Royal Commission into
Victoria's Mental Health System

# ATTACHMENT NC-3

This is the attachment marked 'NC-3' referred to in the witness statement of Dr Neil Coventry dated 29 July 2020.

# Policy and funding guidelines 2019–20

## Policy guide

## Appendices – Funding rules

VICTORIA State Government | Health and Human Services

The *Policy and funding guidelines 2019–20* (guidelines) represent the system-wide terms and conditions (for funding, administrative and clinical policy) of funding for government-funded healthcare organisations.

The guidelines reflect the government and department's role as a system manager and underpin the agreements at an organisational level. The guidelines are relevant for all funded organisations including health services and hospitals, community service organisations and other funded organisations such as Ambulance Victoria and the Victorian Institute of Forensic Mental Health that are funded pursuant to the Statement of Priorities.

Service agreements are the contractual arrangements between the organisation delivering services and the department providing funding to the organisation. For community service sector funding information and activity tables that underpin service agreements, visit the Policy and funding guidelines webpage <https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>.

In addition to these guidelines, funded organisations are expected to comply with all relevant policy documents and guidelines. A list of key policies and guidelines can be found at the Policy and funding guidelines webpage <https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>.

*Hospital circulars* provide updates on the changes that affect health services during the year. These are available at the Hospital circulars webpage <https://www2.health.vic.gov.au/about/news-and-events/hospitalcirculars>.

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

Where these guidelines refer to a statute, regulation or contract, the reference and information provided is descriptive only.

In the case of any inconsistencies or ambiguities between these guidelines and any legislation, regulations and contractual obligations with the State of Victoria acting through the department or the Secretary to the department, the legislative, regulatory and contractual obligations will take precedence. Each funded organisation should refer to the relevant statute, regulation or contract to ascertain all the details of its legal obligations. If any funded organisation has questions in relation to its legal obligations, it should seek independent legal advice.

To receive this publication in an accessible format, please phone 03 9096 8572 using the National Relay Service 13 36 77 if required, or email policy and funding guidelines <pfg@dhhs.vic.gov.au>.

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Where the term 'Aboriginal' is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

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# Contents

# Ministers' foreword

The *Victorian Budget 2019–20* invests a further $5.5 billion over the next four years to ensure every Victorian can get the best care, in the very best facilities, when they need it.

For our hospitals, the budget provides an unprecedented additional $2.5 billion over four years for hospital service delivery. This includes additional funding for emergency department presentations, critical care admissions, elective surgery, maternity admissions, outpatient services, sub-acute care services, chemotherapy treatments and radiotherapy treatments.

This year's budget also provides $13.6 million for the Royal Commission into Victoria's Mental Health System – a once-in-a-generation opportunity to redesign our system, and ensure people get the services they need, when they need them.

In 2019–20 it is expected that 203,020 patients will be admitted from the elective surgery waiting list and 756,000 patients will be admitted into our hospitals from emergency presentations. In all, a total of 2,021,000 admitted patients are expected to move through our health system in 2019–20.

We're rolling out new programs to dramatically expand healthcare provision across the State including our flagship demand driven school dental program, which will progressively scale up to provide free treatment to all public school students by 2022. The budget also delivers $214 million in support for new parents including building seven new early parenting centres and expanding our 24 hour maternal and child health line with specialists in sleep and settling issues. We've funded Bass Coast Health to deliver free 24 hour care to Phillip Island residents and visitors on an ongoing basis. The budget also funds an additional 500,000 specialist appointments in rural and regional Victoria.

## Strengthening nurse to patient ratios

To ensure our dedicated health professionals have the support they need, there is additional $64.4 million investment to further improve patient ratios across our hospitals and recruit more nurses and midwives, new investment to equip frontline health workers with the skills they need to recognise and respond to occupational violence, and 100 scholarships will be available to hospital staff seeking to grow their careers in the health sector.

## Responding to people's end of life care choices

The Government continues to support Victorians requiring end of life care, including home-based palliative care. A 24 hour support line will be established giving people access to expert advice and guidance on issues and concerns regarding all aspects of end of life and palliative care.

## Backing our paramedics to keep saving lives

In a medical emergency, every second of every minute counts and can be the difference between life and death. The budget invests nearly $300 million in our ambulance service to meet growing demand, support improved response times and deliver on the Government's election commitment in full.

This includes $109 million to deploy a 23-vehicle surge fleet across Victoria to improve emergency ambulance availability and reduce paramedic fatigue. Ocean Grove and Gisborne branches will be upgraded, and new stations will be built in Clyde North and East Bentleigh. An additional 90 paramedics will be employed to facilitate the upgrade of 15 single officer branches to dual-officer crewing, base MICA officers in Ararat and Bellarine, and new resources at Churchill, Geelong, Gisborne, Bendigo region and South-Barwon region to meet higher demand for ambulance services across Victoria.

The budget goes beyond the Government's election commitment. $190.8 million will also be invested to enable Ambulance Victoria to meet the ever-increasing demand for ambulance services, maintain significant improvements in response performance, and support Ambulance Victoria's 24/7 Secondary Triage Service.

Since 2014, the Labor Government has invested $1 billion in Victoria's ambulance service, ensuring Victorians get the best emergency care, when they need it, faster than ever before.

## Royal Commission into Victoria's Mental Health System

The Government has established the Royal Commission into Victoria's Mental Health System – the first of its kind in the country. The Royal Commission will give us the answers we need to transform our mental health system and change lives. While the Royal Commission is underway, the *Victorian Budget 2019–20* will invest in prevention and recovery care facilities, additional community services to meet demand, an extra 28 acute mental health inpatient beds, 30 residential rehabilitation beds to support Victorians recovering from addiction, investment in treatment and support services for Aboriginal Victorians, and further investment in the Mental Health Complaints Commissioner and Mental Health Tribunal to safeguard patients' rights.

## Health infrastructure

The budget kickstarts the Labor Government's unprecedented $3.8 billion plan to build modern hospitals and health infrastructure for a growing Victoria.

The centrepiece of the budget is the landmark $1.5 billion 504-bed New Footscray Hospital. The new hospital will cut waitlist times, allowing almost 15,000 additional patients to be treated and almost 20,000 additional people to be seen by the emergency department each year. The world-class New Footscray Hospital will ensure that people in Melbourne's west have greater access to quality care closer to home.

Key highlights of the budget also include:

- $100 million boost to the Regional Health Infrastructure Fund, helping build the world-class hospitals and health facilities that rural and regional communities count on
- $60 million for the medical equipment and engineering infrastructure replacement programs in the coming year to help our hospitals and health services maintain assets and grow services
- $31 million for an expansion of the Royal Children's Hospital, including a new 30-bed flexi ward and expansion of the emergency department to treat some of our sickest young patients.

Bendigo patients recovering from injury or illness will benefit from a $60 million investment in a cutting-edge Bendigo Hospital Day Rehabilitation Centre, consolidating the various rehabilitation services spread across the Bendigo Hospital site into one new location.

The budget also includes funding to enable important planning work to progress for a number of the Government's election commitments including the Frankston Hospital Redevelopment, Latrobe Regional Hospital Stage 3 expansion, ten new community hospitals and dedicated children's emergency department space at Geelong, Maroondah, Frankston, Casey and the Northern hospitals.

Funding has also been set aside for the $100 million Marybourgh Hospital Redevelopment and $100 million Geelong Women's and Children's Hospital.

This budget builds on our $3.2 billion investment in hospital infrastructure during our first term and keeps our promises – building the hospitals our state needs and backing the first-class care Victorians deserve.

**Jenny Mikakos MP**
Minister for Health
Minister for Ambulance Services

**Martin Foley MP**
Minister for Mental Health
Minister for Equality
Minister for Creative Industries

# Guidelines overview

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

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

The guidelines are relevant for all funded organisations, which includes health services, community service organisations and other funded organisations such as Ambulance Victoria.

## Policy guide

The policy guide articulates the funding policy priorities, and performance and financial frameworks, including their conditions, within which Victorian government-funded organisations operate.

### Chapter 1: Funding arrangements for Victoria's health system

Details funding arrangements for funded organisations and all other outputs provided by the department.

### Chapter 2: Conditions of funding

Outlines relevant standards and policies that funded organisations must adhere to in order to receive funding from the Victorian Government, ensuring the delivery of safe, high-quality services and responsible financial management.

## Appendices – Funding rules

The funding rules specify the financial parameters, specifically the detailed pricing and prescribed budgetary targets, that funded organisations are expected to work to, and within, in order to achieve the outcomes expected by the Victorian Government.

### Appendix 1: Pricing arrangements for Victoria's health system

Details pricing arrangements for funded organisations and all other outputs provided by the department.

### Appendix 2: Funding and activity levels

Provides funding and activity tables detailing the modelled budgets for 2019–20, as well as the 2019–20 targets for a range of programs across the health system.

# Policy guide

# Overview of chapters

The policy guide articulates the funding policy priorities, and performance and financial frameworks, including their conditions, within which State government-funded organisations operate.

## Chapter 1: Funding arrangements for Victoria's health system

Details funding arrangements for funded organisations and all other outputs provided by the department.

## Chapter 2: Conditions of funding

Outlines relevant standards and policies that funded organisations must adhere to in order to receive funding from the Victorian Government, ensuring the delivery of safe, high-quality services and responsible financial management.

# Chapter 1: Funding arrangements for Victoria's health system

# Introduction

Chapter 1 details the funding arrangements for funding the broad range of services delivered in the Victorian health system. It details the mechanisms used to fund organisations and the rules about how these prices apply. The funding models vary across the activities depending on the nature of the service to be delivered. This chapter also explains the Commonwealth–State Government funding arrangements that affect funded organisations.

**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*, regarding 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' refers to registered community health centres, local government authorities and non-government organisations that are not health services.

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

# 1.1 Budget highlights

The *Victorian Budget 2019–20* continues to build on our State's economic success, with Victoria outperforming the nation across a broad range of economic indicators. Victoria's economic growth ensures more Victorians have the security and dignity of work, and in 2019–20, investment in infrastructure will reach a record $14.2 billion, delivering new schools, better hospitals, and more reliable road and rail for Victorians.

Continued strong investment in our health system will help meet the needs of our growing state, ensuring more patients will receive care, treatment and surgeries sooner.

Highlighted additional budget investments for 2019–20 include:

- $780 million of additional funding for hospital demand
- $17.3 million to ensure the end of life care choices of Victorians continue to be met
- $58.9 million for Ambulance services and paramedic support
- $50.4 million for mental health services.

Table 1.1 details departmental health operations funding by the output categories provided in the *Victorian Budget 2019–20.*

A summary of health service modelled budgets for 2019–20 is provided in the Appendices.

**Table 1.1: *Victorian Budget 2019–20* by output group**

| Output group | 2018–19 Budget ($m) | 2019–20 Budget ($m) | % increase 2018–19 to 2019–20[1] |
|---|---|---|---|
| Acute health services | 14,106.7 | 14,667.2 | 4.0% |
| Ageing, aged and home care | 804.8 | 809.9 | 0.6% |
| Ambulance services | 1,084.3 | 1,120.0 | 3.3% |
| Drugs services | 259.9 | 273.1 | 5.1% |
| Mental health | 1,605.7 | 1,742.6 | 8.5% |
| Primary, community and dental health | 655.1 | 645.0 | –1.6% |
| Public health | 369.0 | 389.5 | 5.6% |
| Small rural services | 592.0 | 630.6 | 6.5% |
| **Total** | **19,477.5** | **20,277.9** | **4.1%** |

Source: 2019–20 Victorian Budget Paper No. 3

# 1.2 Output initiatives 2019–20

The *Victorian Budget 2019–20* has allocated $1.1 billion in 2019–20 and $5.5 billion over five years for new output initiatives that will grow and strengthen the health, ambulance, mental health and aged care sectors.

## 1.2.1 Acute health and ambulance services

The *Victorian Budget 2019–20* is investing $888.1 million in 2019–20 ($2.8 billion over four years) in health and ambulance services programs across metropolitan Melbourne and in rural communities.

[1] Variation between 2018–19 Budget and 2019–20 Budget.

- $2.3 billion over four years will respond to growing patient demand across Victoria including additional funding for emergency department presentations, critical care admissions, elective surgery, maternity admissions, outpatient services, subacute care services, chemotherapy treatments and radiotherapy treatments.
- $190.8 million investment in ambulance services over four years will respond to the growing demand for emergency services, including an additional 90 paramedics. Funding will also support Ambulance Victoria's secondary triage service, maintain non-emergency transport capacity and further improve Code 1 response times.
- $72 million over four years will continue support for Victorians requiring end-of-life care, including home-based palliative care in rural and regional Victoria and regional palliative care consultancy as well as a 24-hour support line.
- $70.5 million will upgrade the emergency services radio, transitioning Ambulance Victoria from the outdated analogue system to digital communication, enabling our paramedics to better respond to emergencies across Victoria.
- $64.4 million over four years will be provided to increase nurse and midwife to patient ratios in rehabilitation, mental health, special care nurseries and medical surgery wards. The changes will also upgrade Warrnambool Hospital to a level 2 hospital to reflect increasing demand.
- $53.9 million over four years will support paramedics to recruit an additional 90 paramedics to facilitate the upgrade of 15 single officer branches and for new resources at five ambulance stations to meet higher demand for ambulance services across Victoria.
- $50 million over four years will help establish the Nursing and Midwifery Workforce Development Fund to retain, recruit and train more nurses and midwives in Victoria including increasing the graduate program for nurses, midwives and enrolled nurses.
- $15.4 million over four years will enable the Health Complaints Commissioner to continue resolving complaints about health service providers and the handling of health information, conducting investigations and reviewing health complaints data to help providers improve the quality of their services.
- $3.5 million over four years will be provided to enhance the skills of frontline health service workers to recognise and respond to occupational violence as well scholarships to health service workers with a capped fund to supplement employee wages to ensure health service workers can train while maintaining their income.
- $2.4 million over two years will deliver the first stage and planning of a new Melton Hospital to determine the capacity and range of services and how it will link into services at other hospitals in the region over the long term.
- $2 million in 2019–20 will be provided to develop a business case to establish public IVF services that are bulk-billed and subsidised for low-income Victorians in metropolitan Melbourne and at least one regional location.

### 1.2.2 Primary, community, public and dental health

The *Victorian Budget 2019–20* is investing $97.9 million in 2019–20 ($551.4 million over four years) in primary, community, public and dental health including the following:

- $321.9 million over four years will ensure the School Dental Program provides free dental care each year to Victorian government school students. Once fully implemented, oral health teams will visit all government primary and secondary schools once per year to conduct a dental check-up of all students and provide oral health education. Children who are identified as requiring follow-up treatment will be offered this treatment free of charge in a dental van that will separately visit the school or via a free follow-up treatment at a public dental service.
- $116.5 million over two years will maintain Victoria's position as a leader in health and medical research through:
  - establishing the Australian Drug Discovery Centre at the Walter and Eliza Hall Institute for Medical Research

  - the Australian Clinical Trials Network 'Trial Hub'
  - establishing a Gamma Knife Service at the Peter MacCallum Cancer Centre
  - further planning for the Aikenhead Centre for Medical Discovery at St Vincent's Hospital.
- $90.7 million over four years will provide more help for new Victorian mums and dads with infants experiencing sleep and settling problems from dedicated sleep and settling specialists on the Maternal Child Health Line.
- $15.1 million over four years will provide grants to schools and community groups to increase shading and provide hats, sunscreen and other sun protection measures as well as promotion for early detection and intervention.
- $4.1 million over four years will enable the Victorian Assisted Reproductive Treatment Authority to continue administering the registration system of assisted reproductive treatment providers, provide public education about treatments and continue managing donor registers, including counselling support services.
- $2.8 million over four years will be provided to continue PRONTO, Victoria's existing community-based, rapid, peer-led HIV testing service in Fitzroy. The service uses an innovative non-clinical and patient-centred approach to HIV testing.
- $0.3 million in 2019–20 will help increase services to vulnerable people and communities at the Merri Health facility.

### 1.2.3 Mental health and drug services

The *Victorian Budget 2019–20* is investing $52.5 million in 2019–20 ($106.3 million over four years) in mental health and drug services including the following:

- $173 million over four years will focus on early intervention and better supporting our mental health care workers.
- $67.6 million over two years will address critical mental health service demand by including an additional 28 inpatient beds, more intensive services and additional community service hours for new clients as well as an increase in capacity of the nurse transition program, and more support provided to psychiatrists, in response to workforce pressures.
- $16.2 million in 2019–20 will allow the Victorian Fixated Threat Assessment Centre to continue to deliver coordinated responses with collocated police and mental health clinicians to respond to serious threats of violence posed by people with complex needs. Specialised mental health services will continue to provide support to this cohort.
- $6.0 million over four years will provide better mental health care for our emergency workers. This includes establishing an Early Intervention and Prevention Fund for Victoria Police employees to access better mental health and wellbeing support services and for the department to establish a specialist network of clinicians to provide support services for emergency service workers. A Centre of Excellence for emergency worker mental health will also be established as well as a provisional acceptance payment scheme pilot to support emergency workers suffering from mental health injuries sustained at work.
- $4.2 million over two years will be provided to roll out the new nasal spray containing naloxone with essential training and education provided across Victoria. Additional needle and syringe products will also be made available to help address drug harms. Extended hours of operation will improve access to the Medically Supervised Injecting Room.
- $3.6 million over two years will provide additional support for the Office of the Chief Psychiatrist and establish a campaign to reduce the stigma around mental health while the Royal Commission into Mental Health undertakes its wide-ranging inquiry.
- $3.2 million over four years will ensure the Mental Health Tribunal continues to protect the rights of mental health patients receiving compulsory treatment.
- $3.0 million in 2019–20 will provide services to asylum seekers living in the Victorian community. Funding will go towards mental health and trauma counselling, material aid (food, clothing), health

assistance and subsidised medications, housing assistance and case coordination while applications for asylum are being processed.

- $2.5 million over two years will enable the Mental Health Complaints Commissioner to continue safeguarding rights, resolving complaints about Victorian public mental health and recommending improvements for service and system improvements.

### 1.2.4 Ageing, aged and home care

The *Victorian Budget 2019–20* is investing $44.6 million in 2019–20 ($81.8 million over four years) in ageing, aged and home care including the following:

- $49.5 million over four years will mean Victorian carers benefit from increased support through additional respite hours including expanded eligibility for carers of people with a mental illness and younger carers as well as public transport travel initiatives and grants to both grassroots and statewide carer support groups that focuses on regional areas and under-recognised carer groups.
- $26.9 million in 2019–20 will support public sector residential aged care services to provide high-quality care to vulnerable aged persons, including those with mental health issues.
- $5.4 million in 2019–20 will support multicultural aged care in Victoria through upgrades to facilities at seven multicultural aged care providers. Funding will also be provided to purchase land for three multicultural aged care facilities. This will help improve and expand aged care services for culturally diverse Victorians.

## 1.3 Asset initiatives

The *Victorian Budget 2019–20* includes a $1.8 billion acute health capital, infrastructure and equipment program incorporating the construction, upgrade and expansion of metropolitan and regional hospitals as well as $54.9 million for essential ambulance services equipment and infrastructure. There is also $20 million in capital funding allocated for mental health facilities, $103.4 million in capital funding for a new 120-bed public sector residential aged care facility in Wantirna, grants for upgrades to multicultural residential aged care facilities, and the purchase of land for three new multicultural residential aged care facilities. Capital expenditure of $123 million will provide seven new centres and safety equipment for new families (see Table 1.2 to Table 1.6).

**Table 1.2: Funding for asset initiatives – acute health**

| Initiative | Description | TEI ($ million) |
|---|---|---|
| Building a better hospital for Melbourne's inner west | A new 504-bed Footscray Hospital will be built in Footscray to cater for the growing demand for health services in Melbourne's inner west, specifically allowing up to 15,000 additional patients to be treated. It will boost capacity and services in outpatients, palliative care and mental health services. | $1,430 |
| Regional Health Infrastructure Fund | Further funding provided to the Regional Health Infrastructure Fund to improve infrastructure across a range of rural and regional health services to respond to local priorities and maintain and enhance their service delivery capacity. This initiative includes funding for Ararat Hospital (East Grampians), the renewal of rural residential aged care facilities and to begin planning for stage 2 of the Goulburn Valley Health redevelopment. | $100 |
| Engineering infrastructure and medical equipment replacement programs | Critical engineering infrastructure that has reached the end of its useful life will be replaced in selected metropolitan, rural and regional hospitals to enable the continuity of health service delivery and compliance with regulatory requirements to reduce risks to patients and improve service availability. | $60 |
| Building a new rehabilitation centre for Bendigo | A new rehabilitation centre will be built at Bendigo Hospital, which will include the relocation and consolidation of outpatient rehabilitation services and staff administration services into newly upgraded buildings. | $59.5 |

| Initiative | Description | TEI ($ million) |
|---|---|---|
| Royal Children's Hospital expansion | 30 new inpatient beds and an expansion of the emergency department to cater for growing demand. | $31.4 |
| Clinical technology refresh | To provide the technical infrastructure to improve operational stability and enhance cybersecurity required to support and deliver patient-related services such as diagnostic imaging, patient management systems and electronic medical records will be upgraded. | $13 |
| Building a bigger and better Latrobe Regional Hospital | Planning to redevelop and expand the Latrobe Regional Hospital to increase the service capacity of operating theatres and the maternity and intensive care units. | $7 |
| Building a world-class hospital for Frankston families | Funding to begin planning for the redevelopment of Frankston Hospital, providing new hospital beds, operating theatres, expanded child and maternal health services and areas dedicated to mental health services. | $6 |
| Planning for new children's emergency departments | Planning will begin for dedicated children's emergency departments at Northern Hospital, Frankston Hospital, Casey Hospital, Maroondah Hospital and Geelong University Hospital. | $5.9 |
| Angliss Hospital expansion | Planning will begin for the next stage of the Angliss Hospital expansion at Ferntree Gully, which will provide additional hospital beds, upgrade infrastructure and support the re-accommodation of clinical functions. | $4.6 |
| Phillip Island Urgent Care Centre | To provide funding to expand the Phillip Island Health Hub for operation 24-hours a day, seven days per week for uninterrupted access to urgent health care. | $3.4 |
| World-class care for Wangaratta | To begin infrastructure and service planning work for the redevelopment of Wangaratta Hospital. | $2.4 |
| Ten new community hospitals to give patients the best care | Funding will be provided to plan the construction and expansion of 10 community hospitals to increase capacity and ensure patient access to high-quality healthcare services in key growth areas. This investment will increase capacity and ensure patient access to high-quality healthcare services in key growth areas. | $2 |

**Table 1.3: Funding for asset initiatives –ambulance services**

| Initiative | Description | TEI ($ million) |
|---|---|---|
| New ambulances and new stations | Funding for 23 ambulances, giving Victorians confidence that in an emergency they will continue to get the fast, life-saving care they need. Two new stations in Clyde North and East Bentleigh, and upgrades to Ocean Grove and Gisborne stations, and 15 single-officer stations to make them dual-officer crews. | $54.9 |

**Table 1.4: Funding for asset initiatives – ageing, aged and home care**

| Initiative | Description | TEI ($ million) |
|---|---|---|
| Wantirna Public Sector Residential Aged Care redevelopment | A new 120-bed aged care facility will be constructed at Wantirna Health, including 60 high-care beds and 60 mental health aged-care beds. It will also provide accommodation for the aged care residents during the Angliss Hospital stage 2 expansion. | $81.6 |
| Multicultural Victoria – residential aged care | To support multicultural aged care in Victoria through upgrades to facilities at seven multicultural aged care providers. Funding will also be provided to purchase land for three multicultural aged care facilities. This will help improve and expand aged care services for culturally diverse Victorians. | $21.8 |

**Table 1.5: Funding for asset initiatives – mental health**

| Initiative | Description | TEI ($ million) |
|---|---|---|
| Relocation of Barwon Health clinical facilities | The relocation of Barwon Health clinical facilities to an alternate site in the central Geelong area will enable a transformation of drug and alcohol and mental health service delivery, through development of integrated continuing care service responses for people with coexisting mental health and alcohol / other drug problems. | $20 |

**Table 1.6: Funding for asset initiatives – primary, community and dental health**

| Initiative | Description | TEI ($ million) |
|---|---|---|
| More help for new Victorian families | Funding for seven new early parenting centres to be established. Funding will be provided for free car seat fitting and safety checks plus approximately 35,000 new parents will receive a baby bundle and up to 7,000 vulnerable new families will receive extra home-based sleep support from a maternal child health nurse. | $123 |

# 1.4 Pricing and funding

## 1.4.1 Pricing and funding framework

Refer to the pricing framework for 2018–19 <https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/pricing-funding-framework>.

## 1.4.2 Commonwealth funding

### 1.4.2.1 National Health Reform Agreement

Health services are required to ensure their operations comply with the obligations of the Victorian Government under various Commonwealth–state government agreements. These agreements include the National Health Reform Agreement (and the addendum to this agreement), which has provided joint funding for public hospital services since 1 July 2012.

The National Health Reform Agreement outlines the responsibilities for delivering key health services including: public hospital services; general practitioner and primary healthcare; and aged care and disability services. Health services are expected to comply with the business rules contained in the national agreement.

In April 2017 Victoria signed the National Health Reform Addendum Agreement, which substantially rolls over National Health Reform Agreement arrangements from 2017–18 to 2019–20 and commits to:

- delivering reforms designed to improve health outcomes for patients and decrease avoidable demand for public hospital services
- introducing models to integrate quality and safety into hospital funding and pricing and reduce avoidable readmission rates in conjunction with the Australian Commission on Safety and Quality in Health Care and the Independent Hospital Pricing Authority.

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

In February 2018 the Council of Australian Governments (COAG) considered a draft Heads of Agreement for a longer term 2020–25 National Health Agreement Addendum. Victoria did not sign the offer because it was insufficient to meet the state's growing demand for public hospital services and did not restore the conditions under the original National Health Reform Agreement.

Cooperative development of the 2020–25 National Health Agreement Addendum for COAG's consideration before end of 2019 is underway with commencement of the new Agreement from 1 July 2020. Victoria will continue to negotiate for a sustainable funding outcome. Public hospital funding is a shared responsibility between the Commonwealth, state and territory governments.

### 1.4.2.2 Commonwealth investment in public dental services

Through the Mid-Year Economic and Fiscal Outlook 2018–19, the Commonwealth announced a one-year extension of the existing *National partnership agreement on public dental services for adults.* Funding under this 12-month extension reflects the 30 per cent reduction in Commonwealth investment for this National Partnership Agreement compared with previous National Partnership Agreements.

Public dental providers also have access to the Commonwealth's Child Dental Benefits Schedule, a means-tested scheme (Family Tax Benefit A) for children aged 2–17 years, capped at $1,000 per child over two years. A three-year extension to public sector access to the Child Dental Benefits Schedule until 31 December 2022 was announced in the 2019–20 Commonwealth Budget.

## 1.4.3 Funding reforms 2019–20

The department continues to refine and develop its hospital funding models to ensure the investment made is delivering the best value to all Victorians. Funding models must remain contemporary if Victoria is to continue to deliver better value through high-quality care, delivered in the most effective settings using the most efficient model of care.

In 2019–20 the department has further refined existing funding models and will also continue to develop more innovative approaches such as capitation and bundled payments.

In line with the Victorian *Pricing and funding framework*, Victoria will maintain a state-based funding system that adopts and adapts elements of the national approach where it is suitable in the Victorian context.

In addition to the funding reforms outlined below, in 2019–20 regular updates, including rebasing, have been made to account for the most recent cost and activity data. Changes include updates to the Weighted Inlier Equivalent Separation model (WIES27), the Non-Admitted Emergency Services Grant and Subacute Weighted Inlier Equivalent Separation (SWIES) model. See Chapter 1 for more details.

The 2019–20 funding reforms will improve system outcome by:

- encouraging accountability for both health service providers and government
- remaining simple and transparent
- supporting efficient and sustainable health service operations.

These reforms will not affect patient access or care and will ensure patients receive appropriate care in a timely way, and in the most appropriate setting, by the right providers.

### 1.4.3.1 HealthLinks: Chronic Care

HealthLinks: Chronic Care is a funding reform that aims to improve care for patients who have a combination of specific characteristics that identify them as experiencing chronic and complex health conditions and are at risk of multiple unplanned admissions.

The basis of the model is a capitated grant, converted from existing funding, and based on the modelled utilisation of the enrolled patient cohort. The capitation grant can be used flexibly to design care around patient needs. This can include services that reach beyond traditional hospital-based settings, delivered by a range of providers. Any acute activity that is delivered to the enrolled patients is also funded from the capitation grant. Over time, it is anticipated that patients with chronic and complex needs will be provided with targeted active management, therefore reducing unplanned hospitalisations and improving patient outcomes.

Implementation is staggered based on health service readiness. Four health services actively participated in HealthLinks: Chronic Care in 2018–19.

The *HealthLinks: Chronic Care business rules* provide more detailed information about the funding model, the enrolled patient cohort and the implementation model. The rules and information about some of the interventions being implemented at participating health services are available at the HealthLinks – Chronic Care webpage <https://www2.health.vic.gov.au/primary-and-community-health/integrated-care/healthlinks>.

### 1.4.3.2 Department of Veterans' Affairs

In March 2017 the Secretary to the Department of Veterans' Affairs, delegates from the Military Rehabilitation and Compensation Commission and Repatriation Commission, and the Victorian Minister for Health, signed the Hospital Services Arrangement between the Commonwealth of Australia and the Repatriation Commission and the Military Rehabilitation and compensation Commission and the State of Victoria. The arrangement implements a uniform national purchasing arrangement for public hospital services provided to eligible veterans.

The arrangement saw the Department of Veterans' Affairs pay Victoria according to the Independent Hospital Pricing Authority's funding models, with modifications to reflect the contribution that the Department of Veterans' Affairs makes separately to medical practitioners. As a result of these new funding arrangements, the Department of Veterans' Affairs will pay the department the National Efficient Price.

Funding for admitted acute and subacute services will continue to be paid to actuals, while the funding for emergency departments, acute non-admitted services and the Health Independence Program will continue to be provided on a block basis, with the available revenue from Department of Veterans' Affairs allocated based on a health service's share of the total weighted activity.

Further information on eligibility and funding arrangements is available in Chapter 1, section 1.24.3.1 'Department of Veterans' Affairs patients'.

#### 1.4.3.3 Mental health

The department will fund acute admitted mental health care on an input basis in 2019–20. Health services will be funded based on their capacity to provide inpatient mental health care, with the number of bed days available. Acute adult, child, aged and specialist bed types will receive the same price regardless of the location of the health service.

To further support the transition to a single price model, a transition grant will continue to be provided to health services to maintain funding equivalence with 2019–20 allocations.

Further review of the funding model for acute mental health admitted care across all patient types will be considered in the future. As the Victorian Cost Data Collection will be used to further understand the costs of mental health care, health services should continue to contribute to mental health costing processes within the collection.

Admitted extended care and non-admitted acute mental healthcare (such as ambulatory, subacute and residential aged mental health services) will continue in 2019–20 via a mixture of input (per day or service hour) and block grants.

Mental health services will receive additional funding packages in 2019–20 to provide more community care for their most severe group of adult community-based mental health consumers.

The purpose of the Intensive Community Mental Health Packages is to provide more hours of treatment, focused on delivering evidence-based multidisciplinary therapeutic interventions for a cohort of adults with serious mental illness and high needs being treated in the community. The funding targets adult consumers whose diagnosis and wellbeing assessments indicate they are at risk of recurring acute episodes and associated hospital admissions without more intensive therapeutic intervention.

Further information on the 2019–20 prices is available in the Appendices, Appendix 1, section 1.1 'Price tables'.

#### 1.4.3.4 Specialist clinics

In 2017–18, the department introduced the Weighted Ambulatory Service Event (WASE) funding model for acute non-admitted specialist clinic activity that is not funded by another Victorian funding model (such as home renal, radiotherapy, home enteral nutrition). The WASE model is intended to encourage health services to improve their data reporting, drive technical efficiency, and deliver greater transparency and accountability for the funding received by services.

Activity is counted as service events and classified according to the national Tier 2 classification with cost weights calculated based on Victorian cost data. The funding unit is a WASE.

In 2019–20 the model will continue to include public and MBS-billed acute non-admitted specialist clinic activity and has different prices for both these types of activity. The model has been revised using cost data of 2017–18.

Health services have been allocated WASE activity targets that match their historical non-admitted specialist clinics funding. Targets are calculated based on a health service's public and MBS-billed activity split.

Further information on the 2019–20 prices is available in the Appendices, Appendix 1, section 1.1 'Price tables' and information on the technical aspects of the funding model are available in the Appendices, Appendix 1, Addendum 1.6: 'Weighted ambulatory service events – technical specifications'.

### 1.4.3.5 Pricing for quality

In 2014–15 Victoria implemented a pricing for quality scheme, providing an opportunity to link funding allocations to discrete performance measures that demonstrate a health service's success in reducing preventable harm and improving the quality of care.

In line with COAG commitments, commencing in July 2017, Victoria will progressively introduce funding policies to reflect non-payment for avoidable harm.

Victoria's 2019–20 approach to pricing for sentinel events involves a staged implementation of the national pricing model for sentinel events. If a sentinel event occurs, and the event is deemed to be avoidable, health services will not receive payment for the episode of care.

A national pricing and funding model for Hospital Acquired Conditions (HAC), developed by the Independent Hospital Pricing Authority, will continue in 2019–20. The national HAC model applies a risk-adjusted discount factor for each episode in which a HAC is present. The national model adopted by Victoria will apply the same discount factors to WIES to determine a WIES adjusted HAC value. In 2019–20, Victoria will adopt a shadow funding approach to the introduction of the HAC adjustment and not apply any discount to health service funding.

### 1.4.3.6 Subcutaneous immunoglobulin therapy

The National Blood Authority has made available immunoglobulin products since 1 September 2013, which can be delivered at home to treat:

- primary immunodeficiency with antibody deficiency
- specific antibody deficiency
- acquired hypogammaglobulinaemia secondary to haematological malignancy
- secondary hypogammaglobulinaemia (including iatrogenic immunodeficiency).

There are about 2,200 patients who are currently treated with intravenous immunoglobulin. Approximately 30 per cent of these patients could be treated with subcutaneous immunoglobulin therapy.

The department will provide hospitals with quarterly funding for each patient being treated with subcutaneous immunoglobulin at home in 2019–20. More information can be found on the Subcutaneous Immunoglobulin (SCIg) access program webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/blood-matters/scig-implementation-program>.

### 1.4.3.7 Dental pricing

The Victorian Auditor-General's report *Access to public dental services in Victoria* made a range of recommendations in relation to pricing, funding, performance management and other parameters for state government-funded services. The department is working with Dental Health Services Victoria to review current Dental Weighted Activity Unit (DWAU) pricing arrangements, with a view to developing options to standardise pricing across the state.

The development of standardised pricing will be addressed through a staged approach. The first stage was completed in 2017–18 when a new minimum floor price per DWAU was introduced for all public dental providers.

The department will continue to work with Dental Health Services Victoria in 2019–20 to pursue a common single price and other associated pricing arrangements for implementation in accordance with the Auditor-General's recommendations.

### 1.4.3.8 High cost, low volume cross-border patients

The department allocates funding according to the expected activity levels. The department usually estimates its expected revenue for a relevant financial year (Commonwealth, state, net cross boarder funding) and also sets aside funding for known commitments to be incurred during the financial year.

In general, funded organisations are cash-flowed during the financial year according to their funding allocations. Funded organisations are expected to manage their resident and non-resident demand based on the funding provided.

Where required, adjustments to this funding for over- and under-activity are made in the following financial year according to the policies set out in the prior year adjustment section of the guidelines. The prior year adjustment policy does not make adjustments for changes for annual variations in this cohort.

In accordance with Clause A91 of the National Health Reform Agreement, cross-border agreements are developed between jurisdictions that experience significant cross-border flows. The department has established agreements with all other states and territories (jurisdictions), based on a standard agreement. These agreements form the basis of the flow of funds between Victoria and other jurisdictions for residents treated from those respective states and territories. Annual reconciliations of cross-border flows occur to determine the liability of each jurisdiction. This revenue/liability is then factored into the available revenue available for redistribution as part of the modelled budget each year.

Under these agreements, all financial transactions are to be transacted by the relevant health departments and not through inter-agency transfers (for example, hospital to hospital or state health department to hospital).

Under the cross-border agreement, there is an exemption for high cost procedure. A high cost procedure is defined as a procedure that is not reasonably funded by the existing classification system and cost weights and are agreed to at a jurisdictional level prospectively on a case-by-case basis. For the avoidance of doubt, this definition excludes experimental procedures.

Admitted acute high cost procedures (for example, those funded by WIES) are defined by procedures that:

- are provided at limited sites nationally
- have low volume (< 200 separations nationally)
- cost significantly more (> $20,000) than the funding provided based on the relevant year's National Efficient Price Determination <https://www.ihpa.gov.au/what-we-do/national-efficient-price-determination>.

Prior to the procedure, hospitals may seek this exemption (in limited circumstances) from the department for those services classified as high cost procedures and that will be provided to patients who reside in another state or territory. Subject to meeting the definition of a high cost procedure and complying with the agreed criteria and process, hospitals may be paid a supplementary payment by the department through the prior year adjustment process to meet the difference between the department's funding allocation and the actual cost of the procedure paid by the resident's jurisdiction.

Hospitals should advise the department in advance (wherever possible) and care to non-resident patients should not be subject to or impacted by financial arrangements and should be based on standard clinical protocols.

Hospitals may not seek an exemption for Nationally Funded Centre (NFC) procedures as the funding for these procedures are already shared by jurisdictions and set annually by the Australian Health Ministers' Advisory Council.

# 1.5 Notification obligations

## 1.5.1 Issues of public concern

The *Health Services Act 1988* (HSA), *Ambulance Services Act 1986* (ASA) and *Mental Health Act 2014* (MHA) specify the functions of health service boards and chief executive officers. Included in these functions is the requirement for boards to ensure that the relevant portfolio Minister (Health, Mental Health or Ambulance Services) and the Secretary are advised about significant board decisions and are promptly informed about any issues of public concern or risks that affect or may affect the public health service (HSA ss. 65S(2)(i), 33(2)(i) and 115E(2)(l); ASA s. 18(1)(i); MHA s. 345). Chief executive officers must also inform the board, Secretary and relevant Minister, without delay, of any significant issues of public concern or significant risks affecting the health service (HSA ss. 40I(1)(h), 65XB(1)(h) and 115JC(1)(h); ASA s. 21(3)(h); MHA s. 340(3)(ch)).

## 1.5.2 Changes to range or scope of activities

Before health services undertake a significant change in the range or scope of services, the planning implications of such a move must be discussed with the department. All health services should contact their departmental performance lead. The department must provide explicit approval before a health service may significantly alter its services.

## 1.5.3 Exceptional events

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

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

# 1.6 Data and reporting changes

## 1.6.1 Revisions to the *Victorian Admitted Episode Dataset: Criteria for Reporting*

The Victorian Admitted Episodes Dataset: Criteria for Reporting document provides guidelines to enable health services to distinguish between admitted and non-admitted patient episodes for the purpose of data reporting. The document can be downloaded from the HDSS website <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems>.

Refer to the VAED policy, related factsheets and the procedure code lists <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vaed>.

## 1.6.2 Data collection changes

The following sections describe the key data collection changes. Refer to information about data collection changes <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/annual-changes>.

### 1.6.2.1 Victorian Admitted Episodes Dataset

The department will undertake a proof of concept project during 2019–20 to investigate the feasibility of collecting clinical data from health service clinical systems instead of from the Victorian Admitted Episodes Dataset (VAED). This project will focus on key data elements already in the VAED and may provide an alternative for health services that record VAED-related data outside of their patient administration systems.

There are no major changes to VAED for 2019–20.

### 1.6.2.2 Elective Surgery Information System

The following changes to the Elective Surgery Information System (ESIS) will apply from 1 July 2019:

- add an identifier for the surgeon referring the patient onto an elective surgery waiting list
- implement a new codeset to describe the elective procedure for which the patient has principally been placed on the waiting list.

### 1.6.2.3 Agency Information Management System

The following changes to the Agency Information Management System (AIMS) will apply from 1 July 2019:

- a new Clinical Indicators for Breathlessness collection for admitted and community palliative care
- a new data collection for Transition Care Program Key Performance Indicators
- expansion of the Public Sector Residential Aged Care Services data collection to include quality indicators.

### 1.6.2.4 Victorian Emergency Minimum Dataset

The following changes to the Victorian Emergency Minimum Dataset (VEMD) will apply from 1 July 2019:

- telehealth presentations will be included within the scope of VEMD
- mental health, alcohol and drug treatment hubs will be incorporated into the VEMD for non-admitted patients.

### 1.6.2.5 Victorian Ambulance Dataset

There are no major changes to the Victorian Ambulance Dataset (VADS) for 2019–20.

### 1.6.2.6 Victorian Integrated Non-Admitted Health dataset

The department will focus on improving the coverage of the Victorian Integrated Non-Admitted Health dataset (VINAH) in 2019–20, as well as investigating complementary systems to collect non-admitted patient activity. Additional programs and health services that are not currently in scope for VINAH reporting will be investigated and a plan for implementation will be developed.

The following key changes to the VINAH will apply from 1 July 2019:

- record the start and end time of all non-admitted patient contacts (optional)
- include activity for a new stream of non-admitted patients attending the Palliative Care Day Hospice program
- report the health condition for all specialist clinic episodes (optional).

### 1.6.2.7 Victorian Perinatal Data Collection

Health services where births occur (or where a midwife or medical practitioner attends a birth not in a health service) are required to report the information set out in the birth report specified by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) for inclusion in the Victorian Perinatal Data Collection (VPDC). Refer to Chapter 2, section 2.13.2.13 'Consultative councils reporting requirements'. Under the Public Health and Wellbeing Regulations 2009, VPDC data is to be submitted within 30 days of the birth, unless otherwise specified by the CCOPMM.

The VPDC is a population-based surveillance system to collect and analyse comprehensive information on and in relation to the health of mothers and babies to contribute to improvements in their health outcomes. It contains information on obstetric conditions, procedures and complications, neonatal morbidity and congenital anomalies relating to every birth in Victoria from 20 weeks' gestation. The definition of a birth for this purpose means a birth or stillbirth that is required to be registered under the *Births, Deaths and Marriages Registration Act 1996*.

The VDPC manual, including data definitions, business rules and submission guidelines, is available at Notifying to the Victorian Perinatal Data Collection – Better Safer Care website <https://bettersafercare.vic.gov.au/about-us/about-scv/councils/ccopmm/notifying-the-vpdc>.

In 2019–20 there will be a continuing data compliance focus to ensure the data is received in a timely manner and that data quality issues are identified as early as possible.

### 1.6.2.8 Public sector residential aged care services

Performance and quality improvement changes:

- Services should note that from 1 July 2019 a set of performance measures for PSRACS will be piloted, with a sector-wide rollout expected in 2020–21.
- From 1 July 2019 health services will be accredited against a new set of aged care standards and it is expected that services develop a transition plan to support this change.

The following key changes to the Agency Information Management System (AIMS) will apply from 1 July 2019:

- Public sector residential aged care data collections Forms S5_129 and S5_115: following on from changes implemented on 1 July 2018, further changes have been made to improve the quality of data and to augment the data collection to better inform policy and planning. Changes include additional demographic data fields (noting that this is no longer collected monthly) to include for example, the numbers of residents under 65 years of age and numbers of residents; services will also be able to record additional residential aged care activity that is over and above that funded by DHHS as well as record other care provided in the PSRACS. These changes come into effect 1 July 2019 and it is

envisaged that minimal staff training will be required and that software modifications will not be required with the proposed amendments.

#### 1.6.2.9 Aged Care Assessment Services

On 7 March 2016 Victorian Aged Care Assessment Services transitioned to operating in the national My Aged Care gateway. The former ACE database has been decommissioned. Since August 2016, all Aged Care Assessment Services data is being recorded in the My Aged Care system. The Commonwealth provides monthly performance reports to the department.

#### 1.6.2.10 Home and Community Care Program for Younger People: NDIS reporting

Organisations funded by the Home and Community Care Program for Younger People (HACC-PYP) should use the provider report available online to monitor the impact of the NDIS rollout in the three years to December 2019.

The department produces the provider report twice a month. Its spreadsheets contain information that is essential to HACC-PYP-funded providers during the phase-in period, charting the progress of clients through NDIS intake and assessment.

This is in addition to continuing to participate in the quarterly HACC minimum dataset.

# 1.7 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.

Read more about the casemix funding model <https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/activity-based-funding>.

In 2019–20 the unit of measure for acute admitted casemix-adjusted throughput will be known as WIES26.

## 1.7.1 Acute admitted services

In Victoria health services are funded to provide 24-hour acute admitted care. Some health services provide specialist admitted care services (for example, intensive care) or designated statewide services (for example, trauma or transplantation).

Health services are responsible for:

- ensuring the health service has the capability and capacity to deliver services described in its SOP with the ability to transfer patients to another health service if a patient requires services outside the scope of the health service's service delivery
- the medical, nursing and personal care, hotel services (for example, nutrition, bed, clean facilities), the required clinical support services (for example, allied health, pharmacists and medicines, blood management and blood products, pathology) and other support services (for example, infection prevention, language services, clinical trial support)
- the provision of prosthetics, devices, medicines and wound care consumables prescribed during the admission and, if required, on discharge from the health service
- the availability of suitably credentialed and privileged staff and the management of contracted or brokered staff or services
- ensuring equitable access to services, treating each patient based on their clinical need
- offering services in the person's home via telehealth, with the required cultural and linguistic support
- ensuring discharge planning and service coordination with other health service programs (for example, rehabilitation, the Health Independence Program) and community-based services in the form of a timely clinical handover that includes a complete and current medication list
- offering services such as patient pathways and electronic or telephone advice lines to support referring clinicians that may reduce demand for admitted services
- clinical governance
- ensuring that no charges are raised for any service during the admission and that charges raised on discharge are only those included in the *National Health Reform Agreement*
- meeting all requirements for claiming monies through private health insurance, Medicare, Department of Veterans' Affairs, Transport Accident Commission (TAC), WorkSafe and patients that are ineligible for Medicare

- ensuring there are fit-for-purpose facilities to:
  - support the treatment of inpatients by multidisciplinary teams
  - reduce the risk of errors, accidents and hospital-acquired conditions
  - ensure the safety of patients, staff, visitors, volunteers and students
  - ensure the privacy and dignity of patients, their carers and family
  - enable isolation or transfer of patients with infectious conditions or who are immunocompromised
  - support the care of terminally ill and dying patients
  - support home-delivered admitted care.

### 1.7.2 Admission policy

Please note the following:

- Admission policy applies to acute (admitted and non-admitted), subacute and specialist clinics patients' admissions.
- Only acute non-admitted services that are not funded by another Victorian funding model are eligible to be funded under the acute non-admitted specialist clinics weighted ambulatory service event (WASE) funding model.

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

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

Patients not meeting one of these criteria are non-admitted patients. No data for these encounters is 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 2019–20.)

## 1.7.3 Classification, counting and costing

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

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

### 1.7.3.1 Classifying patients

**Diagnosis-related groups**

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

- 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 9.0 (AR-DRG9.0) being the latest available version at the time of the WIES26 formulation. Victoria will use AR-DRG9.0 for funding purposes in 2019–20.

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.

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

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

Read more about the VAED <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems>.

### 1.7.3.3 Costing patients

It is expected that health services maintain and report acute (admitted and non-admitted), subacute, mental health, emergency and specialist clinic patient-level costing data which is used in the development of funding models.

Victorian public hospitals are required to report patient-level cost information about the services used to deliver care across all hospital patient settings. The department currently maintains annual cost data collections for all patients treated covering admitted, non-admitted and emergency services from all metropolitan, major rural and some small rural public hospitals. The data collections include:

- admitted including acute, subacute (geriatric evaluation and management (GEM)), palliative care (including phase of care), rehabilitation and mental health
- non-admitted contacts including subacute and mental health
- home-based service delivery
- emergency activity including all emergency department presentations and urgent care centre activities
- mental health community activity including subacute residential services (prevention and recovery care, community care units, aged persons residential) and consultation liaison services
- radiotherapy
- community health services
- specialty programs such as the Victorian Perinatal Autopsy Service and other diagnostic and therapeutic services.

Health services' cost method is to allocate actual expenditure to patients' actual interactions and events (including allocation of hospital overhead expenses) known as patient-level costing. This approach is more direct and sophisticated because it uses service volumes (for example, actual tests and minutes in theatre) and minimises assumptions, thereby achieving more accurate cost allocations at the individual patient level.

By contrast, cost modelling is a top-down allocation method where expenses are allocated based on averages and apportionments attributing the same costs to all patient episodes. This method of patient costing is not recommended because it achieves a less accurate cost allocation. However, hospitals cost-model to some extent when there is an absence of patient service volumes, but hospitals can differ widely in the extent to which they model.

In Victoria, actual expenditure (direct and indirect/overhead) is allocated, capital and depreciation costs are excluded (not allocated) and all allocated costs must reconcile with the general ledger. Costs are reported by service areas (cost centres as found in the chart of accounts) and by account types such as salary and wages (by professions), medical supplies or drugs etc. For ease of analysis these are mapped into generic cost buckets such as nursing, medical, theatre and pathology etc.

Health services must adhere to the specifications, business rules and costing guidance outlined in the documentation found within the data collections list of reports for the Victorian Cost Data Collection <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vcdc>. The VCDC document is guided by the *Australian Hospital Patient Costing Standards* (version 4.0 or the most recent version available).

