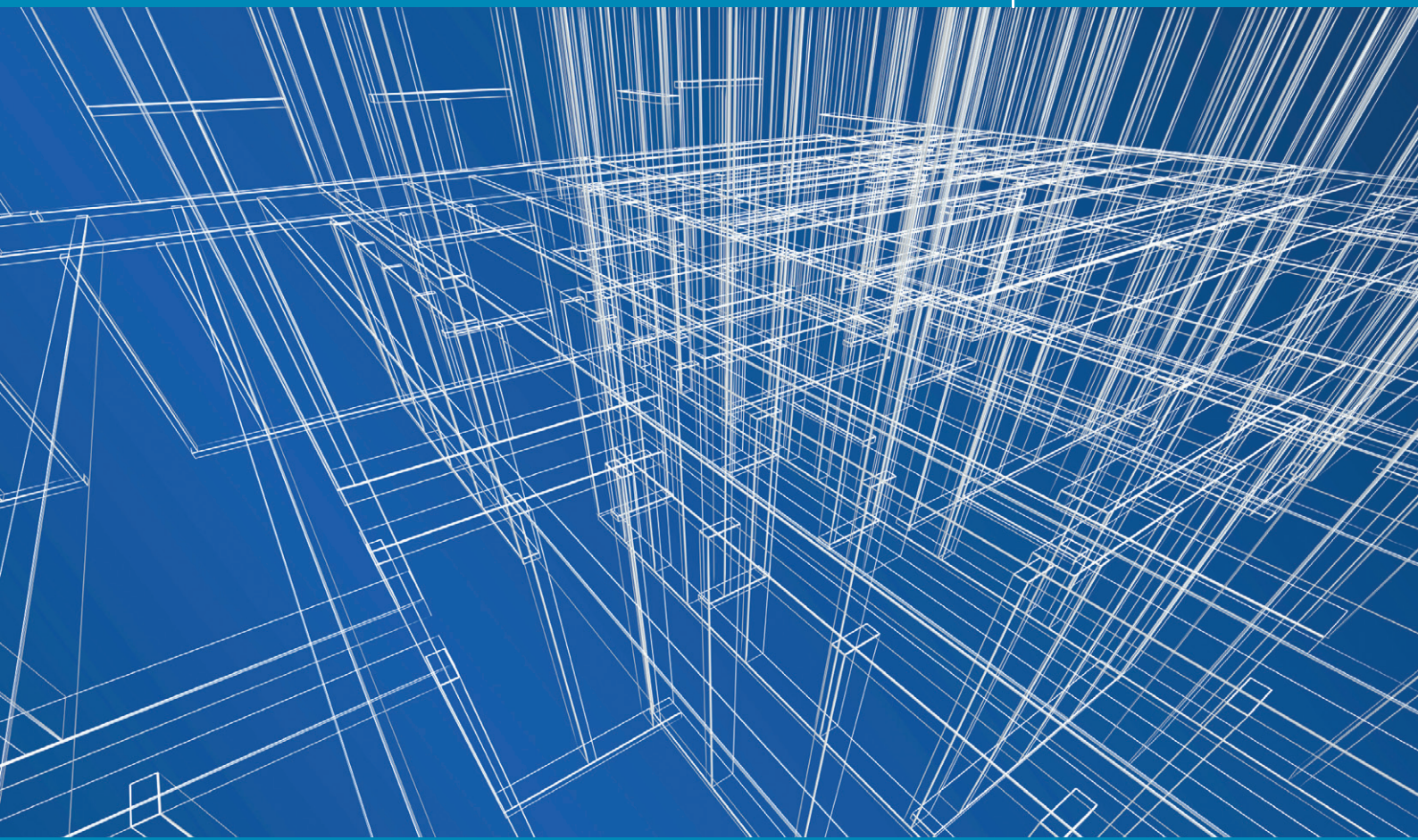
Department of Health

health

Planning the future of Victoria's sub-acute service system

A capability and access planning framework



State Government Victoria

Planning the future of Victoria's sub-acute service system

A capability and access planning framework

The improving care design symbolizes the person-centered focus of the work that health services and the Ambulatory and Continuing Care section of the department are striving to achieve together. Our mutual goal is to improve and maintain a person's optimal independence within the community.

The design element is a visual representation showing how people of all ages, from all walks of life and cultural backgrounds with differing levels of physical and intellectual ability, move through a journey of icons that represent the home, health centres, work and recreational pursuits.

Accessibility

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This document is available as a PDF on the internet at: www.health.vic.gov.au/subacute

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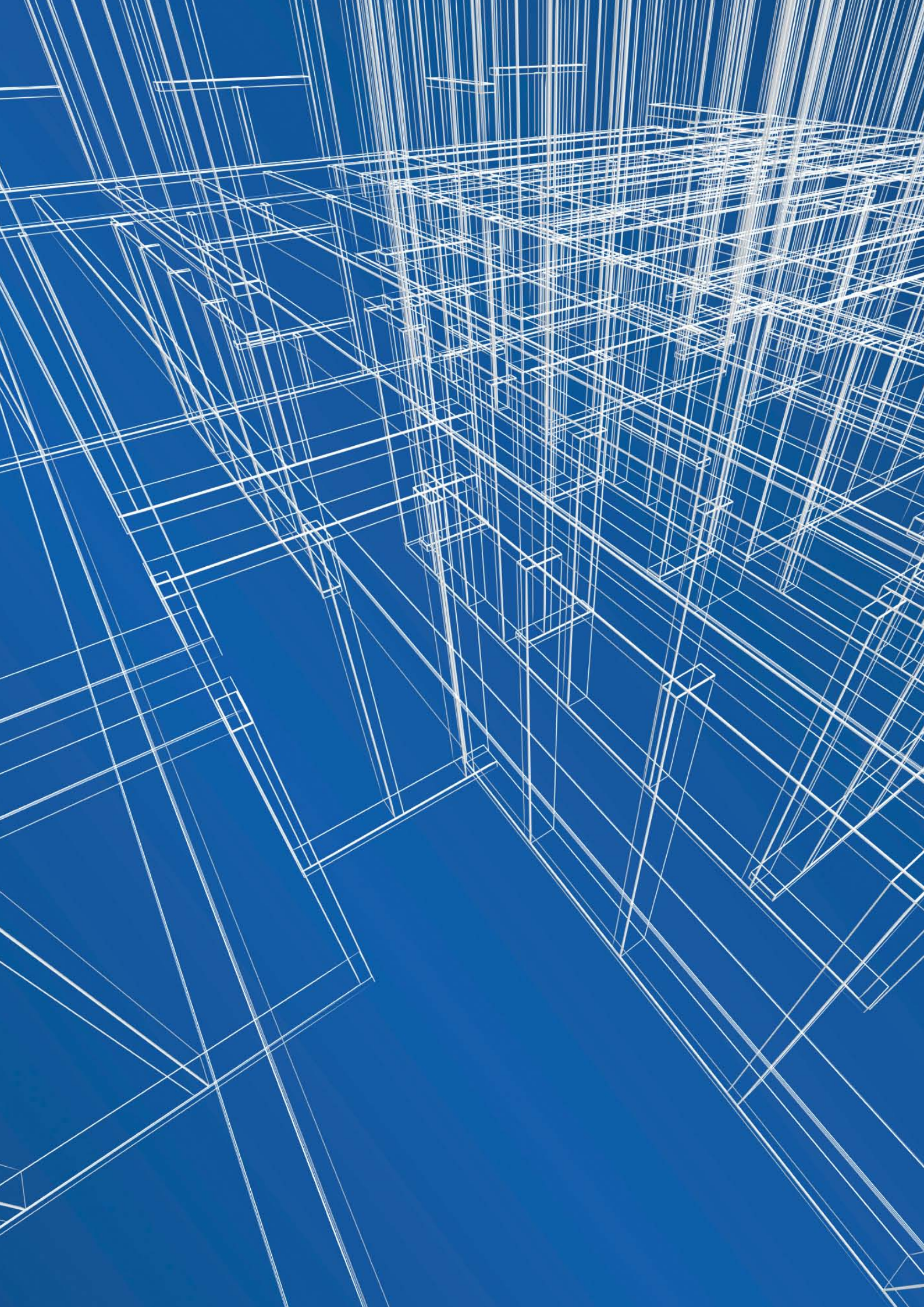


