Department of Health

health

Victorian health policy and funding guidelines 2014–15

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

State Government Victoria

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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

Printed by Doculink Australia, Port Melbourne. Printed on sustainable paper.

August 2014 (1406004)

Contents

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 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.

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.

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

- 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.

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

- 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.

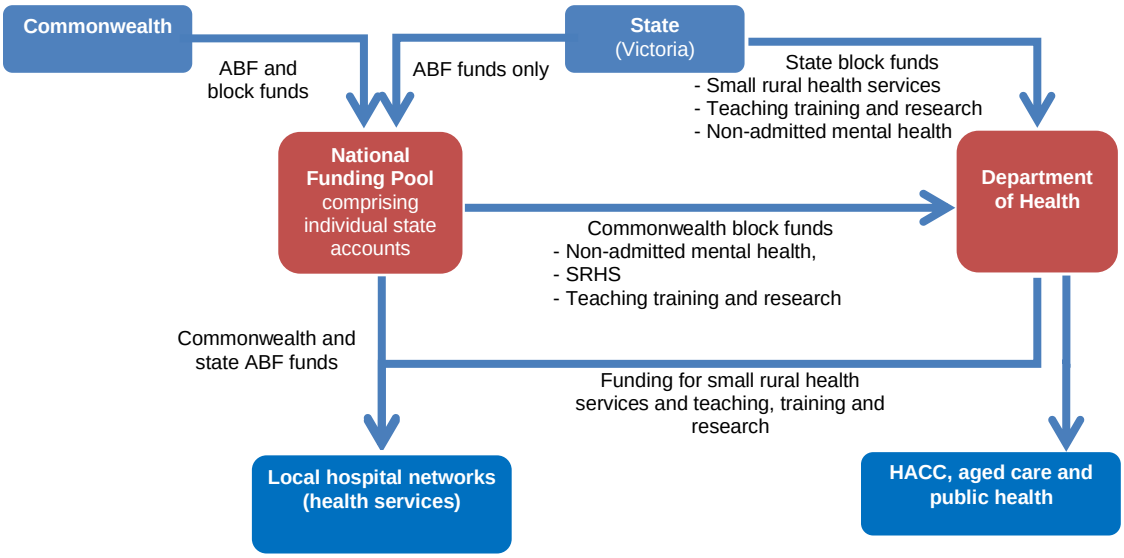
NWAU targets will be included in health services' SoPs Part D, in addition to WIES targets (Part C).

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.

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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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		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
Code	Label												
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

WIES21 2014–15 Victorian cost weights													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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													
Victorian Modified AR-DRG 7.0x		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
Code	Label												
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		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
Code	Label												
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

Health services	Admitted subacute		Health Independence Programs														Non-acute care
	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	✓	✓	✓	✓	✓	✓	✓	✓			✓		✓	✓		✓	✓

Health services	Admitted subacute		Health Independence Programs														Non-acute care
	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

Health services	Admitted subacute		Health Independence Program								Non-acute care	
	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

```
    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	l_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 × 1.372) + (11 × 1.488) + (13 × 1.825) – (2 × 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

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.