To ensure the integrity and assurance of quality data and as part of good hospital management practice health services are expected to:

- maintain activity and costing systems
- review allocation methodologies
- reconcile financial and non-financial information to source systems
- identify and review fluctuations in cost results.

## 1.7.4 Basic WIES cost weights

### 1.7.4.1 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 weighted inlier equivalent separation (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 costlier the episode will be, and the more WIES that will be allocated (for instance, patients who stay five hours will generally use fewer resources and cost less than a patient who stays five days, even though both patients might be in the same DRG).

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

### 1.7.4.2 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 are clinically heterogeneous and contain high-cost cases, the inlier range is given by the ALOS multiplied and divided by 2/3 (L2/3H3/2 boundary policy).

For some DRGs, separate cost weights are developed for same-day and multi-day patients to ensure that multi-day cost weights are not diluted by high-volume, low-cost, same-day patients. Similarly, for other DRGs, separate cost weights are developed for cases with a LOS of one day to ensure that multi-day cost weights are not diluted by high-volume, low-cost, same-day and overnight patients.

If the patient stays longer than the inlier, the hospital will receive an additional payment for every day over the inlier range.

In most DRGs, the costs per day decrease with a longer LOS; in others the costs can remain the same.

To account for this, the daily payment level beyond the inlier range can be altered to suit the DRG patient profile. Payment rates are set at 80 per cent of the average daily inlier cost for medical patients and 70 per cent of the average inlier daily cost (excluding theatre and prosthesis costs) for surgical patients.

The total value of the WIES is based on the sum of cost weights for the inlier and outlier components of the stay (if appropriate).

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

For 2019–20 (WIES26), boundary points have been informed by trends in ALOS within the VAED over the period from 1 July 2012 to 31 March 2018.

#### 1.7.4.3 WIES co-payments

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

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

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

Details and technical specifications of all current WIES co-payments are in the Appendices, Appendix 1, Addendum 1.1: 'Calculating WIES26 for individual patients'. These co-payments include the following procedures and patients:

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

To improve outcomes for Aboriginal and Torres Strait patients, hospitals that receive WIES co-payments are required to complete the *Aboriginal health and wellbeing – improving care for Aboriginal patients* continuous quality improvement tool.

### 1.7.5 Development of WIES26 cost weights

#### 1.7.5.1 WIES26 cost weights

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

As mentioned, in 2019–20 the unit of measure for acute-admitted, casemix-adjusted throughput is known as WIES26. WIES26 cost weights have been developed using 2017–18 acute-admitted cost data as reported by Victorian public hospitals to the annual Victorian Cost Data Collection. WIES26 cost weights are scaled to equal the number of WIES25 reported by public hospitals for the latest 12 months of measured activity available at the time of WIES25 formulation (1 March 2018 to 28 February 2019).

The following changes from the WIES25 (2018–19) funding model have been introduced for WIES26:

- Inclusion of a Victorian modification of AR-DRG v 9.0 where 31 specific Eleventh Edition ICD-10-AM diagnosis codes, when not coded as the principal diagnosis, will be omitted for the purpose of grouping to VIC-DRG 9.0 (see the Appendices, Appendix 1, Addendum 1, section A1.1.2 'Victorian AR-DRG modifications'). This modification anticipates the 2020–21 implementation of AR-DRG v 10.0 where these same 31 diagnosis codes will also be excluded from the AR-DRG v 10.0 episode clinical complexity model.
- Pharmacy costs that are funded by the Commonwealth under the Highly Specialised Drugs program (i.e. Section 100 and Pharmaceutical Benefits Scheme) are excluded from the cost weight set for VIC-DRG90 R63Z Chemotherapy. This change results in a closer alignment of funding with cost by more accurately accounting for the Commonwealth's funding contribution for DRG R63Z Chemotherapy.
- Inclusion of three new public hospital intensive care units (ICU) for eligibility to receive ICU-related WIES co-payments triggered by hours of mechanical ventilation or non-invasive ventilation, namely: Angliss Hospital, Casey Hospital and Werribee Mercy Hospital (see the Appendices, Appendix 1, Addendum 1, section A1.1.3 'Co-payments, Table 1.33).

The DRG cost weights to be applied in 2019–20 are listed in the Appendices, Appendix 1, section 1.3.1 'WIES26 Victorian cost weights'. The table in this section shows the boundary points, co-payments and the ALOS for inliers used to determine high outlier per diem cost weights.

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

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

Detailed instructions about calculating the WIES for individual patients is at the Appendices, Appendix 1, Addendum 1.1: 'Calculating WIES26 for individual patients'.

The definitions of WIES26 variables are in the Appendices, Appendix 1, Addendum 1.2: 'Definition of WIES26 variables'.

### 1.7.5.2 WIES26 eligibility

The majority of patients in hospital will be allocated a WIES26 price weight. However, as in previous years, WIES cannot be calculated for incomplete or uncoded episodes. Further, WIES is not necessarily an appropriate measure of resource use for many non-acute patients.

WIES cost weights are sometimes allocated to some patient episodes that are ineligible for casemix funding. WIES from these episodes will need to be excluded when comparing health service activity against targets during 2019–20.

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-DRG9.0. WIES co-payments are made to cover the higher costs of care provided to some special types of patients.

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

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

- private hospital separations
- incomplete or uncoded episodes, or episodes coded to a problem VIC-DRG9.0 (zero weight) including Ungroupable (960Z), Unacceptable Principal Diagnosis (961Z) and Neonatal Diagnosis Not Consistent W Age/Weight (963Z)
- episodes with an account class on separation of Newborn – Unqualified, not birth episode (NT), Victorian WorkCover Authority (WC), Ineligible non-Australian residents – not exempted from fees (XX), Armed Services (AS), Common Law Recoveries (CL), Other compensable (OO) and Seamen (SS)
- episodes where the contract role is B (service provider hospital)
- episodes from hospitals not eligible for WIES funding
- episodes with DRG L42Z unless the episode is reported by St Vincent's Health, Ballarat Health Services, Bendigo Health, Barwon Health, Goulburn Valley Health, The Royal Children's Hospital, Mildura Base Hospital, Western Health or Mercy Health (Werribee campus only)
- episodes that have been coded as follows – this activity has been funded through specified grants:
  - include an electroconvulsive therapy code [9334100–9334199]
  - care type 4 (Acute)
  - separated from The Royal Melbourne Hospital (campus code 1334)
  - funding arrangement 2 (Hub and Spoke)
  - contract/spoke identifier in (0010, 0011 and 0012).

## 1.7.6 Pricing

The standard WIES26 price is established in terms of the general budget and considers other forms of funding. It is not the same as the average cost per WIES.

WIES26 prices can be found in the Appendices, section 1.1 'Price tables'.

The funding provided to any patient or all patients can be calculated by multiplying WIES26 by the price.

### 1.7.6.1 Peer group prices

The 2018–19 peer groups have been maintained for 2019–20. The two peer groups are:

- **metropolitan and regional** – this group is unchanged
- **subregional and local** – this group is unchanged.

The WIES peer groups for 2019–20 are outlined in the Appendices, section 1.2 'Peer groups for WIES purposes'. Note that these peer groups only relate to the price for acute hospital activity and are for recall and throughput policy purposes.

### 1.7.6.2 Normative pricing

In 2019–20 as a continuation of efficient pricing, the WIES26 cost weights for the following VIC-DRG9.0s are based on the median (rather than average) prosthesis costs:

- I03A Hip Replacement for Trauma, Major Complexity
- I03B Hip Replacement for Trauma, Minor Complexity
- I04A Knee Replacement, Major Complexity
- I04B Knee Replacement, Minor Complexity
- I33A Hip Replacement for Non-Trauma, Major Complexity
- I33B Hip Replacement for Non-Trauma, Minor Complexity.

## 1.7.7 Pricing for quality

In line with recommendations arising from the Independent Hospital Pricing Authority (IHPA) *Consultation paper on the pricing framework for Australian public hospital services 2017–18* (2016), the Australian Government determined that, from 1 July 2017, any admitted or non-admitted episode of hospital care associated with a sentinel event would not be funded in its entirety (also known as 'pricing for quality'). In response, Victoria introduced a new pricing mechanism for sentinel events in 2017–18, where episodes of care with an avoidable sentinel event, as defined by the nationally agreed sentinel event categories, are not funded. This model excludes 'category 11 (previously category 9) – Other catastrophic' because this sentinel event category is only used in Victoria and not subject to the national pricing for quality.

Health services are required to report all sentinel events (see list below) to the Sentinel Event Program, which is coordinated by Safer Care Victoria. All sentinel events in categories 1–10 are analysed to determine avoidability. If an event is found to be avoidable, a health service will not receive payment for the entire episode of care.

The IHPA has developed a national pricing and funding model for hospital-acquired conditions (HAC). This model applies a risk-adjusted discount factor to each HAC episode. In 2019–20 Victoria will continue to apply the IHPA model and the national discount factors to the WIES model. Victoria will apply a shadow funding approach in 2019–20 and will not adjust health services funding for HAC episodes.

### 1.7.7.1 Sentinel events list

- Surgery or other invasive procedure performed on the wrong *site* resulting in serious harm or death
- Surgery or other invasive procedure performed on the wrong *patient* resulting in serious harm or death
- Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death
- Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death
- Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death
- Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward
- Medication error resulting in serious harm or death
- Use of physical or mechanical restraint resulting in serious harm or death (new)
- Discharge or release of an infant or child to an unauthorised person
- Use of an incorrectly positioned oro- or nasogastric tube resulting in serious harm or death (new)
- Other catastrophic: Incident severity rating one (ISR1)

### 1.7.7.2 Hospital-acquired conditions

A HAC refers to a complication that is acquired in hospital for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.

The list of HACs was determined by a joint working group of the Australian Commission on Safety and Quality in Health Care and the IHPA.

The HACs are:

- pressure injury
- falls resulting in fracture or other intracranial injury
- healthcare-associated infection
- surgical complications requiring unplanned return to theatre
- unplanned intensive care unit admission
- respiratory complications
- venous thromboembolism

- renal failure
- gastrointestinal bleeding
- medication complications
- delirium
- persistent incontinence
- malnutrition
- cardiac complications
- third- and fourth-degree perineal laceration during delivery
- neonatal birth trauma.

More information on the HAC list, including diagnosis codes used to identify each HAC, is available at Hospital-acquired complications – Australian Commission on Safety and Quality in Health Care <https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications>.

The funding adjustment for HACs has been risk-adjusted to take account of the increased predisposition of some patients to experiencing a HAC during their hospital stay and adjusts the reduction in funding accordingly.

More information on the risk adjustment model for HACs, including the risk factors for each HAC group, is contained in the National Pricing Model Technical Specifications 2019–20 – Independent Hospital Pricing Authority website <https://www.ihpa.gov.au/publications/national-pricing-model-technical-specifications-2019-20>.

### 1.7.8 Transport supplement to health services

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

In 2019–20 the eligible threshold for health services that had transport costs (as a proportion of total funding) will be 1.45 per cent.

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

### 1.7.9 Interpreter supplement to health services

Departmental policy requires health services to provide professional interpreting and translating services for people who speak limited or no English when making significant health decisions.

The current funding approach of including all interpreter services funding in WIES is not aligned with the distribution of total costs associated with providing interpreter services.

The department will continue to provide a funding supplement for those services with significantly higher than average costs for the provision of interpreter services in 2019–20.

In 2019–20, health services with reported interpreter costs that exceed 0.2 per cent of their total funding will receive additional funding from the department (excluding Dental Health Services Victoria). Health services deemed to be eligible will receive funding equal to 75 per cent of the reported costs above the 0.2 per cent of total funding threshold.

### 1.7.10 Hospital in the Home

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

HITH patients must fulfil the criteria for admission as per the department's *Victorian Admitted Episode Dataset: criteria for reporting* 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 in-hospital WIES-funded acute care.

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

# 1.8 Acute specialist services

## 1.8.1 Emergency department funding

Patients attending the 40 designated and funded emergency departments are either admitted to hospital or discharged after they receive care in the emergency department. The funding approach for emergency department activity mirrors this patient flow through two streams of funding.

In 2019–20 the department will continue funding reforms from previous years and maintain the split-funding approach for the different patient pathways (admitted or non-admitted). Improving the specificity of the two funding streams will provide a clearer signal to health services about the efficient level of resources required for admitted and non-admitted emergency care.

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

**Urgent care centres**

Many small rural health services operate urgent care centres, which are equipped to provide first-line emergency care to patients.[2]

Local health services with urgent care centres receive the Group C Accident and Emergency Grant. Small rural health services with urgent care centres fund these services within their small rural health service flexible funding.

At a minimum, urgent care centres have the capacity to perform emergency resuscitation and stabilisation for adults and children and prepare and manage patients for transfer to a higher level of care as clinically appropriate. Depending on the model, patients treated by general practitioners may be billed by the general practitioner.

### 1.8.1.1 Non-Admitted Emergency Services Grant activity component

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

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

### 1.8.1.2 Total funding provided through the Non-Admitted Emergency Services Grant

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

The spilt between the availability and activity pools (80:20) within the 2019–20 NAESG is consistent with the split used in the 2018–19 model.

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

To provide budget stability for health services, a specified grant (positive or negative) has been retained but adjusted to partly reflect the changes observed in the NAESG between years. This approach will be continued in 2019–20

[2] Urgent care centres also provide minor injury/illness services after hours when general practitioner services are not available.

## 1.8.2 Hepatitis C

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

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

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

## 1.8.3 Renal services

### 1.8.3.1 Facility dialysis

The funding model for routine haemodialysis in designated public health services providing same-day haemodialysis is through the admitted WIES payment paid to all dialysis providers, and a non-admitted WASE component.

Currently all health services providing satellite dialysis are required to pay their hubs a set rate for each per L61Z dialysis separation based on expected activity levels.

Renal activity and WIES are incorporated within the total agency public and private WIES activity targets. As such, they are subject to the standard health service recall policy.

The WIES recall policy does not apply to small rural health services, which continue to be funded to actual renal activity in 2019–20. Their health service targets have been adjusted based on the average actual activity over the past three years. Recall adjustments for small rural health services will be made at the end of the financial year.

### 1.8.3.2 Home dialysis funding

Home dialysis is funded as an annual grant of $57,499 per patient in 2019–20 and includes payments to be administered by the hub services for home peritoneal dialysis and home haemodialysis.

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

## 1.8.4 Radiotherapy

Public radiotherapy services are provided at 12 hospitals in Victoria across metropolitan and regional campuses.

### 1.8.4.1 Non-admitted radiotherapy funding model

Radiotherapy is predominantly (~90 per cent) provided on an outpatient basis and funded under a specific complexity-based funding model. Under this model, the various components of a course of radiotherapy are weighted and aggregated for each course of care. Remaining activity (~10 per cent) is admitted and WIES-funded.

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

Find radiotherapy locations <https://www2.health.vic.gov.au/about/health-strategies/cancer-care/radiotherapy/radiotherapy-locations>.

In 2019–20 funding for non-admitted radiotherapy services will continue to comprise:

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

The WAU price can be found in the Appendices, section 1.1 'Price tables'.

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

The Victorian Radiotherapy Minimum Dataset is the key source of radiotherapy data for funding and service planning. Consultations will continue to be collected via the Agency Information Management System (AIMS) S8 and S10 in 2019–20. In addition, it is expected that health services maintain and report radiotherapy patient level costing data via the Victorian Cost Data Collection.

### 1.8.4.2 Contracted services

The department funds contract arrangements with private sector radiotherapy operators to provide services at South West Healthcare Warrnambool and at Albury Wodonga Health. Under these arrangements all patients are treated at no cost to them, with the private operators actively participating in public multidisciplinary cancer meetings and providing specialist outreach services across their regions.

### 1.8.4.3 Shared care

The department provides funding to eligible metropolitan public health services that have entered into shared care contracts with local private radiotherapy operators. Under these arrangements, cancer patients receiving care as public patients and can access local radiotherapy in coordination with their public hospital care at no cost to them. Health services that currently receive funding for radiotherapy shared care are Western Health (Footscray Hospital), Northern Health, Peninsula Health (Frankston Hospital) and Monash Health (Casey Hospital).

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

Current year WAU targets and health service information are available on the Radiotherapy webpage <https://www2.health.vic.gov.au/about/health-strategies/cancer-care/radio-therapy>.

### 1.8.4.4 Quality

**Statewide Knowledge Based Learning Project**

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

The project will continue to develop models across new tumour streams in 2019–20.

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

Victorian public radiotherapy providers assess their services against the Tripartite Radiation Oncology National Practice Standards using the relevant Self Audit Tool. The tool is used as part of their internal quality management protocols. The results of these assessments are integrated into the annual performance discussions with the department.

**Radiotherapy providers forums**

The department convenes a public radiotherapy providers forum biannually to discuss system improvement and coordination, performance, outcomes and service planning with the sector. A focus in 2019–20 will be on service planning, mortality and morbidity analysis, pathways of care and variations in practice and utilisation.

### 1.8.5 Perinatal autopsy service

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

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

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

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

### 1.8.6 Organ and tissue donation

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

Read more about organ and tissue donation <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/organ-tissue-donation>.

### 1.8.7 Blood products supply funding

Funding for the Victorian blood and blood products supply will continue as per the *National Blood Agreement* (2003) using the Commonwealth–state government 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 2019–20. This supply plan has been negotiated between the government, the National Blood Authority and the Blood Service. Victoria's contribution in 2019–20 will be over $110 million.

Access to blood and blood products will be guided by the *Blood and blood products charter*, which continues to be implemented with health providers nationally in 2019–20. The National Stewardship Expectations for the Supply of Blood and Blood Products is available from the National Blood Authority website <https://www.blood.gov.au>.

Intravenous immunoglobulin is made available through the supply plan to health services for uses that have been agreed according to the *Criteria for the clinical use of 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 about intravenous immunoglobulin is available at Version 3 Criteria – National Blood Authority website <https://www.blood.gov.au/igcriteria-version3>.

Subcutaneous immunoglobulin is available to health services through the supply plan for agreed uses. The department is funding hospitals for patients being treated at home with self-administered subcutaneous immunoglobulin. More information about access is available from the department's website <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/blood-matters/scig-implementation-program>.

Normal immunoglobulin is subject to national governance arrangements. More information about normal immunoglobulin is available at Access to Normal Human Immunoglobulin (NHIg) – National Blood Authority website <https://www.blood.gov.au/NHIg>.

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

Read more about blood and blood products <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/national-blood-authority>.

### 1.8.8 Genetics outpatient program

Public genetic outpatient services in Victoria provide a range of clinical consultations and laboratory testing. Services are provided in outpatient settings, with hospital ward consultations provided as needed. This program does not fund genetic or genomic tests for admitted patients. As genetics and genomics become more integrated with routine health care in both the acute and outpatient settings, funding and policy models will be reviewed for both inpatient (WIES) and outpatient settings (Tier 2 class 20.08).

This program funds access to public genetic services, with referral from a general practitioner or medical specialist, but self-referral may occur.

Public clinical genetic services are located at three metropolitan hubs:

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

These hubs also provide periodic clinical outreach clinics to other metropolitan, regional and rural centres.

Accredited laboratories provide genetic and genomic testing. Publicly funded testing can only be requested by publicly funded clinical genetic services. If a genetic or genomic test is not available in Victoria, it can be requested from an interstate or overseas-accredited laboratory.

In 2017–18 the Victorian Government allocated an additional $8.3 million over four years for genomic sequencing for children and adults with rare diseases and undiagnosed conditions. This budget commitment facilitates access to clinical diagnosis, therefore avoiding the costly and lengthy diagnostic odyssey that these patients currently undergo. This funding supports access to genomic sequencing currently not funded under Medicare. The clinical care is provided through the metropolitan hubs, including regional and rural Victoria through outreach clinics. Laboratory testing will be provided by accredited laboratories.

As new genetic and genomic tests are added to Medicare, it is expected that publicly funded clinical genetic services, where appropriate, will redirect savings to address growing demand.

Participating services must use AIMS to upload and report genetic outpatients clinic activity and report the costs using the Victorian Cost Data Collection.

Read more about genetic services in Victoria <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/genetic-services>.

### 1.8.9 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.

### 1.8.9.1 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.

Read more about the pharmaceutical reforms <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/pharmaceuticals/public-hospital-pbs>.

### 1.8.9.2 Highly Specialised Drugs Program

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

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

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

The prescribing doctor must be affiliated with the specialised hospital unit. Health services are reimbursed for the medicine supplied, less a patient co-payment, via claims submitted to Medicare Australia.

Read more about the Highly Specialised Drugs Program <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/pharmaceuticals/highly-specialised-drug-program>.

### 1.8.9.3 Direct-acting antiviral hepatitis C treatments

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

Read more about direct-acting antiviral hepatitis C treatments <https://www.pbs.gov.au/info/publication/factsheets/hep-c/hepc-factsheet-hospital-prescribers-dispensers>.

## 1.8.10 Total parenteral nutrition

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

Service targets were introduced in 2016–17 based on the latest 12 months of activity. These service targets have been updated based on the latest 12 months of activity. A recall/throughput adjustment will be applied at the full rate at the end of 2019–20 for health services whose activity is below or over target.

### 1.8.11 Home enteral nutrition

Service targets were introduced in 2016–17 based on the latest 12 months of activity. These service targets have been updated based on the latest 12 months of activity. A recall/throughput adjustment will be applied at the full rate at the end of 2019–20 for health services whose activity is below or over target.

# 1.9 Subacute inpatient services (subacute WIES)

## 1.9.1 Classification, counting and costing

Subacute admitted rehabilitation and GEM activity moved to an episodic funding model in 2016–17. Subacute admitted palliative care moved to an episodic funding model in 2017–18.

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

All metropolitan, regional and sub-regional health services are delineated to provide rehabilitation and GEM services through the *Subacute capability framework*. Local health services delineated as level 2 (and Swan Hill) will provide and report maintenance care.

Read the Subacute capability framework <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/subacute-planning>. Targets for these health services can be found in the Appendices, Appendix 2, 'Table 2.15: Admitted subacute and non-acute targets (subacute WIES4) 2019–20'.

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

### 1.9.1.1 Care type

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

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

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

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

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

Details of the national care type definitions are outlined below. The National Minimum Dataset definitions can be found at the metadata online registry (METeOR) <https://meteor.aihw.gov.au>.

**Rehabilitation**

Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating in rehabilitation.

Rehabilitation care is always:

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

**Geriatric evaluation and management**

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 that improves the quality of life for patients and their families facing the problems associated with life-threatening or life-limiting illness through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems/symptoms – physical, psychosocial and spiritual (World Health Organization).

Palliative care:

- is always managed or informed by a clinician with specialist qualifications in palliative care
- is always evidenced by an individualised multidisciplinary assessment and management plan that is documented in the patient's medical record; it covers the physical, psychological, emotional, social and spiritual needs of the patient and their negotiated goals
- offers a support system to help patients live as actively as possible until death
- is applicable early in the course of a patient's illness, in conjunction with other therapies that are intended to prolong life such as chemotherapy or radiation therapy
- should be responsive to the needs, preferences and values of the person, their family and carers.

The *National Palliative Care Standards* (5th edition) 2018 define the patient, their carer and family as the one unit of care. The needs of carers and families should be addressed in each palliative care patient's management plan. The plan must outline the negotiated goals of care evidenced by a collaborative approach with the patient and/or their family or carer.

**Maintenance care**

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

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

### 1.9.1.2 Care type changing

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

Only one care type can be assigned at a time. In cases where a patient is receiving multiple types of care, the care type that best describes the primary clinical purpose or treatment goal should be assigned. It is essential that any change in care type is supported by documentation reflecting the change in

purpose and goal of care. Care type changes must be reported in accordance with the VAED business rules.

The care type is assigned by the clinician responsible for managing the care based on clinical judgements as to the primary clinical purpose of the care provided and, for subacute care types, the specialised expertise of the clinician who will be responsible for managing the care.

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

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

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

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

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

### 1.9.1.3 Counting patients

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

Funding for subacute admitted services is based on episodes for eligible care types (see Appendices, Appendix 1, Addendum 1.4: 'Calculating subacute WIES for individual patients'). The following episodes are not eligible for subacute WIES funding:

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

### 1.9.1.4 Costing patients

It is expected that health services maintain and report subacute patient level costing data, to the Victorian Cost Data Collection which is used in the development of funding models.

**Counting and reporting geriatric evaluation and management activity**

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

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

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

### 1.9.2 Pricing

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

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

See the Appendices, Appendix 1, section 1.1 'Price tables'.

# 1.10 Acute specialist clinics (weighted ambulatory service events)

## 1.10.1 Classification, counting and costing

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

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

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

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

Classification rules exist to guide the decision making regarding which Tier 2 class a clinic should be classified to. The IHPA has developed two reference documents to assist with consistently allocating non-admitted services to a Tier 2 class:

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

Read more about the Tier 2 classification system <https://www.ihpa.gov.au/what-we-do/tier-2-non-admitted-care-services-classification>.

Further information can be found in the Appendices, Appendix 1, Addendum 1.6: 'Weighted ambulatory service events – technical specifications'.

### 1.10.1.1 Counting patients

The WASE model is based on the 'service event' unit of count.

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

A non-admitted service event must be counted once only, regardless of the number of healthcare providers present:

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

Care provided to two or more patients by the same service provider(s) at the same time can also be referred to as a group session when the patients within the group receive the same service. One service

event is recorded for each patient who attends a group session regardless of the number of healthcare providers present, where the definition of a non-admitted patient service event is met.

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

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

Read the department's Agency Information Management System (AIMS) manual <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/aims-manual-2016-17>.

#### 1.10.1.2 Costing patients

The WASE model also uses the cost data to determine the funding therefore all health services are expected to report patient level cost data to the Victorian Cost Data Collection.

### 1.10.2 Pricing

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

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

See the Appendices, Appendix 1, section 1.1 'Price tables'.

### 1.10.3 Exclusions

The majority of non-admitted acute patient service events reported to the AIMS S10 data collection will be allocated a Weighted Ambulatory Service Event cost weight. However, a cost weight will not be allocated for Tier 2 clinics that are funded by another Victorian funding model. For more information on Tier 2 clinics excluded from the WASE funding model, refer to Appendices, Appendix 1, Addendum 1.6: 'Weighted ambulatory service events – technical specifications'.

# 1.11 Subacute non-admitted services

## 1.11.1 Health Independence Program and community palliative care

In 2019–20 non-admitted subacute programs and services under HIP and community palliative care will remain block-funded. These programs will receive an associated activity target (health services will receive an aggregate HIP activity target).

Services that do not meet the overall HIP target are subject to recall. Community palliative care targets for 2019–20 are not subject to recall. Funding recall will be applied to subacute non-admitted services. When determining whether recall applies, the department will consider 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.

Non-admitted targets by health service and program type can be found in the Appendices, Appendix 2, section 2.2.7 'Health Independence Program contact targets 2019–20'.

HIP funding considers all elements of care delivery. The unit price for direct non-admitted considers the time spent completing both indirect and administrative tasks.

Activity with patients in admitted (including admitted services that are provided in the home or other settings) and emergency department settings is expected but not recorded as a direct contact towards target. The foundation principle is that the direct contact count assumes that indirect, inpatient and emergency department activity may be required to deliver HIP direct care to clients.

**Funding for throughput above target**

There is no funding for any over-activity for non-acute care (Transition Care Program or nursing home activity) or non-admitted HIP.

**Department of Veterans' Affairs patients**

Victoria will fund eligible veterans in alignment with the revised Commonwealth revenue in 2019–20.

Funding for admitted acute and subacute services will continue to be paid to actual throughput based on the Victorian WIES and subacute WIES funding models.

Funding for emergency departments (non-admitted presentations), acute non-admitted and HIP will be paid as a block grant and based on the health service's activity share of total weighted activity.

**Community palliative care**

Designated community palliative care services are integral to achieving the goals of *Victoria's end of life and palliative care framework* (July 2016). Designated community palliative care services must provide care in line with the Palliative care webpage <https://www2.health.vic.gov.au/palliative-care>.

A designated community palliative care service is assigned to each Victorian local government area. Each service has a prescribed catchment area. It is expected designated services will accept referrals and provide care to clients in residential aged care facilities and disability group homes as these facilities are the client's home.

All community palliative care services have access to flexible funds to care for clients at home. These funds are incorporated in each service's annual non-admitted (community) palliative care funding allocation.

#### 1.11.1.1 Counting unit

In 2019–20 the counting unit for HIP and community palliative care activity will continue to be a 'contact', which is reported in the VINAH dataset. The definition of a HIP and community palliative care contact is defined in the VINAH business rules.

**Health Independence Program**

The HIP counting unit will be 'direct non-admitted contacts'. Contacts where all of the following VINAH characteristics are met will count as contacts:

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

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

Work will continue to review the HIP price and service stream weights to better reflect stream costs over 2019–20. Further work to improve the HIP classification data, including potential VINAH refinements for 2019–20, will also continue.

**Community palliative care**

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

#### 1.11.1.2 Reporting of activity

The VINAH dataset is the data collection on which recall will be based.

In 2019–20 the activity level of each community palliative care provider will not be subject to funding recall or additional payments.

#### 1.11.1.3 Reporting of costs

It is expected that health services maintain and report subacute patient level costing data to the Victorian Cost Data Collection which is used in the development of funding models.

#### 1.11.1.4 HIP WASE3 Shadow funding model

HIP provides non-admitted care to subacute patients. Broadly, the setting and incentives of the program are similar to specialist clinics activity. The key difference between the two programs is that HIP patients can receive home-based, centre-based and community-based care because they require regular services across a range of disciplines over an extended period.

HIP currently includes the following program streams:

- post-acute care (PAC) services
- subacute ambulatory care services (SACS), including centre-based, home-based and specialist clinics

- Hospital Admission Risk Program (HARP) services
- residential in-reach (RIR) services.

In 2019–20 non-admitted subacute programs and services under the HIP are block-funded. These programs will receive an associated activity target (health services receive an aggregate HIP activity target, with the counting unit being 'direct non-admitted contacts'). Services that do not meet the overall HIP target are subject to recall.

The department will continue to shadow HIP through the WASE3 funding model by using HIP-specific cost weight segments and provide shadow reports to health services during 2019–20.

This will enable the sector to become familiar with the new funding model, including a different counting unit for these services (service events versus contacts) and a different pricing model, and allows the department to assess whether the proposed funding model aligns with program objectives or if any unforeseen consequences are created.

HIP activity is currently reported at patient level through the VINAH dataset and at an aggregate service event level through the AIMS S11 form.

Reported VINAH activity will be the basis for the service event count under the shadow WASE3 model. This is consistent with the current measurement of HIP activity, being VINAH contacts.

For further details on the HIP shadow funding model, refer to the Weighted Ambulatory Service Event Technical Specifications.

## 1.11.2 Victorian Artificial Limb Program

Funding for the Victorian Artificial Limb Program will continue to be provided as a block grant to health services as a non-admitted subacute service. Victorian Artificial Limb Program services are required to report service events as a non-admitted subacute service through the AIMS S11 form. Services expected to provide artificial limbs under the Victorian Artificial Limb Program in 2019–20 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 the maintenance of effort, the pre-existing annual activity statement regarding limbs and repairs, including expenditure, will also be required for 2019–20.

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

Recall will not apply to Victorian Artificial Limb Program activity in 2019–20.

A review of the program outcomes and funding methodology will commence in 2019–20.

### 1.11.2.1 Costing patients

It is expected that health services maintain and report Victorian Artificial Limb Program patient-level costing data to the Victorian Cost Data Collection.

## 1.11.3 Victorian Respiratory Support Service

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

Recall will not apply to Victorian Respiratory Support Service activity in 2019–20.

#### 1.11.3.1 Costing patients

It is expected that health services maintain and report Victorian Respiratory Support Service patient-level costing data to the Victorian Cost Data Collection.

### 1.11.4 Palliative care consultancy services

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

Consultancy services work across all healthcare settings. They provide specialist advice and support to clinical services within hospitals and in the community, including to community palliative care services and residential facilities. They address complex issues that otherwise would necessitate admission to hospital. They also provide education and training about palliative care to other clinicians and provide palliative care input for cancer streams and at chronic disease management meetings.

#### 1.11.4.1 Hospital-based palliative care consultancy

Funding for hospital-based palliative care consultancy is part of the price paid for acute inpatient activity. In 2019–20, 11 metropolitan health services will receive a specified grant to support their palliative care consultancy teams to respond to immediate service demand and to develop systems that support an outreach model. This model may include expediting early discharge and supporting clients in the short term with some acute supports until such time as community services can take over the ongoing care component.

It is anticipated this funding will be allocated as a specified grant over the next four years with plans to incorporate the funds into the base funding allocation in year five.

#### 1.11.4.2 Regional palliative care consultancy

Regional consultancies provide regular primary and secondary consultation to generalist health (including general practitioners, acute and subacute services) and community services (including aged care and disability services) on a region-wide basis. All generalist health and community services are expected to be able to care for people who are at the end of life, and the consultancy teams provide the specialist expertise and skill to support these services to provide good end-of-life care.

Funding for regional palliative care consultancy teams is provided as a block grant in 2019–20. In the majority or regions, this funding includes aged and disability link nurses. This funding is recurrent.

#### 1.11.4.3 Statewide palliative care consultancy

Funding for statewide palliative care consultancy teams is also provided as a block grant in 2019–20. Statewide consultancy services include the Victorian Paediatric Palliative Care Program, Very Special Kids, Motor Neurone Disease Association (Vic) and the Australian Centre for Grief and Bereavement.

#### 1.11.4.4 Costing patients

It is expected that health services maintain and report Palliative care consultancy services patient-level costing data to the Victorian Cost Data Collection.

### 1.11.5 Day hospice

Acute health services funded to provide day hospice receive a non-admitted funding allocation for this activity. Recall does not apply to day hospice services in 2019–20.

# 1.12 National programs

## 1.12.1 Nationally Funded Centres Program

The objective of the Nationally Funded Centres Program is to ensure there is optimal access for all Australians to high-cost but low-demand technologies and procedures. While the program operates nationally, funding for this program is provided by state and territory governments. Health services that provide Nationally Funded Centre services will be funded based on estimated annual activity and the cost per procedure as determined by the Nationally Funded Centres Program and the Australian Health Ministers' Advisory Council. This figure will then be adjusted after the financial year to reflect actual activity. The health services that host Nationally Funded Centre services in Victoria are Alfred Health, The Royal Children's Hospital, Monash Health and St Vincent's Hospital Melbourne.

## 1.12.2 Transition Care Program

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

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

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

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

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

The state-funded component of the Transition Care Program is subject to recall for under performance as outlined in the recall policy detailed in these guidelines.

The Commonwealth Government continues to implement its aged care reforms. All Transition Care Program referrals are received via the My Aged Care provider portal. It is imperative that program staff ensure that clients have current approvals to avoid loss of the Commonwealth subsidy component for episodes of care. Approvals can be verified with ACAS or online with Medicare.

# 1.13 Ambulance Victoria

The Victorian Government funds clinically necessary transport for concession patients, primarily pensioners and Health Care Card holders. The government provides this funding to Ambulance Victoria, which is responsible for delivering these transports. Ambulance Victoria's Membership Subscription Scheme insures patients against Ambulance Victoria ambulance transport costs. The membership subscription scheme fees will be indexed and are due to rise by 2.5 per cent in 2019–20. A single 12-month membership is now $48.35, and a family 12-month membership is $96.70.

Ambulance Victoria also receives fees from third parties that are responsible for transporting patients using Ambulance Victoria services including:

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

## 1.13.1 Fee structure

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

Fees for ambulance services are included in the Appendices, Appendix 1, section 1.1 'Price tables' and can be found on the Ambulance fees webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/ambulance-and-nept/ambulance-fees>.

A number of additional services provided through Ambulance Victoria will be funded directly or are included as loading in the above costs. For example, adult retrieval services.

In addition to the funding provided directly to Ambulance Victoria, the government also provides funding to Victoria's health services for the inter-hospital transfer of patients (for example, the transfer of patients between health services or between the different campuses of a health service). Health services have discretion as to which patient transport provider they choose to engage to transfer non-concessional patients – either Ambulance Victoria or from a range of private non-emergency patient transport providers that are licensed by the department. Timely payment for ambulance transports provided through Ambulance Victoria is expected under normal commercial terms.

# 1.14 Mental health acute admitted

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

In 2019–20, funding for admitted mental health activity will be distributed to health services based on the bed capacity that is available at each health service, with the number of bed days available. Adult, child, aged and specialist bed types will receive the same price regardless of the location of the health service.

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

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

In 2019–20, acute (child and adolescent, adult, aged and specialist care) provided by health services that deliver admitted inpatient mental health care will be reimbursed based on a single unit price, irrespective of the bed setting or patient characteristics.

The health service target will be based on the total number of acute bed days. Statewide targets associated with acute admitted care are set out in *Victorian State Budget Paper No 3*.

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

The unit price is not intended to reimburse health services for the total cost of providing admitted care because there are a number of supplementary funding grants. The transition grant and other mental health specified grants contribute to meeting the costs of mental health admitted care.

## 1.14.2 Transition funding

As funding for admitted mental health care progresses towards a single price, and to ensure budget stability for health services, a transition grant (block funding) has been applied in 2019–20. This transition grant is under review.

## 1.14.3 Costing patients

It is expected that health services maintain and report mental health acute admitted patient-level costing data to the Victorian Cost Data Collection.

# 1.15 Mental health non-admitted

In Victoria, 18 health services, including Mildura Base Hospital and Forensicare, are funded on a service hours basis to provide mental health clinical non-admitted services. Victoria's non-admitted mental health care encompasses clinical (ambulatory) community care and non-admitted bed-based treatment services (prevention and recovery care services, community care units and aged care residential beds). Statewide targets associated with mental health non-admitted care are set out in the *Victorian State Budget Paper No 3*.

**Clinical community care**

Clinical community (ambulatory) care consists of a range of community-based clinical services, including bed substitution programs provided to people with a mental illness.

**Intensive community mental health packages**

Mental health services will receive additional funding packages in 2019–20 to provide more community care for their most severe group of adult community-based mental health consumers.

The purpose of the intensive community mental health packages is to provide more hours of treatment, focused on the delivery of evidence-based multidisciplinary therapeutic interventions for a cohort of adults with serious mental illness and high needs being treated in the community. The funding targets adult consumers whose diagnosis and wellbeing assessments indicate they are at risk of recurring acute episodes and associated hospital admissions without more intensive therapeutic intervention.

This targeting reflects development work on an activity-based funding model appropriate to mental health that can allocate resources for adult community mental health services on the basis of the severity and complexity of consumers' needs, and the associated volume and intensity of service responses. The funding model will be linked to developments in performance monitoring and clinical guidelines outlining expected levels and types of service responses for consumers of varying levels of need for treatment and care.

## 1.15.1 Mental health outputs

Targets for the number of service hours to be provided are set per health service. They are calculated on the hours of service provided per clinician and adjusted for historical and projected service levels. The funding rate per service hour has been used in setting ambulatory targets. This rate is provided in the Appendices, Appendix 1, 'Table 1.6: Mental health – funded units applicable to clinical bed-based services 2019–20 – admitted care'. A description of all mental health outputs is at the Appendices, Appendix 1, section 1.4 'Output and activity tables'.

Targets for 2019–20 are provided in the Appendices, Appendix 2, section2.2.13 'Mental health ambulatory targets 2019–20'.

## 1.15.2 Mental health community support services

The mental health community support services (MHCSS) program is an integral part of the Victorian Government's specialist mental health service system.

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

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

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

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

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

Funding commitment to in-scope MHCSS programs will fully transition to the National Disability Insurance Scheme (NDIS) by mid-2019 as clients of these services become NDIS participants. In-scope programs include individualised client support packages, adult residential rehabilitation and select supported accommodation services.

**Early Intervention Psychosocial Support Response**

The *Early Intervention Psychosocial Support Response* is a psychosocial support model targeted to adult clients of the clinical mental health service system living with a severe mental illness and associated psychiatric disability who are:

(a) not eligible for the NDIS because they do not have significant, permanent functional impairment/s associated with their mental health condition, or

(b) are eligible for the NDIS and are waiting for an access decision and their NDIS plan to begin.

The service model will provide short to medium term, specialist psychosocial support to help eligible clients to:

- build their capacity to better manage their mental illness
- develop practical life skills for independent living and social connectedness
- achieve healthy, functional lives, and
- if eligible, transition to the NDIS.

## 1.15.3 Performance targets

Funding for MHCSS activities is output-based. Statewide targets are set out in the *Victorian State Budget Paper No 3*. Targets for MHCSS activities are listed in the *Funding and Service Agreement* and these represent the minimum deliverables expected for the funding provided. See Chapter 2, section 2.3.8 'Mental health services' for more information.

Targets for individualised client support packages, adult residential rehabilitation and supported accommodation services will be reduced as these activity types progressively transition to the NDIS by mid-2019.

## 1.15.4 Costing patients

It is expected that health services maintain and report mental health non-admitted patient-level costing data to the Victorian Cost Data Collection.

## 1.15.5 National Disability Insurance Scheme

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

The Victorian Government has been working closely with the National Disability Insurance Agency to support the phased implementation of the NDIS, which has been rolling out across Victoria since 1 July 2016.

Victoria and the Commonwealth have agreed that people will not be disadvantaged by the rollout of the NDIS. Victoria will continue to fund supports for existing state clients until they become NDIS

participants. Victoria will also continue to provide MHCSS to older Victorians and others who are not eligible for the NDIS.

From 1 July 2019, Victoria will contribute $2.5 billion per annum to the NDIS, including funding for MHCSS. Victoria's contribution to the NDIS includes funding withdrawn from service providers as clients transition to the scheme.

Funding committed to the following MHCSS activity types is in scope for transition to the NDIS: individualised client support packages, adult residential rehabilitation services, and selected supported accommodation services.

Victoria has been responsible for operating quality and safeguards for in-scope existing and new NDIS providers during the transition period. These arrangements will be replaced by the new *National quality and safeguards framework* for the NDIS from 1 July 2019. For more information, visit NDIS Victoria – Quality and safeguards for Victorian approved providers <https://w.www.vic.gov.au/ndis/service-providers/quality-and-safeguards-for-victorian-approved-providers.html>.

# 1.16 Alcohol and drug services

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

- Residential services and the majority of adult community-based services are funded via drug treatment activity units.
- Aboriginal and youth-specific services and some out-of-scope community-based services are funded on the basis of episodes of care.
- Other drug treatment activities such as research, drug prevention and control, local initiatives and pharmacotherapy programs continue to be block or grant-funded.

Funding provided to service providers is indexed in line with the government's annual determination for community service organisations.

# 1.17 Ageing, aged and home care services

Ageing, aged and home care unit prices are provided at the Appendices, Appendix 1, section 1.1 'Price tables'.

## 1.17.1 Aged care assessment services

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

## 1.17.2 Regional assessment services

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

## 1.17.3 Home and Community Care Program for Younger People

Targeted to people aged under 65 (and Aboriginal people aged under 50) who need assistance with daily activities due to physical and/or psychosocial functional impairment related to disability (for which they are not eligible for the NDIS), chronic illness and short-term health needs and their carers. The Home and Community Care Program for Younger People (HACC-PYP) is funded by the Victorian Government to provide a range of services in the home or in the community. The goal of the program is to allow participants to continue living in their homes and their communities.

About 380 organisations, including local councils and health services, will continue to receive funding to support younger people by providing a range of services including domestic assistance, personal care, nursing, allied health and social support. Funding for most recurrent services is based on a published set of unit prices per hour to determine the output targets for each service provider. Outputs are reported and monitored via the HACC minimum dataset.

Read the fees policy for HACC-PYP services <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/hacc-schedule-of-fees>.

Recurrent funds may be recalled from service providers. See Chapter 1, section 1.23.1 'Victorian funding recall policy'.

### 1.17.3.1 Home and Community Care and the NDIS

The Victorian and Commonwealth governments have committed to implement the NDIS from July 2016.

A proportion of HACC-PYP clients aged under 65 will transfer to the NDIS as it rolls out in Victoria. About 16,000 HACC-PYP clients will get into the NDIS.

## 1.17.4 The Victorian Aids and Equipment Program

The Victorian Aids and Equipment Program (VA&EP) is a statewide program that provides a range of subsidised aids and equipment such as hoists, home and vehicle modifications and other items such as continence products and domiciliary oxygen. The program also funds the repairs of equipment owned by the department.

Other assistive technology programs and schemes funded under the VA&EP include:

- an equipment loan service for people who have been diagnosed with motor neurone disease
- specialist low cost aids and equipment for people who have vision impairment
- lymphoedema compression garments
- individualised solutions
- electronic communication devices
- smoke alarms for those with a profound/severe deafness.

The VA&EP assists eligible clients to enhance their independence and participate in the community. It supports families and carers to maintain care arrangements.

The client group for this activity is people of all ages where their need for the aids and equipment items available under the VA&EP relates to a health condition and those aged over 65 years with age- or disability-related needs for aids and equipment. Applicants must be permanent residents of Victoria or hold a permanent protection visa.

## 1.17.5 Aged support services

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

### 1.17.5.1 Supported residential services and accommodation support

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

### 1.17.5.2 Personal Alert Victoria

Personal Alert Victoria is a daily monitoring and emergency response service for frail older people and people with a disability who have high ongoing health and support needs and mostly live alone. Personal Alert Victoria aims to keep clients living independently for as long as possible. Personal Alert Victoria assists more than 29,000 Victorians.

Personal Alert Victoria relies on nominated contacts (such as family, friends and neighbours) to provide assistance in responding to calls, ensuring public emergency services are used effectively.

The Personal Alert Victoria Response Service is used when people do not have any relatives or other contact people. About 15 per cent of Personal Alert Victoria clients use the Personal Alert Victoria response service.

### 1.17.5.3 Support for Carers Program

The Support for Carers Program provides $18.5 million distributed to 49 agencies for services for people in care relationships where other services are not available or where clients are not eligible for other services. Services may include respite, information, advice, counselling and subsidised goods and equipment. Eligibility criteria was expanded in January 2019 to include carers of all ages.

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

### 1.17.5.4 Victorian Eyecare Service

The Victorian Eyecare Service (VES) provides subsidised eyecare and visual aids to people experiencing disadvantage via metropolitan, outreach and rural services. The VES is delivered by the Australian College of Optometry in Melbourne metropolitan regions and private practice optometrists in rural regions. Every year, the VES delivers 75,800 occasions of service. Clients eligible for VES pay from $39 to $95 for visual aids, depending on clinical need and choice of glasses. To deliver the VES (and

complementary programs), the Australian College of Optometry delivers approximately 50,000 visual aids per year. Clients who identify as Aboriginal or Torres Strait Islander will be eligible for the Victorian Aboriginal Spectacles Scheme (VASS), which is an additional subsidy to the VES. It aims to improve access to visual aids and eyecare to Aboriginal Victorians by further reducing the client contribution to $10. The VASS is delivered through the VES statewide and is supported by the Commonwealth Government's Visiting Optometrist Scheme.

Since commencing in 2010, the Aboriginal Health and Wellbeing branch has managed and provided funding annually to the VASS. More than 11,000 pairs of visual aids have been supplied to Aboriginal Victorians since its introduction, and it has made significant improvements to the eye health of Aboriginal people, particularly in rural Victoria.

#### 1.17.5.5 Dementia services

Within the Support for Carers Program, support for carers of people with dementia (including young people with dementia) is available through 10 agencies. Dementia Australia (Victoria) is funded for support, counselling, education and training, Dementia Awareness Week activities and dementia service hubs in regional centres.

### 1.17.6 Public sector residential aged care

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

In 2019–20 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 or programs (such as transition care)
- Requests by PSRACS providers to reinstate non-operational (off-line) places or increase operational places
- A review indicates failure to optimise service provision for those requiring residential care.

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

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

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

If services obtain additional residential aged care places though the Commonwealth's Aged Care Approvals Round without the approval of the 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.

### 1.17.7 Seniors programs and participation

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

# 1.18 Rural health

Rural and regional health services play a key role in delivering safe, high-quality care close to where people live. The system has a hierarchy of health services with small rural, local, subregional and regional hospitals providing services appropriate to their capacity, capability and the needs of their community.

Providing health care in rural areas presents particular issues including:

- Victorians living in rural and regional areas are generally older and have poorer health outcomes on measurements including life expectancy and cancer survival rates.
- Remote and sparsely populated communities must travel relatively long distances to access care.
- Workforce shortages are often most acute in regional area.

Rural and regional health services and hospitals work hard to improve the health and wellbeing of their communities, delivering services ranging from health promotion and primary health through to acute inpatient services, aged care, mental health, drug services and end-of-life care.

*Targeting Zero* made a number of recommendations that are particularly relevant to rural health services.

The Rural and Regional Health branch within Health and Wellbeing has responsibility for the performance management and policy leadership for the rural health service system.

## 1.18.1 Small rural health services

Public hospitals in communities across Victoria play a vital role as part of an integrated healthcare system, which allows care to be safely provided closer to where people live.

Forty-two small rural health services (SRHS), including seven multipurpose services, deliver public admitted acute services in Victoria. This enables health services to use funds flexibly to deliver a range of admitted and non-admitted services that meet the needs of their community including primary health care, health promotion and prevention activity.

Flexible funding to SRHS includes an allocation to health promotion and prevention activity (under the activity name 'Small rural – primary health flexible services').

