively the number of midnights the patient stays in the health service. It is

calculated by subtracting the admission date from the separation date and subtracting the number of leave days (the number of midnights the patient was away from the health service, if any).

The VAED data items required to calculate the LOS for activity classified to the rehabilitation, GEM and maintenance classes are:

- admission date: date on which an admitted patient commences an episode of care (formal or statistical)
- separation date: date on which an admitted patient completes an episode of care.
- leave with permission days total: the total number of days during this episode of care that the patient was out of hospital 'on leave with permission', including days from the previous financial year(s).

The leave with permission days total cannot be less than one day for rehabilitation, GEM or maintenance. If the patient was admitted and separated on the same day and therefore did not spend a midnight in the subacute care type, the LOS is adjusted upwards to be one day.

Calculating the i-SNAC value

Once the LOS and the class have been determined for the rehabilitation, GEM or maintenance activity, the i-SNAC value is calculated by multiplying the effective LOS by the class weight for the activity. Table 2.36 shows the 2014–15 weights for the rehabilitation, GEM and Maintenance classes.

Table 2.36: Rehabilitation, GEM and maintenance weights in 2014–15

i-SNAC care type	i-SNAC sub-class	Price weight
Rehabilitation	Stroke	1.332
	Brain dysfunction	1.730
	Neurological	1.325
	Spinal cord	2.514
	Amputation	1.333
	Pain	1.260
	Orthopaedics	1.239
	Cardiac	1.266
	Burns	1.227
	Major multiple trauma	1.728
	Other	1.188
Geriatric evaluation and management	GEM	1.188
Maintenance	Maintenance	0.865

Example

A patient is admitted with a stroke on 11 September 2014, and is separated from the hospital on 16 October 2014. The patient goes on leave with permission on 10 October 2014 and returns on 13 October 2014.

Length of stay

Episode start 11 September episode end 16 October = 35 days

Leave start 10 October; leave end 13 October = 3 days' leave

LOS = 35 – 3 = 32 days.

i-SNAC value = 32 × 1.332 = 42.624

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A2.3.4 Determining the weighted bed day value

The WBD value is calculated using the i-SNAC value and applying any applicable loading. There are loadings in two areas: the indigenous status of the patient and the postcode of the patient's usual address. The VAED records this information for each episode.

Loadings can be applied at the episode level for all arms of i-SNAC. As the loadings will not change across the different palliative care phases, it is easiest to calculate the WBD value for the entire episode once the i-SNAC value is known.

A2.3.4.1 Indigenous status

An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander background who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives. Table 2.37 shows the eligible VAED codes that will attract an Indigenous loading to the i-SNAC value.

Table 2.37: The VAED codes and description for the Indigenous loading

i-SNAC Indigenous loading	VAED code	Descriptor
Yes	1	Aboriginal but not Torres Strait Islander origin
	2	Torres Strait Islander but not Aboriginal origin
	3	Both Aboriginal and Torres Strait Islander origin
No	4	Neither Aboriginal nor Torres Strait Islander origin
	8	Question unable to be asked
	9	Patient refused to answer

A2.3.4.2 Remoteness

Remoteness is assigned based on the available data using the following hierarchy:

- The patient's postcode of usual residence is mapped to remoteness areas.
- If the postcode was missing or invalid, then the Department of Health derived Statistical Local Area (SLA) code is used.
- If the SLA code was also missing or invalid, then the remoteness area of the hospital is used. The remoteness code of the hospital was based on the remoteness area of the Australian Bureau of Statistics collection district within which the hospital was located. This table is available from the Department of Health upon request. Please email <abf@health.vic.gov.au> if you would like a copy of the hospital remoteness area table.

A2.3.4.3 Calculating the weighted bed day

The 2014–15 loadings for subacute activity are shown in Table 2.38. If an episode of care attracts two loadings, the loadings are added together before being applied to the i-SNAC value.

Table 2.38: 2014–15 loadings for Indigenous and remoteness

Loading	Loading area	%
Indigenous	Indigenous status: Aboriginal and/or Torres Strait Islander	30%
Remoteness	Outer regional	8%
	Remote	15%
	Very remote	24%

Example

Stroke patient previously described lives in an outer regional area and identifies as indigenous.

i-SNAC value = 42.624

Indigenous loading = 30%

Remoteness loading = 8%

WBD = (1 + 0.3 + 0.08) × 42.624 = 1.38 × 42.624 = 58.82112

A2.3.5 Determining the revenue

The level of revenue an episode generates for a health service is calculated as the product of the WBD value and the appropriate price based on the VAED account class. The VAED account class is used to determine which of three price groups the episode is allocated in i-SNAC. Not all activity is funded through i-SNAC and there are VAED account classes that are funded through alternative means that are outside the scope of i-SNAC.

A2.3.5.1 Account class (public/private, DVA)

Account class is the agency/individual chargeable for this episode. This item is used to determine the price per WBD payable. Account class is used to determine public/private/DVA/ineligible status. Table 2.39 provides a mapping between the i-SNAC price groups and the VAED account class codes.

Table 2.39: Mapping between VAED account class and i-SNAC price groups

i-SNAC model price group	VAED descriptor	VAED code	Descriptor
Public	Public (acute care) patient	MP	Public: eligible
		ME	Ineligible: hospital exempt
		MF	Ineligible: Asylum Seeker
		MR	Geriatric respite care
		MN	Public NHT – without NH5
		M5	Public NHT – with NH5
		MA	Reciprocal health care agreement
Private	Private patient	PA	Advanced surgery 1 (1–14 days)
		PB	Advanced surgery 2 (15+ days)
		PC	Surgery (1–14 days)
		PD	Surgery 2 (15+ days)
		PE	Medical 1 (1–14 days)
		PF	Medical 2 (15+ days)
		PG	Obstetric 1 (1–14 days)
		PH	Obstetric 2 (15+ days)
		PI	Rehabilitation 1 (1–49 days)
		PJ	Rehabilitation 2 (50–65 days)
		PK	Rehabilitation 3 (66+ days)
		PL	Psychiatric 1 (1–42 days)
		PM	Psychiatric 2 (43–65 days)
		PN	Psychiatric 3 (66+ days)

i-SNAC model price group	VAED descriptor	VAED code	Descriptor
		PO	Same day (Band 1)
		PP	Same day (Band 2)
		PQ	Same day (Band 3)
		PR	Same day (Band 4)
		PS	Private NHT – with general care-without NH5
		PT	Private NHT – with general care-with NH5
		PU	Private NHT – with extensive care-without NH5
		PV	Private NHT – with extensive care-with NH5
DVA	Department of Veterans' Affairs patients	VX	Department of Veterans' Affairs (DVA)
		VN	Department of Veterans' Affairs NHT-without NH5
		V5	Department of Veterans' Affairs NHT-with NH5
Not applicable to the i-SNAC model; activity funded through alternative means	Compensable patient	WC	Victorian WorkCover Authority (VWA)
		WN	Victorian WorkCover Authority (VWA) – Non-Acute
		TA	Transport Accident Commission (TAC)
		TN	Transport Accident Commission (TAC) – Non-Acute
		AS	Armed services
		AN	Armed services – non-acute
		SS	Seamen
		SN	Seamen – non-acute
		CL	Common law recoveries
		CN	Common law recoveries – non-acute
		OO	Other compensable
		ON	Other compensable – non-acute
		JP	Prisoner
		JN	Prisoner non-acute
	Ineligible	XX	Ineligible non-Australian residents (not exempted from fees)
		XN	Ineligible non-Australian residents (not exempted from fees) – non-acute

A2.3.5.2 Calculating the i-SNAC revenue

The i-SNAC revenue is calculated as the product of the WBD and the appropriate price group for the episode. Table 2.40 shows the 2014–15 prices for the three price groups.

Table 2.40: 2014–15 prices for i-SNAC activity

i-SNAC payment group	Payment rate per WBD
Public episode	$480
Private episode	$446
DVA episode	$581

Example

Previously described stroke patient is admitted as a public patient.

i-SNAC revenue = WBD × price = 58.82112 × $480= $28234.14

Appendix 2.4: Calculating funding recall

Funding adjustments are calculated as follows.

Step 1: Calculate the proportion of public and private activity.

Using actual activity figures, calculate the percentage of public and private activity for the service.

Step 2: Calculate revised activity targets.

Using the percentages obtained in Step 1, recalculate the public and private targets for the service. The total activity target will remain the same, but the public and private target split may change.

Step 3: Calculate the public / private cash flow adjustment.

To calculate the dollar amount of the public / private cash flow adjustment:

- Subtract the initial activity target from the revised activity target.
- Multiply the difference between initial and revised activity targets by the relevant price to calculate the cash flow adjustment.

Step 4: Calculate the revised total funding for the health service.

- Multiply the revised activity targets from Step 2 by the relevant public and private prices.
- Add the figures for targets together to get the revised target value.
- Multiply the actual activity figures by the relevant public and private prices.
- Add the figures for actuals together to get the actual value.

Step 5: Calculate the total performance percentage.

- Express the actual value as a percentage of the revised target value (calculated in Step 4). This will show the extent to which the health service has performed above or below target.

Step 6: Calculate the throughput adjustment.

To calculate the dollar amount of the throughput recall/payment adjustment:

- Multiply the percentage falling within each bracket (in Table 2.7) by the amount of revised target value (calculated in Step 4).
- Multiple that amount by the relevant recall / payment rate for that bracket (in Table 2.7 and Table 2.8).
- Add the amounts for all brackets together to obtain the throughput adjustment.

Step 7: Calculate the total financial adjustment.

Add the public / private cash flow adjustment (Step 3) to the throughput adjustment (Step 6) to calculate the total financial adjustment for the health service.

Part 3: Conditions of funding

Introduction to Part 3

Part 3 of these guidelines detail the conditions and expectations of funding that apply to funded agencies, including relevant standards and policies.

These guidelines are a functional document that articulates 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, as well as the funding linked to various services, in order to achieve the expected outcomes of the Victorian Government.

Part 1 of the guidelines sets out new funding and initiatives in 2014–15. Part 2 focuses on the financial framework for providing funding. The focus of this part, Part 3, is on funding conditions. Part 4 of these guidelines 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 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 or the Secretary to the Department of Health, the legislative, regulatory and contractual obligations will take precedence.

A note on terminology

The term 'funded organisations' 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,* with 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, which are not health services.

These guidelines are also relevant for Ambulance Victoria, Dental Health Services Victoria, Health Purchasing Victoria and the Victorian Institute of Forensic Mental Health. The guidelines specify where aspects of the guidelines are relevant for these organisations.

3.1 Standards

3.1.1 Public sector values and principles

Values define what is important to an organisation and how things will be done. In the Victorian public sector, they underpin an employee's interaction with the government, community, suppliers and other employees. Section 7 of the *Public Administration Act 2004* outlines the values and how they can be demonstrated:

Responsiveness

- Providing frank, impartial and timely advice to the government
- Providing high-quality services to the Victorian community
- Identifying and promoting best practice

Integrity

- Being honest, open and transparent in their dealings
- Using powers responsibly
- Reporting improper conduct
- Avoiding real or apparent conflicts of interest
- Striving to earn and sustain public trust at the highest level

Impartiality

- Making decisions and providing advice on merit without bias, caprice, favouritism or self-interest
- Acting fairly by objectively considering all relevant facts and applying fair criteria
- Implementing government policies and programs equitably

Accountability

- Working to clear objectives in a transparent manner
- Accepting responsibility for their decisions and actions
- Seeking to achieve best use of resources
- Submitting themselves to appropriate scrutiny

Respect

- Treating others fairly and objectively
- Ensuring freedom from discrimination, harassment and bullying
- Using their views to improve outcomes on an ongoing basis

Leadership

- Actively implementing, promoting and supporting these values

Human rights

- Making decisions and providing advice consistent with the human rights set out in the *Charter of Human Rights and Responsibilities Act 2006*
- Actively implementing, promoting and supporting human rights

Section 8 of the Public Administration Act outlines the principles and what employers must do with them. Employers must establish employment processes to ensure:

- employment decisions are based on merit
- employees are treated fairly and reasonably
- equal employment opportunity is provided
- human rights, as set out in the Charter of Human Rights and Responsibilities Act, are upheld
- public sector employees have a reasonable avenue of redress against unfair or unreasonable treatment
- a career in the public service is fostered (in the case of public service bodies).

The Public Sector Standards Commissioner issues codes of conduct to reinforce the public sector values, and standards on how to apply the employment principles. The codes and standards are binding, but not detailed. They enable employers to introduce policies and practices that suit their organisation while also complying with the codes and standards. Employees should consider the codes, standards and any organisational policies when deciding what action to take.

Further information is available on the Victorian Public Sector Commission's website at <www.vpsc.vic.gov.au/behaviours-aamp-culture/codes-and-standards.html>.

3.1.2 Safety

3.1.2.1 Pre-employment screening

The department and all funded organisations must undertake relevant pre-employment/pre-placement police record checks on all employees to minimise the risk of employing unsuitable people. Safety screening may also include a Working with Children Check, which is a mandatory screening process for people who volunteer or work with children.

3.1.2.2 Staff safety

Health services are required to develop strategies to ensure staff safety, including:

- a policy that defines the organisational response to an incident of clinical aggression (Code Grey) and that aligns with the department's evidence-based principles for such incidents
- review of training programs for clinical and security staff to ensure consistency with the department's principles and minimum standards for training on violence and aggression prevention and management.

More information is provided at <www.health.vic.gov.au/emergency-care/hospital-safety>.

3.1.2.3 Safe environment for transgender or intersex individuals

Funded organisations have a responsibility to provide a safe environment for women, men, transgender people or people with intersex variations. Services should develop local policies and procedures to facilitate gender-sensitive and safe practice, to promote sexual safety andto guide staff in preventing sexual activity and responding appropriately to allegations of sexual assault or harassment.

The department has developed the following documents to provide guidance to services:

- *Service guideline for gender sensitivity and safety*, available at <docs.health.vic.gov.au/docs/doc/Service-Guideline-for-Gender-Sensitivity-and-Safety>
- the Chief Psychiatrist's guideline: *Promoting sexual safety, responding to sexual activity and managing allegations of sexual assault in adult acute inpatient units*, available at <docs.health.vic.gov.au/docs/doc/Promoting-sexual-safety-responding-to-sexual-activity-and-managing-allegations-of-sexual-assault-in-adult-acute-inpatient-units--June-2012>.

3.1.2.4 Patient and client safety

All funded organisations are responsible for the safety of their patients or clients. Funded organisations should have systems and processes in place to enable them to identify, manage and respond to adverse incidents, reducing the risk of such incidents recurring in future.

Health services and agencies that provide health services on behalf of the department are subject to the *Victorian health incident management policy*, available at <www.health.vic.gov.au/clinrisk/vimp>.

The Victorian Health Incident Management System (VHIMS) may be used to report patient or client safety incidents.

The department's *Incident reporting instruction 2013* sets out the management and reporting requirements for incidents involving clients or staff in funded CSOs, registered community health centres and supported residential services (SRSs). The *Incident reporting instruction* clarifies which incidents need to be reported to the department, when and how. It does not supplant organisations' own incident management systems and processes. Organisations' incident management processes may be reviewed as part of the department's routine contract and performance management arrangements.

During 2014–15 the department will issue a revised *Incident reporting instruction* applicable to all funded organisations not using VHIMS (or another approved incident management system).

3.2 Expectations, policies and performance

The following sections outline non-financial performance and behavioural expectations for funded agencies. These expectations are consistent with the *Victorian health service performance monitoring framework business rules 2014–15*. The framework is discussed in Part 1, section 1.3 'Accountability framework' and is available at <www.health.vic.gov.au/hospital-performance/index>.

3.2.1 Acute and subacute

3.2.1.1 National performance measures

National Emergency Access Target

The National Emergency Access Target (NEAT) is part of the health services' Statements of Priorities to reflect the *National partnership agreement on improving public hospital services.*

The NEAT target included in relevant health services' Statements of Priorities for 2014–15 will be a target of 81 per cent of patients presenting to a public hospital emergency department to physically leave the emergency department for admission to hospital, be referred to another hospital for treatment, or be discharged within four hours.

National Elective Surgery Target

The National Elective Surgery Targets (NEST) are part of the health services' Statements of Priorities to reflect the *National partnership agreement on improving hospital services.*

Implementation has been incremental and requires a portion of category 2 and 3 elective surgery patients to be treated within clinically recommended timeframes.

The NEST (part 1) included in relevant health services' Statements of Priorities for 2014–15 are:

- for category 1, a target of 100 per cent will apply
- for category 2 patients, a target of 88 per cent will apply
- for category 3 patients, a target of 97 per cent will apply.

3.2.1.2 Integrated cancer services

All health services that treat cancer patients are expected to be active members of the integrated cancer service for their region and:

- implement best practice models of care
- improve the integration of care through system coordination and integration
- systematically monitor processes and outcomes of care
- participate in statewide initiatives to support improvement in cancer outcomes.

A particular focus for integrated cancer services in 2014–15 is to work in collaboration with relevant cancer centres to streamline governance processes and service improvement priorities, within and across the integrated cancer service regions.

Host organisations are required to hold funds on behalf of integrated cancer services, and act as employers for integrated cancer services staff. Host organisations need to ensure that appropriate human resource management, fiscal management processes and accounting procedures are in place. A senior executive should be nominated as the key management contact regarding these matters.

The integrated cancer services governance groups, with clinician input, are responsible for:

- decision making about using funds in accordance with both local and statewide priorities for cancer reform

- accountability for the integrated cancer service funding
- ensuring value for money
- ensuring sound project management and evaluation processes are employed.

Host organisations and the integrated cancer services governance groups must agree to any charges levied by the host agency for infrastructure support. These charges must be reflective of actual costs incurred, and should be reported in the integrated cancer service's budget. A detailed reporting schedule for integrated cancer services, which identifies requirements and dates/timelines, will be provided in September 2014.

Accountability requirements of the integrated cancer services governance groups are to:

- provide an annual review and report of progress against the current strategic plan
- provide half-yearly financial statements (for periods ending 31 December and 30 June)
- participate in the department's cancer reform meetings and workshops
- provide an annual report (for 2013–14)
- participate in processes to evaluate the impact of cancer reform activities, including reporting outcomes against targets and milestones.

Further information about Victoria's integrated cancer services is available at <www.health.vic.gov.au/cancer/integrated>.

3.2.1.3 Maternity and neonatal services

The department publishes an annual report of Victorian maternity services performance indicators that contains public-hospital-identified and statewide (public and private) data. The report enables health services to:

- track their own performance trends
- compare results with services of similar profile
- identify priority areas for future focus
- regularly review and plan for performance improvement within a continuous quality framework
- evaluate improvement programs and provide feedback to relevant stakeholders.

Consumer-appropriate information is also included in the report. Future reports will look to include indicators relating to neonatal services (special care nurseries and neonatal intensive care units).

Further information about the Maternity and Newborn Program can be found at <www.health.vic.gov.au/maternitycare>.

3.2.1.4 Blood Matters Program

As part of the ongoing commitment to safe transfusion practice, the Blood Matters Program assists health services to monitor transfusion practices against guidelines and provide recommendations for best practice.

Performance reporting through participating in audits and surveys on clinical practice and governance is required. Health services will be advised of the audits to be conducted in 2014–15.

Serious transfusion incident reporting continues as a voluntary reporting system for serious adverse events with transfusion of blood or blood components, including near-miss incidents. Participation in the program is strongly encouraged.

Blood and blood products are provided to health services, with the expectation that product use will align with the Australian health ministers' endorsed *National stewardship expectations for the supply of blood and blood products*, and the associated strategies including *National blood and blood product wastage reduction strategy*.

The national stewardship expectations and the wastage reduction strategy are available at <www.nba.gov.au>.

The department provides funds for transfusion nurses in some metropolitan and regional health services, and also funds a part-time transfusion trainer role in some rural health services.

The following conditions are applicable to the funding:

- employment of an appropriately trained nurse, such as one who holds a Graduate Certificate of Transfusion Practice
- the transfusion nurse/trainer operates within an effective health service transfusion/quality governance structure
- alignment to strategic program directions, including
  - the Patient Blood Management Program, which is an approach to safe and appropriate transfusion care, as defined on the Blood Matters website, including national directions from the National Blood Authority
  - Australian Commission on Safety and Quality in Health Care, *National standards of health care* Standard 7
  - a focus on cancer-specific activity, in addition to existing hospital-wide transfusion practice
  - attendance at professional development days offered by the program (at least one per year)
  - use of performance indicators, including specific indicators communicated by Blood Matters
- transfusion nurses at the regional health services will work in conjunction with the transfusion trainers in their region
- annual progress reports to the Blood Matters Program are required, in accordance with a Blood Matters template and including cancer-related transfusion activities conducted by the health service. Transfusion reports are also required as part of the minimum reporting requirements of the 2012–13 quality of care report.

Further details on the Blood Matters Program can be found at <www.health.vic.gov.au/bloodmatters>.

3.2.1.5 Subacute and non-acute services

Subacute capability and access planning framework

Providers of rehabilitation services, geriatric evaluation and management (GEM) services and Health Independence Program (HIP) services should ensure that they provide, or are working towards providing, services based on their service capability level as defined in the *Subacute capability and access planning framework* ('service capability framework').

Palliative care services 'must adhere to the framework from 2014–15 the framework during 2014–15.

The framework is available at <www.health.vic.gov.au/subacute/pubs>.

Performance monitoring and supporting improvements

Subacute services are subject to the department's broader monitoring of health services, which focuses on the overall activity levels of health services when compared with the target. Additional monitoring is undertaken by the department to benchmark models of care between peers and across the state to support practice and service delivery improvements and better understand patient cohorts.

Subacute activity reports have been developed to provide benchmarking and model of care information. The department will continue to work with subacute services to confirm and describe the models of care required to deliver effective and efficient admitted and non-admitted subacute services. This will include articulating the components of care for programs and service streams and the workforce capacity required to deliver expected outcomes for clients, carers and the overall health system.

Health Independence Program

In 2014–15 the HIP guidelines will continue to guide health service and departmental directions for these services and are at <www.health.vic.gov.au/subacute>.

Over 2013–14 post-acute care (PAC) consortia and fund-holding arrangements were reviewed and disaggregated to better align with other HIP service components. From 1 July 2014 all rural PAC activity and funding has been allocated to the HIP delivering the service.

It is expected that health services will continue to provide the HIP service components for which they are funded based on their subacute service capability framework level. In 2014–15 the HIP service components are articulated through process and service delivery components.

HIP process components

The HIP model of care outlines key processes in the client journey through HIP:

- access and initial contact
- initial needs identification
- assessment
- care planning and implementation
- monitoring and review
- transition and exit.

HIP service delivery components

The components of HIP that a client receives will be based on the client's assessed needs and will assist the clients to meet their identified goals. This may consist of one or more of the following:

- rehabilitation (such as rehabilitation at home or in a community rehabilitation centre)
- care coordination – short term or medium/long term
- client self-management, education and support
- access to specialist services including specialist assessment (such as linking to residential in-reach services, a specialist medical clinic or specialist subacute clinic – falls and balance or continence clinics)
- short-term supports (such as post-acute care)
- complex psychosocial issues management

In 2014–15 the department will continue to work with health services to progress HIP consolidation including reducing variation across services and developing components of care.

3.2.1.6 Providing aids, equipment and domiciliary oxygen

In 2013 the department updated *Fees and charges for acute health services in Victoria: a handbook for public hospitals* to clarify the responsibilities of public hospitals in providing aids, equipment and domiciliary oxygen for patients being discharged from hospital. A statewide equipment program managed by Ballarat Health Services is the main service provider for the Department of Human Services Victorian Aids and Equipment Program.

The guidelines provide information on the Victorian Aids and Equipment Program, a suite of measures funded by the Department of Human Services providing subsidised aids and equipment for people with a permanent or long-term disability to enhance independence in their home, facilitate community participation and support families and carers in their role.

The guidelines have been expanded to provide additional guidance on:

- domiciliary oxygen
- continence aids
- compensable patients

- non-compensable spinal cord patients
- a home renovation service and home renovation loan scheme.

Further information on the Victorian Aids and Equipment Program is available at <www.health.vic.gov.au/feesman/fees9.htm#SectionC7>.

3.2.1.7 Advance care planning

All health services are expected to implement formal advance care planning structures and processes.

Health services will be supported by *Advance care planning: have the conversation – a strategy for Victorian health services 2014–2018*, which provides actions, outcomes and measures to guide the implementation of advance care planning in and across health services.

An implementation advisory group has been established to guide advance care planning across health services. Resources and tools that support the strategy will be made available.

There is a particular focus on priority implementation for patient groups that would most likely benefit from support to articulate their wishes for future treatment and care. These patient groups include:

- frail older people
- people of any age with chronic progressive and life-limiting conditions
- people approaching end of life
- people who are managing multiple comorbidities and/or are at risk of conditions such as stroke or heart failure
- people diagnosed with early cognitive impairment.

Further information on advance care planning is available at <www.health.vic.gov.au/acp>.

3.2.1.8 Palliative care services

Strengthening palliative care: policy and strategic directions 2011–2015 outlines actions to strengthen access to quality palliative care services. The policy will continue to guide the work of palliative care services, consortia and government in 2014–15. The actions outlined in the policy will equip specialist palliative care services in Victoria to meet growing demand for palliative care.

The policy's implementation strategy sets out performance measures, responsibilities for implementation, the evidence required and timeframes. A policy implementation audit tool is completed by palliative care services annually and provides the additional data required to report on policy implementation progress.

In 2014–15 work will continue to develop the next palliative care policy from 2015–16. Health services, NGOs, community providers, academics and peak organisations with a stake in the palliative care sector will be consulted in this process.

Palliative care service planning framework

In 2014–15 the department will align the palliative care services within the subacute planning framework and finalise the capabilities associated with each level.

Regional palliative care consortia

Regional palliative care consortia will continue to play a central role in the planning and coordination of the policy's goals in each region.

In 2014–15 consortia are expected to finalise any strategic projects stemming from the policy and advise the department on the regional arrangements for their ongoing delivery by service providers.

All consortia members should be familiar and act in accordance with the palliative care role statements and policy principles and objectives.

Palliative care consortia and Victorian paediatric palliative care program business rules

These rules relate to:

- funding for consortia to undertake regional planning, coordinate service provision and determine regional priorities for future service development (the following business rules should be read in conjunction with the consortia role statement)
- funding for the Victorian Paediatric Palliative Care Program to provide statewide consultation and liaison for children requiring paediatric palliative care, to build the capacity of health professionals to provide paediatric palliative care and to manage the paediatric palliative care flexible funds.

Funding received by the fund holders should be treated as revenue in accordance with AASB 1004.

Funding distributed to consortia members and Victorian Paediatric Palliative Care Program members should be recorded under '22091-22100 Grant received on behalf of and paid to other agencies' in the books of the fund holders. Likewise, consortia members and Victorian Paediatric Palliative Care Program members are to recognise the distributions as revenue.

Expenses incurred by fund holders and consortia members and Victorian Paediatric Palliative Care Program members on this program are to be reported as salaries and wages and non-salary costs accordingly.

Unspent funding held by health services for consortia projects is to be retained in the next year and used in the same program in the following year. Unspent funds held by community or NGO services for consortia projects may or may not be retained for use in the following year, in line with individual consortia decisions.

Consortia and Victorian Paediatric Palliative Care Program members are required to disclose any unspent funding in their special purpose financial statement to the department.

After-hours palliative care

Funding for community palliative care is provided to designated providers. Funding for after-hours provision and the Unassigned Bed Program is not be separately identified in 2014–15 and is included as part of the non-admitted palliative care funding.

Business hours normally fall between 7.00 am and 4.30 pm Monday to Friday, excluding public holidays. Outside these times, it is expected that community palliative care services will provide or arrange for the following minimum level of service:

- telephone advice to clients, carers and families primarily (but not only) about symptom management if required
- a nursing visit if required based on the client's, carer's and/or family's needs (if it is safe for staff to undertake the visit).

Any other after-hours care negotiated between clients and the community palliative care service will be on an individual basis.

Community palliative care services will ensure that the phone number for an appropriately staffed after-hours service is provided to all clients and carers upon admission to that service. To ensure the safe and effective delivery of after-hours services, all community palliative care services will have:

- a multidisciplinary care planning process that anticipates and addresses the need for after-hours palliative care
- a policy and procedures regarding after-hours access to medication
- occupational health and safety procedures and equipment for staff undertaking visits after hours (in accordance with the VWA *Working safely in visiting health services*).

Unassigned Bed Program

The aim of the Unassigned Bed Program is to provide equipment or services that allow palliative care clients to remain at home with a comparable quality of care to an inpatient setting. The Unassigned Bed Program is designed to fund services or equipment that a community palliative care service would not normally provide as part of a standard service or that are above the usual level of service provision.

The inclusion of the Unassigned Bed Program into non-admitted palliative care funding does not change the eligibility criteria or type of services that should be provided to clients. Community palliative care services are expected to manage the demand for equipment and services for their clients.

The community palliative care services will continue to provide equipment or services to:

- clients who have been assessed as meeting the admission criteria of the community palliative care service
- clients who are living in their own home, in an SRS or in residential care
- clients who would otherwise require admission to an inpatient setting, but the client's preference is to remain at home (their care will not be compromised by this decision)
- carers who require additional short-term support in order to continue their caring role for the client who remains in a home-like setting and who would otherwise require admission to an inpatient setting
- clients and carers who are unable to meet the cost of the service without assistance.

All other avenues of funding for the equipment or services should be explored. This includes Home and Community Care (HACC), PAC, Department of Veterans' Affairs (DVA) and Carer's Choice or Commonwealth respite centres.

Clients in residential care services are able to access items specifically related to providing palliative care if they are not included in Schedule 1 Specified Care and Services for Residential Care Services, Part 3, which is found in the *Residential care manual 2009, Edition 1*.

Palliative care programs

The following programs should continue to be provided as part of the palliative care consultancy, community and/or inpatient funding arrangements:

- Aged care link workers are to be appointed in each region, with the aim of improving palliative care capacity in residential aged care facilities.
- Disability link workers are to be appointed in each region, with the aim of improving palliative care capacity in disability accommodation services.
- Health services will continue to support the nurse practitioner program and appointed nurse practitioners in their health services.
- The palliative care interpreter line providing non-government community palliative care services with telephone interpreting, on-site interpreting (both spoken and sign languages) and translation for people making significant life decisions and where essential information is being communicated. Interpreter line funding is included in the community palliative care grant lines from 1 July 2013.

3.2.2 Mental health services

3.2.2.1 Key policies and guidelines for mental health services

The Chief Psychiatrist's guidelines provide specialist advice on clinical practice, especially those areas regulated by the *Mental Health Act 2014*.

The current guidelines are available at <www.health.vic.gov.au/mentalhealth/cpg>.

Program management circulars articulate or clarify departmental policy on key aspects of service provision and are posted at <www.health.vic.gov.au/mentalhealth/pmc>.

The revised *National standards for mental health services 2010* apply to all funded clinical and non-government mental health services. Accreditation frameworks for services delivering specialist mental healthcare treatment and care should reference these standards in 2014–15. The *National safety and quality health service (NSQHS) standards* commenced in January 2013 in all health services.

As a condition of funding, organisations are required to adhere to the service standards and guidelines applicable to the funded activity, including program management circulars and the Chief Psychiatrist's guidelines that have been issued by the department (refer to Appendix 3.2: 'Service standards and guidelines' for further detail of standards and guidelines by activity).

Organisations can obtain copies of the relevant standards and guidelines from their department program and service advisor or, in some instances, through the department's Funded Agency Channel.

Standards and guidelines are at <www.dhs.vic.gov.au/funded-agency-channel>.

Further information on mental health services is available at <www.health.vic.gov.au/mentalhealth>.

3.2.2.2 Clinical mental health performance reporting

Victoria's publicly funded clinical mental health services and clinicians provide highly specialised assessment and integrated care planning for individuals and families in significant distress.

Victorian clinical mental health services employ a mental health triage scale. This scale guides decision making to inform the nature and timeliness of response required for those seeking help for themselves, and for family, carers or concerned others seeking help on another's behalf, and for referrals from other practitioners and services.

The mental health triage scale classifies the outcome of a triage assessment according to the person's eligibility and priority for mental health services and the response required by mental health or other services. The triage scale is designed to be used in community-based mental health services (encompassing child, adolescent, youth, adult and older persons services) to record the outcome of the triage assessment. The mental health triage scale consists of seven categories (A to G), with category A the most urgent and requiring an immediate clinical response for current actions that are endangering self or others. The rating on the scale occurs at the end of the triage process, and records the outcome of the triage assessment.

The mental health triage scale and guidelines for services in implementing the scale are available at <www.health.vic.gov.au/mentalhealth/triage/scale>.

The Program Report for Integrated Service Monitoring (PRISM) now includes triage category B (very high risk of imminent harm to self or others requiring very urgent face-to-face response assessment within two hours (including assessment requested by police under s. 10 of the Mental Health Act) and category C (high risk of harm to self or others and/or high distress, especially in the absence of capable supports requiring an urgent response face-to-face assessment within eight hours) as key focus areas for 2014–15.

From 2012–13 these two triage categories have been shadowed and monitored to orient health services to these activities. This process will continue for 2014–15, including these two triage categories in the *Program report for integrated service monitoring*, is important because they are key measures relating to the responsiveness of services to help-seeking access to clinical mental health services. This responsiveness is the focus for a statewide quality improvement endeavour.

Consistent with the government's commitment to improving access to information on the availability of mental health beds through better bed coordination, services have been improving real-time recording of bed occupancy through the Client Management Interface (CMI) and Operational Data Store (ODS), and access to information about available beds has been improved. Further enhancements of web-based information systems providing information regarding bed availability will be undertaken during 2014–15.

Clinical public mental health services are currently required to report against a series of consumer participation and carer- and family-related data fields. Services will be notified of developments in

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consumer, carer and family reporting obligations following the current review of carer and consumer programs and through the health data standards and systems (HDSS) bulletin and program management circulars.

More detailed information on reporting requirements and timelines is provided in Part 3, section 3.12 'Data collection requirements'.

3.2.2.3 Mental health community support services performance framework

As part of the planned reform of mental health community support services (MHCSS), the department has developed a new funding model and is currently developing a performance framework for selected programs and functions. The framework will be finalised in the first quarter of the 2014–15 financial year.

The new funding model and performance framework (for selected programs) will specify outcome-focused performance measures, outputs and targets, and will take effect from 1 August 2014, as will new service delivery and reporting arrangements. Performance reporting adjustments, to be implemented in 2014–15, will be specified for those MHCSS-funded organisations commencing new services on 1 August 2014.

3.2.2.4 Mental health community support services incident reporting

Agencies funded to provide MHCSS are required to comply with departmental incident reporting processes as part of their service agreement.

Requirements are set out in the department's *Incident reporting instruction*, available at <docs.health.vic.gov.au/docs/doc/Department-of-Health-Incident-Reporting-Instruction-2013>.

Organisations that are also subject to funding agreements with the Department of Human Services are recommended to confirm their conditions of funding directly with the Department of Human Services for reporting incidents related to Department of Human Services clients.

3.2.2.5 Mental Health Act implementation

Victoria's new Mental Health Act will commence on 1 July 2014. The legislation introduces supported decision making, increased safeguards to rights and encourages recovery-oriented service delivery and innovation. Health services must comply with the new Act.

The department will provide indexed recurrent funding of $5.84 million from 2014–15 to support health services to meet the new and changed requirements of the legislation.

To provide additional transition support, the department will also fund specified grants totalling $1.1 million to extend health service Mental Health Act implementation project officers until 31 October 2014.

3.2.2.6 Reducing Restrictive Interventions Project

As part of preparing to implement the new mental health legislation, this project will develop plans to reduce, and where possible eliminate, restrictive interventions in mental health services, initially targeting areas with high seclusion usage. It will also include initiatives to support emergency departments to meet their reporting obligations under the Mental Health Act and to promote best practice use of restrictive intervention for patients.

A framework has been developed to guide services about how to reduce restrictive interventions. Health services were asked to develop local action plans to support a reduction in seclusion and restraint in 2013–14. This occurred through an expression of interest process and was assessed by a committee to establish distribution of funding. Services were supported to develop their plans by a statewide Reducing Restrictive Interventions (RRI) team. This team also developed and implemented training packages for trauma-informed care and sensory modulation. Following an assessment process, $820,000 in funding has been distributed between all services to support the implementation of their plans. An additional

$230,000 has been allocated to services to purchase sensory modulation equipment. As a separate but related initiative, $1 million has been allocated to support a trial of the Safewards model in a number of Victorian services to help reduce the use of restrictive practices.