Introduction

Sub-acute services play an integral role within the health care continuum, supporting patients to maximise their independence and functioning and, in doing so, minimise long-term health and community care needs. This diverse group of services are fundamental in promoting effective and seamless services across the care continuum. The separation between acute and sub-acute care, once so marked, is narrowing. Increased demand for access to acute care beds is leading to an increase in the medical acuity of patients admitted to sub-acute care. An appreciation of how sub-acute models of care can improve outcomes and avoid functional decline in vulnerable patients with chronic and complex care issues has also led to strong demand for sub-acute services.

The nature of sub-acute services is constantly evolving. Better aligning and integrating community-based programs to support discharge from admitted services and to prevent or substitute hospitalisation is a key focus of policy and program development. Victoria's vision is for a modern, integrated system aimed to meet the future health care needs and expectations of both individuals and the community.

Concepts of ageing, and what is considered 'elderly', are also rapidly changing, with a strong focus in sub-acute services on restoring and maintaining abilities for people of all ages. In Victoria the response to the impact of ageing and chronic illness has been multifaceted, developing systemic and coordinated responses to meet current and future demand. These changes have been underpinned by policy that communicates broad directions to enable people to receive improved access to evidence-based care. Service development has consequently had an increased focus on the needs of the individual, an understanding of the impact of hospitalisation and the need for developing coordinated and integrated community responses.

A sub-acute services planning framework for Victoria needs to be dynamic and responsive to changes that occur in both acute and community-based services.

Background and context

In response to the need to better understand the demand for sub-acute services in Victoria, work on a planning framework commenced in 2007–08. The framework aims to establish a process to guide planning towards equity and consistency of service quality in sub-acute services. This framework outlines a comprehensive strategy to ensure fair access to high-quality, integrated sub-acute services across Victoria. It is intended that this document provides some interim information so as to allow regional and health service planning to be undertaken while the final framework is being prepared for publication.

The development of the planning framework needs to be seen in the context of both Commonwealth and state government policy developed over the past few years. These are:

- *Improving care for older people: a policy for health services* (2003), see: www.dhs.vic.gov.au/health/older/policy
- *From hospital to home: improving care outcomes for older people. National action plan for improving the care of older people across the acute-aged care continuum, 2004–2008*, see: www.health.vic.gov.au/acuteagedcare
- *Care in your community: a planning framework for integrated ambulatory health care* (2006), see: www.health.vic.gov.au/ambulatorycare/careinyourcommunity
- *Rural directions - for a stronger healthier Victoria. Update of rural directions for a better state of health* (2009), see: www.health.vic.gov.au/ruralhealth

The major sub-acute settings in each major metropolitan health service, and each rural region, have been designated as the level 4 health service for their catchment areas. These centres provide the full suite of sub-acute services, including admitted services both for rehabilitation and geriatric evaluation and management (GEM), and a comprehensive range of ambulatory services. The level 4 service will therefore:

- provide a significant sub-acute inpatient service, with the size dependent on the catchment's population
- provide or facilitate access to a range of ambulatory care services to enable people living in regional and remote areas access to clinical expertise, including: centre-based and home-based rehabilitation services and the full suite of sub-acute specialist services, including HARP
- be the focus for developing statewide specialist services that provide health care professionals with additional skills and access to a wider support network for managing people with complex needs
- have strong links with community services such as programs providing aids and equipment, aged care assessment services (ACAS), programs providing packages of care, general practice clinics and Home and Community Care programs. These linkages are fundamental to promoting effective and seamless services across the care continuum.

These services will demonstrate a strong person-centred approach through a greater understanding of the complexities of older people's health care needs and provide strong integration within and between health services and the broader community, better facilitating seamless transition along the health care continuum.

Aim

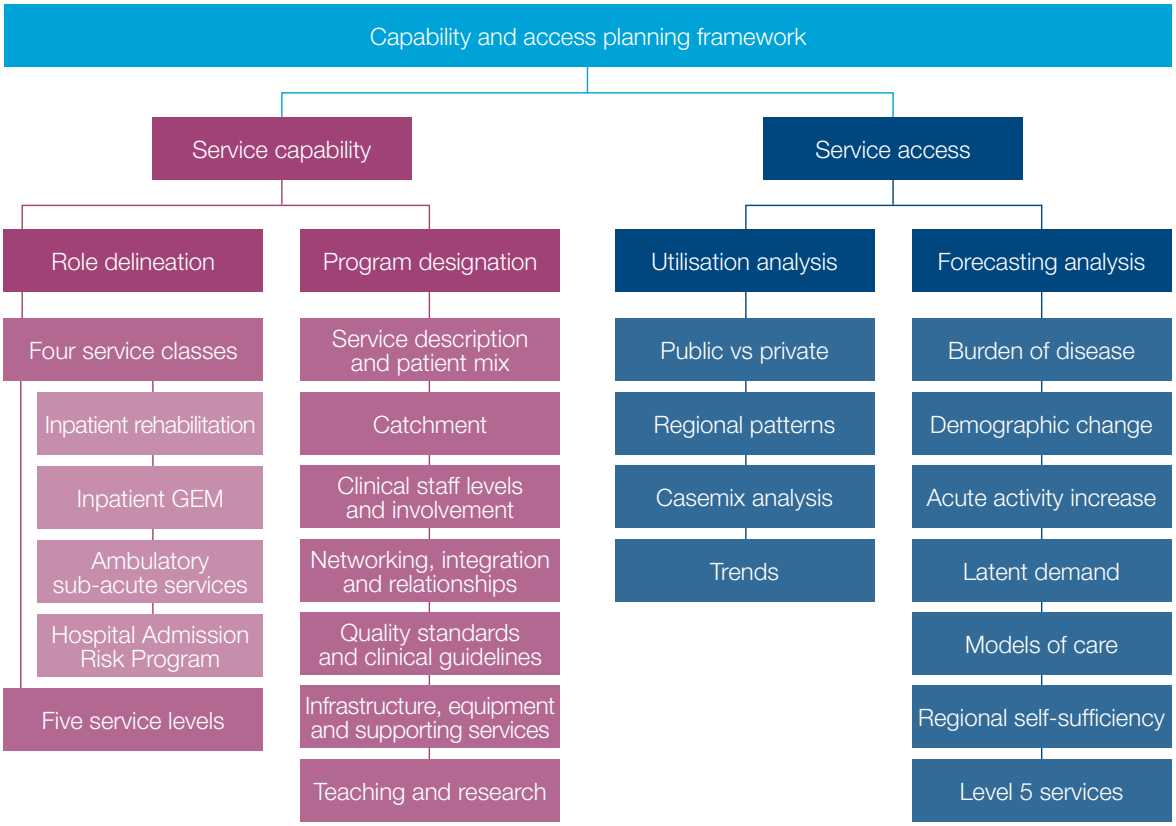
The sub-acute planning framework will develop an evidence-based approach to guide planning towards equity of access and consistency of service quality. More specifically, policy objectives that may be achieved through a planning framework include:

- introducing consistent and comparable information on the type and location of sub-acute services provided across the state and within regions
- identifying service gaps in the type, level or location of sub-acute services at local, regional and state level
- providing explicit guidance about the standards required to provide sub-acute services at a particular level
- encouraging clinical risk management procedures where services do not meet the minimum standards, including referral protocols and networking arrangements with other sub-acute service providers
- supporting clinical benchmarking across the sub-acute service system based on descriptions of similar services
- building stronger relationships between health services based on their different capabilities to manage patients with different needs and complexities.

A diagrammatic representation of the framework is provided as Figure 1. The left-hand side of the figure lists the components that determine the capability of a health service to provide sub-acute care at a specific level. On the right are the drivers of demand for sub-acute services that can be usefully employed to determine benchmarks for access to sub-acute services.

To guide the development of the framework, an advisory group was established with representation from key stakeholders from a wide range of health services and clinical backgrounds as well as from the department. Aspex Consulting and Health Policy Solutions were contracted to develop a draft sub-acute services planning framework. Extensive consultation with metropolitan and regional providers of sub-acute services, as well as peak bodies, was undertaken to inform the work.

Figure 1:
Diagrammatic representation of the capability and access planning framework



Service capability framework

A new approach for Victorian sub-acute services

Establishing a framework to guide sub-acute service delivery in Victoria requires explicit expectations about service standards and capability requirements for health care providers to be developed. It is also important that these are readily understood and are flexible enough to be broadly applied. A service capability framework (SCF) defines scope of practice and resources needed to provide care at a designated level. It also allows an expected sub-acute service profile to be developed in order to deliver an appropriate and accessible service. This profile would be applied at both the regional and statewide levels.

Integrating role delineation and program designation underpins an SCF's development. While program designation has been historically used in Victoria for defining and assessing the suitability of a health service to provide rehabilitation, role delineation has not been as broadly adopted as it has in other states. The concepts behind role delineation, however, have been incorporated into a variety of Victorian health plans including the following.

- The *Stroke care strategy for Victoria* develops role delineation for stroke services, recommending that a review of the current designation of sub-acute services should be undertaken. The approach taken in this document provides a useful starting point for further development of a more comprehensive framework.
- Recent statewide planning strategies for trauma, cancer services, renal services, rural birthing and rural procedural services have a strong focus on clinical networks and shared roles, consistent with the approach used in role delineation frameworks.
- A service capability framework for a broad range of clinical services, including acute care, is currently being developed and the framework for sub-acute services will need to align with the approach taken.

In addition, the integrated area-based planning approach at the core of the rural directions strategy, as outlined in *Rural directions for a stronger healthier Victoria*, are highly consistent and aligned with a clear delineation of roles for different types of health service agencies.

Key features

Key features of the SCF are that it:

- integrates role delineation and program designation
- applies to four classes of sub-acute service, each delineated on a five-level scale and based on how the standards are met under seven service criteria
- develops explicit expectations about service standards and capability requirements
- defines the scope of practice and resources needed to provide care at the designated level
- is readily understood and flexible enough to be broadly applied
- allows an expected sub-acute service profile to be developed (applied at both the regional and statewide levels).

The SCF outlines a standard set of capability requirements for Victorian public sub-acute services. This framework is built upon four sub-acute care types and is delivered across a number of settings, which, for the purpose of this framework, are admitted and ambulatory.

The four classes of sub-acute services defined in the SCF are:

- admitted rehabilitation services
- admitted GEM services
- sub-acute ambulatory care services (SACS)
- Hospital Admission Risk Program (HARP).

Service description and patient mix in sub-acute services

Admitted services

Rehabilitation

Rehabilitation is care in which the clinical purpose or treatment goal is to improve the functional status of a patient with an impairment, activity limitation or participation restriction.

It is evidenced by:

- an individualised and documented initial and periodic assessment of functional ability using a recognised functional assessment measure
- an individualised interdisciplinary rehabilitation plan that includes negotiated rehabilitation goals and indicative time frames.

In recognising rehabilitation as a core element of sub-acute services, the department stresses that rehabilitation must provide care that is person-centred, proactive and goal-oriented. It should aim to maximise independence and quality of life for people with a disabling condition and minimise the long-term care and community support required.

Geriatric evaluation and management

GEM is care of chronic or multidimensional presenting conditions associated with ageing, cognitive dysfunction, chronic illness or loss of functional ability. The GEM client group is predominantly older people but may include younger adults with clinical conditions generally associated with ageing. These conditions require admission for review, treatment and management by a geriatrician and multidisciplinary team for a defined episode of care.

The key features of the GEM patient group are people who have complex and multiple medical, functional and often cognitive conditions requiring a multidisciplinary assessment. They are most commonly older and are assessed as having reasonable potential for improvement in health status and function. Health care service delivery must be coordinated and is always based on an individualised plan containing goals and indicative timeframes.

Ambulatory services

SACS

SACS is available to people of all ages and may follow a hospital admission or may be accessed directly from the community. These services extend and complement admitted services through ongoing care either in a client's home or at an ambulatory care centre. SACS comprises rehabilitation services and a range of specialist clinics that provide specialist assessment, diagnosis, management and education to clients with the following specific conditions:

- cognitive impairment and dementia
- continence
- falls, mobility and balance
- movement disorders
- chronic pain
- chronic wounds.