The department will continue to explore and develop options for any revisions to the SRHS funding model. It is important that the SRHS funding model maintains organisations' flexibility to determine service mix and models of care to meet local needs while also increasing accountability, transparency and equity. Any proposed adjustments will be subject to endorsement processes and staged implementation.

Updates on the development of the funding model will be provided to the sector throughout 2019–20.

The description of SRHS outputs and activities are provided in the Appendices, Appendix 1, section 1.4 'Output and activity tables' (see also the Appendices, Appendix 1, 'Table 1.30: Small rural health services – outputs and activities 2019–20'). Funding arrangements for public sector residential aged care services are outlined in Chapter 1, section 1.17.6 'Public sector residential aged care'.

## 1.18.2 Rural and regional health partnerships

The *Statewide design, service and infrastructure plan for Victoria's health system 2017–2037* emphasises the importance of regional and local partnerships to Victoria's future health system. It outlines an ambitious vision for a more connected and networked service system supported by close and effective partnerships with Victoria's regional and rural health services. These partnerships would:

- improve the safety and quality of care to patients
- increase the capacity and accessibility of care and regional self-sufficiency
- strengthen the sustainability of rural services and their workforce.

The plan articulates 13 Local Area Health Partnerships that make up six larger Regional Partnership Areas.

The *Rural and regional health partnership guidelines 2018–19* were released in September 2018 and outline the increased scope for health partnerships across five functional areas:

- planning and networks
- workforce planning, recruitment and development
- quality and safety
- access and care
- key enablers.

Regional and Local Health Partnerships will create a platform for long-term and systemic collaboration on service planning, delivery and coordination by health services. The department is actively working with both Regional and Local Area Health Partnerships to embed and expand their functions in line with the guideline expectations.

### 1.18.3 Victorian Patient Transport Assistance Scheme

The Victorian Patient Transport Assistance Scheme (VPTAS) subsidises the travel and accommodation costs incurred by rural Victorians and an approved escort(s), who have no option but to travel more than 100 kilometres one way or an average of 500 kilometres a week for one or more weeks to receive approved medical specialist services or specialist dental treatment.

The 2019–20 VPTAS guidelines <https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/vptas-how-to-apply> include a new online claim form to support electronic banking for travel and accommodation subsidy payments. This will mean Victorians eligible to receive this financial assistance will receive the subsidy in a timelier manner compared to being paid by cheque.

In the *Victorian Budget 2019–20*, the Victorian Government allocated $2.6 million to VPTAS to ensure sustainability and meet the growth in new claims. Demand for VPTAS assistance, growth in claims, has been increasing by an average of 8.1 per cent per annum over the past five years.

The current eligibility criteria and subsidy rates include:

- private vehicle costs reimbursement rate of 21 cents per kilometre
- the rate of a patient and an approved escort(s) staying in accommodation is a maximum of $49.50 per night including GST
- entitlement to two escorts if the travelling patient is a newborn infant (up to six months of age)
- entitlement for up to two escorts (parents, guardians or family members) when the patient requires treatment or admission to a hospital over two or more consecutive days for patients over six months of age and under the age of 18 years
- being available to living organ donors from other Australian states or territories who travel to Victoria to participate in a transplant procedure where the recipient is a Victorian resident. This includes travel for donor screening, specialist assessment and transplant procedures.

The four-year review cycle of VPTAS commenced in January 2019.

### 1.18.4 Bush nursing centres

The *Statewide design, service and infrastructure plan for Victoria's health system 2017–2037* sets out the framework for planning across settings and locations. In planning for service delivery, bush nursing centres should align with Victoria's strategic and service planning frameworks where applicable. Bush nursing centres are to maintain their current service profile and provision to rural isolated communities.

During 2019–20 the department will continue to work with bush nursing centres to implement longer term arrangements that best align with bush nursing centre service delivery and government policy and administration, with oversight mechanisms that enable safety and quality.

This includes bush nursing centres moving to undertake accreditation against the *National Safety and Quality Health Service Standards* (second edition) from 1 January 2019. It also includes memoranda of understanding between bush nursing centres and health services to enable the bush nursing centres to participate in clinical governance activities.

Similarly, the department will continue to support bush nursing centres in transitioning to reporting on the Community Health Minimum Dataset.

### 1.18.5 Director of Medical Services

The Victorian public healthcare system is predicated upon a medical leader being appointed in the role of Director of Medical Services or Chief Medical Officer for each health service. This role includes:

- leading the development, monitoring and reporting of effective clinical governance systems
- giving strategic guidance on service planning issues
- contributing to the accreditation efforts of a health service.

The department recognises the critical function of this role. It will continue to work with health services and with Safer Care Victoria in 2019–20 to address several issues identified in consultation with the sector including:

- developing the Rural and Regional Director of Medical Services role outline
- establishing a Rural and Regional Directors of Medical Services Forum
- the priority areas of the Medical Workforce Planning Advisory Group
- encouraging Rural and Regional Health Partnerships to collaboratively address clinical governance across rural services.

Outcomes of this body of work will be communicated to health services as work progresses.

# 1.19 Primary, community, public and dental health

## 1.19.1 Primary health services

### 1.19.1.1 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 prioritises access for populations, families and children and those at risk of stigma and discrimination that are socially or economically disadvantaged, experience poorer health outcomes and have complex care needs, or have limited access to appropriate healthcare services.

The program's priority population groups are:

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

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

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

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

Community health services are also funded to also deliver a range of other health care services and programs, including sexual and reproductive health and place-based primary prevention (under the activity name 'Community health – health promotion'). Primary prevention aims to prevent illness occurring by eliminating or reducing underlying causes.

Additional support for specific population groups is also provided through the following programs:

- The Refugee Health Program – this program aims to increase refugee and asylum seeker access to primary health services and assist newly arrived communities to improve their health and wellbeing.
- The Healthy Mothers, Healthy Babies Program – this program provides pregnancy, resilience and antenatal material support. It aims to improve the health outcomes for pregnant vulnerable women and their babies. The *Victorian Budget 2018–19* invested $1.2 million (over two years) to continue the program through community health services in rural and regional locations.
- Early Intervention in Chronic Disease – this initiative aims to assist people with chronic disease to improve their capacity to manage their condition, prevent complications and improve their health and wellbeing.
- The Community Health Nurse Program in Sexual Assault Multidisciplinary Centres– this program provides health needs identification, holistic person direct care planning and support and referral to

appropriate services to children and adults who have experienced sexual assault and their non-offending family members. More recently, nurses now also support clients of family violence referrals. The nurses also raise awareness and educate health care providers, community organisations and MDC partner and client groups on client's health issues

Agencies receiving specific initiative funding are required to demonstrate that funds are targeted to meet the aims of the initiative. This is achieved through reporting requirements (refer to Chapter 2, section 2.13.7: 'Primary, community and dental health data reporting requirements').

The community health schedule of fees and income ranges used when assessing clients are available from the Community health fees policy webpage <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/community-health-fees-policy>.

### 1.19.1.2 Supercare Pharmacies

The Victorian Government committed $28.7 million over four years from the 2015–16 State Budget to introduce 20 Supercare Pharmacies by 2018. An additional $25.7 million was provided in 2016–17 to further support the rollout of the Supercare Pharmacies initiative.

Supercare Pharmacies are open 24 hours a day, seven days a week, with a nurse onsite from 6.00 pm to 10.00 pm for assessment and treatment of minor injuries and illnesses and risk assessment of lifestyle conditions. Supercare Pharmacies provide round-the-clock access to pharmacists for advice, supply of medicines and dispensing prescriptions.

Five Supercare Pharmacies began operating in June 2016, with a further seven commencing in June 2017. The final eight Supercare Pharmacies opened in June 2018. This brings the number of Supercare Pharmacies across Victoria to 20, in line with the government's commitment. Six Supercare Pharmacies are located in regional areas of the state.

Pharmacies and nursing services in the initiative are engaged through fixed-price contracts with the department. Out-of-hours service delivery must be in line with key performance indicators set out in these contracts. These performance indicators include access and safety and quality measures, and are reviewed and monitored by the department on an ongoing basis.

Activities to further embed the initiative in the primary health sector include significant communication work and marketing activities to increase awareness of the initiative. In late 2019, the department will arrange for experts to evaluate the initiative.

### 1.19.1.3 Health Condition Support Grants Program

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

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

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

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

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

In 2019–20 there will be a new round of Health Condition Support Grants. For further details, please refer to the Health Conditions Support Grants webpage <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/health-conditions-support-grants>.

#### 1.19.1.4 Primary Care Partnerships

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

The focus for Primary Care Partnerships is to align priorities to the department's strategic focus on place-based efforts, prevention and population health, family violence, the integration of health and social care and strategic partnership development or chronic disease management, where this work is already occurring or has been identified as a local need.

Read more about Primary Care Partnerships <https://www2.health.vic.gov.au/primary-and-community-health/primary-care>.

### 1.19.2 Dental health services

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

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

#### 1.19.2.1 Participation in Commonwealth initiatives

The Child Dental Benefits Schedule is a means-tested benefit scheme (Family Tax Benefit A) for children aged 2–17 years covering preventative and basic dental treatment. Eligible children have access to a benefit cap of $1,000 over a two-calendar-year period. A three-year extension to public sector access to the Child Dental Benefits Schedule until 31 December 2022 was announced in the 2019–20 Commonwealth Budget.

#### 1.19.2.2 Dental Health Program fees policy

Fees for public dental services apply to:

- people aged 18 years or older 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.

Read more about the policy, including a fees schedule and exemptions, on the Dental health webpage <https://www2.health.vic.gov.au/primary-and-community-health/dental-health>.

# 1.20 Public health

## 1.20.1 Health promotion and primary prevention

The department invests in a range of activities that aim to reduce the likelihood of developing a chronic disease or disorder. The focus is on environmental, social and behavioural approaches at the population level that contribute to reducing or eliminating the causes of poor health and wellbeing.

Primary prevention aims to prevent problems occurring in the first place by eliminating or reducing underlying causes. This is achieved by controlling the exposure to risk and promoting factors that protect health, wellbeing, safety and social outcomes. Examples include immunisation, tobacco control legislation and universal maternal and child health services.

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

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

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

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

The plan also identifies three platforms through which change can be achieved: healthy and sustainable environments, place-based approaches and people-centred approaches. Place-based approaches focus on intervening at the local level to deliver an integrated approach to chronic disease prevention.

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

The next plan is due on 1 September 2019.

The *Victorian public health and wellbeing outcomes framework* provides a new approach to monitoring and reporting on our collective efforts to improve Victorians' health and wellbeing over the long term. It provides a comprehensive set of outcomes, indicators, targets and measures for our major population health and wellbeing priorities and their determinants. Where data is available, the framework also enables an assessment of health and wellbeing inequalities.

Measures of shorter term change – or progress measures – have been identified for selected priorities of the *Victorian public health and wellbeing plan 2015–2019*. Progress measures can be used at the state and local levels for priority setting and monitoring the impact of collective effort.

Community health services and some small rural health services are funded to deliver place-based primary prevention (under the activity names 'Community health – health promotion' and 'Small rural – primary health flexible services'). It is expected that their local prevention effort is coordinated with councils, the department and other local partners to establish a common approach to preparing local

health and wellbeing plans, and that there is alignment to the *Victorian public health and wellbeing plan* and other key strategic directions of the government. Further information can be found in *Advice for public health and wellbeing planning in Victoria: planning cycle 2017–2021* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/public-health-wellbeing-planning-advice-2017-2021>.

### 1.20.1.1 Chronic disease prevention

The Victorian Government funds a range of strategies to reduce the risk factors for chronic disease.

The Achievement Program is a comprehensive health and wellbeing quality framework for schools, early childhood services and workplaces (including health services) to support the creation of healthier environments. The framework provides best practice benchmarks to guide settings in determining the policy, cultural and environmental changes needed to improve the health of their workers, students, children and the wider community. The standards cover health priority areas such as healthy eating, physical activity and mental health and wellbeing. Once the settings and benchmarks for the health priority areas have been met, the organisations can apply for Victorian Government recognition. Further information is available on the Achievement Program website <https://www.achievementprogram.health.vic.gov.au>.

Reducing risk factors for chronic disease through a place-based approach to prevention also includes increasing access to healthy food and drinks in places where people spend their time. The Healthy Choices policy guidelines are a framework for improving the provision and promotion of healthier foods and drinks that are available in the community through retail outlets, vending machines and workplace catering. The policy guidelines support the implementation of Healthy Choices in hospitals, health services, sport and recreation centres, workplaces and parks. There are similar guidelines for schools and early years services. Many health services are integrating the Healthy Choices policy guidelines into their retail food service and vending contracts.

Read the Healthy Choices policy guidelines. <https://www2.health.vic.gov.au/public-health/preventive-health/nutrition/healthy-choices-for-retail-outlets-vending-machines-catering>.

The Healthy Choices policy guidelines have been integrated into the funding requirements for local government sport and recreation grants. This includes the 2017–18 Better Indoor Stadiums Fund and the 2018–19 Community Sports Infrastructure Fund in the criteria of the Better Pools category.

Funded by the Victorian Government and delivered by Nutrition Australia Vic Division, the Healthy Eating Advisory Service (HEAS) provides free support for implementing the Healthy Choices policy guidelines. It supports organisations to develop the skills and knowledge needed to remove sugary drinks and increase healthy food choices in their retail food outlets, vending and catering. HEAS is available to health services, as well as early childhood services, schools, workplaces, sport and recreation facilities, parks and universities. It provides: email and phone implementation advice from qualified dietitians; comprehensive online resources, recipes, tips, factsheets and case studies; FoodChecker – an online food and drink assessment tool; online and face-to-face training, including a mentorship program. Further information is available on the Healthy Eating Advisory Service website <https://heas.health.vic.gov.au>.

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

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

Results for participants in the Life! program are collected quarterly. Data collection and reporting requirements and the funding recall policy are provided in the relevant sections of these guidelines (Table 1.7).

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

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

The NBCSP is in a period of expansion. From January 2019 all eligible people aged 50–74 will be invited to screen every two years.

During the NBCSP expansion period, all Victorian public hospitals providing colonoscopy are allocated a separate NBCSP WIES target. This funding is provided in addition to the funding provided for other activity and is paid according to actual activity. The WIES target will be modelled to align with growth resulting from the NBCSP. A prior year adjustment process will reconcile NBCSP activity with targets. Variation in activity against the NBSCP WIES target will be recalled or paid at the full WIES rate. It is not part of public and private WIES for determining recall and throughput.

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

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

NBCSP activity will be paid against the health service's NBCSP WIES target based on actual throughput. Reconciliation for under or over activity will be adjusted at the end of 2018–19.

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

Read more about the National Bowel Cancer Screening Program <https://www2.health.vic.gov.au/public-health/population-screening/cancer-screening/bowel-cancer-screening>.

### 1.20.1.4 Sexual health and viral hepatitis

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

A wide range of agencies are funded to provide peer-based care and support, clinical care, health promotion, research, surveillance and workforce training.

The *BBV/STI program guidelines for funded agencies* outline reporting requirements against funded activity. All agencies funded for BBV/STI activities are required to acquit funding using the guidelines. Standard contract management processes apply, including performance output monitoring, regular reporting and face-to-face meetings.

Read the *Victorian HIV strategy 2017–2020*, and hepatitis C and B strategies 2016–2020 at the department's Sexual health webpage <https://www2.health.vic.gov.au/public-health/preventive-health/sexual-health>.

#### 1.20.1.5 Tobacco control

To reduce the burden of smoking on the community, the Victorian Government funds non-government organisations, such as Quit Victoria, the Victorian Aboriginal Community Controlled Health Organisation and Alfred Health, to provide:

- clinical smoking cessation support services, including the Quitline and dedicated Aboriginal Quitline, which provide expert advice and personalised counselling to smokers wanting to quit
- programs targeted at sub-populations with the highest rates of smoking, low socioeconomic groups, Aboriginal Victorians, people experiencing mental illness and those affected by alcohol and drugs
- continuous, sustained Victorian anti-smoking social marketing campaigns (integrated across television, radio, print and social media) to reduce smoking uptake and increase cessation
- research to inform tobacco control policy and regulatory reform such as annual surveys of smoking prevalence and behaviours
- training for health professionals (including Aboriginal health workers) in providing brief smoking cessation interventions
- support for health services to implement best practice smoking cessation support in routine care.

The department funds the Municipal Association of Victoria to manage the distribution of funds to councils to educate businesses and the community regarding their responsibilities under the *Tobacco Act 1987*, and to take enforcement action where necessary.

#### 1.20.1.6 Victorian Tuberculosis Program

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

### 1.20.2 Health protection

The Victorian Chief Health Officer leads the Health Protection branch, is the lead public health adviser to the Minister for Health and the Victorian Government and is the state's spokesperson on public health issues. The Chief Health Officer also leads the department's response to climate change, including chairing the Climate Change Reference Group and having overarching responsibility for delivering the department's climate change adaptation plan and emissions reduction plan under the *Climate Change Act (2017)*. The Chief Health Officer has statutory powers under the *Public Health and Wellbeing Act 2008* to protect the health and wellbeing of Victorians and is involved in overseeing strategy and policy in health protection, coordinating investigations and management of public health risks, and undertaking all manner of risk communication with stakeholders including the Victorian public.

The Chief Health Officer regularly informs Victorians about issues that have the potential to affect their health. Information is provided via health alerts and a range of other documents accessible on the Victorian Chief Health Officer's website <https://www2.health.vic.gov.au/about/key-staff/chief-health-officer>.

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

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

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

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

#### 1.20.2.1 The Peter Doherty Institute

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

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

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

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

# 1.21 Teaching and training

## 1.21.1 Training and development grants

Training and development funding is provided to public health services to recognise the additional costs inherent in the teaching and training activities of public health services. The grants aim to support the development of a high-quality future health workforce for Victoria through subsidising:

- professional-entry student placements
- transition-to-practice positions for medical, nursing and allied health
- postgraduate medical, nursing and midwifery study
- other targeted workforce training and development initiatives.

In 2019–20 the department will be increasing our investment in the nursing and midwifery workforce through a range of programs, including expanding existing graduate and postgraduate programs.

In 2019–20 the department will be investigating options to confirm training and development program funding and expected activity levels earlier in the fiscal year to provide health services with greater certainty of annual budgets, with the aim of making minimal adjustments during the year if reported activity is within the expected range.

### 1.21.1.1 Professional-entry student placements

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

A limited number of professional clinical placements, professional development year or industry-based learning positions are not eligible for the professional-entry student placement subsidy because they are funded through the transition-to-practice and postgraduate study streams of the grant. These include internships in hospital pharmacy, medical imaging (radiography), nuclear medicine, radiation therapy, medical biophysics, medical laboratory science and employment model midwifery.

Beginning in 2020, the department will be providing additional funding on a time-limited basis to increase clinical placements to support the Victorian Government's commitment to expanding enrolled nurse training through the offer of free training with Victorian Technical and Further Education (TAFE) providers. Health services will be advised of the conditions of this funding through an application process to provide an increase in placements in 2020.

### 1.21.1.2 Transition to practice – (graduate) positions

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

The transition-to-practice funding stream includes five program areas:

- allied health graduates
- allied health interns
- nurse and midwifery graduates
- medical graduates (year one and two – PGY1 and PGY2)

Subsidies to health services contribute to the cost of supervision and on-the-job training in the first year for approved nursing, midwifery and allied health graduate positions, and the first two years for approved medical graduate positions.

A limited number of funded transition-to-practice positions are allocated to university students undertaking professional clinical placements in medical imaging and radiation therapy and to students completing industry-based learning placements in medical biophysics and medical laboratory science.

Public mental health services across Victoria are excluded from receiving transition to practice subsidies for nursing and allied health graduates as they are provided with subsidies through the Mental Health Training and Development grant.

For all program areas subsidies are approved and allocated based on each health service's activity as a proportion of total reported graduate activity.

### 1.21.1.3 Postgraduate positions – medical, nursing and midwifery

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

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

**Medical specialist training**

The following programs are available for postgraduate medical specialist training.

*Victorian Medical Specialist Training Program*

The Victorian Medical Specialist Training Program provides funding in targeted specialties to assist health services to increase the number of accredited medical specialist training positions. The program is being reviewed in 2019–20 to ensure it is the best model to support the expansion of accredited medical specialists training.

Funding allocation for the program is determined through an Expression of Interest process that occurs once every two years.

*Victorian Paediatric Training Program*

The Victorian Paediatric Training Program provides subsidies to support a statewide basic paediatric training program. Subsidies ensure that the distribution and rotation of accredited paediatric trainees are aligned with the workforce requirements of outer metropolitan, regional and rural Victoria and that they promote access to local paediatric services across the state. The program is being reviewed in 2019–20 to ensure it is the best model to support the required development of paediatric specialists.

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

*Basic Physician Training Consortia*

The Basic Physician Training Consortia program provides annual funding to five consortia comprising all Victorian hospitals with accredited physician training positions to support distribution and management of basic physician trainees, address workforce shortages and improve the quality of education and training in rural Victoria. The program is being reviewed in 2019–20 to ensure it is the best model to support the required development of physicians.

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

**Nursing and Midwifery**

The postgraduate nursing and midwifery program provides subsidies for postgraduate studies that lead to an award classification of graduate certificate, graduate diploma or master's-level studies.

In 2019–20 the department will be reviewing the eligibility requirements to prioritise postgraduate qualifications that assist health services to implement the amended *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015*.

### 1.21.1.4 Other targeted workforce training and development programs

**Allied Health Leadership Program**

The *Allied health leadership strategy* is underpinned by the *Allied health leadership development framework*, which identifies four levels of leadership development across the career continuum: Transition to Practice, Emerging Leaders, Growing Leaders and Established Leaders. This framework will underpin the development and delivery of targeted interventions by the sector, in partnership with the department.

**Allied Health Research Translation and Clinical Educator Roles**

To support allied health workforce development 10 senior allied health research and translation roles and 10 clinical education positions have been implemented across Victorian health services. The plan also supports Victoria's investment in building the leadership capability and capacity of the allied health workforce.

**Continuing Nursing and Midwifery Education Program**

The Continuing Nursing and Midwifery Education program provides funding to health services to support planned and targeted nursing and midwifery education that maintains and improves the skills and knowledge of nurses and midwives employed in their organisation.

Funding is allocated on the bases of total nursing/midwifery full-time equivalent staff.

**Nursing and Midwifery Postgraduate Scholarships**

Postgraduate scholarships are allocated to registered nurses and midwives working in Victorian public health services, to undertake postgraduate study in areas of clinical practice where there is an identified workforce need.

Scholarship funding is allocated annually to eligible public health services (or for rural health services, to fund holders within the five rural health regions) and calculated based on nursing/midwifery full-time equivalent staff.

**Maternity Connect Program**

The Maternity Connect Program provides funding that supports the ongoing education of rural midwives and neonatal nurses through facilitating clinical placements in larger, higher acuity services. The funding covers travel and accommodation of participants, backfill of staff for the rural service and a subsidy for the placement service to ensure clinical support. Participants are prioritised according to rural workforce need and the availability of placements.

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

**Nuclear Medicine Intern Cluster Program**

St Vincent's Hospital Melbourne will be provided with funding to provide centralised clinical education support for workplaces involved in the Nuclear Medicine Intern Cluster Program. This funding will facilitate the continued employment of up to one full-time equivalent statewide nuclear medicine clinical educator.

**Prevocational Medical Education and Training**

Prevocational medical education and training funding is provided to health services to support junior medical staff training, primarily through employing medical education officers. Funding is limited to the size of the funding pool, with the allocated model including a base payment per health service, plus a per capita allocation per intern position as reported for 2018. In addition, rural and regional health services receive a rural loading on the per capita allocation. Payment rates for 2019–20 are outlined in the Appendices, Appendix 1, 'Table 1.18: Training and development funding rates in 2019–20'.

**Rural Clinical Academic Program**

The Rural Clinical Academic Program supports rural and regional health services that, in conjunction with Rural Clinical Schools, provide academic teaching and regional coordination for medical students hosted at the health service for an extended period. The funding recognises the increased costs of providing academic teaching, support, coordination and infrastructure for medical students while based at a rural and regional health service for a period greater than six weeks. The program is intended to ensure that the types of learning experiences that medical students receive in rural and regional health services are of a high quality and demonstrate the varied and rewarding work occurring in these services. This funding is provided in addition to other training and development funding for professional-entry clinical placements that help students acquire clinical skills through applying theoretical knowledge to practice.

In 2019–20 the department will review the rural clinical academic funding with the aim of ensuring greater alignment with rural training pathways.

**Rural Community Intern Training program**

The Rural Community Intern Training (RCIT) program provides medical interns with exposure to a wide range of clinical experiences that emulate the practice of a rural general practitioner, both within the hospital system and in community general practice settings. Interns are based in small rural and sub-regional hospitals, with core and non-core rotations to larger regional hospitals, general practices and community settings. The RCIT program will be merged into an overarching Victorian Rural Generalist training pathway and will be renamed the Rural Generalist Intern Year (RG- Year 1) in 2020.

**Rural Generalist Training Program**

The Victorian General Practitioner – Rural Generalist (GP-RG) program supports medical practitioners to gain advanced skills as part of supported pathways of general practice training. This helps ensure Victorian rural generalists are well equipped to work across general practice and achieve advanced skills competency. Following two years of prevocational training, trainees who intend to pursue general practice training will have successfully enrolled within the Australian General Practice Training Program. The program provides trainees with an opportunity to obtain advanced skills in areas such as obstetrics, anaesthetics, emergency medicine, geriatric medicine, paediatrics, indigenous health and mental health. In addition to trainees, the program is also available to fully qualified general practitioners who wish to undertake advanced skills training through a lateral entry pathway. The GP-RG program will be merged into an overarching Victorian Rural Generalist Training Program and will be renamed as the Rural Generalist Advanced (RG-Advanced) training year in 2020.

**Rural Health Workforce Support**

The department works collaboratively with Rural Workforce Agency Victoria to support education and training to meet a range of identified rural workforce development requirements. Funding in 2019–20 will be allocated to support recruitment, training and professional development for the rural medical workforce.

### 1.21.1.5 Funding conditions and allocation

Health services that receive training and development grant funding should ensure they meet eligibility and reporting requirements as outlined in Chapter 2, section 2.13.9 'Training and development funding reporting and eligibility requirements'.

Nursing and midwifery program areas must comply with the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015*. Where the department is made aware of noncompliance with the Act, training and development grant funding may be withheld or recovered.

All programs supported through training and development funding must conform to the most recent versions of guidelines (where available), including the guidelines and standards set by the Australian Health Practitioner Regulation Agency and the national health practitioner boards.

Allocation of the training and development funding is limited by the total grant pool. Funding allocations for professional-entry student placements, transition-to-practice and postgraduate programs are based on weighted prior year activity and depend on appropriate reporting of all activity by health services.

If programs or training positions include a period of rotating placements, lead organisations are required to ensure the other host organisation(s) receive a pro rata portion of the grant equal to the length of the rotation.

Training and development allocations in 2019–20 are listed at the Appendices, Appendix 1, section 1.1 'Price tables'.

For further details regarding these funding streams refer to the Health Workforce website <https://www2.health.vic.gov.au/health-workforce> or download the *Training and development program guidelines 2019–20* from the Training and Development Funding webpage <https://www2.health.vic.gov.au/health-workforce/education-and-training/training-development-grant>.

# 1.22 Capital Funding Programs

The department administers several capital grant programs to assist health services with the costs of hospital infrastructure. The Infrastructure Renewal Contribution Grant, Regional Health Infrastructure Fund, Medical Equipment Replacement Program and Engineering Infrastructure Replacement Program support health services to manage risk and maintain patient safety, occupational health and safety, and service availability and continuity by maintaining and replacing assets in a planned manner, prior to failure.

The department has adopted a coordinated approach to the allocation and management of funds from these four separate sources. Where projects are unable to be completed and acquitted within a two-year period, allocations may be recalled and re-appropriated to other priority projects.

Read more about the programs at the Medical equipment and engineering infrastructure webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/planning-infrastructure/medical-equipment>.

## 1.22.1 Infrastructure Renewal Contribution Grant

In 2019–20, $40 million will be distributed to all hospitals including rural and small rural health services to assist health services with the costs of replacing hospital infrastructure. Grants will be appropriated to health services from October, on receipt of Asset Management Plans by the health service to the Victorian Health and Human Services Building Authority.

Read more about asset management plans at the Asset property management and operations webpage <http://www.capital.health.vic.gov.au/Asset_property_management_and_operations>.

## 1.22.2 Medical Equipment and Engineering Replacement Funding

In 2019–20, $35 million will be provided for the Medical Equipment Replacement program and $25 million for the Engineering Infrastructure Replacement program. $17.5 million from the Medical Equipment Fund and $12.5 million from the Engineering Replacement Fund will be distributed to metropolitan and regional hospitals based on activity as a specific purpose grant. The balance of funding from each program will be centrally managed and allocated through a submission-based process by the department for highest priority at-risk, high-value replacements.

### 1.22.2.1 Specific-purpose capital grants

Replacement priorities for medical equipment and engineering infrastructure specific-purpose capital grants are to be determined by health services in accordance with highest critical risk assessment of in-scope assets. Grant expenditure will be acquitted in accordance with the requirements for capital appropriations and reported through the Agency Information Management System – 7B reporting.

### 1.22.2.2 High Value Statewide Replacement Funds

The High Value Statewide Replacement Funds for medical equipment and engineering infrastructure are bid-based and centrally managed. The funds replace critical high-value in-scope assets that carry a high risk to the statewide provision of acute services in public hospitals. The assessments, prioritisation and allocations consider a whole-of-system perspective and proposals are prioritised to highest critical risk scores against set criteria.

Health service investments should align with health service asset management plans, must maximise value-for-money procurement and be consistent with government policies, practices and asset management frameworks.

### 1.22.3 Regional Health Infrastructure Fund

In 2019–20, $50 million will be provided for regional and rural health services on a bid-based process and will be managed by the department centrally where projects exceed $1 million. Investment will be targeted to construction, remodelling and refurbishment projects; equipment (including furniture, fittings); medical equipment; engineering infrastructure and plant; information and communications technology; and new technologies including systems to reduce usage and increase efficiencies of power and/or water. Applications will be assessed on readiness of the project, demand for services, compliance risk, clinical risk and if infrastructure and assets are fit for purpose.

### 1.22.4 National activity-based funding arrangements

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

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

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

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

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

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

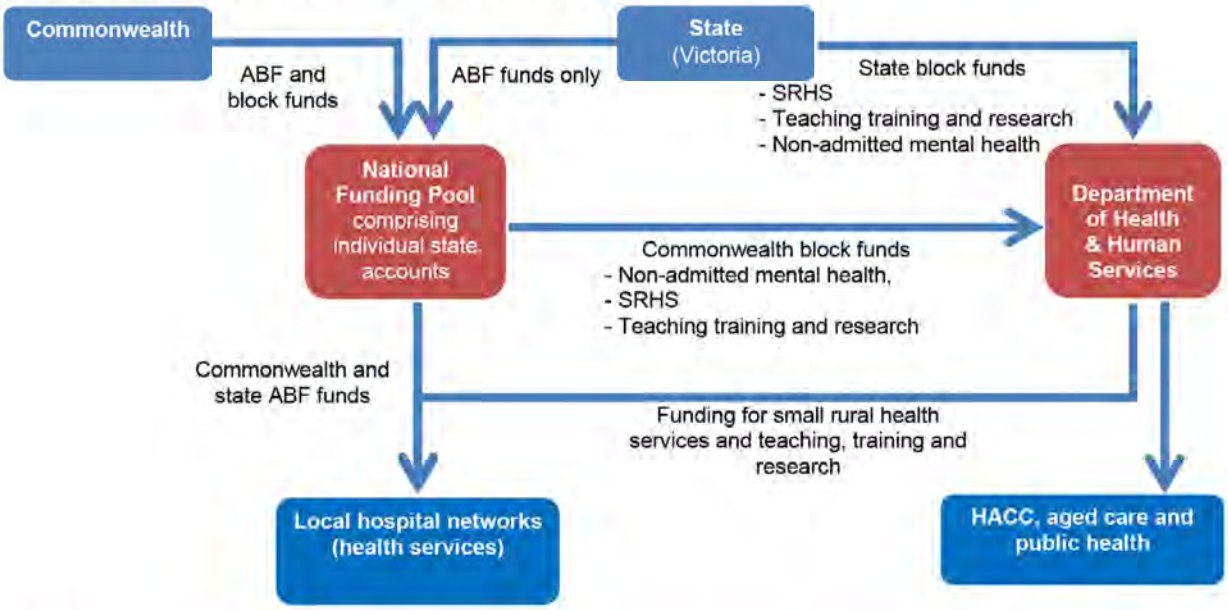
The national weighted activity unit targets will be included in health services' Statement of Priorities Part D, in addition to the WIES targets (Part C).

In 2019–20 the NEP has been set at $5,134 per NWAU(19). Details are published in the IHPA's NEP determination and pricing framework each year. Documents relating to the NEP and NWAUs are available at the Independent Hospital Pricing Authority website <https://www.ihpa.gov.au>.

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

As system managers, the Victorian Government instructs when payments are to be made out of the pool in accordance with the activity levels agreed between the state and each health service in their SOP. The Victorian Government will continue to manage block-funded payments, including small rural health services, teaching, training and research and non-admitted mental health services. Block-funded payments will be paid to health services by the department through the state-managed fund (see Figure 1).

**Figure 1: Payment flows under national activity-based funding**




## 1.22.5 The pricing framework for Australian public hospitals: activity-based

In 2019–20 the in-scope public hospital services that will be funded through the *National Health Reform Agreement* are:

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

In 2019–20:

- The national activity unit will be known as NWAU(19).
- The national efficient price is set by the IHPA at $5,134 per NWAU. Costing information used to determine the NEP was drawn from the 2016–17 National Hospital Cost Data Collection (Round 21).

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

- admitted patient services: AR-DRG Version 9.0
- emergency department services: Urgency Related Groups Version 1.4 (for recognised emergency departments at levels 3B–6) and Urgency Disposition Groups Version 1.3 (for recognised emergency departments at levels 1–3A)
- non-admitted patient services: Tier 2 Outpatient Clinics Definitions Version 4.1
- admitted mental health patient services: modified version of AR-DRG Version 9.0
- admitted subacute patient services: Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) Version 4.0.

Health services' total funding will continue to be determined based on activity volumes and prices according to the Victorian funding models such as WIES and subacute WIES in 2019–20. 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 activity-based funding model are referred to in the IHPA's National Pricing Model Technical Specifications 2019–20 <https://www.ihpa.gov.au/publications/national-pricing-model-technical-specifications-2019-20>.

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

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

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

The IHPA has applied these criteria in developing the national costing model and the national efficient cost determination for 2019–20 that applies to block-funded services.

In 2019–20 the national efficient cost is $5.319 million. This represents the average cost of a block-funded hospital. The national efficient cost was determined using the average in-scope expenditure data for 2016–17 reported to the National Public Hospital Establishment Database of $4.783 million indexed at 3.6 per cent per annum (based on national cost data) to account for price and activity growth over the three years.

Read more about the pricing framework for Australian public hospitals and the categorisation of small rural health services <https://www.ihpa.gov.au/publications/national-efficient-cost-determination-2019-20>.

# 1.23 Prior year adjustment: activity-based funding reconciliation

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

## 1.23.1 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 1.7.

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

In 2019–20, public/private WIES and subacute WIES will be recalled based on the rates detailed in Table 1.7. The marginal WIES policy aims to maintain minimal levels of funding for under-activity in recognition of fixed costs and variable demand but incentivise efficient service delivery above target where it is cost-effective for health services to do so and up to a capped amount.

Department of Veterans' Affairs and TAC activity will continue to be funded to actual activity that is approved by the Department of Veterans' Affairs. Health services are expected to update the VAED for any rejected or denied episodes of care prior to reconciliation. Any denied or rejected records that are not amended will not be paid as either public or Department of Veterans' Affairs when the 2019–20 Prior Year Adjustment is calculated.

In 2019–20, National Bowel Cancer Screening Program WIES be recalled based on rates detailed in Table 1.7 and continue to be funded to actual activity.

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

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

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

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

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

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

Recall will apply to the total HIP activity target. Recall will also apply to the Transition Care Program. Transition Care Program recall will be calculated separately and will not be included in the subacute wrap. Funding recall applies for the state component of the Transition Care Program, with recall for the Transition Care Program wrapped between bed-based and home-based.

A recall policy also applies to Home and Community Care Program for Younger People, and Aged Care and Assessment Services as outlined in Table 1.7. Funded organisations should note that significant underperformance in any activity should be discussed with the department in a timely manner.

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

In 2019–20, recall will not apply to acute admitted specialist clinics activity eligible to be funded under the Weighted Ambulatory Service Event (WASE) funding model.

An overview of the calculation process for recall can be found at the Appendices, Appendix 1, Addendum 1.7: 'Calculating funding recall'.

**Table 1.7: Victorian funding recall rates 2019–20**

| Service | Funding recall policy |
|---|---|
| Acute admitted services<br>Subacute admitted services (wrap includes GEM, rehabilitation and palliative care)<br>Non-acute admitted services (maintenance care) | • 0–3 per cent below target: 50 per cent of the weighted relevant rate or wrap value.<br>• > 3 per cent below target: 100 per cent of the relevant rate. |
| Nationally Funded Centres (NFC) | Full recall of under-activity at the NFC determined cost per procedure. |
| National Bowel Cancer Screening Program | Full recall of under-activity. |
| Department of Veterans' Affairs<br>• Acute admitted services<br>• Subacute admitted services (wrap includes GEM, rehabilitation and palliative care) | Full recall of under-activity. |
| Transport Accident Commission and WorkSafe<br>• Acute admitted services | Full recall of under-activity. |
| Small rural health services | Recall applies to renal, HACC-PYP, ACAS and residential aged care services.<br>No recall applies for acute, subacute and primary health. |
| Acquired brain injury unit | Full recall of under-activity at the full rate. |
| Mental health admitted services | The department may recall funds associated with funded beds, which remain unopened or have been temporarily closed.<br>Recall will depend on statewide priorities and the need for funding redistribution to achieve these priorities as defined by the department. |
| Non-admitted emergency services | Non-admitted emergency services are currently not subject to recall. |
| Subacute non-admitted services | Funding recall will be applied to subacute non-admitted services. When determining whether recall applies, the department will consider activity against the total HIP target:<br>• 0–5 per cent below target: no recall.<br>• > 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. |

| Service | Funding recall policy |
|---|---|
| Mental health non-admitted services | • 0–5 per cent below target: no recall.<br>• > 5 per cent below target: the department may recall at the relevant rate. The amount subject to recall is that beyond the five per cent underperformance. |
| Transition Care Program (bed-based and home-based wrapped) | • 0–5 per cent below target: no recall.<br>• > 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 the end of the year, before the recall is applied.<br>Home dialysis activity (determined on a monthly basis) under target will be subject to full recall. |
| Non-admitted radiotherapy | Funding will be recalled at the full rate for performance below target. |
| Non-admitted specialist clinics | Funding recall will not be applied for non-admitted specialist clinics. |
| 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.<br>• > 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.<br>Read more about the primary health funding approach recall policy on the Community health webpage <https://www2.health.vic.gov.au/primary-and-community-health/community-health>. |
| BreastScreen Victoria services | • 0–3 per cent below target: no recall.<br>• 3–5 per cent below target: recall at 50 per cent of relevant rate.<br>• > 5 per cent below target: recall at full rate.<br>Recall policy is subject to the terms and conditions of BreastScreen Victoria's Funding and Service Agreement with the department. |
| Aged Care Assessment Service (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. |
| Home and Community Care Program for Younger People (HACC-PYP) | Recurrent and/or one off funds HACC-PYP s may be recalled from service providers, including small rural 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. |
| Total parenteral nutrition | Total parenteral nutrition activity (determined on a monthly basis) under target will be subject to full recall. |
| Home enteral nutrition (HEN) | Recall may apply for health services where reported HEN service events are below the target. Funding may be recalled based on the service events below target. |

### Exceptional events

There may be circumstances (including industrial action and natural disasters) beyond the reasonable control of health service management that prevent targeted throughput being met. At its discretion, and

on a case-by-case basis, the department will consider submissions to adjust funding to health services, irrespective of throughput, for as long as such events continue.

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

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

### 1.23.2 Funding for throughput above target

Funding for health service throughput above target will be based on a proportion of the funding rate (see Table 1.8).

The Department of Veterans' Affairs and the TAC will continue to be funded to actual activity and will therefore attract additional funding for throughout above target.

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

Throughput funding for above target will not apply for acute non-admitted specialist clinics WASE activity in 2019–20.

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

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

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

There is no funding for any over-activity for non-acute care (Home and Community Care Program for Younger People, Transition Care Program or nursing home activity) or non-admitted HIP.

**Table 1.8: Funding for throughput above target 2019–20**

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

### 1.23.3 Prior-year adjustment of Commonwealth contribution

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

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

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

### 1.23.4 Hospital activity, WIES and subacute WIES reports

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

Further information, including the report specifications, are available on the Victorian Admitted Episodes Dataset webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vaed>.

# 1.24 Health service compensable and ineligible patients

## 1.24.1 Funding for interstate patients

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

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

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

## 1.24.2 Medicare-ineligible patients and international patients seeking health services

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

Exemptions from charging fees are as follows:

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

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

### 1.24.2.1 Medicare-ineligible patients – principles

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

- Health services have a duty of care to treat emergency patients. All patients are able to access care in an emergency department regardless of their eligibility status. Medicare-ineligible patients are expected to pay for these services.
- Fees charged to Medicare-ineligible patients are at the discretion of individual health services. Fees should be set at a minimum to achieve full cost recovery.

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

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

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

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

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

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

- Fees charged to international patients are at the discretion of individual health services. Fees may be set to achieve a profit.

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

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

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

Health services can email the department's International Health team <internationalhealth@dhhs.vic.gov.au> if they require further advice or assistance in relation to treating international patients.

## 1.24.3 Compensable patients

### 1.24.3.1 Department of Veterans' Affairs patients

**Eligibility**

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

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

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

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

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

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

**Admission requirements**

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

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

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

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

**Pharmaceuticals**

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

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

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

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

**Long stay**

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

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

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

**Nursing home type patients**

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

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

### Discharge planning

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

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

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

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

To arrange home and personal care services for eligible veterans, health services must contact the National Veterans' Home Care assessment agency (1300 550 450). Discharge aids and equipment for veteran patients must be provided to facilitate safe discharge for a period of 30 days after discharge. For further information visit the Rehabilitation Appliances Program (RAP) webpage <https://www.dva.gov.au/health-and-wellbeing/home-and-care/rehabilitation-appliances-program-rap> or call 1300 550 457 (metro) or 1800 550 457 (rural).

### Funding arrangements

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

Victoria will fund eligible veterans in alignment with revised Commonwealth revenue in 2019–20. Funding for admitted acute and subacute services will continue to be paid to actual throughput based on the Victorian WIES and subacute WIES funding models. Funding for emergency departments (non-admitted presentations), acute non-admitted and HIP will be paid as a block grant and based on the health service's activity share of total weighted activity.

Funding arrangements for Department of Veterans' Affairs patients are detailed in Table 1.9. Throughput-based services will continue to attract a premium from the department for eligible veterans in recognition of the cost of treating these patients. Payment will be made on a reconcilable basis.

Payment for interfacility transport (excluding Secondary Aeromedical retrieval) is included in the payment arrangements for services.

**Table 1.9: Funding arrangements for Department of Veterans' Affairs patients**

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

### Payments

If a claim is not accepted by the Department of Veterans' Affairs either:

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

Health services are required to make changes before consolidating the VAED, otherwise funding will not be paid at either the Department of Veterans' Affairs or public rate.

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

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

Subcontracting for Transition Care is exempt from this requirement, as public hospitals do not directly bill the Department of Veteran's Affairs for this service (see Table 1.9).

### 1.24.3.2 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 the errors are addressed by health services, the TAC and the department.

#### Funding arrangements

Funding arrangements for TAC patients are detailed in Table 1.10. View TAC rates in the *Fees manual* <https://www.health.vic.gov.au/feesman>.

**Table 1.10: 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 emergency department only. Health services should bill the TAC directly for medical and diagnostic costs. |
| Admitted patient services | Acute: Health services receive WIES throughput payments from the department at the TAC-specific rate.<br>Rehabilitation: Health services charge the TAC directly at the TAC-specific bed day rate.<br>Other admitted services: Health services charge the TAC directly at the public rate.<br>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* <https://www.health.vic.gov.au/feesman>. |

#### Payments

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

Funding for TAC patients is provided to the department by the TAC. This is cash flowed to health services throughout the year and adjusted to actual at year end based on data reconciled with the TAC. Separate uncapped TAC WIES targets are incorporated into health service budgets for 2019–20 based on the latest available 12-month throughput reported in the VAED.

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

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

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

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

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

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

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

In 2019–20 the department will no longer make changes to the VAED for denied or rejected claims after consolidation through the prior year's adjustment. Health services are required to make changes before consolidating the VAED, otherwise funding will not be paid at either the TAC or public rate.

**Additional information**

More detailed information on the TAC's policy, services and funding is available at Public hospitals– TAC website <https://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.

### 1.24.3.3 Victorian WorkCover Authority patients

Victorian WorkCover Authority patients treated in Victorian health services are directly funded by Victorian WorkCover Authority insurers. This process will continue in 2019–20 at the rates agreed between the authority and the department on behalf of health services.

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

Read more about the current services and prices in the *Fees manual* <https://www.health.vic.gov.au/feesman>.

### 1.24.3.4 Prisoners

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

- Acute admitted activity is funded at the public WIES price.
- Admitted subacute services are funded at the public subacute WIES price.
- Emergency department services are funded through the Non-Admitted Emergency Services Grant, as the prisoner population is included in the calculation of this grant.
- Specialist clinic services are funded through the Acute Specialist Clinics Grant.

- Health services should not bill the Department of Justice and Regulation via primary care providers for these services provided to prisoners.

Health services should ensure they:

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

Health services are not permitted to raise additional fees or charges for pharmaceuticals or other items described in Chapter 2, section 2.12.4 'Health service fees and charges'.

#### 1.24.3.5 Direct billing compensable patients

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

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

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

# Chapter 2: Conditions of funding

# Introduction

Chapter 2 details the conditions and expectations of funding that apply to funded agencies, including the relevant standards and policies.

**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*, regarding 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' refers to registered community health centres, local government authorities and non-government organisations that are not health services.

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

# 2.1 Standards

## 2.1.1 Public sector values and principles

**Responsiveness**

- Providing frank, impartial and timely advice to the government
- Providing high-quality services that acknowledge, and are tailored to meet the needs of Victoria's diverse community
- Identifying and promoting best practice

**Integrity**

- Being honest, open and transparent in their dealings
- Using powers responsibly
- Reporting improper conduct
- Avoiding real or apparent conflicts of interest
- Striving to earn and sustain public trust at the highest level

**Impartiality**

- Making decisions and providing advice on merit without bias, caprice, favouritism or self-interest
- Acting fairly by objectively considering all relevant facts and applying fair criteria
- Implementing government policies and programs equitably

**Accountability**

- Working to clear objectives in a transparent manner
- Accepting responsibility for their decisions and actions
- Seeking to achieve best use of resources
- Submitting themselves to appropriate scrutiny

**Respect**

- Treating others fairly and objectively
- Ensuring freedom from discrimination, harassment and bullying
- Using their views to improve outcomes on an ongoing basis

**Leadership**

- Actively implementing, promoting and supporting these values

**Human rights**

- Making decisions and providing advice consistent with the human rights set out in the *Charter of Human Rights and Responsibilities Act 2006*
- Actively implementing, promoting and supporting human rights

Section 8 of the *Public Administration Act 2004* outlines the principles of the public sector and articulates what employers must do to comply. Employers must establish employment processes to ensure:

- employment decisions are based on merit
- employees are treated fairly and reasonably
- equal employment opportunity is provided
- human rights, as set out in the Charter of Human Rights and Responsibilities Act, are upheld
- public sector employees have a reasonable avenue of redress against unfair or unreasonable treatment
- a career in the public service is fostered (in the case of public service bodies).

The Public Sector Standards Commissioner issues codes of conduct to reinforce the public sector values, and standards on how to apply the employment principles. The codes and standards are binding but not detailed. They enable employers to introduce policies and practices that suit their organisation while also complying with the codes and standards. Employees should consider the codes, standards and any organisational policies when deciding what action to take.

Further information about public sector values is available at Public sector values – Victorian Public Sector Commission website <http://vpsc.vic.gov.au/ethics-behaviours-culture/public-sector-values>.

## 2.1.2 Safety

### 2.1.2.1 Pre-employment screening

There are pre-employment screening requirements for all health practitioners registered with the Australian Health Practitioners Regulation Authority. Pre-employment screening of medical practitioners with independent responsibility for patient care is subject to the requirements of the *Credentialing and defining scope of clinical practice for senior medical practitioners policy*. See the *Credentialing and defining scope of clinical practice for senior medical practitioners policy* <https://bettersafercare.vic.gov.au/reports-and-publications/credentialing-and-scope-of-clinical-practice-for-senior-medical-practitioners-policy>.

Prior to undertaking any relevant pre-employment and pre-placement police record checks, the department and all funded organisations must undertake identity checks on all applicants to minimise the risk of employing unsuitable or unqualified people. Safety screening may also include a Working with Children Check, which is a mandatory screening process for people who work with children.
Referee checks should be undertaken by direct contact with nominated referees. The bona fides of the referees should be considered.