3.2.2.7 Establishment of the Mental Health Complaints Commissioner

The Mental Health Act establishes the Mental Health Complaints Commissioner (MHCC) in response to community calls for a specialised mental health complaints body in Victoria. The MHCC is operational from 1 July 2014 and will have jurisdiction to receive and resolve complaints about public mental health services. The MHCC will be able to investigate issues arising from complaints, make recommendations and issue compliance notices.

The Governor in Council appointed Lynne Coulson Barr as the first Mental Health Complaints Commissioner on 15 April 2014.

The new MHCC will work with services delivering mental healthcare to develop procedures and processes for receiving and resolving complaints.

3.2.2.8 Mental health tribunal

The new Mental Health Act establishes a Mental Health Tribunal (MHT) to replace the Mental Health Review Board and the Psychosurgery Review Board from 1 July 2014. Additional recurrent funding will be provided from 2014–15 to support the expanded scope and operations of the MHT.

Health services that provide compulsory mental health treatment are funded to facilitate MHT hearings according to legislative requirements. These health services will be required to facilitate MHT hearings in a manner that complies with the Mental Health Act.

3.2.3 Alcohol and other drug services

3.2.3.1 Key standards and guidelines

Service standards and guidelines that apply to funded alcohol and other drug (AOD) services are listed at Appendix 3.2: 'Service standards and guidelines'. Where organisations receive funding for an activity or service, it is a condition of funding that they adhere to the service standards and guidelines listed under the relevant activity.

Organisations can obtain copies of the relevant standards and guidelines from their departmental program and service advisor or, in some instances, through the department's Funded Agency Channel.

Standards and guidelines are available at <www.dhs.vic.gov.au/funded-agency-channel>.

Information can also be obtained from the drug-related services internet site at <www.health.vic.gov.au/aod>.

Organisations are required to deliver services in line with the *Victorian alcohol and other drug client charter*.

Copies of the charter are available at <www.health.vic.gov.au/aod>.

3.2.3.2 Performance management framework

Victorian AOD service system reform brings a renewed focus on outcomes-focused performance monitoring. This will be supported by a new performance management framework for state-funded AOD treatment services scheduled for a phased implementation commencing in late 2014.

The purpose of the framework is to strengthen accountability mechanisms and support the department in monitoring and assessing the efficiency and effectiveness of state-funded AOD treatment.

The new framework, among other things, will:

- drive improved outcomes for consumers, their families, carers and significant others
- hold funded agencies accountable for achieving these outcomes through the efficient and effective use of government funding
- clearly define service deliverables, requirements and framework quality standards
- set out the accountability and reporting requirements of funded agencies, including how performance will be measured and monitored
- enable the department to measure, monitor and assess performance – including level of integration and service collaboration – at an agency and whole-of-system level
- facilitate organisational and program learning to support continuous improvement
- contribute to the evidence base regarding interventions, approaches, processes and behaviours that effectively support people with AOD problems.

3.2.4 Ageing, aged and home care services

Service standards and guidelines that apply to funded aged care services are listed at Appendix 3.2: 'Service standards and guidelines'. If organisations receive funding for an activity or service, it is a condition of funding that they adhere to the service standards and guidelines listed under the relevant activity. The performance targets and monitoring requirements for ageing, aged and home care services are outlined at Appendix 3.1: 'Performance targets and monitoring'.

3.2.4.1 Protection of residential aged care residents' rights and interests

Health services operating public sector residential aged care services (PSRACS) are required to meet Commonwealth legislative requirements relating to protecting residents' rights and interests. Health services should review their PSRACS operations in line with residents' needs and consumer expectations, and the opportunities and risks of the Commonwealth aged care reforms. The department is providing funding to the Victorian Healthcare Association to support services to understand these reforms and assist in re-focusing their operations accordingly.

SRS proprietors have obligations to residents under the *Supported Residential Services (Private Proprietors) Act 2010* and regulations. The department will continue supporting services to address the *Accommodation and personal support standards*, including through the Supporting Accommodation for Vulnerable Victorians Initiative as well as working with CSOs through a partnerships management model to implement the Pension Level Projects initiative in other pension-level SRSs.

3.2.5 Primary, community and dental health

3.2.5.1 Community health

Providing appropriate healthcare for people in the community is a priority in Victoria. The Community Health Program, which is delivered through community health services, provides more than one million service hours per annum. The program focuses on providing person-centred and well-coordinated care comprising flexible service models that are grounded in current evidence.

The *Community Health Integrated Program guidelines* will be released and implemented in 2014–15, after extensive development and consultation with the sectors. The guidelines draw on relevant evidence to provide direction and improve statewide consistency in planning, program design and service delivery.

Supplementary, updated guidelines for chronic disease management, refugee and asylum seeker health and child and family health will also be included. These guidelines will outline considerations for community health when working with these specific populations.

3.2.5.2 Victorian Community Health Indicators Project

The Victorian Community Health Indicators Project supports the delivery of client-centred and integrated services, encourages reflective practice, strengthens clinical governance and contributes to the evidence base for services delivered by community health services. The indicators are consistent with the Australian Commission on Safety and Quality's practice-level indicators and all accreditation standards.

The Victorian Community Health Indicators comprise:

- Community Health Practice Indicators (CHPIs), which focus on key component of service delivery and care coordination, including initial contact, needs identification, assessment, care planning and implementation, monitoring and review and transition and exit
- Community Health Impact Indicators (CHIIs), which aim to enable community health services to measure the efficacy of chronic disease management programs.

Both sets of indicators are being trialled in partnership with the sector and the Victorian Healthcare Association in 2014–15.

3.2.5.3 Aboriginal health

Koolin Balit means 'healthy people' in the Boonwurrung language. *Koolin Balit: Victorian Government strategic directions for Aboriginal health 2012–2022* sets out what the department, together with Aboriginal communities, other parts of government and service providers, will do to achieve the government's commitment to improve Aboriginal health. *Koolin Balit* was launched at the Victorian Aboriginal Health Conference in May 2012 and now drives the strategic directions for the Aboriginal Health Promotion and Chronic Care (AHPACC) partnership initiative and all other department activity relating to Aboriginal health.

Through the *Koolin Balit* performance management framework, agencies funded for Aboriginal health initiatives will be asked to provide six-monthly reports (a mid-year progress report and a final report).

Funded organisations should also ensure they comply with requirements contained in other relevant policies and programs when providing services to Aboriginal Victorians.

Aboriginal health committees

In 2013–14 the department established regional Aboriginal health committees to develop and implement local *Koolin Balit* regional action plans and address local issues in relation to Aboriginal health. The committees form part of a robust governance structure that will support performance monitoring for *Koolin Balit*.

Regional directors co-chair the Aboriginal health committees along with a nominated Aboriginal person from the local community. Committees develop and submit implementation plans to head office and provide six-monthly reports on progress against their plans. All agencies receiving funding through regional offices for Aboriginal health are required to participate in the committee structure.

Aboriginal Health Promotion and Chronic Care partnership initiative

Activity for the AHPACC partnership initiative will be captured within the *Koolin Balit* regional action plans, with reporting carried out in accordance with the *Koolin Balit* performance management framework. Reporting requirements are outlined in Part 3, section 3.12.9 'Primary, community and dental health data reporting requirements'.

New guidelines for the AHPACC initiative were introduced in 2011–12 and have been reviewed and updated in 2013–2014. Funded agencies are required to develop an annual work plan and are encouraged to complete a continuous quality improvement tool to help identify priorities.

The program logic for the defining the funded activities for the AHPACC initiatives can be found in the guidelines at <www.health.vic.gov.au/aboriginalhealth/access/index>.

Karreeta Yirramboi – Victorian Aboriginal public sector employment and career development action plan

The *Karreeta Yirramboi: Victorian Aboriginal public sector employment and career development action plan 2010–15* details a government commitment to increase the participation of Aboriginal people in the Victorian public sector workforce to one per cent by 2015. Under *Karreeta Yirramboi*, which was developed in partnership with the Aboriginal community, public health employers with more than 500 employees are required to develop an Aboriginal employment plan.

To support the growth of Aboriginal employment, the department has prepared the *Employer training funding guide* (April 2014), the *Cultural resource guide* (October 2014) and *Reserving employment positions for Aboriginal people – Using 'special measures' in the Equal Opportunity Act* (August 2012).

Karreeta Yirramboi and associated guides and resources are available at <www.health.vic.gov.au/aboriginalhealth/publications>.

Further information on Aboriginal health initiatives can be found at <www.health.vic.gov.au/aboriginalhealth>.

3.2.6 Identification and management of vulnerable children

Health services are required to provide an annual update reporting against the accountability framework criteria outlined in the *Vulnerable babies, children and young people at risk of harm – best practice framework for vulnerable children* on how their service protects and promotes the safety, health and wellbeing of vulnerable children and families.

Health services should continue to review and improve current practice in this area. The focus of practice improvement should be on strengthening governance systems within health services to ensure the protection and promotion of the safety and wellbeing of children and also on promoting collaborative and innovative relationships with local child protection and family welfare services across all health service areas to ensure integrated service delivery.

The *Best practice framework for vulnerable children* is currently being revised and updated. For the first time, the framework will extend its reach to provide direction for all health providers across the continuum of care, including community and primary health services, mental health and AOD services as well as acute hospitals.

The revised framework will include action areas to guide health service providers and professionals to identify, respond early and support vulnerable children, to protect them from harm and to improve the quality of health service provision. The action areas provide a quality assurance mechanism for health providers to ensure they have the relevant systems in place to meet minimum standards of safety and quality. Health services will be consulted during the development of the revised framework.

The revised framework is expected to be in place during 2014–15.

Further information to assist health professionals in understanding their roles and responsibilities towards vulnerable children can be found at <www.health.vic.gov.au/childrenatrisk>. Free online training for health professionals is also available at <vulnerablechildren.e3learning.com.au>.

Victorian Forensic Paediatric Medical Service

The Royal Children's Hospital is the statewide governing body for Victorian Forensic Paediatric Medical Services (VFPMS). Services are provided by the Royal Children's Hospital, Monash Medical Centre and all regional health services. A key function of the VFPMS is to provide a forensic assessment of injury and neglect to children from birth to 18 years where there is suspected child abuse and neglect. While the Royal Children's Hospital is responsible for providing leadership and clinical guidance for the statewide service, all regional health services are expected to provide appropriate 24-hour clinical forensic services for these children. Locally based agreements between regional health services and VFPMS outlining roles and responsibilities are expected to be in place during 2014–15.

3.3 Accreditation

Funded organisations have a range of obligations related to clinical service provision. These requirements have been put in place to ensure the quality of services and the safety of patients.

3.3.1 Australian Health Service Safety and Quality Accreditation Scheme

Since 1 January 2013 accreditation of health services now falls under the Australian Health Service Safety and Quality Accreditation Scheme. Under this scheme, health services are required to be accredited against the National safety and quality health service (NSQHS) standards.

All eligible health services will be assessed against the national standards at their next accreditation assessment scheduled after 1 January 2013. This scheme applies to all health services, including small rural health services (SRHS), clinical mental health services and public dental services housed in community health services.

Under the scheme the department, as the jurisdictional regulator, has responsibility for verifying the accreditation status of health services.

Accreditation status will be monitored by the department in accordance with the *Accreditation – performance monitoring and regulatory approach business rules 2013.* These business rules detail the department's regulatory approach to accreditation outcomes and provide health services with a clear understanding of the requirements of the new scheme and reporting obligations.

Performance against accreditation will be reviewed at performance meetings with health services. The regulatory response will be based on the outcome of the accreditation assessment and allow for escalation of monitoring and intervention

3.3.2 Pathology services

In September 2004 Victoria entered into a memorandum of understanding (MOU) with the National Association of Testing Authorities (NATA), Australia, in recognition of their role as the national authority in Australia for accrediting laboratories and as an accreditor of inspection bodies.

One of the undertakings made in the MOU is that Victoria will encourage all service providers to adhere to the principles of good laboratory practice contained in NATA's relevant accreditation criteria.

An additional MOU that specifically relates to pathology laboratories was entered into by NATA and the chief health officer on behalf of the department. It embodies the spirit of cooperation between the department and NATA in relation to protecting public health.

On the basis of these undertakings, the conditions of funding are:

- Any laboratory operated by a health service whose principal function is to conduct pathology services[1] must obtain and maintain accreditation from NATA or the Royal College of Pathologists of Australasia for the pathology services it provides.
- Any pathology service required for a public, private or compensable admitted patient of a health service must only be requested from a laboratory that holds accreditation from NATA or the Royal College of Pathologists of Australasia for the type of service required.

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[1] A pathology service, for the purposes of these guidelines, is any service (excluding those conducted solely for research purposes) that:

- subjects human tissue, fluids or body products to analysis for the purposes of diagnosis or prevention of disease
- advises on ways to improve overall health and/or wellbeing
- advises on nutritional status and/or dietary needs
- advises on genetic constitution or risk.

- Any pathology service required for a patient attending an outpatient clinic of a health service must only be requested from a laboratory that holds accreditation from NATA or the Royal College of Pathologists of Australasia for the type of service required.
- The conduct of any pathology service provided for a health service that is not under the direct management of a pathology laboratory accredited by NATA or the Royal College of Pathologists of Australasia (for example, services provided by research laboratories, specialist clinical laboratories or at the point of care) must be overseen by a pathology laboratory that is accredited by NATA or the Royal College of Pathologists of Australasia for the relevant scope of services.

3.3.3 Ambulance Victoria

Ambulance Victoria is not currently required to be accredited against the NSQHS standards. During 2014–15, the Australian Commission on Safety and Quality in Health care will examine the applicability of the NSQHS standards for ambulance services across Australia. This work will result in developing specific information and resources to help ambulance services prepare for accreditation to relevant NSQHS standards. Ambulance services in Australia are not currently part of an accreditation or external assessment process, with the exception of Victoria. Ambulance Victoria has organisation-wide accreditation to the business standards ISO9001.

3.3.4 Mental health clinical and community support services

All funded clinical mental health services are required to be accredited against the *National standards for mental health services 2010.* In addition, as outlined above, the NSQHS standards apply to all mental health services delivered by Victorian health services.

In 2012–13 organisations that received funding for a PSRSS program were required to implement the *National standards for mental health services 2010.* Ongoing implementation of these standards is expected of organisations that will receive funding for MHCSS in 2014–15.

These services are also required to continue to be accredited within existing generic accreditation frameworks by an entity certified by either the International Society for Quality in Health Care or the Joint Accreditation System of Australia and New Zealand.

3.3.5 Alcohol and drugs treatment services

Likewise, in 2012–13 organisations that received funding for AOD services were required to establish and implement plans to deliver services consistent with the *Victorian alcohol and other drug charter.* Ongoing implementation of plans to deliver services consistent with the Victorian charter are expected of organisations that will receive funding for AOD services in 2014–15.

3.3.6 Aged care

3.3.6.1 Residential aged care

The Commonwealth Government has primary responsibility for funding and regulating residential aged care services under the *Aged Care Act 1997.* In accordance with this legislation, all Victorian PSRACS are expected to comply with minimum aged care accreditation standards at all times to receive recurrent Commonwealth subsidies. There are four *Aged care accreditation standards* comprising 44 expected outcomes in areas relating to management, staffing, health and personal care, resident lifestyle, living environment, catering, cleaning, continuous improvement, and safety and security.

Accreditation of residential aged care services against the aged care accreditation standards is undertaken by the Australian Aged Care Quality Agency. The Quality Agency is a statutory body that replaced the Aged Care Standards and Accreditation Agency Ltd on 1 January 2014.

As well as meeting the minimum Commonwealth requirements, it is expected that Victorian PSRACS will actively engage and participate in the department's initiatives that aim to support safe, high-quality, evidenced-based, person-centred care.

3.3.6.2 Home and Community Care

Quality assurance applies to managing and delivering all Victorian HACC services.

The 'HACC quality framework' section of the *Victorian HACC program manual* outlines the details of the quality framework, which aims to ensure HACC services are of high quality and people's rights are upheld (see <www.health.vic.gov.au/hacc>).

The quality framework comprises the:

- *Community care common standards guide*
- *HACC statement of rights and responsibilities*
- *Victorian HACC program complaints policy*.

The community care common standards (CCCS) have been applicable to the HACC program, Commonwealth home care packages and the National Respite for Carers Program since 1 March 2011. Every three years each HACC-funded organisation will have a quality review against the CCCS. The quality review process for organisations funded to provide HACC services in Victoria is detailed in the *Victorian HACC program manual*. Quality reviews for Commonwealth-funded programs will be conducted by quality reviewers from the Department of Social Services.

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3.4 Clinical governance

3.4.1 Health service clinical governance

All health services and funded organisations are required to ensure their clinical governance policies/frameworks comply with the provisions contained in the *Victorian clinical governance policy framework: enhancing clinical care* (2008). Health services are required to measure and monitor compliance with the policy and report in their annual quality of care report under the framework's quality and safety domains: consumer participation, clinical effectiveness, effective workforce and risk management. Compliance at a state level is monitored through accreditation mechanisms.

Links to the policy and toolkit can be found at <www.health.vic.gov.au/clinrisk/publications/clinical_gov_policy>.

3.4.1.1 Clinical risk management

The Victorian Health Incident Management System (VHIMS) is a standardised dataset and methodology for clinical (patient) incident management. This dataset was designed to enable health services and the department to undertake aggregation, data analysis and trend identification of multi-severity clinical incident data from across Victorian public health services and funded organisations.

The VHIMS is supported by the *Victorian health incident management policy*. The department is committed to developing a culture and environment that:

- promotes an open and positive approach to incident management
- recognises that most incidents occur because of problems with systems rather than individuals
- emphasises continuous improvement
- facilitates the safety of patients, staff and others.

The *Victorian health incident management policy* provides guidance for health services (and organisations) on best practice principles and governance of incident management, including open disclosure.

Further information is available at <www.health.vic.gov.au/clinrisk/vimp>.

3.4.1.2 Sentinel event reporting

All health services and funded organisations that identify an incident that reflects a national sentinel event as defined in the *Victorian health incident management policy* are required to report the incident to the department's sentinel event program as follows:

- organisations must notify the department within three days of the incident occurring or the organisation becoming aware of the incident
- the final de-identified root cause analysis summary report must be provided to the department within 60 days of notification.

Report templates and additional information on the department's sentinel event program can be accessed at <www.health.vic.gov.au/clinrisk/sentinel/ser>.

3.4.1.3 Core hospital-based outcome indicators

The Australian Commission on Safety and Quality in Health Care (ACSQHC) developed a suite of core hospital-based outcome indicators to enable all Australian health services to routinely review their performance. Core hospital-based outcome indicators reveal where patient outcomes are within the expected range for the state and peer hospitals, are significantly better than expected or are potentially in need of improvement.

The indicators measure in-hospital mortality, unplanned readmissions and healthcare-associated infections (HAIs). With the exception of the indicators for HAIs, the core hospital-based outcome indicators utilise routinely collected hospital administrative data as an information source.

The core hospital-based outcome indicators are:

- in-hospital mortality
  - hospital standardised mortality ratios
  - death in low-mortality diagnostic related groups
  - death following treatment for acute myocardial infarction
  - death following treatment for pneumonia
  - death following treatment for stroke
  - death following treatment for fractured neck of femur
- unplanned readmission
  - following treatment for acute myocardial infarction
  - following a knee replacement
  - following a hip replacement
  - following treatment for paediatric tonsillectomy and adenoidectomy
- HAI
  - Staphylococcus aureus bacteraemia
  - hospital-identified Clostridium difficile.

The ACSQHC developed these indicators to flag areas of potential improvement and not as definitive measures of poor quality and/or safety in patient care. Health services are required to investigate outcomes that vary from state and peer group rates to understand whether the variation is clinically significant, and whether improvements in processes of care are required.

The department will continue to monitor the Victorian-based unplanned or unexpected readmission indicators quarterly in PRISM.

The department will commence reporting the in-hospital mortality indicators in PRISM in 2014–15 for major providers, regional, sub-regional and local peer group health services as a quality improvement activity. Mortality measures are not classed as a performance measure in this context.

3.4.1.4 Infection control

Effective prevention, monitoring and control of infection are an integral part of the quality, safety and clinical risk management operations of any health service.

A key initiative to improve infection control is Victoria's HAI surveillance program and the Victorian Healthcare Associated Infection Surveillance System (VICNISS) Coordinating Centre.

The VICNISS Coordinating Centre collects and analyses data from individual hospitals on risk-adjusted, procedure-specific infection rates. All public health services are required to provide data to the VICNISS Coordinating Centre according to the type one (more than 100 beds) and type two (fewer than 100 beds) participation indicators.

The indicators can be found at <www.vicniss.org.au>.

These data are then submitted to the department for monitoring against the *Victorian health service performance management framework* and associated *National health reform agreement* performance measures.

Improved hand hygiene practices are linked to a reduction in HAI rates. All health services are required to participate in the ACSQHC National Hand Hygiene Initiative. This initiative was established to implement a national hand hygiene culture-change program to standardise hand hygiene practice and placement of alcohol-based hand rub in every Australian hospital. Health services are required to complete three compliance audits against the five moments of hand hygiene:

- before touching a patient
- before a procedure
- after a procedure or body fluid exposure
- after touching a patient
- after touching a patient's surroundings.

Hand hygiene performance is measured against a benchmark rate of 70 per cent. For submission criteria see <www.hha.org.au>.

Public reporting of individual hospital/health service hand hygiene compliance is via the My Hospitals (www.myhospitals.gov.au) and the Victorian Health Services Performance (http://performance.health.vic.gov.au/Home/Category.aspx?CategoryKey=5#Anchor) websites.

The Victorian cleaning standards are a performance requirement of the department and are applicable to all relevant acute and subacute Victorian public hospitals, regardless of whether the cleaning service is outsourced or performed in house.

Cleaning standards performance and reporting requirements are available at <www.health.vic.gov.au/ideas/infcon/cleaning>.

3.4.1.5 Streamlining clinical trial research

The government continues to encourage clinical trial activity within health services. In particular, the department has established a system for streamlining the ethical review of multisite clinical trials managed centrally by the Coordinating Office for Clinical Trial Research.

Health services that participate in research projects involving human subjects at more than one site are required to do the following:

- They must first sign the standard MOU between the department and the health service to facilitate the central ethical review system's operation. This has extended to a new initiative involving national mutual acceptance of multisite ethical review for clinical trials. Ethics committees providing inter-jurisdictional ethical review are required to be certified with the National Health and Medical Research Council. It is expected that health services will participate in national mutual acceptance of ethical review of multisite clinical trials that will supersede the interstate mutual acceptance system.
- They must comply with all matters agreed in the MOU, including acceptance of a single ethics review decision by an accredited human research ethics committee and the reporting and research governance obligations associated with the conduct of clinical trials.
- They must help consolidate research activity information concerning Victoria's public hospital sector by using the Australian Research Ethics Database to enter data for all research governance assessments and ethics applications for single and multisite studies involving human subjects.

Health services hosting a human research ethics committee that conducts reviews of clinical trial research and was accredited by the former Consultative Council for Human Research Ethics will be required to conduct sufficient ethical reviews to maintain expertise.

Further information is available at <www.health.vic.gov.au/clinicaltrials>.

3.4.2 Community health clinical governance

Funded organisations receiving community health program funding are expected to have strong clinical governance systems and practices to ensure the quality and safety of services. They are required to review their clinical governance structures and have adequate internal documentation to ensure consistency and compliance with the *Victorian clinical governance policy framework*.

Funded organisations that receive funding through Primary Health Output Group activities must be accredited by a body or entity that is accredited by the International Society for Quality in Health Care or the Joint Accreditation System of Australia and New Zealand.

All public dental services are required to be assessed against the NSQHS standards at their next accreditation assessment.

The department is committed to streamlining accreditation requirements for funded organisations. During 2014–15 the department and sector representatives will collaborate with the ACSQHC to develop a workbook and electronic monitoring tool to help implement the NSQHS standards in community-based health settings, including community health.

Performance monitoring of accreditation against the national standards by the department and Dental Health Services Victoria in 2014–15 will be undertaken as per the *Accreditation – performance monitoring and regulatory approach business rules* (2013).

3.5 Consumer rights and community participation

3.5.1 Australian Charter of Healthcare Rights in Victoria

The *Australian charter of healthcare rights in Victoria* is based on the *Australian charter of healthcare rights*, and is aligned with the Victorian Charter of Human Rights and Responsibilities Act. It describes and promotes the rights of patients, consumers and family members using the Victorian healthcare system.

The charter specifies seven healthcare rights: access, safety, respect, communication, participation, privacy and comment. These rights are applicable across all funded organisations in Victoria, including public and private hospitals, general practice clinics, medical specialists, aged care services and disability services, mental health services, registered community health centres and allied health providers.

The aim of the *Australian charter of healthcare rights in Victoria* is to ensure that healthcare is provided in a manner that embodies the seven healthcare rights, and is safe and of high quality. The Victorian charter should be distributed and available at all funded organisations. Access to the *Australian charter of healthcare rights in Victoria* is a requirement of the new NSQHS standards under the Australian Health Service Safety and Quality Accreditation Scheme.

The *Australian Charter of healthcare rights in Victoria* can be ordered in a variety of formats, including audio file, from <www.health.vic.gov.au/patientcharter>.

3.5.2 Consumer, carer and community participation

The consumer, carer and community participation standards and indicators are outlined in the department's policy *Doing it with us not for us: strategic direction 2010–13.* As part of the commitment to implement the *Victorian Health Priorities Framework 2012–2022*, the department began evaluating the policy with consumers and carers and health services in 2013–14. The department, in partnership with health services, consumers and carers, is:

- evaluating the *Doing it with us not for us* policy
- developing a new policy to lead consumer participation across the Victorian health system and enhance responsiveness to our diverse community
- developing a policy to guide health literacy improvement and development of consumer health information
- implementing new methods to measure and report consumers' and carers' healthcare experiences to guide improvements in healthcare provision.

During this period health services should continue to achieve the priority actions set out in *Doing it with us not for us*. All funded organisations are required to actively support and promote consumer, carer and community participation at all levels of healthcare, including support for community advisory committees. The policy's comprehensive suite of participation standards and performance indicators should be reported in the annual quality of care report. In achieving the standards and indicators of the policy, health services will be ensuring that they meet the new NSQHS standards under the accreditation scheme.

The policy, standards and indicators and updates on the evaluation and new policy development are available at <www.health.vic.gov.au/consumer>.

Under the *Carers Recognition Act 2012* people in care relationships, and the contribution of carers, need to be recognised by:

- councils, within the meaning of the *Local Government Act 1989*

- organisations funded by government that are responsible for developing or providing policies, programs or services that affect people in care relationships.

The Act lists principles that must be respected by councils and relevant funded organisations. These principles promote understanding of the significance of care relationships, and the people in them. The Act is supported by the Victorian charter supporting people in care relationships. Councils and relevant funded organisations are required to report on how they met their obligations under the Act in their annual report; this may be as simple as including a paragraph detailing the actions taken during the year to comply with the Act.

Information, including legal responsibilities and obligations of local government and organisations, is available at <www.dhs.vic.gov.au/carersact>.

3.5.3 Victoria's health experience

3.5.3.1 Victorian Healthcare Experience Survey

The department supports health services to collect patient experience data and to use this information to improve patient experiences. The Victorian Healthcare Experience Survey (VHES) has been established to assist health services understand how consumers and, where appropriate, carers feel about their recent experience of care provided by a Victorian public health service.

The establishment of a new measurement and public reporting process under the VHES will include moving from a largely patient satisfaction questionnaire to one more focused on patient experiences. Measuring patient experiences identifies areas where these experiences can be improved and the measures that are enhancing person- and family-centred care; it provides health services with actionable results.

The adult inpatient survey is based on the United Kingdom's National Health Service's (NHS) survey and includes some questions from the American National Research Corporation. The adult maternity and emergency department patient experience surveys are based on the relevant UK's NHS surveys.

All surveys are being developed with funded agencies and consumer and carer working groups. They are cognitively tested with consumers (and where appropriate carers), piloted through a sample of the appropriate funded agencies and will include verbatim comments thematically streamed from survey respondents.

3.5.3.2 Ambulance Patient Satisfaction Survey

The Council of Ambulance Authorities undertakes an annual Patient Satisfaction Survey for ambulance services across Australia. The survey investigates service quality and satisfaction ratings of Australian ambulance services, including Ambulance Victoria, by state/territory. Patients evaluate their experience of using the ambulance service across different dimensions including timeliness, telephone assistance, treatment received, paramedics' care, journey quality and overall satisfaction.

3.5.4 Health service community advisory committees

Under Schedule 5 of the Health Services Act public health services are required to have a board community advisory committee. Health services should continue to work with their committee to ensure that consumer, carer and community participation are integrated into service development, quality improvement planning and other relevant activities across all levels of their organisation.

A community participation plan covering a one- to five-year period shall be developed as part of each scheduled public health service's strategic plan. It must outline the role of the community advisory committee, the health service's board and executive management to ensure that consumers, carers and community members are involved in service development, planning and quality improvement. The community participation plan, depending on the rolling period, should be lodged with the department as

part of the health service's overall strategic plan by 30 November 2014. The plan should address the key areas outlined in *How to develop a community participation plan*.

The plan is available at <docs.health.vic.gov.au/docs/doc/How-to-develop-a-community-participation-plan>.

A report monitoring the progress towards meeting the targets, outputs and outcomes articulated in the community participation plan must be lodged with the department's Consumer Partnerships and Quality Standards unit by 30 November each year. Any changes to the plan, as part of the scheduled public health service's review cycle, should be forwarded to the department as part of this annual report.

Primary care and population health advisory committees

Under the Health Services Act health services are required to have a primary care and population health advisory committee. Health services should continue to work through these committees to consider the broader needs of the community.

3.5.5 Reporting on quality of care

All health services, multipurpose services and registered community health services are required to produce an annual quality of care report. The quality of care report for 2013–14 is required by the department by Friday 31 October 2014.

Further information, including contact details and recommended reporting guidelines, is provided at <www.health.vic.gov.au/consumer/quality-of-care-reports>.

3.5.6 Partnerships

All funded organisations are required to participate actively in Primary Care Partnerships including encouraging staff participation in Primary Care Partnership activities where appropriate.

The *2013–17 program logic* guides the work and priorities of Primary Care Partnerships. It consists of three key domains: early intervention and integrated care; consumer and community empowerment; and prevention. This encompasses the system level work of Primary Care Partnerships, including service coordination, e-health, integrated disease management, integrated health promotion and strategic partnership development. Further information can be found at <www.health.vic.gov.au/pch/commhealth/improvement>.

Partner agencies on the governing board or managing committee of the Primary Care Partnership are required to sign the partnering agreement and be listed as a party to the *Department of Health consortia agreement*.

Where beneficial to the care of clients (for example, to improve access to services or to improve coordination of care), all funded organisations are expected to develop effective relationships with general practitioners and other private providers. Primary Care Partnerships and Medicare Locals provide mechanisms to facilitate systematic engagement with these private providers.

3.5.7 Service coordination

Service coordination aims to place consumers at the centre of service delivery, and ensure that they have access to services they need, early intervention and coordinated care.

Well-developed enablers to service coordination exist, including common practice standards (the *Victorian service coordination practice manual 2012*), common screening and referral tools (service coordination tool templates, or 'SCTTs'), electronic referral systems and the *Service coordination continuous improvement framework*.

All organisations are expected to provide quality service coordination and use the SCTTs (where relevant) to make referrals and share consumer information.

In 2014–15 the focus of work will include:

- continuing to implement the *Common service coordination practice standards*, as documented in the *Victorian service coordination practice manual 2012*
- developing local agreements to progress inter-agency shared care planning
- working with the Department of Human Services to facilitate service coordination for Services Connect clients
- continuing to work on a sustainable approach to workforce development to improve skills and knowledge in service coordination practice (this includes the roll-out of a Victorian-accredited service coordination course available through registered training organisations)
- continued implementation of the 2012 SCTTs. The templates support the collection, recording and consented sharing of initial contact, initial needs identification, referral and coordinated care planning information in a standardised way. The 2012 revision resulted in a number of significant improvements, including the introduction of more support for managing accommodation and safety, drug, alcohol and tobacco issues, and health and social needs. The review also introduced amendments to support a better focus on people with a disability, carers and people from an Aboriginal or Torres Strait Islander background.

3.5.8 Informed consent for receipt of services

Funded organisations are required to ensure all clients receiving services have had an opportunity to discuss options regarding their care and provide full consent to the care they receive. Evidence of informed consent should be documented in the client record. Victorian public health services will be provided with a comprehensive suite of high-quality, plain-language, current, evidence-based, endorsed, electronically accessible patient information brochures (in English, 'easy read' format and community languages) on speciality medical procedures. This information can be readily disseminated to patients, consumers and carers to help ensure informed consent and consumer participation in clinical decision making.

3.5.9 Complaint management

All funded organisations are required to have effective and responsive management systems in place to respond to complaints in a timely and appropriate way.

Resources for organisations to manage complaints are provided by the Office of the Health Services Commissioner (OHSC) and can be accessed via its website at <www.health.vic.gov.au/hsc>. This includes train-the-trainer modules to assist health service providers to develop and implement effective complaint handling practices as well as training and online resources to increase understanding and awareness about the *Health Records Act 2001*.

Public hospital patient representatives should report complaint data to the OHSC in an aggregated form in quarterly and annual reports via the VHIMS.

3.5.10 Health service cultural and linguistic diversity requirements

The *Cultural responsiveness framework: guidelines for Victorian health services* is a tool to strengthen the capacity of health services to respond to the needs of culturally and linguistically diverse patients.

The standards specified in the framework require that all health services demonstrate the following:

- a whole-of-organisation approach to planning and review
- leadership for planning by senior management
- provision of accredited interpreters to patients who require one
- inclusive practice in care planning for patients
- participation of culturally and linguistically diverse consumers in the planning, improvement and review of programs

- provision of professional development opportunities for staff at all levels across the organisation to enhance their cultural responsiveness.

The framework specifies that health services must develop and submit a cultural responsiveness plan to the department, covering at least a three-year planning cycle. Reporting on achievements towards the standards began in 2011 and is a continued requirement in health services' annual quality of care reports for 2014–15. The *Cultural responsiveness framework* is currently being evaluated as part of the *Doing it with us not for us* evaluation.

Further information about the standards and reporting requirements of the *Cultural responsiveness framework* can be found at <www.health.vic.gov.au/cald/cultural-responsiveness-framework>.

The *Language services policy* guides the provision of language services and outlines critical points for providing interpreters and translated material. All health services are required to ensure completion of two data elements in the Victorian Admitted Episodes Dataset (VAED), Victorian Emergency Minimum Dataset (VEMD) and Victorian Integrated Non-Admitted Health (VINAH) collections relating to preferred language spoken and interpreter required as proxy measures of local demand for language services.

Information about the *Language services policy* is available at <www.health.vic.gov.au/diversity/cald>.

3.6 Financial requirements

3.6.1 Health service procurement and purchasing requirements

Under the Health Services Act the chief executive officer (CEO) of a health service must provide Health Purchasing Victoria (HPV) (on request, and within the period specified in the request) with audited reports stating compliance with HPV purchasing policies and HPV directions. Health services are also required to provide HPV with information and data relating to the supply of goods and services and the management and disposal of goods.

Health services must conduct periodic reviews of compliance with HPV policies, directions and any HPV agreement applicable to the health service, using an appropriate compliance monitoring strategy such as an internal audit program. The health service CEO must report the result of these reviews to their board and to HPV.

Through the annual HPV compliance survey, the health service must also provide a report to HPV that the health service has undertaken an assurance process.

HPV is currently reviewing its purchasing policies to incorporate the strategic procurement approach of the recently revised Victorian Government Purchasing Board (VGPB) supply policies, with a view to establishing a new procurement policy framework for health services, aligned to the VGPB policies. These policies will be mandated for all health services after a transition period of two years, effective from June 2016.

Openness and probity in purchasing, tendering and contract activities

Health services should ensure the following overlapping probity directives are met:

- Until the new HPV purchasing polices are in place, health services must, as a minimum requirement, continue to adopt the standards of probity required under VGPB guidelines.
- Health services are required to ensure their probity controls take into consideration the recommendations contained in the Victorian Ombudsman's report *Probity controls in public hospitals for the procurement of non-clinical goods and services*.
- Health services should begin transitioning to the new HPV policy framework once the new policies are gazetted.

3.6.2 Compliance with financial requirements

Section 30(2) of the Health Services Act requires registered funded agencies to obtain approval from both the Minister for Health and the Treasurer before seeking financial accommodation. An approved borrower may obtain financial accommodation, whether within or outside Victoria, secured or arranged in a manner and for a period approved by the Treasurer. These borrowings are guaranteed by the State.