In developing a role delineation framework for SACS it is acknowledged that this program comprises a diverse range of services. Rather than separately delineating each type of service, such as a community rehabilitation centre or a falls clinic, the service level is determined on the basis of whether there is a comprehensive range of services available, the extent to which these are integrated and effectively networked and its alignment with the overall service level of the health service. The availability of such services across a geographic area or region would also need to be considered.

Further work in developing the SCF for SACS will be informed through regionally mapping existing services against the SCF and implementation planning. Matching current services against the service profile expectations that are outlined in the next section should also be considered.

HARP

HARP is a hospital admission risk program. It prevents avoidable re-admissions to emergency departments (ED) and acute hospital settings by utilising a number of evidence based approaches delivered in the community/ambulatory setting including:

- care coordination
- access to specialist medical care
- self management support
- complex psychosocial issues management

HARP targets those clients who are frequent presenters or at risk of presentations to acute health services due to chronic disease and/or complex needs. HARP is under the auspices of health services and:

- reduce avoidable ED presentations
- provide priority access to those most at risk
- streamline access to specialist medical care

HARP services have access to hospital systems that enable early recognition and prompt referral with linkages into either an appropriate hospital or out of hospital care pathways. HARP programs work within the Health Independence Program (HIP) Guidelines.

HARP expectations of service within the sub acute capability and access planning framework align HARP programs with the capabilities of the Health Service for example a level 4 health service they would provide a level 4 HARP service.

Sub-acute service profile expectations

The SCF for sub-acute services uses a five-level classification where level 1 is the 'lowest' level and level 5 is the 'highest'. A set of service profile expectations are established that guide how and where sub-acute services are provided. In addition, the major role of the level 4 health service in supporting and promoting sub-acute services at a regional or major metropolitan health service level is reinforced through applying the SCF.

It is expected that all sub-acute services at a designated health service are provided at the same SCF level and are preferably collocated. That is, a designated level 4 health service would provide rehabilitation, GEM, SACS and HARP at level 4 and, similarly, all sub-acute services would be at level 3 at a health service designated as a level 3 provider.

The expected features of specific service levels are detailed below.

Statewide (level 5)

- Provides statewide services focusing on complex care in targeted streams including traumatic/ non-traumatic spinal, burns, paediatric, acquired brain injury, degenerative neurological conditions and polio.

Regional (level 4)

- Provides a full range of clinical services with specialist assessment and management across multiple clinical programs.
- Provides one level 4 service in each of the major rural health services and at each metropolitan health service.

Sub-regional (level 3)

- Provides a dedicated program for a broad range of services and definitive care for most sub-acute patients.
- Provides at least one level 3 sub-regional service(s) in each of the rural regions where the population
  and geographic factors indicate it is needed to ensure equitable access to services.
- Services are suitability distributed in metropolitan regions, taking into account proximity of services in adjoining regions.

Local (level 2)

- Provides a single stream and/or restorative care service with the aim of maintaining function in patients with less complex needs. Likely to be overseen by a medical practitioner with access to a visiting specialist and supported by core allied health and nursing staff. More complex rehabilitation and GEM patients would be referred to higher level services.

Local (level 1)

- Provides a service with the aim of maintaining function with limited goals. Not designated or funded as a sub-acute program. Likely to be overseen by a local medical practitioner supported by staff with knowledge of the principles of rehabilitation or aged care.

Ambulatory

- Improve access to community rehabilitation services in rural areas for catchments with a threshold minimum of approximately 15,000. Priority consideration for any new service will be given to catchment populations over 20,000. The determination of catchments can extend beyond towns and will incorporate current demand/waiting lists, and local travel patterns, irrespective of current planning boundaries.
- Access to ambulatory paediatric rehabilitation services at the regional level 4 health service and at a number of metropolitan health services.
- Improve access to the core suite of specialist clinics: continence; cognitive, dementia and memory service (CDAMS); and falls and mobility. Departmental planning will determine appropriate access to chronic pain, chronic wound and movement disorder clinics, but these services would be considered to be available only at a regional level at this stage.

Service criteria within the service capability framework

Service levels within the SCF are determined according to seven criteria.
These criteria are detailed below.

1. Service description and patient mix

Defines the type of care provided and nature of the program; its comprehensiveness, range of the services offered and the complexity of the patients that can be cared for.

2. Catchment

Planning for health services needs to consider the needs of the catchment population, together with population size sufficient to sustain a viable clinical service at particular levels in the SCF. For instance, it is expected that at regional level there would be one level 4 sub-acute service while there would be at least one level 3 service at a sub-regional level.

3. Clinical staff levels and involvement

Health services would need to consider the following when assessing itself against the SCF:

- staff qualifications
- workforce profile including minimum requirements for service provision
- numbers of staff (where minimum requirements exist)
- degree of substitution by other professionals or through assistants
- credentialing and scope of practice
- mandatory training and accreditation requirements, especially if clinical specific
- professional development requirements.

For all staffing categories (medical, allied health and nursing), the general principle is that the patient mix and conditions would determine the requirement for staff with particular qualifications.

These service standards are not intended to be prescriptive of the particular range or levels of staff required to treat all possible types of patients needing sub-acute services. The extent to which roles are interchangeable or able to be safely managed by suitably qualified but non-speciality staff needs to be considered. Changing clinical practice patterns as well as growing workforce flexibility and role substitution mean it is preferable to allow staffing requirements to evolve. This is especially the case were workforce availability is an issue. The support of higher level services in ensuring patients are able to access care that meets their more complex needs but is reasonably close to home is an expectation outlined in criteria 4.

4. Networking, integration and relationships

A core element of an SCF is that patients will be appropriately assessed and referred to services that can provide the right level of treatment. Each of the agencies providing care at particular service levels has a responsibility to treat patients with needs up to that service level (including providing support and outreach to agencies at a lower service level) and ensure patients are referred for treatment by other agencies at higher service levels as required. Equally, that in the interests of providing services as close to home as is reasonable and to ensure regional access for patients to higher service levels, that lower level services readily accept referrals into their services.

The designation of individual health services as a level 4 health service is another way in which networking of all sub-acute services can be translated into action. These health services would be expected to take a leadership role in articulating and promoting appropriate referral arrangements with level 2 and 3 services in its region across the full spectrum of sub-acute services.

Another important component of networking and integration is appropriate 'inreach' and networking with acute services so there is a seamless continuum of care for patients and effective referral and patient management arrangements between acute and sub-acute services.

5. Quality standards and clinical guidelines

The quality standards and clinical guidelines should reflect the specific conditions and complexity of services provided by the health service. These should take into account the range and complexity of services and models of care that aligns with appropriate clinical governance, risk management and performance-monitoring frameworks. All sub-acute services should meet core quality standards applying to the whole agency or health service and it would be expected that sub-acute services participate in health-service-level assessment and accreditation processes.