Health services must have a vaccination policy for all workers. Each worker and their role should be individually assessed for specific vaccine requirements before, or at the start of employment. This is determined by the likelihood of contact with patients and/or blood or body substances, taking possible contraindications into account. Health Care Workers (HCW) are required to provide a vaccination record and or documented evidence of natural immunity to vaccine preventable diseases recommended for HCWs to their health service employer. The employer is required to keep the information on file in the event the HCW is in contact with a vaccine preventable disease. Refer to information about Vaccination for healthcare workers <https://www2.health.vic.gov.au/public-health/immunisation/adults/vaccination-workplace/vaccination-healthcare-workers>.

### 2.1.2.2 Staff safety in Victorian health services

All funded organisations are responsible for the safety of their staff, patients and visitors. Funded organisations must have the systems and processes in place to enable them to identify, assess and control occupational health and safety risks in accordance with their obligations under the *Occupational Health and Safety Act 2004*.

The department is committed to working collaboratively with health services to enhance the health, safety and wellbeing of health service staff. Fundamental to this work will be an emphasis on building a positive and respectful workplace culture, with actions focused in the immediate term on addressing systemic issues in relation to bullying and harassment, and occupational violence and aggression.

### 2.1.2.3 Child safety

#### Commission for Children and Young People

The Commission for Children and Young People commenced operation in March 2013, replacing the former Office of the Child Safety Commissioner, and is an independent statutory authority. The *Commission for Children and Young People Act 2012* provides for the role of the commission.

The commission provides guidance across systems to ensure child-friendly and child-safe practices. The objective of the commission is to promote continuous improvement and innovation in policies and practices relating to the safety and wellbeing of children and young people and the provision of out-of-home care services for children.

The commission's functions include: conducting inquiries into the deaths of children known to child protection, monitoring out-of-home care services and Working with Children Checks, administration of the Victorian Reportable Conduct Scheme, oversee and enforce compliance of organisations with the Child Safe Standards and conducting inquiries into individual cases involving:

- child protection clients
- youth justice clients
- young people under the age of 21, who have or are leaving the care of the Secretary to the Department of Health and Human Services to live independently
- children who die from abuse or neglect
- children who, or whose primary family carer is, receiving or has received services from registered community services, such as out-of-home care or community-based child and family services.

The commission may also initiate or undertake inquiries, on referral by the Minister for Families and Children, into services provided to children and their primary carers such as health, human and educational services where systemic or recurring issues have been identified that impact on a child's safety or wellbeing.

***Children, Youth and Families Act 2005***

The *Children, Youth and Families Act 2005* creates a shared responsibility for family services, the Child Protection program, out-of-home care services and the Children's Court to act in the best interests of the child. This must always be the paramount consideration. To determine whether an action or decision is in a child's best interests, the following must be considered:

- protect the child from harm
- protect the child's rights
- promote the child's development.

There are other numerous other principles that, where they are relevant to the decision or action, must also be considered. The 'best interests' principles focus on children's safety, development and wellbeing in the context of their age and stage of life, their culture and gender. They draw attention to critical dimensions of a child's experience, which may be affected by their family dynamics and circumstances, and the need for timely decision-making, given the possible harmful effects of delay, and continuity and permanency in the child's care. Intervention into the parent-child relationship is limited to that necessary to secure the safety and wellbeing of the child, and removal from parental care only where there is unacceptable risk of harm.

Departmental and community services are also required to consider various decision-making principles when making decisions or taking action in relation to a child. The decision-making principles promote fair and transparent processes and enabling active participation of relevant parties. Additional decision-making principles are included for Aboriginal children, recognising Aboriginal self-determination and self-management.

To adhere to these principles, all services are required to adopt an approach to practice that is child-centred and family-focused.

The Children, Youth and Families Act provides for intervention by the Child Protection program to protect children from abuse and neglect where their parents have not or are unlikely to protect them from harm, and balances these powers with comprehensive safeguards, including judicial oversight, and accountability procedures to protect the rights of children and parents.

This Act enables the Family Division of the Children's Court to make various orders for the care or protection of children. These orders are administered by the Child Protection program.

The legislation also provides for the department and community services to support to families and, where necessary, care for children. It allows for the principal officer of an Aboriginal agency to be authorised to undertake specified functions and powers in relation to a protection order for an Aboriginal child. The department is working with Aboriginal agencies to progressively implement these provisions, with the first authorisations having been made in 2018.

### *Child Wellbeing and Safety Act 2005* and the *Commission for Children and Young People Act 2012*

The Victorian Government's *Children Legislation Amendment (Information Sharing) Act 2018* amends the *Child Wellbeing and Safety Act 2005*, to create the Child Information Sharing scheme to enable prescribed workers to share information to promote children's wellbeing and safety. The Act also authorises the creation of Child Link, an IT platform that will extract and collate a thin layer of factual information about children's enrolment in universal services, as well as the presence of child protection orders and out-of-home care status. Child Link will be accessible to a subset of prescribed professionals working directly with children, and will assist in forming a full picture of a child's service history and identifying potential risks early on.

The scheme promotes earlier intervention to prevent harm to children, as well as enabling better collaboration between government agencies and funded services. The scheme responds to several child death inquiries and is consistent with the recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse. The scheme commenced operation in September 2018 in alignment with related family violence reforms, and was accompanied by comprehensive guidelines and an implementation strategy. The scheme is being introduced in a phased approach with a further phase of professionals being prescribed in the scheme in 2020.

### *Working with Children Act 2005*

The *Working with Children Act 2005* ensures that only people with a valid Working with Children Check (Check) are engaged in child-related work (where a child is under the age of 18 years).

It is the department's expectation that, the places and occupations that require a Check are those that involve regular and direct contact with children. Though the facility may not be a paediatric specific ward, if the ward has regular or planned admissions of patients below the age of 18 years, this is considered non-incidental contact and all staff including the admissions, theatre, recovery, ward staff cleaning staff and food services would require a Check. See further information about the Working with Children Check <https://www.workingwithchildren.vic.gov.au>

### Child Safe Standards – Child Safeguarding Regulation

Child Safe Standards aim to improve the way organisations that provide services for children prevent and respond to child abuse that may occur within their organisation.

The standards are compulsory for organisations providing services to children, and aim to drive cultural change in organisations, so that protecting children from abuse is embedded in the everyday thinking and practice of leaders, staff and volunteers. This will assist organisations to:

- prevent child abuse
- encourage reporting of any abuse that does occur
- improve responses to any allegations of child abuse.

The Child Safe Standards are a central feature of the Victorian Government's response to the Family and Community Development Committee of the Victorian Parliament's *Betrayal of Trust: Inquiry into the Handling of Child Abuse by Religious and Other Non-Government Organisations* (Betrayal of Trust Inquiry).

The Commission for Children and Young People has primary oversight and regulatory responsibility for the Child Safe Standards. The department is defined as a relevant authority under the *Child Wellbeing and Safety Act 2005* and has responsibility for promoting and overseeing compliance with the Child Safe Standards for organisations that it funds and/or regulates which provide services or facilities to children.

The Commission and department play important complementary roles in promoting and overseeing compliance with the Child Safe Standards.

The *Child Safe Standards Compliance Monitoring Framework (the framework)* <http://providers.dhhs.vic.gov.au/child-safe-standards-compliance-monitoring-framework-2018-2019-word> sets out the department's approach to monitoring compliance of in-scope organisations with the Child Safe Standards. The framework is supported by a maturity assessment model which provides guidance to in-scope organisations about their obligations in implementing the standards and focuses on continuous improvement following an identified non-compliance. The *Child Safe Standards Compliance Monitoring Framework* and *Child Safe Standards Compliance Assessment Model* are available on the Resources for Child Safe Standards webpage <http://providers.dhhs.vic.gov.au/resources-child-safe-standards>.

**Reportable Conduct Scheme – Child Safeguarding Regulation**

The scheme requires organisations with a degree of responsibility for children to report allegations of abuse to the Commission for Children and Young People.

**Safe environments for Aboriginal and Torres Strait Islander people**

Funded organisations have a responsibility to provide a culturally safe environment for their Aboriginal and Torres Strait Islander patients and clients. Services should develop local policies and procedures in consultation with local Aboriginal staff and community members.

This includes:

- being respectful of cultural protocols
- offering patients or clients the opportunity to access male or female staff as required
- preventing stigmatism and racial discrimination.

It includes a responsibility for developing an understanding about what cultural safety means for managers, staff, patients and clients. All staff should undertake cultural safety training specific to their region.

The department has developed the following documents to provide guidance to health services:

- The *Aboriginal health, wellbeing and safety strategic plan* (currently under development) addresses the responsibility of health and human services to deliver services to Aboriginal Victorians that are culturally safe, culturally responsive and free of racism.
- The department is currently developing an *Aboriginal cultural safety framework*, which will outline an approach to actively strengthen the inclusion of Aboriginal culture in the workplace and support successful Aboriginal participation in the design, implementation and assessment of policies and programs.

Refer also to:

- the Aboriginal culturally informed addendum to the *Department of Human Services Standards evidence guide (September 2015)* <https://providers.dhhs.vic.gov.au/human-services-standards-evidence-guide-word>.
- Enable 3: Cultural responsiveness chapter (Page 60) in *Koolin Balit: Victorian Government strategic directions for Aboriginal health 2012–2022* <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/koolin-balit>.
- *Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health: A National Approach to Building a Culturally Respectful Health System* <http://www.health.gov.au/internet/main/publishing.nsf/Content/indigenous-crf>.

### 2.1.2.4 Safe environments for people who are trans and gender diverse or have intersex variations

Funded organisations have a responsibility to provide a safe and inclusive environment for people who are trans and gender diverse or have intersex variations. In response to increasing service access and demand by trans and gender diverse people and people with intersex variations, the department expects all funded services to develop local policies, procedures and appropriate training for staff to competently and respectfully engage in gender and body-diverse sensitive practice. This includes using pronouns and names preferred by the individual, providing non-gendered facilities where possible, minimising potentially embarrassing encounters with other patients, and avoiding assumptions about gender and sex-specific health issues, such as the need for cervical or breast/chest screening for women and some trans and gender diverse people. For trans and gender diverse people, it also means providing respectful, supportive advice on access to health services associated with gender affirmation.

To support these policy priorities, an LGBTI Taskforce and Commissioner for Gender and Sexuality have been established. The Taskforce's Health and Human Services Working Group is working to support safe environments for people who are trans and gender diverse or have intersex variations and has identified the following priorities:

- Inclusive practices within hospitals and health services.
- Implementation of the new trans and gender diverse health initiative, which will expand the health system's capacity to support and better meet the needs of trans and gender diverse Victorians, which can be accessed at the Populations webpage <https://www2.health.vic.gov.au/about/populations>.
- Development of a suite of health policies and resources to support and enhance the wellbeing of people with intersex variations, which can be accessed at the Health of people with intersex variations webpage <https://www2.health.vic.gov.au/about/populations/lgbti-health/health-of-people-with-intersex-variations>.
- Following an inquiry undertaken by the Health Complaints Commissioner (HCC) into "gay conversion therapy" in 2018, the Victorian Government announced that new legislation will be developed and introduced to ban this practice in Victoria. In addition, the Victorian Government has committed to developing mental health supports needed for survivors (including lesbian, gay, bisexual and trans and gender diverse Victorians). See the Executive Summary of the Health Complaints Commissioner Inquiry into gay conversion therapy <https://hcc.vic.gov.au/file/permalink/7019>.

The department has developed the following documents to provide guidance to services:

- *Rainbow eQuality: a guide to LGBTI inclusive practice for health and human services* <https://www2.health.vic.gov.au/rainbowequality>
- *Service guideline for gender sensitivity and safety* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/service-guideline-for-gender-sensitivity-and-safety>
- Development of Trans and Gender Diverse Services in Victoria <https://www2.health.vic.gov.au/about/populations/lgbti-health/trans-gender-diverse>.

Funded organisations are encouraged to consider working towards the Rainbow Tick accreditation. The Rainbow Tick guides organisations through a cycle of self-assessment and review by external assessors to determine the extent to which the organisation (or a service within the organisation) meets the needs of LGBTI consumers.

Further information is available at About us – Gay and Lesbian Health Victoria website <http://www.glhv.org.au/about-us>.

### 2.1.2.5 Patient and client safety

All funded organisations are responsible for the safety of their patients or clients. Funded organisations should have systems and processes in place to enable them to identify, manage and respond to adverse events, reducing the risk of such events recurring in future.

Health services and community service organisations that provide services on behalf of the department and report patient or client safety incidents through the Victorian Health Incident Management System (VHIMS) are subject to the Victorian health incident management policy (currently under review) <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-risk-management>.

Community service organisations that provide services on behalf of the department and do not report incidents through VHIMS are subject to the (former) Department of Health's *Incident reporting instruction 2013*. The *Incident reporting instruction 2013* and accompanying incident report form are available at the Funded Agency Channel. More information can be found at the Funded Agency Channel's Health incidents webpage <https://fac.dhhs.vic.gov.au/incident-reporting/health>.

The *Incident reporting instruction 2013* provides guidance for reporting incidents or alleged incidents that involved or impacted patients or clients during service delivery. It does not replace an organisation's own incident management systems and processes. Organisations' incident management policies and processes may be reviewed as part of the departments' routine contract and performance management arrangements.

For community health services a dedicated community health services incident reporting webpage hosts health and human services incident reporting instructions and forms. Visit Incident reporting arrangements for community health services <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/incident-reporting> for more information.

**Supported Residential Services**

- Supported Residential Services (SRS) are privately operated services, not funded by the department.
- Supported Residential Services are registered with the department, which has responsibility for administration of the legislation governing SRS under the *Supported Residential Services (Private Proprietors) Act 2010* and a regulatory responsibility under the Supported Residential Services (Private Proprietors) Regulations 2012.
- Effective from 10 April 2014, the incident reporting process for SRS is as follows:
  - Prescribed reportable incidents in SRS are detailed in the Supported Residential Services (Private Proprietors) Act and Regulations. Authorised Officers are responsible for recording prescribed reportable incidents through a separate and independent database, the Compliance Reporting and Monitoring System (CRAMS).
  - SRS Authorised Officers are no longer required to report SRS incidents via the Category One reporting process.

### 2.1.2.6 Meeting the needs of all Victorians

The government is committed to pursuing a safe and secure Victoria, good health and wellbeing, full participation in society, cultural connection and genuine equality for every Victorian. The department promotes an intersectional approach in designing services and developing policies, which recognises that communities are not homogenous and that services must ultimately be designed to the unique needs of individuals.

The pursuit of these outcomes is reflected in the following policy documents: *Safe and Strong: A Victorian Gender Equality Strategy*, *Victorian. And proud of it: Victoria's Multicultural Policy Statement*, *Absolutely everyone: state disability plan 2017–2020*. The *Premier's Circular* on Good Board Governance (from *Victoria's Multicultural Policy Statement*) also outlines the government's drive to obtain more equitable gender and cultural representation on boards.

The department is focused on improving the lives of all Victorians, especially those vulnerable and at risk. In addition to the whole-of-government policies, this focus is reflected in the department's plans and resources including:

- *Designing for Diversity: Policy and service design resources*: <https://www2.health.vic.gov.au/about/populations/designing-for-diversity>.

- *Delivering for diversity: cultural diversity plan 2016–2019*
- *Language services policy: Department of Health and Human Services*, and its supporting guidelines: *How to work with interpreting and translating services*
- *Rainbow eQuality: a guide to LGBTI inclusive practice for health and human services*
- *Development of Trans and Gender Diverse Services in Victoria* available at the department's Trans and gender diverse health and wellbeing webpage <https://www2.health.vic.gov.au/about/populations/lgbti-health/trans-gender-diverse>
- *Victoria's 10-year mental health plan*, including the *Aboriginal social and emotional wellbeing framework*
- *Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027*.

Some of these policies require reporting for some types of services. For example, in relation to the arrangement for the provision of language services, and for public sector bodies: the development of a Disability Action Plan.

Services should consider the effectiveness of the ways in which they respond to the diversity in the Victorian community.

### 2.1.2.7 Language services

Language service provision is an important aspect of the department's efforts to deliver accessible, person-centred services that respond to the needs of culturally and linguistically diverse (CALD) and deaf communities. Language services are a key component in achieving our strategic directions of person-centred services and care, and advancing quality, safety and innovation.

Failure to provide an appropriately certified interpreter or have important health and human services information translated accurately into community languages can have significant negative impacts, including reduced or adverse health and well-being outcomes. Staff may breach their duty of care to a client if they unreasonably fail to provide or inform a client of their right to an interpreter. Government and its agencies can fulfil their duty of care by taking reasonable steps to actively identify whether language assistance is required and acting accordingly.

The department's *Language services policy* reflects the priority that the department places on ensuring the provision of quality interpreting and translating to support Victorians. It identifies critical points for language service provision, and details implementation support measures to ensure people with low English proficiency, or who use a form of sign such as Auslan, have access to those services.

The policy also stipulates appropriately certified interpreters and translators should be used to ensure the provision of high quality language services. The use of automated interpreting and translating technologies in place of certified interpreters and translators should be carefully considered, noting the duty to ensure translations are accurate, culturally appropriate, not likely to cause harm, and communicate concepts effectively. To that end, the policy also states that requesting family or friends, who are children under 18 years of age, to act in place of an accredited interpreter is not appropriate.

The department expects all those involved in the planning, funding and delivery of funded health and human services to familiarise themselves with this policy and ensure quality language services are an integral part of their service responses. All funded services are required to ensure interpreters engaged through an external language services provider are remunerated in accordance with Victorian government minimum remuneration rates and conditions.

Find further information on the new remuneration rates for interpreters – Victorian Multicultural Commission website <https://www.multicultural.vic.gov.au/images/2018/Victorian-Government-Minimum-Rates-for-Interpreters---1-July-2018.pdf>.

# 2.2 Capability frameworks

## 2.2.1 Maternity and newborn capability levels

The *Capability frameworks for Victorian maternity and newborn services* describe the requirements for providing safe and high-quality maternity and newborn care across six levels. Health services are required to operate in within their agreed and published maternity and newborn capability level.

The service capability levels for all public health services providing planned maternity and newborn care are reviewed and determined by the department, in conjunction with individual services. Capability levels are published at the Maternity and newborn care in Victoria webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/maternity-newborn-care>.

The recently released *Capability frameworks for Victorian maternity and newborn services* (2019) replaces the existing *Capability framework for Victorian maternity and newborn services* (2010) and *Defining levels of care for Victorian newborn services* (2015).

**Continuity of maternity services**

Planned or unplanned changes to a services maternity and newborn capability (such as planned infrastructure works, unplanned changes to essential workforce) must be escalated to the department and a management plan developed, agreed and communicated to staff, patients, key partners and the community.

The periods of time a service cannot meet their capability requirements should be rare, and each health service must have plans to ensure service continuity.

Rural services that are unable to provide care at their determined level for short periods (such as a weekend) are required to:

- Ensure the details of the change in service capability and the plan to manage the temporary change in service delivery (such as transfer of labour care agreements), is formally agreed and documented with local health services and other providers that will be impacted (including Ambulance Victoria and PIPER).
- Develop and communicate a clear, personalised care plan for women who are booked in and likely to deliver over the period, including key contacts at both the referring and the receiving hospital(s).
- Ensure information about how the local community can access care during this period is communicated effectively.
- Advise the department in advance of this change by contacting the Manager, Performance, Governance and Quality, Rural and Regional Health (in the regional office). Regional office staff will then advise the department's central office staff of the change and steps taken to action the above requirements.

The frequency and duration of service provision outside the determined capability level will be monitored by the department and (along with other factors) will inform decision making about ongoing capability levels for the service.

### 2.2.2 New capability frameworks

In addition to the existing capability frameworks for maternity and newborn service, subacute services and palliative care, and in line with the recommendations of Targeting Zero[3] and the Statewide Design, Service and Infrastructure Plan[4], the department will release four new capability frameworks in 2019–20. The new frameworks are for the following clinical service streams:

- cardiac care
- surgery and procedural care
- urgent, emergency and trauma care
- renal care.

For each clinical service stream, there are six levels of complexity from Level 1 (the lowest complexity of care) to Level 6 (the highest complexity of care). As a rule, each service level builds on the preceding service level.

In 2018–19, the department worked with health services and other key stakeholders to develop the service descriptors and service requirements for each level of complexity for each of these clinical streams. In 2019–20, the department will begin a process to assess health services current capability levels and service gaps. This step will be the baseline to assist health services to develop action plans to meet the service requirements in each clinical stream capability framework.

[3] A key recommendation of *Targeting Zero* was that "within three years, the department has expanded its capability frameworks to cover all major areas of hospital clinical practice, be monitoring adherence to them (across public and private hospitals) and sharing information on adherence with hospitals and boards" – recommendation 2.12.2. Targeting Zero is available from the Review of hospital safety and quality assurance in Victoria webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-safety-and-quality-review>.

[4] Department of Health and Human Services (DHHS) (2017) *Statewide design, service and infrastructure plan for Victoria's health system 2017–2037* <https://www2.health.vic.gov.au/hospitals-and-health-services/health-system-designplanning/statewide-plan> commits to the development of capability frameworks to ensure that:

- patients are treated at facilities that can appropriately manage their level of clinical risk, and
- within each capability level, health services are providing the same quality of care, regardless of location.

# 2.3 Expectations, policies and performance

As a condition of funding, funded agencies are required to comply with the following published expectations, guidelines, policies and performance reporting requirements.

## 2.3.1 Acute and specialist

### 2.3.1.1 Surgical and procedural services

All Victorian health services are to meet the requirements of Victoria's *Access policy for planned surgery and procedures.* This new policy will be released in 2019 and provides guidance to the clinical, administrative support staff, managers and executives of all public health services that provide surgery and other planned procedures.

The *Access policy for planned surgery and procedures 2019* will be available at https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/surgical-services.

See details of the Elective Surgery Information System (ESIS) reporting requirements <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/esis>.

### 2.3.1.2 Non-admitted specialist services

An updated Access policy for Non-admitted specialist services in Victorian public hospitals will be released in 2019. This new policy builds on and replaces the previous version of the specialist clinic access policy. It provides guidance to the clinical, administrative support staff, managers and executives of all public health services that provide non-admitted specialist services.

The updated Access policy for non-admitted services will be available at the Access to specialist clinics in Victoria webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/specialist-clinics/access-policy>.

### 2.3.1.3 Victorian endoscopy categorisation guidelines

Victorian health services who provide endoscopy services are expected to ensure that clinicians use the Victorian endoscopy categorisation guidelines.

The *Guidelines for the categorisation for clinical urgency of patients being waitlisted for a colonoscopy* and gastroscopy can be accessed online at the Specialist clinics – resources webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/specialist-clinics/specialist-clinics-program/specialist-clinics-resources>.

### 2.3.1.4 Bariatric surgery

Bariatric surgery is limited to three designated centres: The Alfred, The Austin and Western District Health Service. In 2019–20, there will be a review of the current service model, including referral and eligibility criteria and services requirements.

### 2.3.1.5 Cardiac care

Refer to the *Design, service and infrastructure plan for Victoria's cardiac system* (2016) (the cardiac plan) <https://www2.health.vic.gov.au/hospitals-and-health-services/health-system-design-planning/cardiac-design-service-and-infrastructure-plan>.

To implement the priority actions from the cardiac plan, all public health services providing cardiac care are part of one of three designated service networks. The funding provided to the designated service network fund holder is to support the activities of all the health services in the network, in a coordinated and collaborative way.

### 2.3.1.6 Admitted palliative care

Palliative care is provided in designated inpatient palliative care beds (or units) and by specialist consultancy services. Specified palliative care beds can be located in acute hospitals or as part of subacute units or stand-alone facilities.

All designated palliative care inpatient units must provide care in line with the *Guidelines for Victorian designated palliative care providers, 2019–20*. These can be accessed at: <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care>.

All health services providing designated inpatient palliative care are required to report data elements linked to the AN-SNAP phase of care, including specific elements for the final phase. This is a mandatory VAED reporting requirement. Relevant reports submitted to the department without a phase of care identified will be rejected. They are also required to report patient level costs for palliative care at the phase through the Victorian Cost Data Collection to enable a more accurate link of cost data to the phase of care.

Designated services are required to submit quarterly Clinical Indictors for Pain (CLiP) audit data via the HealthCollect data portal, and participate in the palliative care experience module of the Victorian Health Experience Survey.

**Day hospice**

Some acute health services are funded to provide day hospice.

Day hospice provides people living with a life-limiting illness and their families and carers with a supportive environment to help improve their quality of life. This may include therapeutic activities, social interaction or assistance with treatments. This service applies to people of all ages living with a life-limiting illness and does not include overnight stays.

Health services funded for day hospice must submit activity data using the AIMS form and cost data to the Victorian Cost Data Collection.

### 2.3.1.7 Maternity and newborn services

All health services providing maternity services are required to have an arrangement to regularly review all maternal and perinatal deaths and morbidity. The hospital's processes should align to the *Perinatal Society of Australia and New Zealand: Clinical practice guideline for perinatal mortality* <http://www.psanz.com.au/guidelines>.

All level 2–4 rural health services that provide birthing are expected to participate in the Maternity and Newborn Education (MANE) program provided by The Royal Women's Hospital and PIPER. This multidisciplinary training program commenced in 2017 and ensures all small rural services have regular access to high-quality training and a specific program for level 1 maternity services with a focus on the skills and knowledge needed to manage unplanned maternity care.

For further information see:

- Maternity and newborn services <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services>.
- Eligible midwives and collaboration arrangements <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Eligible-midwives-and-collaborative-arrangements-An-implementation-framework-for-Victorian-public-health-services>.
- Implementing a public home birth program <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/implementing-public-home-birth-program>.

### Maternal and perinatal mortality and morbidity committees

All rural public hospitals providing birthing services have been participating in one of six regional maternal and perinatal mortality and morbidity review committees since 2015. The regional committees provide an additional layer of case review for cases of serious harm or death, and specifically support smaller rural services to ensure all maternal and perinatal deaths have a comprehensive and multidisciplinary case review. The committees have also been reviewing selected morbidity cases and time-critical transfers since 2017.

### Incentivising Better Patient Safety

The Victorian Managed Insurance Authority (VMIA) launched the Incentivising Better Patient Safety (IBPS) program in July 2018. The program supports Victorian maternity services who provide planned maternity care to continue their commitment towards improvements in quality and safety through the increased throughput of birth suite staff in certain evidence based, maternity skills education and training programs. The program identifies three high-risk, maternity focus areas. A refund on the maternity component of the health services medical indemnity premium will be provided when education and training is delivered, according to the programs' eligibility criteria.

From 2018, health services providing planned birthing services (levels 2–6 maternity capability) are expected to be working towards achieving the eligibility criteria established by the Incentivising Better Patient Safety program.

### Adult, paediatric and neonatal intensive care registry data reporting

Health services that operate an adult or paediatric critical care unit must submit data to the Adult Patient Database and the Australian and New Zealand Paediatric Intensive Care Registry, administered by the Australian and New Zealand Intensive Care Society (ANZICS) Centre for Outcome and Resource Evaluation (CORE).

Health services operating a level 5 or level 6 newborn service must submit data on babies who meet the collection's eligibility criteria to the Australian and New Zealand Neonatal Network (ANZNN).

### Retrieval and Critical Health Information System (REACH) system capacity

To facilitate statewide access to critical care beds, all health services providing adult, newborn and paediatric critical care services are required to update bed occupancy data on the Retrieval and Critical Health Information System (REACH) website four times a day as per the REACH manual.

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

### Koori Maternity Services

Victoria's Koori Maternity Services provide culturally safe and responsive care. All Aboriginal women and women having an Aboriginal baby are eligible to access pregnancy care through a Koori Maternity Service.

Strong and effective partnerships between Koori Maternity Services and public health services underpin good perinatal outcomes for Aboriginal women, babies and their families. Koori Maternity Services and public hospitals operate with formal partnerships and agreed referral pathways for the provision of high quality and safe antenatal, intrapartum and postnatal care for Aboriginal women and boorai.

The *Koori Maternity Services guidelines: Delivering culturally responsive and high-quality care* (March 2017) establish the program objectives and requirements for service delivery. All maternity services are encouraged to also consider how the guidelines principles can be incorporated into their maternity service models.

There are 14 Koori Maternity Services located across Victoria, with 11 services located in Aboriginal community-controlled organisations and three in public health services. The key partnerships between Koori Maternity Services and public health services are outlined in Table 2.1.

**Table 2.1: Public health services partnering with Koori Maternity Services**

| Region | Koori Maternity Service | Key birthing partners |
|---|---|---|
| North and West Metropolitan | Victorian Aboriginal Health Service | The Royal Women's Hospital |
| | Western Health (Sunshine Hospital) | Sunshine Hospital (Western Health |
| | Northern Health (The Northern Hospital) | The Northern Hospital (Northern Health) |
| Southern Metropolitan | Dandenong and District Aboriginal Cooperative | Monash Health |
| | Peninsula Health (Frankston Hospital) | Frankston Hospital (Peninsula Health) |
| Barwon South West | Wathaurong Aboriginal Health Service | University Hospital Geelong |
| | Gunditjmara Aboriginal Cooperative | Warrnambool (South West Healthcare) |
| Hume | Rumbalara Aboriginal Cooperative | Goulburn Valley Health |
| | Mungabareena Aboriginal Cooperative | Albury Wodonga Health |
| Gippsland | Gippsland and East Gippsland Aboriginal Co-operative | Bairnsdale Regional Health Service |
| | Central Gippsland Aboriginal Health Service | Central Gippsland Health Service (Sale) |
| Loddon Mallee | Mallee District Aboriginal Service | Mildura Base Hospital |
| | Swan Hill Aboriginal Health Service | Swan Hill District Health |
| | Njernda Aboriginal Corporation | Echuca Regional Health |

Public health services funded to provide a Koori Maternity Service (Western Health, Northern Health and Peninsula Health) are required to submit data to the Koori Maternity Services minimum dataset via the online form at the Aboriginal maternity services webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/aboriginal-maternity-services>.

See the *Koori Maternity Services guidelines* <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/aboriginal-maternity-services>.

### 2.3.1.8 Victorian Paediatric Rehabilitation Service

The Victorian Paediatric Rehabilitation Service (VPRS) specifically caters for children and adolescents who, as a result of injury, medical and surgical intervention, or functional impairment, will benefit from a program of developmentally appropriate, time-limited, goal-focused multidisciplinary rehabilitation.

The Victorian Paediatric Rehabilitation Service is composed of:

- a statewide director and program manager
- two inpatient services at The Royal Children's Hospital and Monash Children's Hospital (Monash Health) and medical directors
- eight ambulatory services, as part of the Health Independence Program at Ballarat Health Services, Barwon Health, Bendigo Health Care Group, Eastern Health, Goulburn Valley Health, Latrobe Regional Hospital, Monash Health and The Royal Children's Hospital.

The Victorian Paediatric Rehabilitation Service statewide appointments provide support, leadership and clinical services where appropriate across the Victorian Paediatric Rehabilitation Service sites. Participating health services facilitate visiting rights for Victorian Paediatric Rehabilitation Service staff conducting clinical work. Visiting clinical staff will observe local policies and procedures, enabling the safe and effective provision of specialist paediatric rehabilitation care.

An advisory group is comprised of members of all Victorian Paediatric Rehabilitation Services and departmental representatives.

Activity is reported through the Victorian Admitted Episodes Dataset (VAED) and VINAH datasets respectively. Cost data is reported at patient level through the Victorian Cost Data Collection.

### 2.3.1.9 Hospital in the Home

Treatment provided to patients at home as Hospital in the Home (HITH) is equivalent to in-hospital acute care.

Health services are encouraged to continually investigate opportunities to utilise HITH as a substitute for in-hospital acute admitted care as acute care practice and treatments evolve.

HITH patients must fulfil the criteria for admission as per the department's Victorian *Admitted Episode Dataset: Criteria for Reporting* policy.

Client consent must be obtained before providing admitted services in the home. Documentation to support that the home-delivered services are a direct substitution for in-hospital WIES funded acute admitted care must be in the health record.

HITH separations and bed days are reported in the program report for integrated service monitoring (PRISM) reports sent to chief executive officers. This enables benchmarking against other health services, particularly the percentage of multi-day separations provided through HITH.
Cost data is reported at patient level through the Victorian Cost Data Collection.

See the *Hospital in the Home Guidelines* <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/hospital-in-the-home>. These guidelines will be refreshed in 2019–20.

### 2.3.1.10 Specialist clinics

**Specialist clinic access policy**

Health services currently in scope to report specialist clinics data through the VINAH minimum dataset are expected to comply with the *Non-admitted specialist services in Victorian public hospitals: Access Policy 2019*. This new policy comes into effect from 1 July 2019 and provides guidance to the clinical, administrative support staff, managers and executives of all public health services that provide non-admitted specialist services in Victorian public hospitals. This document builds on and replaces previous versions of the specialist clinics access policy. Key changes introduced with the new policy include that the policy now applies to both Acute Specialist Clinics and the Health Independence Programs.

See the *Non-admitted specialist services in Victorian public hospitals: Access Policy 2019* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Specialist-clinics-in-Victorian-public-hospitals-Access-policy>.

Other health services providing specialist clinic services practice, must ensure that their procedures and policies align with the objectives and principles of the policy.

In line with health services responsibility for payment of ambulance transport to specialist clinics, health services are responsible for booking and authorising any Ambulance Victoria ambulance transport needed to transport patients to specialist clinics or health independence programs where clinically necessary.

Hospitals must provide patient level specialist clinics data to the Victorian Integrated Non-Admitted Health (VINAH) dataset. Those health services currently reporting specialist clinics activity only through the Agency Information Management System (AIMS) will progress their capability to report patient level specialist clinics data through the VINAH dataset.

Hospitals are expected to report patient level cost data for all specialist clinic activity through the Victorian Cost Data Collection. All health services are expected to continue to improve their AIMS and cost data.

### 2.3.1.11 Telehealth

Health services should continue to drive choice and better patient experience through increased use of telehealth (video consulting), to deliver acute and specialist services in 2019–20 particularly to target patient cohorts that are underserviced by the conventional face to face service model irrespective of the clinic/specialty. This includes people from rural areas, Aboriginal Victorians, the elderly and people with mobility issues or disabilities.

The commitment to deliver an additional 500,000 specialist appointments to rural and regional patients over four years will also begin in 2019–20. Health services will be expected to increase telehealth activity to support this commitment in line with a new telehealth activity target.

Telehealth activity in specialist clinics and emergency departments is funded through existing funding models for acute care.

Services provided via telehealth video consultations in specialist clinics must align to the advice in the *VINAH and Telehealth consultations* factsheet. The factsheet can be accessed at the department's Telehealth program website <https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/telehealth>. The telehealth activity must be reported through the VINAH as described in the VINAH manual for 2019–20.

Services provided via telehealth video consultations in emergency departments to patients located in other Victorian public emergency departments or Urgent Care Centres or Victorian sub-regional government or non-government residential aged care services must align with the *Funding Telehealth Video Consultations in the Emergency Department* guidelines. The Guidelines can be accessed at the Telehealth program website <https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/telehealth>. The emergency department telehealth services can now be reported through the VEMD as described in the VEMD manual for 2019–20.

Further information on telehealth is available at the Telehealth program website <https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/telehealth>

### 2.3.1.12 Integrated Hepatitis C Services

The department funds 10 public health services and two community health services to provide nurse-led Integrated Hepatitis C Services.

In 2019–20, health services are to continue to re-align their service to focus on the effective use of primary care and targeted use of hospital specialist services. This includes:

- implementing localised hepatitis C pathways developed by Public Health Networks with local Public Health Networks
- building capacity in primary care and community settings to deliver hepatitis C testing, treatment and care for non-complex clients
- strengthening referral pathways between specialist clinics and primary care for management of complex clients
- working with pharmacy providers to have drug supply in the community.

**Direct acting antiviral hepatitis C treatments**

The Commonwealth lists a number of medicines for the treatment of hepatitis C on the Pharmaceutical Benefits Scheme and the Highly Specialised Drugs Program. Medicines for the treatment of hepatitis C are listed for prescribing by authorised nurse practitioners under the General Schedule only. Medicines for the treatment of hepatitis C are not listed for prescribing by authorised nurse practitioners under the S100 Highly Specialised Drugs Program. See Further information about hepatitis C treatments <https://www.pbs.gov.au/info/publication/factsheets/hep-c/hepc-factsheet-hospital-prescribers-dispensers>.

In 2019–20, the department will be undertaking a review of the revenue generated by health services in the supply of Hepatitis C medications to patients.

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

Health services who are funded to provide Integrated Hepatitis C Services are required to provide aggregate data on the numbers of patients attending clinics, waiting times and the numbers of patients being transitioned to community providers to the department on request.

For further information please visit:

- Community Health Minimum Dataset <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/community-health-data-reporting>.
- Victorian Health Services Performance website <http://performance.health.vic.gov.au/Home/Category.aspx?CategoryKey=138#Anchor>.
- Hepatitis C – Better Health Channel <https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/hepatitis-c>.

### 2.3.1.13 NDIS – health interface

Health services are expected to deliver high-quality care that is accessible, welcoming, safe and effective to all Victorians, including people with a disability, wherever they are treated. People with a disability should receive treatment and care, and the application of patient rights and responsibilities, that are afforded to any person in the community receiving healthcare with the same or similar clinical needs.

Consistent with person-centred care, aids (such as Auslan) should be used where necessary to overcome communication difficulties and promote active participation of people with a disability in decisions about their treatment and care.

*Absolutely everyone: state disability plan 2017–2020* recognises the opportunities for Victoria as we transition to the National Disability Insurance Scheme (NDIS). The plan sets out 10 key priorities for the state public and private sectors to ensure that people with disability can participate in everyday life.

Health services are encouraged to develop disability action plans to improve the quality of care for people with a disability.

See further information on *Absolutely everyone* <http://statedisabilityplan.vic.gov.au>.

See Guidance on developing disability action plans <https://providers.dhhs.vic.gov.au/disability-action-plans>.

**Working with the National Disability Insurance Scheme**

Health services are responsible for effective interaction with the NDIS to enable timely access to supports and services for people with disability that have new or changed needs following a hospital admission. Health services are expected to understand and operate effectively in the new market based environment that is presented by the NDIS for the delivery of disability services:

- People accessing health-funded services and equipment may be eligible for the NDIS Health services are expected to identify NDIS participants, or those eligible to become participants. When providing care to NDIS participants, health services should ensure that NDIS eligible activity and equipment is billed to the NDIS.
- NDIS participants may access health services to seek care that is funded in their NDIS support plan. It may be that health services are their provider of choice for specialist services or the provider of last resort in areas where markets are developing.

Health services should register as NDIS service providers. This will enable health services to access additional revenue by billing the NDIS for funded activities in relation to eligible clients. In regional areas this will ensure access to certain NDIS-eligible allied health and nursing interventions for NDIS participants where these services may otherwise not be available locally.

**Health service responsibility for aids, equipment and domiciliary oxygen**

This information is provided to clarify responsibilities of public health services in the provision of aids, equipment and domiciliary oxygen for patients being discharged.

Health services have a responsibility to provide aids and equipment for up to 30 days at no cost to the patient (excluding a refundable deposit if applicable). This includes domiciliary oxygen and continence aids required by patients for recuperation, and safe and effective discharge in order to prevent unnecessary continued hospitalisation or readmission. This responsibility applies with the exception of pre-existing Victorian Aids and Equipment Program and NDIS clients in receipt of domiciliary oxygen or continence aids.

Health services may charge the patient fees for these aids and equipment after the expiry of the 30-day post discharge period. Alternatively, patients may choose to make their own arrangements.

Health services will need to work closely with the NDIS to ensure the smooth discharge for admitted patients who are eligible for NDIS. For admitted patients being discharged who are not eligible for the NDIS, health services should provide any aids or equipment necessary to enable discharge for as long as these are required.

For more information about fees and charges for the provision of aids, equipment and domiciliary oxygen see the department's *Fees manual* <http://www.health.vic.gov.au/feesman>.

## 2.3.2 Subacute and non-acute

### 2.3.2.1 Rehabilitation geriatric evaluation and management and maintenance care

**Rehabilitation**

Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating in rehabilitation.

Rehabilitation care is always:

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

**Geriatric evaluation and management**

Geriatric evaluation and management (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.

Geriatric evaluation and management is always:

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

**Maintenance care**

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

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

Health services are delineated to provide rehabilitation and GEM services through *Planning the future of Victoria's subacute service system: a capability and access planning framework*. Services are expected to align their services with the department's published capability level at all times.

Health services providing rehabilitation, GEM and Health Independence Program (HIP) services should ensure they align their services based on their service capability level. Local health services delineated as level 2 will provide and report maintenance care.

**Admitted GEM and rehabilitation – reporting requirements**

All health services providing inpatient rehabilitation and geriatric evaluation and management services are required to report a Functional Independence Measure (FIM™) score on admission and separation for patients with rehabilitation (excluding paediatric rehabilitation) and GEM. This is a mandatory VAED reporting requirement. Relevant records submitted to the department without a FIM™ score will be rejected.

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

A Program Identifier for Specialist Spinal Rehabilitation Service (code 10) is to be reported for patients in the two designated specialist ABI rehabilitation services located at Caulfield Hospital, Alfred Health and the Royal Talbot Rehabilitation Centre, Austin Health.

See *Planning the future of Victoria's subacute service system: a capability and access planning framework* <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/subacute-planning>.

For program details and service model information refer to the department's Patient care webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care>.

### 2.3.2.2 Transition Care Program

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

Refer to further information on the Transition Care Program <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/transition-care-program>.

### 2.3.2.3 Health Independence Program

Health Independence Program (HIP) services aim to provide hospital substitution and diversion services by supporting people in the community, in ambulatory settings and in their homes, this may include disability residential facilities. Health Independence Program services focus on improving and optimising people's function and participation in activities of daily living to allow them to maximise their independence and return to, or remain in, their usual place of residence.

**Non-admitted specialist services in Victorian public hospitals: Access Policy 2019**

Health services that currently reporting HIP data through the VINAH minimum dataset are expected to comply with the *Non-admitted specialist services in Victorian public hospitals: Access Policy 2019*. This new policy comes into effect from 1 July 2019 and provides guidance to the clinical, administrative support staff, managers and executives of all public health services that provide non-admitted specialist services in Victorian public hospitals. Health services will have 12 months in which to make the necessary changes to comply with the policy.

Refer to the Non-admitted specialist services in Victorian public hospitals: Access Policy 2019 <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Specialist-clinics-in-Victorian-public-hospitals-Access-policy>.

### Conditions of funding

It is expected that health services will continue to provide the HIP service components for which they are funded, based on their subacute service capability framework level <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care>.

### HIP service delivery components

The components of the HIP that a client receives will be based on the client's assessed needs and will assist the client to meet their identified goals. This may consist of one or more of the following:

- non-admitted rehabilitation (such as rehabilitation at home or in a community rehabilitation centre)
- care coordination – short-term or complex
- client self-management, education and support
- access to specialist services, including specialist assessment (such as linking to residential in-reach services, a specialist medical clinic or specialist subacute clinic such as chronic pain management, falls and balance or continence clinics)
- short-term supports (such as post-acute care)
- complex psychosocial issues management.

In 2019–20 health services will continue to progress the HIP consolidation, with the aim of providing a responsive, integrated and flexible approach to service provision.

### Reporting requirements

Health services must report their non-admitted subacute costing data to the Victorian Cost Data Collections as detailed in Chapter 1, section 1.11 'Subacute non-admitted services'.

The definition of a HIP contact is provided in the VINAH business rules. The HIP counting unit will be 'direct non-admitted contacts' which are defined as contacts where all of the following VINAH characteristics are met:

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

Organisations that receive funding under any of the following programs must transmit data to the VINAH MDS:

- specialist clinics (outpatient)
- HIP:
  - subacute ambulatory care services (including paediatric rehabilitation)
  - Hospital Admission Risk Program (HARP)
  - post-acute care (PAC)
  - residential in-reach service
- community-based palliative care
- Family Choice Program
- Victorian HIV Service
- Victorian Respiratory Support Service
- Medi-hotel (optional)
- Transition Care Program (TCP)
- hospital-based palliative care consultancy teams.

The AIMS S11 form will continue to be required to report service events for Commonwealth reporting processes.

Non-admitted subacute care programs and 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.

Hospitals are expected to report patient level cost data for all subacute and non-acute activity through the Victorian Cost Data Collection.

For further information:

- *Planning the future of Victoria's subacute service system: a capability and access planning framework (2013)* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Planning-the-future-of-Victorias-subacute-service-system-A-capability-and-access-planning-framework---February-2013>.
- The *Health Independence Program guidelines* will continue to guide health service and departmental directions for these services in 2019–20 and are available at <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/health-independence-program/hip-guidelines>.

### 2.3.2.4 Community palliative care

Designated community palliative care services provide end of life and palliative care to clients and carers that is responsive, multidisciplinary and evidence-based. Care is tailored to the preferences, values and goals of the individual and to their stage of illness, and can be early or late in the illness trajectory. Care includes complex pain and symptom management and assistance with physical, spiritual, social and cultural concerns related to life-limiting illness and bereavement. Practical help includes respite and financial assistance for equipment that supports the safety of clients, carers and staff in the home.

These services must provide care in line with the *Guidelines for Victorian designated palliative care providers, 2019–20*. These can be accessed at the End of life care webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care>.

**After hours**

Outside business hours (usually between 7.00 am and 5:00 pm Monday to Friday, excluding public holidays), all designated community palliative care services must provide or arrange the following minimum level of service to their clients:

- Specialist palliative care telephone advice to clients, carers and families primarily (but not only) about symptom management if required. This may include secondary consultation with a specialist palliative care provider where relevant.
- A health professional visit if required based on the client's, carer's or family's needs (if it is safe for staff to undertake the visit).
- Any other after-hours care negotiated between clients, their carer and the community palliative care service will be on an individual basis.

**Reporting requirements**

All designated community palliative care services must report activity using the program and stream element, as described in the VINAH data collection system:

- Contacts will be reported through VINAH as per the standard VINAH reporting requirements.
- The AIMS form will continue to be required to report service events for commonwealth reporting processes.
- Funded services are required to submit quarterly Clinical Indictors for Pain (CLiP) and Breathlessness (CLiB) audit data via the HealthCollect data portal. Noting the CLiB data collection is scheduled to commence in 2019–20.
- Funded services are required to participate in the palliative care experience module of the Victorian Health Experience Survey.
- Patient level cost data for community palliative care activity are to be reported through the Victorian Cost Data Collection.

### 2.3.2.5 Palliative care consultancy teams

**Hospital-based consultancy teams**

*Reporting requirements*

Hospital-based consultancy programs are eligible to report patient-level data using the VINAH dataset in 2019–20. Individual health services should make an assessment about the resource impacts of reporting their information using the VINAH dataset against the benefits.

If a service does not report hospital-based consultancy activity data in VINAH, they must report their activity in AIMS.

**Regional palliative care consultancy teams**

Funding allocations for regional palliative care consultancy form part of the health service modelled budgets in their Acute & Subacute allocation (refer to the Appendices, Appendix 2, section 2.1.1 'Health service modelled budgets 2018–19 and 2019–20' for health services and the Appendices, Appendix 2, section 2.1.5 'Registered community health centres budgets 2018–19 and 2019–20' for NGO providers).

Recall does not apply to specified grants for regional palliative care consultancy services in 2019–20.

*Reporting requirements*

Regional consultancy programs are required to use the AIMS form to ensure aggregate activity counts comply with the definition of a service event in 2019–20.

Regional consultancy teams must report:

- number of contacts
- number of referrals
- active episodes
- number of episodes opened
- number of episodes closed
- number of patients.

Services are required to report AIMS data by the 14th of each month.

**Statewide consultancy services**

A range of statewide services are funded to provide specialist advice in relation to particular diagnoses or population groups. These are:

- Victorian Paediatric Palliative Care Consultancy Program
- Very Special Kids
- Statewide Specialist Bereavement Service
- Motor Neurone Disease Association (MNDA) Victoria.

Funding allocations for palliative care statewide consultancy services are included in the organisations Acute & Subacute allocation (refer to the Appendices, Appendix 2, section 2.1.1 'Health service modelled budgets 2018–19 and 2019–20' for health services and the Appendices, Appendix 2, section 2.1.5 'Registered community health centres budgets 2018–19 and 2019–20' for NGO providers).

Recall does not apply to statewide palliative care consultancy services in 2019–20.

***Reporting requirements***

Statewide consultancy programs are required to report data via AIMS in 2019–20 Services must report:

- number of contacts
- number of referrals
- active episodes
- number of episodes opened

- number of episodes closed
- number of patients.

Hospitals are expected to report patient level cost data for all Statewide consultancy program activity through the Victorian Cost Data Collection.

For further details relating to all palliative care consultancy services including Victorian Paediatric Palliative Care Consultancy Program business rules go to the Palliative care webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/palliative-care>.

### 2.3.2.6 Palliative care consortia

Palliative care consortia support the department to implement *Victoria's end of life and palliative care framework* across the state. Consortia play an important role in regional education and training activities, and linking palliative care into the regional health and community care system.

Each consortium receives funding to support the manager role and contribute to consortium activities. One member organisation of each consortium acts as the fund holder.

- All funding grants for consortia are allocated to the nominated fund holder organisations.
- Each Consortium Executive Committee is responsible for the allocation of funds to consortium activities in their region.

Each consortium is required to submit an annual report to the department prior to the 30 September 2019. The report should outline their key achievements and activities for 2018–19 and include a financial statement that accounts for expenditure throughout the financial year.