Section 44 of the *Ambulance Services Act 1986* requires an ambulance service to obtain approval from the Treasurer before seeking financial accommodation. An approved borrower may obtain financial accommodation, within Australia, secured or arranged in a manner and for a period approved by the Treasurer.

All registered funded agencies and ambulance services must obtain the appropriate approvals prior to seeking to borrow funds from third parties and prior to entering into third-party finance arrangements for any overdrafts, borrowings or finance leases. These may be for purposes such as capital works and equipment expenditure, including motor vehicles.

In addition, registered funded agencies and ambulance services must not enter into any expenditure related to equipment purchases and capital works where the estimated total costs or total end costs of the works exceeds 10 per cent of the annual revenue of the agency or health service or $2 million, whichever is the lesser amount, unless:

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- the agency or health service has provided a detailed business plan relating to the proposed expenditure to the Secretary to the department
- the expenditure has been approved by the Secretary to the department.

The Secretary's approval in relation to any expenditure referred to the above clauses does not imply or in any way obligate the Secretary or the department to provide any financial support for the works by.

While the department does not place restrictions on the particulars of operating leases, operating lease proposals must comply with the Department of Treasury and Finance's *Prudential risk management framework*. A financial evaluation must be performed on any operating lease longer than 12 months and for capital value worth more than $1 million. This must be approved by the board of management of the registered funded agency.

3.6.3 Goods and services tax

Funded organisations must register for an Australian Business Number and register for goods and services tax (GST) if required. Each funded organisation is responsible for its own tax compliance and liabilities.

Funding between one government-related entity and another government-related entity that is sourced from appropriations and for non-commercial activity is outside the scope of GST pursuant to ss. 9–17(3) of the *Goods and Services Tax Act 1999*. Commercial-type sales of goods or services to the department are taxable supplies.

Public hospitals and Ambulance Victoria are government-related entities under s. 41 of the *Australian Business Number Act 1999*.

3.6.4 Strategic procurement

Health system procurement reform will focus on enhancing hospital cost containment and improved procurement processes by:

- increasing the range of agencies able to procure from HPV contracts and tenders
- increasing the value of contracts managed by HPV and the number of sourcing activities (invitations to supply)
- working with the sector to improve procurement processes
- improving contract delivery and bringing process innovation through category management
- working towards an agreed future model for the health supply chain that improves efficiency and cost-effectiveness.

The Health Services Act was amended during 2012–13 to enable community health centres and women's health centres to access HPV contracts and was further amended in 2013–14 to enable access by entities that deliver ambulance services, health services in association with correctional services, disability services and residential care services, and the Victorian Institute of Forensic Mental Health (VIFMH). HPV will focus on collective procurement, volume optimisation and further broadening the scope of agencies that access HPV's sourcing activities and contracts.

In 2014–15 HPV will work towards achieving further savings and reaching $600 million in contract value.

HPV is committed to implementing the Victorian Product Catalogue System (VPCS). The VPCS is now available to hospitals and health services via the VPCS web access tool, which contains product and pricing information from 20 HPV contracts. The content and functionality of the VPCS web access tool will be enhanced in quarterly releases. The VPCS contains approximately 250,000 items from more than 230 suppliers. The VPCS will serve as an enabler for future supply chain initiatives.

With the VPCS now live, the next goal is to develop and implement a Victorian Common Catalogue. A Common Catalogue builds on the VPCS concept and will provide up-to-date product and pricing information, a centrally defined set of item descriptions, identifiers and categories for all health services.

In 2014–15 HPV will continue to support health services as they transition towards a new strategic procurement policy framework, which will become mandatory in mid-2016.

HPV has also began scoping measurable end-to-end supply chain efficiencies, investigating various reform options and taking into account the practices of other jurisdictions and industries in order to recommend a preferred future state and a phased approach to achieve that state.

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3.7 Asset and environmental management

Asset management is the process of guiding the planning, acquisition, use and disposal of assets to make the most of their service delivery potential and to manage the related risks and costs over their entire life.

Funded organisations must meet government asset management policy requirements and are required to manage, maintain and replace assets so as to optimise value for money, minimise risk and sustain maximum service provision.

The department requires each funded organisation to provide effective and sustainable asset management for assets under its stewardship or control. This responsibility is for all the physical asset classes held and extends across all stages of their lifecycle, including planning, acquisition, operation and maintenance and disposal.

The CEO of a funded organisation is expected to assign responsibility, accountability and reporting requirements, and to establish and maintain management processes to plan, report, monitor and assess controlled assets.

Consistent with Victorian Government policy expressed in *Sustaining our assets* (2000), the department expects asset management governance, planning and practice in funded organisations to be consistent with the scale of their organisation.

The health service board should be regularly informed about the status of asset performance and any risk posed in addition to planned timing of specific investment or disinvestment.

Further information on government asset management policy is available at <www.dtf.vic.gov.au/CA25713E0002EF43/pages/asset-management-in-the-victorian-public-sector>.

Health services procuring public construction works and services must comply with the requirements of the *Project Development and Construction Management Act 1994* and written directions from the responsible Minister in relation to public construction.

For further information refer to <www.dtf.vic.gov.au> or <www.capital.health.vic.gov.au>.

3.7.1 Asset management planning

Effective asset management planning relies on strong governance, aligned corporate leadership and the input of key affected and specialist groups across the health service. If also coupled with ongoing strategic oversight and prudent risk assessment, asset allocation, overall planning quality and implementation improves.

Asset management planning by health services should consider factors highlighted in the *Medical equipment asset management framework*, which has application across asset classes. Additionally, project readiness, project delivery risk management and implementation resourcing are required.

In 2014–15 each health service is required to lodge an updated basic asset management plan for medical equipment and engineering infrastructure. These should be accountable, transparent and underpin quality annual reporting.

3.7.1.1 Basic asset management plans

Health services are expected to develop basic asset management plans covering four year rolling asset management data for medical equipment and engineering infrastructure.

Participating health services are required to lodge updated basic asset management plans with the department as a condition of funding for the specific-purpose capital grant funding and a prerequisite to making a submission for funding in 2014–15 from central funds for high-cost/high-risk replacements.

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Basic asset management plan templates have been provided to participating health services, and further information is available at <www.health.vic.gov.au/med-equip>.

Reporting

All specific-purpose capital grant expenditure is required to be reported as part of Agency Information Management System (AIMS) reporting at the end of the financial year, consistent with departmental requirements. The report needs to correlate with the lodged health service basic asset management plans to demonstrate effective asset management planning and prioritised replacement of in-scope assets.

Health services must report on assets replaced under these programs as a condition of funding. This annual reporting helps demonstrate financial and asset accountability, including reporting on the investment against asset management plans and critical risk mitigation achieved. The department will use this reporting for accountability (including potential audits), policy and practice development purposes, and to inform advice to government on program status and requirements.

3.7.1.2 Planning and implementation

Each participating health service is to prepare and lodge their updated multi-year basic asset management plan for both medical equipment replacement and engineering infrastructure replacement/renewal, consistent with its role in the statewide service system and appropriate to its asset management requirements.

The plan will prioritise asset replacement according to critical risk and thereby guide investment of specific-purpose capital grants at the health service level, and is a prerequisite to inform an invited submission to the departmental central fund.

The devolved funding model facilitates responsive and flexible time-critical replacements, enabling a health service to intervene to avert unacceptable clinical service interruptions or failures.

A health service may also qualify for submission to the High Value Statewide Replacement Fund. The evaluation process applies best practice principles and an Australian Risk Standard-based approach and will be restricted to highest system-wide priorities, in excess of $300,000 in value (exclusive of GST).

Consistent with prioritisation and rationing requirements, health services will be required to contribute from their grant when submitting for funding of high-cost equipment from the centralised funding pool.

Accountability

The specific-purpose capital grant must be managed and invested in compliance with health service or hospital board fiduciary responsibilities and as set out in the program guidelines.

Health services reporting on asset replacement under the initiative are required to demonstrate financial and asset accountability, including investment against asset management plans. Grant reporting will be used for both accountability and policy and practice development purposes. For more information refer to <www.health.vic.gov.au/med-equip>.

Procurement of medical equipment

Health services must comply with government policies and guidelines in their procurement activities.

The department requires health services to engage early and work collaboratively with HPV to maximise value-for-money procurement of medical equipment and deliver the most efficient purchasing arrangements, including standardisation and bulk purchasing and achievement of economies of scale.

For further information, refer to procurement and purchasing requirements and the HPV website at <www.hpv.org.au>.

3.7.2 Property portfolio management

Property portfolio management forms part of asset management and represents actions necessary to realise the full service delivery potential from real property assets. In this context, real property means both the land and the buildings attached to that land.

Funded organisations are responsible for establishing an appropriate legal and administrative framework for occupying and using real property assets under their ownership and/or control.

Health services should:

- ensure the real property assets under its management are zoned appropriately for its current or proposed use
- ensure Land Registry records of its freehold property are up to date
- regularly review their holdings of freehold property and consolidate multiple parcels held under separate title to simplify their future property management activities, including arranging legal agreements for occupying or developing premises and periodic revaluation for financial reporting purposes.

As funded organisations seek to best match services to patient needs, service agreements with third parties will require legal agreements relating to occupying premises that adequately address legislative and service requirements and related risks. Where tenure agreements are proposed for premises located on Crown land, funded organisations must ensure they have the right to enter into such agreements and must comply with legislative requirements and government policy regarding their implementation.

Further information on government Crown land management policy and procedures is available at:

http://www.dse.vic.gov.au/__data/assets/pdf_file/0004/108958/CoMGuidelines.pdf

http://www.dse.vic.gov.au/__data/assets/pdf_file/0008/140777/Crown-land-leasing-policy-Oct-2010.pdf

http://www.dse.vic.gov.au/__data/assets/pdf_file/0015/140190/6977-DSE-Crown-Land-Leasing-Guidelines_2012.pdf

3.7.3 Asset maintenance

Maintenance forms part of asset management. It represents the actions necessary to retain an asset as near as is practical to its original condition. It excludes building cleaning, rehabilitation and any capital investment to replace or renew.

Funded organisations are responsible for providing effective asset maintenance for assets under their stewardship or control to ensure adequate maintenance is sustained over the life of assets, in order to:

- keep them in appropriate condition for the health services they support
- prevent service delivery interruptions or service quality risks
- minimise risks to patient safety and occupational health and safety
- ensure long-term service performance.

Funded organisation maintenance management processes and reporting should include:

- internal information on the condition, suitability and capacity of assets
- reporting on asset-related risks and strategies in place to mitigate them
- establishing annual and long-term maintenance plans for all key sites.

3.7.4 Health service environmental management planning and reporting

In order to assist health services to manage their environmental impact and increase their operational efficiency, health services are required to develop and implement a whole-of-organisation environmental management plan and report publicly on environmental performance.

The environmental management plan is to focus on energy, carbon, water and waste for those campuses that constitute the organisation's material environmental impacts. The plan must include a clear direction for expanding to all major sites and environmental impacts, including procurement, within two years from producing the first plan. A template environmental management plan is available at <www.health.vic.gov.au/sustainability/programs>.

Health services are to report publicly on environmental performance in accordance with the department's *Environmental reporting guidelines.* The guidelines are available at <www.health.vic.gov.au/sustainability/programs>.

The department is adopting a new online environmental data management system to replace the energy and water form in AIMS. It is anticipated that the new system will be implemented over 2014–15 and 2015–16, with health services gradually transitioning from AIMS to the new system. All health services will be required to use the new system once it is operational.

3.8 Information and communication technology standards

In late 2012 the Minister for Health convened an expert panel to review the future directions of Victorian health information and communication technology (ICT), including priorities for future investment. One of the key recommendations from the panel's report was that a statewide health ICT plan be developed. Specifically the panel noted that:

- A statewide health ICT plan should be developed, building on the core strategic recommendations established by this review. The statewide health ICT plan should be developed as a matter of priority.
- The statewide health ICT framework is utilised by the department and health services to ensure that local ICT strategic planning is aligned with government policy and system strategic priorities. Funded organisations must follow to the principles of the statewide health ICT framework.

In addition the expert panel also noted that health service providers should have prime accountability and responsibility through their boards for deploying ICT to support service delivery with governance arrangements that recognise existing devolved accountabilities and responsibilities of health service providers, set against the requirement to obtain system benefits. System benefits that accrue at the system level (such as interoperability) beyond the level of the individual health service provider should be further delineated in the statewide health ICT plan.

The conformance with and adoption of prevailing standards that support interoperability are essential in the healthcare system where the continuum of care traverses many organisational boundaries, and there is devolved accountabilities. For 2014–15 minimum interoperability requirements and an associated interoperability maturity framework have been introduced. Existing ICT standards and specifications that support the new framework continue to be in operation. Details and relevant links are provided on the Office of Chief Information Officer (OCIO) Health Design Authority website at <www.health.vic.gov.au/designauthority>.

Funded organisations must adhere to these standards when planning or implementing ICT projects, including:

- national individual healthcare identifiers for patients (IHIs), healthcare provider identifiers for individual clinicians (HPI-Is) and healthcare provider identifiers for organisations (HPI- Os), as well as other requirements under the *Healthcare Identifiers Act 2010* (Cwlth). These identifiers should be incorporated into all new or updated applications as defined in the minimum interoperability requirements.
- national terminology for enterprise-wide electronic medical record implementations: Australian standard terminology (SNOMED-CT) and the Australian Medicines Terminology (AMT)
- the prevailing Australian version of the Health Level 7 (HL7) as referenced on the OCIO Health Design Authority website for use in Victoria (currently the recommended Victorian standard is HL7 v2.4)
- interaction with the evolving Personally Controlled Electronic Health Record (PCEHR) system and the requirements of the *Personally Controlled Electronic Health Record Act 2012* (Cwlth)
- the national eReferral, Discharge Summary and Shared Health Summary standards and specifications, as defined by Standards Australia and the National E-Health Transition Authority (NEHTA)
- the National Product Catalogue and associated standards and specifications as defined by Standards Australia and NEHTA
- adoption of the *National Health Services Directory* as the primary source for services directory information, previously operating as the Victorian *Human Services Directory*

- the recommended national telehealth standards as defined by the National Health Information and Performance Principal Committee and Standards Australia
- alignment with the *National ehealth security and access framework* (currently version 4.0) developed by NEHTA and endorsed for national adoption by the National Health Information and Performance Principal Committee.

The websites of the Department of Health, OCIO Health Design Authority, the National E-Health Transition Authority, Commonwealth Department of Health and Ageing and Commonwealth Department of Humans Services are important sources of reference material for ICT planning. The information contained on those sites is subject to continual change, both to the standards and their policy settings. Health services should always first review the information on the OCIO Health Design Authority website to determine their applicability within Victoria.

3.9 Risk management

3.9.1 Risk management and assurance

Risk management and assurance activities are essential components of good corporate governance for all funded organisations. These activities will facilitate better service outcomes and quality care, and minimise claims and losses.

3.9.1.1 Risk management

The Health Services Act, *Public Administration Act 2004* and *Financial Management Act 1994* require funded organisations to have effective and accountable risk management systems and strategies in place.

Management and the board are responsible for their organisation's governance, risk management and control processes. Internal auditors assist both management and the audit committee by examining, evaluating, reporting and recommending improvements on the adequacy, efficiencies and effectiveness of these processes.

To ensure risks are being managed in a consistent way, some funded organisations are required under the department's service agreement, Direction 4.5.5 of the *Standing directions of the Minister for Finance* and/or the *Victorian Government risk management framework* to attest annually that:

- they have risk management processes in place that are consistent with the Australian risk management standard *AS/NZS ISO 31000:2009 Risk management – principles and guidelines*
- these risk management processes are effective in controlling risks to a satisfactory level
- a responsible body or audit committee verifies that view.

An organisation's risk management framework can consist of the following components:

- a risk management policy and plan that integrates with corporate planning
- risk registers and profiles
- an incident management system and/or the VHIMS (refer to Part 3, section 3.1.2.4 'Patient and client safety')
- risk management tools, templates and training
- business continuity and emergency management plans
- compliance and quality systems
- a fraud and corruption control plan.

These components assist funded organisations in developing an effective risk-aware culture that includes clinical and all other operational activities.

For more information on risk management, refer to *SA/SNZ HB 436:2013 Risk management guidelines: companion to AS/NZS ISO 31000:2009* and *HB 158:2010 Delivering assurance based on ISO 31000:2009 Risk management – principles and guidelines.*

3.9.1.2 Assurance activities

Assurance activities are designed to provide independent conclusions and a degree of confidence regarding the outcome of the evaluation or measurement of the subject matter against predetermined criteria. The subject matter can take many forms, such as:

- corporate governance practices
- effectiveness and efficiency of operations
- systems, processes, people and performance
- data reliability, completeness, integrity and availability

- accreditation and certifications
- patient or client outcomes and satisfaction
- compliance with laws, regulations and contracts.

Attestations, internal/external audits, accreditations and surveys are some categories of assurance activities that funded organisations may use to provide independent and reasonable assurance to their board, audit committee and/or management that they are on track to achieve their objectives.

An organisation's assurance framework can consist of the following components:

- an assurance strategy and internal audit charter linked to organisational objectives
- an assurance map detailing sources of all assurance activities
- a risk-based assurance/audit plan outlining planned activities
- registers and reports to track implementation progress of recommendations
- key performance indicators of assurance activities.

For more information on assurance and audits, refer to The Australian National Audit Office's *Better practice guide: public sector internal audit* and The Institute of Internal Auditor's *International professional practices framework*, practice advisories and practice guides.

3.9.2 Emergency management

3.9.2.1 Emergency preparedness clients and services policy

The department works with funded organisations to prepare for, respond to and recover from emergencies that affect health sector agencies and the health of Victorians. The department has developed the *Emergency preparedness clients and services policy: summer 2013–14* to assist funded organisations to prepare for external hazards that may occur during the period of heightened risk associated with summer, thereby better protecting and enhancing the health and safety of clients.

The policy describes responsibilities and considerations for emergency planning and preparedness. It aligns with the overarching direction in Victoria's emergency management arrangements requiring organisations to include an 'all hazards approach' in their planning.

The policy encourages a consistent health sector-wide approach to emergency management planning that takes into consideration local conditions, resources and environmental circumstance. Departmental services are defined as those that are:

- delivered from department-owned or managed facilities
- provided through departmental funding
- SRSs regulated by the department.

The policy is at <docs.health.vic.gov.au/docs/doc/Department-of-Health:-Emergency-preparedness-clients-and-services-policy>.

3.9.2.2 State health emergency response plan

The *State health emergency response plan* (SHERP) outlines the arrangements for coordinating the health response to emergency incidents that go beyond day-to-day business arrangements.

Emergencies are complex incidents and local resources may not be able to respond effectively to events such as mass casualty incidents, complex trauma events, mass gatherings and other incidents that affect the health of Victorians.

SHERP is a sub-plan of the Victorian *State emergency response plan*. It is an all hazards, scalable plan and now includes detailed arrangements for regional and state health responses.

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SHERP also incorporates contemporary directions in emergency management, with an increased focus on the needs of children in emergencies and on psychological support to prevent long-term health impacts.

The basis for the department's emergency management responsibilities come from its portfolio responsibilities in health, the Emergency Management Act and the *Emergency management manual Victoria*. The department's two key responsibilities are: to act as the Control Agency for the protection of health; and to manage pre-hospital and hospital responses to emergency incidents. SHERP describes the arrangements for this second responsibility.

SHERP is available at <www.health.vic.gov.au/sherp>.

3.9.3 Fire risk management

Funded organisations are responsible for ensuring they comply with the department's guidelines on fire safety management relevant to the premises they operate. The guidelines are available at <http://www.dhs.vic.gov.au/about-the-department/our-organisation/organisational-structure/our-groups/fire-risk-management>.

Any building surveyor, fire safety engineer or auditor must be accredited by the department. A list of accredited practitioners is at <www.dhs.vic.gov.au/about-the-department/documents-and-resources/forms-and-templates/capital-development-guidelines-series-7-accreditation-application>.

Funded organisations are responsible for ensuring they comply with all laws, regulations and mandatory standards relating to fire protection (from external threats, such as bushfire), fire suppression (fire within the organisation), and general safety that apply to any premises from which the funded organisation operates – irrespective of whether the relevant regulatory requirements place the obligation on the owner or occupier of those premises.

Key fire risk management requirements include the following:

- Funded organisations must ensure that appropriate operational readiness measures are developed, implemented and reviewed. In doing so, funded organisations should prepare for, respond to and recover from emergencies in accordance with the 'all hazards' approach. This includes bushfire, flood, relocation and evacuation and prolonged service interruption. Funded organisations must also ensure that essential services are maintained.
- At the time of client placement in any premises, funded organisations must ensure the premises comply with all laws relating to fire protection, health and general safety that apply to any premises from which the organisation operates. Funded organisations must also ensure the premises are suitable for efficient client evacuation, taking into account the fire systems installed, and the relocation and evacuation capacities of the client. If any relevant change occurs that may affect a client's ongoing ability to evacuate safely, the suitability of the placement must be reassessed and appropriate action taken.

Fire risk management services are now provided through a shared services agreement with the Department of Human Services.

Health services and funded organisations that are required to comply with the department's guidelines on fire safety management shall complete and return Certificate No. 6 of fire safety compliance for 2013–14 to the Department of Human Services via: healthcertificates.frmu@dhs.vic.gov.au, or through their respective regional fire risk management unit coordinator by 30 September 2014.

More information, and a copy of this certificate template, is available at:

http://www.capital.health.vic.gov.au/TechnicalGuidelines

3.10 Legal obligations

3.10.1 Privacy

The obligations of funded organisations regarding collecting, using and disclosing of 'personal information' as defined the *Information Privacy Act 2000* (Vic) (personal information) and health information as defined by the Health Records Act) (health information) are set out in those Acts and in the relevant funding agreement between the parties (funding agreement).

Funding is provided on the condition that the funded organisation must:

- comply with the provisions of the Information Privacy Act and the Health Records Act
- take reasonable steps to ensure its employees, officers, agents and subcontractors comply with the Acts and the terms of the funding agreement.

3.10.2 Intellectual property

The rights and obligations of funded organisations and the Victorian Government regarding ownership and management of intellectual property are set out in the relevant agreement between the funded organisation and the department.

Funding is provided with the following conditions:

- All intellectual property developed by the funded organisation with funding provided by the department vests in the funded organisation unless the department advises the funded organisation otherwise in writing.
- The funded organisation grants a licence to the Victorian Government to use all the intellectual property that vests or was vested in the funded organisation that relate to the funded activities.

The funded organisation will ensure it obtains all the necessary consents (including moral rights consents) to enable the Victorian Government to exercise all the rights conferred on the Victorian Government under the licence referred to above.

- Immediately following a written request from the department, the funded organisation will hand over all materials covered by the licence referred to above.
- The funded organisation will properly manage the intellectual property developed with funding provided by the department to allow the Victorian Government to enjoy the full benefit of providing the funding to the funded organisation.
- The funded organisation must not accept co-funding or involve anyone in providing services without the department's prior written consent if that will impact in any way on intellectual property ownership or the Victorian Government's rights in respect of the use of any intellectual property as set out above.

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3.11 Payments and cash flow

3.11.1 Payments to funded organisations

In 2014–15 the department will make single monthly payments to all health services through the Hospital Budget and Payments System (apart from July when two payments will be made), with standard cash flow percentages. The department will monitor hospital cash flows as reported monthly in the F1 cash flow statement.

The department will make single monthly payments to other funded organisations through the My Agency system, which is accessible through the Department of Human Services website. Monthly cash flows will reflect the terms of individual service agreements.

Payments may be adjusted for recall, loans and prepayments (refer to Part 2, section 2.17 'Prior-year adjustment: activity based funding reconciliation').

3.11.2 Enterprise bargaining

3.11.2.1 Expiring agreements and enterprise bargaining

No hospital enterprise agreements are due to expire during the 2014–15 financial year. Instead attention will be focused on expired but unresolved enterprise bargaining agreements (EBAs) carried over from the 2013–14 financial year and preparation for major EBAs due to expire in the 2015–16 financial year. These EBAs are listed in Table 3.1 (correct at the time of publication).

Table 3.1: EBAs for which negotiation may continue in 2014–15

Employee group	Nominal expiry date
Ambulance Victoria Enterprise Agreement 2009	16 November 2012
General Dentists' Victorian Public Sector Multi-Enterprise Agreement 2009–2013	30 May 2013
Biomedical Engineers Agreement 2010–2013 (13 individual agreements)	11 August 2013
Ambulance Victoria (Management and Administrative Staff) Enterprise Agreement 2010	26 September 2013
Victorian Health Promotion Foundation (VicHealth) Enterprise Agreement 2010	8 March 2014

3.11.2.2 Wages policy

The government's wages policy allows for increases such that the 'total cost of an agreement is no more than 2.5 per cent annualised'. Higher increases are possible provided they are offset by 'genuine productivity gains linked to workforce reform achieved as part of the agreement negotiations'.

3.11.2.3 Budgeting for new agreements

Enterprise bargaining settlements are rarely timed to coincide with the beginning of a financial year. There may therefore be part-year cost effects in any given financial year relating to both expiring and new enterprise bargaining outcomes. On the other hand, budget indexation does apply on a full financial year basis.

Health services must identify and account for indexation as it relates to supporting increased wage and salary costs. When new EBAs take effect, or are likely to take effect in a financial year, health services must keep indexation funding available for such increases. This remains true even when enterprise

bargaining processes become protracted or complex and remain unresolved at the end of the financial year in which settlement was expected to occur and have cost effect.

Health services must also ensure EBA costs are properly attributed to other relevant revenue sources where existing employment costs are met from those other sources.

3.11.3 Interim payments for long-stay, high cost patients

The department will consider interim payments (both cash flow and recorded weighted inlier equivalent separation (WIES) revenue) for long-stay patients who have accumulated significant amounts of WIES, or bed days, and who remain admitted at 30 June 2015.

Health services may apply to the department for special consideration for individual admitted patient episodes. Applications for special consideration must indicate the number of WIES or bed days. For WIES funded episodes, the interim diagnosis related group (DRG) must also be indicated. Under no circumstances should agreement to fund an interim payment result in a statistical separation.

If the department agrees to provide an interim payment, the health service will be asked to designate the episode as a contracted patient, using a specific contract/spoke identification code. When the patient is finally separated, the payment will be adjusted accordingly. For example, the interim amount will be deducted from the final payment. The final DRG may differ from the interim DRG, due to the addition of further complications, comorbidities and procedures, in which case the payments will be adjusted to reflect actual activity.

Interim payments for long-stay, high-cost patients will be considered on a case-by-case basis. While interim payments are not governed by strict length of stay (LOS) or WIES criteria, a patient might be recognised as a long-stay, high-cost patient if the patient is:

- still admitted at 30 June 2015 and their LOS already exceeds a year
- still admitted at 30 June 2015, their LOS already exceeds six months and the patient might reasonably be expected to still be in the hospital at 31 December 2015
- still admitted at 30 June 2015, their LOS already exceeds six months and the patient is receiving significant mechanical ventilation.

3.11.4 Use of contract WIES

On occasion, where a health service has reduced capacity (for example, due to workforce shortages or capital works) it may contract with another service to undertake activity for a time-limited period. Contract arrangements of this type must be approved in advance by the department's Director of Sector Performance, Quality and Rural Health. Approval will only be granted where the health service can demonstrate that the capacity reduction is temporary and that the contract is an appropriate use of allocated WIES, taking into account local demand for services. Technical information for recording and reporting contract WIES is available in the VAED manual.

3.11.5 Health service fees and charges

Any fees and charges raised by health services must be in accordance with the department's manual, *Fees and charges for acute health services in Victoria: a handbook for public hospitals.*

The fees are available at <www.health.vic.gov.au/feesman>.

Health services are permitted to raise fees for the following non-admitted patient services:

- dental services
- spectacles and hearing aids
- surgical supplies
- prostheses, however, the following categories of prostheses must be provided free of charge
  - artificial limbs

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  - prostheses that are surgically implanted, either permanently or temporarily, or are directly related to a clinically necessary surgical procedure
- external breast prostheses funded by the National External Breast Prostheses Reimbursement Program
- other services, as agreed between the Commonwealth and Victoria.

Upon an admitted patient separation, a health service may raise fees:

- for pharmaceuticals at a level consistent with the Pharmaceutical Benefits Scheme statutory co-payments
- for aids,
- for appliances and
- for home modification.

3.11.6 Private patient accommodation charges

Section 72.1(2) of the *Private Health Insurance Act 2007* states that an insurance policy covering hospital treatment must provide at least the 'minimum benefit' for that treatment. The Commonwealth Minister for Health stipulates the minimum benefits payable by private health insurers for shared ward accommodation in public hospitals through the *Private health insurance (benefit requirements) rules*. The Commonwealth does not set a minimum benefit for single-room accommodation.

Health services are able to make their own determination on accommodation fees to be charged to private patients who receive treatment at their campuses. In coming to this decision, health services should consider the following:

- the benefit that private health insurance funds will assign to the public hospital in their health insurance products
- any co-payment a patient may be willing to pay as a private patient
- the amount of any co-payment or excess the hospital can viably forgo.

To assist health services with this decision, the department provides a recommended fee schedule for private patient accommodation in the department's *Fees manual* available at <www.health.vic.gov.au/feesman>.

At a minimum, these rates would be reasonable to apply to private patient charges.

Health services should note the *Private health insurance (health insurance business) rules 2007* Part 3 s. 8(b), which state that treatment provided to a person at an emergency department is excluded treatment for the purposes of private health insurance. Health services should ensure that private health funds are not billed for accommodation or services provided to admitted private patients at an emergency department.

3.11.7 Redirection of funds

If total revenue for a funded program exceeds the expenses incurred in delivering the full quantity of services specified in the Statement of Priorities (SoP) or service agreement, the surplus may be used by the funded organisation for any purpose connected with its agreed function. This clause does not apply if there is a contrary arrangement regarding unexpended funding provided for a specially identified purpose.

3.11.8 Doctors in training secondment arrangements

Many training programs for junior doctors involve a rotation to a site other than their parent hospital. The parent hospital is responsible for managing and paying the annual leave of doctors in training while on rotation, and where annual (or other) leave is planned within the rotation period, both hospitals should approve this leave. Only the parent hospital is to pay out annual leave, as this is included in the overheads paid to the parent hospital (refer to Hospital Circular 2/2013).

The parent hospital will make every endeavour to organise suitable relief when a doctor in training takes other leave (either planned or unexpected) for a period longer than one week. The parent hospital should also make every endeavour to ensure the relieving doctor has commensurate experience and skills to ensure the expected level of service in the external hospital can continue to be provided.

3.11.9 Accountability for visiting medical officer payments

Health services that have engaged medical practitioners on a fee-for-service basis are required to establish and maintain appropriate accountability procedures over these payments. These financial controls are in addition to regular review of credentials and clinical privileges.

The type of accountability measures to be established will vary according to the size of the organisation and the extent to which fee-for-service arrangements are used. Accountability measures may include:

- installing and using purpose-specific software to monitor and audit claims
- obtaining specific advice relating to fee-for-service contract negotiation from the health services' industrial representative and/or from independent legal advisors
- ensuring that fee-for-service contracts:
  - clearly specify performance expectations and the requirement to participate in annual performance reviews
  - require contractors to comply with the health services' code of conduct, by-laws, policies and protocols and procedures in force from time to time and relevant to the services provided.
- conducting a comprehensive regular audit of fee-for-service claims on a routine or random basis (this may include the review of guidelines and procedures governing the administration and payment of fee-for-service costs to ensure that contractual agreements are current for all providers who are remunerated on a fee-for-service basis, and that all such contracts clearly specify applicable rates and conditions of payment reviewing trends in service delivery and outputs for patient care provided on a fee-for-service basis).
- the department, from time to time, requiring organisations to report on the nature and extent of fee-for-service claims and the accountability measures that have been put in place to monitor claims.

3.11.10 Long service leave

The department assumes the liability arising from the net increase in the long service leave provision for public health services. Refer to Hospital Circular 5/2013 for more details on funding, accounting and reporting of long service leave, in effect from 22 April 2013.

In 2014–15 the department will continue to assume this liability. As in 2013–14, the department will fund an amount of 2.8 per cent through the funding model as a contribution to an organisation's long service leave liability.

The difference between this contribution and the health service's annual provision will be accounted for by services by creating a non-cash long service leave revenue and will be receivable from the department for the same amount. More details are found in Hospital Circular 5/2013.

3.11.11 Medical indemnity insurance

The department has developed the medical indemnity risk-rated premium (RRP) model in consultation and on the advice of the Victorian Managed Insurance Authority (VMIA) and its actuaries. The RRP model allocates a share of the statewide medical indemnity insurance premium to individual hospitals and health services. The RRP methodology for 2014–15 policy year has been enhanced to reduce volatility in the premium and to ensure the premium pool is equitably distributed across the sector.

For detailed information on the RRP please contact the VMIA directly on either (03) 9270 6909 or (03) 9270 6876.

3.12 Data collection requirements

Data reporting and analysis are core elements of the department's health monitoring and funding system. In general, health services and other funded organisations are required to comply with standard definitions for reporting financial and statistical data, as set out in the relevant 2014–15 versions of data collection manuals and any other amending documents prepared by the department.

3.12.1 Data integrity

Accurate data are critical for performance monitoring, reporting, policy and planning and for maintaining public confidence.

Health service boards of management are accountable for the accuracy of reported data. Boards are expected to make data integrity the responsibility of their audit committee, and ensure that data accuracy is subject to appropriate controls, including regular internal audits.

Health services are required to:

- maintain board and board audit committee scrutiny of data integrity practices
- complete implementation of security improvements for elective surgery and emergency department information technology systems, including implementation of unique user identity and password controls, and the activation of transaction logs
- implement recommendations from audits conducted at their health services
- make a data quality attestation in the health service's annual report
- comply with the Minister for Finance Standing Direction 3.4.13 *Information collection and management*.

Each health service will have its VAED, Elective Surgery Information System (ESIS) and VEMD data collection, recording and reporting practices audited. These audits will cover data accuracy and health service compliance with department policies and business rules. In addition, the data integrity audit program will be progressively expanded to include other health service data collection and reporting activities.

3.12.1.1 System updates

These data collections are reviewed annually to ensure they are relevant for performance monitoring against current operational priorities, as well as to provide up-to-date indicators of ongoing clinical activity trends. The department remains committed to balancing the resources required to collect and report data against the need for quality data for monitoring, planning and fulfilment of the department's own reporting obligations. These aims are achieved through various consultative committees and reference groups for specific data collections and feedback received through specific departmental program areas.

Proposed changes to data collections are released for comment, and final specifications for change are published by 31 December prior to the financial year to which they apply.

The HDSS bulletin provides advice on data quality issues to health services that contribute to the VAED, VEMD, ESIS, VINAH and AIMS. The bulletin is the primary method by which amendments to standards and reporting timelines are published during the year.

Health services should ensure that appropriate staff subscribe to the HDSS bulletin to remain up to date with any changes. The HDSS bulletin is issued electronically via both web and email and is free. Subscriptions may be arranged through the HDSS help desk by emailing <HDSS.Helpdesk@health.vic.gov.au>.

3.12.1.2 Penalties for noncompliance

If health services are noncompliant with the timelines specified in these guidelines, penalties may apply. Refer to the relevant dataset for more information.

3.12.1.3 Exemptions from penalties

If difficulties are anticipated in meeting the timelines, the funded organisation must contact the department and indicate the nature of the difficulties, remedial action being taken and the expected transmission schedule.

A pro forma to assist this, together with contact details for transmission, is provided on the HDSS website at <www.health.vic.gov.au/hdss>.

Health services are encouraged to flag any emerging difficulties at the earliest opportunity, to enable the department to gauge whether or how best it can assist to resolve these difficulties. Health services are also encouraged to use the forums provided by the relevant reference groups to raise issues that may also be of interest or concern to other health services and share knowledge and experience in resolving them.

Exemptions for late penalties will only be considered for circumstances beyond the control of the health service. Software problems are, of themselves, insufficient justification for late submission of data. Health services are expected to have arrangements in place with their software vendor to ensure that statutory reporting requirements are met.

3.12.2 Key systems

The department operates several data collections on different aspects of health service activity. Key systems include:

- Financial Data (F1) / Common Chart of Accounts, outpatient services (formerly the Victorian Ambulatory Classification Funding System) and other non-admitted and financial data collected through AIMS
- the VAED for admitted patient activity
- the VEMD for designated emergency department activity
- the ESIS for monitoring elective surgery waiting lists
- the VINAH Minimum Dataset for non-admitted patient activity
- AIMS used primarily to collect summary-level financial and statistical information
- Victorian Cost Data Collection (VCDC) for patient-level costs.