Quality standards that are specific to each class of sub-acute service would be expected to increasingly apply as service levels rise. For example:

- collection and monitoring through the most recent version of the Australian Council of Healthcare Standards (ACHS) Clinical Indicators in Rehabilitation Medicine
- through clinical audit, reporting and ongoing review
- it would be expected that all level 3 and above admitted rehabilitation services are members of the Australasian Rehabilitation Outcomes Centre (AROC) and submit data to AROC
- clinical guidelines or quality standards for particular subspecialties of rehabilitation services may also be developed by the special interest groups of the Australasian Faculty of Rehabilitation Medicine (AFRM), and are likely to be most relevant to level 4 and 5 services.

All SACS would be expected to adhere to the *Health Independence Programs guidelines*. These can be found at <www.health.vic.gov.au/subacute/hip-manual08.pdf>.

6. Infrastructure, equipment and supporting services

The infrastructure and equipment required to provide effective care will vary according to the patient mix and types of services provided. The range and level of equipment, infrastructure and therapy areas would be expected to increase as the service level increases.

Consideration should be given to how patients will access equivalent core and/or supporting clinical services to safely meet a service's clinical requirements. Access to clinical support services, such as pharmacy, pathology and diagnostic imaging, are required to provide a clinical service. Also, the availability of such services after hours or on weekends would determine the level of complexity that a service can reasonably provide. Therefore, the higher the level of complexity the greater the need for these supporting clinical services to be available. Where patients are requiring significant acute care input then access to medical and surgical support would be necessary and collocating sub-acute with these services may need to be considered.

A primary goal for sub-acute services is to improve a patient's function and minimise the effects of activity limitations, with the aim of the patient returning into the community with as much independence as possible. Integration with community support services is vital in ensuring a patient's successful transition from hospital to home. Links to SACS and other services such as the Transition Care Program, Restorative Care, Post Acute Care, Home and Community Care, HARP, primary health services, aged care assessment services and disability services are essential supports for many patients, especially those with more complex care needs.

7. Teaching and research

At a minimum, all services at level 2 and above would be expected to ensure staff are provided with the opportunity to participate in regular training and education programs. All level 4 services (and some level 3 services) would involve training across relevant clinical specialties. Level 4 and 5 services would be actively participating in clinical research.

Table 1 summarises all these elements of the SCF. It provides an overview of the standards that would be expected to apply for each of the relevant service levels for admitted rehabilitation, admitted GEM, SACS and HARP provided in Victorian public health services.

Table 1: Service capability framework for sub-acute services

* Columns shaded in light grey are 'precursor' services that do not constitute a formal sub-acute service.

Service type	Service criteria	Level 1*	Level 2	Level 3	Level 4	Level 5
Inpatient services: rehabilitation	Service description and patient mix	Low-level rehabilitation provided by staff with knowledge of rehabilitation principles, but no recognised rehabilitation program	Single stream and/or short-term rehabilitation involving management of less complex patients and targeted groups (such as orthopaedic), with referral of other patients	Dedicated rehabilitation program providing a broad range of rehabilitation streams, able to provide definitive care for most patients with well-developed outpatient clinics	Specialist rehabilitation with specialist assessment and management of a full range of rehabilitation streams and programs across all settings (admitted, outpatient, community, home)	Statewide rehabilitation service focusing on the most complex patients for targeted streams (burns, trauma and non-trauma spinal injury, secure ABI, paediatrics)
	Catchment	Local	Local	Sub-regional	Regional or sub-regional	Statewide
	Clinical staff levels and involvement	Medical practitioner with some allied health input	GP/medical practitioner with access to visiting rehabilitation medicine specialist, interdisciplinary team of core allied health and nursing staff	Interdisciplinary team led by rehabilitation medicine specialist with access to a broad range of allied health staff (physiotherapist, occupational therapist, speech pathologist, social worker and other relevant allied health types) and dedicated, experienced nursing staff	Multiple rehabilitation specialists, also likely to include geriatricians, involvement of clinical and neuropsychologists, prosthetist, orthotist, clinical nurse consultants, with strong interdisciplinary team involvement and case management approach	Dedicated interdisciplinary team comprising specialists with extensive senior experience in all disciplines (medical, allied health, nursing) that are involved in leadership, liaison, research and support for other services
	Networking, integration and relationships	May have informal links with medical specialists in level 2 and 3 services; does not formally 'refer' patients elsewhere for rehabilitation as only offers limited range of acute services	Scope of practice clearly defined for rehabilitation services, with referral protocols to level 3 and 4 services in region; may also operate as 'outreach' service with visiting specialist	Accepts a sub-regional role and responsibility; provides outreach services to level 2; refers most complex patients to levels 4 or 5 services; strong links with acute specialists	Accepts regional (rural agencies) and sub-regional (metropolitan agencies) roles and responsibilities; provides outreach, consultancy and liaison services to levels 2 and 3; strong role in leading rehabilitation 'network' across admitted, outpatients, community and home-based services	Accepts statewide role and responsibility; receives and manages referrals for most complex patients from level 3 and 4 services; potential for role in assessing and managing interstate patients
	Quality standards and clinical guidelines	Documents clinical outcomes for individual patients	Rehabilitation program is included in hospital's quality assurance program; clinical guidelines and protocols exist for offered rehabilitation streams	Clinical governance, outcome monitoring and clinical risk assessment are at the core of the rehabilitation programs; membership of, and submission of data to, the Australasian Rehabilitation Outcomes Centre	Participation in external quality assurance processes; contributions to academic literature on clinical outcomes and guidelines development	As for level 4
	Infrastructure, equipment and supporting services	Access to pharmacy, pathology, some imaging	Basic range of equipment used in rehabilitation programs	Access to complex diagnostic imaging, well-developed therapy areas and equipment; may provide access to hydrotherapy; access to clinical support services and post-hospital services to facilitate ongoing community management	Extensive therapy areas (work conditioning, activities daily living); likely to have on-site manufacture of specialist aids and equipment, hydrotherapy; access to full range of clinical support services and comprehensive post-hospital services	As for level 4, plus additional infrastructure and equipment commensurate with rehabilitation needs of most complex patients
	Teaching and research	Not applicable	Staff in rehabilitation program participate in external training and education programs	May have rehabilitation registrars, strong teaching focus with allied health and nursing staff trained/specialist in specific rehabilitation streams	Accredited training site for AFRM trainees; could offer education/training modules on regional role to staff in levels 2 and 3 services; active research program	Teaching and education programs attract external experts across Australia and internationally, leadership in research output is nationally recognised