For more information about palliative care consortia visit the Palliative care webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/palliative-care>.

### 2.3.2.7 Victorian Artificial Limb Program

Funding for the Victorian Artificial Limb Program will continue to be provided as a block grant to health services as a non-admitted subacute service.

Victorian Artificial Limb Program services are required to report service events as a non-admitted subacute service through the AIMS S11 form and report the cost data to the Victorian Cost Data Collection.

Services expected to provide artificial limbs under the Victorian Artificial Limb Program in 2019–20 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 annual activity and expenditure report regarding limbs and repairs will again be required for 2019–20.

A funding review of the Victorian Artificial Limb Program will be undertaken in 2019–20.

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

Recall will not apply to Victorian Artificial Limb Program activity in 2019–20.

### 2.3.2.8 Victorian Respiratory Support Service

Funding for the Victorian Respiratory Support Service will continue to be provided as a block grant to Austin Health as a non-admitted subacute service.

The Victorian Respiratory Support Service is required to report service events as a non-admitted subacute service through the AIMS S11 form and report contacts through VINAH. They are also required to report patient level cost data through the Victorian Cost Data Collection.

### 2.3.2.9 Total parenteral nutrition

In 2019–20 funding will again be provided to five health services to support total parenteral nutrition (TPN) services for non-admitted patients who self-administer total parenteral nutrition at home. The services are Austin Health, Melbourne Health, Monash Health, St Vincent's Health and The Royal Children's Hospital.

All non-admitted patient sessions performed in a single month will be bundled and counted as one, non-admitted service event. A recall/throughput adjustment will be applied for health services whose activity is below or over target.

Health services funded to provide total parenteral nutrition will be required to report activity and cost data to the department in 2019–20.

Activity is to be reported via the AIMS S12 by the 14th day following the end of month and to be reported to VINAH. Cost data reported via the Victorian Cost Data Collection should consider the cost of consumables, equipment, maintenance and overheads. It should not include the cost of consultations with a health professional. Health services should count and report consultations with health professional separately.

For more information see references in the Home Enteral Nutrition section below.

### 2.3.2.10 Home enteral nutrition

Funding is provided to support home enteral nutrition (HEN) services given to non-admitted patients who self-administer enteral nutrition at home. All non-admitted patient sessions performed in a single month will be bundled and counted as one, non-admitted service event. A recall/throughput adjustment will be applied for health services whose activity is below or over target. For a list of event targets by health service, see the Appendices, Appendix 2, 'Table 2.19: Home enteral nutrition service event targets 2019–20'.

Health services funded to provide home enteral nutrition are required to report activity and cost data to the department in 2019–20.

Activity is to be reported via the AIMS S12 by the 14th day following the end of month and to be reported to VINAH. Cost data reported via the Victorian Cost Data Collection should consider the cost of consumables, equipment, maintenance and overheads. It should not include the cost of consultations with a health professional. Health services should count and report consultations with health professional separately.

For more information about subacute non-admitted services:

- See *Planning the future of Victoria's subacute service system: a capability and access planning framework (2013)* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Planning-the-future-of-Victorias-subacute-service-system-A-capability-and-access-planning-framework---February-2013>.
- Further information on VINAH is contained in the VINAH manual <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vinah>.

Information on what type of equipment can be provided; client eligibility criteria and the application process can be found in the *Victorian Aids and Equipment Program Guidelines (2010)* <https://providers.dhhs.vic.gov.au/aids-and-equipment>.

## 2.3.3 System improvements

### 2.3.3.1 Strengthening hospital responses to family violence

Health services are expected to progressively rollout and embed a whole-of-hospital model for responding to family violence. They should implement a train-the-trainer approach to staff education; actively participate in the community of practice; coordinate reporting and be prepared to meet the requirements for future information sharing legislation and the revised Common Risk Assessment Framework.

Lead health services are expected to actively mentor and support their nominated health services to rollout and embed their whole-of-hospital model.

The project is managed by The Royal Women's Hospital and Bendigo Health, and reporting requirements are outlined by the project managers. The project toolkit is available at SHRFV Documents – The Royal Women's Hospital website <http://haveyoursay.thewomens.org.au/shrfv-project/documents>.

For more information, see:

- Family violence reform website <https://www.vic.gov.au/familyviolence.html>
- Have Your Say @ The Women's <https://haveyoursay.thewomens.org.au>.

### 2.3.3.2 Prevent and respond to risks of occupational violence and aggression and bullying and harassment

All funded organisations are responsible for the safety of their staff, patients and visitors. Funded organisations must have the systems and processes in place to enable them to identify, assess and control occupational health and safety risks in accordance with their obligations under the *Occupational Health and Safety Act 2004*.

The department will continue to work with health services in 2019–20 to implement initiatives to better prevent and respond to risks of occupational violence and aggression and bullying and harassment. These initiatives can be found at the Worker Wellbeing webpage. Health services are expected to regularly refer to the information provided on the webpage and implement the guidance and resources including minimum standards.

The implementation of the minimum standards, guidance and supporting tools at each health service will be monitored by the department during 2019–20. The department requires that all Victorian public health services undertake the Victorian Public Sector Commission's People Matter Survey in 2019, including the Diversity and Inclusion and Sexual Harassment modules.

Health services are required to publicly report all incidents of occupational violence in their annual report. The department will be working with health services and boards in 2019–20 to improve the reporting and support risk management.

For more information about occupational violence and bullying and harassment resources visit the Worker health and wellbeing in Victorian health services webpage <https://www2.health.vic.gov.au/health-workforce/worker-health-wellbeing>.

#### 2.3.3.3 Implementation of the Medical Treatment Planning and Decisions Act 2016

The *Medical Treatment Planning and Decisions Act 2016* came into effect on 12 March 2018. The Act places a greater emphasis on person-directed care and clarifies the health practitioner's obligations when treating people who do not have decision-making capacity.

The Act ensures that people are provided with medical treatment that is consistent with their preferences and values.

The Act establishes a single framework for health practitioners that will support good clinical practice. This will require an emphasis on good communication between health practitioners, patients, families and carers.

The Act clarifies the legal effect of an advance care directive and provides a single process for identifying who should make decisions on behalf of a person, and a process for making these decisions. This will clarify decision making and reduce conflict by creating clear roles and responsibilities.

If a registered health practitioner fails to act in accordance with the Act, this will constitute unprofessional conduct.

Health services should continue to be working towards:

- including advance care planning and identification of medical treatment decision-makers in communication with other providers
- including advance care planning as a parameter in assessment of outcomes such as mortality and morbidity review reports, patient experience and other routine data collection
- enabling and promoting the use of My Health Record, an initiative of the Commonwealth Government, to support communication of advance care plans.

As advance care planning delivery becomes embedded into the usual care health services provide, health services should be seeing an increase in the number of both admitted and non-admitted patients with an advance care directive/plan alert and an identified medical treatment decision-maker. This will be measured through mandatory VAED, VEMD and VINAH data items.

A suite of resources has been created in collaboration with the Victorian Office of the Public Advocate and the Victorian Medical Treatment Planning and Decisions Act Implementation Working Group.

These resources are available at the Advance care planning webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning>.

### 2.3.4 Improving Care for Aboriginal and Torres Strait Islander Patients

The Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) program was established in 2004 and built on the previous Aboriginal Hospital Liaison Officer (AHLO) program. The program requires health services to report progress against four key result areas through the Continuous Quality Improvement (CQI) tool, to demonstrate the provision of quality care for Aboriginal patients. The four Key Result Areas (KRA) are:

1. Engagement and partnerships
2. Organisational development
3. Workforce development
4. Systems of care

The department supports the sharing of best practice through the ICAP program. It encourages relationship building, peer support and professional development across health services.

Version 2 of the *National Safety and Quality Health Service Standards* (NSQHS) was released in 2017, for commencement from 1 January 2019. Version 2 requires health services across Australia to adhere to six actions across three standards, with the objective to improve access and outcomes for Aboriginal peoples.

The purpose of the standards is to ensure that health services:

- increase the recruitment and retention of Aboriginal people
- develop career pathways for Aboriginal people working in clinical and non-clinical roles
- develop and strengthen partnerships between both Aboriginal communities and Aboriginal community-controlled organisations
- improve the cultural safety for Aboriginal workers and service users.

The department undertook a review of the 30 per cent Aboriginal WIES loading in 2017, *Improving the effectiveness of the Aboriginal WIES loading (the loading review).* As part of the recommendations from the loading review and the need to align with Version 2 of the standards, the department has committed to a review of the ICAP program. The purpose of this review is to:

- improve health outcomes for Aboriginal patients
- improve the accountability of health services who are in receipt of funding for Aboriginal patients
- support and prepare Victorian health services for accreditation.

Further information on the loading review is provided below.

*Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027*, section 3, highlights the importance and necessity of the ICAP program to improve health outcomes for Victorian Aboriginal peoples.

Further information regarding the revised ICAP program will be provided in late 2019.

**Aboriginal and Torres Strait Islander loading**

Cultural safety is a key driver of Aboriginal health outcomes in Victoria. In 2016, an independent evaluation identified numerous deficits in cultural safety practices in Victorian hospitals, particularly in areas such as; a strong Aboriginal health workforce, cultural safety training, a welcoming environment, and relationships with Aboriginal community-controlled health organisations (ACCHOs).

In 2017, the department undertook a review of the loading applied to acute and subacute funding for Aboriginal patients, which is a key policy lever for improving outcomes for Aboriginal people in hospital care. To address the findings of the review, a range of recommended reforms were proposed to Aboriginal patient funding, monitoring and cultural safety guidance, which will be fully implemented in 2020–2021. The four broad recommendations relate to funding design, funding accountability, supporting reforms and Aboriginal self-determination.

There will be no reduction in overall funding provided across health services in Victoria. Under the changes, new reporting requirements will be introduced to ensure all health services are accountable for using Aboriginal funding for Aboriginal patients. WIES funded health services will be required to develop a cultural safety investment strategy at the start of each financial year, and acquit against this strategy at the end of each financial year. Further information on these new changes will be provided to health services in the first half of the financial year. The revised ICAP program will provide health services with adequate support to meet these new requirements, as well as prepare them for Version 2 of the NSQHS.

In line with *Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027*, self-determination is central to the proposed reforms. Health services are strongly encouraged to partner with Aboriginal-led organisations in developing their cultural safety investment strategies. They are also strongly encouraged to employ Aboriginal people and engage Aboriginal-led organisations in the delivery of cultural safety and clinical services.

**Requirements for 2019–20**

The department will shadow alternate funding arrangements during 2019–20 and work with and support health services to understand the proposed changes to the funding model for Aboriginal patients.

Under the shadow arrangements, health services will have additional requirements in the 2019–20 financial year. WIES and SWIES funded services will be required to complete an acquittal form at the end of the financial year, outlining cultural safety expenses incurred over the year.

**Expected changes in 2020–2021**

In 2020–2021 the 30 per cent Aboriginal loading will be split into three distinct streams.

1. A reduced loading closer to the National pricing adjustment of 5 percent (on top of normal activity-based funding) will be retained to cover excess clinical costs for Aboriginal patients.
2. A significant proportion of the remaining loading will be redirected into annual block grants to contribute to key workforce (e.g. AHLO) costs, and other recurrent costs associated with cultural safety and supplementary programs for Aboriginal patients. The size of the block grant will vary and will be calculated using a number of criteria which may include, but not limited to, the size of the health service and the Aboriginal population within the health services catchment.
3. Funding grants will be available through a competitive application process to cover the costs of one-off purchases for innovative projects (including research and evaluation) designed to improve cultural safety.

Ahead of the 2020–2021 financial year, the department will clarify expectations of cultural safety and how this funding is to be used. Guidance on best practice in improving cultural safety will also be provided through the revised ICAP program.

### 2.3.5 Integrated cancer services

All health services that treat cancer patients are expected to be active members of the Integrated Cancer Service (ICS) for their area and support the implementation of the network's vision to improve patient experiences and outcomes by coordinating cancer care and driving best practice. The Integrated Cancer Services will support the achievement of the following goals stated in the Victorian cancer plan:

- Victorians know their risk and have their cancer detected earlier
- Victorians with cancer have timely access to optimal treatment
- Victorians with cancer and their families live well.

A continuing focus for the ICS in 2019–20 is to work in collaboration with the relevant cancer centres to streamline service improvement priorities within and across the ICS areas. This is in addition to participating in statewide initiatives to support improvement in cancer outcomes.

Host organisations are required to hold funds on behalf of the ICS and act as employers for ICS program staff. Host organisations need to ensure that appropriate human resource management, fiscal management processes and accounting procedures are in place. A senior executive should be nominated as the key management contact regarding these matters.

The ICS governance committees, with clinician input, are responsible for:

- decision making about using funds in accordance with both local and statewide priorities for cancer reform
- accountability for the ICS funding
- ensuring value for money
- ensuring sound project management and evaluation processes are employed.

Host organisations and the ICS governance committees must agree to any charges levied by the host for infrastructure support. These charges must be reflective of actual costs incurred and should be reported in the ICS budget. A detailed reporting schedule for Integrated Cancer Services will be provided in September 2019. The report will identify requirements, dates and timelines.

The accountability requirements of the ICS governance committees are to:

- provide an annual review and report of progress against the current strategic plan
- provide half-yearly financial statements (for periods ending 31 December and 30 June)
- participate in the department's cancer reform meetings and workshops
- provide an annual report (for 2019–20) for public dissemination
- participate in processes to evaluate the impact of cancer reform activities, including reporting outcomes against targets and milestones.

The department reserves the right to conduct an ICS program office performance and financial audit.

See further information about Victoria's Integrated Cancer Services <https://www2.health.vic.gov.au/about/health-strategies/cancer-care>.

### 2.3.6 Perinatal services performance indicators

Safer Care Victoria publishes an annual report of Victorian perinatal services performance indicators. The report contains individual hospital (or campus) level data allowing comparison with the statewide public hospital average and the statewide private hospital average.

Health services should use this report to:

- track their own performance and trends, using raw local data more frequently if required
- compare results with services of a similar profile (size and capability)
- undertake ongoing local audits, including adverse event reviews through their perinatal mortality and morbidity committees
- perform local analysis of specific groups or cohorts of cases such as age profiles
- identify priority areas for focus and plan for performance improvement within a continuous quality framework
- evaluate improvement programs and provide feedback to relevant stakeholders
- disseminate results internally to build engagement with the maternity team
- provide education and support to staff and local communities
- collaborate with neighbouring health services and community-based healthcare providers to improve local practice, referral systems and performance.

Each indicator has a list of recommended actions that should be undertaken by health services and, in particular, health services with unexpected outcomes to ensure ongoing performance improvement. These include:

- an assessment of their local capability and the processes to support regular clinical audits and the provision of performance data feedback to clinicians
- a multidisciplinary review of local clinical practice guidelines and protocols to ensure they are based on current evidence and research
- a review of organisational barriers that constrain continual practice improvement
- benchmarking with peer group services
- engaging with other health services to achieve better outcomes that support local and regional improvement (this may include referral of results to their regional perinatal morbidity and mortality committee for expert multidisciplinary consideration).

Identifying improvement goals including timelines, and working with Safer Care Victoria and the department to monitor performance and improvement initiatives over time. Safer Care Victoria will work with health services to identify areas warranting attention in 2019–20. See further information about the perinatal services indicators report <https://bettersafercare.vic.gov.au/reports-and-publications/victorian-perinatal-services-performance-indicators-reports>.

## 2.3.7 Blood Matters Program

The Blood Matters Program assists health services to monitor patient blood management and transfusion practices in line with guidelines and standards to provide recommendations and support for best practice.

Health service performance reporting is required through participation in audits and surveys on practice and governance. Health services will be advised of the audits to be conducted in 2019–20.

Participation in the Blood Matters Program's Serious Transfusion Incident Reporting Program is strongly encouraged and supports national healthcare standards. It is expected that serious adverse events related to blood or blood components are reported. These are clinical reactions and procedural events including:

- near-miss incidents
- events related to Rh D immunoglobulin
- cell salvage.

Health services are expected to align blood management and transfusion practices with national guidelines, standards and strategies such as:

- *National Stewardship Expectations for the Supply of Blood and Blood Products* and the *National Patient Blood Management Guidelines Modules 1–6*, both available at the National Blood Authority website <https://www.blood.gov.au>
- *National Safety and Quality Health Service (NSQHS) Standards*, second edition available at Assessment to the NSQHS Standards – Australian Commission on Safety and Quality in Health Care website <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards>
- *National wastage and haemovigilance strategies*, available at the National Blood Authority website <https://www.blood.gov.au>.

The department established the transfusion nurse/trainer/safety officer, patient blood management role across Victoria, and continues to financially support these positions. Health services are expected to have roles in place to ensure compliance with national guidelines and the NSQHS standards, and are funded to achieve this through acute admitted funding.

Health services are expected to support compliance with the national guidelines and the *NSQHS standards through activities that* include:

- Employment of an appropriately trained nurse or scientist, such as one who holds a Specialist Certificate in Blood Management Foundations/Graduate Certificate of Transfusion Practice.
- Ensuring the role operates within an effective health service blood management and quality governance structure.
- Incorporating patient blood management practices – that is, a patient-centred approach to safe and appropriate transfusion practice in line with national clinical guidelines, standards and strategies (NSQHS Blood Management Standard (7)).
- Participation in Blood Matters Program audits, educational forums and other activities.
- Annual progress reports to the Blood Matters Program.

See further details on the Blood Matters Program <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/blood-matters>.

## 2.3.8 Mental health services

Clinical mental health services in Victoria are delivered to three specific age groups:

- children and adolescents (0–18 years)
- adults (16–64 years)
- aged persons (65 years or older).

Youth-specific mental health services have also been developed for adolescents and young people (16–25 years) and are delivered largely through adult mental health services.

#### 2.3.8.1 Clinical mental health services for children and adolescents (0–18 years)

Child and adolescent mental health services (CAMHS) provide specialist mental health treatment and care to children and adolescents. These services assess and treat children and adolescents experiencing moderate to severe mental health problems and disorders, and assist those with less severe problems with advice and information about where and how to access help. Vulnerable children and young people, particularly those involved with statutory services such as child protection, are prioritised.

There are 13 health services that provide CAMHS services across the system. The CAMHS acute inpatient service units are located in general hospitals, and mostly admit young people aged 13–18 years of age:

- The Royal Children's Hospital admits young people aged 13–17 years of age from their local catchment.
- Orygen Youth Health admits young people aged 18–25 years of age from their local catchment.

Austin Health's child mental health inpatient unit is a specialist statewide service for children aged less than 13 years. Monash Children's Hospital recently opened a new specialist statewide inpatient service for children up to 12 years of age.

Each Area Mental Health Service has referral relationships with CAMHS inpatient services across the state.

#### 2.3.8.2 Young people's mental health services (16–25 years)

- Youth program – early psychosis services are for young people who are experiencing a first episode of psychosis. These services are provided statewide as a subspecialty program in some specialist adult mental health services (Melbourne Health).
- Orygen Youth Health (Melbourne Health) provides a specialised youth mental health clinical service for young people 15–25 years old, with a focus on early intervention and youth-specific approaches.
- Youth Prevention and Recovery Centres (PARC) are for young people experiencing significant mental health problems who are either leaving an acute hospital inpatient admission or who would benefit from 24-hour support to avoid a hospital admission. Youth PARCs are located in Dandenong, Bendigo and Frankston and are intended to support regional accesses.

#### 2.3.8.3 Adult mental health services (16–64 years)

17 health services constitute the Victorian adult clinical mental health system. Adult specialist mental health services are provided for people experiencing severe mental illness (for example, schizophrenia). People may also present in situational crisis that may lead to self-harm or inappropriate behaviour towards others.

Clinical adult area mental health services generally include:

**Inpatient treatment services**

- *Acute inpatient services* – provide a range of therapeutic interventions and programs to patients and their families during an acute episode to learn more about the impact of the illness, explore ways to better manage the illness, improve coping strategies and move towards recovery. (All of the age-based mental health services provide acute inpatient services for people who cannot be assessed and treated safely and effectively in the community).
- *Consultation and liaison psychiatry* – delivers mental health services to people who have a primary medical condition admitted to general hospital settings that may be associated with a mental illness. The Victorian Government funds 14 health services to provide consultation and liaison psychiatry.

- *Psychiatric assessment and planning units* (PAPUs) – deliver fast access to short-term specialist psychiatric assessment and treatment for people experiencing an acute episode of mental illness.

**Residential treatment services**

- *Secure extended care units* (SECUs) – provide medium to long-term inpatient treatment and rehabilitation for people who have unremitting and severe symptoms of mental illness or disorder. These units are located in hospital settings. As SECU are not in all catchments cross area access arrangement are established.
- *Community care units* (CCUs) – provide medium to long-term clinical care and rehabilitation services in a home-like environment. They support the recovery and rehabilitation of people seriously affected by mental illness to develop or relearn skills in self-care, communication and social skills in a community-based residential facility with the aim to returning to the community.
- *Prevention and Recovery Centres (PARC)* – adult prevention and recovery care (PARC) services are community-based, short-term supported residential services for people experiencing a mental health problem, but who do not need (or no longer require) a hospital admission.

**Outpatient treatment services (community based clinical treatment)**

- *Acute community intervention service* – provides urgent advice, referral and treatment to people with a mental illness who are acutely ill or in crisis. The service is provided through telephone triage, mental healthcare in emergency departments and community mental health.
- *Continuing care* – provide non-urgent assessments, treatment, case management, support and continuing care services in the community. This is the largest component of adult community-based services.

### 2.3.8.4 Aged persons mental health services (65 years and over)

Fourteen health services constitute the Victorian aged clinical mental health system. These are specialist mental health services for people with longstanding mental illness or for those who have developed a functional illness such as depression, a mood disorder, anxiety or schizophrenia later in life. Services include inpatient units located in general hospitals or with other aged care facilities, and specialist residential care.

**Statewide, area based and specialist mental health services**

There are a range of specialist mental health services that are specifically targeted to Victorians with severe and complex illnesses that are offered in a smaller number of health services and support the needs of a broader area catchment or the state. These include:

- *Eating disorder services* are delivered by the Royal Children's Hospital, Melbourne Health, Austin Health and Monash Health. Services include intensive community-based treatment models for children, young people and adults with eating disorders, and their families, in addition to specialist beds.
- *A personality disorder service* (Spectrum based at Eastern Health) works with local area-based clinical services to provide treatment for those aged 16–64 years old with a personality disorder, focusing on people who are at risk from serious self-harm or suicide and who have complex needs. Spectrum receives referrals from area-based clinical services and primary health providers such as GPs or private psychiatrists.
- *Parent and Infant mental health services* (previously Mother and Baby Units) provide support for parents experiencing severe mental illness in the antenatal or postnatal period. Six health services have specialist parent and infant units that provide a residential setting for psychiatric treatment, assessment and support for parents experiencing severe mental illness and their infants aged up to 12 months. The units are located in the Austin, Bendigo, Ballarat, La Trobe, Mercy, Monash.
- *Brain disorder service,* located at Austin Health, is for people with acquired brain injury or neurogenerative conditions with associated psychiatric conditions. Services include inpatient, residential and community programs, outreach services and secondary consultation.

- A statewide specialist *neuropsychiatry service* specialises in mental illnesses associated with disorders of the nervous system. The service is located at the Royal Melbourne Hospital (Melbourne Health).
- The *Victorian Dual Disability Service* is located at St Vincent's Hospital Melbourne and works with specialist mental health services across Victoria to assess, treat and support people with a dual disability. A person with a dual disability has an intellectual disability or autism spectrum disorder, as well as a mental illness.
- *Dual diagnosis* services aim to improve treatment outcomes for individuals who have co-existing mental health and substance use issues. Services include education and training for Area Mental Health Services, drug and alcohol and MHCSS staff, support to organisations to develop dual diagnosis capabilities, and clinical consultations in collaboration with primary case managers. The service is auspice by Melbourne Health, St Vincent's, Eastern Health and Monash Health.
- *Aboriginal mental health services* aim to improve access and the cultural appropriateness of services provided to Aboriginal people. Koori mental health liaison officers are based in rural/ regional mental health services and provide culturally appropriate support and services. St Vincent's Hospital Melbourne has five specialist Aboriginal beds in the mental health acute inpatient unit that are managed with the Victorian Aboriginal Health Service Family Counselling Service.
- *Victorian Transcultural Mental Health* supports area-based clinical services and MHCSS to work with consumers, carers and communities from diverse cultural backgrounds. It is a nonclinical unit administered by St Vincent's Hospital Melbourne and provides education and training, clinician support through an external enquiries service, consultation and service development and research.
- *Torture and trauma counselling* is provided by the Victorian Foundation for Survivors of Torture ('Foundation House'). Victorian adults and children who have experienced torture, persecution or war-related trauma prior to arrival in Australia. Foundation House receives direct referrals to its services and also works to improve the skills and competency of healthcare services providing other treatment and support to refugees.

**Other programs**

There are a range of other programs provided by health services. Recent programs include:

- *Hospital Outreach Post-Suicidal Engagement (HOPE) program* – mental health professionals provide one-on-one support to people who have attempted suicide and make sure they get the support they need to recover. Current sites: Albury Wodonga Health; St Vincent's Hospital; Maroondah Health; Barwon Health; Peninsula Health; Alfred Health; Latrobe Regional Hospital; Sunshine Hospital; Casey Hospital; Ballarat Health Service including Horsham, Werribee Mercy Health; and Bendigo Health Service including Mildura.
- *Mental health and AOD hubs* – people presenting at Emergency Departments with acute mental health and AOD issues can be fast tracked to specialist, dedicated care, providing them with the right support sooner and easing pressure on emergency departments. The mental health and AOD hubs will be located at Monash Medical Centre, St Vincent's, the Royal Melbourne, Geelong, Sunshine and Frankston Hospitals. Operations will commence in April 2019.
- *Aboriginal mental health traineeship program* – provides full-time ongoing employment to Aboriginal Victorians who successfully undergo supervised workplace training and clinical placements over three years while concurrently completing the three-year full-time Bachelor of Health Science (Mental Health) degree at Charles Sturt University. The program is offered through: Eastern Health (two positions), Bendigo Health (two positions), Alfred Health, Peninsula Health, Monash Health, Latrobe Regional Health, Mildura Base Hospital and Forensicare.
- *Improving Outcomes Aboriginal Victorians with moderate to severe mental illness* – four consortia demonstration projects are being funded to deliver integrated, culturally safe mental health services that are designed to meet the mental health, and social and emotional wellbeing needs of their local Aboriginal communities. The four demonstration sites are: Ballarat and District Aboriginal Co-operative (in partnership with Ballarat Health), Mallee District Aboriginal Services (in partnership with Mildura Base Hospital and Mallee Family Care, Victorian Aboriginal Health Service (in partnership

with St Vincent's Health, Austin Health, North Western Mental Health) and Wathaurong Aboriginal Co-operative (in partnership with Barwon Health).

**Forensic mental health**

The Victorian Institute of Forensic Mental Health (better known as Forensicare) delivers inpatient and community forensic mental health services across Victoria. Services include clinical assessment, treatment and management of people with a severe mental illness and offending behaviours, provision of psychiatric reports for court, and multidisciplinary treatment for people at high risk in the community.

Forensicare is a statutory authority and provider of specialist forensic mental health services under the *Mental Health Act 2014*. Forensicare provides adult mental health services in Victoria for people involved in the criminal justice system, or who are at high risk of offending.

Services include:

- Thomas Embling Hospital, a 134-bed secure hospital for people from the criminal justice system who need specialist psychiatric assessment and treatment, and patients from the public mental health system who require specialised management
- Community Forensic Mental Health Service, providing assessment and multidisciplinary treatment to high-risk consumers referred from area mental health services, correctional providers, courts, the Adult Parole Board, Thomas Embling Hospital, prison services, government agencies and private practitioners.

**Joint Regional Planning for Integrated Regional Mental Health and Suicide Prevention**

Commonwealth, state and territory governments have agreed that Public Health Services and Primary Health Networks will develop and publicly release joint mental health and suicide prevention plans by 2020.

Joint regional mental health and suicide prevention planning is vital to embed integrated mental health and suicide prevention pathways for people with or at risk of mental illness or suicide through a whole of system approach.

### 2.3.8.5 Key policies and guidelines for mental health services

The *Chief Psychiatrist's guidelines* provide specialist advice on clinical practice, especially in those areas regulated by the *Mental Health Act 2014.*

See the *Chief Psychiatrist's guidelines* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines>.

Program management circulars articulate or clarify departmental policy on key aspects of service provision and are available at the Chief Psychiatrist website <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist>.

All funded clinical mental health services are required to be accredited against the *National Safety and Quality in Health Service (NSQHS) Standards (Second edition)* in 2019–20. As a condition of funding, organisations are required to adhere to the service standards and guidelines applicable to the funded activity, including program management circulars, Chief Psychiatrist's and the *Chief Psychiatrist's guidelines*.

Information on mental health programs and program guidelines can be found at the Mental health webpage <https://www2.health.vic.gov.au/mental-health>.

See the Guidelines for Joint Regional Planning for Integrated Mental Health and Suicide Prevention <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-health-intergrated-reg-planning>.

Organisations can obtain copies of the relevant standards and guidelines from their department program and service advisor or, in some instances, through the department's Funded Agency Channel.

Standards and guidelines are available at the Funded Agency Channel website <http://www.dhs.vic.gov.au/funded-agency-channel>.

Further information on mental health services is available at the Mental health webpage <https://www2.health.vic.gov.au/mental-health>.

The Your Experience of Service (YES) survey is designed to collect information on consumer experience in adult mental health services and selected Mental Health Community Support Services. This survey will be implemented annually.

#### 2.3.8.6 Mental health community support services performance framework

The *Mental health community support services performance management framework* specifies the performance requirements of the department for funded mental health community support services (MHCSS) agencies and outlines how the department will measure, monitor and assess performance at the agency, service and program levels. In this regard, the framework provides a key mechanism for monitoring whether a funded agency is delivering services consistent with the requirements of their Funding and Service Agreement.

The framework also outlines the processes, roles and responsibilities of all relevant stakeholders who are involved in the performance management of the MHCSS program.

### 2.3.9 Alcohol and drug services

#### 2.3.9.1 Key standards and guidelines

Service standards and guidelines that apply to funded alcohol and drug services are listed in Chapter 2, Addendum 2.2: 'Service standards and guidelines'. Where organisations receive funding for an activity or service, it is a condition of funding that they adhere to the service standards and guidelines listed under the relevant activity.

Organisations can obtain copies of the relevant standards and guidelines from their departmental program and service advisor or, in some instances, through the department's Funded Agency Channel.

Standards and guidelines are available at the Funded Agency Channel website <http://www.dhs.vic.gov.au/funded-agency-channel>.

Information can also be obtained from the Alcohol and other drugs webpage <https://www2.health.vic.gov.au/alcohol-and-drugs>.

Organisations are required to deliver services in line with the Victorian alcohol and other drug program guidelines, the Victorian alcohol and other drug client charter and the Victorian alcohol and drug treatment principles.

Copies of the guidelines, charter and principles are available at the Alcohol and other drugs webpage <https://www2.health.vic.gov.au/alcohol-and-drugs>.

### 2.3.10 Ageing, aged and home care services

Service standards and guidelines that apply to funded aged care services are listed in Chapter 2, Addendum 2.2: 'Service standards and guidelines'. If organisations receive funding for an activity or service, it is a condition of funding that they adhere to the service standards and guidelines listed under the relevant activity. The performance targets and monitoring requirements for the relevant ageing, aged and home care services are outlined at Chapter 2, Addendum 2.1: 'Performance targets and monitoring'.

#### 2.3.10.1 Public sector residential aged care – infection control

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

Health services are required to report on the aged care infection control module to the Victorian Healthcare Associated Infection Surveillance System (VICNISS) Coordinating Centre to monitor of infection control practices and antimicrobial use in PSRACS.

#### 2.3.10.2 Ageing, aged residents' rights and interests

Health services operating public sector residential aged care services (PSRACS) are required to meet Commonwealth Government legislative requirements relating to protecting residents' rights and interests. This includes meeting obligations for resident accommodation agreements, aged care accreditation standards, police checks for key personnel, staff and volunteers, compulsory reporting for reportable assaults and unexplained absences, and responsive management of complaints including those lodged through the Aged Care Complaints Commissioner.

Supported residential services proprietors have obligations to residents under the *Supported Residential Services (Private Proprietors) Act 2010* and Regulations. The department will continue supporting services to address the Accommodation and Personal Support Standards, including through the Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI), as well as working with community service organisations through a partnerships management model to implement the Pension Level Projects initiative in other pension-level supported residential services.

### 2.3.11 Primary, community and dental health

#### 2.3.11.1 Community health

The service standards and guidelines that apply to the community health program are listed in Chapter 2, Addendum 2.2: 'Service standards and guidelines'. If organisations receive funding for an activity or service, it is a condition of funding that they adhere to the service standards and guidelines listed under the relevant activity. The performance targets and monitoring requirements for community health are outlined in Chapter 2, Addendum 2.1: 'Performance targets and monitoring'.

#### 2.3.11.2 Identification and management of vulnerable children

*Healthcare that counts: a framework for improving care for vulnerable children in Victorian health services* was produced in 2017 and articulates the role of all Victorian health services in the early identification and effective response to vulnerable children. The framework is a quality improvement and best-practice guide that should be implemented in all health services and community service organisations delivering health programs in Victoria.

*Healthcare that counts* replaces and broadens the scope of an earlier framework for acute health providers. The framework includes five action areas to guide system improvement, as well as indicators of best practice. This will enable health services to annually benchmark and self-assess their implementation progress using the accompanying *Self-Assessment Tool*.

*Healthcare that counts* aligns with the Child Safe Standards and assists all health services to meet these and other legislative requirements relevant to the safety and wellbeing of children.

*Healthcare that counts* is also supported by free online training at the Children at Risk Learning Portal <https://vulnerablechildren.kineoportal.com.au> and the Vulnerable Children website <https://www2.health.vic.gov.au/about/populations/vulnerable-children>, where copies of the framework and other resources are available.

### Victorian Forensic Paediatric Medical Service

The Royal Children's Hospital is the statewide governing body for Victorian Forensic Paediatric Medical Services (VFPMS). Services are provided by The Royal Children's Hospital, Monash Medical Centre and all regional health services. A key function of the VFPMS is to provide a forensic assessment of injury and neglect to children from birth to 18 years where there is suspected child abuse and neglect. The Royal Children's Hospital is responsible for providing leadership and clinical guidance for the statewide service and all regional health services are expected to provide appropriate 24-hour clinical forensic services for these children.

# 2.4 Accreditation

Funded organisations have a range of obligations related to clinical service provision. These requirements have been put in place to ensure the quality of services and the safety of patients.

## 2.4.1 Australian Health Service Safety and Quality Accreditation Scheme

Accreditation of health services falls under the Australian Health Service Safety and Quality Accreditation Scheme. Under this scheme, health services are accredited against the *National Safety and Quality Health Service Standards (second edition)*. Information regarding the standards can be found at NSQHS Standards – Australian Commission on Safety and Quality in Health Care website <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/nsqhs-standards-second-edition>.

All Victorian public health services, including metropolitan (this includes specialist and denominational health services), regional, subregional, local and small rural and multi-purpose services, clinical mental health services provided by public health services (including Forensicare), public dental housed within health or community health services, and Bush Nursing Centres, must undergo regular assessments to maintain their accreditation through the Australian Health Service Safety and Quality Accreditation Scheme

The department, as the regulator, is responsible for monitoring and responding to the accreditation status of health service organisations. This response includes addressing and resolving issues, concerns, recommendations and instances of non-compliance.

Accreditation status is monitored by the department in accordance with the *Accreditation policy for Victorian publicly funded health services organisations* <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-accreditation>. This policy details the department's regulatory approach to accreditation outcomes and provides health services with a clear understanding of the requirements of the new scheme and reporting obligations.

Performance against accreditation will be reviewed as part of the department's performance monitoring processes. The regulatory response will be based on the outcome of the accreditation assessment and allow for escalation of monitoring and intervention, including possible action under the *Health Services Act 1988*, *Mental Health Act 2014*, or terms of the Funded Organisation Performance Monitoring Framework.

## 2.4.2 Pathology services

Victoria entered into a memorandum of understanding (MOU) with the National Association of Testing Authorities (NATA) in September 2004, in recognition of their role as the national authority in Australia for accrediting laboratories and as an accreditor of inspection bodies.

One of the undertakings made in the MOU is that Victoria will encourage all service providers to adhere to the principles of good laboratory practice, which are contained in NATA's relevant accreditation criteria.

An additional MOU that specifically relates to pathology laboratories was entered into by NATA and Victoria's chief health officer on behalf of the department. It embodies the spirit of cooperation between the department and NATA in relation to protecting public health.

On the basis of these undertakings, the conditions of funding are:

- Any laboratory operated by a health service whose principal function is to conduct pathology services must obtain and maintain accreditation from NATA or the Royal College of Pathologists of Australasia for the pathology services it provides.

- Any pathology service required for a public, private or compensable admitted patient of a health service must only be requested from a laboratory that holds accreditation from NATA or the Royal College of Pathologists of Australasia for the type of service required.
- Any pathology service required for a patient attending an outpatient clinic of a health service must only be requested from a laboratory that holds accreditation from NATA or the Royal College of Pathologists of Australasia for the type of service required.

The conduct of any pathology service provided for a health service that is not under the direct management of a pathology laboratory accredited by NATA or the Royal College of Pathologists of Australasia (for example, services provided by research laboratories, specialist clinical laboratories or at the point of care) must be overseen by a pathology laboratory that is accredited by NATA or the Royal College of Pathologists of Australasia for the relevant scope of services.

### 2.4.3 Ambulance

With the exception of Victoria, ambulance services in Australia are not currently part of an accreditation or external assessment process. Ambulance Victoria has organisation-wide accreditation to the business standards ISO9001. Ambulance Victoria self-assess against appropriate and relevant *National Safety and Quality Health Service Standards* and continue to investigate broader implementation or incorporation of those standards.

### 2.4.4 Mental health clinical and community support services

All funded clinical mental health services are required to be accredited against the *National Safety and Quality in Health Service (NSQHS) Standards (Second edition).*

Organisations that receive funding for a Mental Health Community Support Services program are encouraged to implement the *National Standards for Mental Health Services 2010*. During transition to the National Disability Insurance Scheme (NDIS), Victoria will monitor providers of defined MHCSS programs who deliver funded NDIS supports to ensure they meet the quality and safeguards in accordance with the Bilateral Agreement for Transition to the NDIS.

New providers who register to deliver psychosocial supports in scope of Victoria's Quality and Safeguarding arrangements for the NDIS are also required to be accredited against the *National Standards for Mental Health Services 2010.*

Health services providing alcohol and other drug treatment services are required to be accredited against the NSQHS standards (see Chapter 2, section 2.4.1 'Australian Health Service Safety and Quality Accreditation Scheme').

Organisations that receive funding for alcohol and other drug services are required to establish and implement plans to deliver services consistent with the Victorian alcohol and other drug charter. The ongoing implementation of plans to deliver services consistent with the Victorian charter is also expected of organisations that will receive funding for alcohol and other drug services in 2018–19.

These services are also required to continue to be accredited within existing generic accreditation frameworks by an entity certified by either the International Society for Quality in Health Care or the Joint Accreditation System of Australia and New Zealand.

### 2.4.5 Aged care

#### 2.4.5.1 Public sector residential aged care service accreditation and quality approach

The Commonwealth Government has the primary responsibility for funding and regulating residential aged care services under the *Aged Care Act 1997*. In accordance with this legislation, all Victorian public sector residential aged care services (PSRACS) are expected to comply with minimum aged care accreditation standards at all times to receive recurrent Commonwealth subsidies. Accreditation of

residential aged care services against the aged care accreditation standards is undertaken by the Australian Aged Care Quality Agency.

The department actively supports PSRACS to provide high-quality care to residents. The department's *Beyond compliance* strategy provides the strategic framework for focusing on safety and quality in PSRACS. It aspires to broaden approaches to quality, beyond minimum Commonwealth accreditation requirements and support care excellence.

*Beyond compliance* programs and initiatives are designed to encourage and support PSRACS to excel in the delivery of person-centred, safe, effective, appropriate, integrated and coordinated services so that a good quality of life is experienced by every resident, every day.

The focus of initiatives to be progressed in 2019–20 include:

- supporting PSRACS transition to the new aged care standards and other Commonwealth regulatory changes
- progressing priorities for strengthening PSRACS governance and leadership
- building nurse workforce capacity
- better use of evidence in practice to reduce care variation
- rollout of additional measures within the quality indicator program
- piloting performance measures for safety and quality in PSRACS.

#### 2.4.5.2 Home and Community Care Program for Younger People

Organisations funded under the Home and Community Care Program for Younger People (HACC-PYP) who also have funds under the Commonwealth Home Support Programme (CHSP) must meet certain quality review requirements. These organisations are required to provide the department with a copy of the Home Care Standards: Final Quality Review Report and/or Plan for Continuous Improvement (PCI) and/or Timetable for Improvement (TFI), following their review by the Australian Aged Care Quality Agency (AACQA).

The Home Care Standards are common to both the CHSP and the Victorian HACC-PYP. Therefore, the AACQA quality review results against the Home Care Standards will meet quality reporting requirements for HACC-PYP funded organisations.

The department will provide further information about quality review arrangements for providers funded under HACC-PYP.

# 2.5 Clinical governance

## 2.5.1 Health service clinical governance

All health services and funded organisations are required to ensure that their clinical governance policies and frameworks comply with the current *Delivering high-quality healthcare: Victorian clinical governance framework*. The framework can be found at < https://bettersafercare.vic.gov.au/our-work/governance/clinical-governance>.

### 2.5.1.1 Incident management and the sentinel event program

In 2019, Safer Care Victoria will publish a new clinical incident management policy and associated resources, specifying the requirements for all funded health services. During 2019–20, health services will be expected to:

- notify Safer Care Victoria's Sentinel Event program and complete an open disclosure process within the specified timeframes
- ensure sentinel event review processes are timely, appropriately resourced and high quality (utilising human factors and systems thinking)
- ensure the review team is led by suitably qualified staff, including a consumer representative and an independent external expert
- apply learnings from the review to improve systems of care and patient safety, and
- work with Safer Care Victoria to continually improve the quality of sentinel event review processes in Victoria – see Sentinel events program – Safer Care Victoria <https://bettersafercare.vic.gov.au/our-work/incident-response/sentinel-events>.

Sentinel event notifications and review outcomes must be submitted by emailing Sentinel events as Safer Care Victoria <sentinel.events@safercare.vic.gov.au>.

Guidance on review processes and additional resources can be accessed from Sentinel events program – Safer Care Victoria <https://bettersafercare.vic.gov.au/our-work/incident-response/sentinel-events>.

### 2.5.1.2 Health services quality and safety reporting

The Victorian Agency for Health Information (VAHI) currently reports a range of quality and safety measures as part of its suite of four reports on the performance of health services, Monitor, Program Report for Integrated Service Monitoring (PRISM), Inspire, and Board Safety and Quality Report (BSQR). VAHI has also produced a Quality and safety in Victorian private hospitals report on safety and quality of private hospitals and intends to produce further private hospital reporting in the future.

In the Performance Monitoring Framework, the department identifies performance measures relating to high quality and safe care, strong governance, leadership and culture, timely access to care and effective financial management. VAHI reports these measures in Monitor and the measures reflect the targets set for performance in each health services' SOP. The audience for Monitor is public health services executives and the department.

PRISM reports on health services' performance on a wide range of access, quality and safety, operational and financial performance measures not reported in Monitor. These include the Core Hospital Indicators (CHBOIs) developed by the Australian Commission for Safety and Quality in Health Care (ASCQHC), including unplanned readmissions for acute myocardial infarction (AMI), knee replacement, hip replacement, paediatric tonsillectomy and adenoidectomy and heart failure; overall in-hospital mortality and in-hospital mortality for AMI, fractured neck of femur, stroke and pneumonia. The audience for PRISM is also public health services executives and the department.

The Inspire report is produced quarterly and specifically targeted towards clinicians such as chief medical and nursing officers. It contains results for a range of quality and safety measures, including safety

culture, patient experience, infection prevention and control and potentially preventable infections, maternity and newborn care, continuing care, mental health, unplanned readmissions, hospital-acquired complications and sentinel events. VAHI also produces a biannual Mental Health Inspire to report on the safety and quality of mental health services. BSQR is also released quarterly and reports on a similar set of measures but is designed for board members to support their governance role.

VAHI has undertaken consultations to seek feedback from health services and other stakeholders on what additional measures should be developed and reported and is currently undertaking a process to prioritise areas of additional reporting for development in 2019–20. VAHI has undertaken work to adapt the national ACSQHC measures for the Victorian context, such as the death in low mortality diagnosis related groups measure and hospital acquired complications measures, including cardiac complications. It is also developing a number of new measures for reporting, including a 30-day in- and out-of-hospital mortality measure for AMI and all-cause, all-hospital unplanned readmissions measures.

### 2.5.1.3 Clinical quality registries

Clinical registries collect information to drive improvements in the quality and safety of healthcare. Victorian hospitals and clinicians currently contribute data to approximately 50 health-related national and state-based clinical registries. The Victorian Government provided direct or indirect funding for 20 clinical registries in 2017–18, ten of which met the criteria as clinical quality registries.

The Victorian Government is committed to ensuring that data from clinical quality registries (CQRs) could be much better used by the government and the health sector to drive quality improvements.

In 2018–19 the Victorian Agency for Health Information (VAHI) worked with registry custodians and key stakeholders to implement standardised contractual arrangements for CQRs with a contract expiry date in financial years 2018–19 and 2019–20. The new three-year contracts for CQRs address key recommendations in Targeting Zero as they relate to the distribution of quarterly reports, the provision of data to the department and escalation of outliers. In consultation with Safer Care Victoria and the department, VAHI has prepared a clinical registry strategy. The strategy will guide future investment for identified priority areas, as well as additional operational requirements for registries funded by the Victorian Government. Any policy implications will be clearly communicated to health services regarding any changed data collection requirements for identified priority clinical registries funded by the Victorian Government. It is noted that for the State Trauma Registry, the Cardiac Surgery Registry and the Australian and New Zealand Intensive Care Society Adult Patient Database that it is mandatory for public health services covering procedures captured by these registries to provide data to these collections.

### 2.5.1.4 VICNISS surveys and health service reporting requirements

The effective prevention and control of infection are an integral part of the quality, safety and clinical risk management operations of any health service.

Monitoring the occurrence and rate of infections at your health service and comparing these with peer services will provide you information on how well you are doing. The following measures to assist in this process can be found on the VICNISS website <http://www.vicniss.org.au>.

**Healthcare associated infections**

VICNISS collects and analyses data from individual hospitals on risk-adjusted, procedure-specific infection rates, *Staphylococcus aureus* bacteraemia (SAB) associated infections and Central Line Associated Blood Stream Infections (CLABSI) in intensive care units.

**Hand hygiene**

Improved hand hygiene practices are linked to a reduction in healthcare-associated infection rates. All health services are required to participate in the National Hand Hygiene Australia Initiative. This initiative was established to implement a national hand hygiene culture-change program to standardise hand hygiene practice and placement of alcohol-based hand rub in every Australian hospital. For submission criteria see the Hand Hygiene Australia website <https://www.hha.org.au>.

Public reporting of individual hospital or health service hand hygiene compliance is via the My Hospitals website <https://www.myhospitals.gov.au> and the Victorian Health Services Performance website <https://performance.health.vic.gov.au/Home/Category.aspx?CategoryKey=5#Anchor>.

**Healthcare worker influenza immunisation**

Health services must take all reasonable steps to ensure staff members are protected against vaccine-preventable diseases. High coverage rates for immunisation in healthcare workers are essential to reduce the risk of transmission in healthcare settings.

Health services are required to report healthcare workers' influenza vaccination rates to the department annually. Information on the healthcare worker influenza immunisation program can be found at the Vaccination for healthcare workers webpage <https://www2.health.vic.gov.au/public-health/immunisation/adults/vaccination-workplace/vaccination-healthcare-workers>. It is expected that by 2022, 90 per cent of the healthcare workforce will receive an influenza vaccination annually.

**Health service and hospital reporting requirements**

Depending on the size and type of services provided, all public health services are required to provide data to the VICNISS for one or more of the above measures. This data is then submitted to the department for monitoring against the *Victorian health service performance monitoring framework* and associated *National Health Reform Agreement* performance measures.

The measure results are shared with health services through the Monitor, PRISM and Inspire reports.

### 2.5.1.5 Streamlining clinical trial research

The government continues to encourage clinical trial activity within health services. In particular, the department's framework for streamlining the ethical and scientific review of multisite clinical trials is managed centrally by the Coordinating Office for Clinical Trial Research. Since January 2015, the scope of this framework also includes multisite health and medical research projects.

The streamlining framework includes all human research that is conducted as a single site or multisite project. All health services participating in the Victorian framework to streamline ethical and scientific review should assist the consolidation of research activity information concerning Victoria's public hospital sector. This is done by using the electronic information platform nominated by the department to enter data for all ethics applications (both single and multisite) and research governance/site specific assessments for single and multisite studies involving human subjects. Additional data collection may be required at health services as determined by the department and communicated through the Coordinating Office for Clinical Trial Research.