3.12.2.1 Financial Data (F1)

F1 financial returns for all health services (including SRHS and Ambulance Victoria), at the entity level, are required 12 days after the end of the month for which the financial data are provided (for example, the F1 for July is required by 12 August).

3.12.2.2 Victorian Admitted Episodes Dataset

The VAED contains the core set of clinical, demographic, administrative and financial data about every admitted patient episode occurring in Victorian health services. Maintaining the accuracy of the VAED is critical to ensuring accurate and equitable funding outcomes, supporting health services' planning, policy formulation, program evaluation and epidemiological research. Analyses and consolidated activity data are provided from the VAED to meet the department's reporting obligations to the Commonwealth and to various research institutes.

Further information on the VAED is contained in the VAED manual at <www.health.vic.gov.au/hdss/vaed>.

Transmission of admitted patient data

All organisations that receive funding under any of the following programs must transmit data to the VAED minimum dataset:

- admitted acute services
- admitted subacute services, including rehabilitation and maintenance care
- admitted dialysis services
- admitted mental health services
- admitted palliative care program
- Hospital in the Home.

Health services (including SRHS) will code patient episodes reported to the VAED in accordance with the current Australian Coding Standards, along with Victorian additions, and any amending documents issued by the department.

Health services shall transmit admitted patient data to the VAED via PRS/2 according to the following timelines:

- Admission and separation details for any month must be transmitted in time for the VAED file consolidation on the 10th day of the following month.
- Diagnosis, procedure, subacute and palliative care details in any month must be transmitted in time for the VAED consolidation on the 10th day of the second month following separation.
- Data for the 2014–15 financial year must be completed in time for the VAED file consolidation on 10 August 2015. Any final corrections must be transmitted before consolidation of the VAED database on 10 September 2015.

It is the health service's responsibility to ensure data are transmitted to the VAED to meet the processing schedule for inclusion in the PRS/2 file consolidation on the 10th of each month. VAED data (sent electronically) must be received by 5 pm on the 10th of each month, regardless of the actual day of the week. VAED (sent on physical media) must be received by 12 pm (noon) on the 10th of the month.

Penalties for noncompliance

Where health services are noncompliant with the timelines specified above, the department may apply the following penalties:

- $3,800, if more than one per cent of admission and separation details for a given month are submitted after the timeline specified above
- $1,900, if more than one per cent of episodes for a given month are transmitted without diagnosis, procedure, subacute or palliative care details by the deadline specified above.

Data submissions will be monitored based on the number of annual separations reported by the individual health service. The frequency of VAED compliance monitoring is shown in Table 3.2.

Table 3.2: VAED compliance monitoring frequency

Health service type	VAED compliance monitoring frequency
Metropolitan and rural health services with more than 5,000 annual separations	Monthly
Metropolitan and rural health services with fewer than 5,000 annual separations	Annually

The above requirements apply to all account classes, including DVA.

If difficulties are anticipated in meeting the relevant data transmission timeframes for admission, separation, diagnosis, procedure, subacute or palliative care data, the health service must contact the

department indicating the nature of the difficulties, remedial action being taken and the expected transmission schedule.

A pro forma to assist this process, together with contact details for submission, is provided on the HDSS website at <www.health.vic.gov.au/hdss/vaed>.

Exemptions for late submission penalties

Exemptions for late submission of admission and separation (e-record) data may be granted to health services maintaining a consistently high level of timely data submission. Exemptions for late submission of admission and separation data and diagnosis, procedure, subacute or palliative care data will also be considered for circumstances that are beyond the control of the health service.

Health services undertaking the PRS/2 data submission testing process are exempted from penalties for the applicable months of data as per the testing period agreement.

Submissions for exemption from late penalties will only be considered if received prior to the appropriate consolidation deadline outlined in the clauses above. For any period that the health service is unable to supply unit record data, the health service is required to submit aggregate data. Additional penalties may apply for failure to submit aggregate data when required.

3.12.2.3 Victorian Emergency Minimum Dataset

Emergency departments will transmit data to the VEMD according to the timelines in Table 3.3. Health services may submit more frequently than the minimum standards specified below.

Table 3.3: VEMD timelines

VEMD 2014–15	Timeline
All presentations for the first 14 days of the month	At least one submission must be received by the third working day after the 14th of the reporting month
All presentations for the full month	Data for the remainder of the month must be supplied by the third working day of the following month
All presentations for the full month without errors	Must be complete and correct; that is, zero rejections and notifiable edits by the 10th day of the following month, or the prior business day Any corrections must be transmitted before consolidation of the VEMD database on 20 August 2015

Health services may submit more frequently than the minimum requirements. The department will endeavour to process submissions within one working day of receipt.

Penalties for noncompliance

If health services are noncompliant with these timelines, the department may apply a penalty of up to:

- $3,000, if a file containing presentations for the full month is not submitted by the timelines specified in Table 3.3
- $6,000, if a file with all presentations for the full month contains errors by the timelines in Table 3.3.

Exemptions from penalties

In addition to the general requirements specified in Part 3, section 3.12.1 'Data integrity', requests for an exemption from late penalties will only be considered if it is received prior to the relevant deadlines, as outlined in Table 3.3.

Extensions or exemptions are not issued in advance. Late submissions penalties are assessed after the end-of-year consolidation deadline, taking into account the health service's submission performance for the financial year.

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Manual aggregate data submission

For any period that the health service is unable to supply unit record data, the health service is required to submit aggregate data using the spreadsheet.

The spreadsheet is available from the HDSS website at <www.health.vic.gov.au/hdss>.

Refer to the 'Compilation and submission' section of the VEMD manual for more information. Additional penalties may apply for failure to submit aggregate data when required.

Data resubmissions for previous months

Health services wishing to resubmit data for a previous period must complete a VEMD data resubmission request as soon as the health service is aware of the circumstances requiring resubmission. The request form must be submitted either prior to the resubmissions or accompanying the resubmitted files. Resubmissions received without the request form will not be processed.

Table 1: The pro forma is available on the HDSS website at <www.health.vic.gov.au/hdss>.

3.12.2.4 Elective Surgery Information System

Health services reporting to ESIS will be required to adhere to the minimum submission timelines in Table 3.4. Health services may submit more frequently than the minimum standards specified below.

Table 3.4: Elective Surgery Information System timelines

ESIS 2014–15	Timeline
First 15 days of the month	At least one submission must be received by the third working day after the 15th of the reporting month
The remaining days of the month (16th and subsequent)	Data for the remainder of the month must be supplied by the third working day of the following month
All activity for the full month without errors	Data must be complete: that is, zero rejections, notifiable or correction edits by the 14th day of the following month, or the prior business day

The department will endeavour to process submissions within one working day of receipt.

Any corrections to 2014–15 data must be transmitted before final consolidation of the ESIS database on 20 August 2015.

Penalties for noncompliance

If health services do not comply with these timelines, the department may apply a penalty of up to:

- $3,000, if a file containing episodes for the full month is not submitted by the timelines specified in Table 3.4
- $6,000, if a file with all episodes for the full month contains errors by the timelines specified in Table 3.4.

Exemptions from penalties

In addition to the general requirements specified in Part 3, section 3.12.1 'Data integrity', requests for exemption from late penalties will only be considered if received prior to the relevant deadlines outlined in Table 3.4.

Extensions or exemptions from late data penalties are not issued in advance. Late submissions are assessed after the end-of-year consolidation deadline to determine whether a penalty should apply.

Manual aggregate data submission

For any period that the health service is unable to supply unit record data, the health service is required to submit aggregate data using the spreadsheet.

The spreadsheet is available from the HDSS website at <www.health.vic.gov.au/hdss>.

Refer to the 'Compilation and submission' section of the ESIS manual for more information. Additional penalties may apply for failure to submit aggregate data when required.

3.12.2.5 Victorian Integrated Non-Admitted Health Minimum Dataset

The VINAH MDS is a patient-level electronic reporting system built around a generic framework suitable for reporting a wide range of non-admitted patient-level data.

Organisations that receive funding under any of the following programs must transmit data to the VINAH MDS:

- specialist (outpatient) clinics
- HIP
  - subacute ambulatory care services (including paediatric rehabilitation)
  - Hospital Admission Risk Program (HARP)
  - PAC
  - residential in-reach service
- community-based palliative care
- Family Choice Program
- Victorian HIV Service
- Victorian Respiratory Support Service
- medi-hotel (optional)
- Transition Care Program (TCP)
- hospital-based palliative care consultancy teams.

TCP clients are non-admitted hospital patients. Health services must adhere to relevant TCP reporting arrangements negotiated between the Victorian and Commonwealth governments. In 2014–15 this includes the monthly claim form, the transition care quarterly report and the transition care annual accountability report.

All health services are required to ensure two data elements are complete in the VINAH MDS. These relate to preferred language spoken and interpreter required as proxy measures of local demand for language services.

VINAH supports optional reporting for medi-hotel activity.

Further information on VINAH is contained in the VINAH manual at <www.health.vic.gov.au/hdss/vinah>.

Submission guidelines

Submitting funded organisations are encouraged to transmit VINAH MDS data frequently and may transmit as often as desired. Funded organisations must meet the following minimum requirements:

- VINAH data compliance is reckoned on a monthly basis. Data for each calendar month (reference month), as specified in the 'reported when' component of each data element in the VINAH manual, must be transmitted as specified below.
- Funded organisations must make at least one submission to the HealthCollect portal for the reference month by no later than 5 pm on the 10th day of the month following the reference month.
- All errors are to be corrected in time for the VINAH MDS file consolidation at 5 pm on the 17th day of the month following the reference month. Complete data for the month are expected to be transmitted by the 17th.

Data for the financial year must be completed in time for the VINAH MDS file consolidation on 17 August. Any final corrections must be received at the HealthCollect portal before the VINAH MDS database is finalised on 10 September 2015.

It is the funded organisation's responsibility to ensure the department receives the data in time to meet the processing schedule detailed above, regardless of the actual day of the week.

Penalties for noncompliance

If funded organisations do not comply with these timelines, the department may apply a penalty of up to:

- $3,800, if an initial transmission of a reference month's activity for a program is not submitted within the timelines specified above
- $3,800, if a reference month's complete activity for a program is not submitted in accordance with the timelines specified above.

Funded organisations that have VINAH MDS reporting obligations for multiple programs (for example, subacute ambulatory care services, HARP, PAC) should note that the above penalties apply per program.

Exemptions from penalties

General requirements are specified in Part 3, section 3.12.1 'Data integrity'.

Organisations seeking exemption from penalties for late data must write to the manager of non-admitted and ambulance data advising of the issues experienced, the organisation's plan for overcoming the issues and the expected submission date.

Note that during the initial VINAH MDS implementation period for new organisations and program types, flexible arrangements may be negotiated with submitting organisations on a case-by-case basis.

Organisations must report aggregate data for acute non-admitted activity via the AIMS S10 form, and subacute non-admitted activity via the AIMS S11 form. The department has developed a process and criteria for discontinuing reporting via AIMS where patient-level data are being reported to VINAH for selected programs. The process and application details can be found at http://www.health.vic.gov.au/hdss/reffiles/reporting>.

3.12.2.6 Agency Information Management System

Health services will provide AIMS data to the department electronically via the HealthCollect web portal, and in accordance with the timelines specified in the *AIMS public hospital user manual.*

The HealthCollect web portal is at <www.healthcollect.vic.gov.au>.

To help calculate the prior year's adjustment, all AIMS forms relating to the 2014–15 financial year must be completed by 10 September 2015.

Penalties for noncompliance

If health services are noncompliant with these timelines, the department may apply a penalty of no more than $3,800 for each return not submitted by the due date specified in the AIMS manual.

Organisations seeking exemption from penalties for late data must write to the manager of non-admitted and ambulance data advising of the issues experienced, the organisation's plan for overcoming the issues and the expected submission date.

Further details are available at <www.health.vic.gov.au/hdss/aims>.

3.12.2.7 Victorian Cost Data Collection

All major provider health services are required to operate and maintain patient costing systems that monitor service provision to patients and allow accurate patient-level costs to be determined.

Costing methodology should be guided by the *Australian hospital patient costing standards – version 2.0, 1 March 2011* (or the most recent version in the instance that a successor becomes available) and any other guidance provided by the department in the coming year.

Cost data episodes for 2013–14 are to be submitted to the department by 31 October 2014. The submission must comply with the VCDC file specifications and follow the VCDC reporting requirements of the relevant financial year.

The specifications and requirements are published at <www.health.vic.gov.au/hdss/vcdc>.

Data provided should cover all areas of costed activity provided by the health service including all admitted, non-admitted (specialist outpatients) and emergency presentations.

Health services are asked to examine their current cost data for completeness across subacute (admitted and non-admitted), mental health programs and non-admitted (non-specialist outpatients activity generally. The *National health reform agreement* specifies that these areas will be activity-based funded from 1 July 2013 and cost data continues to be required to support development of national weights.

Penalties for noncompliance

Penalties for not providing costing data across all streams of activity will be based on, and may not exceed, the average cost of operating an appropriate patient costing system according to the operating size of the organisation.

Exemptions from penalties

Exemptions for late data penalties will only be considered for circumstances beyond the control of the health service. Health services are expected to have arrangements in place with their software vendor to ensure compliance with statutory reporting requirements.

3.12.2.8 Victorian Health Incident Management System

Reporting to the Victorian Health Incident Management System

Health services and other relevant funded organisations (including registered community health services) must provide a de-identified data extract of all clinical incidents to the department on a monthly basis.

De-identified data must be sent to the department via an electronic secure data exchange process. This secure pathway allows for data encryption.

Funded organisations are required to provide data according to the timelines detailed below.

- Incident data for each month must be transmitted in time for the VHIMS file consolidation on the 12th day of the following month.
- Corrections or amendments to incident data can be submitted in the following month's data transmission.
- Final cut-off for amendments is 1 September of the new financial year; for example, amendments to 2013–14 data must be completed and transmitted to the department by 1 September 2014.

Health services are responsible for ensuring that the incident data submitted to the department meets the VHIMS dataset specification and validation rules.

Further information is available at <www.health.vic.gov.au/clinrisk/vimp>.

3.12.3 Acute data reporting requirements

3.12.3.1 Victorian Healthcare Associated Infection Surveillance System

The department receives infection surveillance reports from health services via the VICNISS coordinating centre. All public health services are required to participate in the VICNISS HAI surveillance program.

Mandatory reporting requirements exist for hip and knee arthroplasty, coronary artery bypass graft surgery and caesarean section (restricted to the Royal Women's Hospital and Mercy Health only) , intensive care unit central line-associated blood stream infections, hand hygiene compliance rates,

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hospital identified *Clostridium difficile* infections and *Staphylococcus aureus* bacteraemia. Further infection surveillance activities can be undertaken by health services on a voluntary and needs basis.

Health services with a statistically significant higher rate than the aggregate are notified and requested to provide information on actions that are being taken to reduce this rate.

Health services receive their individual results, and these can be compared with de-identified hospitals and state aggregate data. State aggregate data are reported every year in the HAI annual report.

The reports are available at <www.health.vic.gov.au/infectionprevention/publications.htm>.

A limited number of HAI performance indicators are reported publicly on the Victorian Health Services Performance website at
<http://performance.health.vic.gov.au/Home/Category.aspx?CategoryKey=5#Anchor>.

Compliance rates for *Staphylococcus aureus* bacteraemia and hand hygiene are publicly reported on the MyHospitals website at <www.myhospitals.gov.au>.

Staphylococcus aureus bacteraemia is a quality and safety performance benchmark under the *National health reform agreement.*

3.12.3.2 Health care worker immunisation – influenza

Health services must take all reasonable steps to ensure staff members are protected against vaccine-preventable diseases. High coverage rates for immunisation in healthcare workers are essential to reduce the risk of transmission in healthcare settings. Health services are required to report healthcare workers' influenza immunisation compliance to the department annually. The benchmark rate requires 75 per cent of health service category A and B healthcare workers (as outlined in Table C2.1 of the *National guidelines for the prevention and control of infection in health care*) who are permanently, temporarily or casually (bank staff) employed by the health service throughout the influenza period, to be immunised.

The national guidelines are available at <http://www.nhmrc.gov.au/book/australian-guidelines-prevention-and-control-infection-healthcare-2010/c2-2–1-staff-health-scre>.

3.12.3.3 Cleaning standards for Victorian public hospitals

All health services are required to report on cleaning standards four times per year.

The auditing process, which has been standardised, is to be undertaken by people who are qualified Victorian cleaning standards auditors.

A minimum acceptable quality level (AQL) of cleaning is to be achieved by all health services; those health services that fail to achieve the AQL are required to rectify the issues and reaudit within a predetermined timeframe.

The external audit results reported to the department in August 2014 will be included in patient management framework Q1 reporting.

3.12.3.4 Victorian State Trauma System

All public health services, including the three designated major trauma services, are required to participate in the Victorian State Trauma Registry. The department contracts the Victorian State Trauma Registry to collect data on major trauma patients from health services.

The performance and effectiveness of the Victorian State Trauma System is monitored via the registry. State aggregate data is reported every year in the Victorian State Trauma Registry summary report. Annual reports are available at <health.vic.gov.au/trauma/trauma-registry>.

3.12.3.5 Victorian Audit of Surgical Mortality

The Victorian Audit of Surgical Mortality (VASM) is a systematic peer-review audit of deaths associated with surgical care that is undertaken through the Royal Australasian College of Surgeons (Victorian

Office). The VASM is similar to audits undertaken in other Australian states and territories and is part of the Australian and New Zealand Audit of Surgical Mortality. The objective of the audit is a peer review of all surgical deaths, including all deaths that occur in a hospital following a surgical procedure, and deaths that occur in a hospital while under the care of a surgeon, even though no procedure was performed.

All health services and surgeons are encouraged to participate in this audit. More details are available at <www.health.vic.gov.au/surgicalperformance/vasm>.

3.12.3.6 Consultative councils reporting requirements

Consultative councils are specialist advisory committees created to advise on specialised areas within healthcare to reduce mortality and morbidity. Consultative councils operate under the provisions of the *Public Health and Wellbeing Act 2008* and its Regulations.

Victorian Consultative Council on Anaesthetic Mortality and Morbidity

The Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM) monitors, analyses and reports on potentially preventable anaesthetic mortality and morbidity in the Victorian health system. VCCAMM reviews cases of mortality and morbidity reported to it on a voluntary basis. Health services should support and encourage clinicians to report anaesthesia-related events to the council to allow system-wide learning to be disseminated.

Further information is available at <www.health.vic.gov.au/vccamm>.

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

The Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) conducts research and analysis into the incidence and causes of maternal deaths, stillbirth and the deaths of children in Victoria (under 18 years age). It also analyses trends in perinatal health, including congenital anomaly.

Section 48 of the Public Health and Wellbeing Act requires that all births are reported to CCOPMM. Health services are also required to provide information on all maternal and perinatal death (stillbirths and neonates) and child deaths (up to the age of 18).

Templates and guidance for reporting maternal and perinatal deaths are available at <www.health.vic.gov.au/ccopmm>.

Victorian Perinatal Data Collection

Health services (or the midwife or medical practitioner in attendance at a birth when the birth does not occur in a health service) where births occur are required to report the information set out in the birth report specified by the CCOPMM for inclusion in the Victorian Perinatal Data Collection (VPDC).

The VPDC is a population-based surveillance system to collect and analyse information on and in relation to the health of mothers and babies to contribute to improvements in their health. It contains information on obstetric conditions, procedures and outcomes, neonatal morbidity and congenital anomalies relating to every birth in Victoria. The definition of a birth for this purpose means a birth or stillbirth that is required to be registered under the *Births, Deaths and Marriages Registration Act 1996*.

The VDPC manual, including data definitions, business rules and submission guidelines are available at <www.health.vic.gov.au/ccopmm/vpdc>.

Transmitting perinatal data

All data are to be supplied to the VPDC via an extract of the health service's birthing information system. Due to the detailed nature of the information captured in the VPDC, electronic submissions are only permissible via the HealthCollect portal.

HealthCollect is a web-based interface that organisations use to submit statistical and financial data to the department and is the portal for submitting VPDC data.

Birth data must be submitted within 30 days from the date of a birth (up to a maximum of 90 days). To meet this requirement, at least one submission for each calendar month is recommended. All edits triggered via the submission process should be resolved as soon as possible, but up to 30 days from the date of notification of the edit is allowed.

Further information on the HealthCollect secure data exchange user manual is available at <www.health.vic.gov.au/hdss/healthcollect>.

Victorian Surgical Consultative Council

The Victorian Surgical Consultative Council (VSCC) studies causes of avoidable mortality and morbidity and provides feedback to the medical profession to improve the quality and safety of surgery. VSCC reviews reported cases of morbidity and possibly preventable mortality, via the VASM, coroner's cases and sentinel events reported to the department. Participation by surgeons is now a requirement of the Royal Australian College of Surgeons' Continuing Professional Development Program. Health services should encourage clinicians to report relevant events to the VSCC to allow system-wide lessons relating to surgery to be disseminated.

Further information is available at <www.health.vic.gov.au/vscc>.

VSCC's Surgical Outcomes Information Initiative (SOII) analyses and reports on areas of potentially preventable surgical mortality and morbidity within the health system. SOII provides benchmarked surgical outcome data from the VAED to individual public and private hospitals. Health services are asked to review cases and provide a summary report to the VSCC where a defined procedure performance is significantly different to the state average.

Further information is available at <www.health.vic.gov.au/vscc/surgical-outcomes-information-initiative>.

3.12.3.7 Critical care and neonatal reporting

Relevant health services must submit data relating to adult and paediatric intensive care to the Adult Patient Database (see Table 3.5) administered by the Australian and New Zealand Intensive Care Society.

To facilitate statewide access to critical care beds, health services providing adult, paediatric and, from 1 July 2014, neonatal critical care services are required to update the REtrieval And Critical Health (REACH) website four times per day.

Table 3.5: Health services required to submit data to the ANZICS Adult Patient Database

Health service	
Albury Wodonga Health	Monash Health
Alfred Health	Northeast Health Wangaratta
Austin Health	Northern Health
Ballarat Health Services	Peninsula Health
Barwon Health	Peter MacCallum Cancer Centre
Bendigo Health Care Group	South West Healthcare
Central Gippsland Health Service	St Vincent's Health
Eastern Health	The Royal Children's Hospital
Goulburn Valley Health	Western Health
Latrobe Regional Hospital	Western District Health
Melbourne Health	Wimmera Health Care Group
Mildura Base Hospital	

3.12.3.8 Maternity services reporting

Health services providing maternity and neonatal care submit data to the VPDC and the VAED for inclusion in the Victorian maternity services performance indicators report.

3.12.3.9 Cardiac surgery registry

Since 2001 the department has contracted the Australian and New Zealand Society of Cardiac and Thoracic Surgeons to provide a system that collects data to monitor clinical performance in cardiac surgery. The Cardiac Surgery Database Project is coordinated by the Monash University School of Public Health and Preventative Medicine, and the department expects all health services that perform cardiac surgery to participate.

The Cardiac Surgery Database Project includes maintenance of a comprehensive clinical registry, statistical analysis and report generation. These components enable a structured peer-review process that can identify variation in performance at the practitioner and health service level.

The department publishes a public version of the Cardiac Surgery Database Project annual reports on its website and more detailed reports are provided to participating health services.

Further information is available at <www.health.vic.gov.au/surgicalperformance/cardiac>.

3.12.3.10 Victorian Cardiac Outcomes Registry

The department has supported the development and implementation of a cooperative cardiac registry that aims to help improve the safety and quality of healthcare provided to cardiovascular patients in Victoria. All public and the majority of private health services that perform percutaneous coronary interventions (PCI) now provide this data to the Victorian Cardiac Outcomes Registry, and a module is being piloted for acute management of early STEMI in regional and rural settings.

Additional modules planned relate to implantable cardiac devices (such as pacemakers and defibrillators) and a dataset for patients presenting to hospital with heart failure.

This registry is coordinated by the Monash University School of Public Health and Preventive Medicine and has the support of the Cardiac Society of Australia and New Zealand. The Victorian Cardiac Clinical Network supports and promotes the implementation of the registry.

3.12.3.11 Australian Stroke Clinical Registry

The Australian Stroke Clinical Registry is a collaborative national effort to monitor, promote and improve the quality of acute stroke care. It is a prospective, multicentre, observational outcomes database designed to collect data on the demographics, presentation, diagnosis, treatment and outcomes of hospitalised patients with stroke. The Victorian Stroke Clinical Network promotes the implementation of the Australian Stroke Clinical Registry at all metropolitan and regional health services.

3.12.3.12 Radiotherapy services reporting

Radiotherapy providers are required to report:

- monthly to AIMS using forms S8 and S10
- quarterly to the Victorian Radiotherapy Minimum Dataset.

The department will continue to work with services during 2014–15 to finalise national reporting of radiotherapy waiting times, which will be delivered through the Victorian Radiotherapy Minimum Dataset, and developing clinical performance metrics. It is envisaged that implementation of national reporting of radiotherapy waiting times will occur in 2015–16.

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3.12.3.13 Renal dialysis reporting

All health services that provide facility dialysis report public and private admitted activity at a unit record level to the VAED. This includes activity in all facilities.

Aggregate data for all non-admitted patients, including both clinic activity and home dialysis service events, is reported through AIMS S10 Non-Admitted Clinical Activity. This includes reporting on dialysis performed by the patient in their home without the presence of a healthcare provider.

The department maintains a dialysis register comprising patient-level data provided by specialist services and coordinated by Melbourne Health. The register excludes private patients dialysing in private hospitals.

3.12.3.14 Registry of kidney disease

The department is supporting the establishment of a clinical outcomes registry for chronic kidney disease that aims to support quality improvement in renal services. The registry data will be used to drive clinical improvement initiatives through early identification of chronic kidney disease and intervention to prevent or slow the progression of renal disease, and developing complications.

The registry initially incorporates data from six major metropolitan renal units but will expand to include all units over time. It will eventually be linked to the Australian and New Zealand Dialysis and Transplant Registry (ANZDATA) to provide a robust evidence-base of chronic kidney disease from diagnosis to disease progression, including dialysis and transplant and death.

This registry is being coordinated by the Monash University School of Public Health and Preventive Medicine. The Renal Health Clinical Network supports and promotes the implementation of the registry.

3.12.3.15 Readmissions

Following the 2012–13 report by the Health Innovation and Reform Council, reducing hospital readmission rates is incorporated year on year in the SoP, reported quarterly through PRISM and monitored under the performance management framework.

In 2014–15, work will continue to improve readmission measures including aligning national and state measures. At the same time, the department will continue to fund the participation of a number of health services in the Dr Foster Intelligence (DFI) Global Comparators Program and the Quality Investigator Tool to support benchmarking and improvement of readmission performance. The department has also developed a statewide online portal for health services to access performance reports and other business intelligence tools to facilitate benchmarking activities.

There has been a focus on developing models of care that prevent admission/readmission through various local and state-funded initiatives. This includes the Victorian Government's $8.4 million over four years (2011–12 to 2014–15) to the patient treatment coordinator (PTC) initiative to ensure there are staff in place (such as PTCs or similar roles) in the Victorian public health system to provide case management, coordinate comprehensive care planning and discharge, and to facilitate patient-specific communication across care settings. In 2013–14 to 2014–15, the department has also funded a pilot project at Barwon Health aimed at preventing admissions/readmissions with a 'personalised health care' model, with an interim evaluation report due in 2014.

3.12.3.16 Victorian Healthcare Experience Survey

The VHES aims to understand how consumers and, where appropriate, carers feel about their recent experience of care provided by a Victorian public health service. The VHES began in the April–June 2014 quarter collecting continuous data for adult and child inpatient and emergency department consumers, and maternity clients.

Health services are required to upload contact details of eligible consumers to the contractor by the 10th of the month following discharge. This includes the service received (inpatient, maternity, emergency department) which determines the type of questionnaire sent.

Data transfers occur in a secure online environment through the Project Control Portal <www.vhes.com.au/depthealth>. The Project Control Portal provides access to the *Data upload manual* and the template required for submission.

Quarterly reports will be available online from September 2014 at <www.health.vic.gov.au/vhes>.

3.12.4 Subacute data reporting requirements

3.12.4.1 Admitted GEM and rehabilitation

All health services providing inpatient rehabilitation and GEM services are required to report a Functional Independence Measure (FIM) score on admission and separation for patients with rehabilitation (excluding paediatric rehabilitation) and GEM care types. This is a mandatory VAED reporting requirement, and reports submitted to the department without a FIM score will be rejected.

From July 1 2014, health services will be able to report 'in the home' as an accommodation type for GEM episodes. Health services are encouraged to investigate innovative approaches to providing care for older people presenting to hospital. Given the risks associated with hospitalisation for vulnerable older people, consideration should be given to providing the earliest definitive care and in the least restrictive care setting. It is intended that GEM provided in a person's home will fulfil all the expectations of GEM care as nationally defined.

3.12.4.2 Admitted palliative care

All health services providing inpatient palliative care services are required to report data elements linked to the phase of care, including specific elements for the final phase. This is a mandatory VAED reporting requirement, and reports submitted to the department without a phase of care identified will be rejected.

3.12.4.3 Admitted maintenance care

All health services providing maintenance care are required to report a Resource Utilisation Group – Activity of Daily Living (RUG ADL) score. This is a mandatory VAED reporting requirement, and reports submitted to the department without these measures will be rejected.

3.12.4.4 Nursing home type care

Only block-funded SRHSs will be funded for nursing home type care. A patient co-contribution payment cannot be levied on patients in admitted acute and subacute care types (excluding TCP).

3.12.4.5 Health Independence Program and Community Palliative Care

All health services providing HIP and/or Community palliative Care (CPC) services are required to report activity using the program and stream element, as described in the VINAH data collection system.

The department requires services to continue to report in VINAH program streams for activity undertaken in HIP and CPC. Health services are expected to maintain sustained effort across all HIP service components. Recall will be applied to the total HIP activity target.

In the first instance, HIP and CPC services are required to submit data to both VINAH and the AIMS S11 form for activity to count towards the target. VINAH is the preferred data collection. Non-admitted subacute care programs/services that reliably submit VINAH data for all subacute program streams will be able to cease providing AIMS data once agreement has been reached with the department.

The department will continue to work with HIP and CPC services to better understand data compliance and quality issues for non-admitted services. The department aims to identify models of care that support good practice across the service delivery components in order to reduce unexplained variations across services.

3.12.4.6 Reporting requirements for palliative consultancy programs

There are different reporting requirements across the three consultancy programs.

Reporting the VINAH dataset

Hospital consultancy programs are eligible to report patient-level data using the VINAH dataset in 2014–15. Individual health services should make an assessment about the resource impacts of reporting their information using the dataset against the benefits. Services that undertake the service but do not report their data will not receive the aggregated feedback reports that provide activity benchmarking across all services.

Statewide and regional consultancy programs are not required to report data using the VINAH dataset in 2014–15

Aggregate reporting – AIMS

In 2014–15 the statewide consultancy programs are required to use the AIMS S11 form to ensure aggregate activity counts comply with the definition of a service event.

Hospital and regional consultancy programs are not required to report in AIMS on the S11 form in 2014–15.

Aggregate reporting – quarterly

Current reporting datasets (VINAH and AIMS) do not capture consistent information across all consultancy programs. To capture information that is uniform across all consultancy programs, in 2014–15 the department will seek aggregate counts from each consultancy program. At the conclusion of each financial quarter (October, January, April and July) the department will contact organisations delivering a consultancy program (hospital, regional and statewide) and request aggregate counts of activity: total contacts, number of active episodes in the quarter, number of episodes opened, number of episodes closed, number of referrals and number of patients.

3.12.5 Ambulance Victoria data reporting requirements

From 1 July 2014 Ambulance Victoria will provide unit-record activity data for all service streams to the department as part of the new Victorian Ambulance Data Set (VADS). VADS will be used to support and further develop the new funding model for Ambulance Victoria and to fulfil the department's public accountability requirements.

During its first year of operation, the department will work with Ambulance Victoria to validate and extend the VADS collection. The validation process will require Ambulance Victoria to continue existing reporting requirements until both the department and Ambulance Victoria confirm its accuracy for the purposes of public reporting and performance monitoring.

Penalties for data noncompliance will not apply in 2014–15 while the data submission process transitions to the VADS.

Ambulance Victoria will supply data to the department according to the timelines specified in Table 3.6.

Table 3.6: VADS timelines

VADS 2014–15	Timeline
All activity for the first 14 days of the month	At least one submission must be received by the third working day after the 14th of the reporting month
All presentations for the full month	Data for the remainder of the month must be supplied by the third working day of the following month
All activity for the full month without errors	Data must be complete and correct; that is, zero rejections by the 10th day of the following month, or the prior business day Any corrections to previously submitted data must be transmitted before quarterly consolidation of the VADS database, which is the 10th day of the month or prior business day after the end of each quarterly period (by 10 April for the January–March quarter)

Ambulance Victoria will also supply the existing datasets (as outlined in Table 3.7) until such time as an agreement has been reached between Ambulance Victoria and the department that the VADS collection is an accurate replacement for these collections. Existing datasets (as outlined in Table 3.7) will include all current data elements.

Table 3.7: Existing data collections

Collection	Description and submission timeline
Aggregate Ambulance Minimum Dataset	The indicators identified in Table 3.17 will be supplied to the department in spreadsheet format on or after the 15th day of the month following the monthly reporting period.
Daily ambulance patient transfer times	A rolling two-week unit-record data submission of all ambulance patient transports to Victorian emergency departments, to be emailed to a nominated departmental contact each day.
Weekly ambulance patient transfer times	A weekly unit-record data submission of all ambulance patient transports to Victorian emergency departments to be submitted to the department via the Department of Human Services portal
Ambulance membership movements	Changes in Ambulance membership in spreadsheet format to be emailed to a nominated departmental contact on the seventh day of each month following the end of the monthly reporting period

3.12.6 Mental health services data reporting requirements

Information about clinical mental health services relevant to funding, activity and performance monitoring is collected by the department through a range of channels, including:

- the CMI/ODS, which includes data on bed status as required by the bed coordination initiative, and seclusion and restraint as required by the Mental Health Act
- the mental health triage minimum dataset
- the electroconvulsive therapy register
- reportable deaths
- quarterly data collection for disability services
- quarterly PDRSS activity
- annual mental health establishments collection
- the VAED
- the VEMD.

The collections form an essential underpinning of public accountability for service provision, with the outputs from these collections contributing to a range of national datasets, as well as performance measurement and monitoring for Commonwealth, state and departmental purposes.

3.12.6.1 Client Management Interface and Operational Data Store

The statewide ODS is simultaneously updated from local CMI systems as data are captured, providing a live 24-hour, seven-day-a-week statewide view of the transactional history of mental health services.

Services are expected to use the CMI/ODS for data collection, which includes outcome measurement and client-related activity and complies with the due dates as summarised in Table 3.8.

Table 3.8: CMI/ODS reporting timelines

Data entry	Rationale	Due date
Legal status	To ensure timely monitoring of involuntary/forensic/ security clients	As soon as is practicably possible
Admission, transfer and separation	Maintain statewide bed register	Twice daily, seven days per week
Contacts	Monitoring	10th of the month following the contact
Outcome measures	Monitoring	Within two weeks of the measure collection
Electroconvulsive (ECT) therapy task	Statutory reporting	As soon as is practicably possible
Seclusion and restraint	Statutory reporting	10th of the month following the episode

Departmental circulars detail the business rules for key data requirements and guidelines for data recording practices. Admission, transfer and separation data entry timeliness is likely to increase to meet the need for improved access to bed availability data.

Business rules for data recording can be found under CMI/ODS at <www.health.vic.gov.au/mhdr-info/bulletin>.

Regular meetings are held with hospital mental health system administrators to discuss system and data issues. Regular system upgrades are performed to improve the functionality and utility of the system and data.

Electroconvulsive therapy register

It is a statutory requirement that all occasions of ECT be reported to the Chief Psychiatrist. A regular submission (at least monthly) must be made on an electronic ECT register sent to the following secure email address: ect.mhd@dhs.vic.gov.au.

Data for monitoring payment under ECT funding arrangements will be collected via the VAED.

3.12.6.2 Mental Health Establishment National Minimum Dataset

The Mental Health Establishment National Minimum Dataset replaced the National Survey of Mental Health Services in 2005–06. This annual collection captures all mental health workforce data and all expenditure, and is compiled to meet Victoria's national mental health reporting requirements.

The data collection for the previous year (stage 1) begins in September each year, with health services, residential service providers and regions required to submit a return.