Service type	Service criteria	Level 1*	Level 2	Level 3	Level 4	Level 5
Inpatient services: GEM	Service description and patient mix	Maintenance of function for elderly patients, short-term medical management of patients waiting for residential aged and community care services. This is not a formal GEM service	Provides a level of restorative care with limited goals for improved functional status. Main focus is function maintenance. Does not meet evaluation and active management requirements of a GEM program	Formal program of evaluation and active management of elderly patients with the goal of improved functional status	Formal program of evaluation and active management of elderly patients with the goal of improved functional status; includes some specialised patients	Statewide geriatric service focusing on the most complex patients of targeted groups (such as those with degenerative neurological conditions)
	Catchment	Local	Local	Sub-regional	Regional or sub-regional	Statewide
	Clinical staff levels and involvement	Medical practitioner; some limited allied health staff; nursing staff; no or limited access to geriatrician	Medical practitioner with an interest in geriatrics; desirable for there to be periodic oversight by a geriatrician or rehabilitation specialist	Established multidisciplinary team led by geriatrician with access to a broad range of more dedicated and experienced allied health and nursing staff	Multiple resident geriatricians, also likely to include rehabilitation specialist, with dedicated multidisciplinary team in all relevant allied health and nursing staff, with strong interdisciplinary and case management approach	Subspecialist geriatrician, also likely to include rehabilitation specialist, involvement of neuropsychologists, clinical nurse consultants; strong interdisciplinary team involvement and case management approach; senior clinicians involved in leadership, liaison, research and support for other services
	Networking, integration and relationships	Referral to level 3 and 4 services for patients requiring specialist assessment by a geriatrician; links with GPs and community support services	Referral to level 3 and 4 services for patients requiring specialist assessment by a geriatrician; links with GPs and community support services	Integration and protocols with acute specialist units in the hospital, and psycho-geriatrics; may receive outreach support from level 4 services	Meet patient's acute care needs on site (not involving patient transport) and may include collocation with acute medical unit and linkages with relevant specialties (such as psycho-geriatrics) and ambulatory-based assessment and support services; provides advisory role to level 2 and 3 services	Receives and manages referrals for most complex patients from level 3 and 4 services, also role in assessing and managing patients on an outreach or consultation basis
	Quality standards and clinical guidelines	Quality assurance activities operate at the agency level	Quality assurance activities operate at the agency level	Clinical protocols and use of validated assessment tools and programs focused on measuring and improving functional status	As for level 3, and participation in external benchmarking and quality assurance processes; contribution to academic literature on clinical outcomes and guidelines development; analysis of patient and carer experience	As for level 4
	Infrastructure, equipment and supporting services	Meets policy guidelines on older-people-friendly environment in public hospitals	Meets policy guidelines on older-people-friendly environment in public hospitals	Suitable equipment, may provide hydrotherapy, space for patient assessment and therapy, access to relevant diagnostic services; access to clinical support services and post-hospital services to facilitate ongoing community management	Comprehensive range of equipment and dedicated assessment and therapy areas with strong focus on improving functional independence; access to full range of clinical support services and comprehensive post-hospital services	As for level 4, plus additional infrastructure and equipment commensurate with specialised patient needs
	Teaching and research	Not applicable	Not applicable	May have geriatrics registrars; strong teaching focus with allied health and nursing staff	Approved training site with strong teaching focus including offering education/training modules for staff in level 2 and 3 services; active research program	Teaching and education programs attract external experts across Australia and internationally; leadership in research output is nationally recognised

Service type	Service criteria	Level 1*	Level 2	Level 3	Level 4	Level 5
Health Independence Program – Sub-acute ambulatory care service (SACS	Service description and patient mix	Informal services (that are outside state-funded rehabilitation services) that contribute to the goal of rehabilitation; may be accessed directly by patients without formal assessment and referral	Individual ambulatory services that provide access to a narrow or targeted range of ambulatory rehabilitation services including a stand-alone CRC	Partially integrated network of ambulatory services involving 1 CRC that is integrated/linked and 1 to 3 specialist assessment clinics, with outreach support for level 2 and other level 3 and referral to level 4 service for diagnostics and geriatrician input	Fully integrated network of ambulatory services (linked system involving 1 or more CRCs) and a full range (at least four) of specialist assessment clinics	Statewide ambulatory care service focusing on most complex patients for targeted streams (such as polio services)
	Catchment	Local	Local	Sub-regional	Regional or sub-regional	Statewide
	Clinical staff levels and involvement	GPs, allied health service providers	May involve visiting rehabilitation medicine specialist, geriatrician, allied health, nursing staff that are relevant to type of specialist assessment clinic (some allied health and nursing staff may be shared with other services); some interdisciplinary focus	Established multidisciplinary team led by rehabilitation medicine specialist and/ or geriatrician, with team including more dedicated access to relevant allied health and nursing staff	May involve multiple rehabilitation specialists and/or geriatricians providing outreach and visiting services across network; complete range of experienced allied health and nursing staff; all services operate with strong multidisciplinary team focus	Dedicated interdisciplinary team comprising specialists with extensive senior experience in all disciplines (medical, allied health, nursing) that are involved in leadership, liaison, research and support for other services
	Networking, integration and relationships	No formal relationships	Patients will usually be referred from hospital-based acute or sub-acute services; may share administrative support if collocated with other agencies, but clinical services more likely to be 'stand-alone' or episodic basis	More likely to be defined scope of practice and referral arrangements with both level 2 and level 4 services; some integration and staff sharing across the partial network	Well-developed relationships involving assessment and referral of patients across all agencies in the region/ sub-region, provides support and outreach to all other ambulatory rehabilitation providers in the region/sub-region	Accepts statewide role and responsibility; receives and manages referrals for most complex patients from level 3 and 4 services, also potential for role in assessment and management of interstate patients
	Quality standards and clinical guidelines	Quality standards relevant to professional craft group	Adhere to the Health Independence Program guidelines; may adhere to specific clinical guidelines for relevant specialist assessment clinics; may have quality assurance activities specific to rehabilitation services depending on size of agency	Shared participation and contribution to clinical protocols, clinical risk assessment and outcomes measurement	Well-established clinical governance across all providers in the region/ sub-region; active participation in benchmarking at regional and cross-regional level; specialist clinics including 'inreach' into necessary acute services	As for level 4
	Infrastructure, equipment and supporting services	Access to pharmacy, pathology, imaging	Basic range of assessment and management aids and equipment	Expanded access to therapy areas, aids and equipment; referrals for diagnostic imaging; integrated services through adherence to HIP guidelines	Full range of infrastructure and equipment, may have access to hydrotherapy, access to complex diagnostic imaging, access to relevant diagnostics (such as urodynamics for continence service)	As for level 4, plus additional infrastructure and equipment commensurate with rehabilitation needs of most complex patients
	Teaching and research	Not applicable	Participation in external education programs	May involve some rehabilitation registrars, stronger focus on skills enhancement	May be AFRM-accredited training site; may provide training for level 2 and 3 staff; likely to be involved in some research	Teaching and education programs attract external experts across Australia and internationally; leadership in research output is nationally recognised