Health services that participate in the review and those accepting single scientific and ethical review of research on human subjects involving multisite research at more than one public health service site are required to:

- sign the standard MOU between the department and the health service for the purpose of facilitating a single ethical review in Victoria – this has extended to the initiative involving national mutual acceptance of multisite ethical review for clinical trials and health and medical research in other jurisdictions that have joined national mutual acceptance
- have their ethics committees provide intra and inter-jurisdictional ethical review, certified with the National Health and Medical Research Council and accredited by the department in Victoria and comply with any additional accreditation requirements.

It is expected that health services participating in the streamlining of ethical and scientific review of multisite research will comply with all matters agreed in the MOU, including acceptance of a single ethics review decision by an accredited and certified human research ethics committee, reporting requirements, research governance obligations associated with the conduct of a research project. They must also ensure that electronic data is captured for national reporting of clinical trial activity under the directive of the Council of Australian Governments Health Council (COAG HC).

Health services hosting an accredited and certified human research ethics committee that reviews multisite clinical trials and health and medical research are required to demonstrate sufficient ethical reviews to maintain expertise.

Further information is available at the Clinical trial research webpage <https://www2.health.vic.gov.au/about/clinical-trials-and-research/clinical-trial-research>.

### 2.5.2 Community health clinical governance

Funded organisations receiving community health program funding are expected to have strong clinical governance systems and practices in place, to ensure the quality and safety of services. Organisations are required to review their clinical governance structures and have adequate internal documentation to ensure consistency and compliance with the *Victorian clinical governance policy framework*.

Accreditation is a key measure of the performance of organisational clinical governance and the management systems which underpin good governance.

Organisations that receive funding through primary health output group activities must be accredited by a body or entity that is accredited by the International Society for Quality in Health Care or the Joint Accreditation System of Australia and New Zealand. For governance and management standards, community health services are able to choose an accreditation body, which offers standards that are consistent with the governance and management requirements of the Human Services Accreditation. See the Human Services Standards webpage <https://dhhs.vic.gov.au/publications/human-services-standards> for details. Relevant quality standards could include the *National Standards for Disability Services*, EQuIP, ISO 9001:2015, the *National Safety and Quality Health Service Standards* and the QIC Standards.

Where the selected governance and management standards do not cover all gazetted requirements for registered community health services, these requirements will be included under the Funded Organisation Performance Management Framework.

Community health services are also guided by The Community Services Quality Framework and with Safer Care Victoria's Clinical Governance Framework.

All public dental services are required to be assessed against the *National Safety and Quality Health Service Standards*.

Performance monitoring of accreditation against the national standards by the department and Dental Health Services Victoria in 2019–20 will be undertaken as per the *Accreditation: performance monitoring and regulatory approach business rules* (2013).

# 2.6 Consumer rights and community participation

## 2.6.1 Australian Charter of Healthcare Rights in Victoria

The *Australian Charter of Healthcare Rights in Victoria* (the Charter) is based on the *Australian Charter of Healthcare Rights* (2008) and is aligned with the *Victorian Charter of Human Rights and Responsibilities Act 2006*. It describes and promotes the rights of patients, consumers and family members using the Victorian healthcare system. The charter specifies seven healthcare rights: access, safety, respect, communication, participation, privacy and comment. These rights are applicable across all funded organisations in Victoria. This includes public and private hospitals, general practice clinics, medical specialists, aged care services, disability services, mental health services, registered community health centres and allied health providers.

The aim of the Charter is to ensure that healthcare is provided in a manner that embodies the seven healthcare rights and is safe and of high quality. Access to the Charter is a requirement of the *National Safety Quality Health Service Standards* under the Australian Health Service Safety and Quality Accreditation Scheme.

The Australian Commission for Safety and Quality in Healthcare has undertaken a review of the *Australian Charter of Healthcare Rights* during 2018–19, in partnership with all States and Territories. Revisions to the national Charter are expected to be completed in 2019, including resources and strategies to improve Charter awareness and activation across the healthcare sector. The outcome of this work will inform future enhancements to the Victorian Charter, as well as system-level strategies to better embed the Charter into the foundations of Victorian healthcare. Safer Care Victoria will be contributing to this process and health services will be expected to be ready to implement the revised Charter and activation strategies during 2019–20.

The Charter is available in a variety of formats in Victoria, including audio file, Auslan video, Braille and 25 community languages, at the department's Australian Charter of Healthcare Rights webpage <www2.health.vic.gov.au/about/participation-and-communication/australian-charter-healthcare-rights>.

## 2.6.2 Consumer, carer and community participation

Safer Care Victoria has developed the Partnering in healthcare framework (2019) to support health services with practical strategies for consumer participation and partnerships between consumers and health professionals to deliver higher quality care that is safe, equitable and clinically effective. The Partnering in healthcare framework replaces Doing it with us not for us: Strategic Direction 2010–2013 (2011) and the Cultural Responsiveness Framework: guidelines for Victorian health services (2009). It states the expectations Victorians have about how we can improve partnering with consumers to achieve better outcomes. The framework the sector with a single integrated consumer participation in healthcare policy that aligns diversity, equity and consumer participation in response to the diversity of Victoria's population.

The framework comprises five domains that are interdependent and together can have a cumulative effect to produce better outcomes. The five domains are: Personalised and holistic; Working together; Shared Decision Making, Equity and inclusion; and Effective communication. The framework supports implementation of a new approach to strengthen person and family-centred healthcare, equity, health literacy, partnerships and participation across the Victorian healthcare system. It focuses on direct care, at the service and system levels to improve Victorians' participation and experience in their own healthcare. It is an iterative guide designed to bring consistency to how Victorians can participate in their own healthcare and clearly describes consumer priorities for health services, SCV and aligns with the department's priority areas.

The framework will be progressively implemented in public hospitals from February 2019.

All funded organisations are required to actively support and promote consumer, carer and community participation at all levels of healthcare, including support for community advisory committees. In achieving the baseline requirements of the policy, health services will be required to meet the second edition of the National Safety Quality Health Service Standards <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/nsqhs-standards-second-edition>.

Under the *Carers Recognition Act 2012* people in care relationships, and the contribution of carers, need to be recognised by:

- Councils, within the meaning of the *Local Government Act 1989*.
- Organisations funded by government that are responsible for developing or providing policies, programs or services that affect people in care relationships.

The Act lists the principles that must be respected by councils and relevant funded organisations. These principles promote understanding of the significance of care relationships, and the people in them. The Act is supported by the *Victorian charter supporting people in care relationships*. Councils and relevant funded organisations are required to report on how they have met their obligations under the Act in their annual report. This may be as simple as including a paragraph detailing the actions taken during the year to comply with the Act.

Information, including legal responsibilities and obligations of local government and organisations, is available at the Supporting people in care relationships webpage <https://www2.health.vic.gov.au/ageing-and-aged-care/supporting-independent-living/supporting-people-in-care-relationships>.

## 2.6.3 Victoria's health experience

### 2.6.3.1 Victorian Healthcare Experience Survey

The Victorian Healthcare Experience Survey (VHES) seeks feedback from recent users of Victoria's public health services. It is a voluntary survey, focusing on both adult and paediatric inpatient and emergency department care as well as maternity care. These data are collected continually throughout the year. An independent organisation Ipsos is under contract to administer the survey on behalf of the Victorian Agency for Health Information.

The VHES program measures patient experiences. This enables identification of the areas where these experiences can be improved leading to actions that enhance person-and family-centred care. The program also provides health services, Safer Care Victoria, VAHI and the department with actionable results.

All questionnaires were developed in consultation with key stakeholders including clinicians and consumers. They were cognitively tested with consumers (and, where appropriate, carers) and piloted through a representative sample. The results include verbatim comments thematically streamed from survey respondents.

Annual program specific surveys have been established for community health services, specialist clinics, ambulance services, paediatric inpatient, paediatric emergency and palliative care services. In 2019 a state-wide Cancer Patients' Experiences of Care survey will be released.

The Victorian Agency for Health Information will continue in 2019–20 with its VHES program of reform, to ensure patient quality and safety is central to its design, and consistent with a patient-centred approach to service delivery. Key areas of focus will include the current length of the survey questionnaire, opportunities for inclusion of questions relating to patient reported outcomes and alternative approaches to measuring patient experiences in rural areas. In 2019, at the end of the current contract with Ipsos, an approach to market will be made for a survey administrator.

Health services will be kept updated on the progress of the review, and any changes to the VHES program.

#### 2.6.3.2 Community Health Services Victorian Healthcare Experience Survey

All community health services are expected to participate in the Community Health Services Victorian Healthcare Experience Survey. As part of their participation in the annual survey, each service will be required to identify three areas of improvement using the Community Health Services Victorian Healthcare Experience Survey data. Community health services will report their performance under the three areas in their annual Quality Accounts.

### 2.6.4 Patient-reported outcome measures

Patient-reported outcome measures (PROMS) are data obtained from structured surveys of patients, conveying information about patients' assessments of their health-related quality of life. PROMS can be used to measure the health gain associated with a treatment of a disease or management of a chronic condition. They are particularly useful for providing information about a patient's health outcomes that are best known to the patient and best measured from the patient's perspective. They differ from data obtained from patient experience surveys, which focus on patients' experiences of care.

In 2019–20 the Victorian Agency for Health Information will run three PROMs initiatives:

1. Utility of PROs in Cancer Care
2. Closing the data feedback loop utilising Clinical Quality Registry patient reported outcomes data
3. Australian Orthopaedic Association Joint Replacement Registry PROMs Pilot

The outcome of these initiatives with inform the future approach to a rollout of PROMs.

### 2.6.5 Health service community advisory committees

Public health services listed under Schedule 5 of the *Health Services Act 1988* are required to have a community advisory committee. Health services should continue to work with their committee to ensure that consumer, carer and community participation are integrated into service development, quality improvement planning and other relevant activities across all levels of their organisation.

Public health services have been required to develop and report to the department on their community participation plan covering a one- to five-year period as part of each scheduled public health service's strategic plan.

Health services are no longer required to submit their community participation plan or progress report on implementation to the department. However, health services should continue to undertake relevant planning outlining the role of the community advisory committee, the health service's board and executive management to ensure that consumers, carers and community members are actively involved and supported to participate in service development, planning and quality improvement.

**Primary care and population health advisory committees**

Health services are required to have a primary care and population health advisory committee under the *Health Services Act 1988*. Health services should continue to work through these committees to consider the broader needs of the community.

### 2.6.6 Reporting on quality of care

All public health services, multipurpose services and registered community health services are required to produce an annual quality account. Safer Care Victoria will provide guidelines on the content and submission requirements for the quality account for 2019–20.

Further information, including contact details and recommended reporting guidelines, is provided at <https://bettersafercare.vic.gov.au/our-work/governance/quality-accounts>.

## 2.6.7 Partnerships

All funded organisations are encouraged to participate in locally relevant partnerships, local collaboratives and alliances with other health and human services organisations where appropriate.

The focus for State-funded Primary Care Partnerships is in prevention, access, equity and integration. The work of Primary Care Partnerships should align with the department's focus on place-based efforts, prevention and population health, family violence, the integration of health and social care and strategic partnership development or chronic disease management, where this work is already occurring or has been identified as a local need.

Commonwealth funded Primary Health Networks are charged with improving access to primary care services and ensuring better coordination of care with local health care providers. They do not deliver services but commission and integrate local services to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes.

The department has entered into a Memorandum of Understanding (MOU) with the six Victorian PHNs and the Victorian PHN Alliance to strengthen collaborative working arrangements. The MoU will support and enable the successful implementation of national and state health policies, including Mental Health, Alcohol and Other Drugs and will provide governance to support key joint initiatives.

The *Coordinated Care Bilateral Agreement* between the Victorian and the Commonwealth Government aims to improve the delivery of care for patients with chronic and complex conditions to improve health outcomes and reduce avoidable demand for health services through system integration and reform activities. PHNs have been implementing stepped models of care in Mental Health and look to build the capacity and capability of the mental health workforce and development of more effective mental health services.

## 2.6.8 Primary Health Network funding and emergency management

The department provides annual indexed funding of $15,484 to each of the six Primary Health Networks to support Victoria's response to an emergency event. This funding requires networks to be responsive in the event of an emergency and support the department by; participating in local, regional and health service emergency planning in line with the *State Health Emergency Response Plan* (SHERP) and to facilitate the department's access to general practitioners to work in a range of local, time-limited primary care settings, such as field primary care clinics.

The department requires Primary Health Networks to establish and enable communications with general practitioners; other primary care services; local emergency planning and response organisations, and neighbouring Primary Health Networks as requested in an emergency. The department also requires Primary Health Networks to provide intelligence to the department on local factors affecting the delivery of general practice and other primary healthcare, in and around areas affected by the emergency. The networks also aid the provision of recovery services after an emergency and document their activity during an emergency event.

## 2.6.9 Informed consent for receipt of services

Funded organisations are required to ensure all clients receiving services have had an opportunity to discuss options regarding their care and to provide full consent to the care they receive. Health services must ensure that their informed consent policy and processes comply with legislation and best practice. Evidence of informed consent should be documented in the client record. Whereby the client is regularly accessing services or treatment over an extended period of time it is best practice to review their consent periodically and ensure their decision-making capacity and their choices (which can change) are understood and documented and any necessary action taken to address the changes. Where necessary health services need to have processes that can identify a substitute decision maker if the patient does not have the capacity to make decisions for themselves. See NSQHS Standards – Healthcare rights and

informed consent <https://nationalstandards.safetyandquality.gov.au/2.-partnering-consumers/partnering-patients-their-own-care/healthcare-rights-and-informed-consent>.

### 2.6.10 Complaint management

All funded organisations are required to have effective and responsive complaint management systems in place, which are timely, appropriate and lead to improvements in quality and safety. All hospitals are required to have an identified person who is responsible for addressing patient concerns and who is visible and accessible to patients. The contact details for the identified person should be readily accessible (including on the hospital's website) and consumers must be able to meet with them in person within a week of initial contact.

Under the *Health Complaints Act 2016*, the Health Complaints Commissioner (HCC) is actively engaged in the health sector through training in complaints handling and the relevant laws governing health service and health records complaints. The HCC's revised Complaint Handling Standards (2019) expand on the interim standards originally specified within the Act. These revised standards stipulate the legislative requirements for health services in effectively managing complaints. The revised standards are available at the Health Complaints Commissioner website <https://hcc.vic.gov.au>.

Under the Act, the HCC has the authority to ensure that health service providers implement quality improvement recommendations made by the Commissioner during the complaint resolution process.

Training sessions regarding the Act, the role of the HCC and the expectations of health services are provided on the Health Complaints Commissioner website <https://hcc.vic.gov.au>.

### 2.6.11 Health service cultural and linguistic diversity requirements

The *Cultural responsiveness framework: guidelines for Victorian health services*, was evaluated in 2014 as part of the *Doing it with us not for us* summative evaluation.

Safer Care Victoria has developed the *Partnering in healthcare framework* to help improve participation of consumers and carers in healthcare, as well as healthcare experience and outcomes. The framework will be progressively implemented in public hospitals in 2019–20.

The framework will implement a new approach to strengthen person and family-centred healthcare, equity, health literacy, partnerships and participation across the Victorian healthcare system. It will focus on direct care, service and system levels to improve Victorians' participation and experience in their own healthcare.

All funded organisations are required to actively support and promote cultural responsiveness at all levels of healthcare. Health services should continue to report on the provision of accredited interpreters to patients who require one in the annual quality account. In achieving the standard and indicators of the policy, health services will be ensuring that they meet the *National Safety and Quality Health Service Standards*.

The department's *Language services policy* and accompanying guidelines, *How to work with interpreters and translators: a guide to effectively using language services*, support the department and its funded services in responding to the needs of linguistically diverse people, including migrants, refugees and people seeking asylum and those who use sign language. All health services are required to ensure completion of two data elements in the Victorian Emergency Minimum Dataset (VEMD) and VINAH collections relating to preferred language spoken and interpreter required as proxy measures of local demand for language services.

Refer to information about the *Language services policy* <https://dhhs.vic.gov.au/publications/language-services-policy-and-guidelines>.

# 2.7 Financial requirements

## 2.7.1 Health service procurement and purchasing requirements

Under the *Health Services Act 1988,* Health Purchasing Victoria has responsibility to:

- develop, implement and review policies and practices to promote best value and probity in relation to the supply of goods and services to health services, along with the management and disposal of goods
- ensure probity is maintained in purchasing, tendering and contracting activities in health services
- provide advice, staff training and consultancy services in relation to the supply of goods and services to the health sector
- monitor compliance by health services with purchasing policies and Health Purchasing Victoria directions and to report irregularities to the Minister for Health.

The Health Purchasing Policies establish a procurement policy framework for health services incorporating the strategic approach and guidance of the Victorian Government Purchasing Board (VGPB) policies. These policies are mandated for all Schedule 1 and 5 health services and may be viewed on the Health Purchasing Victoria website at <https://www.hpv.org.au/resources/health-purchasing-policies/>.

To meet its responsibilities in monitoring health service compliance with Health Purchasing Policies and reporting irregularities to the Minister for Health, Health Purchasing Victoria has developed a compliance framework that includes support and prevention activities such as education, training, advice and guidance, as well as monitoring. All mandated health services must:

- Complete an annual compliance self-assessment requiring:
  - Compliance with Health Purchasing Policies and the Health Purchasing Victoria Collective Agreements.
  - The self-assessment to be approved and submitted to Health Purchasing Victoria by the health service chief executive officer (CEO) or delegated officer for inclusion in the Health Purchasing Victoria annual report.
- Complete compliance audits to the Health Purchasing Policies:
  - As per the *Health Services Act 1988*, Health Purchasing Victoria requires the CEO of a mandated health service to audit compliance with Health Purchasing Policies.
  - Health services are required to audit their compliance to the policies once every three years as per Health Purchasing Victoria's rolling audit program. Health services are required to provide the final audit report to Health Purchasing Victoria by 30 June in the year the audit is scheduled.
  - Findings identified as part of the compliance audits will be reported to the Health Purchasing Victoria Board and monitored until the health service has addressed and closed the issues. Health Purchasing Victoria has a responsibility to report high-risk areas of non-compliance to the Minister for Health.
- Provide information and data on procurement activities:

Health Purchasing Victoria can require the CEO of a mandated health service to provide information and openness and probity in purchasing, tendering and contract activities.

Health services should ensure the following overlapping probity directives are met:

- Mandated health services must be compliant with the Health Purchasing Policies to support best-value procurement.
- Health services are required to ensure their probity controls take into consideration recommendations contained in the Victorian Ombudsman's report *Probity controls in public hospitals for the procurement of non-clinical goods and services* <https://www.ombudsman.vic.gov.au/Publications/Parliamentary-Reports/Probity-controls-in-public-

hospitals-for-the-procu> and the Victorian Auditor-General's report *Procurement practices in the health sector* <https://www.audit.vic.gov.au/report/procurement-practices-health-sector>.

All health services are encouraged to complete the probity training provided by Health Purchasing Victoria for health service management and staff with procurement responsibilities. Health services are also encouraged to consult with Health Purchasing Victoria on any high-value or high-risk procurement activities.

## 2.7.2 Compliance with financial requirements

Section 30(2) of the *Health Services Act 1988* requires registered funded agencies to obtain approval from both the Minister for Health and the Treasurer before seeking financial accommodation. An approved borrower may obtain financial accommodation, whether within or outside Victoria, secured or arranged in a manner and for a period approved by the treasurer. These borrowings are guaranteed by the state.

Section 44 of the *Ambulance Services Act 1986* requires an ambulance service to obtain approval from the Treasurer before seeking financial accommodation. An approved borrower may obtain financial accommodation, within Australia, secured or arranged in a manner and for a period approved by the treasurer.

All registered funded agencies and ambulance services must obtain the appropriate approvals prior to seeking to borrow funds from third parties and prior to entering into third-party finance arrangements for any overdrafts, borrowings or finance leases. These funds may be for purposes such as capital works and equipment expenditure.

The Standard Motor Vehicle Policy issued under the authority of the Minister for Finance now mandates the acquisition of new vehicles through VicFleet, which is funded through the government's finance lease facility. Under these requirements, all registered funded agencies and ambulance services are approved borrowers for the purpose of motor vehicle finance leases obtained through VicFleet asset acquisition and disposal.

Registered funded agencies and ambulance services must not enter into any expenditure related to equipment purchases, capital works or purchase or disposal of real property where the estimated total costs, real property value or total end costs of the works exceeds ten per cent of the annual revenue of the agency or health service or $2 million (whichever is the lesser amount) unless:

- the agency or health service has provided a detailed business plan relating to the proposed expenditure to the Secretary of the department
- the expenditure has been approved by the Secretary to the department.

The Secretary's approval in relation to any expenditure referred to the above clauses does not imply or in any way obligate the Secretary or the department to provide any financial support for the works.

### 2.7.2.1 Operating leases

From 1 July 2019 compliance with AASB16 *Leases* will require most operating leases (the exceptions being low value leases and leases of less than 12 months duration) to be reported on the balance sheet and it will be mandatory for all balance sheet leases to be reported in the lease software provided by the department.

All leases are also required to be assessed to determine whether they include a Financial Accommodation as defined by the *Borrowing and Investment Powers Act 1987* (which is referenced in the *Health Services Act 1988*) and health services are required to follow the existing processes for approving a lease that includes a Financial Accommodation (borrowing). As a guideline, leases that would have been accounted for as an operating lease under the previous lease standard are deemed not to include a financial accommodation.

Lease commitments should continue to be undertaken in accordance with the *Victorian Government Risk Management Framework* (2015). The framework adopts the Australian and New Zealand Standard

AS/NZS ISO 31000:2009 *Risk Management – Principles and Guidelines*, which provides a generic, internationally accepted basis for best practice risk management.

All agencies must fully comply with the requirements of Ministerial Standing Direction 3.7.1 *Risk management framework and processes*, and are responsible for appropriately identifying, assessing and managing all risks to which they are exposed. Agencies should establish and maintain effective risk governance that includes an appropriate internal management structure and oversight arrangements for managing risk. The responsible bodies are directly accountable for their organisation's risk management obligations.

Even though the accounting distinction between operating and finance leases does not exist, there is still a legal distinction between operating and finance leases based on the transfer of rights between the lessor and lessee. This means that the definition of Financial Accommodation under the Borrowing and Investment Powers Act 1987 (which is referenced in the Health Services Act 1988) does not include operating leases. As such, there is no change to the processes for approving operating leases and borrowings for health agencies.

See information about the Victorian Government Risk Management Framework <https://www.dtf.vic.gov.au/planning-budgeting-and-financial-reporting-frameworks/victorian-risk-management-framework-and-insurance-management-policy>.

### 2.7.2.2 Investments

Ministerial Standing Direction 3.7.2 *Treasury management, including Central Banking System* requires all public sector entities, including public hospitals, to ensure that all money, subject to the exceptions identified in the Standing Direction, be deposited within the Central Banking System unless an exemption has been provided by the Treasurer.

Exemptions include money held on trust by the Agency for, and repayable to, a known beneficiary pursuant to a statutory function or where the Treasurer has provided an exemption under Direction 1.5(b). This means that:

- Investments that health services currently hold with the Victorian Funds Management Corporation and other compliant managed funds are not required to be transferred to the Central Banking System, where these investments were in accord with the previous version (February 2016) of the Standing Directions
- Funds raised by hospital auxiliaries or community fundraising are not required to be transferred to the Central Banking System. In recommending the establishment of the Central Banking System (and as subsequently approved by the Treasurer) the Department of Treasury and Finance specifically addressed the issue of money receipted by agencies from a specific donation (i.e. a bequest, parents and friends or hospital auxiliaries).

## 2.7.3 Goods and services tax

Funded organisations must register for an Australian Business Number and register for goods and services tax (GST) if required. Each funded organisation is responsible for its own tax compliance and liabilities.

Funding between one government-related entity and another government-related entity that is sourced from appropriations and for non-commercial activity is outside the scope of GST pursuant to s. 9–17(3) of the *Goods and Services Tax Act 1999*. Funding from the department to non-government organisations are taxable supplies.

Public hospitals and Ambulance Victoria are government-related entities under s.8 and s. 41 of the *Australian Business Number Act 1999*.

### 2.7.4 Strategic procurement

Health Purchasing Victoria and health services are collaborating on a strategy to expand the definition of 'best value' procurement to better meet health service needs and improve patient outcomes.

Health services support a more versatile operating model for Health Purchasing Victoria that encourages a more strategic approach to procurement, involving long-term category management strategies to drive improved financial and patient outcomes.

Health Purchasing Victoria is committed to deploying a common catalogue across the state to support high-quality patient care. The common catalogue improves efficiencies for health services and suppliers by integrating supply chain data into the patient care cycle.

In addition, Health Purchasing Victoria continues to support the implementation of Bravo as a contract management and sourcing system as well as the implementation of electronic data interchange (EDI) capabilities.

# 2.8 Asset and environmental management

Asset management is the coordinated activities, carried out over the asset's whole lifecycle, to realise the full value from assets in delivering their service delivery objectives. Realisation of value will normally involve a balance of costs, risks, opportunities and performance benefits.

Health services are required to manage, maintain and replace assets in accordance with the Standing Directions of the Minister for Finance under the *Financial Management Act 1994* and the Victorian Government's *Asset Management Accountability Framework* (AMAF).

The Standing Directions of the Minister for Finance made under the *Financial Management Act 1994* requires the Chief Executive Officer of funded organisations (health services) to attest compliance with the requirements of AMAF in their annual reports, and that their organisation is compliant with the requirements of AMAF. In meeting its compliance with the AMAF, the department requires health services to submit annual asset management plans and maintenance assets registers.

This requirement is for all the physical asset classes held and extends across all stages of the lifecycle, including planning, acquisition, operation and maintenance and disposal.

The Chief Executive Officer of funded organisations (health services) is required to assign responsibility, accountability and reporting requirements, and to establish and maintain management processes to plan, report, monitor and assess controlled assets.

Consistent with Victorian Government policy expressed in AMAF, the department expects asset management governance, planning and practice in funded organisations to be consistent with the scale of their organisation.

The health service board should be regularly informed about the status of asset performance and any material risk posed in addition to any planned timing of specific investment or disinvestment.

Health services should refer to the *Asset Management Policy (2018)* <https://vhhsba.vic.gov.au/sites/default/files/VHHSBA-Asset-Management-Policy-2019.pdf> and the *Strategic Asset Management Plan (2019)* and associated guidelines for further information when developing their asset management plans.

Further information on the Victorian government's asset management framework is available at the Asset management webpage <https://www.dtf.vic.gov.au/infrastructure-investment/asset-management-accountability-framework>.

## 2.8.1 Asset management strategy and planning

Health services need to systematically identify their service delivery and asset needs over time, to establish a plan on how to manage their entire asset base and how to manage individual assets throughout their lifecycle.

A key requirement of the Victorian Government's *Asset Management Accountability Framework* is an asset management strategy. The asset management strategy should consider various options to achieve the desired service delivery results, and include an evaluation of the costs, benefits and risks associated with each option.

Effective asset management planning relies on strong governance, aligned corporate leadership and the input of key affected and specialist groups across the health service. It also requires ongoing strategic oversight to facilitate prudent risk assessment, asset allocation, overall asset management planning quality and implementation.

Each health service is required to submit an asset management plan for 2019–20 detailing how they are managing their asset base.

### 2.8.1.1 Asset Management Plans

As part of the assurance framework for appropriate management of assets, health services are required to annually submit asset management plans to the Victorian Health and Human Services Building Authority no later than 30 September covering (as a minimum) summary asset data, asset performance, current condition, asset risk, demand analysis, maintenance program, renewal forecast (operation and capital), disposal plan and resourcing plan.

Asset management plans are to be submitted with the department annually at the end of September in order to receive appropriation of their Infrastructure Renewal Contribution grant.

Further information, and templates are available at the Asset management webpage <http://www.capital.health.vic.gov.au/Asset_property_management_and_operations/Asset_management>.

### 2.8.1.2 Reporting

As a condition of funding, all 2018–19 specific-purpose capital grant expenditure is required to be reported as part of Agency Information Management System (AIMS) by the end of September 2019. The report needs to correlate with the lodged health service asset management plans to demonstrate effective asset management planning and prioritised replacement of in-scope assets. This annual reporting helps demonstrate financial and asset accountability (including potential audits) and that critical risk mitigation is achieved.

### 2.8.1.3 Planning and implementation

Health services should use their asset management plans to prioritise asset replacement according to critical risk and to guide investment of specific-purpose capital grants at the health service level. The devolved funding model facilitates responsive and flexible time-critical replacements, enabling a health service to intervene to avert unacceptable clinical service interruptions or failures.

Health services may also submit for funds to replace high-value engineering infrastructure or medical equipment. Consistent with prioritisation and rationing requirements, health services are required to fund the installation and infrastructure associated with the replacement of the high-cost medical equipment, or the scoping of the works/tender documentation for high-cost engineering infrastructure. Health services may choose to use their specific-purpose capital grant for this purpose if it is considered by the health service to be the highest risk of all the outstanding in-scope assets.

### 2.8.1.4 Accountability

Specific-purpose capital grants must be managed and invested in accordance with health service or hospital board fiduciary responsibilities and as set out in the program guidelines.

Health services reporting on asset replacement under the initiative are required to demonstrate financial and asset accountability, including investment against asset management plans. Grant reporting will be used for both accountability and policy and practice development purposes.

The level of grant is conditional upon meeting funding requirements – risk-based prioritisation of investment aligned with health service asset management plans.

Where health services have not fully acquitted received capital funding, the Victorian Health and Human Services Authority may recall distributed funds for reallocation to other high-risk projects across the sector.

### 2.8.1.5 Procurement of medical assets

Health services must comply with government policies and guidelines in their procurement activities.

The department requires health services to engage early and work collaboratively with Health Purchasing Victoria to maximise value-for-money procurement of medical equipment and deliver the

most efficient purchasing arrangements, including standardisation and bulk purchasing and achievement of economies of scale.

For further information, refer to procurement and purchasing requirements and the Health Purchasing Victoria website <http://www.hpv.org.au>.

#### 2.8.1.6 Disposal of assets

Planning for disposal should start well before the economic life of the asset has ended or the need for service has finished. It should incorporate consideration of unplanned disposals or destruction of assets.

Health services must comply with relevant approval processes and, where possible select a disposal method including retirement, replacement, renewal or redeployment that maximises the financial benefits associated with the disposal.

The asset status should be updated in the asset management plan and asset register.

### 2.8.2 Property portfolio management

Property portfolio management supports the delivery of services from real property assets. In this context, real property means both the land and the buildings attached to that land.

Health services are required to actively manage their property portfolios to ensure real property assets under their control or ownership are fully utilised and realise full service delivery potential.

Health services must:

- maintain an accurate dataset of all real property assets and annually review landholdings in accordance with the Victorian Government landholding policy
- ensure formal tenure agreements are executed on all land which is department owned or controlled (such as Crown land Committee of Management)
- ensure all real property transactions undertaken comply with the requirements of all relevant legislation, ministerial directions and Victorian Government policy (such as the *Land Transactions Policy and Guidelines*).

It is desirable that real property assets under health service management are zoned appropriately for current or proposed use and health services consolidate multiple freehold parcels held under separate titles to simplify future property management activities.

As funded organisations seek to best match services to patient needs, service agreements with third parties will require legal tenure agreements relating to the occupation of premises that adequately address legislative and service requirements and related risks. Where tenure agreements are proposed for premises located on Crown land, funded organisations must ensure they have the right to enter into such agreements and must comply with legislative requirements and government policy regarding their implementation.

Further information on government land policies and processes, including Crown land management, is available at the Property management – Related legislation, policies and guidelines webpage <http://www.capital.health.vic.gov.au/Property_Management/Related_legislation_policies_and_guidelines>.

### 2.8.3 Asset maintenance

In accordance with the Victorian Government's *Asset Management Accountability Framework*, Clause 3.4.3 requires the establishment of systems and processes for undertaking maintenance activities.

Maintenance is defined as 'a combination of all technical, administrative and managerial actions during the life cycle of an item intended to retain it in, or restore it to, a state in which it can perform the required function'.

Asset maintenance enables targeted action to be undertaken in a timely and cost-effective manner. This helps the asset portfolio to remain safe and reliable for the lowest possible long-term cost.

Health Services are responsible for providing appropriate maintenance activity within the right frequency for assets under their direct or indirect control to ensure asset risks are being mitigated or eliminated during the lifecycle in order to:

- keep them in an appropriate condition for the health services they support;
- prevent service delivery interruptions or service quality risks;
- minimise risks to patient safety and occupational health and safety; and
- Ensure long-term service performance.

The *Maintenance standards for critical areas in Victorian health facilities* <https://www2.health.vic.gov.au/about/publications/researchandreports/maintenance-standards-for-critical-areas-in-victorian-health-facilities> provides a set of general and additional maintenance standards that should be applied to all critical areas in hospitals and health services.

### 2.8.4 Critical Asset Service Failure

In accordance with the Victorian Government's *Asset Management Accountability Framework*, Clause 3.1.5 requires appropriate risk management strategies and processes to support the establishment of asset management, including processes to identify and maintain assets that are at risk of critical service failure.

Within business continuity plans, health services are required to define critical assets, recovery procedures for systems as well as processes for the management of emergency events and issues within its operational context, capability and associated risk.

In the event of a critical asset service failure, health services are required to provide a summary incident report detailing the critical asset service failure and the corrective action to the Victorian Health and Human Services Building Authority within four weeks of the incident.

### 2.8.5 Health Service environmental management and planning and reporting

In order to assist health services to manage their environmental impact and increase their operational efficiency, health services are required to develop and implement a whole-of-organisation environmental management plan and report publicly on environmental performance.

The environmental management plan is to focus on the organisation's material environmental impacts, which could include energy, carbon, water, waste and procurement. Health services are encouraged to expand the plan to include all sites under their control.

Health services are to report publicly on environmental performance in accordance with the department's *Environmental reporting guidelines*. As a minimum health services are to publicly report environmental data relating to carbon, energy, water, waste and transport (fleet and air travel). The environmental data management system produces a standard report, which meets these reporting guidelines.

A template environmental management plan and the environmental reporting guidelines are available at the Environmental management planning and reporting webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/planning-infrastructure/sustainability/planning-reporting>.

Health services are to report any energy, water, waste and paper data, which is not centrally uploaded, in to the environmental data management system. The reporting of medical gases and refrigerant data is encouraged but is not mandated for the 2019–20 reporting year. The environmental data management system can be accessed at the Edensuite website <https://dse.edensuite.com.au>.

# 2.9 Information and communication technology standards

The Digital Health Branch, through the department's health systems manager role, aims to ensure health services operate their ICT safely, securely, cost-effectively and in alignment with Victorian and national digital health strategies.

Health services have accountability and responsibility through their boards for deploying ICT and digital health technology to support service delivery within their health service, based on their local needs.

The *Digitising health* strategy was endorsed by the Minister for Health in November 2016. The department, in partnership with health services, has primary accountability for delivering the outcomes and realising the benefits from *Digitising health*.

Health services are required to work with the Digital Health Branch within the department to develop and agree digital health initiatives that:

- align to the *Digitising health* strategy
- adhere to architecture and interoperability standards that enable the sharing of clinical information across the health sector.

## 2.9.1 Governance

The Victorian Health Chief Information Officer Forum (VHCIOF) meets monthly. It is the sector's primary information sharing and decision-making forum, seeking to achieve a consistent and interoperable public health system for Victoria. VHCIOF is chaired by a health service CIO, with secretariat provided by the Digital Health Branch. All health service and Rural Health ICT Alliance CIOs (or their equivalent) are expected to attend on a regular basis, and contribute to the working groups that support VHCIOF. These are:

- cyber security
- ICT operational assurance
- Microsoft licensing
- Clinical Grade Network
- image-sharing.

## 2.9.2 Statewide programs

Through VHCIOF and its working groups, health services are expected to align with and participate in sector wide initiatives. These include Unique Patient Identification (UPI), the Victorian health sector cyber security program, and ICT operational assurance.

### 2.9.2.1 Strategic investments

Prior to approaching the market for strategic ICT investments, health services are required to seek approval from the Secretary, Department of Health and Human Services (via the Digital Health Branch) This includes business projects with a strategic ICT component. Strategic projects should align with *Digitising health* strategy and where there is ambiguity, health services should consult with the Digital Health Branch.

Health services are required to report their ICT strategies, plans and projects to the Digital Health Branch. The Branch has a planning and assurance role for the sector, to ensure:

- minimum levels of ICT capability are in place to support safe clinical care
- appropriate project governance and planning is in place to support the delivery of successful ICT-enabled health service projects.

All health service projects with an ICT component greater than $1 million must be reported to the Department of Premier and Cabinet for inclusion in the ICT project dashboard, for reporting to the government on public sector ICT activities. Additionally, all projects on this dashboard with ICT budget $10m and above are to be subjected to independent project quality assurance.

### 2.9.3 ICT incidents

Digital Health in its role as System Manager needs to be informed of unscheduled critical or major ICT incidents when they occur in health services. In many cases, the Digital Health Branch and the department's Health Technology Solutions can contribute to resolution of incidents.

*Critical incidents* are those that impact the delivery of quality and safe care to patients. These are to be reported to the department within one hour of the incident occurring.

Critical incidents also include data breaches and cyber incidents. For more information on cybersecurity, please refer to the *Victorian Public Health Sector – Cybersecurity Incident Management Plan.*

*Major incidents* are those that place the delivery of patient safety and care at risk. Incidents that may have a significant clinical impact on business processes are also included in this classification. Major incidents are to be reported within two hours of occurrence.

### 2.9.4 Health ICT standards

Adoption of health ICT health standards enhances patient safety and supports continuity of care across settings, as specified in the *Statewide Health Strategic ICT Framework (2015)* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Statewide-Health-ICT-Strategic-Framework>.

The health ICT standards cited below are specified on the Catalogues and guides webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/planning-infrastructure/health-design-authority/catalogues-guides>.

Funded health services must comply or align with these standards when planning or implementing digital health and ICT projects:

- National terminology for enterprise-wide electronic medical record (EMR) implementations: Australian standard terminology (SNOMED-CT-AU) and the Australian Medicines Terminology (AMT).
- The prevailing Australian version of the Health Level 7 (HL7), as referenced on the Digital Health Digital Design website for use in Victoria. Currently the recommended Victorian standard is HL7 v2.4.
- Interaction with the My Health Record system and the requirements of the *My Health Record Act 2012* (Cwlth) will enhance the safety and continuity of patient care. This includes the ability to apply national individual healthcare identifiers (IHIs) for patients, healthcare provider identifiers for individual clinicians (HPI-Is) and healthcare provider identifiers for organisations (HPI-Os), as well as other requirements under the *Healthcare Identifiers Act 2010* (Cwlth). These identifiers should be incorporated into all new or updated applications as defined in the minimum interoperability requirements).
- Interactions with My Health Record are also cited in Action 1.17 and Action 1.18 of the National Safety and Quality Standards <https://www.nationalstandards.safetyandquality.gov.au/1.-clinical-governance/patient-safety-and-quality-systems/healthcare-records>.
- Similarly, standard national clinical documents including *eReferral*, *Discharge Summary*, *Shared Health Summary* and *Event Summary* are specified at Clinical documents – Australian Digital Health Agency website <https://developer.digitalhealth.gov.au/specifications/clinical-documents>.
- The *National Product Catalogue* and associated standards and specifications are specified by GS1 at the National Product Catalogue website <https://www.gs1au.org/our-services/national-product-catalogue>.
- Adoption of the *National Health Services Directory* as the primary source for services directory and location information.

- Alignment with the *National ehealth security and access framework (NESAF)* <https://www.digitalhealth.gov.au/implementation-resources/ehealth-foundations/national-ehealth-security-and-access-framework> maintained by the Australian Digital Health Agency through its national Cybersecurity Centre. The NESAF can be found at.
- Compliance with the *Health Records Act 2001* Health Privacy Principles for security of health information and for storing personal and sensitive information outside of Victoria.
- Compliance and alignment with international standards for Cybersecurity: ISO27001/2, and ISO27018 and the National Institute of Standards and Technology (NIST) *Cybersecurity Framework*.
- Alignment with Standards Australia's *Digital Hospital Handbook* <https://www.standards.org.au/news/new-australian-publication-to-accelerate-digital-hospitals>.
- Alignment with the *Electronic Medications Management Systems – A guide to safe implementation* maintained by the Australian Commission on Safety and Quality in Health Care (ACSQHC).
- Alignment with National Guidelines for On-Screen Display of Medicines Information and National Guidelines for On-Screen Display of Discharge Summaries maintained by the Australian Commission on Safety and Quality in Health Care.
- ACSQHC reference documents can be found at Safety in e-Health – Australian Commission on Safety and Quality in Health Care website <https://www.safetyandquality.gov.au/our-work/safety-in-e-health>.

The Australian Digital Health Agency (the Agency) website is a useful source of reference material for digital health planning. Technical specifications can be found at the Agency's Resources for Implementers and Developers webpage <https://digitalhealth.gov.au/implementation-resources>.

The information contained on the site is subject to changes in both standards and their policy settings. Health services are required to always review the information on the Digital Health Branch website. This references information from the Agency, but includes specific Victorian extensions and other local information that take account of the Victorian legislative and policy framework.

# 2.10 Risk management

## 2.10.1 Risk management and assurance

Risk management and assurance activities are essential components of good corporate governance for all funded organisations. These activities will facilitate better service outcomes and quality care, and minimise claims and losses.

### 2.10.1.1 Risk management

The *Health Services Act 1988*, *Public Administration Act 2004* and the *Financial Management Act 1994* require funded organisations to have effective and accountable risk management systems and strategies in place.

Management and the board are responsible for their organisation's governance, risk management and control processes. Internal auditors assist both management and the audit committee by examining, evaluating, reporting and recommending improvements on the adequacy, efficiencies and effectiveness of these processes.

To ensure risks are being managed in a consistent way, some funded organisations are required under the department's service agreement, Direction 3.7.1 of the *Standing Directions of the Minister for Finance* and the *Victorian Government Risk Management Framework* to attest annually that the responsible body is satisfied that:

- the organisation has a risk management framework in place consistent with *AS ISO 31000:2018 Risk Management – Guidelines*
- the risk management framework is reviewed annually to ensure it remains current and is enhanced, as required; and supports the development of a positive risk culture within the organisation
- the risk management processes are effective in managing risks to a satisfactory level
- it is clear who is responsible for managing each risk
- inter-agency risks are addressed, and the organisation contributes to the management of shared risks across government, as appropriate
- the organisation contributes to the identification and management of state significant risks, as appropriate
- risk management is incorporated in the organisation's corporate and business planning processes
- adequate resources are assigned to risk management
- the organisation risk profile has been reviewed within the past 12 months.

An organisation's risk management framework can consist of the following components:

- a risk management policy and plan that integrates with corporate planning
- risk registers and profiles
- an incident management system (refer to Chapter 2, section 2.1.2.5 'Patient and client safety')
- risk management tools, templates and training
- business continuity and emergency management plans
- compliance and quality systems
- a fraud and corruption control plan.

These components assist funded organisations in developing an effective risk-aware culture that includes clinical and all other operational activities.

Health services should articulate how they are managing asset related risk in their asset management strategy as developed as part of their compliance with the *Asset Management Accountability Framework*

For more information on risk management, refer to AS ISO 31000:2018 Risk Management – Guidelines <https://infostore.saiglobal.com/en-au/Standards/AS-ISO-31000-2018-1134720_SAIG_AS_AS_2680492> and *HB 158:2010 Delivering assurance based on ISO 31000:2009: Risk management – principles and guidelines* <https://infostore.saiglobal.com/en-au/Standards/HB-158-2010-129591_SAIG_AS_AS_274229>.

#### 2.10.1.2 Assurance activities

Assurance activities are designed to provide independent conclusions and a degree of confidence regarding the outcome of the evaluation or measurement of the subject matter against predetermined criteria. The subject matter can take many forms such as:

- corporate governance practices
- effectiveness and efficiency of operations
- systems, processes, people and performance
- data reliability, completeness, integrity and availability
- accreditation and certifications
- patient or client outcomes and satisfaction
- compliance with laws, regulations and contracts.

Attestations, internal and external audits, accreditations and surveys are some categories of assurance activities that funded organisations may use to provide independent and reasonable assurance to their board, audit committee and management that they are on track to achieve their objectives.

An organisation's assurance framework can consist of the following components:

- an assurance strategy and internal audit charter linked to organisational objectives
- an assurance map detailing the sources of all assurance activities
- a risk-based assurance and audit plan outlining planned activities
- registers and reports to track implementation progress of recommendations
- key performance indicators of assurance activities.

#### 2.10.1.3 Integrity governance

All health services must have the appropriate assessment and mitigation strategies in place to ensure better integrity practice across their organisation. The *Integrity Governance Framework and Assessment Tool* has been developed as a better practice assessment and reporting tool to guide and support better integrity practice. The tool focuses on four domains of integrity risks within a health service; employment principles and personnel, procurement, contract and project management, finance and governance. Refer to the Integrity Governance Framework and Assessment Tool <https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/integrity-governance-framework>.

Health services will also be required to attest that appropriate internal controls exist to review and address integrity, fraud and corruption risks in their Annual Reports.

### 2.10.2 Emergency management

#### 2.10.2.1 Health and human services sector emergency preparedness policy

The department's *Health and human services sector emergency preparedness policy 2018–19* supports the health and human services sector to maximise the health, wellbeing and safety of Victorians who access their services before, during and after emergencies.

The policy requires the health and human services sector to prepare for and respond to emergencies. It achieves a consistent sector-wide approach to preparing for emergencies, whilst considering the need for local flexibility and individual client needs.

Compliance requirements of funded agencies are outlined in the policy.

The policy and other emergency management information relevant to funded organisations is available at the Emergency preparedness webpage <https://providers.dhhs.vic.gov.au/emergency-preparedness>.

### 2.10.2.2 Vulnerable people in emergencies policy

The *Vulnerable people in emergencies policy* assists funded organisations to improve the safety and wellbeing of people who are vulnerable in emergencies through personal emergency planning.

The policy applies to in-home and community-based services that are delivered within the 64 municipal council areas wholly or partly covered by Country Fire Authority (CFA) districts.

The *Vulnerable people in emergencies policy* and relevant guidelines are available at the Emergency preparedness webpage <https://providers.dhhs.vic.gov.au/emergency-preparedness>.

### 2.10.2.3 State health emergency response arrangements

The *State health emergency response plan, edition 4* (SHERP4) is a subplan of the *Victorian State emergency response plan.* It outlines the arrangements for coordinating the health response to emergency incidents that go beyond day-to-day business arrangements. Under these arrangements, the department's key health responsibilities include Control Agency for public health emergencies and managing the health response during any emergency.

Such emergencies are complex incidents and local resources may not be able to respond effectively to emergencies such as mass casualty and complex trauma incidents, mass gatherings and other incidents that can affect the health of Victorians.

SHERP4 is supported by a suite of operational response plans and protocols that provide additional detail to support the health sector before during and after emergencies.

SHERP4 and the operational response plans, protocols and guidelines make up the State Health Emergency Response Arrangements and are available at the State Health Emergency Response Arrangements webpage <https://www2.health.vic.gov.au/emergencies/shera>. Plans relevant to health services include:

- *Code Brown guidelines* – each health service and facility is required to have a site-specific Code Brown plan to manage a significant surge in demand in emergency presentations resulting from an external emergency.
- *Emergency Incident Casualty Data Collection Protocol* – each health service is required to provide casualty information related to an emergency incident when the protocol is activated by the department.

Copies of SHERP4, the *Code Brown guidelines* and the *Emergency Incident Casualty Data Collection Protocol* are available at the State Health Emergency Response Arrangements webpage <https://www2.health.vic.gov.au/emergencies/shera>.

**Emergency incident notifications to the department**

- The CEO or delegated officer of a health service is required to notify the department:
  - when they become aware of a notifiable public health incident (refer to the list of notifiable conditions and the timeframes in which to notify at the Notify a condition webpage <https://www2.health.vic.gov.au/public-health/infectious-diseases/notify-condition-now>
  - immediately, upon declaration of a Code Brown emergency
  - immediately, following declaration of any other emergency, where that emergency is likely to have an impact on any other or all health services in Victoria
  - as soon as practicable following activation of any other emergency arrangements or awareness of an emergency incident where the emergency is likely to have an impact on service continuity (for example, an energy disruption that results in declaration of a code yellow emergency).

- Notifications are to be made in accordance with the State Health Emergency Response Arrangements.
- Stand down notification must also be provided once the event has concluded.

**Hospital single contact points for emergency management**

Each health service must maintain a 'hospital single contact point' for emergency management purposes, comprised of the following:

- a 24/7 mobile phone number (to receive SMS early advisory notifications)
- a 24/7 generic email address (to receive first wave email notifications and other emergency management correspondence)
- a 24/7 contingency landline number (preferably a direct line as opposed to a switchboard, for use if mobile communications are down)
- an internal process that embeds the hospital single contact point arrangements within their organisation as appropriate.

Health services are strongly encouraged to introduce or maintain a hospital single contact point arrangement that is not tied to an individual within the organisation, to ensure the 24/7 operability of the contact point.

Further detail, including maintenance of the arrangements can be found in the *Hospital single contact point factsheet*.

**Real-time Health Emergency Monitoring System**

For emergency management and broader health system management purposes, the department has a need to access unvalidated data at any time to more immediately understand the issues affecting the sector. This is especially the case if issues are across geographic areas or the whole health system.

Public health services must have systems in place to enable the electronic transmission and integration of a health service's data into departmental data collection systems, such as, but not limited to, the Real-time Health Emergency Monitoring System (RHEMS).