The 2013–14 Mental Health Establishment collection for health services performance data will be pre-populated using CMI/ODS. This information is subject to health service confirmation and/or amendment as required.

The F1 finance return (where applicable) will be used to pre-populate the organisation-level information page for health services. Further advice will be provided prior to the HealthCollect portal opening for the stage 1 2013–14 data submission.

Reporting timelines for the Mental Health Establishment National Minimum Dataset are outlined in Table 3.9.

Table 3.9: Mental Health Establishment National Minimum Dataset reporting timelines

Collection	Reporting requirements	Due date
2012–13	Stage 3: This process is required to be finalised by 29 August 2014. Timely resolution of these issues enables the department to submit validated data to the Report on Government Services	29 August 2014
2013–14	Stage 1: Data submission will open, through the HealthCollect portal, on 16 September 2014, with data entry by services to be finalised by 17 October 2014, when the portal will close	17 October 2014
2013–14	Stage 1: Resolution of services' validation issues arising from the HealthCollect	12 December 2014
2013–14	Stage 2: Resolution of issues identified by the Commonwealth	TBA

3.12.6.3 Mental Health Triage Minimum Dataset

In 2010–11 the department introduced a triage minimum dataset. A new code was established as part of the triage minimum data in October 2011. It identifies referrals to mental health services for infants, children and young people who are placed and live in out-of-home care. Quarterly reports and an annual detailed report are to be drawn from this data in support of the Chief Psychiatrist's guideline *Priority access for out-of-home care* (September 2011).

Triage data are required to be provided monthly to the department in the prescribed format. The data file must be sent to the following secure email address: triagemds@health.vic.gov.au.

Documents detailing the format and reporting timelines can be found at <www.health.vic.gov.au/mentalhealth/triage/dataset>.

3.12.6.4 Mental health community support services

In 2005–06 the department introduced a new funding model for MHCSS. This model established a firm foundation for the future growth of the sector. The data required to support the implementation of this model is captured through the quarterly data collection system and supplemented via an Excel spreadsheet capturing key agency deliverable outcomes.

Under the PDRSS agency implementation guidelines, compliance with these reporting requirements has become a key accountability requirement to be used as part of the ongoing review and monitoring processes. The Department of Health is currently developing a performance management framework for MHCSS. The framework will specify any changes to the types of data and reporting process for MHCSS. In the interim, submitting data through the quarterly data collection system managed by the Department of Human Services Disability Services Division and the supplementary Excel spreadsheet remains a core service accountability requirement.

The Disability Services Division has a dedicated help desk support team (disabilityit@dhs.vic.gov.au) to assist users with the quarterly data collection.

3.12.6.5 Reportable deaths

Under the Mental Health Act, services are required to report the death of a current inpatient, a person being treated as an involuntary patient, and the unnatural, unexpected or violent death of a person receiving treatment in the community. Guidance in relation to reportable deaths is provided in a Chief Psychiatrist's guideline available on the website. The Chief Psychiatrist maintains a record of all deaths reported and liaises with the coroner when indicated.

3.12.7 Alcohol and other drug services data reporting requirements

Information about AOD treatment services relevant to funding, activity and performance monitoring is collected through a range of channels, including:

- the Alcohol and Drugs Information System (ADIS)
- the Needle and Syringe Program Information System
- the Drugs and Poisons Information System
- the Opioid Replacement Therapy Dispenser Census.

3.12.7.1 Alcohol and Drugs Information System

The ADIS forms an essential underpinning of public accountability for service provision. Outputs contribute to a range of national datasets, as well as performance measurement and monitoring for Commonwealth, state and departmental purposes. The quality of this data is the subject of ongoing review, with the department liaising directly with organisations where data quality issues are identified. The department also maintains a strong support and training capacity to ensure users are fully aware of data entry requirements, including a help desk facility for system users at: adishelpdesk@health.vic.gov.au.

The ADIS collection is generated using the following applications:

- ADIS
- Switch
- health shared services (Trak, iPM)
- other service-provider-managed third-party applications.

ADIS data are to be provided to the department by the 15th of the month following the end of the quarter. The file must be submitted to: adisdata@health.vic.gov.au.

Guidelines and supporting information for the ADIS collection can be found at <www.health.vic.gov.au/mhdr-info/rules>.

3.12.7.2 Needle and Syringe Program Information System

The Victorian and Commonwealth governments fund services to reduce harms associated with AOD use. The harm reduction services data collection records the level of activity in these services in terms of contacts, service provision (for example, needles provided and returned, education and referrals), responses to harm reduction questions, as well as information about the free provision of a range of injecting and safe-sex equipment, and the disposal of returned waste.

The following services are expected to complete the Needle and Syringe Program Survey, which feeds the data collection:

- the Needle and Syringe Program
- mobile overdose response services
- mobile drug safety workers
- the Cambodian, Laotian and Vietnamese Initiative.

Data are reported monthly either via an application (NSPISAR) or a paper survey. Organisations using the application can generate the extract and email it to: nsp-is@health.vic.gov.au.

The completed paper survey is sent to the department via email at: nsp-is@health.vic.gov.au, by fax ((03) 9096 8726) or post to:

NSP Data Collection
Information Data and Analysis
Mental Health, Drugs and Regions Division
Department of Health
GPO Box 4541
Melbourne VIC 3001

3.12.7.3 Drugs and Poisons Information System

The department uses an electronic information system known as the Drugs and Poisons Information System to support its administration of the *Drugs, Poisons and Controlled Substances Act 1981*.

The Drugs and Poisons Information System is a stand-alone system and gives the department the ability to record treatment permits issued to doctors prescribing Schedule 8 drugs to patients. This includes methadone and buprenorphine prescriptions for opioid replacement therapy (pharmacotherapy). Through this system, the department can identify possible instances of a patient seeking Schedule 8 drugs from multiple prescribers ('doctor shopping') in the event that other prescribers apply for permits to treat the same patient. When potential concurrent prescribing is detected, the doctors involved are advised.

The Drugs and Poisons Information System also records licences and permits issued to organisations or individuals who have a legitimate need to use, possess, manufacture or supply drugs and poisons as part of their course of practice or business (such as for research or industrial purposes).

3.12.7.4 Opioid Replacement Therapy Dispenser Census

The department conducts the Opioid Replacement Therapy Dispenser Census annually. It surveys all community, correctional, health service and specialist pharmacotherapy service dispensaries dosing opioid replacement therapy clients in Victoria. All dispensers are faxed the survey form, to be returned by fax, recording numbers of clients being dosed with respective opioid replacement therapy medications. It also records the numbers of opioid replacement therapy clients on a minimal supervision regimen who are eligible for departmental dispensing support, or with interstate prescriptions.

The data provides a count of clients being dosed at a given time. This allows patterns of opioid replacement therapy access to be closely monitored across the state, which in turn informs departmental sector support activities.

3.12.8 Aged Care data reporting requirements

Data collection requirements and timelines for ageing, aged and home care services are provided at Table 3.10. This includes information for HACC, public sector residential aged care and Aged Care Assessment Service (ACAS), through a range of channels, including:

- the HACC national minimum data set
- the Aged Care Assessment Program national minimum data set
- HACC fees data collection
- HACC annual service activity reports
- residential services data collection.

The Carers Recognition Act sets out obligations for councils and organisations covered by the Act, including the obligation to raise awareness and understanding of the care relationship principles as set out in the Act. Relevant organisations are required to report on their compliance against these obligations in their annual report. Specific requirements can be found in ss. 5, 11 and 12 of the Act.

Table 3.10: Ageing, aged and home care data collection and reporting requirements

Activity no.	Activity name	Measure description
13004	ACAS project	ACAP data collection
13005	ACAS assessment	ACAP data collection
		Annual report on quality improvement by teams
		Six-monthly report on ACAP operations
		Six-monthly report on ACAP staffing
13009	ACAS evaluation	Annual report on ACAP activities
13015	HACC linkages packages	HACC national minimum data set
		HACC fees data collection
13023	HACC service development grant	Project report
13024	HACC assessment	HACC national minimum data set
		HACC fees data collection
13026	HACC domestic assistance	HACC national minimum data set
		HACC fees data collection
13027	HACC respite	HACC national minimum data set
		HACC fees data collection
13031	Public sector residential aged care supplement	Annual returns data collection
		Residential aged care services data collection and residential aged persons mental health data collection
13035	Support for carers	HACC national minimum data set
13038	HACC service system resourcing	Annual HACC service activity report
		HACC fees data collection
13043	HACC flexible service response	HACC national minimum data set
		Annual HACC service activity report
		HACC fees data collection
13053	Victorian eyecare service	Victorian eyecare service program data collection (program guidelines updated 2013)
13056	HACC planned activity group – core	HACC national minimum data set
		HACC fees data collection
13057	HACC planned activity group – high	HACC national minimum data set
		HACC fees data collection
13059	Residential aged care complex care supplement	Residential aged care services data collection
		Residential services data collection
13063	HACC volunteer coordination	HACC national minimum data set
		HACC fees data collection
		Annual HACC service activity report

Activity no.	Activity name	Measure description
13082	Low-cost accommodation support	HACC national minimum data set
		Community connection program annual narrative report
		Housing support for the aged program annual narrative report
		Older persons high-rise support program annual narrative report
		SRS oral health initiative service activity six monthly report
13096	HACC allied health	HACC national minimum data set
		HACC fees data collection
		Annual HACC service activity report
13097	HACC delivered meals	HACC national minimum data set
		HACC fees data collection
13099	HACC property maintenance	HACC national minimum data set
		HACC fees data collection
13103	Language services	VITS data collection
13107	Rural small high-care supplement	Annual returns data collection
		Public sector residential aged care services quality activities
13130	HACC volunteer coordination – other	Annual HACC service activity
13131	RDNS HACC allied health	HACC national minimum data set
		HACC fees data collection
13155	Dementia services	Support for carers of people with dementia data collection
13156	Seniors health promotion	Healthy ageing demonstration project report
13211	Aged annual provisions – minor works	Annual returns data collection
13223	HACC nursing	HACC national minimum data set
		HACC fees data collection
13226	HACC personal care	HACC national minimum data set
		HACC fees data collection
13229	HACC access and support	HACC national minimum data set
		HACC fees data collection
13227	ACCO services – aged and home care	HACC national minimum data set
		HACC fees data collection
		Annual HACC service activity report
13301	Aged quality improvement (INVEST)	Public sector residential aged care services quality activities
13302	SRS Supporting Accommodation for Vulnerable Victorians Initiative	Annual SAVVI (narrative) reports, which will include data regarding SAVVI expenditure
13303	SAVVI Supporting Connections	HACC national minimum data set
		SAVVI supporting connections annual narrative report
13352	Victorian Seniors Festival	Seniors community programs data collection

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Activity no.	Activity name	Measure description
13354	Elder abuse prevention and response	HACC national minimum data set (adapted for SRV)
		Seniors community programs data collection
13355	Seniors community programs	Seniors community programs data collection
13356	Information and lifelong learning	HACC national minimum data set (adapted for SIV)
		Seniors community programs data collection
35010	Small rural – aged support services	Seniors Health Promotion Project report
35011	Small rural – residential aged care	Annual returns data collection
		Public sector residential aged care services quality performance data collection
		Residential aged care services data collection (AIMS S5_129 form)
		Residential aged care services aged persons mental health data collection (AIMS S5_115 form)
35030	Small rural – HACC health care and support	HACC national minimum dataset
		HACC fees data collection
35036	Small rural – DVA HACC	HACC national minimum dataset
		HACC fees data collection

3.12.9 Primary, community and dental health data reporting requirements

The department requires a monthly extract of Dental Health Program Data Set items. This extract includes all episodes created during the reporting period and any episodes modified during the reporting period. Agencies with multiple databases should provide one extract per database.

Funded organisations are required to submit data to the department by the third business day of each month. The department is responsible for validating monthly extracts and providing error reports to agencies. Funded organisations must correct errors in their data before the next extract of Dental Health Program Data Set Items is submitted.

The department will provide validated data to funded organisations and Dental Health Services Victoria.

A summary of reporting requirements is shown in Table 3.11.

3.12.9.1 Community health services

All funded organisation receiving community health program funding are required to submit data reports that outline service delivery performance against targets. Agencies are responsible for the timely submission of data as per the documented reporting requirements.

The *Community Health Minimum Dataset reporting guidelines* are available from the department's website at <www.health.vic.gov.au/pch/service_providers/reporting>.

All health services receiving community health program funding are required to ensure that:

- information systems comply with the department's reporting requirements
- client information management systems comply with the current specification for the SCTTs, and support secure sharing of the SCTTs (e-referral)
- service information remains up to date on the *Human Services Directory*.

The SCTT are available at <www.health.vic.gov.au/pcps/sctt>.

Additional evidence may be required from time to time to demonstrate that funding has been used appropriately.

Community health services are also required to contribute to the Primary Care Partnership reporting, as outlined in Part 3, section 3.12.9.2 'Primary Care Partnerships'.

The acquisition, processing and reporting of the Community Health Minimum Dataset has been simplified and standardised, as outlined in the *Community health data update 2013*.

Further work to update guidance for agencies on data definitions and collection will be undertaken in 2014–15.

3.12.9.2 Primary Care Partnerships

Primary Care Partnerships are required to report annually to demonstrate progress in achieving the strategic objectives outlined in the *Primary Care Partnership program logic 2013–17*. These reporting requirements will demonstrate system improvements against the domains: 'Early intervention and integrated care', 'Consumer and community empowerment' and 'Prevention' in the program logic. For 2014–15 Primary Care Partnerships will be required to provide the following reports:

- Domain – *Early Intervention and Integrated Care*
  - partnership report
  - financial statement
  - e-referral report
  - Assessment of Chronic Illness Care survey (used to assess organisation-wide systems for chronic illness care consistent with the Wagner model)
- Domain – *Consumer and Community Empowerment*
  - vignette
- Domain – *Prevention*
  - short report detailing progress in implementing strategies for integrated practice and application of integrated health promotion indicators.

Further details about each of these domains is included in the program logic.

The *Primary Care Partnerships funding and reporting guidelines 2014–15* is available at <www.health.vic.gov.au/pcps/about/prr>.

3.12.9.3 Dental health services

Funded organisations delivering public dental services are required to submit a monthly extract to the department. This extract includes all episodes created and any episodes modified during the reporting period. Funded organisations with multiple databases will need to provide one extract per database. Funded organisations are required to submit data to the department by the third business day of each month. Data are then validated by the department and error reports sent back to health services (one report per site). Funded organisations must correct errors in their data before the next extract of Dental Health Program Data Set Items is submitted. A summary of reporting requirements is shown in Table 3.11.

Table 3.11: Primary and dental health data collection and reporting requirements

Activity no.	Activity name	Data collection description
27017	Oral health – health promotion	Report against agreed deliverables linked to *Healthy Together Victoria – Action plan for oral health promotion 2013–17*
27019	RDHM dental care	Dental health program data set
27023	Community dental care	Dental health program data set
28015	FARREP	Report against health promotion plan
28016	FARREP – health promotion	Report against health promotion plan
28018	Family planning – health promotion	Report against health promotion plan
28021	IHSHY – health promotion	Community health minimum data set
28048	Language services	Community health minimum data set
28050	Women's health – health promotion	Report against health promotion plan
28061	Primary health – DVA	Community health minimum data set
28063	Family planning – education and training	Community health minimum data set
28064	Family planning – clinical services and training	Community health minimum data set
28066	IHSHY	Community health minimum data set
28067	Women's health	Community health minimum data set
28068	Family planning	Community health minimum data set
28071	Aboriginal services and support	Community health minimum data set
28072	Integrated chronic disease management	Community health minimum data set
28074	Diabetes self-management	Community health minimum data set
28076	Refugee health nurses	Community health minimum data set
28080	Healthy Mothers Healthy Babies	Community health minimum data set
28085	Community health – health promotion	Community health minimum data set
28086	Community health	Community health minimum data set
28087	Primary Care Partnerships	Membership report
		Financial statement
		E-referral report
		Integrated health promotion case study
		Integrated chronic disease management case study
		Service coordination and integrated chronic disease management impact report
28088	ACCO services – primary health	Round table reporting

3.12.9.4 Aboriginal Health Promotion and Chronic Care partnership initiative

AHPACC reporting requirements in 2014–15 are outlined in Table 3.12 and Table 3.13.

Table 3.12: For state-funded primary health services – activity number 28071

Reporting measure	Data collection tools	Frequency	Reporting to
Progress with program implementation	Mid-year progress report and final end-of-year report against the agreed annual work plan in accordance with the *Koolin Balit* performance management framework	Six-monthly	Department regional office
Direct service delivery: • number of clients receiving direct services through AHPACC • type of service(s) provided	Community and women's health reporting requirements	Quarterly	HACC/department regional offices

Table 3.13: For Aboriginal community-controlled organisations – activity number 28088

Reporting measure	Data collection tools	Frequency	Reporting to
Progress with program implementation	Mid-year progress report and final end-of-year report against the agreed annual work plan in accordance with the *Koolin Balit* performance management framework	Six-monthly	Department regional office
Direct service delivery: • number of clients receiving direct services through AHPACC • type of service(s) provided	Collected through discussion with the department's relevant regional office	Quarterly	Department regional office

3.12.10 Public health data reporting requirements

Table 3.14: Public health data collection and reporting requirements

Activity no.	Activity name	Data collection requirements description
16034	Languages services	Cultural and linguistic diversity level of interpreter data collection
16038	Tuberculosis screening – management	TB screening data collection
16084	Immunisation services	National Australian Childhood Immunisation Register data collection
16102	Infectious disease surveillance	Public Health and Wellbeing Regulations 2009 Schedule 4 Notifiable Conditions
16107	Public health research capacity building	Project-specific data collection for public health research projects
16108	Health research projects	Project-specific data collection for public health research projects
16119	School and adult immunisation services	School immunisation data collection report
16203	Regulation of ART and associated legislation	Donor register data collection
16206	Laboratory testing	Public Health and Wellbeing Regulations 2009 Schedule 4 – Notifiable conditions
16373	BBV and STI – clinical services	Annual agency report (public health)
16377	BBV and STI – surveillance	BBV STI surveillance data collection
16462	Prevention system initiatives	Percentage of schools reached by 2014
16505	BBV and STI – training and development	Annual agency report, including financial acquittal against BBV STI training and development data plan
16506	BBV and STI – research	Project-specific data collection for public health research projects
16507	BBV and STI – laboratory services	Annual financial acquittal against funding provided; any emerging issues identified must be tabled
16508	BBV and STI – health promotion and prevention	Annual agency report, including acquittal against BBV STI health promotion plan
16509	BBV and STI – community-based care and support	Annual agency report, including financial acquittal against CBCS plan (public health)
16517	Cancer and screening registers	Victorian Cervical Cytology Registry data collection
		BreastScreen data collection
		Cancer Registry data collection

3.12.11 Workforce data reporting requirements

Reporting requirements include those for training and development grants, the Clinical Training Networks, the *Best practice clinical learning environment framework*, early graduate/postgraduate nursing/midwifery programs and the Health Services Payroll and Workforce Minimum Employee Dataset.

3.12.11.1 Health Services Payroll and Workforce Minimum Employee Dataset

Health services are required to transmit information detailed in the Health Services Payroll and Workforce MDS to the department. Data must be transmitted to the department by the 10th day of the following month, or the prior working day if this falls on a weekend or public holiday. Payroll data is required monthly, while workforce information is required biannually, covering the periods ending 31 December and 30 June each year.

Where health services undertake their own payroll processing, they are required to transmit the information directly to the department. In cases where health services engage a payroll bureau to process their payroll, health services may authorise the bureau to transmit the data to the department on their behalf. Notwithstanding such an arrangement, health services remain responsible for the accuracy of the data transmitted.

Where a health service decides to change payroll providers, it will be necessary to complete an accreditation process, prior to the change, to ensure that continuity of data transmission to the department will not be compromised.

Full details regarding the MDS can be found at <www.health.vic.gov.au/accounts/payroll>.

3.12.11.2 Training and development grant reporting requirements

Allied health graduates

To access funding support, health services will be required to report on the numbers and full-time equivalent of new graduates in the following 12 professions: physiotherapy, clinical psychology, speech pathology, occupational therapy, social work, dietetics, podiatry, optometry, exercise physiology, orthotics/prosthetics, orthoptics and audiology as well as report on the methods the health service is using to support these graduates to transition effectively to professional practice.

Medical graduates

To receive postgraduate Year 1 funding, the following criteria must be met:

- Funded positions must be accredited by the Postgraduate Medical Council of Victoria.
- The positions must be filled through the statewide intern match process, or another process agreed by the Postgraduate Medical Council of Victoria.
- The health service must allocate adequate training and supervision to each position as specified in the Medical Board of Australia's guidelines and standards.
- The health service must notify the department and the Postgraduate Medical Council of Victoria if a medical graduate does not commence in, or complete, an intern position.

Postgraduate Year 2 funded positions can be part of accredited medical specialist vocational training or within a generalist experiential program designed to provide candidates with exposure to a range of medical positions. Health services must complete an annual survey of postgraduate Year 2 positions, and must notify the department if a funded position is not filled, as funding cannot exceed the number of actual postgraduate Year 2 positions.

Graduate and postgraduate nursing and midwifery programs

All health services receiving funding are required to reconcile current year activity at the completion of the calendar or academic year cycle and provide actual commencing data for each new academic year as detailed in the program guidelines.

The program guidelines are available on the Nursing in Victoria website at <www.health.vic.gov.au/nursing/furthering/training>.

The reporting timetable for training and development grants is shown by Table 3.15.

Table 3.15: Training and development grants – reporting timetable

Program	Reporting required by health services	Due date
Postgraduate nursing and midwifery education grants	Report on postgraduate nursing and midwifery training places	February 2015
Nursing and midwifery graduate grants	Report on nursing and midwifery places for early graduate places	February 2015
Graduate allied health	Report on graduate allied health	January 2015
Professional-entry student placements	Automated reporting of clinical placement activity from viCPlace bi-annually commencing in January 2014; an interim reporting tool is available in 2014 for disciplines not yet using viCPlace	1 August 2014 (for activity January–June 2014) and 6 February 2015 (for activity July–December 2014).
	Automated reporting of six externally reportable *Best practice clinical learning environment (BPCLE) framework* indicators through BPCLEtool	6 February 2015
	Annual executive-level endorsement of clinical training activities to ensure visibility and prioritisation of developing the health workforce	31 July 2015

Professional-entry student placements – Clinical Training Networks

Geographically-defined Clinical Training Networks (CTN) were established in 2010 to provide a platform for partnership building, coordination, research and innovation in the area of professional-entry clinical training. In 2011 the Victorian Clinical Training Council (VCTC, the overarching statewide leadership group then known as the Victorian Clinical Placement Council), released its four-year plan for clinical placements titled *Well placed. Well prepared: Victoria's strategic plan for clinical placements 2012–15.* This document is intended to provide strategic direction for:

- increasing Victoria's capacity for quality clinical placements around the agreed dimensions of capacity building, quality, innovation and governance
- CTNs to inform and evaluate their own strategic initiatives.

Further information is available at <www.health.vic.gov.au/placements>.

Health services are required to participate in this statewide governance model and contribute to achieving the overarching objectives of the plan. In particular, health services must respond in a timely manner to requests for information and advice (including on data).

- From 2014–15, and in the interests of reducing the reporting burden on health services, the F1 monthly financial acquittal and the annual retrospective clinical placement activity data collection have been removed. Instead the following reporting requirements are included:
- automated reporting of clinical placement activity from viCPlace bi-annually commencing in January 2014 (an interim reporting tool is available for disciplines not using viCPlace in 2014)
- automated reporting of six externally reportable BPCLE indicators through BPCLEtool

- annual executive-level endorsement of clinical training activities to ensure visibility and prioritisation of developing the health workforce.

To improve the accuracy and timeliness of data on which the subsidy is paid, 2014 clinical placement activity data will be collected in two half-year periods with the following two census dates: 1 August 2014 (for activity January–June 2014) and 6 February 2015 (for activity July–December 2014). This will replace the previous annual clinical placement activity data collection and allow the subsidy to transition to align with financial year activity.

As of July 2014, health services will have cash-flowed their 2013–14 allocations. In September 2014, adjusted cash flows will be issued based on reported 2013–14 activity. Further information regarding eligibility, definitions, funding allocations and reporting requirements will be distributed to health services in September 2014, after which information will be accessible at <health.vic.gov.au/workforce/learning/professional>.

To be eligible for the professional-entry student placement subsidy, health services are expected to:

- partake in Victorian Clinical Training Council (VCTC)- and CTN-endorsed activities and projects including clinical placement planning and capacity-building initiatives
- continue implementation of the BPCLE framework using BPCLEtool
- participate in transparent data provision to CTN stakeholders
- adhere to the Standardised schedule of fees for clinical placement of students in Victorian public health services, including recording of fees in viCPlace.

A brief summary of the schedule, viCPlace, and the BPCLE framework is provided below.

Standardised schedule of fees for clinical placement of students in Victorian public health services

At the December 2011 meeting of the VCTC it was agreed that the variation in fees charged for clinical placements, and the associated lack of transparency in setting those fees, were undesirable features of Victoria's clinical placement system. A subsequent extensive consultation with Victorian stakeholders resulted in the schedule.

The schedule applies to students placed within all public health services, where the clinical placement is a component of an accredited curriculum undertaken with supervision in order to put theoretical knowledge into practice. It outlines the maximum financial contributions that may be levied directly by public health services to education providers.

The schedule is effective from 1 July 2013. The department is reviewing the schedule in 2014. This review will assess the implementation of, and inform any modifications to, the schedule. It will also provide consideration for including additional disciplines within the schedule.

Further information is available at <www.health.vic.gov.au/placements/fees>.

viCPlace

viCPlace is a secure, web-based information system to assist Victorian clinical placement providers to plan, manage and administer clinical placements with their partnered education providers. Because viCPlace stores and records clinical placement activity data, reports generated directly from viCPlace will substitute for the annual student clinical placement activity data collection.

From 2014–15, the allocation of the grant for professional-entry student placements will be based on the activity reports generated directly from viCPlace. Since 1 January 2014 health services have been required to use viCPlace. For disciplines that are yet to be included in viCPlace, an option of an interim reporting tool is available to health services in 2014.

Best practice clinical learning environment framework

The BPCLE framework provides guidance to health services, in partnership with their education provider partners, to help create and maintain positive education cultures and improve the student experience through strategies and mechanisms that monitor the quality of the clinical education environment.

Health services are required to implement the BPCLE framework using the online BPCLEtool. BPCLEtool is an online organisational self-assessment tool that allows health services to compare their own arrangements for organising, managing and delivering clinical education against the BPCLE framework. The tool suggests goals and tasks for a quality improvement action plan and appropriate indicators for internal monitoring, based on the self-assessment results.

3.12.12 Commonwealth–state reporting requirements

Funded organisations may receive payments arising from Commonwealth/state agreements. Funding received under such arrangements is subject to each program's specific conditions of funding. Organisations funded funding under Commonwealth/state programs are required to submit regular statistical and financial reports for the monitoring of activity, payment of grants and acquittal to the Commonwealth. The information required, format and timelines for individual programs are detailed in the relevant contractual documentation and the guidelines applicable to the appropriate Commonwealth/state programs.

Appendix 3.1: Performance targets and monitoring

Table 3.16: Ageing, aged and home care performance targets and monitoring

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
13004	ACAS project	Report against agreed objectives	Reports	Yearly	Mandatory	Key output measure
13005	ACAS assessment	*Percentage of priority 1, 2 and 3 clients assessed on time – in community – 80%	Percentage	Quarterly	Mandatory	Other standard measure
		*Percentage of priority1, 2 and 3 clients assessed on time – in hospital – 85%	Percentage	Quarterly	Mandatory	Other standard measure
		Number of assessments	Assessments	Quarterly	Mandatory	Key output measure
13015	HACC linkages packages	Number of packages	Packages	Quarterly	Mandatory	Key output measure
13023	HACC service development grant	One electronic project report submitted	Reports	Yearly	Mandatory	Key output measure
13024	HACC assessment	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13026	HACC domestic assistance	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13027	HACC respite	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13031	Public sector residential aged care supplement	Number of occupied bed days	Occupied bed days	Monthly	Mandatory	Key output measure
13035	Support for carers	Number of carers	Carers	Yearly	Non-mandatory	Other standard measure
		Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13038	HACC service system resourcing	Service activity report	Reports	Yearly	Mandatory	Key output measure
13043	HACC flexible service response	Service activity report	Reports	Yearly	Mandatory	Key output measure
13053	Victorian eyecare service	Number of occasions of service (metropolitan)	Occasions of service	Quarterly	Mandatory	Key output measure

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
		Number of occasions of service (outreach)	Occasions of service	Yearly	Mandatory	Other standard measure
		Number of occasions of service (rural)	Occasions of service	Yearly	Mandatory	Other standard measure
13056	HACC planned activity group – core	Number of hours of service (provided to clients)	Hours	Quarterly	Mandatory	Key output measure
13057	HACC planned activity group – high	Number of hours of service (provided to clients)	Hours	Quarterly	Mandatory	Key output measure
13059	Residential aged care complex care supplement	Number of occupied bed days	Occupied bed days	Monthly	Mandatory	Key output measure
13063	HACC volunteer coordination	Number of hours of coordinator time	Hours	Yearly	Non-Mandatory	Key output measure
		Number of hours of service (provided to clients)	Hours	Quarterly	Mandatory	Other standard measure
13067	Aged community grants	Number of projects	Projects	Yearly	Mandatory	Key output measure
13082	Low-cost accommodation support	Number of clients assisted	Clients	Quarterly	Mandatory	Key output measure
13083	Aged training and development	Number of filled positions (academic)	Positions	Quarterly	Mandatory	Key output measure
		Number of filled positions (training)	Positions	Quarterly	Non-mandatory	Other standard measure
13096	HACC allied health	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13097	HACC delivered meals	Number of meals (funding is a subsidy only)	Meals	Quarterly	Mandatory	Key output measure
13099	HACC property maintenance	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13100	Aged research and evaluation	Report against agreed objectives	Reports	Yearly	Mandatory	Key output measure
13103	Language services	Number of occasions of service	Occasions of service	Monthly	Mandatory	Key output measure
13107	Rural small high-care supplement	Number of occupied bed days	Occupied bed days	Monthly	Mandatory	Key output measure
13109	ACAS evaluation	Evaluation unit meets requirements of Commonwealth conditions of grant	Rating	Yearly	Mandatory	Key output measure

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
13131	RDNS HACC allied health	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13155	Dementia services	Number of contacts	Contacts	Yearly	Mandatory	Other standard measure
		Number of hours of service	Hours	Yearly	Mandatory	Key output measure
		Number of sessions	Sessions	Yearly	Mandatory	Other standard measure
13156	Seniors health promotion	Report against agreed objectives	Reports	Yearly	Mandatory	Key output measure
13210	ACAS training and development	Funds expended on training needs of staff	Dollars	Yearly	Mandatory	Key output measure
13223	HACC nursing	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13226	HACC personal care	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13227	ACCO services – aged and home care	Development of service profile	Completed service profile	Yearly	Mandatory	Key output measure
13229	HACC access and support	Hours of client care coordination	Hours	Quarterly	Mandatory	Key output measure
13301	Aged quality improvement	Current authorisations for information exchange between the Department of Health and: • Department of Social Services • Australian Aged Care Quality Agency	Signed documents	Yearly	Mandatory	Other standard measure
		Number of alleged incidents reported during the month	Reports	Within 24 hours of incident allegation	Mandatory	Other standard measure
13302	SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI)	Number of facility cost relief expenditure plans developed and implemented	Plans	Yearly	Mandatory	Key output measure
		Number of facility cost relief cluster plans developed and implemented	Plans	Yearly	Mandatory	Other standard measure
		Number of proprietors of assisted supported residential services that meet accountability and reporting requirements for facility cost relief	Proprietors	Yearly	Mandatory	Other standard measure

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
13303	SAVVI Supporting Connections	Number of clients	Clients	Yearly	Mandatory	Key output measure
13352	Victorian Seniors Festival	Number of events and participants	Events Participants	Yearly	Non-mandatory	Other standard measure
13354	Elder abuse prevention and response	Number of telephone calls	Calls	Six-monthly	Non-mandatory	Other standard measure
		Number of professional educations sessions attendees	Events participants	Six-monthly	Non-mandatory	Other standard measure
		Number of community education sessions	Events	Six-monthly	Non-mandatory	Other standard measure
13355	Seniors community programs	Number of projects	Reports	Quarterly	Non-mandatory	Other standard measure
13356	Information and lifelong learning	Number of information requests/contacts	Contacts	Quarterly	Non-mandatory	Other standard measure
		New programs New U3As	Programs U3As	Six-monthly	Non-mandatory	Other standard measure

Table 3.17: Ambulance Victoria performance targets and monitoring

Service plan	Activity	Measure description	Unit of measure	Reporting frequency	Status
Quantity – incidents[a]	Emergency road: all	Number of 000 or planned events to which one or more ambulance resources are dispatched	Number	Monthly	Mandatory
	Emergency road: metro				
	Emergency road: non-metro				
	Treat-not-transport				
	Non-emergency stretcher: all				
	Non-emergency stretcher: metro				
	Non-emergency stretcher: non-metro				
	Non-emergency clinic car				
	Fixed wing				
	Rotary wing				

Service plan	Activity	Measure description	Unit of measure	Reporting frequency	Status
Quantity – transports[a]	Emergency road: all	Number of transports provided	Number	Monthly	Mandatory
	Emergency road: metro				
	Emergency road: non-metro				
	Non-emergency stretcher: all				
	Non-emergency stretcher: metro				
	Non-emergency stretcher: non-metro				
	Non-emergency clinic car				
	Fixed wing				
	Rotary wing				
Quality	Clinical compliance audits: emergency	Audited cases meeting clinical practice standards	Percentage	Monthly	Mandatory
	Clinical compliance audits: non-emergency				
	Clinical compliance audits: CERT				
	Patients experiencing severe cardiac or traumatic pain	Reported level of pain is reduced significantly: adult and paediatric patients combined	Percentage	Annually	Mandatory
	Patient satisfaction	Satisfied or very satisfied with quality of care provided by paramedics	Percentage	Annually	Mandatory
	Cardiac arrest survived event rate	Adult VF/VT cardiac arrest patients with vital signs at hospital	Percentage	Quarterly	Mandatory
		Adult VF/VT cardiac arrest patients surviving to hospital discharge	Percentage	Quarterly	Mandatory
	Stroke patients transported	Adult patients suspected of having a stroke who were transported to a stroke unit with thrombolysis facilities within 60 minutes	Percentage	Quarterly	Mandatory

Service plan	Activity	Measure description	Unit of measure	Reporting frequency	Status
Timeliness	Emergency (Code 1) response: statewide	Emergency incidents (Code 1) responded to within 15 minutes – total catchment	Percentage	Monthly	Mandatory
	Emergency (Code 1) response: urban	Emergency incidents (Code 1) responded to within 15 minutes – in centres with a population greater than 7,500	Percentage	Monthly	Mandatory
	Emergency (Code 1) response: CERT	Community emergency response team arrival prior to ambulance where dispatched	Percentage	Quarterly	Mandatory
	Call referral[b]	Events where 000 caller receives advice or service from another health service provider in the Melbourne metropolitan region	Percentage	Monthly	Mandatory

[a] These requirements apply to all account classes. User groups: CSO, MSS, DVA, general patients, TAC, WorkCover, public hospitals, private hospitals

[b] Additional measures will be developed and included in the data submissions

Table 3.18: Mental health service performance indicators

Measure or indicator	Unit	Adult report	CAMHS report	Older person report	Government target
28-day readmission rate	per cent	Yes	No	Yes	< 14
					Adult Services Only
Pre-admission contact	per cent	Yes	Yes[1]	Yes	60
					Adult Services only
Post discharge follow up	per cent	Yes	Yes[1]	Yes	75
					All age ranges
Total seclusion rate	episodes per 1,000 bed days	Yes	Yes	Yes	< 15
					All age ranges
HoNOS[2] compliance – all inpatient, all ages	per cent	Yes	Yes	Yes	> 85
HoNOS[2] compliance – ambulatory, all ages	per cent	Yes	Yes	Yes	> 85

Measure or indicator	Unit	Adult report	CAMHS report	Older person report	Government target
Emergency department presentations departing to a mental health bed within 8hrs	per cent	Yes	No	No	80
Basis/SDQ[3] Compliance	Per cent	No	Yes	Yes	> 85

Notes:

1. *Slight variation in definition as results attributed to client's home AMHS not the separating AMHS as for adult and older person.*
2. *HoNOS refers to Health of the Nation Outcome Scale and is a key mental health consumer outcome measure that has been implemented nationally.*
3. *Basis and Strengths and Difficulties Questionnaire (SDQ) are used by the consumer's and/or carer's (SDQ only) to present their views on behaviour to inform discussions with the AMHS. There are collected as part of the Outcome Measures suite at predefined points of time.*

Table 3.19: Public health performance targets and monitoring

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
16119	School and adult immunisation services	Number of people immunised	People	Yearly	Mandatory	Key output type
16163	Food safety education	Report against agreed objectives	Reports	Yearly	Mandatory	Key output type
16203	Regulation of ART and associated legislation	Report against agreed objectives	Reports	Yearly	Mandatory	Key output type
16206	Laboratory testing	Provision of a public health reference/testing service	Services	Yearly	Mandatory	Key output type
		Percentage of notifications within specified timelines	Notifications	Yearly	Mandatory	Other standard measure
		Provision of required testing in accordance with accredited standards	Testing	Yearly	Mandatory	Other standard measure
16234	Public Health Legislative Review	Report against agreed objectives	Reports	Yearly	Mandatory	Key output type
16308	Injury prevention	Report against agreed objectives	Reports	Yearly	Mandatory	Key output type
16348	Children's obesity	Report against agreed objectives	Reports	Half-yearly	Mandatory	Key output type
16349	Obesity – community projects	Report against agreed objectives	Reports	Yearly	Mandatory	Key output type
16373	BBV and STI – clinical services	Report against agreed objectives	Report	Annual	Mandatory	Key output type

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
16381	Risk management and emergency response	Report against agreed objectives	Reports	Yearly	Mandatory	Key output type
16449	Smoking information – advice and interventions	Research reports	Reports	Yearly	Mandatory	Key output type
16450	Diabetes prevention	Report against agreed objectives	Reports	Quarterly	Mandatory	Key output type
16452	Aboriginal health advancement	Report against agreed objectives	Reports	Half-yearly	Mandatory	Key output type
16453	Aboriginal health worker support	Report against agreed objectives	Reports	Half-yearly	Mandatory	Key output type
16454	Health promotion initiatives	Report against agreed objectives	Reports	Quarterly	Mandatory	Key output type
16460	Targeted recruitment for screening programs	Report against agreed deliverables	Reports	Yearly	Mandatory	Key output type
16505	BBV and STI – training and development	Report against agreed deliverables	Reports	Yearly	Mandatory	Key output type
16507	BBV and STI – laboratory services	Report against agreed deliverables	Reports	Reports	Mandatory	Key output type
16508	BBV and STI – health promotion and prevention	Report against health promotion plan	Reports	Yearly	Mandatory	Key output type
16509	BBV and STI – community based care and support	Report against agreed deliverables	Reports	Yearly	Mandatory	Key output type
16513	Screening and preventative messages	Report against agreed deliverables	Reports	Yearly	Mandatory	Key output type
16514	Screening service development	Report against agreed deliverables	Reports	Yearly	Mandatory	Key output type
16515	Education and training in screening programs	Report against agreed deliverables	Reports	Yearly	Mandatory	Key output type
16516	Screening counselling and support	Number of occasions of service	Occasions of service	Yearly	Mandatory	Key output type

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
16517	Cancer and screening registers	Statistical report within an agreed timeline and publicly available	Reports	Yearly	Mandatory	Key output type
16518	Cancer and screening intelligence	Report against agreed objectives	Reports	Yearly	Mandatory	Key output type
16519	Screening tests and assessments	Percentage of target population screened over an agreed period	Percentage	Yearly	Mandatory	Other standard measure
		Number of clients screened	Clients	Yearly	Mandatory	Key output type

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Appendix 3.2: Service standards and guidelines

Table 3.20: Small rural health services – service standards and guidelines

Activity no.	Activity name	Service standards and guidelines description
35010	Small rural – aged support services	*The Home and Community Care national standards instrument and guidelines*, Commonwealth Department of Health and Ageing, 2000
		Small Rural Health Services Guide 2003–04 and updates
35011	Small rural – residential aged care	*Aged Care Act 1997* as amended
		Forthcoming manual – Department of Social Services
		Small rural health services guide 2003–04 and updates
35024	Small rural – flexible health service delivery	*Small rural health services guide 2003–04* and updates
35025	Small rural – TAC – acute health	*Small rural health services guide 2003–04* and updates
35026	Small rural – DVA – acute health	*Small rural health services guide 2003–04* and updates
35028	Small rural – acute health service system development and resourcing	*Small rural health services guide 2003–04* and updates
35030	Small rural – HACC health care and support	*Victorian HACC program manual*
		Small rural health services guide 2003–04 and updates
35036	Small rural – DVA HACC	*Victorian HACC program manual*
		Small rural health services guide 2003–04 and updates
35042	Small rural – drugs services	*Victoria's alcohol and drug treatment services – the framework for service delivery*, Department of Human Services, 1997
		Supported Accommodation Assistance Program and alcohol and drug treatment services guide, 1997
		Specialist Assessment Form for Alcohol and Drug Treatment Services, 2000
		Assessment and intervention tool for youth alcohol and drug treatment services, prepared by Turning Point Alcohol and Drug Centre Inc. for Department of Human Services, 2004
		Small rural health services guide 2003–04 and updates
		DHS Incident reporting departmental instruction, 2005
		Incident reporting protocol for the alcohol and drug sector, 2005
		Drug Treatment organisations receiving government funding are required to accept referrals from COATS in a timely manner and provide drug treatment services to forensic clients
35048	Small rural – primary health flexible services	*Small rural health services guide 2003–04* and updates
35052	Small rural – specified services	*Small rural health services guide 2003–04* and updates

Table 3.21: Mental health services – service standards and guidelines

Standards and guidelines description	Activity number
Accreditation standards and outcomes for residential aged care services	15049, 15250
Adult prevention and recovery care (PARC) services framework and operational guidelines 2010	15057
Aged Persons Mental Health Intensive Community Treatment Program statement	15352
Aged persons psychosocial rehabilitation in mental health	15082
Chief psychiatrist guidelines	15005, 15006, 15007, 15008, 15009, 15012, 15014, 15019, 15022, 15026, 15027, 15028, 15030, 15031, 15032, 15041, 15049, 15056, 15057, 15059, 15060, 15320, 15300, 15350, 15351, 15352, 15353, 15354, 15355
Child and adolescent services – framework for service delivery	15026, 15028, 15031, 15058, 15300
Cultural responsiveness framework	All mental health activities
Evaluation of consumer participation in Victoria's mental health services	15264
Expanding support and treatment options within mental health *Prevention and recovery care services service guidelines*	15057
Framework for recovery-oriented practice	All mental health activities
General adult community mental health services guidelines for service provision	15007, 15008, 15056, 15057, 15099, 15200, 15202, 15252, 15320, 15350, 15351, 15356, 15357
Identifying and responding to family violence: a guide for mental health clinicians in Victoria	15005, 15006, 15007, 15008, 15009, 15012, 15014, 15019, 15022, 15026, 15027, 15028, 15030, 15031, 15032, 15041, 15049, 15056, 15057, 15059, 15060, 15251, 15252, 15320, 15300, 15350, 15351, 15352, 15353, 15354, 15355
Mental Health Act 2014 and amendments	All mental health activities
Mental Health Carer Support Program guidelines	15274, 15275
Mental Health Homeless Program *Intensive home-based outreach psychiatric disability rehabilitation support Guidelines* (October 2003) (IHBOS, linked to *Victorian homeless strategy* only)	15063
Mobile support and treatment services guidelines for service provision 95 0003	15008, 15009
National action plan for promotion, prevention, early intervention	15262
National outcomes and casemix protocols 2002	15059
National safety priorities in mental health: a national plan for reducing harm (Department of Health and Ageing, Australian Government, 2005)	15500,15501,15502,15503,15504
National standards for mental health services	All mental health activities

Standards and guidelines description	Activity number
Non-custodial supervision orders – policy and procedure manual	15005, 15006, 15007, 15008, 15009, 15012, 15014, 15019, 15022, 15026, 15027, 15028, 15030, 15031, 15032, 15041, 15049, 15056, 15057, 15059, 15060, 15251, 15252, 15320, 15300, 15350, 15351, 15352, 15353, 15354, 15355
Procedure for relationships between Office of the Public Advocate – Community Visitors Program and DHS Mental Health Branch and mental health services	15006, 15012, 15014, 15022, 15030, 15031, 15041, 15049, 15057, 15250, 15255, 15353, 15354, 15360
Program management circulars	15005, 15006, 15007, 15008, 15009, 15012, 15014, 15019, 15022, 15026, 15027, 15028, 15030, 15031, 15032, 15041, 15049, 15056, 15057, 15059, 15060, 15251, 15252, 15320, 15300, 15350, 15351, 15352, 15353, 15354, 15355
Psychiatric crisis assessment and treatment services guidelines for service provision, 1994	15005, 15008, 15204, 15355
Psychiatric disability rehabilitation and support services – guidelines for service delivery	15057, 15061, 15062, 15063, 15064, 15065, 15066, 15067, 15068, 15069, 15075, 15076, 15077, 15078, 15079, 15084, 15087, 15088, 15089, 15090, 15091, 15092, 15093, 15094, 15095, 15096, 15097, 15098, 15099, 15365, 15451
Quarterly data collection (QDC) data guide, October 2002, revised 2004	15062, 15063, 15064, 15065, 15066, 15067, 15068, 15069, 15075, 15077, 15078, 15082, 15087, 15090, 15099
Relevant authorities fire safety standard	15078
Service guideline for gender sensitivity and safety Promoting a holistic approach to wellbeing	All mental health activities
Statewide Dual Diagnosis Initiative	15056
Statewide mental health triage scale guidelines	15204
The PDRSS Young Persons Residential Rehabilitation Program, revised guidelines and information, February 2005 (Young Persons Program only)	15077, 15079
The Victorian public mental health caseload management standard	15005, 15006, 15007, 15008, 15009, 15012, 15014, 15019, 15022, 15026, 15027, 15028, 15030, 15031, 15032, 15041, 15049, 15056, 15057, 15059, 15060, 15251, 15252, 15320, 15300, 15350, 15351, 15352, 15353, 15354, 15355
Veterans Hospital Circular 17/1998	15012, 15022, 15041, 15049, 15250
Victoria's mental health service – improved access through coordinated care 1995 (as applicable)	15005, 15006, 15007, 15008, 15009, 15019, 15026, 15028, 15032, 15054, 15056, 15058, 15072, 15073, 15099, 15200, 15204, 15252, 15274, 15275, 15300, 15320, 15350, 15351, 15352, 15355, 15356, 15357, 15358, 15359, 15360
Victoria's mental health service – the framework for service delivery – aged persons services, May 1998 95 | 0179 (as applicable)	15019, 15022, 15049, 15058, 15073, 15250, 15352
Victorian Charter of Human Rights and Responsibilities Act 2006	15500,15501,15502,15503,15504
Victorian *Disability Act 2006*	15500,15501,15502,15503,15504
Victorian framework for recovery-oriented practice (Victorian Department of Health, 2001)	15500,15501,15502,15503,15504
Victorian guidelines for consumer participation in mental health services, March 1996	15264

Standards and guidelines description	Activity number
Victoria's mental health services – the framework for service delivery	15005, 15006, 15007, 15008, 15009, 15012, 15030, 15032, 15041, 15054, 15056, 15057, 15070, 15071, 15072, 15099, 15200, 15202, 15203, 15204, 15252, 15255, 15267, 15320, 15321, 15350, 15351, 15353, 15354, 15355, 15356, 15357, 15358, 15359, 15360, 15361
Victoria Police mental health protocol 2010	15005, 15006, 15007, 15008, 15009, 15012, 15014, 15019, 15022, 15026, 15028, 15030, 15031, 15032, 15041, 15049, 15054, 15056, 15057, 15058, 15060, 15070, 15071, 15072, 15073, 15200, 15202, 15203, 15204, 15250, 15251, 15252, 15255, 15264, 15265, 15266, 15267, 15272, 15274, 15300, 15320, 15321, 15350, 15351, 15352, 15353, 15354, 15355, 15356, 15357, 15358, 15359, 15360, 15361
Victorian quality improvement framework for healthcare 2013–2022	15500,15501,15502,15503,15504
Working with the suicidal person: clinical guidelines for emergency departments and mental health services	15005, 15006, 15007, 15008, 15009, 15012, 15014, 15019, 15022, 15026, 15027, 15028, 15030, 15031, 15032, 15041, 15049, 15056, 15057, 15059, 15060, 15251, 15252, 15320, 15300, 15350, 15351, 15352, 15353, 15354, 15355

Table 3.22: Drug services – service standards and guidelines

Standards and guidelines description	Activity number
Alcohol in the workplace – guidelines for developing a workplace alcohol policy	34009
Assessment and intervention tool for youth alcohol and drug treatment services (prepared by Turning Point Alcohol and Drug Centre Inc. for Department of Human Services) 2004	34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34075, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208
Child Wellbeing and Safety Act 2005	34001, 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34043, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34054, 34056, 34057, 34058, 34059, 34060, 34061, 34062, 34064, 34065, 34066, 34068, 34069, 34070, 34071, 34074, 34075, 34078, 34079, 34080, 34082, 34083, 34084, 34200, 34201, 34202, 34203, 34204, 34205, 34206, 34207, 34208, 34209, 34210, 34211, 34212, 34213, 34214
Children, Youth and Families Act 2005	34001, 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34043, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34054, 34056, 34057, 34058, 34059, 34060, 34061, 34062, 34064, 34065, 34066, 34068, 34069, 34070, 34071, 34074, 34075, 34078, 34079, 34080, 34082, 34083, 34084, 34200, 34201, 34202, 34203, 34204, 34205, 34206, 34207, 34208, 34209, 34210, 34211, 34212, 34213, 34214
Clinical treatment guidelines for alcohol and drug clinicians – co-occurring acquired brain injury / cognitive impairment and alcohol and other drug use disorders *National co-morbidity guidelines*	34001, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34043, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34054, 34056, 34057, 34058, 34059, 34060, 34061, 34062, 34064, 34065, 34066, 34068, 34069, 34070, 34071, 34074, 34075, 34079, 34080, 34082, 34083, 34084, 34200, 34201, 34202, 34203, 34204, 34205, 34206, 34207, 34208, 34209, 34210, 34211, 34212, 34213

Standards and guidelines description	Activity number
Clinical treatment guidelines for methamphetamine dependence and treatment	34001, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34043, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34054, 34056, 34057, 34058, 34059, 34060, 34061, 34062, 34064, 34065, 34066, 34068, 34069, 34070, 34071, 34074, 34075, 34079, 34080, 34082, 34083, 34084, 34200, 34201, 34202, 34203, 34204, 34205, 34206, 34207, 34208, 34209, 34210, 34211, 34212, 34213
Code of practice for running safer music festivals and events	34004
Cultural diversity guide	34001, 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34043, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34054, 34056, 34057, 34058, 34059, 34060, 34061, 34062, 34064, 34065, 34066, 34068, 34069, 34070, 34071, 34074, 34075
COATS, Community Correctional Services and Drug Treatment Services protocol Drug treatment organisations receiving government funding are required to accept referrals from COATS in a timely manner and provide drug treatment services to forensic clients	34001, 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34043, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34054, 34056, 34057, 34058, 34059, 34060, 34061, 34062, 34064, 34065, 34066, 34068, 34069, 34070, 34071, 34074, 34075, 34079, 34080, 34082, 34083, 34084, 34200, 34201, 34202, 34203, 34204, 34205, 34206, 34207, 34208, 34209, 34210, 34211, 34212, 34213
Drugs, Poisons and Controlled Substances Act 1981 (Victoria), reprint no. 6 Act No 9719 1981	34061, 34070
Incident reporting protocol for the alcohol and drug sector (2008) *AOD sector incident reporting protocol*, supplement to IR instructions March 2008 (May 2009)	34001, 34004, 34006, 34021, 34040, 34041, 34042, 34043, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34051, 34053, 34054, 34056, 34057, 34058, 34059, 34060, 34061, 34062, 34064, 34065, 34066, 34068, 34069, 34070, 34071, 34074, 34075, 34079, 34080, 34082, 34083, 34084, 34200, 34201, 34202, 34203, 34204, 34205, 34206, 34207, 34208, 34209, 34210, 34211, 34212, 34213, 34214
Interagency protocol between Victoria Police and nominated agencies (2004)	34041, 34045, 34046, 34049, 34056, 34062, 34071, 34074, 34078, 34079, 34084, 34202, 34204, 34207, 34208
Management response to inhalant use – guidelines for the community care and drug and alcohol sector (2005)	34041, 34045, 34046, 34049, 34056, 34062, 34071, 34074, 34078, 34079, 34202, 34204, 34207, 34208
Victorian policy for maintenance pharmacotherapy for opioid dependence (2013) National clinical guidelines and procedures for the use of methadone in the maintenance treatment of opioid dependence (2003) *National clinical guidelines and procedures for the use of buprenorphine in the maintenance treatment of opioid dependence* (2006)	34047, 34057
Third national hepatitis C strategy 2010–2013 *National hepatitis B strategy 2010–2013*	34070
Sixth national HIV strategy 2010–2013 Second national sexually transmissible infections strategy, 2010–2013 *Third National Aboriginal and Torres Strait Islander blood borne viruses and sexually transmissible infections strategy 2010–2013*	34070

Standards and guidelines description	Activity number
National needle and syringe programs strategic framework 2010–2014	34070
National amphetamine-type stimulant (ATS) strategy 2008–2011	34070
Protocol between drug treatment services and Child Protection for working with parents with alcohol and other drug issues	34001, 34004, 34006, 34021, 34040, 34041, 34042, 34043, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34051, 34053, 34054, 34056, 34057, 34058, 34059, 34060, 34061, 34062, 34064, 34065, 34066, 34068, 34069, 34070, 34071, 34074, 34075, 34079, 34080, 34082, 34083, 34084, 34200, 34201, 34202, 34203, 34204, 34205, 34206, 34207, 34208, 34209, 34210, 34211, 34212
Severe Substance Dependence Treatment Act 2010	34001, 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34043, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34054, 34056, 34057, 34058, 34059, 34060, 34061, 34062, 34064, 34065, 34066, 34068, 34069, 34070, 34071, 34074, 34075, 34079, 34080, 34082, 34083, 34084, 34200, 34201, 34202, 34203, 34204, 34205, 34206, 34207, 34208, 34209, 34210, 34211, 34212, 34213
Shaping the future – the Victorian alcohol and other drug quality framework, April 2008	34001, 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34043, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34054, 34056, 34057, 34058, 34059, 34060, 34061, 34062, 34064, 34065, 34066, 34068, 34069, 34070, 34071, 34074, 34075, 34079, 34080, 34082, 34083, 34200, 34201, 34202, 34203, 34204, 34205, 34206, 34207, 34208, 34209
SHPA standards of practice for Australian poisons information centres	34003
Specialist assessment form for alcohol and drug treatment services, 2000	34001, 34042, 34043, 34044, 34045, 34049, 34050, 34051, 34053, 34059, 34060, 34065, 34066, 34068, 34069, 34074, 34075, 34078, 34079, 34080, 34082, 34083, 34084, 34201, 34202, 34203, 34205, 34206, 34208, 34209, 34210, 34211, 34212, 34213, 34214
Supported Accommodation Assistance Program and alcohol and drug treatment services guide, 1997	34043, 34046, 34047, 34057, 34059, 34061, 34062, 34071, 34082, 34201, 34207
Victoria's alcohol and drug treatment services – the framework for service delivery, Department of Human Services, 1997	34001, 34004, 34040, 34041, 34042, 34043, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34051, 34053, 34054, 34056, 34057, 34058, 34059, 34060, 34061, 34062, 34064, 34065, 34066, 34068, 34069, 34071, 34074, 34075, 34078, 34079, 34080, 34082, 34083, 34084, 34200, 34201, 34202, 34203, 34204, 34205, 34206, 34207, 34208, 34209, 34210, 34211, 34212, 34213, 34214
Victorian needle and syringe programs operating policy and guidelines, Department of Health (revised Nov 2008)	34070
Working with Children Act 2005	34001, 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34043, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34054, 34056, 34057, 34058, 34059, 34060, 34061, 34062, 34064, 34065, 34066, 34068, 34069, 34070, 34071, 34074, 34075, 34078, 34079, 34080, 34082, 34083, 34084, 34200, 34201, 34202, 34203, 34204, 34205, 34206, 34207, 34208, 34209, 34210, 34211, 34212, 34213, 34214

Table 3.23: Ageing, aged and home care service standards and guidelines

Activity no.	Activity name	Service standards and guidelines description
13004	ACAS projects	*Aged Care Assessment Program guidelines*, January 2014
		Aged care assessment teams revised delegations policy, Commonwealth Department of Health and Ageing November 2011
		Aged Care Act 1997, as amended
		Aged care client record (ACCR) user guide, August 2013
		ACAP national training strategy January 2012
		National Transaction File Format (NTFF), version 5.1 and 5.2
		Service coordination tool templates and associated guidelines; *Victorian service coordination practice manual*, Primary Care Partnerships, Victoria, 2007
		Commonwealth Department of Health and Ageing ACAP financial guidelines, November 2004
		Dissemination of information and materials policy, Commonwealth Department of Health and Ageing, May 2007
		Branding and due recognition policy, Commonwealth Department of Health and Ageing, June 2003
		Disability Services – aged care assessment services protocol: younger people with a disability (Department of Human Services, 2009)
		Protocol between Victorian aged care assessment services and aged persons mental health (APMH) (Department of Human Services, 2008)
		Transition Care Program – program guidelines, 2011
		Aged Care Assessment Program data dictionary, version 3.0
13005	ACAS assessment	*Aged care assessment teams revised delegations policy*, Commonwealth Department of Health and Ageing, November 2011
		Aged Care Act 1997, as amended
		Aged care client record (ACCR) user guide, August 2013
		ACAP national training strategy, January 2012
		National Transaction File Format (NTFF), version 5.1 and 5.2
		Service coordination tool templates and associated guidelines, *Victorian service coordination practice manual*, Primary Care Partnerships, Victoria, 2007
		Commonwealth Department of Health and Ageing ACAP financial guidelines, November 2004
		Dissemination of information and materials policy, Commonwealth Department of Health and Ageing, May 2007
		Branding and due recognition policy, Commonwealth Department of Health and Ageing, June 2003
		Disability Services – aged care assessment services protocol: younger people with a disability (Department of Human Services, 2009)
		Protocol between Victorian aged care assessment services and aged persons mental health (APMH) (Department of Human Services, 2008)
		Transition Care Program – program guidelines, 2011
		Strengthening aged care assessments for Aboriginal consumers – a guide for aged care assessment services in Victoria, Department of Health, 2011
		Guidelines for streamlining pathways between ACAS and HACC Assessment Services 2009
		Victorian HACC program manual

Activity no.	Activity name	Service standards and guidelines description
13015	HACC linkages packages	*Victorian HACC program manual*
13022	HACC capital development	*Victorian HACC program manual*
13023	HACC service development	*Victorian HACC program manual*
13024	HACC assessment	*Victorian HACC program manual*
13026	HACC domestic assistance	*Victorian HACC program manual*
13027	HACC respite	*Aged Care Act 1997*, as amended
13031	Public sector residential aged care supplement	Forthcoming manual – Department of Social Services
		Carers Recognition Act
		A Victorian charter supporting people in care relationships and information kit program guidelines – Support for Carers Program
		Victorian HACC program manual
13035	Support for carers	*Victorian HACC program manual*
13038	HACC service system resourcing	*SRS Service Coordination and Support Program service activity report, guidelines and pro forma*
		Community Connection Program quality standards framework and data collection guidelines 2001
13043	HACC flexible service response	*Victorian HACC program manual*
		SRS Service Coordination and Support Program service activity report, guidelines and pro forma
		Victorian HACC program manual
13056	HACC planned activity group – core	*Victorian HACC program manual*
13057	HACC planned activity group – high	*Aged Care Act 1997*, as amended
13059	Residential aged care complex care supplement	Forthcoming manual – Department of Social Services
		Victorian HACC program manual
13063	HACC volunteer coordination	*Community Connection Program quality standards framework and data collection guidelines 2001*
13082	Low-cost accommodation support	*Flexible Care Fund guidelines for the Older Persons High Rise Support Program*, August 2002
		Flexible Care Fund guidelines for the Housing Support for the Aged Program, May 2002
		Flexible Care Fund guidelines for the Community Connection Program, August 2001
		Older Persons High Rise Support Program submission guidelines 2001
		Housing Support for the Aged Program submission guidelines 2000
		SRS Oral Health initiative service model specifications 2011
		Victorian HACC program manual

Activity no.	Activity name	Service standards and guidelines description
13096	HACC allied health	*Victorian HACC program manual*
13097	HACC delivered meals	*Victorian HACC program manual*
13099	HACC property maintenance	*Aged Care Act 1997*, as amended
		The residential care manual 2009, Commonwealth Department of Health and Ageing
13107	Rural small high-care supplement	*Aged Care Assessment Program operational guidelines*, Commonwealth Department of Health and Ageing, 2006
13109	ACAS evaluation	*Commonwealth framework for determining delegation to positions on aged care assessment teams*, Commonwealth Department of Health and Ageing, October 2005
		Aged Care Act 1997, as amended
		Service coordination tool templates and associated guidelines, *Victorian service coordination practice manual*, Primary Care Partnerships, Victoria, 2007
		ACAP financial guidelines, November 2004, Commonwealth Department of Health and Ageing
		Disability Services – aged care assessment services protocol: younger people with a disability (Department of Human Services, 2009)
		Protocol between Victorian aged care assessment services and aged persons mental health (APMH) (Department of Human Services,2008)
		Transition care training handbook for ACATs, Commonwealth Department of Health and Ageing, 2006
		Victorian HACC program manual
13130	HACC volunteer coordination – other	*Victorian HACC program manual*
13131	RDNS HACC allied health	Carers Recognition Act
		Program guidelines – Support for carers of people with dementia including younger people with dementia guidelines (updated 2013)
13155	Dementia services	*Support and Links Service Program statement*
		Victorian HACC program manual
13156	Seniors health promotion	*The residential care manual 2009*, Commonwealth Department of Health and Ageing
		Older Persons High Rise Support Program guidelines
		Victorian HACC program manual
13217	HACC minor capital	*Victorian HACC program manual*
13223	HACC nursing	*Victorian HACC program manual*
13224	DVA HACC	*Victorian HACC program manual*
13226	HACC personal care	*The residential care manual 2009*, Commonwealth Department of Health and Ageing
13227	ACCO services – aged and home care	*Aged Care Act 1997*, as amended
		Victorian HACC program manual
		Victorian HACC program manual

Activity no.	Activity name	Service standards and guidelines description
13229	HACC access and support	*Aged Care Act 1997*, as amended
13301	Aged quality improvement	Forthcoming manual – Department of Social Services
		Supporting Accommodation for Vulnerable Victorians guidelines, 2012
13302	Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI)	*SRS Supporting Accommodation for Vulnerable Victorians guidelines*, 2012
		SAVVI Supporting Connections flexible funds guidelines 2010
		SAVVI Supporting Connections services specifications 2008
13303	SAVVI Supporting Connections	*VSF Community Grants Program guidelines*
13352	Victorian Seniors Festival	Contract guidelines and schedules
13354	Elder abuse prevention and response	Funded program guidelines
13355	Seniors community programs	Funded program guidelines
13356	Information and lifelong learning	

Table 3.24: Public health – service standards and guidelines

Standards and guidelines description	Activity number
Seamless national economy: labelling review, kilojoules disclosure	16047
Standardised Inspection assessment	16047
Food safety & regulation reform: Reduced Records Initiative	16047
Risk management framework – Municipal Association of Victoria	16047
Review of the Safe Drinking Water Regulations 2005	16380

Table 3.25: Primary, community and dental health service standards and guidelines

Activity name	Activity no.	Service standards and guidelines description
Dental health	27010 27011 27017 27019 27020 27023 27024 27025 27026 27028 27029	www.health.vic.gov.au/dentistry/index
Community health	28033 28043 28069 28074 28080 28084 28085 28086	www.health.vic.gov.au/pch/index www.health.vic.gov.au/pch/commhealth/index
Maternal health	28080 28085 28086	www.health.vic.gov.au/pch/cyf/mothers_babies
Child health	28082 28085 28086	www.health.vic.gov.au/pch/cyf/child_health_teams
Young people	28021 28066 28085 28086	www.health.vic.gov.au/pch/cyf/index www.health.vic.gov.au/pch/cyf/ihshy
Women's health	28015 28016 28018 28050 28063 28064 28068 28067 28085 28086	www.health.vic.gov.au/vwhp www.health.vic.gov.au/healthpromotion/index docs.health.vic.gov.au/docs/doc/Gender-and-Diversity-Lens-for-Health-and-Human-Services-

Activity name	Activity no.	Service standards and guidelines description
Aboriginal health	28071 28085 28086	www.health.vic.gov.au/communityhealth/aboriginal_health www.health.vic.gov.au/aboriginalhealth/publications/
People with chronic disease	28072 28074 28081 28085 28086	www.health.vic.gov.au/pch/icdm/early_intervention.htm www.health.vic.gov.au/pch/icdm/index
Culturally diverse groups	28048 28076 28085 28086	www.health.vic.gov.au/pch/downloads/rhnp www.healthtranslations.vic.gov.au www.health.vic.gov.au/__data/assets/pdf_file/0008/381068/cultural_responsiveness.pdf docs.health.vic.gov.au/docs/doc/Making-the-Connection---Language-services-in-the-human-services-sector
Partnerships and system support	28054 28087	www.health.vic.gov.au/pcps/about/index www.health.vic.gov.au/pcps/about/prr.htm www.health.vic.gov.au/pcps/coordination/index www.health.vic.gov.au/pch/gpp/index.htm www.health.vic.gov.au/pch/gpp/working/position_resource.htm www.health.vic.gov.au/pcps/hp/index

Notes:

1. *Organisations that receive funds associated with activity 28085 and 28086 should note that these funds can be applied flexibly across the broad range of programs and initiatives to meet the needs of the local community*

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Part 4: Funding and activity levels

4.1 Budget tables

4.1.1 Health service modelled budgets 2013–14 and 2014–15

Notes:

i. Please see Part 4, Table 4.1.3 'Activity Based Funding: Health service expenditure budgets 2013–14 and 2014–15 by service category' for detail on funding flowing through the National Health Funding Pool.
ii. Please see Part 4, Table 4.1.4 'Mental health expenditure budgets 2013–14 and 2014–15 by service type' for detail on mental health expenditure.
iii. The 2013–14 expenditure budget has been adjusted to account for one-off and lapsing funding. This includes alcohol and other drugs services subject to recommissioning.
iv. 2014–15 expenditure includes replacements funds, provided by Victoria, for the lapsing subacute NPA.
v. Albury Wodonga data does not yet include the NSW funding for transfer of services from 1 July 2014.

	2013–14 expenditure budget							2014–15 expenditure budget						
	Acute and subacute	Mental health	Drug services	Ageing, aged and home care	Primary, community and dental health	Public health	Total	Acute and subacute	Mental health	Drug services	Ageing, aged and home care	Primary, community and dental health	Public health	Total
Health service	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Major provider														
Alfred Health	594,173	48,559	125	9,373	1,839	8,006	**662,075**	624,883	49,373	127	9,545	1,871	8,125	**693,924**
Austin Health	484,703	50,530	1,307	3,096	-	6	**539,643**	501,761	53,391	1,330	3,148	-	6	**559,636**
Barwon Health	337,536	33,988	969	18,636	4,130	95	**395,354**	360,750	34,511	2,255	18,959	4,200	97	**420,772**
Melbourne Health	458,095	155,606	125	6,845	-	19,448	**640,119**	474,960	158,231	127	6,971	-	19,566	**659,854**
Mercy Public Hospitals Inc	203,795	27,259	125	-	75	-	**231,255**	216,386	30,714	127	-	77	-	**247,304**
Monash Health	882,657	116,073	4,614	17,309	9,827	416	**1,030,896**	949,552	118,004	4,718	17,753	10,883	417	**1,101,328**
Peter MacCallum Cancer Centre	140,848	-	-	1,442	-	-	**142,290**	150,258	-	-	1,471	-	-	**151,728**

	2013–14 expenditure budget							2014–15 expenditure budget						
	Acute and subacute	Mental health	Drug services	Ageing, aged and home care	Primary, community and dental health	Public health	Total	Acute and subacute	Mental health	Drug services	Ageing, aged and home care	Primary, community and dental health	Public health	Total
Health service	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Royal Children's Hospital	329,087	16,102	167	18	300	512	**346,186**	350,251	16,544	170	18	305	516	**367,804**
Royal Victorian Eye & Ear Hospital	68,980	-	-	-	-	-	**68,980**	71,070	-	-	-	-	-	**71,070**
Royal Women's Hospital	166,798	347	822	-	245	-	**168,211**	173,507	353	836	-	249	-	**174,944**
St Vincent's Hospital Melbourne Ltd	362,354	43,596	2,629	5,146	268	151	**414,144**	372,917	44,800	2,674	5,242	273	151	**426,057**
Major provider total	**4,029,025**	**492,061**	**10,883**	**61,865**	**16,685**	**28,634**	**4,639,152**	**4,246,294**	**505,921**	**12,363**	**63,107**	**17,857**	**28,878**	**4,874,420**
Outer metro & large regional														
Ballarat Health Services	172,837	30,166	125	12,986	995	-	**217,108**	182,693	30,643	127	13,387	1,012	-	**227,861**
Bendigo Health Care Group	170,523	38,455	125	17,488	1,012	-	**227,602**	180,521	39,141	127	17,841	1,029	-	**238,660**
Eastern Health	526,634	84,815	7,998	8,740	3,451	-	**631,638**	555,633	86,323	10,468	8,896	3,624	-	**664,943**
Latrobe Regional Hospital	120,357	36,865	125	-	-	-	**157,347**	124,644	38,662	127	-	-	-	**163,434**
Northern Health	299,916	-	125	8,041	-	-	**308,081**	317,762	-	127	8,194	-	-	**326,083**
Peninsula Health	322,964	35,185	1,077	8,349	6,329	-	**373,904**	337,843	35,849	2,053	8,256	6,437	-	**390,438**
Western Health	479,760	578	4,672	2,722	-	400	**488,132**	510,795	588	5,961	2,756	-	407	**520,507**
Outer metro & large regional total	**2,092,990**	**226,063**	**14,246**	**58,326**	**11,787**	**400**	**2,403,812**	**2,209,891**	**231,206**	**18,990**	**59,329**	**12,101**	**407**	**2,531,925**

	2013–14 expenditure budget							2014–15 expenditure budget						
	Acute and subacute	Mental health	Drug services	Ageing, aged and home care	Primary, community and dental health	Public health	Total	Acute and subacute	Mental health	Drug services	Ageing, aged and home care	Primary, community and dental health	Public health	Total
Health service	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Regional and rural														
Albury Wodonga Health	154,420	19,813	-	1,712	513	-	**176,458**	157,961	21,802	125	1,745	522	-	**182,155**
Bairnsdale Regional Health Services	43,234	-	-	2,527	194	-	**45,956**	46,300	-	125	2,560	198	-	**49,183**
Bass Coast Health	25,529	-	96	4,816	1,209	-	**31,649**	27,553	-	97	4,913	1,230	-	**33,792**
Benalla Health	16,021	-	1	2,036	1,568	-	**19,626**	16,764	-	1	2,077	1,725	-	**20,566**
Castlemaine Health	17,501	-	-	3,764	-	-	**21,265**	18,529	-	-	3,841	-	-	**22,370**
Central Gippsland Health Service	48,018	-	-	5,916	816	-	**54,750**	50,017	-	125	6,034	830	-	**57,005**
Colac Area Health	20,162	-	61	3,169	559	-	**23,952**	20,932	-	67	3,234	569	-	**24,802**
Djerriwarrh Health Services	35,063	-	6	4,827	2,238	-	**42,134**	36,073	-	7	4,875	2,419	-	**43,374**
East Grampians Health Service	14,309	-	-	2,286	758	-	**17,352**	14,789	-	-	2,332	771	-	**17,891**
Echuca Regional Health	33,677	-	33	2,579	691	-	**36,980**	35,894	-	37	2,633	703	-	**39,267**
Gippsland Southern Health Service	15,819	-	53	4,043	414	-	**20,328**	16,577	-	58	4,124	421	-	**21,181**
Goulburn Valley Health	115,693	19,381	151	7,704	1,373	-	**144,301**	121,771	19,902	671	7,850	1,396	-	**151,590**
Kyabram & District Health Services	11,391	-	-	2,007	1,022	-	**14,420**	11,942	-	-	2,078	1,040	-	**15,059**