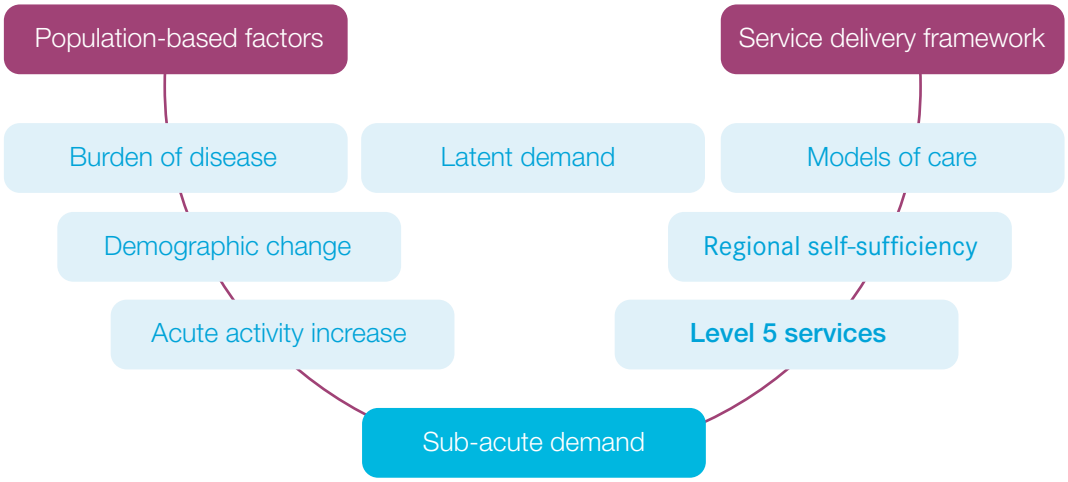
Service type	Service criteria	Level 1*	Level 2	Level 3	Level 4	Level 5
Health Independence Program— Hospital Admission Risk Program (HARP)	Service description and patient mix	There are no HARP services at level 1.	HARP services providing complex care coordination in a generic HARP service model. Client may have co-morbidities and require specific services but limited streams.	Provide complex care coordination. Some stream specific specialised clinical care, particularly allied health and nursing with specialist training (e.g. Diabetes Nurse Educator-DNE). Some access to specialist assessment and management across the chosen streams of care. Access to level 4 service for high complexity clients requiring additional specialist care.	Provide a full range of complex care coordination, support, self management and access to specialist assessment and management across the HARP streams of care: respiratory, chronic heart failure, diabetes, aged/complex needs and psychosocial.	Health Services at a level 5 will provide a full range of HARP services. The Health Service will provide consultation to other Health services and focus on the most complex clients within their specialty areas. Health Services at level 5 will be involved in research, conferences and forums where they will be an active contributor.
	Catchment	Local	Local	Sub-regional	Regional or sub-regional	Statewide
	Clinical staff levels and involvement		Experienced staff provide services across all HARP streams, good experience providing care coordination to chronic/ complex needs/ psychosocial clients. HARP services have access to a generalist multidisciplinary team through local services. Level 2 services can have a satellite relationship with the respective level 3 and 4 service.	Experienced staff in HARP streams, good experience providing care coordination to chronic/ complex needs/ psychosocial clients. HARP clients have access to an established multi disciplinary team either with their HARP team or within their health service.	Experienced staff in specialist HARP streams, strong experience providing care coordination to chronic/ complex needs/ psychosocial clients. HARP clients have access to a strong multi disciplinary team with clinical expertise and specialised services for targeted HARP cohorts (e.g. diabetes, CHF, respiratory). HARP clients have access to medical specialists. Staff will provide support and consultation to level 2 and 3 health services. May provide outreach visits, telehealth, clinical support and accept referrals for clients who require specialist assessments and interventions within HARP. Provide clinical governance support and consultation for level 3 and 2 services as required.	Dedicated interdisciplinary team comprising specialists with extensive senior experience in all disciplines (medical, allied health, nursing) that are involved in leadership, liaison, research and support for other services
	Networking, integration and relationships		Have a strong relationship and referral pathways with level 3 and 4 services. Accept referrals of HARP eligible clients from these ED departments, local Urgent Care departments and acute and subacute inpatient services, dependent on local capacity and access specialist services from level 3 and 4 services. Clinical governance support and consultation from level 3 or 4 service. This could include participation in a shared clinical governance committee across a region. HARP well integrated with other HIP services, acute and community services.	Defined scope of practice and established referral arrangements with level 2 and 4 HARP services. Provide some support and consultation within the region to level 2 HARP services and access some support and consultation from level 4 HARP services. HARP well integrated with other HIP services, acute and community services	Well developed relationships with other HARP providers in the region/sub region. Provide support and outreach via consultation to all other HARP providers in the region/ sub region. Have access to a broad range of community and hospital- based specialised services. Where health services share clients there are expectations of working together on coordination of shared care plans. HARP well integrated with other HIP services, acute and community services.	Accepts state-wide role and responsibility; receives and manages referrals for most complex patients from level 3 and 4 services, also potential for role in assessment and management of interstate patients. HARP well integrated with other HIP services
	Quality standards and clinical guidelines		Adhere to the HIP Guidelines, clinical guidelines for specialist care of chronic illnesses and self management.	Shared participation and contribution to clinical protocols, clinical risk assessment and outcome measures. Accessing best practice information and clinical practice guidelines from level 4 HARP service as required. Providing support to level 2 HARP service as required.	Well established clinical governance of all HARP services provided by a level 4 health service. Active participation in benchmarking across all HARP services in region	As for level 4
	Infrastructure, equipment and supporting services		Basic range of assessment and management aids or access to this via level 3 health service. Access to tele-health equipment.	Expanded access to therapy areas and community rehab programs, aids and equipment, referrals for diagnostics for HARP clients.	As for level 3 and have access to complex diagnostic testing, access to relevant diagnostics, tele-health equipment, relevant ambulatory rehabilitation programs. Access to appropriate community and acute services according to client's need. HARP well integrated with other HIP services, acute and community services.	As for level 4, plus additional infrastructure and equipment commensurate with needs of most complex patients
	Teaching and research		Participation in external education programs	Strong focus on skill enhancement of HARP staff	May provide training for HARP staff in level 2 and 3, likely to be involved in research.	Teaching and education programs attract external experts across Australia and internationally; leadership in research output is nationally recognised

Measuring access to sub-acute services

Contextualising demand for sub-acute services within the overall continuum of care, from the front-end interface with acute care through to transitional or community support, are important if meaningful access benchmarks are to be developed. These need to reflect actual demographic need and be responsive to future demand. In addition, the dynamic nature of health care requires that these benchmarks be able to be refreshed over time as the current context of service delivery changes.

A number of demand drivers have been identified and are briefly discussed below. Figure 2 outlines these demand drivers schematically.