Ongoing connection to data collection systems should also be factored into any ICT upgrades to ensure continuity of current applications. Any unvalidated data received is not used to formally measure performance against key performance indicators, which can only be based on validated data.

## 2.10.3 Fire risk management

Funded organisations are responsible for ensuring they comply with the department's Capital Development Guidelines on Fire Risk Management relevant to the premises they operate. The guidelines are available at < http://providers.dhhs.vic.gov.au/fire-risk-management-procedures-and-guidelines >.

Any building surveyor, fire safety engineer or auditor appointed for any works must be accredited by the department. A list of accredited practitioners is at the Fire risk management accreditation webpage <https://providers.dhhs.vic.gov.au/fire-risk-management-accreditation>.

Funded organisations are responsible for ensuring they comply with all laws, regulations and mandatory standards relating to fire and life safety in buildings (also includes protection from external threats such as bushfire), and general safety requirements that apply to any premises from which the funded organisation operates – irrespective of whether the relevant regulatory requirements place the obligation on the owner or occupier of those premises.

Key fire risk management requirements include the following:

- Funded organisations must ensure that appropriate operational readiness measures are developed, implemented and reviewed. In doing so, funded organisations should prepare for, respond to and recover from emergencies in accordance with the 'all hazards' approach. This includes bushfire, flood, relocation and evacuation and prolonged service interruption.
- Funded organisations must also ensure that essential services are maintained.

- Funded organisations must comply with the department's capital development guidelines on fire risk management.
- At the time of client placement in any premises, funded organisations must ensure that the premises comply with all laws relating to fire protection, health and general safety that apply to any premises from which the organisation operates.
- Funded organisations must also ensure that the premises are suitable for efficient client evacuation, taking into account the fire systems installed, and the relocation and evacuation capacities of the client. If any relevant change occurs that may affect a client's ongoing ability to evacuate safely, the suitability of the placement must be reassessed, and appropriate action taken.

Health services and funded organisations that are required to comply with the department's guidelines on fire safety management shall complete and return Certificate No. 6 of fire safety compliance for 2018–19 to the department via the certificates email <FRMUCertificatesFidhhs.vic.gov.au>, or through their respective regional fire risk management unit coordinator by 30 September 2019.

More information on fire risk management, and a copy of the certificate template is available at the Fire risk management procedures and guidelines webpage <http://providers.dhhs.vic.gov.au/fire-risk-management-procedures-and-guidelines>.

# 2.11 Legal obligations

## 2.11.1 Privacy

Funding is provided on the condition that the funded organisation:

- complies with the provisions of the *Privacy and Data Protection Act 2014*, the *Health Records Act 2001* and other information-sharing and privacy obligations imposed by law, codes of practice or guidelines made under those laws in performing funded services
- ensures its employees, officers, agents and subcontractors comply with the Acts and the terms of a funding agreement.

## 2.11.2 Protected disclosure

Where applicable, the funded organisation agrees to comply with and be bound by the provisions of the *Protected Disclosure Act 2012*.

## 2.11.3 Intellectual property

The rights and obligations of funded organisations and the State of Victoria regarding ownership and management of intellectual property are set out below.

Funding is provided with the following conditions:

- All intellectual property developed by a funded organisation with funding provided by the department (Project IP) vests in the funded organisation unless the department advises the funded organisation in writing prior to the delivery of all or part of the funded services that the State of Victoria will own the Project IP.
- The funded organisation grants to the State of Victoria a non-exclusive, world-wide, everlasting, irrevocable, royalty free licence to exercise all rights in relation to the Project IP (including background and third party intellectual property incorporated into Project IP) as if the State of Victoria was the owner, including the right to sub-license. For the avoidance of doubt, the rights conferred on the State of Victoria under the licence include, without limitation, the right to use, reproduce, adapt, broadcast, publish, communicate to the public, and otherwise disseminate the Project IP for the benefit of the Victorian public.
- The funded organisation will ensure it obtains all necessary consents (including moral rights consents) to enable the State of Victoria to exercise all the rights conferred on the State of Victoria referred to above.
- Immediately following a written request, the funded organisation will provide all Project IP to the department.
- The funded organisation will properly manage the Project IP in a manner which allows the State of Victoria to enjoy the full benefit of providing the funding to the funded organisation.
- The funded organisation must not accept co-funding, or involve any person in the delivery of the services, on terms that would jeopardise or limit any licence to be granted to the State of Victoria without obtaining the department's prior agreement and consent in writing.

Where a funded organisation has a service agreement with the department, the department's service agreement more fully records the parties' rights with respect to Project IP and takes precedence over these guidelines.

# 2.12 Payments and cash flow

## 2.12.1 Payments to funded organisations

In 2019–20 the department will make monthly payments over 13 periods (two payment periods in July) to all health services through the Modelling and Payments System (MAPS). Details of grants and payments can be accessed via the Tableau website <https://tableau.reporting.dhhs.vic.gov.au>. The department will monitor hospital cash flows as reported monthly in the financial data (F1) cash flow statement.

The department will make monthly payments to community service organisations through the Service Agreement Management System (SAMS2). Cash flow percentages of individual payment schedules of service agreements and details of the funded activities can be found on the Funded Agency Channel website <https://fac.dhhs.vic.gov.au>. The department will monitor community service organisation performance and financial sustainability.

Payments may be adjusted for recall, loans, enterprise bargaining agreements, indexation, awards and prepayments (refer to Chapter 1, section 1.23 'Prior year adjustment: activity-based funding reconciliation').

## 2.12.2 Enterprise bargaining

### 2.12.2.1 Expiring agreements and enterprise bargaining

Five Enterprise Agreements will expire in the 2019–20 financial year (covering Ambulance Victoria administrative staff, Nurses and Midwives, Mental Health, Institute of Forensic Medicine and Allied Health staff). Another Enterprise Agreement is currently in negotiation (Ambulance Victoria). It is possible that some of these agreements will be settled in the 2019–20 financial year.

### 2.12.2.2 Wages policy

The Victorian Government's updated Wages Policy and Enterprise Bargaining Framework (Framework) commenced on 17 April 2019. The Wages Policy has three pillars:

- Wages – increases in wages and conditions capped at a rate of growth of 2.0 percent per annum.
- Best Practice Employment Commitment – public sector agencies are to outline measures to operationalise elements of the Government's Public Sector Priorities that reflect good practice and can be implemented operationally or without significant cost.
- Additional Strategic Changes – changes to allowances and other conditions will only be allowed if Government agrees that the changes will address key operational or strategic priorities

Health services are generally expected to comply with other aspects of government policy, including wages and industrial relations policy as made from time to time.

More information on the Framework is available at the Wages Policy and the Enterprise Bargaining Framework website <https://www.vic.gov.au/wages-policy-and-enterprise-bargaining-framework>.

### 2.12.2.3 Budgeting for new agreements

Enterprise bargaining settlements are rarely timed to coincide with the beginning of a financial year. Therefore, there may be part-year cost effects in any given financial year relating to both expiring and new enterprise bargaining outcomes. In contrast, budget indexation applies on a full financial year basis.

Health services must identify and account for indexation as it relates to supporting increased wage and salary costs. The baseline wage increases contained in the applicable wages policy must be funded by health services prior to any additional supplementation being sought from Treasury. When new Enterprise Agreements take effect, or are likely to take effect in a financial year, health services must keep funding equal to these amounts available for such increases. This remains true even when

enterprise bargaining processes become protracted or complex and remain unresolved at the end of the financial year in which settlement was expected to occur and have cost effect.

Health services must also ensure Enterprise Agreement costs are properly attributed to other relevant revenue sources where existing employment costs are met from those other sources.

#### 2.12.2.4 Interim payments for long-stay, high-cost patients

The department will consider interim payments (both cash flow and recorded WIES revenue) for long-stay patients who have accumulated significant amounts of WIES, or Subacute WIES, and who remain admitted at 30 June 2019.

Health services may apply to the department for special consideration for individual admitted patient episodes. Applications for special consideration must indicate the number of WIES or Subacute WIES. For WIES-funded episodes, the interim diagnostic-related group (DRG) must also be indicated. For Subacute WIES-funded episodes, the AN-SNAP V4.0 must also be indicated. Under no circumstances should agreement to fund an interim payment result in a statistical separation.

If the department agrees to provide an interim payment, the health service will be asked to designate the episode as a contracted patient using a specific contract/spoke identification code. When the patient is finally separated, the payment will be adjusted accordingly. For example, the interim amount will be deducted from the final payment. The final DRG may differ from the interim DRG, due to the addition of further complications, comorbidities and procedures, in which case the payments will be adjusted to reflect actual activity.

Interim payments for long-stay, high-cost patients will be considered on a case-by-case basis. While interim payments are not governed by strict length of stay (LOS) or WIES criteria, a patient might be recognised as a long-stay, high-cost patient if the patient is:

- still admitted at 30 June 2019 and their LOS already exceeds a year
- still admitted at 30 June 2019, their LOS already exceeds six months and the patient might reasonably be expected to still be in the hospital at 31 December 2019
- still admitted at 30 June 2019, their LOS already exceeds six months and the patient is receiving significant mechanical ventilation.

### 2.12.3 Use of contract WIES

On occasion, where a health service has reduced capacity (for example, due to workforce shortages or capital works) it may contract with another service to undertake activity for a time-limited period. Contract arrangements of this type must be approved in advance by the health service Performance Lead/Regional Manager.

Applications can be received by emailing the HDSS helpdesk <HDSS.helpdesk@dhhs.vic.gov.au>.

Approval will only be granted where the health service can demonstrate that the capacity reduction is temporary and that the contract is an appropriate use of allocated WIES, taking into account local demand for services. Technical information for recording and reporting contract WIES is available in the VAED manual.

### 2.12.4 Health service fees and charges

Any fees and charges raised by health services must be in accordance with the department's manual, *Fees and charges for acute health services in Victoria: a handbook for public hospitals.*

The fees are available in the department's *Fees manual* <https://www.health.vic.gov.au/feesman>.

Health services are permitted to raise fees for the following non-admitted patient services:

- dental services
- spectacles and hearing aids

- surgical supplies
- prostheses, however, the following categories of prostheses must be provided free of charge:
  - artificial limbs
  - prostheses that are surgically implanted, either permanently or temporarily, or are directly related to a clinically necessary surgical procedure
- external breast prostheses funded by the National External Breast Prostheses Reimbursement Program
- other services, as agreed between the Commonwealth and Victoria.

Upon an admitted patient separation, a health service may raise fees for:

- pharmaceuticals at a level consistent with the Pharmaceutical Benefits Scheme statutory co-payments
- aids
- appliances
- home modification.

### 2.12.5 Private patient accommodation charges

Section 72.1(2) of the *Private Health Insurance Act 2007* states that an insurance policy covering hospital treatment must provide at least the 'minimum benefit' for that treatment. The Commonwealth Minister for Health stipulates the minimum benefits payable by private health insurers for shared ward accommodation in public hospitals through the private health insurance (benefit requirements) rules. The Commonwealth does not set a minimum benefit for single room accommodation.

Health services are able to make their own determination on accommodation fees to be charged to private patients who receive treatment at their campuses. In coming to this decision, health services should consider:

- the benefit that private health insurance funds will assign to the public hospital in their health insurance products
- any co-payment a patient may be willing to pay as a private patient
- the amount of any co-payment or excess the hospital can viably forego.

To assist health services with this decision, the department provides a guide to average costs and nominal cost recovery rates for private patient accommodation in the department's *Fees manual* <https://www.health.vic.gov.au/feesman>.

At a minimum, these rates would be reasonable to apply to private patient charges.

Health services should note the *Private health insurance (health insurance business) rules 2007* Part 3 s. 8(b), which state that treatment provided to a person at an emergency department is excluded treatment for the purposes of private health insurance. Health services should ensure that private health funds are not billed for accommodation or services provided to admitted private patients at an emergency department.

### 2.12.6 Redirection of funds

If the total revenue for a funded program exceeds the expenses incurred in delivering the full quantity of services specified in the SOP or service agreement, the surplus may be used by the funded organisation for any purpose connected with its agreed function. This clause does not apply if there is a contrary arrangement regarding unexpended funding provided for a specially identified purpose.

### 2.12.7 Doctors in training secondment arrangements

Many training programs for junior doctors involve a rotation to a site other than their parent hospital. The parent hospital is responsible for managing and paying the annual leave of doctors in training while on rotation, and where annual (or other) leave is planned within the rotation period, both hospitals should

approve this leave. Only the parent hospital is to pay out annual leave, as this is included in the overheads paid to the parent hospital (refer to Hospital Circular 6/2013 or a successor circular where relevant).

The parent hospital will make every endeavour to organise suitable relief when a doctor in training takes other leave (either planned or unexpected) for a period longer than one week. The parent hospital should also make every endeavour to ensure the relieving doctor has commensurate experience and skills to ensure the expected level of service in the external hospital can continue to be provided.

## 2.12.8 Long service leave

The department assumes the liability arising from the net increase in the long service leave provision for public hospitals and some statutory authorities ('Eligible agencies'), except for changes to the long service leave provision due to the impact of bond rate and probability factors (revaluations), which is in accordance with the Department of Treasury and Finance's Budget Operating Framework. Eligible agencies must, however, reflect the movements in the long service leave provision associated with the revaluations in their long service leave provision.

The department funds the annual increase in the long service leave provision[5] of its eligible agencies as follows:

- An amount equal to 2.8% of defined salaries and wages is included in price and paid as grants to the department's eligible agencies (with a few exceptions).
- A grant payable to the department's eligible agencies is recognised for the balance not paid as the grant described above. (A debtor in respect of this non-cash grant will be recognised by each eligible agency).

Eligible agencies will continue to manage their long service leave and cash requirements. Long service leave funding paid by the department in excess of actual long service leave payouts during the current and prior financial years should be maintained and managed by eligible agencies and be used as the first call for any future settlements over and above the (current) 2.8% of long service leave included in price.

## 2.12.9 Medical indemnity insurance

The department has developed the medical indemnity risk-rated premium (RRP) model in consultation and on the advice of the Victorian Managed Insurance Authority and its actuaries. The medical indemnity risk-rated premium model allocates a share of the statewide medical indemnity insurance premium to individual hospitals and health services.

[5] The increase excludes the impact of bond rate and probability factors (revaluations).

# 2.13 Data collection requirements

Data reporting and analysis are core elements of the department's health monitoring and funding system. In general, health services and other funded organisations are required to comply with standard definitions for reporting financial and statistical data, as set out in the relevant 2019–20 versions of data collection manuals and any other amending documents prepared by the department.

## 2.13.1 Data integrity

Accurate data are critical for funding purposes, performance monitoring, reporting, policy development and planning and for maintaining public confidence in the health system.

Health service boards of management are accountable for the accuracy of reported data. Boards are expected to make data integrity the responsibility of their audit committee and ensure that data accuracy is subject to appropriate controls, including regular internal audits.

Health services are required to:

- maintain board and board audit committee scrutiny of data integrity practices
- complete implementation of security improvements for elective surgery and emergency department information technology systems, including implementation of unique user identity and password controls, and routinely reviewing ICT system transaction logs
- implement recommendations from audits conducted at their health services
- provide a data quality attestation in the health service's annual report.

*Data integrity guidelines for health services* are also provided to assist health services in ensuring the integrity of data they report about their activity and performance.

The Health Data Integrity Program plan 2018–19 to 2019–20 supports the transition of the health data integrity program from an emphasis on random reviews (or audits) designed to achieve statewide estimates of overall accuracy, to a more targeted approach based on data analytics and risk assessment. It sets out the initiatives designed to ensure that health data collections accurately reflect the care that was provided to patients and increase confidence in the accuracy of health services' data by:

- reviewing data recording and reporting practices and health service compliance with department policies and business rules
- monitoring, reporting on and strengthening internal controls used in health services
- monitoring, detecting, reporting on and mitigating the risks and consequences of inaccurate health data
- providing stakeholders with an accurate picture of the strengths, weaknesses and threats related to health data integrity and recommend opportunities to improve it.

The program covers the same core health data collections that were previously the subject of regular review, including:

- Victorian Admitted Episodes Dataset (VAED)
- Elective Surgery Information System (ESIS)
- Victorian Emergency Minimum Dataset (VEMD)
- Victorian Cost Data Collection (VCDC)
- Victorian Integrated Non-Admitted Health (VINAH) – Specialist clinics
- Admitted Subacute Care data reported to VAED.

The health data integrity program may be expanded to additional health service data collections based on stakeholder priorities and analytics.

Health services are expected to actively participate in the program of system-wide inspections, checks and reviews of their health service data and related processes, including responding to data analytics queries

#### 2.13.1.1 System updates

These data collections are reviewed annually to ensure they are relevant for performance monitoring against current operational priorities, as well as to provide up-to-date indicators of ongoing clinical activity trends. The department remains committed to balancing the resources required to collect and report data against the need for quality data for monitoring, planning and fulfilment of the department's own reporting obligations. These aims are achieved through various consultative committees and reference groups for specific data collections and feedback received through specific departmental program areas.

Proposed changes to data collections are released for comment, and specifications for change are published by 31 December prior to the financial year to which they apply.

The *Health Data Standards and Systems (HDSS) bulletin* provides advice on data quality issues to health services that contribute to the VAED, VEMD, ESIS, VINAH and AIMS. The bulletin is the primary method by which amendments to standards and reporting timelines are published during the year.

Health services should ensure that appropriate staff subscribe to the *HDSS bulletin* to remain up-to-date with any changes. The *HDSS bulletin* is issued electronically via both web and email and is free. Subscriptions may be arranged by emailing the Health data standards and systems helpdesk <HDSS.Helpdesk@dhhs.vic.gov.au>.

#### 2.13.1.2 Penalties for noncompliance

If health services are noncompliant with the timelines specified in these guidelines, penalties may apply. Refer to the relevant dataset for more information.

### 2.13.2 Key systems

The department operates several data collections on different aspects of health service activity. Key systems include:

- F1/Common Chart of Accounts
- Portfolio Financial Reporting
- the VAED for admitted patient activity
- the VEMD for designated emergency department activity
- the ESIS for monitoring elective surgery waiting lists
- the VINAH minimum dataset for non-admitted patient activity
- AIMS, used primarily to collect summary-level financial and statistical information
- the VCDC for patient-level costs
- the Victorian Perinatal Data Collection (VPDC) for births
- total parenteral nutrition activity
- CMI/ODS for mental health client data.

#### 2.13.2.1 Financial data

F1 financial returns for all health services and other portfolio entities (excluding cemeteries and VicHealth), at the entity level, are required 12 calendar days after the end of the month to which the financial data relates (for example, the F1 for July is required by 12 August). Data relating to approved budgets and revised estimates are required less frequently and as advised by the department.

A timetable for the portfolio financial reporting requirements for whole-of-government will be released separately. F1 submitted data will be used each month as a basis for further data requirements in the portfolio financial reporting system (also called "PFR") which is used for whole-of-government reporting.

This collective data is then reported to the Department of Treasury and Finance and must be complete and accurate. If the data submitted to the department is inaccurate or incomplete, hospitals will be required to amend and re-submit this data through the F1. This re-submission must occur in a timely manner.

Public hospitals are also required to report both an approved budget and a revised estimate (end-of-year forecast) to the department through the F1.

- The submitted approved budget should match the agreed Statement of Priorities and only be amended when agreed with the department.
- The revised estimate is to be in the form of a full end-of-year trial balance and reflect the most up to date forecast result and financial position. At certain dates, as advised separately by the department, the revised estimate submissions must be accompanied by a Chief Financial Officer sign-off (a template will be provided by the department). The revised estimates due dates for sign-off will be in line with the budget update and end-of-year forecast timelines required for reporting to the Department of Treasury and Finance which are generally as follows:
  - initial estimate – 12 August
  - mid-year estimate – 12 December
  - year-end forecast – 12 April, 12 May and 5 June.

Public hospitals will provide this information in accordance with the department's timelines, except where an extension is sought and approved. Late data submissions of trial balances for both the F1 and Portfolio Financial Report, will be monitored and reported through performance monitoring staff in the department.

### 2.13.2.2 Victorian Admitted Episodes Dataset

The Victorian Admitted Episodes Dataset (VAED) contains the core set of clinical, demographic, administrative and financial data for admitted patient episodes occurring in Victorian health services. Maintaining the accuracy of the VAED is critical to ensuring accurate and equitable funding outcomes, supporting health services' planning, policy formulation, program evaluation and epidemiological research. Analyses and consolidated activity data are provided from the VAED to meet the department's reporting obligations to the commonwealth and to various research institutes.

Further information on the VAED is contained in the *VAED manual* <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems>.

**Submission of admitted patient data**

All organisations that receive funding for admitted patient services must submit data to the VAED minimum dataset.

Health services (including small rural health services) will code patient episodes reported to the VAED in accordance with the current Australian Coding Standards, along with Victorian additions, and any amending documents issued by the department.

Public health services must submit admitted patient data to the VAED according to the timelines in Table 2.2. Health services may submit data more frequently than the minimum standards specified in the table.

**Table 2.2: Victorian Admitted Episodes Dataset timelines**

| VAED | Timeline |
|---|---|
| Admission and separation details for the month (E5, J5 and V5 records) | Must be submitted by 5.00 pm on the 10th day of the following month |
| Diagnosis and procedure, subacute and palliative details (X5, Y5, S5 and P5 records) | Must be submitted by 5.00 pm on the 10th day of the second month following separation |
| Data for the 2019–20 financial year | Must be submitted by 5.00 pm on 10 August 2020 |
| Final corrections to data for 2019–20 | Must be submitted by 5.00 pm on 24 August 2020 |

It is the health service's responsibility to ensure that data files are submitted on or prior to the 10th of each month regardless of the actual day of the week.

**Penalties for noncompliance**

Where health services are noncompliant with the timelines specified above, the department may apply the following penalties:

- up to $20,000 per month if more than one per cent of admission and separation details (E5, J5) for a given month are submitted after the timeline specified
- up to $20,000 per month if more than one per cent of episodes for a given month are submitted without diagnosis, procedure, subacute or palliative care details (X5, Y5, S5, P5) by the deadline specified
- up to $2,000 per episode if there is a significant number of episodes that are 'dummy coded' or do not meet the VAED business rules.

The above requirements apply to all account classes, including Department of Veterans' Affairs.

**Exemptions for late submission penalties**

If difficulties are anticipated in meeting the relevant data transmission timeframes, the health service must contact the department indicating the nature of the difficulties, remedial action being taken and the expected submission schedule.

A pro forma to assist this process is provided on the HDSS website <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems>.

If difficulties prevent the reporting of patient-level data to the VAED, the health service must complete the AIMS S1A form by the 10th of the month. The AIMS S1A form is submitted via HealthCollect. For assistance with the S1A, email the HDSS helpdesk <hdss.helpdesk@dhhs.vic.gov.au>. Failure to complete the S1A form by the due date will result in late submission penalties.

**Software upgrades and migrations**

Health services undertaking software migrations must undertake VAED data submission testing prior to resuming live VAED data submission. Health services will be exempt from late data submission penalties for an agreed period of no more than two months, provided the S1A form is completed on time.

Health services undertaking software upgrades may choose to undertake the VAED data submission testing process prior to resuming live VAED data submission. Health services will be exempt from late data submission penalties for one month, provided the S1A form is completed on time.

### 2.13.2.3 Victorian Emergency Minimum Dataset

Emergency departments must submit data to the Victorian Emergency Minimum Dataset (VEMD) according to the timelines in Table 2.3. Health services may submit more frequently than the minimum standards specified in the table.

**Table 2.3: Victorian Emergency Minimum Dataset timelines**

| VEMD | Timeline |
|---|---|
| All presentations for the first 14 days of the month | At least one submission must be received by 5.00 pm on the third working day after the 14th of the reporting month. |
| All presentations for the full month | Data for the remainder of the month must be supplied by 5.00 pm on the third working day of the following month. |
| All presentations for the full month without errors | Must be complete and correct – that is, zero rejections and notifiable edits by 5.00 pm on the 10th day of the following month, or the prior business day. |

Any corrections to 2019–20 data must be submitted before final consolidation of the VEMD on 27 July 2020.

### Penalties for noncompliance

If health services are noncompliant with these timelines, the department may apply the following penalties:

- up to $5,000 per month, if a file containing presentations for the first 14 days of the month is not submitted by the timelines specified in Table 2.3
- up to $10,000 per month, if a file containing presentations for the full month is not submitted by the timelines specified in Table 2.3
- up to $10,000 per month, if a file with all presentations for the full month contains errors by the timelines specified in Table 2.3.

Data flagged as unfit for reporting and analysis will be regarded as noncompliant and penalties as above will apply.

### Exemptions from penalties

If difficulties are anticipated in meeting the relevant data submission timeframes, the health service must contact the department indicating the nature of the difficulties, remedial action being taken and the expected submission schedule.

A pro forma to assist this process is provided on the Health data standards and systems website <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems>.

Requests for an exemption from late penalties will only be considered if received prior to the relevant deadlines, and the manual aggregate data spreadsheet has been completed by the due date. Extensions or exemptions are not issued in advance. Late submissions penalties are assessed after the end-of-year consolidation deadline, taking into account the health service's compliance performance for the financial year.

For any full month period that the health service is unable to supply unit record data, the health service is required to submit aggregate data using the manual aggregate data spreadsheet. The spreadsheet is available from the Victorian Emergency Minimum Dataset (VEMD) webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vemd>.

Failure to complete the manual aggregate data spreadsheet by the due date will result in late submission penalties.

### Data resubmissions for previous months

Health services wishing to resubmit data for a previous period must complete a VEMD data resubmission request as soon as the health service is aware of the circumstances requiring resubmission. The request form must be submitted prior to the resubmissions. Resubmissions received without the request form will not be processed.

The pro forma is available on the Victorian Emergency Minimum Dataset (VEMD) webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vemd>.

**Software upgrades and migrations**

Health services undertaking software migrations will be exempt from late data submission penalties for an agreed period of up to two months, provided the manual aggregate data spreadsheet is completed on time. Health services undertaking software upgrades will be exempt from late data submission penalties for one month, provided the manual aggregate data spreadsheet is completed on time.

### 2.13.2.4 Elective Surgery Information System

Health services reporting to the Elective Surgery Information System (ESIS) must adhere to the minimum submission timelines in Table 2.4.

**Table 2.4: Elective Surgery Information System timelines**

| ESIS | Timeline |
|---|---|
| First 15 days of the month | At least one submission must be received by the third working day after the 15th of the reporting month. |
| The remaining days of the month (16th and subsequent) | Data for the remainder of the month must be supplied by the third working day of the following month. |
| All activity for the full month without errors | Data must be complete: that is, zero rejections, notifiable or correction edits by the 14th day of the following month, or the prior business day. |

Any corrections to 2019–20 data must be submitted before final consolidation of the ESIS database on 24 August 2020.

**Penalties for noncompliance**

If health services do not comply with these timelines, the department may apply a penalty of:

- up to $5,000 per month if a file containing episodes for the first 15 days is not submitted by the timelines specified in Table 2.4
- up to $10,000 if a file containing episodes for the full month is not submitted by the timelines specified in Table 2.4
- up to $10,000 if a file with all episodes for the full month contains errors by the timelines specified in Table 2.4.

Data that is flagged as unfit for reporting and analysis will be regarded as noncompliant and penalties as above will apply.

**Exemptions from penalties**

If difficulties are anticipated in meeting the relevant data transmission timeframes, the health service must contact the department indicating the nature of the difficulties, remedial action being taken and the expected transmission schedule.

A pro forma to assist this process is provided on the Elective Surgery Information System webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/esis>.

Requests for an exemption from late penalties will only be considered if received prior to the relevant deadlines, and the manual aggregate data spreadsheet is completed by the due date. Extensions or exemptions are not issued in advance. Late submission penalties are assessed after the end-of-year consolidation deadline, taking into account the health service's compliance performance for the financial year. For any full-month period that the health service is unable to supply unit record data, the health service is required to submit aggregate data using the manual aggregate data spreadsheet.

The spreadsheet is available from the Elective Surgery Information System webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/esis>.

Requests for an exemption from late penalties will only be considered if it is received prior to the relevant deadlines and the manual aggregate data spreadsheet is completed.

Failure to complete the manual aggregate data spreadsheet by the due date will result in late submission penalties.

**Software upgrades and migrations**

Health services undertaking software migrations will be exempt from late data submission penalties for an agreed period of up to two months, provided the manual aggregate data spreadsheet is completed on time.

Health services undertaking software upgrades will be exempt from late data submission penalties for one month, provided the manual aggregate data spreadsheet is completed on time.

### 2.13.2.5 Victorian Integrated Non-Admitted Health Minimum Dataset

The Victorian Integrated Non-Admitted Health Minimum Dataset (VINAH MDS) is a patient-level reporting system built around a generic framework suitable for reporting a wide range of non-admitted patient-level data.

Organisations that receive funding under any of the following programs must transmit data to the VINAH MDS:

- specialist clinics (outpatient)
- Health Independence Program
  - subacute ambulatory care services (including paediatric rehabilitation)
  - hospital admission risk program (HARP)
  - post-acute care (PAC)
  - residential in-reach service
- community-based palliative care
- palliative care day hospice
- family choice program
- home enteral nutrition
- total parenteral nutrition
- Victorian HIV service
- Victorian Respiratory Support service
- Medi-hotel (optional)
- Transition care program (TCP)
- hospital-based palliative care consultancy teams.

Further information on VINAH is contained in the VINAH manual <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vinah>.

### Submission guidelines

Health services reporting VINAH will be required to adhere to the minimum submission timelines in Table 2.5. Health services may submit more frequently than the minimum standards specified below.

**Table 2.5: Victorian Integrated Non-Admitted Health timelines**

| VINAH | Timeline |
|---|---|
| Submission date for client, referral, episode and contact details for the month | Must be submitted before 5.00 pm on the 10th day of the following month. |
| Clean date for client, referral, episode and contact details for the month | Must be submitted before the VINAH file consolidation at 5.00 pm on the 14th day of the following month, or the preceding working day if the 14th falls on a weekend or public holiday data must be complete: that is, zero rejections. |

Submitting funded organisations are encouraged to transmit VINAH MDS data frequently and may transmit as often as desired. Funded organisations must meet the following minimum requirements:

- VINAH data compliance is reckoned on a monthly basis. Data for each calendar month (reference month), as specified in the 'reported when' component of each data element in the VINAH manual, must be transmitted as specified below.
- Funded organisations must make at least one submission to the HealthCollect portal for the reference month by no later than 5.00 pm on the 10th day of the month following the reference month.
- All errors are to be corrected in time for the VINAH MDS file consolidation at 5.00 pm on the 14th day of the month following the reference month. Complete data for the month is expected to be transmitted by the 14th.

Data for the financial year must be completed in time for the VINAH MDS file consolidation on 24 August. Any final corrections must be received at the HealthCollect portal before the VINAH MDS database is finalised on 24 August 2020.

It is the funded organisation's responsibility to ensure the department receives the data in time to meet the processing schedule detailed above, regardless of the actual day of the week.

### Penalties for noncompliance

If funded organisations do not comply with these timelines, the department may apply a penalty of:

- up to $10,000 if an initial transmission of a reference month's activity for a program is not submitted within the timelines specified in Table 2.5
- up to $10,000 if a reference month's complete activity for a program is not submitted in accordance with the timelines specified in Table 2.5.

Funded organisations that have VINAH MDS reporting obligations for multiple programs (for example, subacute ambulatory care services, HARP, PAC) should note that the above penalties apply per program.

Data that is flagged as unfit for reporting and analysis will be regarded as noncompliant and penalties as above will apply.

### Exemptions from penalties

Organisations seeking exemption from penalties for late data must complete a 'Late Data Request Form' (available on the HealthCollect portal) advising of the issues experienced, the organisation's plan for overcoming the issues and the expected submission date. Exemptions will be granted at the discretion of the department.

Organisations must report aggregate data for acute non-admitted activity via the AIMS S10 form, subacute non-admitted activity via the AIMS S11 form and episodic non-admitted activity via the AIMS S12 form.

**Software upgrades and migrations**

Health services undertaking software migrations will be exempt from late data submission penalties for three months.

Health services undertaking software upgrades will be exempt from late data submission penalties for one month.

Health services must ensure their 2019–20 VINAH transmitted completely by 24 August 2020, and should ensure software updates and migrations do not prevent complete VINAH transmissions by this date, as no extensions will be possible.

### 2.13.2.6 Agency Information Management System

Health services will provide Agency Information Management System (AIMS) data to the department electronically via the HealthCollect web portal and in accordance with the timelines specified in the *Agency Information Management System (AIMS) public hospital user manual*.

Visit the HealthCollect web portal <https://www.healthcollect.vic.gov.au>.

**Penalties for noncompliance**

If health services are noncompliant with these timelines, the department may apply a penalty of up to $5,000 for each return not submitted by the due date specified in the AIMS manual.

Organisations seeking exemption from penalties for late data must notify the Health data standards and systems helpdesk <hdss.helpdesk@dhhs.vic.gov.au>, advising of the issues experienced, the organisation's plan for overcoming the issues and the expected submission date.

See further details about AIMS <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/aims>.

### 2.13.2.7 Victorian Cost Data Collection

Victorian public hospitals are required to report costs for all hospital activity, regardless of funding source, and are expected to maintain patient level costing systems that monitor service provision to patients and determine accurate patient-level costs.

Victorian health services are required to adhere, where possible, to the *Australian Hospital Patient Costing Standards* – version 4.0 (or the most recent version in the instance that a successor becomes available) in conjunction with VCDC documentation, specifications and business rules and any other guidance provided by the department in the coming year.

**Format and scope**

The cost data submission to the department must comply with the Victorian Cost Data Collection (VCDC) file specifications and reporting requirements. See VCDC specifications and requirements <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vcdc>.

The cost data submitted should be fit-for-purpose and cover all areas of hospital activity undertaken by the health service. Including (but not limited to) four broad categories:

- Admitted – A patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care are provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients) and include acute, subacute and mental health.
- Emergency – A dedicated area in a hospital that is organised and administered to provide emergency care (including reception, triage, initial assessment and management) to people who perceive the need for, or are in need of, acute or urgent care.
- Non-Admitted – A patient who does not undergo a hospital's formal admission process. There are three categories of non-admitted patient: emergency department, outpatient, subacute and other non-

admitted patient (treated by hospital employees off the hospital site – includes community/outreach services).

- Specialist Clinical Mental Health – A dedicated area in a hospital that delivers a range of hospital and community based clinical mental health services. This includes both admitted and non-admitted (community) patients.

Health services are to examine and review their current cost data for completeness across all services and an assurance of the quality of the cost data that provides a level of understanding of the usefulness of the patient level data for analysis, reporting and use in funding models.

The *National Health Reform Agreement* specifies that these areas will be activity-base funded from 1 July 2013 and cost data is required from all these services to support development of national weights.

**Submission and timeframes**

The VCDC submission involves a five-phase process to ensure the data submitted meets the requirements specified in the documentation. The five phases include:

- Phase 1 – receipt of submission
- Phase 2 – file validations
- Phase 3 – linking/matching VCDC to activity
- Phase 4 – data quality assurance checks
- Phase 5 – receipt of reconciliation report.

Health services reporting VCDC data will be required to adhere to the minimum submission timelines in Table 2.6. Health services may submit more frequently than the minimum standards specified below.

**Table 2.6: Victorian Cost Data Collection actions and reporting timelines**

| Actions | Date |
|---|---|
| Submission portal open to accept submission | 23 September 2019 |
| First submission of files to VCDC – Phase 1 | 23 September to 31 October 2019 |
| Final submission of files to VCDC following completion of Phase 2 and Phase 3 | 22 November 2019 |
| DHHS to provide Quality assurance (QA) reports to health services – Phase 4 | 25 November 2019 |
| Health services to provide comments on QA checks and conclude submission to the VCDC | 13 December 2019 |
| Health services to submit signed Reconciliation reports[6] | 20 December 2019 |
| Re-submissions completed following re-costing due to major impacts on cost data following phase 4 checks[7] | 17 January 2020 |
| DHHS to consolidate Victorian cost database | 8 February 2020 |
| DHHS to provide benchmark tool and underlying data to health services (following receipt of consent forms) | 8 March 2020 |

[6] Reconciliation templates including a signed attestation are to be submitted no later than five business days after the final submission of cost data.

[7] Any major corrections to 2018–19 submissions that will impact on the cost data must be submitted before final consolidation of the cost database on 8 February 2020.

**Penalties for noncompliance**

Where health services are noncompliant with the format or timelines specified above, the department may apply the following penalties:

- up to $20,000 per month if cost data is not submitted by the timeline specified
- up to $2,000 per episode if there are a significant number of episodes that are do not meet the VCDC business rules.

**Exemptions from penalties**

If difficulties are anticipated in meeting the relevant data transmission timeframes, the health service must contact the department indicating the nature of the difficulties, remedial action being taken and the expected transmission schedule.

**Software upgrades and migrations**

Health services undertaking software migrations must undertake VCDC data submission testing prior to resuming live VCDC data transmissions. Health services must ensure their 2018–19 VCDC is transmitted by the due date and should ensure software updates and migrations do not prevent complete VCDC transmissions by this date.

### 2.13.2.8 Victorian Health Incident Management System

The Victorian Agency for Health Information is leading the Victorian Health Incident Management System (VHIMS) reform program; to ensure information collected is better able to inform quality, safety and experience improvements for Victorians.

These reforms are detailed at Victorian Health Incident Management System – Better Safer Care website <https://bettersafercare.vic.gov.au/our-work/incident-response/VHIMS>.

In the meantime, interim reporting arrangements have been designed and established to support the collection of a minimum dataset from the current VHIMS for statewide reporting.

Health services and other relevant funded organisations (including registered community health services) must submit quarterly VHIMS extract data to the department's Secure Data Exchange (SDE) according to the timelines in Table 2.7.

**Table 2.7: Victorian Health Incident Management System quarterly reporting timelines**

| 2019–20 VHIMS reporting | Quarterly extract due |
|---|---|
| Quarter 1 | 1st working day in November 2019 |
| Quarter 2 | 1st working day in February 2020 |
| Quarter 3 | 1st working day in May 2020 |
| Quarter 4 | 1st working day in August 2020 |

### 2.13.2.9 Better Patient Dataset

The Better Patient Dataset (BPD) contains a core set of demographic information about every patient who has been treated in Victorian health services. Regular updates of the Better Patient Dataset are essential for optimum health services' planning, policy formulation, program evaluation and epidemiological research.

Health services will provide the Better Patient Dataset to the department electronically via the Secure Data Exchange in accordance with specifications advised directly by the department, by the 10th day of each month, for Patient Master Index data as at the end of the preceding month.

**Penalties for noncompliance**

If health services are noncompliant with these timelines, the department may apply a penalty of up to $3,800 for each return not submitted by the due date specified above.

Organisations seeking exemption from penalties for late data must write to the Manager, Centre for Victorian Data Linkage advising of the issues experienced, the organisation's plan for overcoming the issues and the expected submission date.

### 2.13.2.10 Victorian Healthcare Associated Infection Surveillance System

Safer Care Victoria receives infection surveillance reports from health services via the Victorian Healthcare Associated Infection Surveillance System (VICNISS) coordinating centre. All public health services are required to participate in the VICNISS HAI surveillance program.

Mandatory reporting requirements exist for a number of indicators that are included in the Statement of Priorities Part B. These include:

- surgical site infections following hip and knee arthroplasty, coronary artery bypass graft surgery, colorectal surgery and caesarean section
- intensive care unit central line-associated blood stream infections
- hand hygiene compliance rates
- hospital identified *Clostridium difficile* infections
- *Staphylococcus aureus* bacteraemia.

Further infection surveillance activities can be undertaken by health services on a voluntary and needs basis. Health services with a statistically significant higher rate than the aggregate are notified and requested to provide information on actions that are being taken to reduce this rate.

A limited number of healthcare-associated infections (HAI) performance indicators are reported publicly on the Victorian Health Services Performance website <https://performance.health.vic.gov.au/Home.aspx>.

Rates for *Staphylococcus aureus* bacteraemia and compliance with Hand Hygiene Australia guidelines are publicly reported on the MyHospitals website <https://www.myhospitals.gov.au>.

### 2.13.2.11 Victorian State Trauma Registry

All public health services, including the three designated major trauma services, are required to participate in the Victorian State Trauma Registry. The key requirement is the delivery of trauma data, in the form requested by the Registry, to the Registry on time. The department contracts the Victorian State Trauma Registry to collect data on major trauma patients from health services.

The performance and effectiveness of the Victorian State Trauma System is monitored via the registry. The failure to deliver data on time affects the governance of the Victorian State Trauma System and the ability of the registry to deliver reports to health services. State aggregate data is reported every year in the Victorian State Trauma Registry summary report. Annual reports are available at the Victorian State Trauma System webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/state-trauma-system>.

### 2.13.2.12 Victorian Audit of Surgical Mortality

The Victorian Audit of Surgical Mortality (VASM) is a peer-review audit of deaths associated with surgical care that is undertaken through the Royal Australasian College of Surgeons (RACS) Victorian Office. Surgeon participation in the VASM is a requirement of the RACS continuing professional development program.

### 2.13.2.13 Consultative councils reporting requirements

Consultative councils are ministerial advisory committees that review and report on specialised areas within healthcare to reduce mortality and morbidity. The councils' functions and reporting requirements are legislated under the *Public Health and Wellbeing Act 2008*.

### 2.13.2.14 Koori Maternity Services reporting by public health services

Health services that are funded to provide a Koori Maternity Service program are required to submit data to the Koori Maternity Services minimum dataset via the online form at the Aboriginal maternity services webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/aboriginal-maternity-services>.

**Table 2.8: Public health services funded to provide Koori Maternity Service**

| Public health services Koori Maternity Service |
|---|
| Western Health (Sunshine Hospital) |
| Northern Health (The Northern Hospital) |
| Peninsula Health (Frankston Hospital) |

### 2.13.2.15 Cardiac surgery registry

Since 2001 the department has contracted the Australian and New Zealand Society of Cardiac and Thoracic Surgeons to collect data to monitor clinical performance in cardiac surgery. The Cardiac Surgery Database Project is coordinated by the Monash University School of Public Health and Preventative Medicine. The department expects all health services that perform cardiac surgery to participate.

The Cardiac Surgery Database Project includes maintenance of a comprehensive clinical registry, statistical analysis and report generation. These components enable a structured peer-review process that can identify variation in performance at the practitioner and health service level.

The department publishes a public version of the Cardiac Surgery Database Project annual reports on its website and more detailed reports are provided to participating health services. From 1 July 2018, the Victorian Agency for Health Information will manage the contractual arrangements for the registry.

### 2.13.2.16 Victorian Cardiac Outcomes Registry

The department has supported the development and implementation of a cardiac outcomes registry that aims to help improve the safety and quality of healthcare provided to cardiovascular patients in Victoria. All public health services that perform percutaneous coronary interventions must provide this data to the Victorian Cardiac Outcomes Registry. Additional modules planned relate to implantable cardiac devices (such as pacemakers and defibrillators) and a dataset for patients presenting to hospital with heart failure.

This registry is coordinated by the Monash University School of Public Health and Preventive Medicine and has the support of the Cardiac Society of Australia and New Zealand. The Victorian Cardiac Clinical Network supports and promotes the implementation of the registry. Since 1 July 2018, the Victorian Agency for Health Information has managed the contractual arrangements for this registry.

### 2.13.2.17 Australian Stroke Clinical Registry

The Australian Stroke Clinical Registry is a collaborative national effort to monitor, promote and improve the quality of acute stroke care. It is a prospective, multicentre, observational outcomes database designed to collect data on the demographics, presentation, diagnosis, treatment and outcomes of hospitalised patients with stroke. The Victorian Stroke Clinical Network promotes the implementation of the registry at all metropolitan and regional stroke units, and is supporting the development of automated data extraction platforms to reduce the burden of data entry for clinicians. On 1 July 2018, the Victorian Agency for Health Information assumed responsibility for management and contractual arrangements for the Australian Stroke Clinical Registry.

### 2.13.2.18 Radiotherapy services reporting

Radiotherapy providers are required to report:

- monthly to the Victorian Radiotherapy Minimum Dataset (VRMDS)
- monthly to AIMS form S8 consultations only
- monthly to the AIMS form S10.

The department continues to contribute data from the VRMDS to the Australian Institute of Health and Welfare (AIHW), along with other jurisdictions. The data is included in the AIHW report *Radiotherapy in Australia*, released annually. The report presents waiting times at public radiotherapy providers by state or territory. Waiting times for private providers are amalgamated into a national figure.

### 2.13.2.19 Renal dialysis reporting

All health services that provide facility dialysis must report public and private admitted activity at a unit record level to the VAED. This includes activity in all facilities.

The department maintains a dialysis register comprising patient-level data provided by specialist services and coordinated by Melbourne Health. The register excludes private patients dialysing in private hospitals.

### 2.13.2.20 Victorian Healthcare Experience Survey

The Victorian Healthcare Experience Survey (VHES) seeks feedback from recent users of Victoria's public health services. It is a voluntary survey, focusing on both adult inpatient and emergency department care as well as maternity care. Data for these categories is collected continually throughout the year. An independent organisation Ipsos is under contract to administer the survey on behalf of the Victorian Agency for Health Information.

The VHES program measures patient experiences. This enables identification of the areas where these experiences can be improved leading to actions that enhance person- and family-centred care. The program also provides health services, Safer Care Victoria, VAHI and the department with actionable results.

All questionnaires were developed in consultation with key stakeholders including clinicians and consumers. They were cognitively tested with consumers (and, where appropriate, carers) and piloted through a representative sample. The results include verbatim comments thematically streamed from survey respondents.

Annual program specific surveys have been established for community health services, specialist clinics, ambulance services, paediatric inpatient, paediatric emergency and palliative care services. In 2019 a state-wide Cancer Patients' Experiences of Care survey will be released.

The Victorian Agency for Health Information will continue in 2019–20 with its VHES program of reform to ensure patient quality and safety is central to its design, and consistent with a patient-centred approach to service delivery. Key areas of focus will include the current length of the survey questionnaire, opportunities for inclusion of questions relating to patient reported outcomes and alternative approaches to measuring patient experiences in rural areas. In 2019, at the end of the current contract with Ipsos, an approach to market will be undertaken for a survey administrator.

Health services will be kept updated on the progress of reforms being undertaken, and any changes to the VHES program.

**Upload procedures**

For continuous surveys, health services are required to upload contact details of eligible consumers to the contractor by the 15th of the month following discharge. This upload includes the service received, which determines the type of questionnaire sent.

For the annual specialist clinics survey, nominated health services are required to upload contact details of eligible consumers for the three months nominated for survey collection.

For the annual ambulance services survey, nominated health services are required to upload contact details of eligible patients for the two months nominated for survey collection.

For the annual community health service survey, health services are required to support the census survey process.

For the annual cancer patients survey, nominated health services are required to upload contact details of eligible patients for the three months nominated for survey collection.

Data transfers occur in a secure online environment through the Project Control Portal <https://www.vhes.com.au/depthealth>. The Project Control Portal provides access to the Data Upload manual and the template required for submission.

Quarterly reports are available online at the Victorian Healthcare Experience Survey website <https://results.vhes.com.au>. At present these results are only available to registered health services and departmental staff.

## 2.13.3 Subacute data reporting requirements

For all subacute program data reporting requirements (other than 'Nursing home care type', described below) please see Chapter 2, section 2.3.2. 'Subacute and non-acute'.

### 2.13.3.1 Nursing home type care

The department no longer provides direct funding for public patients reported as nursing home type (NHT) in Victorian hospitals with subacute or non-acute care services. Therefore, it is not expected that health services will report NHT activity. Current arrangements for Department of Veterans' Affairs, compensable and private patients remain in place regarding the NHT process and funding. A patient co-contribution payment cannot be levied on patients in admitted acute and subacute care types (excluding the Transition Care Program).

## 2.13.4 Ambulance Victoria data reporting requirements

Stage 1 of the Victorian Ambulance Data Set (VADS) became operational in 2015–16. The department will continue to work with Ambulance Victoria to validate and extend the VADS collection. Ambulance Victoria will be required to continue existing reporting requirements until both the department and Ambulance Victoria confirm the accuracy of VADS data for the purposes of public reporting and performance monitoring.

Ambulance Victoria will supply data to the department according to the timelines specified in Table 2.9.

**Table 2.9: Victorian Ambulance Data Set timelines**

| VADS | Timeline |
|---|---|
| Request for service and response data | Year-to-date submission to be received by the 10th day of the month following the Case Date. |
| Transport and patient data | Year-to-date submission to be received by the 10th day of the second month following the Case Date. |
| Data for the 2018–19 financial year | Year-to-date submission must be received before final consolidation of VADS on 10 August 2020. |

**Table 2.10: Existing ambulance data collections**

| Collection | Description and submission timeline |
|---|---|
| Aggregate Ambulance Minimum Dataset | The indicators identified in Table 2.19 will be supplied to the department in spreadsheet format by the 10th day of the month following the monthly reporting period. |
| Ambulance membership movements | Changes in Ambulance Victoria membership in spreadsheet format to be emailed to a nominated departmental contact on the seventh day of each month following the end of the monthly reporting period. |

## 2.13.5 Mental health services data reporting requirements

Information about clinical mental health services relevant to funding, activity and performance monitoring is collected by the department through a range of channels including:

- the Client Management Interface and Operational Data Store (CMI/ODS), which captures service activity data and aspects of mental healthcare required under the *Mental Health Act 2014*
- the mental health triage minimum dataset
- reportable deaths and other notifications to the Chief Psychiatrist
- annual Mental Health Establishments collection
- quarterly Data Collection (Mental Health Community Support Services reporting)
- quarterly Mental Health Community Support Service aggregate spreadsheet report
- the VAED (see Chapter 2, section 2.13.2.2 'Victorian Admitted Episodes Dataset')
- the VEMD (see Chapter 2, section 2.13.2.3 'Victorian Emergency Minimum Dataset').