	2013–14 expenditure budget							2014–15 expenditure budget						
	Acute and subacute	Mental health	Drug services	Ageing, aged and home care	Primary, community and dental health	Public health	Total	Acute and subacute	Mental health	Drug services	Ageing, aged and home care	Primary, community and dental health	Public health	Total
Health service	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Maryborough District Health Service	14,239	-	34	3,389	662	-	**18,324**	14,872	-	38	3,458	673	-	**19,040**
Mildura Base Hospital	72,535	10,625	125	-	-	-	**83,284**	77,451	10,857	127	-	-	-	**88,434**
Northeast Health Wangaratta	72,850	-	-	2,499	621	-	**75,970**	77,129	-	125	2,551	632	-	**80,437**
Portland District Health	20,063	-	97	1,547	1,658	-	**23,365**	21,077	-	107	1,578	1,686	-	**24,447**
South West Healthcare	86,139	15,050	76	3,190	1,534	-	**105,987**	91,287	15,273	206	3,354	1,560	-	**111,680**
Stawell Regional Health	11,911	223	-	1,631	1,076	-	**14,842**	12,355	228	-	1,684	1,095	-	**15,361**
Swan Hill District Health	26,803	-	50	2,744	1,573	-	**31,170**	28,592	-	56	2,801	1,600	-	**33,048**
West Gippsland Health Care Group	50,374	-	-	4,671	937	-	**55,982**	54,560	-	-	4,765	952	-	**60,277**
Western District Health Service	35,260	103	-	5,044	892	-	**41,298**	37,099	105	-	5,086	907	-	**43,197**
Wimmera Health Care Group	43,250	-	-	4,899	1,132	-	**49,281**	45,220	-	125	4,998	1,151	-	**51,495**
Regional and rural total	**984,260**	**65,194**	**782**	**76,998**	**21,440**	**-**	**1,148,674**	**1,034,745**	**68,167**	**2,096**	**78,569**	**22,076**	**-**	**1,205,653**
Calvary Health Care Bethlehem Ltd	22,816	-	-	72	-	-	**22,888**	22,979	-	-	73	-	-	**23,052**
Health service total	7,129,091	783,318	25,911	197,261	49,912	29,034	8,214,527	7,513,909	805,294	33,449	201,079	52,035	29,285	8,635,050

4.1.2 Small rural health services budgets 2013–14 and 2014–15

	2013–14 expenditure budget					2014–15 expenditure budget				
	Acute health services	Mental health	Ageing, aged & home care	Primary, community & dental health	Total	Acute health services	Mental health	Ageing, aged & home care	Primary, community & dental health	Total
Health service	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Alexandra District Hospital	5,235	-	246	403	**5,884**	5,346	-	251	405	**6,002**
Alpine Health	10,292	-	2,650	274	**13,216**	10,479	-	2,704	279	**13,462**
Beaufort & Skipton Health Service	3,787	-	1,281	134	**5,201**	3,851	-	1,284	136	**5,271**
Beechworth Health Service	3,466	-	1,723	309	**5,499**	3,524	-	1,734	315	**5,572**
Boort District Health	2,093	-	559	-	**2,652**	2,128	-	571	-	**2,698**
Casterton Memorial Hospital	3,260	-	1,159	34	**4,454**	3,353	-	1,181	35	**4,569**
Cobram District Health	5,553	-	1,276	129	**6,958**	5,663	-	1,276	132	**7,071**
Cohuna District Hospital	4,606	-	700	-	**5,306**	4,699	-	707	-	**5,407**
Dunmunkle Health Services	1,152	-	987	713	**2,852**	1,173	-	1,003	726	**2,902**
East Wimmera Health Service	8,974	-	3,477	552	**13,004**	9,141	-	3,546	558	**13,245**
Edenhope & District Memorial Hospital	3,250	-	924	60	**4,234**	3,305	-	943	61	**4,308**
Heathcote Health	1,810	-	746	114	**2,670**	1,998	-	761	116	**2,876**
Hepburn Health Service	7,475	-	3,337	1,331	**12,143**	7,610	-	3,374	1,357	**12,341**
Hesse Rural Health Service	1,758	-	1,339	526	**3,624**	1,805	-	1,387	536	**3,728**

	2013–14 expenditure budget					2014–15 expenditure budget				
	Acute health services	Mental health	Ageing, aged & home care	Primary, community & dental health	Total	Acute health services	Mental health	Ageing, aged & home care	Primary, community & dental health	Total
Health service	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Heywood Rural Health	2,254	-	541	-	**2,795**	2,294	-	541	-	**2,835**
Inglewood & Districts Health Service	1,643	-	730	493	**2,866**	1,690	-	745	502	**2,937**
Kerang & District Health	5,613	-	1,631	-	**7,244**	5,713	-	1,666	-	**7,379**
Kilmore & District Hospital	9,662	-	1,165	-	**10,827**	10,699	-	1,186	-	**11,885**
Kooweerup Regional Health Services	4,544	-	1,322	-	**5,866**	4,623	-	1,346	-	**5,969**
Kyneton District Health Service	7,782	-	530	-	**8,311**	7,934	-	546	-	**8,480**
Lorne Community Hospital	2,141	-	861	51	**3,054**	2,179	-	891	52	**3,122**
Maldon Hospital	1,011	-	701	-	**1,712**	1,029	-	721	-	**1,750**
Mallee Track Health & Community Service	3,442	-	2,398	-	**5,840**	3,512	-	2,447	-	**5,958**
Mansfield District Hospital	5,878	-	1,297	118	**7,294**	6,013	-	1,321	120	**7,454**
Moyne Health Services	3,312	-	1,921	7	**5,240**	3,374	-	1,961	7	**5,342**
Nathalia District Hospital	1,820	-	833	-	**2,653**	1,847	-	848	-	**2,696**
Numurkah District Health Service	5,826	-	1,416	211	**7,454**	5,944	-	1,443	215	**7,603**
Omeo District Health	1,571	-	639	3	**2,212**	1,598	-	651	-	**2,249**
Orbost Regional Health	5,415	-	1,343	447	**7,205**	5,551	-	1,374	453	**7,378**

	2013–14 expenditure budget					2014–15 expenditure budget				
	Acute health services	Mental health	Ageing, aged & home care	Primary, community & dental health	Total	Acute health services	Mental health	Ageing, aged & home care	Primary, community & dental health	Total
Health service	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Otway Health & Community Services	2,407	-	801	136	**3,344**	2,449	-	817	139	**3,404**
Robinvale District Health Services	5,041	-	1,217	209	**6,466**	5,148	-	1,240	213	**6,601**
Rochester & Elmore District Health Service	4,611	-	1,585	-	**6,196**	4,739	-	1,616	-	**6,355**
Rural Northwest Health	7,577	-	1,924	521	**10,022**	7,716	-	1,937	531	**10,185**
Seymour District Memorial Hospital	11,062	-	1,477	120	**12,659**	11,330	-	1,506	122	**12,958**
South Gippsland Hospital	5,035	-	477	131	**5,643**	5,139	-	487	130	**5,757**
Tallangatta Health Service	3,416	-	1,138	201	**4,754**	3,472	-	1,160	204	**4,836**
Terang & Mortlake Health Service	4,807	-	1,242	1,129	**7,178**	4,901	-	1,232	1,149	**7,281**
Timboon & District Healthcare Service	3,365	-	950	259	**4,573**	3,444	-	969	264	**4,677**
Upper Murray Health & Community Services	3,332	-	1,443	108	**4,883**	3,393	-	1,473	110	**4,976**
West Wimmera Health Service	11,459	242	3,515	1,462	**16,677**	11,693	247	3,523	1,489	**16,952**
Yarram & District Health Service	4,559	90	1,505	369	**6,523**	4,712	12	1,534	372	**6,629**
Yarrawonga District Health Service	7,153	-	1,617	579	**9,349**	7,290	-	1,646	590	**9,526**
Yea & District Memorial Hospital	2,173	-	465	338	**2,975**	2,209	-	473	333	**3,015**
Small rural total	**200,622**	**332**	**57,089**	**11,469**	**269,513**	**205,712**	**258**	**58,020**	**11,651**	**275,642**

4.1.3 Activity Based Funding: Health service expenditure budgets 2013–14 and 2014–15 by service category

Notes:

i. This table shows (State and Commonwealth) funding flowed through the National Health Funding Pool to ABF funded hospitals by NHRA service (refer Part 1, section 1.7.1 'Pricing and funding framework') and out-of-scope funding.

ii. This table does not include public hospital services provided by small rural health services or non-health service organisations.

iii. 2013–14 numbers may differ from the 2013–14 Policy and Funding Guidelines due to changes in classification and funding commitments made during 2013–14.

Health service	Total 2013–14 $'000	Acute admitted $'000	Acute non admitted $'000	ED $'000	Subacute admitted $'000	Subacute non admitted $'000	T&D $'000	Mental health admitted $'000	Mental health non admitted $'000	Out-of-scope funding $'000	Total 2014–15 $'000
Major provider											
Alfred Health	**662,075**	403,289	47,204	36,600	44,953	21,949	16,921	20,399	27,493	75,116	**693,924**
Austin Health	**539,643**	316,190	41,824	32,895	38,799	23,929	16,029	27,726	22,061	40,181	**559,636**
Barwon Health	**395,354**	238,079	27,177	28,345	22,572	14,999	8,548	8,894	24,915	47,207	**420,772**
Melbourne Health	**640,119**	299,853	48,230	30,983	32,014	23,137	19,448	61,123	90,604	54,461	**659,854**
Mercy Public Hospitals Inc	**231,255**	162,385	24,907	13,945	6,351	2,806	4,314	12,742	17,221	2,634	**247,304**
Monash Health	**1,030,896**	680,000	76,888	67,702	49,908	35,428	26,047	50,559	66,425	48,372	**1,101,328**
Peter MacCallum Cancer Centre	**142,290**	68,656	13,107	-	-	-	2,911	-	-	67,054	**151,728**
Royal Children's Hospital	**346,186**	251,890	35,216	28,168	3,195	16,893	7,946	4,402	11,369	13,559	**367,804**
Royal Victorian Eye & Ear	**68,980**	40,339	22,903	5,598	-	-	1,667	-	-	562	**71,070**
Royal Women's Hospital	**168,211**	136,428	34,157	4,342	-	-	3,761	353	-3	2,257	**174,944**

Health service	Total 2013–14 $'000	Acute admitted $'000	Acute non admitted $'000	ED $'000	Subacute admitted $'000	Subacute non admitted $'000	T&D $'000	Mental health admitted $'000	Mental health non admitted $'000	Out-of-scope funding $'000	Total 2014–15 $'000
St Vincent's Hospital Melbourne Ltd	**414,144**	213,312	34,427	20,837	31,794	15,942	17,740	16,344	26,889	48,772	**426,057**
Major provider total	**4,639,152**	**2,810,421**	**406,040**	**269,416**	**229,587**	**155,083**	**125,333**	**202,540**	**286,973**	**400,175**	**4,874,420**
Outer metro & large regional											
Ballarat Health Services	**217,108**	118,742	12,027	15,858	16,181	8,807	5,642	11,147	18,781	20,676	**227,861**
Bendigo Health Care Group	**227,602**	105,848	13,704	12,295	21,247	12,050	5,910	9,625	28,154	29,828	**238,660**
Eastern Health	**631,638**	366,560	33,644	57,899	44,910	26,989	15,069	28,806	57,142	33,924	**664,943**
Latrobe Regional Hospital	**157,347**	85,454	5,031	9,478	10,533	6,390	3,542	11,327	26,337	5,342	**163,434**
Northern Health	**308,081**	193,908	26,903	25,296	33,652	21,089	9,029	11	127	16,069	**326,083**
Peninsula Health	**373,904**	216,567	13,138	32,674	37,134	17,892	7,427	9,988	24,267	31,351	**390,438**
Western Health	**488,132**	344,953	42,396	50,363	31,283	18,790	13,230	2	2,415	17,076	**520,507**
Outer metro & large regional	**2,403,812**	**1,432,030**	**146,844**	**203,861**	**194,940**	**112,007**	**59,848**	**70,907**	**157,222**	**154,266**	**2,531,925**
Regional and rural											
Albury Wodonga Health	**176,458**	58,926	2,694	7,526	3,173	4,186	1,515	5,265	16,339	82,532	**182,155**
Bairnsdale Regional Health	**45,956**	29,869	3,466	4,360	3,299	2,892	880	-	125	4,291	**49,183**
Bass Coast Health	**31,649**	16,358	1,731	3,754	2,055	2,509	677	-	80	6,627	**33,792**

Health service	Total 2013–14 $'000	Acute admitted $'000	Acute non admitted $'000	ED $'000	Subacute admitted $'000	Subacute non admitted $'000	T&D $'000	Mental health admitted $'000	Mental health non admitted $'000	Out-of-scope funding $'000	Total 2014–15 $'000
Benalla Health	**19,626**	13,541	589	-	303	1,243	257	-	-	4,633	**20,566**
Castlemaine Health	**21,265**	10,507	166	-	4,104	2,642	224	-	-	4,727	**22,370**
Central Gippsland Health Service	**54,750**	35,265	4,341	3,951	2,330	1,919	1,091	-	125	7,982	**57,005**
Colac Area Health	**23,952**	16,717	1,735	-	570	1,067	233	-	39	4,442	**24,802**
Djerriwarrh Health Services	**42,134**	27,333	6,066	-	680	1,239	375	-	4	7,676	**43,374**
East Grampians Health Service	**17,352**	12,871	141	-	674	601	241	-	-	3,363	**17,891**
Echuca Regional Health	**36,980**	21,444	2,480	5,461	2,701	2,156	674	-	29	4,322	**39,267**
Gippsland Southern Health Service	**20,328**	13,305	1,516	-	856	261	172	-	10	5,062	**21,181**
Goulburn Valley Health	**144,301**	77,477	8,536	8,579	10,803	6,017	3,529	5,002	14,554	17,093	**151,590**
Kyabram & District Health Services	**14,420**	11,209	119	-	152	-	139	-	-	3,441	**15,059**
Maryborough District Health Service	**18,324**	12,789	768	-	152	545	237	-	18	4,532	**19,040**
Mildura Base Hospital	**83,284**	52,114	3,941	8,330	3,460	2,506	2,258	3,195	7,093	5,537	**88,434**
Northeast Health Wangaratta	**75,970**	51,226	4,892	6,725	4,532	4,239	1,424	12	125	7,262	**80,437**
Portland District Health	**23,365**	16,594	1,723	-	682	984	238	-	42	4,184	**24,447**

Health service	Total 2013–14 $'000	Acute admitted $'000	Acute non admitted $'000	ED $'000	Subacute admitted $'000	Subacute non admitted $'000	T&D $'000	Mental health admitted $'000	Mental health non admitted $'000	Out-of-scope funding $'000	Total 2014–15 $'000
South West Healthcare	**105,987**	59,158	5,451	10,385	6,778	4,055	2,123	4,195	10,756	8,778	**111,680**
Stawell Regional Health	**14,842**	9,796	725	-	152	1,217	161	-	208	3,102	**15,361**
Swan Hill District Health	**31,170**	19,907	1,897	3,322	455	2,141	515	-	19	4,792	**33,048**
West Gippsland Health Care	**55,982**	36,437	3,680	5,777	2,407	2,916	1,506	-	-	7,554	**60,277**
Western District Health Service	**41,298**	22,562	2,845	2,327	1,972	1,861	874	-	104	8,100	**43,197**
Wimmera Health Care Group	**49,281**	29,834	4,532	3,220	2,660	2,495	991	-	125	7,638	**51,495**
Regional and rural total	**1,145,184**	**655,238**	**64,033**	**73,719**	**54,951**	**49,692**	**20,337**	**17,668**	**49,795**	**217,669**	**1,202,103**
Calvary Health Care Bethlehem Limited	**22,888**	1,053	4	-	14,355	6,425	718	-	-	472	**23,052**
Health service total	8,211,037	4,898,743	616,921	546,996	493,833	323,207	206,237	291,115	493,991	772,583	8,631,500

4.1.4 Mental health expenditure budgets 2013–14 and 2014–15 by service type

Notes:

i. 2013–14 and 2014–15 expenditure budgets are recurrent only

ii. 2014–15 expenditure budget includes new beds announced in the 2014–15 budget:
PARC beds due to open at Austin, St Vincents and Albury Wodonga Health
PAPU beds due to open at Mercy Health and Latrobe Regional)

iii. 2014–15 expenditure budget also includes new beds for:
Mother Baby Unit due to open at Latrobe Regional
Acute beds due to open at Mercy Health

iv. 2014–15 expenditure budget excludes:
30 Aged Residential beds closed in 2013–14 (Melbourne Health - Weighbridge)
Excludes 2 Mother Baby Units announced in 2013–14 Budget for Ballarat Health Services and the new Bendigo Hospital

v. 2014–15 expenditure budget for Mental Health Community Support Services (MHCSS) reflect MHCSS recommissioning outcomes.

	2013–14 expenditure budget								2014–15 expenditure budget							
	Adult	Aged	Child and adolescent	Forensic	PDRSS/ MHCSS	Service system capacity development	Specialist	Total	Adult	Aged	Child and adolescent	Forensic	PDRSS/ MHCSS	Service system capacity development	Specialist	Total
Region	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Major provider																
Alfred Health	32,092	6,557	5,551	-	94	3,198	1,068	**48,559**	31,174	6,474	7,301	-	94	3,244	1,086	**49,373**
Austin Health	29,285	-	12,734	-	-	3,148	5,364	**50,530**	31,097	2,722	13,229	-	-	3,196	3,146	**53,391**
Barwon Health	23,913	5,780	2,990	-	-	1,106	199	**33,988**	22,825	5,924	4,356	-	-	1,084	202	**34,391**
Melbourne Health	106,688	22,146	10,656	-	279	8,726	7,112	**155,606**	104,798	22,993	14,105	-	23	8,843	7,229	**157,992**
Mercy Public Hospitals Inc	23,398	-	-	-	-	1,566	2,295	**27,259**	26,137	41	616	-	-	1,588	2,333	**30,714**
Monash Health	74,479	17,340	14,452	-	-	5,657	4,145	**116,073**	71,277	16,461	20,206	-	-	5,728	4,214	**117,885**
Royal Children's Hospital	216	-	11,622	-	108	1,572	2,585	**16,102**	303	-	11,905	-	109	1,598	2,629	**16,544**

	2013–14 expenditure budget								2014–15 expenditure budget							
	Adult	Aged	Child and adolescent	Forensic	PDRSS/ MHCSS	Service system capacity development	Specialist	Total	Adult	Aged	Child and adolescent	Forensic	PDRSS/ MHCSS	Service system capacity development	Specialist	Total
Region	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Royal Women's Hospital	-	-	-	-	-	347	-	**347**	-	-	-	-	-	353	-	**353**
St Vincent's Hospital Melbourne Ltd	28,355	8,600	-	-	-	4,624	2,017	**43,596**	27,891	9,047	1,115	-	-	4,696	2,051	**44,800**
Victorian Institute of Forensic Mental	3,429	-	137	37,700	-	574	-	**41,840**	3,487	-	137	38,341	-	575	-	**42,539**
Outer metro and large regional																
Ballarat Health Services	21,233	4,809	2,985	-	146	993	-	**30,166**	20,916	5,022	3,428	-	148	1,010	-	**30,524**
Bendigo Health Care Group	26,919	6,182	3,568	-	88	1,499	199	**38,455**	26,175	6,690	4,461	-	88	1,525	202	**39,141**
Eastern Health	53,307	12,767	11,275	-	52	3,990	3,423	**84,815**	50,664	13,201	14,756	-	53	4,049	3,481	**86,203**
Latrobe Regional	27,332	5,101	2,981	-	-	1,452	-	**36,865**	27,985	5,290	3,120	-	-	1,473	675	**38,543**
Peninsula Health	24,193	7,822	979	-	-	2,191	-	**35,185**	24,117	7,615	1,892	-	-	2,224	-	**35,849**
Western Health	-	-	-	-	-	578	-	**578**	-	-	-	-	-	588	-	**588**
Regional and rural																
Albury Wodonga Health	14,663	2,505	1,745	-	-	901	-	**19,813**	16,499	2,204	2,182	-	-	916	-	**21,802**
Goulburn Valley Health	13,407	3,626	1,916	-	-	432	-	**19,381**	13,668	3,542	2,136	-	-	437	-	**19,782**

	2013–14 expenditure budget								2014–15 expenditure budget							
	Adult	Aged	Child and adolescent	Forensic	PDRSS/ MHCSS	Service system capacity development	Specialist	Total	Adult	Aged	Child and adolescent	Forensic	PDRSS/ MHCSS	Service system capacity development	Specialist	Total
Region	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Mildura Base Hospital	7,580	1,128	1,176	-	-	740	-	**10,625**	7,467	1,171	1,347	-	-	753	-	**10,738**
South West Healthcare	11,299	1,995	1,271	-	-	455	30	**15,050**	11,289	1,584	1,907	-	-	462	30	**15,273**
Stawell Regional Health	-	223	-	-	-	-	-	**223**	-	228	-	-	-	-	-	**228**
Western District Health Service	-	103	-	-	-	-	-	**103**	-	105	-	-	-	-	-	**105**
Other																
Bouverie Centre	-	-	-	-	-	749	954	**1,703**	-	-	-	-	-	695	970	**1,665**
Lyndoch Warrnambool	-	343	-	-	-	-	-	**343**	-	351	-	-	-	-	-	**351**
West Wimmera Health Service	-	242	-	-	-	-	-	**242**	-	247	-	-	-	-	-	**247**
Total state	521,787	107,270	86,036	37,700	768	44,496	29,388	827,446	517,769	110,912	108,199	38,341	516	45,037	28,248	849,021

4.1.5 Registered community health centres budgets 2013–14 and 2014–15

Notes:

i. Bass Coast Community Health amalgamated with Bass Coast Health for 2014–15.

	2013–14 expenditure budget							2014–15 expenditure budget						
	Acute and subacute	Mental health	Drug services	Ageing, aged & home care	Primary, community & dental health	Public health	Total	Acute and subacute	Mental health	Drug services	Ageing, aged & home care	Primary, community & dental health	Public health	Total
Organisation	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Ballarat Community Health	63	690	910	646	2,497	113	**4,919**	65	60	1,237	714	2,580	116	**4,772**
Banyule Community Health	-	-	586	1,756	2,977	-	**5,320**	-	-	112	1,825	3,034	-	**4,971**
Bass Coast Community Health Service	-	-	570	957	1,156	-	**2,683**	-	-	-	-	-	-	**-**
Bellarine Community Health Ltd	203	-	-	2,661	2,040	-	**4,905**	224	-	-	2,804	2,078	-	**5,106**
Bendigo Community Health Services Ltd	-	-	2,502	666	3,068	63	**6,299**	143	-	3,144	682	3,146	64	**7,180**
Bentleigh-Bayside Community Health	-	-	-	1,873	2,032	-	**3,905**	-	-	-	1,921	2,078	-	**3,999**
Castlemaine District Community Health Ltd	-	-	251	115	769	-	**1,136**	-	-	60	119	781	-	**960**
Central Bayside Community Health Services Ltd	-	321	468	2,930	2,829	-	**6,548**	-	28	125	3,010	2,889	-	**6,051**
Cohealth Ltd	-	1,305	545	1,581	1,469	46	**4,946**	-	10,362	3,602	9,455	9,039	277	**32,735**
Darebin Community Health Service	-	-	417	2,705	4,304	-	**7,426**	-	-	428	2,814	4,415	-	**7,657**

Organisation	2013–14 expenditure budget Acute and subacute $'000	Mental health $'000	Drug services $'000	Ageing, aged & home care $'000	Primary, community & dental health $'000	Public health $'000	Total $'000	2014–15 expenditure budget Acute and subacute $'000	Mental health $'000	Drug services $'000	Ageing, aged & home care $'000	Primary, community & dental health $'000	Public health $'000	Total $'000
Dianella Community Health	-	987	-	2,787	4,153	-	**7,927**	-	88	-	2,937	4,126	-	**7,150**
EACH	-	4,501	3,147	4,243	4,650	-	**16,542**	-	10,262	4,497	5,637	5,951	-	**26,347**
Gateway Community Health	-	447	534	-	1,000	152	**2,134**	-	39	182	-	402	-	**623**
Gateway Health	230	-	660	2,706	1,146	-	**4,742**	118	-	1,085	2,796	1,918	158	**6,074**
Gippsland Lakes Community Health	240	-	867	2,992	2,279	-	**6,378**	244	-	202	3,062	2,559	-	**6,067**
Grampians Community Health	-	467	873	925	1,038	-	**3,302**	-	100	353	947	1,065	-	**2,465**
Inner East Community Health Service	-	-	-	1,912	1,675	-	**3,587**	-	-	-	1,956	1,707	-	**3,663**
Inner South Community Health Service Ltd	1,748	2,399	723	4,678	3,899	674	**14,123**	1,714	2,975	2,646	4,790	4,089	693	**16,907**
Isis Primary Care Ltd	-	-	1,526	9,483	7,553	-	**18,562**	-	-	297	9,894	7,526	-	**17,718**
Latrobe Community Health Service	889	527	2,460	11,611	4,024	-	**19,510**	1,126	158	3,199	12,016	4,174	-	**20,672**
Manningham Community Health Services Ltd	-	-	-	1,870	1,236	-	**3,106**	-	-	-	1,929	1,260	-	**3,189**
Merri Community Health Services Ltd	-	1,330	152	8,605	3,821	-	**13,908**	-	190	26	8,927	3,924	-	**13,068**

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	2013–14 expenditure budget							2014–15 expenditure budget						
	Acute and subacute	Mental health	Drug services	Ageing, aged & home care	Primary, community & dental health	Public health	Total	Acute and subacute	Mental health	Drug services	Ageing, aged & home care	Primary, community & dental health	Public health	Total
Organisation	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
MonashLink Community Health Service Ltd	-	-	-	2,383	2,438	-	**4,821**	-	-	-	2,470	2,485	-	**4,955**
Nillumbik Community Health Service Ltd	-	-	-	2,458	1,177	-	**3,634**	-	-	-	2,541	1,199	-	**3,740**
North Richmond Community Health Ltd	1,507	173	703	214	2,183	769	**5,548**	1,478	15	541	219	2,194	942	**5,389**
Plenty Valley Community Health Ltd	-	-	167	2,122	3,128	-	**5,418**	-	-	47	2,216	3,163	-	**5,426**
Primary Care Connect	-	-	724	-	978	-	**1,703**	-	-	780	-	997	-	**1,777**
Ranges Community Health	-	-	-	1,125	2,099	-	**3,224**	-	-	-	1,169	2,139	-	**3,308**
Sunbury Community Health Centre	-	-	-	2,313	1,893	-	**4,206**	-	-	-	2,411	1,929	-	**4,340**
Sunraysia Community Health Services Ltd	776	-	710	3,314	2,625	-	**7,425**	794	-	304	3,444	2,684	-	**7,225**
Whitehorse Community Health Service Ltd	-	-	428	2,012	2,547	-	**4,987**	-	-	439	2,075	2,595	-	**5,108**
Community health centre total	**5,655**	**13,148**	**19,923**	**83,644**	**78,683**	**1,819**	**202,871**	**5,904**	**24,278**	**23,306**	**94,780**	**88,125**	**2,250**	**238,643**

4.1.6 Local Government Authorities 2013–14 and 2014–15

Notes:

i. This table shows the health funding to Local Government Authorities that receive >$1million from specific health outputs.

	2013–14 expenditure budget						2014–15 expenditure budget					
	Mental health	Drug services	Ageing, aged & home care	Primary, community & dental care	Public health	Total	Mental health	Drug services	Ageing, aged & home care	Primary, community & dental care	Public health	Total
Local Government	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Ballarat City Council	-	-	4,418	-	38	**4,456**	-	-	4,554	-	55	**4,609**
Banyule City Council	-	-	4,611	-	-	**4,611**	-	-	4,710	-	29	**4,739**
Bass Coast Shire Council	-	-	1,996	-	-	**1,996**	-	-	2,027	-	4	**2,031**
Baw Baw Shire Council	-	-	2,648	-	-	**2,648**	-	-	2,731	-	11	**2,742**
Bayside City Council	-	-	5,061	-	-	**5,061**	-	-	5,239	-	15	**5,254**
Boroondara City Council	-	-	5,908	-	-	**5,908**	-	-	6,133	-	44	**6,176**
Brimbank City Council	-	-	4,887	-	-	**4,887**	-	-	4,995	-	28	**5,023**
Campaspe Shire Council	-	-	2,121	259	-	**2,380**	-	-	2,166	264	9	**2,439**
Casey City Council	-	-	10,052	-	-	**10,052**	-	-	10,386	280	39	**10,705**
Central Goldfields Shire Council	-	-	1,194	-	566	**1,760**	-	-	1,199	-	569	**1,767**
Colac Otway Shire Council	-	-	1,181	-	-	**1,181**	-	-	1,216	-	4	**1,220**
Corangamite Shire Council	-	-	990	-	-	**990**	-	-	1,011	-	4	**1,015**
Darebin City Council	-	-	6,420	38	-	**6,459**	-	-	6,658	39	16	**6,713**

	2013–14 expenditure budget						2014–15 expenditure budget					
	Mental health	Drug services	Ageing, aged & home care	Primary, community & dental care	Public health	Total	Mental health	Drug services	Ageing, aged & home care	Primary, community & dental care	Public health	Total
Local Government	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Frankston City Council	-	-	4,709	-	-	**4,709**	-	-	4,858	115	22	**4,995**
Gannawarra Shire Council	-	-	1,042	-	-	**1,042**	-	-	1,058	-	2	**1,060**
Glen Eira City Council	-	-	6,157	-	-	**6,157**	-	-	6,294	-	19	**6,313**
Glenelg Shire Council	-	-	1,422	-	-	**1,422**	-	-	1,431	-	3	**1,433**
Golden Plains Shire Council	-	-	1,007	412	-	**1,419**	-	-	1,035	420	-	**1,455**
Greater Bendigo City Council	-	-	6,070	-	992	**7,062**	-	-	6,198	-	1,011	**7,208**
Greater Dandenong City Council	-	46	7,991	-	1,156	**9,193**	-	113	8,301	-	1,183	**9,597**
Greater Geelong City Council	-	-	10,924	-	1,557	**12,481**	-	-	11,283	-	1,602	**12,885**
Greater Shepparton City Council	-	-	3,117	-	-	**3,117**	-	-	3,184	-	13	**3,197**
Hepburn Shire Council	-	-	1,199	-	-	**1,199**	-	-	1,231	-	1	**1,232**
Hobsons Bay City Council	-	-	4,243	-	-	**4,243**	-	-	4,399	-	12	**4,411**
Hume City Council	-	-	5,858	-	1,308	**7,166**	-	-	6,144	-	1,341	**7,485**
Kingston City Council	-	-	12,828	-	-	**12,828**	-	-	13,123	-	21	**13,144**
Knox City Council	-	-	5,307	-	1,114	**6,420**	-	-	5,128	-	1,130	**6,257**

Local Government	2013–14 expenditure budget						2014–15 expenditure budget					
	Mental health $'000	Drug services $'000	Ageing, aged & home care $'000	Primary, community & dental care $'000	Public health $'000	Total $'000	Mental health $'000	Drug services $'000	Ageing, aged & home care $'000	Primary, community & dental care $'000	Public health $'000	Total $'000
Latrobe City Council	-	-	4,091	-	834	**4,925**	-	-	4,261	-	846	**5,108**
Macedon Ranges Shire Council	-	-	1,812	-	-	**1,812**	-	-	1,829	-	7	**1,836**
Manningham City Council	-	-	6,055	-	-	**6,055**	-	-	6,237	-	19	**6,256**
Maribyrnong City Council	-	-	2,942	-	-	**2,942**	-	-	3,002	-	12	**3,014**
Maroondah City Council	-	-	4,703	-	-	**4,703**	-	-	4,788	-	20	**4,808**
Melbourne City Council	-	-	2,635	-	-	**2,635**	-	-	2,741	-	13	**2,754**
Melton City Council	-	-	3,491	-	-	**3,491**	-	-	3,519	-	16	**3,535**
Mildura Rural City Council	-	-	2,433	320	701	**3,454**	-	-	2,483	325	712	**3,519**
Monash City Council	-	-	8,245	-	-	**8,245**	-	-	8,286	-	39	**8,325**
Moonee Valley City Council	-	-	4,755	-	-	**4,755**	-	-	4,902	-	25	**4,927**
Moorabool Shire Council	-	-	1,586	-	-	**1,586**	-	-	1,652	-	5	**1,657**
Moreland City Council	-	-	6,309	-	-	**6,309**	-	-	6,455	-	14	**6,469**
Mornington Peninsula Shire Council	-	-	7,888	50	-	**7,938**	-	-	8,083	165	23	**8,271**
Mount Alexander Shire Council	-	-	1,388	323	-	**1,712**	-	-	1,406	329	2	**1,737**

	2013–14 expenditure budget						2014–15 expenditure budget					
	Mental health	Drug services	Ageing, aged & home care	Primary, community & dental care	Public health	Total	Mental health	Drug services	Ageing, aged & home care	Primary, community & dental care	Public health	Total
Local Government	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Municipal Association of Victoria	-	-	330	-	1,934	**2,263**	-	-	359	-	2,689	**3,048**
Nillumbik Shire Council	-	-	1,368	-	-	**1,368**	-	-	1,441	-	10	**1,451**
Port Phillip City Council	-	-	3,825	292	-	**4,117**	-	-	3,905	297	8	**4,210**
South Gippsland Shire Council	-	-	1,380	-	-	**1,380**	-	-	1,421	-	6	**1,427**
Southern Grampians Shire Council	-	-	1,313	-	-	**1,313**	-	-	1,296	-	4	**1,301**
Stonnington City Council	-	-	3,776	-	-	**3,776**	-	-	3,855	-	17	**3,873**
Strathbogie Shire Council	-	-	1,054	-	-	**1,054**	-	-	1,043	-	0	**1,043**
Surf Coast Shire Council	-	-	1,124	-	-	**1,124**	-	-	1,146	-	1	**1,147**
Swan Hill Rural City Council	-	-	1,282	-	-	**1,282**	-	-	1,308	-	5	**1,313**
Wangaratta Rural City Council	-	-	2,741	-	-	**2,741**	-	-	2,796	-	5	**2,801**
Warrnambool City Council	-	-	2,048	-	-	**2,048**	-	-	2,069	-	10	**2,079**
Whitehorse City Council	-	-	7,515	-	-	**7,515**	-	-	7,609	-	27	**7,636**
Whittlesea City Council	-	-	5,702	-	1,175	**6,877**	-	-	5,951	-	1,200	**7,150**
Wyndham City Council	-	-	5,154	-	1,234	**6,388**	-	-	5,239	-	1,301	**6,540**

	2013–14 expenditure budget						2014–15 expenditure budget					
	Mental health	Drug services	Ageing, aged & home care	Primary, community & dental care	Public health	Total	Mental health	Drug services	Ageing, aged & home care	Primary, community & dental care	Public health	Total
Local Government	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Yarra City Council	-	-	3,277	-	-	**3,277**	-	-	3,291	-	10	**3,302**
Yarra Ranges Shire Council	86	-	6,113	-	-	**6,199**	8	-	6,184	-	26	**6,218**
All other local government organisations (<$1m)	-	-	11,304	-	1,310	**12,615**	-	-	11,588	-	1,386	**12,974**
Local Government total	86	46	240,999	1,695	13,918	256,745	8	113	246,837	2,234	15,643	264,834

4.1.7 Non-government providers 2013–14 and 2014–15

Notes:

i. This table shows the health funding to non-government organisations that receive >$1million from specific health outputs.