Figure 2: Demand drivers for sub-acute services



What is driving demand for sub-acute services?

84 per cent of all public sub-acute admitted admissions occur following an acute care episode, 8 per cent of these from the private sector.

Population-based benchmarks are widely used for planning services but, at best, they are an unsatisfactory proxy measure of need. They assume uniform burden of disease, uniform assessment of service need, common clinical standards or consistent practices, common thresholds for access and uniform prevalence of available substitute services.

The planning framework uses two alternative benchmark measures that are felt to be a better measure of service need than straight population-based measures:

- utilisation rates, the propensity of the catchment population to receive a service
- referral sources, the 'feeder' origins for patients receiving a service.

Utilisation rates implicitly incorporate changes in population as well as other factors such as changes in burden of disease, changes in technology, and changes in clinical practice. They are not, however, an independent variable and, therefore, not a reliable predictor of service levels.

Referral sources are a reliable proxy measure. Acute separations are a very strong predictor for determining overall demand for sub-acute admitted services.

80 per cent of the total transfers from acute care originated from only 10 major clinical related groups.

Table 2: Major clinical reference groups (MCRG) of acute care predecessor episodes by sub-acute care service categories (Data from 2006–07 VAED)

MCRG	Public hospital acute multi-day separations	Transfers from acute care to public sub-acute care	Acute to sub-acute transfer rate	Transfers to sub-acute as % of total sub-acute care episodes and cumulative %	
Orthopaedics	37,705	5,170	13.7%	28%	28%
Neurology	25,226	2,562	10.2%	14%	42%
Non-subspeciality medicine	34,264	1,504	4.4%	8%	51%
Respiratory	44,390	1,240	2.8%	7%	57%
Cardiology	42,570	969	2.3%	5%	63%
Non-subspeciality surgery	43,995	906	2.1%	5%	68%
Neurosurgery	7,881	693	8.8%	4%	71%
Renal dialysis*	228,641	635	0.3%	3%	75%
Pain management	7,225	508	7.0%	3%	78%
Endocrinology	10,190	451	4.4%	2%	80%
Subtotal	**482,047**	**14,638**	**3.0%**		**80%**
Other MCRGs	**274,343**	**3,608**	**1.3%**		**20%**
Total	**756,390**	**18,246**	**2.4%**		**100%**

* Includes same-day and multi-day separations

Demographic change and burden of disease

Ageing and the prevalence of chronic disease will increase demand for care that is driven primarily by the patient's functional status and quality of life rather than an underlying medical diagnosis.

Changes in demography due to population growth, ageing and trends in burden of disease represent a fundamental driver of demand for sub-acute services. Changes over time in these factors are explicitly incorporated within the planning benchmark methodology, which includes as an input hospital morbidity rates.

Increase in acute activity

Any increase in acute activity will inevitably increase demand for sub-acute services.

Demand for sub-acute services may be substantially influenced by initiatives that aim to increase levels of acute activity within the public hospital system, such as increased elective surgery to reduce the surgical waiting list. The sub-acute planning benchmarks can be used to quantify the expected impact on demand for sub-acute services based on quantifiable transfer rates from acute to sub-acute for defined MCRGs, as shown below for orthopaedics.

Table 3: Expected impact on demand in orthopaedics using planning benchmarks

Orthopaedics	Multi-day surgery separations in public hospitals	Transfer rate to sub-acute	Transfers from public acute to sub-acute
2006–07 acute multiday throughput	37,705	13.7%	5,160
Scenarios for incremental throughput	5% increase	10% increase	15% increase
Increase in orthopaedic acute multiday separations	1,885	3,771	5,656
Resulting incremental sub-acute separations	259	517	776

Latent demand

To determine total demand we need to be able to measure not only those who receive a sub-acute service but those who do not.

The current planning benchmarks use a *relative* measure of demand and are based on measures of actual activity. It would be helpful to identify normative benchmarks of access to sub-acute services that incorporate measures of actual need rather than current levels of performance. Factors such as bed availability and length of time between referral and transfer can influence decisions on a patient's care pathway.

Models of care

Sub-acute care is changing in the way we provide alternative care pathways to address specific care needs.

Changes in clinical practice and service models will influence demand for different components of sub-acute services. For instance, increases in the scope of services provided on an ambulatory basis may result in a substitution of services currently provided on an admitted basis, such as with the Elective Orthopaedic Patient Pathways Project. This project aims to improve the patient journey following total hip and total knee replacement surgery through a greater use of home-based community rehabilitation. Improving access to ambulatory care for appropriate patients potentially leads to reduced lengths of stay in hospital and better clinical outcomes. More detail on this project is available at <www.health.vic.gov.au/subacute/pathways>.

Regional self-sufficiency

Demand for sub-acute services in any given catchment will also be influenced by the net flow of patients into and out of the catchment.

Over time, if resources are allocated on a targeted basis to catchment areas with below average access, it will be expected that there should be a corresponding increase in regional self-sufficiency in these catchment areas. With a reduction in the extent of cross-border flows, this should, in turn, free up resources in catchment areas that may currently have a net inflow of patients from other regions.

Statewide services

Improving access to specialised care will lead to greater demand.

Demand for access to statewide services, identified as level 5 in the capability framework, will be a small but significant factor in ensuring equitable service delivery. Expectations will drive demand where currently this maybe limited by access.

Next steps

The access and planning benchmarking undertaken in developing the Framework utilises 2006-07 activity data from the Victorian Admitted Episode Dataset (VAED). It is intended that the Framework will be regularly refreshed to incorporate the most recently available activity data. In addition, improvement in the quality of data reporting for SACS through the Victorian Integrated Non-Admitted Health Minimum Dataset (VINAH MDS) will allow for more accurate access benchmarks for SACS to be set. There may also be scope to refresh the current planning benchmarks developed on the basis of statewide averages to benchmarks informed by best practice.

Applying the SCF and mapping this against current service provision will initially be a major focus in implementing the framework. Each rural region will have its own challenges and be at very different stages in their preparedness to meet the requirements of the SCF. This is especially the case where work to enhance services to meet the requirements of the SCF will be required. Due to the need to develop and enhance networking inherent in the SCF, it is preferable that each region work through the expectations and what this might mean for their region and develop individual regional plans. Understanding what is required and what is currently in place will determine where the gaps are.

The service level expectations inherent in the SCF will guide service development and create a common language between the department and service providers. Establishing regional working groups involving departmental and health service representatives will facilitate this process.
In the short term the aims are to:

- develop a detailed description of the current level and nature of the services available at a regional level
- match these to the service profile expectations
- develop a description of the specific components that will require enhancement (such as capital infrastructure, equipment, service reconfiguration, changes to the model of care, development of referral protocols, ICT changes, and workforce implications)
- identify capital and infrastructure planning and indicative recurrent costs of these enhancements
- map the existing level of service integration and networking and seek to enhance relationships across regions.