	2013–14 expenditure budget							2014–15 expenditure budget						
Non-government provider	Acute and subacute $'000	Mental health $'000	Drug services $'000	Ageing, aged and home care $'000	Primary, community and dental health $'000	Public health $'000	Total $'000	Acute and subacute $'000	Mental health $'000	Drug services $'000	Ageing, aged and home care $'000	Primary, community and dental health $'000	Public health $'000	Total $'000
Alzheimer's Disease and Related Disorders Association of Victoria Inc	-	-	-	3,923	-	-	**3,923**	-	-	-	4,043	-	-	**4,043**
Anti-Cancer Council of Victoria	444	-	-	-	-	4,159	**4,604**	452	-	-	-	-	4,308	**4,760**
Australian Centre for Grief and Bereavement Inc	1,403	-	-	-	-	-	**1,403**	1,427	-	-	-	-	-	**1,427**
Australian College of Optometry	-	-	-	6,232	94	-	**6,327**	-	-	-	6,338	179	-	**6,517**
Australian Community Support Organisation Inc	-	801	9,820	-	-	-	**10,621**	-	2,777	13,027	-	-	-	**15,805**
Australian Drug Foundation Inc	-	-	1,173	-	-	-	**1,173**	-	-	1,203	-	-	-	**1,203**
Australian Greek Welfare Society Ltd	-	-	-	1,587	-	-	**1,587**	-	-	-	1,644	-	-	**1,644**
Australian Red Cross Blood Service	7,796	-	-	-	-	-	**7,796**	7,928	-	-	-	-	-	**7,928**
Ballarat District Nursing and Healthcare Inc	-	-	-	3,523	-	-	**3,523**	-	-	-	3,601	-	-	**3,601**

Non-government provider	2013–14 expenditure budget							2014–15 expenditure budget						
	Acute and subacute	Mental health	Drug services	Ageing, aged and home care	Primary, community and dental health	Public health	Total	Acute and subacute	Mental health	Drug services	Ageing, aged and home care	Primary, community and dental health	Public health	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Ballarat Hospice Care Inc	1,050	-	-	-	-	-	**1,050**	1,068	-	-	-	-	-	**1,068**
Banksia Palliative Care Service Inc	2,172	-	-	-	-	-	**2,172**	2,221	-	-	-	-	-	**2,221**
Baptcare Ltd	-	216	-	2,435	-	-	**2,651**	-	19	-	2,479	-	-	**2,498**
Bayside Medicare Local Ltd	-	-	516	-	-	-	**516**	-	-	1,196	-	-	-	**1,196**
Break Thru People Solutions	-	727	-	-	-	-	**727**	-	2,102	-	-	-	-	**2,102**
BreastScreen Victoria Inc	-	-	-	-	-	38,072	**38,072**	-	-	-	-	-	38,719	**38,719**
Brotherhood of St Laurence	-	-	-	4,085	-	-	**4,085**	-	-	-	4,189	-	-	**4,189**
Care Connect Ltd	-	-	-	5,723	-	-	**5,723**	-	1,411	-	5,905	-	-	**7,316**
Carers Victoria Inc	-	201	-	3,458	-	-	**3,659**	-	207	-	3,556	-	-	**3,763**
Centacare, Catholic Diocese of Ballarat Inc	-	1,685	-	1,756	-	-	**3,441**	-	281	-	1,804	-	-	**2,085**
Centre of Excellence in Intervention and Prevention Science Ltd	-	-	-	-	-	1,610	**1,610**	-	-	-	-	-	2,033	**2,033**
Co.As.It. - Italian Assistance Association	-	-	-	1,682	-	-	**1,682**	-	-	-	1,734	-	-	**1,734**

Non-government provider	2013–14 expenditure budget							2014–15 expenditure budget						
	Acute and subacute $'000	Mental health $'000	Drug services $'000	Ageing, aged and home care $'000	Primary, community and dental health $'000	Public health $'000	Total $'000	Acute and subacute $'000	Mental health $'000	Drug services $'000	Ageing, aged and home care $'000	Primary, community and dental health $'000	Public health $'000	Total $'000
Cobaw Community Health Services Ltd	-	445	47	959	1,141	-	**2,593**	-	470	19	983	1,166	-	**2,638**
Council On The Ageing (Victoria) Inc	-	-	-	1,269	-	-	**1,269**	-	-	-	1,292	-	-	**1,292**
Darlingford Upper Goulburn Nursing Home Inc	-	-	-	1,032	-	-	**1,032**	-	-	-	1,050	-	-	**1,050**
Diabetes Australia - Victoria	-	-	-	-	1,466	5,278	**6,744**	-	-	-	-	1,064	5,360	**6,424**
Eastern Palliative Care Association Inc	7,161	-	-	-	-	-	**7,161**	7,319	-	-	-	-	-	**7,319**
ERMHA Inc	-	4,142	-	2,339	-	-	**6,481**	-	3,641	-	2,389	-	-	**6,030**
Family Planning Victoria Inc	-	-	-	-	3,700	158	**3,858**	-	-	-	-	3,772	172	**3,944**
Gippsland and East Gippsland Aboriginal Co-operative Ltd	92	-	852	400	127	-	**1,471**	94	-	1,230	369	188	-	**1,880**
Gisborne and District Community Health and Hospital Board Inc	-	-	-	1,044	573	-	**1,617**	-	-	-	1,080	571	-	**1,652**
Goulburn Valley Family Care Inc	-	71	30	995	-	-	**1,097**	-	73	5	1,025	-	-	**1,103**
Healthcare Chaplaincy Council of Victoria Inc	1,091	115	-	-	-	-	**1,206**	1,109	117	-	-	-	-	**1,226**

	2013–14 expenditure budget							2014–15 expenditure budget						
Non-government provider	Acute and subacute $'000	Mental health $'000	Drug services $'000	Ageing, aged and home care $'000	Primary, community and dental health $'000	Public health $'000	Total $'000	Acute and subacute $'000	Mental health $'000	Drug services $'000	Ageing, aged and home care $'000	Primary, community and dental health $'000	Public health $'000	Total $'000
Hepatitis Victoria Inc	-	-	-	-	-	1,015	**1,015**	-	-	-	-	-	1,043	**1,043**
Indigo North Health Inc	-	-	-	1,200	489	-	**1,689**	-	-	-	1,224	499	-	**1,723**
Interchange Outer Eastern Region Inc	-	-	-	972	-	-	**972**	-	-	-	1,002	-	-	**1,002**
Jewish Care (Victoria) Inc	-	-	-	1,820	-	-	**1,820**	-	-	-	1,868	-	-	**1,868**
La Trobe University	475	1,978	-	975	645	467	**4,540**	483	1,940	-	992	656	480	**4,552**
LINK Community Transport Inc	-	-	-	1,248	-	-	**1,248**	-	-	-	1,390	-	-	**1,390**
Loddon Mallee Housing Services Ltd	-	242	-	1,497	-	-	**1,739**	-	21	-	1,533	-	-	**1,554**
Lyndoch Warrnambool	1,077	343	-	4,778	-	-	**6,198**	1,060	351	-	4,870	-	-	**6,281**
MECWA	-	-	-	9,240	-	-	**9,240**	-	-	-	9,594	-	-	**9,594**
Melbourne City Mission	3,900	-	-	171	-	-	**4,072**	3,979	-	-	177	-	-	**4,155**
Mental Illness Fellowship Victoria	-	7,767	-	27	-	-	**7,795**	-	8,695	-	83	-	-	**8,778**
Mercy Hospice Inc	4,891	-	-	-	-	-	**4,891**	4,987	-	-	-	-	-	**4,987**
Merri Outreach Support Service Inc	-	-	-	1,657	-	-	**1,657**	-	-	-	1,710	-	-	**1,710**

Non-government provider	2013–14 expenditure budget							2014–15 expenditure budget						
	Acute and subacute $'000	Mental health $'000	Drug services $'000	Ageing, aged and home care $'000	Primary, community and dental health $'000	Public health $'000	Total $'000	Acute and subacute $'000	Mental health $'000	Drug services $'000	Ageing, aged and home care $'000	Primary, community and dental health $'000	Public health $'000	Total $'000
MHA Care Ltd	-	-	-	2,433	-	-	**2,433**	-	-	-	2,523	-	-	**2,523**
Mildura Aboriginal Corporation Inc	302	139	529	376	284	-	**1,629**	309	143	756	387	289	-	**1,883**
Mind Australia	-	20,754	81	43	-	-	**20,878**	-	15,524	14	-	-	-	**15,538**
Neami Ltd	-	6,338	-	-	-	-	**6,338**	-	18,750	-	-	-	-	**18,750**
Nexus Primary Health	-	-	170	2,656	1,629	-	**4,455**	-	-	124	2,817	1,752	-	**4,693**
Ngwala Willumbong Co-operative Ltd	-	-	1,038	86	75	-	**1,199**	-	-	958	88	127	-	**1,173**
Northern District Community Health Service	-	-	68	440	1,156	-	**1,664**	-	-	28	449	1,177	-	**1,654**
Odyssey House, Victoria	-	-	5,891	-	-	-	**5,891**	-	-	8,634	-	-	-	**8,634**
Pathways Rehabilitation & Support Services Ltd	-	3,001	-	49	-	-	**3,050**	-	1,644	-	50	-	-	**1,695**
Peninsula Home Hospice	2,368	-	-	-	-	-	**2,368**	2,416	-	-	-	-	-	**2,416**
Peninsula Support Services Inc	-	2,341	-	296	-	-	**2,637**	-	2,215	-	292	-	-	**2,507**
People Living with HIV/AIDS Victoria Inc	-	-	-	-	-	970	**970**	-	-	-	-	-	1,111	**1,111**

Non-government provider	2013–14 expenditure budget							2014–15 expenditure budget						
	Acute and subacute	Mental health	Drug services	Ageing, aged and home care	Primary, community and dental health	Public health	Total	Acute and subacute	Mental health	Drug services	Ageing, aged and home care	Primary, community and dental health	Public health	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Prahran Mission	-	3,924	-	125	-	-	**4,049**	-	6,302	-	130	-	-	**6,432**
Royal District Nursing Service Ltd	-	-	-	93,171	99	566	**93,836**	-	-	-	95,925	100	582	**96,607**
Rumbalara Aboriginal Co-operative Ltd	93	52	437	856	180	-	**1,618**	95	53	652	761	314	-	**1,874**
SNAP Gippsland Inc	-	1,830	-	-	-	-	**1,830**	-	2,495	-	-	-	-	**2,495**
South East Palliative Care Ltd	3,200	-	-	-	-	-	**3,200**	3,288	-	-	-	-	-	**3,288**
South Eastern Melbourne Medicare Local Ltd	-	-	-	-	-	-	**-**	-	-	2,107	-	-	-	**2,107**
Southern Migrant and Refugee Centre Inc	-	-	-	1,163	-	-	**1,163**	-	-	-	1,287	-	-	**1,287**
Spectrum Migrant Resource Centre Inc	-	-	-	1,043	-	-	**1,043**	-	-	-	1,080	-	-	**1,080**
St Laurence Community Services Inc	-	-	-	4,847	-	-	**4,847**	-	-	-	4,970	-	-	**4,970**
St Luke's Anglicare	-	2,461	86	-	-	-	**2,547**	-	1,843	88	-	-	-	**1,931**
The Mental Health Research Institute	-	1,544	-	-	-	-	**1,544**	-	1,570	-	-	-	-	**1,570**

Non-government provider	2013–14 expenditure budget							2014–15 expenditure budget						
	Acute and subacute $'000	Mental health $'000	Drug services $'000	Ageing, aged and home care $'000	Primary, community and dental health $'000	Public health $'000	Total $'000	Acute and subacute $'000	Mental health $'000	Drug services $'000	Ageing, aged and home care $'000	Primary, community and dental health $'000	Public health $'000	Total $'000
The Salvation Army (Victoria) Property Trust	-	1,530	7,290	2,482	73	-	**11,375**	-	445	7,902	2,556	74	-	**10,977**
The University of Melbourne	265	1,422	75	-	235	6,333	**8,331**	135	1,411	-	-	239	6,390	**8,174**
The Victorian Foundation for Survivors of Torture Inc	-	1,315	-	-	1,771	-	**3,086**	-	1,353	-	-	1,948	-	**3,301**
Uniting Aged Care Eastern	-	-	-	1,307	-	-	**1,307**	-	-	-	1,356	-	-	**1,356**
Uniting Aged Care Victoria and Tasmania	-	-	-	1,122	-	-	**1,122**	-	-	-	1,166	-	-	**1,166**
UnitingCare Ballarat	-	-	1,593	756	121	-	**2,470**	-	-	1,839	781	123	-	**2,743**
UnitingCare Community Options	-	-	-	4,674	-	-	**4,674**	-	-	-	4,778	-	-	**4,778**
UnitingCare ReGen	-	-	6,364	-	-	-	**6,364**	-	-	8,879	-	-	-	**8,879**
Very Special Kids	1,863	-	-	-	-	-	**1,863**	1,895	-	-	-	-	-	**1,895**
Victorian Aboriginal Community Controlled Health Organisation Inc	369	284	-	-	391	1,039	**2,083**	377	292	-	-	906	1,003	**2,579**
Victorian Aboriginal Health Service Co-operative Ltd	210	1,516	85	965	127	146	**3,049**	215	1,560	87	987	130	160	**3,139**

Non-government provider	2013–14 expenditure budget							2014–15 expenditure budget						
	Acute and subacute	Mental health	Drug services	Ageing, aged and home care	Primary, community and dental health	Public health	Total	Acute and subacute	Mental health	Drug services	Ageing, aged and home care	Primary, community and dental health	Public health	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Victorian AIDS Council Inc	-	40	-	-	-	4,640	**4,680**	-	40	239	-	-	4,638	**4,917**
Victorian Clinical Genetics Services Ltd	5,888	-	-	-	-	1,539	**7,427**	5,988	-	-	-	-	1,565	**7,553**
Victorian Cytology Service Inc	17	-	-	-	-	13,580	**13,597**	17	-	-	-	-	13,643	**13,660**
Victorian Health Promotion Foundation	-	-	-	-	-	36,236	**36,236**	-	-	-	-	-	36,852	**36,852**
Villa Maria Society	-	78	-	3,837	-	-	**3,915**	-	80	-	3,952	-	-	**4,033**
VincentCare Victoria	-	104	890	1,074	-	-	**2,068**	-	9	155	1,107	-	-	**1,271**
Vision Australia Ltd	-	-	-	2,200	-	-	**2,200**	-	-	-	2,261	-	-	**2,261**
Wesley Mission Victoria	-	-	-	3,151	643	-	**3,794**	-	-	-	3,247	655	-	**3,903**
Western Region Alcohol and Drug Centre Inc	-	-	651	-	-	-	**651**	-	-	1,145	-	-	-	**1,145**
Westmont Aged Care Services Ltd	-	-	-	1,128	-	-	**1,128**	-	-	-	1,822	-	-	**1,822**
Wimmera UnitingCare	-	593	-	148	292	-	**1,034**	-	2,117	-	153	405	-	**2,674**
Windana Drug & Alcohol Recovery Inc	-	-	4,662	-	-	-	**4,662**	-	-	5,157	-	-	-	**5,157**

Non-government provider	2013–14 expenditure budget Acute and subacute $'000	Mental health $'000	Drug services $'000	Ageing, aged and home care $'000	Primary, community and dental health $'000	Public health $'000	Total $'000	2014–15 expenditure budget Acute and subacute $'000	Mental health $'000	Drug services $'000	Ageing, aged and home care $'000	Primary, community and dental health $'000	Public health $'000	Total $'000
Women's Health Victoria Inc	635	-	-	-	1,116	-	**1,751**	646	-	-	-	1,148	-	**1,793**
Women's Health West Inc	-	-	-	50	937	-	**986**	-	-	-	51	963	-	**1,014**
Youth Projects Ltd	-	-	2,050	-	-	-	**2,050**	-	-	2,077	-	-	10	**2,087**
YSAS Pty Ltd	-	-	9,756	-	-	-	**9,756**	-	-	10,009	-	-	-	**10,009**
All other non government organisation (<$1m)	5,445	18,718	8,943	52,256	11,288	5,437	**102,086**	4,845	9,840	6,911	51,257	12,444	5,644	**90,941**
Non-government provider total	**52,208**	**86,717**	**63,097**	**248,761**	**28,651**	**121,244**	**600,678**	**52,354**	**89,792**	**74,443**	**254,157**	**30,888**	**123,712**	**625,345**

4.1.8 Other funded organisations 2013–14 and 2014–15

	2013–14 expenditure budget							2014–15 expenditure budget						
	Acute and subacute	Ambu-lance services	Mental health	Ageing, aged & home care	Primary, community & dental health	Public health	Total	Acute health services	Ambu-lance services	Mental health	Ageing, aged & home care	Primary, community & dental health	Public health	Total
Provider Type	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Ambulance Victoria	18,046	372,793	-	-	-	-	**390,839**	12,502	403,277	-	-	-	-	**415,779**
Dental Health Services Victoria	-	-	-	-	171,088	-	**171,088**	-	-	-	-	173,441	-	**173,441**
Health Purchasing Victoria	7,309	-	-	-	-	-	**7,309**	9,543	-	-	-	-	-	**9,543**
Victorian Institute Of Forensic Mental Health	24	-	41,840	-	-	-	**41,864**	24	-	42,539	-	-	-	**42,563**
All health consortiums (<$1m)	-	-	-	87	-	80	**167**	-	-	-	89	-	80	**169**
All other organisations (<$1m)	686	-	577	679	445	545	**2,932**	698	-	565	695	775	664	**3,397**
Other organisation total	**26,065**	**372,793**	**42,417**	**765**	**171,533**	**625**	**614,198**	**22,767**	**403,277**	**43,104**	**784**	**174,216**	**744**	**644,892**

4.2 Activity target tables

4.2.1 Victorian acute admitted activity targets (WIES21) 2014–15

Health service	Public/private WIES (including elective surgery)	DVA	TAC	2014–15 total WIES	2014–15 WIES growth
Major provider					
Alfred Health	88,831	770	5,166	94,767	4,509
Austin Health	72,184	999	668	73,851	1,498
Barwon Health	55,355	781	362	56,498	2,261
Melbourne Health	70,979	492	4,037	75,508	2,055
Mercy Public Hospitals Inc	38,058	111	1	38,170	1,729
Monash Health	156,872	622	584	158,078	10,121
Peter MacCallum Cancer Centre	15,194	163	-	15,357	3
Royal Children's Hospital	48,652	-	382	49,034	3,280
Royal Victorian Eye & Ear Hospital	9,680	79	3	9,762	189
Royal Women's Hospital	32,066	10	23	32,099	1,044
St Vincent's Hospital Melbourne Ltd	49,244	283	89	49,616	1,172
Major provider total	**637,115**	**4,310**	**11,315**	**652,740**	**27,861**
Outer metro & large regional					
Ballarat Health Services	27,214	134	150	27,498	1,310
Bendigo Health Care Group	24,233	516	181	24,930	1,145
Eastern Health	83,861	614	291	84,766	4,935
Latrobe Regional Hospital	19,199	288	90	19,577	436
Northern Health	44,307	306	202	44,815	2,444

Health service	Public/private WIES (including elective surgery)	DVA	TAC	2014–15 total WIES	2014–15 WIES growth
Peninsula Health	50,287	1,019	205	51,511	2,271
Western Health	78,012	578	244	78,834	3,907
Outer metro & large regional total	**327,113**	**3,455**	**1,363**	**331,931**	**16,448**
Regional and rural					
Albury Wodonga Health	12,337	168	5	12,510	374
Bairnsdale Regional Health Services	6,614	242	21	6,877	428
Bass Coast Health	3,482	92	2	3,576	194
Benalla Health	2,759	145	1	2,905	79
Castlemaine Health	2,149	54	4	2,207	105
Central Gippsland Health Service	7,716	114	19	7,849	298
Colac Area Health	3,257	64	10	3,331	29
Djerriwarrh Health Services	4,835	24	5	4,864	364
East Grampians Health Service	2,529	47	6	2,582	33
Echuca Regional Health	4,734	154	10	4,898	268
Gippsland Southern Health Service	2,455	94	2	2,551	134
Goulburn Valley Health	16,943	237	109	17,289	597
Kyabram & District Health Services	2,406	87	1	2,494	119
Maryborough District Health Service	2,415	59	4	2,478	41
Mildura Base Hospital	10,810	241	45	11,096	552
Northeast Health Wangaratta	11,350	228	89	11,667	531
Portland District Health	3,169	74	6	3,249	81
South West Healthcare	12,800	185	66	13,051	550
Stawell Regional Health	2,160	58	9	2,227	184

Health service	Public/private WIES (including elective surgery)	DVA	TAC	2014–15 total WIES	2014–15 WIES growth
Swan Hill District Health	4,421	71	10	4,502	245
West Gippsland Health Care Group	8,068	86	18	8,172	559
Western District Health Service	4,852	170	21	5,043	331
Wimmera Health Care Group	6,733	225	39	6,997	146
Regional and rural total	**138,994**	**2,919**	**502**	**142,415**	**6,242**
Health service total	**1,103,222**	**10,684**	**13,180**	**1,127,086**	**50,551**

4.2.2 Non-admitted radiotherapy activity (WAU) targets 2014–15

Health service	Radiotherapy – base – variable payment (including associated costs)	Radiotherapy – DVA base variable	Total
Alfred Health	75,234	1,300	76,534
Austin Health	62,467	1,723	64,190
Barwon Health	35,431	1,200	36,631
Peter MacCallum Cancer Centre	269,486	5,951	275,437
Total	**442,618**	**10,174**	**452,792**

4.2.3 Admitted subacute weighted bed day targets 2014–15

	Palliative care		Rehabilitation		GEM		Total	
Health service	Public/Private	DVA	Public/Private	DVA	Public/Private	DVA	Public/Private	DVA
Albury Wodonga Health	953	44	5,429	-	-	115	6,382	159
Alfred Health	-	-	49,009	343	42,201	2,132	91,210	2,475
Austin Health	7,398	490	43,595	1,177	31,024	3,005	82,017	4,672
Bairnsdale Regional Health Services	569	49	3,972	287	2,446	104	6,987	440
Ballarat Health Services	2,669	73	12,855	302	17,385	415	32,909	790
Barwon Health	6,399	155	21,519	1,344	18,053	809	45,971	2,308
Bass Coast Health	520	38	1,067	-	2,467	306	4,054	344
Bendigo Health Care Group	3,929	225	16,703	986	22,863	2,055	43,495	3,266
Calvary Health Care Bethlehem Ltd	18,286	441	-	-	12,031	186	30,317	627
Castlemaine Health	-	-	6,812	681	1,629	141	8,441	822
Central Gippsland Health Service	957	55	1,808	-	2,083	141	4,848	196
Colac Area Health	573	74	-	-	-	-	573	74
Djerriwarrh Health Services	1,002	115	-	-	-	-	1,002	115
East Grampians Health Service	419	-	-	-	-	-	419	-
Eastern Health	13,314	402	34,404	835	48,051	2,363	95,769	3,600
Echuca Regional Health	924	-	2,359	-	2,060	-	5,343	-
Gippsland Southern Health Service	522	5	-	-	-	-	522	5
Goulburn Valley Health	911	27	9,635	283	11,598	866	22,144	1,176

	Palliative care		Rehabilitation		GEM		Total	
Health service	**Public/Private**	**DVA**	**Public/Private**	**DVA**	**Public/Private**	**DVA**	**Public/Private**	**DVA**
Latrobe Regional Hospital	1,661	64	13,364	505	7,185	751	22,210	1,320
Melbourne Health	5,201	90	16,649	29	44,429	886	66,279	1,005
Mercy Public Hospitals Inc	5,050	117	-	-	8,239	-	13,289	117
Mildura Base Hospital	1,113	18	3,712	463	2,384	102	7,209	583
Monash Health	7,470	117	46,495	458	51,434	1,453	105,399	2,028
Northeast Health Wangaratta	1,064	13	4,144	166	4,079	366	9,287	545
Northern Health	11,184	728	22,249	202	37,523	2,489	70,956	3,419
Peninsula Health	6,801	230	30,082	2,356	42,103	3,975	78,986	6,561
Portland District Health	446	74	-	-	-	-	446	74
Royal Children's Hospital	-	-	4,748	-	-	-	4,748	-
South West Healthcare	2,727	30	5,993	178	4,560	301	13,280	509
St Vincent's Hospital Melbourne Ltd	16,314	624	26,334	559	25,322	1,894	67,970	3,077
West Gippsland Health Care Group	999	-	-	-	2,207	-	3,206	-
Western District Health Service	525	42	1,836	137	1,415	29	3,776	208
Western Health	4,716	20	21,613	106	39,381	2,070	65,710	2,196
Wimmera Health Care Group	570	-	2,359	-	2,666	383	5,595	383
Health service total	**125,186**	**4,360**	**408,745**	**11,397**	**486,818**	**27,337**	**1,020,749**	**43,094**

4.2.4 Admitted nonacute targets: Maintenance weighted bed days and TCP days

	Maintenance			Transition Care Program		
Health service	**Public**	**DVA**	**Total**	**Beddays**	**Homedays**	**Total**
Alfred Health	-	-	-	24,820	7,300	32,120
Austin Health	-	-	-	7,665	10,585	18,250
Ballarat Health Services	-	-	-	13,870	9,125	22,995
Barwon Health	-	-	-	12,410	6,570	18,980
Benalla Health	631	-	631	-	-	-
Bendigo Health Care Group	-	-	-	18,614	12,411	31,025
Colac Area Health	631	33	664	-	-	-
East Grampians Health Service	947	-	947	-	-	-
Eastern Health	-	-	-	26,280	8,030	34,310
Echuca Regional Health	316	-	316	-	-	-
Gippsland Southern Health Service	1,262	69	1,331	-	-	-
Goulburn Valley Health	-	-	-	13,140	13,505	26,645
Kyabram & District Health Services	316	-	316	-	-	-
Latrobe Regional Hospital	-	-	-	8,395	6,935	15,330
Maryborough District Health Service	316	-	316	-	-	-
Melbourne Health	-	-	-	10,585	12,410	22,995
Mercy Public Hospitals Inc	-	-	-	2,190	1,460	3,650
Mildura Base Hospital	-	-	-	2,920	2,920	5,840
Monash Health	-	-	-	17,520	10,950	28,470
Northern Health	-	-	-	8,760	15,695	24,455
Peninsula Health	-	-	-	16,790	5,475	22,265
Portland District Health	982	-	982	1,460	730	2,190
South West Healthcare	-	-	-	2,920	4,380	7,300
St Vincent's Hospital Melbourne Ltd	-	-	-	10,950	11,315	22,265
Stawell Regional Health	316	-	316	-	-	-
Swan Hill District Health	947	-	947	-	-	-
Western District Health Service	360	-	360	1,095	1,460	2,555
Western Health	-	-	-	12,410	10,950	23,360
Total	**7,024**	**102**	**7,126**	**212,794**	**152,206**	**365,000**

4.2.5 Non-admitted subacute contact targets 2014–15

Notes:

i. Bass Coast Community Health amalgamated with Bass Coast Health for 2014–15. Bass Coast Health targets include targets previously allocated to Bass Coast Community Health.

	Health Independence Program (HIP)					
Funded organisation	**SACS**	**PAC**	**HARP**	**RiR**	**HIP total**	**Community Palliative Care**
Albury Wodonga Health	12,305	4,824	2,069	-	**19,198**	**6,274**
Alfred Health	58,922	-	22,164	1,816	**82,902**	-
Austin Health	35,949	10,345	20,236	1,816	**68,346**	-
Bairnsdale Regional Health Service	10,503	4,341	2,146	575	**17,565**	**1,601**
Ballarat Health Services	24,761	6,806	6,474	1,327	**39,368**	-
Ballarat Hospice Care Inc.	-	-	-	-	-	**10,735**
Banksia Palliative Care Service Inc.	-	-	-	-	-	**21,974**
Barwon Health	37,832	12,616	11,584	1,815	**63,847**	**16,641**
Bass Coast Health	8,676	3,789	1,296	575	**14,336**	**3405**
Bellarine Community Health Ltd	-	-	-	-	-	**3,429**
Benalla Health	2,802	1,357	1,296	-	**5,455**	**2,816**
Bendigo Health Care Group	32,327	7,116	7,352	1,816	**48,611**	**9,276**
Calvary Health Care Bethlehem	9,987	-	-	-	**9,987**	**33,406**
Castlemaine Health	12,069	3,117	944	-	**16,130**	**1,344**
Central Gippsland Health Service	4,512	2,810	1,490	575	**9,387**	**8,624**
Cobram District Health	3,466	-	-	-	**3,466**	-
Colac Area Health	2,915	1,404	1,274	-	**5,594**	**1,277**
Djerriwarrh Health Services	8,046	-	-	-	**8,046**	**1,853**
East Grampians Health Service	-	-	939	-	**939**	**3,397**
Eastern Health	73,935	24,485	26,586	2,113	**127,119**	-
Eastern Palliative Care	-	-	-	-	-	**86,268**
Echuca Regional Health	6,655	2,966	1,133	575	**11,329**	**2,327**
Gippsland Lakes Community Health Service	-	-	-	-	-	**1,952**
Gippsland Southern Health Service	-	-	-	-	-	**3,469**
Goulburn Valley Health	13,531	6,203	7,543	1,098	**28,375**	-
Goulburn Valley Hospice Care Service Inc	-	-	-	-	-	**14,046**
Inner South Community Health Service	-	13,030	-	-	**13,030**	-
Latrobe Community Health						**5,957**

	Health Independence Program (HIP)					
Funded organisation	**SACS**	**PAC**	**HARP**	**RiR**	**HIP total**	**Community Palliative Care**
Latrobe Regional Hospital	15,108	4,999	5,860	1,146	**27,112**	-
Lyndoch Living Inc.	7,402	-	-	-	**7,402**	-
Maryborough District Health Service	-	-	1,301	-	**1,301**	**1,008**
Melbourne Citymission	-	-	-	-	-	**25,823**
Melbourne Health	60,383	13,476	21,761	1,816	**97,436**	–
Mercy Palliative Care	-	-	-	-	-	**67,812**
Mercy Public Hospitals Inc	6,612	-	4,148	917	**11,676**	-
Mildura Base Hospital	5001	3,555	4,236	917	**13,708**	-
Monash Health	98,946	31,257	31,517	1,920	**163,639**	-
North Richmond Community Health Service	-	11,226	-	-	**11,226**	-
Northeast Health Wangaratta	16,570	3,660	2,789	917	**23,935**	**6,549**
Northern Health	54,370	13,174	26,215	1,816	**95,575**	-
Peninsula Health	46,623	13,695	19,669	1,815	**81,802**	-
Peninsula Home Hospice	-	-	-	-	-	**38,301**
Portland District Health	2,566	1,544	1,107	-	**5,217**	**2,843**
Royal Children's Hospital	8,103	4,478	10,685	-	**23,266**	-
Seymour Health	4,652	2,680	737	-	**8,069**	-
South East Palliative Care Ltd	-	-	-	-	-	**47,578**
South West Healthcare – Warrnambool	12,309	5,648	3,971	575	**22,502**	**4,821**
St Vincent's Hospital Melbourne Ltd	38,974	–	23,233	1,348	**63,554**	-
Stawell Regional Health	3,468	3,376	1,153	-	**7,997**	-
Sunraysia Community Health Services Inc	-	-	-	-	-	**5,636**
Swan Hill District Hospital	7,838	1,631	1,490	-	**10,959**	**7,214**
West Gippsland Healthcare Group	10,492	3,098	1,490	917	**15,997**	**5,180**
Western District Health Service	7,103	1,724	1,495	575	**10,897**	**2,269**
Western Health	33,911	26,378	27,085	1,920	**89,295**	-
Wimmera Health Care Group	6,492	3,376	2,125	575	**12,567**	**4,780**
Yarram & District Health Service	3,200	-	-	-	**3,200**	-
Total	**809,316**	**254,184**	**306,593**	**31,274**	**1,401,362**	**459,884**

4.2.6 Mental health ambulatory, inpatient and residential targets

Notes:

1. WOts are being shadowed in 2014–15.
2. Available bed days derived by multiplying bed figures by 365
3. Includes six day places (four at Barwon Health, two at Eastern Health).
4. Includes 26 beds in associated services (twelve for Ballarat Health Services and fourteen for South West Health Care).
5. Includes 30 PARC beds due to open at Austin, St Vincents and Albury Wodonga Health.
6. Excludes 2 Mother Baby Units announced in 2013–14 Budget for Ballarat Health Services and the new Bendigo Hospital, includes 1 Mother Baby Unit due to open at Latrobe Regional.
7. Includes 8 PAPU beds due to open (four at Mercy Health and four at Latrobe Regional). Includes 12 Acute beds due to open at Mercy Health. CAMHS beds at Ballarat, Bendigo and Mildura are funded on the basis of occupied bed days.
8. Includes 12 Acute beds due to open at Mercy Health.
9. Excludes 30 Aged Residential beds closed in 2013–14 (Melbourne Health - Weighbridge). Includes 7700 Community Service Hours for VIFMH. 5000 Community Hours have been included in BP3, with a further 2,700 hours subject to further negotiation.
10. Includes 7700 Community Service Hours for VIFMH. 5000 Community Hours have been included in BP3, with a further 2,700 hours subject to further negotiation.

	WOt[1]				Mental Health Funded Beds[2]								
					Acute			Sub Acute					
Health Service	Low	High	DVA	Total	Specialist	WOt Funded[7,8,9]	Total	Non Acute	CCU	PARC[3,5]	Resi-dential[4,9]	Total	Ambulatory service hours[10]
Major provider													
Alfred Health	23,258	2,081	82	25,421	4	69	73	0	20	10	30	133	64,000
Austin Health	23,426	1,450	2,635	27,511	11	72	83	28	22	10	20	163	47,400
Barwon Health	10,907	843	83	11,833	0	32	32	3	12	10	45	102	53,900
Melbourne Health	69,201	5,664	587	75,452	16	203	219	26	80	40	122	487	191,400
Mercy Health	13,437	2,062	54	15,553	8	45	53	0	20	10	0	83	43,600
Monash Health	54,761	2,872	248	57,881	8	158	166	50	40	50	94	400	123,100
Royal Children's	6,480	132	0	6,612	0	16	16	0	0	0	0	16	31,000
St Vincent's Hospital	22,004	1,554	88	23,646	0	64	64	0	20	10	60	154	50,000
VIFMH	0	0	0	0	0	40	40	76	0	0	0	116	7,700

	WOt[1]				Mental Health Funded Beds[2]								
					Acute			Sub Acute					
Health Service	**Low**	**High**	**DVA**	**Total**	**Specialist**	**WOt Funded[7,8,9]**	**Total**	**Non Acute**	**CCU**	**PARC[3,5]**	**Resi-dential[4,9]**	**Total**	**Ambulatory service hours[10]**
Outer metro and large regional													
Ballarat Health	11,901	132	39	12,072	0	35	35	12	20	0	32	99	41,000
Bendigo Health	11,526	631	244	12,401	0	34	34	8	12	20	30	104	61,100
Eastern Health	41,901	1,957	175	44,033	0	117	117	0	40	20	64	241	114,800
Latrobe Regional	13,173	1,171	129	14,473	5	41	46	6	14	10	10	86	61,000
Peninsula Health	14,554	527	525	15,606	0	44	44	0	20	20	48	132	48,400
Regional and rural													
Albury Wodonga Health	6,723	711	27	7,461	0	20	20	0	26	10	15	71	36,000
Goulburn Valley Health	6,800	711	43	7,554	0	20	20	0	10	10	20	60	29,700
Mildura Base Hospital	4,275	395	38	4,708	0	12	12	0	0	0	0	12	17,000
South West Health	5,213	132	9	5,354	0	15	15	3	2	0	13	33	29,000
Total	**339,540**	**23,025**	**5,006**	**367,571**	**52**	**1037**	**1089**	**212**	**358**	**230**	**603**	**2492**	**1,050,100**

4.2.7 Alcohol and other drugs output targets

Notes:

i. Episodes of care targets include 2 months of all in-scope reform activities being converted to DTAU and 12 months of out of scope activities such as youth programs and specialist pharmacotherapy.

ii. Drug Treatment Activity Units (DTAU) targets apply from 1 September 2014 and are only specified for the lead agency. Only 10/12ths of the annual target is required to be met for 2014–15.

Health service	Episodes of care targets[i]			DTAU Annual Target[ii]
	Residential	Community	Total	
Major provider				
Austin Health	-	140	140	-
Barwon Health	4	412	416	2,296
Monash Health	683	242	925	-
St Vincent's Hospital Melbourne Ltd	649	-	649	-
Royal Women's Hospital	-	160	160	-
Outer metro and large regional				
Eastern Health	648	296	944	4,307
Peninsula Health	3	277	280	1,644
Western Health	812	721	1,533	2,178
Regional and rural				
Bass Coast Health	-	8	8	-
Colac Area Health	1	45	46	-
Djerriwarrh Health Services	-	7	7	-
Echuca Regional Health	-	27	27	-
Gippsland Southern Health Service	-	42	42	-
Goulburn Valley Health	-	18	18	873
Maryborough District Health Service	-	35	35	-
Portland District Health	1	65	66	-
South West Healthcare	-	67	67	-
Swan Hill District Health	-	47	47	-
Total	**2,801**	**2,609**	**5,410**	**11,318**