The collections form an essential underpinning of public accountability for service provision, quality and safety, with the outputs from these collections contributing to a range of national datasets, as well as performance measurement and monitoring for commonwealth, state and departmental purposes.

Mental health data and performance reporting can be found at the Victorian Health Services Performance website <http://performance.health.vic.gov.au> and the Mental health performance reports website <https://www2.health.vic.gov.au/mental-health/research-and-reporting/mental-health-performance-reports>.

### 2.13.5.1 Client Management Interface and Operational Data Store

The statewide Operational Data Store (ODS) is simultaneously updated from local Client Management Interface (CMI) systems as data are captured, providing a live 24-hour, seven-day-a-week statewide view of the transactional history of mental health services.

Health services are expected to use the CMI/ODS to record clinical mental health activity to ensure statewide visibility of client care across all designated mental health services. Data entry timeframes differ according to the type of data being recorded. See Table 2.11 for details.

**Table 2.11: Client Management Interface and Operational Data Store reporting timelines**

| Data entry | Rationale | Due date |
|---|---|---|
| Compulsory order/legal status | Timely information regarding compulsory/forensic/security client status | Twice daily, seven days per week |
| Admissions, transfers and separations | Statutory reporting<br>Maintenance of statewide bed register | Twice daily, seven days per week |
| Contacts | Statutory reporting | 10th of the month following the contact |

| Data entry | Rationale | Due date |
|---|---|---|
| Outcome measures | Statutory reporting | 10th of the month following the measure collection |
| Electroconvulsive therapy procedures | Statutory reporting | As soon as practicably possible |
| Seclusion and restraint | Statutory reporting | 10th of the month following the period of seclusion/restraint |
| Diagnosis | Statutory reporting | 10th of the month following the diagnosis event |

Departmental circulars and bulletins detail the business rules for key data requirements and guidelines for data recording practices.

Business rules for data recording can be found under CMI/ODS at the Reporting requirements and business rules for clinical mental health services webpage <https://www2.health.vic.gov.au/mental-health/research-and-reporting/reporting-requirements-for-clinical%20mental-health-services>.

Regular meetings are held with hospital mental health system administrators to discuss system and data issues. Regular system upgrades are performed to improve the functionality and utility of the system and data.

**Data integrity**

Services are required to review and reconcile data quality issues identified by the department and provide return advice on a quarterly basis. Validation reports are updated monthly.

Quarterly returns are to be submitted by the following due dates:

- July – September 2019: 30 November 2019
- October – December 2019: 28 February 2019
- January – March 2020: 31 May 2020
- April – June 2020: 31 August 2020.

Outstanding validation issues for the 2019–20 financial year must be reconciled by 30 November 2020.

Selected health services may be subject to audits of their mental health service hours reported via the Client Management Interface and Operational Data Store (CMI/ODS).

**Electroconvulsive therapy**

The Chief Psychiatrist requires that all occasions of electroconvulsive therapy (ECT) be reported to the Office of the Chief Psychiatrist. All ECT course details and procedures are to be recorded on the CMI/ODS as soon as practicably possible after each procedure.

### 2.13.5.2 Mental Health Establishments National Minimum Dataset

The Mental Health Establishments National Minimum Dataset collection captures all mental health workforce data and expenditure and is compiled to meet the *Mental health services annual report* and national mental health reporting requirements.

The data collection for the previous financial year (Stage 1) begins in September each year, with health services, residential service providers and departmental divisions required to submit a return.

As has been the practice in previous years, the Mental Health Establishment collection for 2019–20 will be pre-populated with health service activity data from the CMI/ODS. This information is subject to health service confirmation or amendment as required.

Health service finance data from the F1 return is available on request to assist with completion of organisation-level finance information. Further advice will be provided prior to the HealthCollect portal opening for the stage 1 2019–20 data submission.

Visit the HealthCollect web portal <https://www.healthcollect.vic.gov.au>.

Reporting timelines for the Mental Health Establishments National Minimum Dataset are outlined in Table 2.12.

**Table 2.12: Mental Health Establishments National Minimum Dataset reporting timelines**

| Collection period | Reporting requirements | Due date |
|---|---|---|
| 2017–18 | Stage 2: Resolution of final validation issues identified by the AIHW for 2017–18. Validations to be finalised by health services by 30 August 2019 when the HealthCollect portal will close. | 30 August 2019 |
| 2018–19 | Stage 1: Data submission opens through the HealthCollect portal and remains open for one month. Data entry by health services to be finalised by 12 October 2019 when the portal will close. | 12 October 2019 |
| 2018–19 | Stage 1: Resolution of services' initial validation issues arising from the HealthCollect portal. | 26 April 2020 |
| 2018–19 | Stage 2: Resolution of final issues identified by the AIHW for 2018–19. Validations from health services must be finalised by 30 August 2020 when the HealthCollect portal will close. | 16 August 2020 |

### 2.13.5.3 Mental health triage minimum dataset

Triage minimum dataset submissions are to be provided in the prescribed format on a monthly basis by the 15th of each month. The data file must be sent to the mental health triage secure email <triagemds@dhhs.vic.gov.au>.

Documentation detailing the format and reporting timelines can be found at the Reporting requirements and business rules for clinical mental health services webpage <https://www2.health.vic.gov.au/mental-health/research-and-reporting/reporting-requirements-for-clinical%20mental-health-services>>.

### 2.13.5.4 Mental health community support services

Agencies funded to deliver mental health community support service activity are expected to provide data via the Quarterly Data Collection (QDC) and the supplementary MHCSS excel spreadsheet. Compliance with these reporting requirements is a key accountability requirement to be used as part of the ongoing review and monitoring processes.

Quarterly Data Collection data must be submitted by 7th of the month following the end of the quarter. The QDC has a dedicated helpdesk support team to assist users with the quarterly data collection. Contact the team via the QDC helpdesk email <qdchelp@dhhs.vic.gov.au>.

The aggregate supplementary excel spreadsheet data file must be submitted by the 15th of the month following the end of the quarter. The file must be submitted by emailing Mental Health and Drugs Data team <mhcssdata@dhhs.vic.gov.au>.

Due to the transition to the National Disability Insurance Scheme, Individualised Client Support Packages, previously in scope, will cease reporting to the MHCSS in 2019–20.

### 2.13.5.5 Reportable deaths

The Chief Psychiatrist requires that the deaths of consumers of designated mental health services and mental health community support services be reported in the following circumstances.

**Deaths on mental health inpatient units**

All deaths of mental health inpatients, including expected deaths, must be notified to the Chief Psychiatrist within 24 hours. Notifications can be made by telephone (03) 9096 8124, or email the Office of the Chief Psychiatrist<ocp@dhhs.vic.gov.au>.

For the purposes of this policy, an inpatient is defined by the Chief Psychiatrist as any person, regardless of legal status, who:

- has been admitted to a mental health inpatient unit
- is on approved leave from an inpatient unit
- has absconded from an inpatient unit
- has been transferred to a non-psychiatric ward during a mental health admission
- has been discharged from a mental health inpatient unit within the previous 24 hours.

**Deaths in the community**

The Chief Psychiatrist must be notified in writing of:

- All unexpected, unnatural or violent deaths (including suspected suicides) of community-resident persons who were registered as mental health consumers within the previous three months or who had sought service from a mental health provider within that period and not been provided with service.
- All deaths of community-resident patients under the *Mental Health Act 2014* (including forensic orders). People are considered to be mental health consumers until their case is closed and they have been notified of this closure (or the service has made all reasonable efforts to do so).
- Designated mental health services and mental health community support service notify the Chief Psychiatrist of a death consumers using the MHA 125 'Notice of Death' form.
- VHIMS reporting community service organisations providing MHCSS programs are required to report the incident in accordance with the *Victorian health incident management policy*. Non-VHIMS reporting community service organisations providing MHCSS are required to report the incident in accordance with the *Incident reporting instruction 2013*.

More information on what is meant by a 'reportable death' and the procedures for reporting them can be found in the Chief Psychiatrist's guideline on reportable deaths <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/reportable-deaths>.

**Suicides on other hospital wards**

Suicides on inpatient units (including medical, surgical and other are categorised nationally as sentinel events (that is, unexpected health care incidents that result in death or serious disability). The sentinel event program is managed by Safer Care Victoria which must be notified by area mental health services. The non-psychiatric wards are one of eight nationally defined sentinel event categories that must be notified to the department's Sentinel Event Program. See more information on the Sentinel Event Program <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-risk-management/sentinel-event-program>.

### 2.13.5.6 Restrictive Interventions reporting (seclusion and bodily restraint)

The *Mental Health Act 2014* closely regulates the use of 'restrictive interventions'. Part 6 of the Act outlines when restrictive interventions can be used, who can authorize them and the monitoring of restrictive interventions when used. Section 3 of the Act defines 'restrictive interventions' as 'bodily restraint or seclusion'.

All restrictive interventions are required to be reported to the Chief Psychiatrist.

In accordance with the *Mental Health Act 2014* and the Chief Psychiatrist Guidelines *Restrictive interventions in designated mental health* services, an authorised psychiatrist must give a written report to the Chief Psychiatrist on the use of any restrictive intervention (s. 108(1)). This report must contain the details required by the Chief Psychiatrist and be given to the Chief Psychiatrist within the time stipulated (s. 108).

In practice, this information is entered monthly onto the Client Management Interface (CMI) database in each service and must include information relating to restrictive interventions which have occurred in

emergency departments and other areas where the intervention has occurred with people receiving compulsory treatment under the *Mental Health Act 2014*.

The service must also provide appropriate information to persons subject to restrictive interventions about their rights, including post intervention support.

**Episodes of extended seclusion**

In addition to the routine monthly reporting procedures, designated mental health services are required to notify the Chief Psychiatrist of any episode of seclusion which is continuous and exceeds 48 hours. This report must be made before the episode exceeds 48 hours in length.

Where an extended period of seclusion in excess of 48 hours is anticipated, the authorised psychiatrist or delegate must provide the Chief Psychiatrist with a written clinical summary and management plan at the time of notification.

Mental health services will be required to present evidence of an active case conferencing process to assist in bringing the seclusion episode to conclusion for any episode of seclusion exceeding 30 consecutive days and at any time on request thereafter.

**Extended admission to high dependency area**

Designated mental health services are required to notify the Chief Psychiatrist of any extended admission to a high dependency area which is continuous and exceeds 48 hours. This report must be made at the time the episode has not exceeded 48 hours in length.

Where an extended period of seclusion in excess of 48 hours is anticipated, the authorised psychiatrist or delegate must provide the Chief Psychiatrist with a written clinical summary and management plan at the time of notification.

Mental health services will be required to present evidence of an active case conferencing process to assist in bringing the admission to conclusion for any admission to a high dependency area exceeding 30 consecutive days and at any time on request thereafter.

### 2.13.5.7 Sexual safety reporting

The Office of the Chief Psychiatrist established a new reporting process regarding sexual safety incidents in all inpatient units across specialist mental health services effective from March 2018. Designated mental health services are required to report known occurrences or allegations of sexual activity, including sexual activity between patients or staff, sexual harassment or assault on an acute psychiatric inpatient unit within 24 hours of being identified in accordance with the requirements of the Chief Psychiatrist.

### 2.13.5.8 Electroconvulsive therapy

**Treatment reports**

Designated mental health services are required to report the use of ECT to the Chief Psychiatrist. The information to be submitted includes:

- the date, name, UR number, sex and age of each person
- the names of the doctors giving the anaesthetic and ECT
- treatment laterality and stimulus level
- the nature of the consent given for treatment.

The authorised psychiatrist is responsible for ensuring that reports are submitted but may designate a staff member, preferably the ECT coordinator, to undertake this function. Reports are now submitted online. Data must be returned within a month of treatment. Individual services should determine if other information is required for local purposes, such as quality improvement programs.

**Adverse events**

The Chief Psychiatrist must be notified immediately either by telephone or electronically of adverse events directly related to ECT that:

- result in death (including near misses), serious injury, serious illness, or
- require transfer to an emergency department or similar setting.

Other incidents and near misses should be reported to the service's own ECT committee and safety-monitoring bodies.

**People under the age of 18 years**

The Act regulates the use of ECT for '**all young persons**' under the age of 18 years in Victoria, whether voluntary or involuntary, including those in both public mental health services and private hospitals and clinics, even when the young person has given informed consent to treatment.

A psychiatrist must apply to the Mental Health Tribunal to perform a course of ECT, even if the young person provides informed consent. The Chief Psychiatrist does not make decisions concerning treatment but must be informed **in advance** of plans to administer ECT to a young person receiving mental health services from a designated mental health service.

The Chief Psychiatrist must also be informed of the clinical outcomes for the young person after ECT has been administered to assist in the preparation of annual and five-yearly reports to the Minister for Health.

The Chief Psychiatrist is required to monitor outcomes in this age group. To facilitate this, service providers are required to complete a number of outcomes measures at specified intervals before and after ECT is administered.

### 2.13.5.9 Neurosurgery for mental illness

Treatment of psychiatric illness by means of neurosurgery (specifically, deep brain stimulation) must be approved by the Mental Health Tribunal. Following treatment, the authorised psychiatrist treating the person must provide a written report to the Chief Psychiatrist including a description of the treatment's outcome within 3 months after the surgery is performed and again within 9 to 12 months after the surgery is performed.

**Alcohol and other drug services data reporting requirements**

Information about alcohol and other drug services which are relevant to funding, activity and performance monitoring is collected through a range of channels including the:

- Victorian Alcohol and Drug Collection
- Needle and Syringe Program Information System.

### 2.13.5.10 Victorian Alcohol and Drug Collection

The Victorian Alcohol and Drug Collection (VADC) supports public accountability for service provision. Outputs contribute to the national AODTS dataset, as well as performance measurement and monitoring for Commonwealth, state and departmental purposes. All alcohol and drug treatment service providers are required to submit activity data via the VADC.

Alcohol and other drug treatment service providers are required to ensure client management systems can meet VADC reporting requirements. Details on data specifications, bulletins and the submission process can be found at the VADC data specification and supporting documentation webpage <https://www2.health.vic.gov.au/alcohol-and-drugs/funding-and-reporting-aod-services/data-collection/vadc-specifications>.

VADC data must be submitted monthly with data due by the 15th day of the subsequent month.

### 2.13.5.11 Needle and Syringe Program Information System

The Victorian and Commonwealth Governments fund services to reduce the harms associated with alcohol and other drug use. The harm reduction services data collection records the level of activity in these services in terms of contacts, service provision (for example, needles provided and returned, education and referrals), responses to harm reduction questions, as well as information about the free provision of a range of injecting and safe-sex equipment, and the disposal of returned waste.

Harm reduction services data is provided by:

- needle and syringe programs
- mobile overdose response services
- mobile drug safety workers.

All Primary Needle and Syringe Program providers and recipients of Ice Action Plan funding are required to report monthly by the end of each month via the Needle and Syringe Information System Agency Reporting (NSPIS-AR) application. Organisations using the NSPIS-AR application can generate the extract and email it to the Needle and Syringe Program <nsp-is@dhhs.vic.gov.au>.

Paper-based surveys should be sent to the department by emailing NSP Data Collection <nsp-is@dhhs.vic.gov.au>, by fax to (03) 9096 8726, or posted to:

NSP Data Collection
Mental Health & Drugs Data unit
Level 3
Department of Health and Human Services
GPO Box 4541
Melbourne VIC 3001

### 2.13.5.12 Drugs and poisons information system

The department operates an electronic information system known as the drugs and poisons information system to support its administration of the *Drugs, Poisons and Controlled Substances Act 1981*.

The drugs and poisons information system is a stand-alone system. It provides the department with the ability to record treatment permits issued to doctors prescribing Schedule 8 drugs to patients. This includes methadone and buprenorphine prescriptions for opioid replacement therapy (pharmacotherapy).

The system is additionally used to record information collected during prescription-monitoring activities and during investigative processes. Interventions are initiated if unlawful or possibly unsafe prescribing is identified. Non-compliant health practitioners may be subject to further action, ranging from educational counselling to prosecution or other disciplinary action. More serious offending (for example, trafficking) will commonly be the subject of joint investigations involving departmental officers and police.

The drugs and poisons information system also records licences and permits issued to organisations or individuals who have a legitimate need to use, possess, manufacture or supply medicines and poisons as part of their practice or business (such as for research, industrial or health services). The information system also records the payment of fees relating to such licences and permits associated with the possession of drugs and poisons.

### 2.13.5.13 SafeScript, Victoria's Real-Time Prescription Monitoring System

SafeScript is computer software that allows prescription records for certain high-risk medicines to be transmitted in real-time to a centralised database which can then be accessed by doctors, nurse practitioners and pharmacists during a consultation with a patient.

SafeScript provides these practitioners with a clinical tool to make safer decisions about whether to prescribe or dispense a high-risk medicine, as well as facilitating early identification, treatment and support for patients who are developing signs of substance use disorder.

The data for SafeScript is collected automatically from Prescription Exchange Services (PES) which currently support the electronic transfer of prescriptions from medical clinics to pharmacies.

When a prescription is issued at a medical clinic or dispensed at a pharmacy, the PES sends a record of the prescription in real-time to SafeScript. No additional data entry is necessary to record a prescription in SafeScript.

Authorised departmental officers may also access SafeScript as part of their regulatory role in ensuring the safe supply of medicines in the community.

From April 2020, it will be mandatory for doctors, nurse practitioners and pharmacists to check SafeScript before prescribing or dispensing a medicine monitored in SafeScript.

#### 2.13.5.14 Opioid Replacement Therapy Dispenser Census

The department conducts the opioid replacement therapy dispenser census annually. It surveys all community, correctional, health service and specialist pharmacotherapy service dispensaries dosing opioid replacement therapy clients in Victoria. All dispensers are faxed the survey form, to be returned by fax, recording the number of clients being dosed with respective opioid replacement therapy medications. It also records the numbers of opioid replacement therapy clients on a minimal supervision regimen, and persons who are eligible for departmental dispensing support, or with interstate prescriptions. Finally, it collects data of clients who identify as Aboriginal, Torres Strait Islander, Aboriginal and Torres Strait Islander or neither as of June 30.

The data provides a count of clients being dosed at a given time. This allows patterns of opioid replacement therapy access to be monitored across the state, which in turn informs departmental sector support activities.

### 2.13.6 Aged care data reporting requirements

Data collection requirements and timelines for ageing, aged and home care services are provided in Table 2.13. This includes information for the Home and Community Care Program for Younger People (HACC-PYP), public sector residential aged care and aged care assessment services (ACAS) through a range of channels including:

- the HACC minimum dataset
- My Aged Care Reporting
- RAS assessment activity database for reporting hours
- HACC-PYP fees data collection
- HACC-PYP annual service activity reports
- residential aged care services data collection.

Since the Home and Community Care Program was split between the Commonwealth and the state on 1 July 2016, reporting requirements for clients aged 65 and over (and Indigenous clients aged 50 and over) are now determined by the Commonwealth Department of Health, which administers the Commonwealth Home Support Programme.

For clients aged less than 65 (and Indigenous clients aged less than 50) who remain in HACC-PYP managed by Victoria, reporting requirements remain unchanged – that is, via the HACC Minimum Data Set. Organisations should continue to send the data to the department.

The *Carers Recognition Act 2012* sets out obligations for councils and organisations covered by that Act, including the obligation to raise awareness and understanding of the care relationship principles as set out in the Act. Relevant organisations are required to report on their compliance against these obligations in their annual report. Specific requirements can be found in ss. 5, 11 and 12 of the Act.

**Table 2.13: Ageing, aged and home care data collection and reporting requirements**

| Activity no. | Activity name | Measure description |
|---|---|---|
| 13005 | ACAS assessment[8] | Six-monthly report on ACAP operations |
| 13005 | ACAS assessment | Six-monthly report on ACAP staffing |
| 13230 | RAS assessment | RAS assessment activity database for reporting hours |
| 13015 | HACC linkages packages | HACC minimum dataset |
| 13015 | HACC linkages packages | HACC-PYP fees data collection |
| 13023 | HACC service development grant | Electronic project report |
| 13056 | Home and Community Care planned activity group – core | HACC minimum dataset |
| 13056 | Home and Community Care planned activity group – core | HACC-PYP fees data collection |
| 13057 | Home and Community Care planned activity group – high | HACC minimum dataset |
| 13057 | Home and Community Care planned activity group – high | HACC-PYP fees data collection |
| 13038 | Home and Community Care service system resourcing | Service activity report |
| 13043 | Home and Community Care flexible service response | Service activity report |
| 13043 | Home and Community Care flexible service response | HACC minimum dataset where relevant |
| 13063 | Home and Community Care volunteer coordination | Service activity report |
| 13063 | Home and Community Care volunteer coordination | HACC minimum dataset where relevant |
| 13096 | Home and Community Care allied health | HACC minimum dataset |
| 13096 | Home and Community Care allied health | HACC-PYP fees data collection |
| 13096 | Home and Community Care allied health | Service activity report where relevant |
| 13097 | Home and Community Care delivered meals | HACC minimum dataset |
| 13099 | Home and Community Care property maintenance | HACC minimum dataset |
| 13099 | Home and Community Care property maintenance | HACC-PYP fees data collection |
| 13131 | RDNS Home and Community Care allied health | HACC minimum dataset |
| 13131 | RDNS Home and Community Care allied health | HACC-PYP fees data collection |
| 13131 | RDNS Home and Community Care allied health | Service activity report |
| 13223 | Home and Community Care nursing | HACC minimum dataset |
| 13223 | Home and Community Care nursing | HACC-PYP fees data collection |
| 13223 | Home and Community Care nursing | Service activity report |

[8] Where 'HACC' is referred to, the activity name relates to the Home and Community Care Program for Younger People (HACC-PYP)

| Activity no. | Activity name | Measure description |
|---|---|---|
| 13226 | Home and Community Care personal care | HACC minimum dataset |
| 13226 | Home and Community Care personal care | HACC-PYP fees data collection |
| 13227 | ACCO services – aged and home care | HACC minimum dataset |
| 13227 | ACCO services – aged and home care | HACC-PYP fees data collection |
| 13227 | ACCO services – aged and home care | Service activity report |
| 13229 | Home and Community Care access and support | HACC minimum dataset |
| 13229 | Home and Community Care access and support | HACC-PYP fees data collection |
| 13229 | Home and Community Care access and support | Service activity report – A&S activity 6 monthly report |
| 35030 | Small Rural – HACC Health Care and Support | HACC minimum dataset |
| 35030 | Small Rural – HACC Health Care and Support | HACC PYP fees data collection |
| 35030 | Small Rural – HACC Health Care and Support | Service activity report |
| 13026 | HACC domestic assistance | HACC minimum dataset |
| 13026 | HACC domestic assistance | HACC-PYP fees data collection |
| 13027 | HACC respite | HACC minimum dataset |
| 13027 | HACC respite | HACC-PYP fees data collection |
| 13031 | Public sector residential aged care supplements (including Small Rural – residential aged care supplements previously reported under 35011). | Residential aged care services data collection and residential aged persons mental health data collection<br>Forms: AIMS S5_129 for Residential aged care services data collection; AIMS Public sector residential aged care services quality indicators; and AIMS S5-115 for Aged persons' mental health; PSRACS financial data submitted to the department for the F1 data collection must be submitted using the Campus codes allocated to each Health Service (for assistance, email Planning and Operations <Planning&Operations@health.vic.gov.au>)<br>Public sector residential aged care services VICNISS infection control module; participation in the annual Aged Care National Antimicrobial Prescribing Survey (acNAPS); monitoring and reporting on Significant organisms such as MRSA, VRE and CDI; resident vaccination rates for influenza, herpes zoster and pneumococcal; staff vaccination rates for influenza. (for assistance contact VICNISS Coordinating Centre by phone 9342 9333 or VICNISS email <vicniss@mh.org.au>) |

## 2.13.7 Primary, community and dental health data reporting requirements

A summary of reporting requirements is shown in Table 2.14.

### 2.13.7.1 Community health services

All funded organisations receiving community health program funding are required to submit data that outlines service delivery performance against targets. Agencies are responsible for the timely submission of data as per the documented reporting requirements.

The *Community Health Program Data Submission Guidelines* are available from the Community health data reporting webpage <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/community-health-data-reporting>.

All health services receiving community health program funding are required to ensure that:

- information systems comply with the department's reporting requirements
- service information remains up-to-date on the National Human Services Directory.

Additional evidence may be required from time-to-time to demonstrate that funding has been used appropriately.

Community health services can also contribute to the Primary Care Partnerships reporting, as outlined in Chapter 2, section 2.6.7 'Partnerships'.

### 2.13.7.2 Primary Care Partnerships

Primary Care Partnerships are required to report annually to demonstrate progress in achieving strategic outcomes. Primary Care Partnerships are responsible for the timely submission of reports as per the documented reporting requirements.

A key objective of Primary Care Partnership activity is to strengthen integration across health and human services sectors. Reporting should demonstrate meaningful engagement and partnership with organisations from both these sectors and provide an overview of their key activities in prevention. Primary Care Partnership reporting should reflect partnerships with Primary Health Networks and other locally relevant collaboratives and networks to progress this work.

E-referral reporting is used to report annually to the Department of Treasury and Finance on the number of referrals made using electronic referral systems. Reporting provides an indication of the level of participation of health and human services in securely sharing standardised consumer information electronically. Work is ongoing to replace this outdated measure. Updates to Primary Care Partnerships reporting requirements will be provided as changes occur. Primary Care Partnerships are required to submit their annual financial statement in accordance with the department's monitoring framework.

Primary Health Networks reporting requirements for state funded programs and priorities are adhered to as outlined in their service agreements with the department.

### 2.13.7.3 Dental health services

The department requires a monthly extract of dental health program dataset items. This extract includes all episodes created during the reporting period and any episodes modified during the reporting period. Agencies with multiple databases should provide one extract per database.

Funded organisations are required to submit data to the department by the third business day of each month. The department is responsible for validating monthly extracts and providing error reports to agencies. Funded organisations must correct errors in their data before the next extract of all health program dataset items is submitted.

**Table 2.14: Primary and dental health data collection and reporting requirements**

| Activity no. | Activity name | Data collection description |
|---|---|---|
| 27017 | Oral health – health promotion | Report against agreed deliverables linked to the *Victorian action plan to prevent oral disease 2019–23* |
| 27019 | Royal Dental Hospital Melbourne dental care | Dental health program dataset |
| 27023 | Community dental care | Dental health program dataset |
| 28000 | Health Self Help (Band 1) | Annual activity report |
| 28015 | Family and Reproductive Rights Education Program (FARREP) | Community health minimum dataset |
| 28016 | FARREP – health promotion | Report against health promotion plan |
| 28018 | Family planning – health promotion | Report against health promotion plan |
| 28021 | Innovative Health Services for Homeless Youth (IHSHY) – health promotion | Report against health promotion plan |
| 28048 | Language services | Community health minimum dataset |
| 28050 | Women's health – health promotion | Report against health promotion plan |
| 28062 | Telephone counselling | Regional report |
| 28063 | Family planning – education and training | Quarterly report |
| 28064 | Family planning – clinical services and training | Community health minimum dataset |
| 28066 | IHSHY | Community health minimum dataset |
| 28068 | Family planning | Community health minimum dataset |
| 28071 | Aboriginal services and support | |
| 28072 | Integrated chronic disease management | Community health minimum dataset |
| 28076 | Refugee and asylum seeker health services | Community health minimum dataset |
| 28080 | Healthy Mothers Healthy Babies | Community health minimum dataset |
| 28081 | National Diabetes Services Scheme | Monthly report |
| 28085 | Community health – health promotion | Report against health promotion plan |
| 28086 | Community health | Community health minimum dataset |
| 28087 | Primary Care Partnerships | Report against PCP planning and reporting guidelines |
| 28088 | ACCO services – primary health | Round table reporting |
| 28090 | MDC – Community Health Nurse | Community health minimum dataset |
| 28091 | Community Asthma Program | Community health minimum dataset |
| 35048 | Small rural – Primary Health Flexible Services | Community health minimum dataset or other relevant data collection if funding used for another allowable purpose |

**Table 2.15: Ageing, aged and home care performance targets and monitoring**

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
|---|---|---|---|---|---|---|
| 13230 | Regional Assessment Service assessment | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13230 | Regional Assessment Service assessment | Number of completed assessments | Reports | Quarterly | Mandatory | Key output measure |
| 13230 | Regional Assessment Service assessment | My Aged Care Key Performance Indicators | Percentage | Quarterly | Mandatory | Other standard measure |
| 13004 | Aged Care Assessment Service project | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 13005 | Aged Care Assessment Service assessment | Percentage of priority 1, 2 and 3 clients assessed on time | Percentage | Quarterly | Mandatory | Other standard measure |
| 13005 | Aged Care Assessment Service assessment | Average (Median) number of days from referral to first clinical intervention | Number | Quarterly | Mandatory | Key output measure |
| 13005 | Aged Care Assessment Service assessment | Number of assessments | Assessments | Quarterly | Mandatory | Key output measure |
| 13019 | Personal Alert Victoria | Number of units allocated | Number of units | Yearly | Mandatory | Key output measure |
| 13015 | Home and Community Care linkages packages | Number of packages | Packages | Quarterly | Mandatory | Key output measure |
| 13023 | Home and Community Care service development grant | One electronic project report submitted | Reports | Yearly | Mandatory | Key output measure |
| 13024 | Home and Community Care assessment | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13026 | Home and Community Care domestic assistance | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13027 | Home and Community Care respite | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13031 | Public sector residential aged care supplement | Number of occupied bed days | Occupied bed days | Monthly | Mandatory | Key output measure |
| 13035 | Support for carers | Number of carers | Carers | Yearly | Mandatory | Key output measure |
| 13035 | Support for carers | Number of hours of service | Hours | Quarterly | Mandatory | Other standard measure |
| 13038 | Home and Community Care service system resourcing | Service activity report | Reports | Yearly | Mandatory | Key output measure |

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
|---|---|---|---|---|---|---|
| 13043 | Home and Community Care flexible service response | Service activity report | Reports | Yearly | Mandatory | Key output measure |
| 13053 | Victorian Eyecare Service | Number of occasions of service (metropolitan) | Occasions of service | Quarterly | Mandatory | Key output measure |
| 13053 | Victorian Eyecare Service | Number of occasions of service (outreach) | Occasions of service | Quarterly | Mandatory | Other standard measure |
| 13053 | Victorian Eyecare Service | Number of occasions of service (rural) | Occasions of service | Quarterly | Mandatory | Other standard measure |
| 13056 | Home and Community Care planned activity group – core | Number of hours of service (provided to clients) | Hours | Quarterly | Mandatory | Key output measure |
| 13057 | Home and Community Care planned activity group – high | Number of hours of service (provided to clients) | Hours | Quarterly | Mandatory | Key output measure |
| 13059 | Residential aged care complex care supplement | Number of occupied bed days | Occupied bed days | Monthly | Mandatory | Key output measure |
| 13063 | Home and Community Care volunteer coordination | Number of hours of coordinator time | Hours | Yearly | Mandatory | Key output measure |
| 13063 | Home and Community Care volunteer coordination | Number of hours of service (provided to clients) | Hours | Quarterly | Non mandatory | Other standard measure |
| 13067 | Aged community grants | Number of projects | Projects | Yearly | Mandatory | Key output measure |
| 13082 | Low-cost accommodation support | Number of clients assisted | Clients | Quarterly | Mandatory | Key output measure |
| 13083 | Aged training and development | Number of filled positions (academic) | Positions | Quarterly | Mandatory | Key output measure |
| 13083 | Aged training and development | Number of filled positions (training) | Positions | Quarterly | Non-mandatory | Other standard measure |
| 13096 | Home and Community Care allied health | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13097 | Home and Community Care delivered meals | Number of meals (funding is a subsidy only) | Meals | Quarterly | Mandatory | Key output measure |
| 13099 | Home and Community Care property maintenance | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13100 | Aged research and evaluation | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 13103 | Language services | Number of occasions of service | Occasions of service | Monthly | Mandatory | Key output measure |

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
|---|---|---|---|---|---|---|
| 13107 | Rural small high-care supplement | Number of occupied bed days | Occupied bed days | Monthly | Mandatory | Key output measure |
| 13131 | RDNS Home and Community Care allied health | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13155 | Dementia services | Number of contacts | Contacts | Yearly | Mandatory | Other standard measure |
| 13155 | Dementia services | Number of hours of service | Hours | Yearly | Mandatory | Key output measure |
| 13156 | Seniors health promotion | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 13210 | Aged Care Assessment Service training and development | Funds expended on training needs of staff | Dollars | Yearly | Mandatory | Key output measure |
| 13223 | Home and Community Care nursing | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13226 | Home and Community Care personal care | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13227 | ACCO services – aged and home care | Development of service profile | Completed service profile | Yearly | Mandatory | Key output measure |
| 13229 | Home and Community Care access and support | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13301 | Aged quality improvement | Current authorisations for information exchange between the department and:<br>• Department of Health and Human Services<br>• Australian Aged Care Quality Agency | Signed documents | Yearly | Mandatory | Other standard measure |
| 13302 | SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) | Number of facility cost relief expenditure plans developed and implemented | Plans | Yearly | Mandatory | Key output measure |
| 13302 | SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) | Number of facility cost relief cluster plans developed and implemented | Plans | Yearly | Mandatory | Other standard measure |
| 13302 | SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) | Number of proprietors of assisted supported residential services that meet accountability and | Proprietors | Yearly | Mandatory | Other standard measure |

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
|---|---|---|---|---|---|---|
| | | reporting requirements for facility cost relief | | | | |
| 13303 | SAVVI Supporting Connections | Number of clients | Clients | Yearly | Mandatory | Key output measure |
| 13352 | Victorian Seniors Festival | Number of events and participants | Events<br>Participants | Yearly | Non-mandatory | Other standard measure |
| 13354 | Elder abuse prevention and response | Number of telephone calls | Calls | Six-monthly | Non-mandatory | Other standard measure |
| 13354 | Elder abuse prevention and response | Number of professional educations sessions attendees | Events participants | Six-monthly | Non-mandatory | Other standard measure |
| 13354 | Elder abuse prevention and response | Number of community education sessions | Events | Six-monthly | Non-mandatory | Other standard measure |
| 13355 | Seniors community programs | Number of projects | Reports | Quarterly | Non-mandatory | Other standard measure |
| 13356 | Information and lifelong learning | Number of information requests/contacts | Contacts | Quarterly | Non-mandatory | Other standard measure |
| 13356 | Information and lifelong learning | New programs<br>New U3As | Programs<br>U3As | Six-monthly | Non-mandatory | Other standard measure |

**Table 2.16: Primary and dental health performance targets and monitoring**

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
|---|---|---|---|---|---|---|
| 27019 | RDHM Dental Care | Number of clients | Clients | Yearly | Mandatory | Key output measure |
| 27023 | Community Dental Care | Number of clients | Clients | Yearly | Mandatory | Key output measure |
| 28015 | FARREP | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28016 | FARREP – Health Promotion | Report against health promotion plan | Reports | Yearly | Non-mandatory | Other standard measure |
| 28018 | Family Planning – Health Promotion | Report against health promotion plan | Reports | Yearly | Non-mandatory | Other standard measure |
| 28021 | IHSHY – Health Promotion | Report against health promotion plan | Reports | Yearly | Non-mandatory | Other standard measure |
| 28048 | Language Services | Number of occasions of service | Occasions of service | Monthly | Mandatory | Key output measure |
| 28050 | Women's Health – Health Promotion | Report against health promotion plan | Reports | Yearly | Non-mandatory | Other standard measure |

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
|---|---|---|---|---|---|---|
| 28062 | Telephone Counselling | Number of calls answered | Calls | Quarterly | Mandatory | Key output measure |
| 28062 | Telephone Counselling | Percentage of calls answered | Calls | Quarterly | Mandatory | Other standard measure |
| 28063 | Family Planning – Education and Training | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28064 | Family Planning – Clinical Services and Training | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28066 | IHSHY | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28068 | Family Planning | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28071 | Aboriginal Services and Support | Number of hours of service | Hours | Quarterly | Mandatory | Other standard measure |
| 28071 | Aboriginal Services and Support | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 28072 | Integrated Chronic Disease Management | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28076 | Refugee and Asylum Seeker Health Services | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28080 | Healthy Mothers Healthy Babies | Numbers of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28081 | National Diabetes Services Scheme | Number of packs of needles and syringes | Needles and syringes | Monthly | Mandatory | Key output measure |
| 28085 | Community Health – Health Promotion | Report against health promotion plan | Reports | Yearly | Mandatory | Other standard measure |
| 28086 | Community Health | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28087 | Primary Care Partnerships | Report against PCP planning and reporting guidelines | Reports | Yearly | Mandatory | Key output measure |
| 28088 | ACCO Services – Primary Health | Development of service profile | Completed service | Yearly | Mandatory | Key output measure |
| 28090 | MDC – Community Health Nurse | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28091 | Community Asthma Program | Number of hours of service | Hours | Quarterly | Mandatory | Key Output measure |

## 2.13.8 Workforce data reporting requirements

Reporting is required against the workforce programs and datasets to inform statewide policy, planning and funding, to ensure more effective investment in the development of Victoria's future workforce.

### 2.13.8.1 Health Services Payroll and Workforce Minimum Employee Dataset

Health services are required to transmit information detailed in the Health Services Payroll and Workforce MDS Data Dictionary to the department. Data must be transmitted to the department by the 10th day of the following month, or the prior working day if the 10th day of the following month falls on a weekend or public holiday. Payroll data is required monthly, while workforce information is required biannually, covering the periods ending 31 December and 30 June each year. Where health services undertake their own payroll processing, they are required to transmit the information directly to the department. In cases where health services engage a payroll bureau to process their payroll, health services may authorise the bureau to transmit the data to the department on their behalf. Notwithstanding such an arrangement, health services remain responsible for the accuracy of the data transmitted.

Where a health service decides to change payroll providers, it will be necessary to complete an accreditation process, prior to the change, to ensure that continuity of data transmission to the department will not be compromised.

## 2.13.9 Training and development funding reporting and eligibility requirements

### 2.13.9.1 Eligibility requirements

All public health services, Mildura Base Hospital and the Victorian Institute of Forensic Mental Health are eligible to receive training and development funding.

To receive funding organisations are required to:

- ensure that all funded programs conform to the most recent versions of guidelines (where available), including the guidelines and standards set by the Australian Health Practitioner Regulation Agency and the national health practitioner boards
- comply with specific eligibility and reporting requirements for each stream (described below)
- report against the mandatory externally reportable *Best practice clinical learning environment* (BPCLE) Framework indicators through the BPCLE tool.

Further information regarding the BPCLE Framework and detailed guidelines for the training and development funding are available via the following links:

- BPCLE Framework <https://www2.health.vic.gov.au/health-workforce/education-and-training/building-a-quality-health-workforce/bpcle-framework>.
- Training and Development Funding <https://www2.health.vic.gov.au/health-workforce/education-and-training/training-development-grant>.

### 2.13.9.2 Professional-entry student placements

Professional-entry student placement funding is provided for eligible clinical placement days reported for eligible disciplines and courses at Victorian public health services. For details of eligible activity, disciplines and courses, refer to the Training and Development Funding Guidelines <https://www2.health.vic.gov.au/health-workforce/education-and-training/training-development-grant>.

To access the professional-entry student placement subsidy, health services are required to:

- plan and report clinical placement activity through Placeright biannually (or the interim reporting tool for agreed medical placement activity not yet using Placeright)

- adhere to the *Standardised schedule of fees for clinical placement of students in Victorian public health services* ('the schedule'), including recording of fees in Placeright (or the interim reporting tool for agreed medical placement activity not yet using Placeright)

Health services are also encouraged to:

- establish a Student Placement Agreement (SPA) with all education provider partners, including uploading to Placeright where the system is used to manage eligible funded activity
- adhere to the Standard Student Induction Protocol (SSIP) to ensure conformity of practices across the sector.

Note that work is underway to review the SPA template and SSIP provided by the department to assist the sector. Any feedback on these resources should be emailed to Workforce Funding, Performance and Review <vicworkforce@dhhs.vic.gov.au>.

Further information on these resources is available via the following links:

- Fee schedule for clinical placement in public health services <https://www2.health.vic.gov.au/health-workforce/education-and-training/student-placement-partnerships/fee-schedule-for-clinical-placement-in-public-health-services>
- Placeright <https://www2.health.vic.gov.au/health-workforce/education-and-training/student-placement-partnerships/placeright>
- Student Placement Agreement <https://www2.health.vic.gov.au/health-workforce/education-and-training/student-placement-partnerships/student-placement-agreement>
- Standard Student Induction Protocol (SSIP) <https://www2.health.vic.gov.au/health-workforce/education-and-training/student-placement-partnerships/standardised-student-induction-protocol>.

### 2.13.9.3 Transition to practice (graduate) positions

To access transition to practice funding for allied health, medical (year one and two) and nursing midwifery graduates, the following criteria must be met:

- Transition to practice (graduate) positions for medical, nursing and midwifery and medical radiations are filled through the statewide matching process, or by another process as determined by the department.
- Health services are required to report on the headcount and full-time equivalent of new graduates for the previous calendar year and a projection for the forthcoming year.
- Health services must allocate adequate training and supervision to each position and meet the accreditation requirements where relevant and must provide advice to the department if a graduate does not commence in, or complete, an allocated position.
- No fees may be charged to graduates applying for, undertaking, or exiting from transition to practice programs.

For further information relating to eligibility criteria refer to the Health Workforce webpage <https://www2.health.vic.gov.au/health-workforce>.

### 2.13.9.4 Postgraduate positions – medical, nursing and midwifery

All health services are required to reconcile actual activity at the completion of the calendar year.

All health services receiving funding for the Victorian Medical Specialist and Victorian Paediatric Training Programs and the Basic Physician Training Consortia Program are required to provide confirmation at each stage of training, including at recruitment, resignation, completion or any other change in the training pathway by completing program reports.

Funded postgraduate nursing and midwifery programs must lead to an award classification at Graduate Certificate, Graduate Diploma or Master level. Where students are enrolled in a Master-level program with exit points at Graduate Certificate or Graduate Diploma level, only the Graduate Certificate or

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

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

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

For further information relating to eligibility criteria refer to the Health Workforce webpage <https://www2.health.vic.gov.au/health-workforce>.

### 2.13.9.5 Other targeted workforce training and development programs

**Nursing and midwifery postgraduate scholarships**

The department requires annual reporting of the value and number scholarships allocated and the field of study undertaken. Health services in receipt of this stream of funding will be provided with a reporting template and guidelines on the allocation and reporting requirements.

**Continuing nursing and midwifery education**

The department requires the reconciliation of continuing nursing and midwifery activity that occurred in 2019–20 to be submitted by 26 July 2020. A link to an online reporting form will be provided to recipients of the funding.

**Prevocational medical education and training**

The department requires annual reconciliation of the expenditure of funds allocated for prevocational medical education and training. Health services in receipt of this stream of funding will be provided with a reporting template.

**Rural clinical academic program**

Rural clinical academic program accountability requires that health services and their partner universities jointly sign-off an acquittal of 2018–19 funding and provide a funding submission for 2019–20. A template for health services to complete will be provided to participating health services.

**Table 2.17: Training and development funding – reporting requirements**

| Program | Reporting required by health services | Due date |
|---|---|---|
| All programs | Automated reporting of seven externally reportable *Best practice clinical learning environment* (BPCLE) framework indicators through BPCLE tool <https://www.bpcletool.net.au/accounts/login> | 14 February 2020 |
| Professional-entry student placements | Automated reporting of clinical placement activity from Placeright biannually.<br>An interim reporting tool can be provided to health services not yet using Placeright for medical student placements. Email Workforce Funding, Performance and Review <vicworkforce@dhhs.vic.gov.au> to request exemption from using Placeright and access to the interim reporting tool. | 14 February 2020 (for July–December 2019 activity).<br>26 July 2020 (for activity January–June 2020) and |
| Transition to practice (graduate) – allied health, medical (PGY1 and PGY2), nursing and midwifery | Report on the headcount and full-time equivalent hours of 2019 graduate activity. | 14 February 2020 |
| Postgraduate – medical specialist training | Victorian Medical Specialist Training Program acquittal of posts and positions in 2019. | 14 February 2020 |
| | Victorian Paediatric Training Program acquittal of posts and positions in 2019. | 14 February 2020 |

| Program | Reporting required by health services | Due date |
|---|---|---|
| | Basic Physician Training Consortia Program acquittal of posts and positions in 2019. | 14 February 2020 |
| Postgraduate – nursing and midwifery | Report on the headcount and full-time equivalent hours of 2019 postgraduate activity. | 14 February 2020 |
| Targeted workforce training and development programs | Recipients of targeted workforce training and development programs must meet the reporting requirements as specified for each program through the acceptance process. | Annually as specified by each program |

Note: The department is developing a web-based portal through the Health Collect platform for reporting of training and development activity. Health services will be informed when it is available.

## 2.13.10 Commonwealth–state reporting requirements

Funded organisations may receive payments arising from Commonwealth–state agreements. Funding received under such arrangements is subject to each program's specific conditions of funding. Organisations funded under Commonwealth–state programs are required to submit regular statistical and financial reports for the monitoring of activity, payment of grants and acquittal to the Commonwealth. The information required, format and timelines for individual programs are detailed in the relevant Intergovernmental Agreements with the Commonwealth and the guidelines applicable to the appropriate Commonwealth–state programs.

# Addendum 2.1: Performance targets and monitoring

Organisations funded by a Service Agreement can search for activity descriptions. Activity descriptions include: policy and guidelines, data requirements and key performance measures. Visit Health and Human Service activity search at <https://providers.dhhs.vic.gov.au/human-services-activity-search>.

**Table 2.18: Ageing, aged and home care performance targets and monitoring**

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
|---|---|---|---|---|---|---|
| 13230 | Commonwealth Regional Assessment Service assessment | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13230 | Commonwealth Regional Assessment Service assessment | Number of completed assessments | Reports | Quarterly | Mandatory | Key output measure |
| 13004 | Aged Care Assessment Service project | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 13005 | Aged Care Assessment Service assessment | Percentage of priority 1, 2 and 3 clients assessed on time | Percentage | Quarterly | Mandatory | Other standard measure |
| 13005 | Aged Care Assessment Service assessment | Percentage of referrals actioned within 3 calendar days | Percentage | Quarterly | Mandatory | Key output measure |
| 13005 | Aged Care Assessment Service assessment | Number of assessments | Assessments | Quarterly | Mandatory | Key output measure |
| 13019 | Personal Alert Victoria | Security activity report | Reports | Yearly | Mandatory | Key output measure |
| 13015 | Home and Community Care linkages packages | Number of packages | Packages | Quarterly | Mandatory | Key output measure |
| 13023 | Home and Community Care service development grant | One electronic project report submitted | Reports | Yearly | Mandatory | Key output measure |
| 13024 | Home and Community Care assessment | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13026 | Home and Community Care domestic assistance | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13027 | Home and Community Care respite | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
|---|---|---|---|---|---|---|
| 13031 | Public sector residential aged care supplement | Number of occupied bed days | Occupied bed days | Monthly | Mandatory | Key output measure |
| 13035 | Support for carers | Number of carers | Carers | Yearly | Mandatory | Key output measure |
| 13035 | Support for carers | Number of hours of service | Hours | Quarterly | Mandatory | Other standard measure |
| 13038 | Home and Community Care service system resourcing | Service activity report | Reports | Yearly | Mandatory | Key output measure |
| 13043 | Home and Community Care flexible service response | Service activity report | Reports | Yearly | Mandatory | Key output measure |
| 13053 | Victorian Eyecare Service | Number of occasions of service (metropolitan) | Occasions of service | Quarterly | Mandatory | Key output measure |
| 13053 | Victorian Eyecare Service | Number of occasions of service (outreach) | Occasions of service | Yearly | Mandatory | Other standard measure |
| 13053 | Victorian Eyecare Service | Number of occasions of service (rural) | Occasions of service | Yearly | Mandatory | Other standard measure |
| 13056 | Home and Community Care planned activity group – core | Number of hours of service (provided to clients) | Hours | Quarterly | Mandatory | Key output measure |
| 13057 | Home and Community Care planned activity group – high | Number of hours of service (provided to clients) | Hours | Quarterly | Mandatory | Key output measure |
| 13059 | Residential aged care complex care supplement | Number of occupied bed days | Occupied bed days | Monthly | Mandatory | Key output measure |
| 13063 | Home and Community Care volunteer coordination | Number of hours of coordinator time | Hours | Yearly | Mandatory | Key output measure |
| 13063 | Home and Community Care volunteer coordination | Number of hours of service (provided to clients) | Hours | Quarterly | Non-mandatory | Other standard measure |
| 13067 | Aged community grants | Number of projects | Projects | Yearly | Mandatory | Key output measure |
| 13082 | Low-cost accommodation support | Number of clients assisted | Clients | Quarterly | Mandatory | Key output measure |
| 13083 | Aged training and development | Number of filled positions (academic) | Positions | Quarterly | Mandatory | Key output measure |
| 13083 | Aged training and development | Number of filled positions (training) | Positions | Quarterly | Non-mandatory | Other standard measure |

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
|---|---|---|---|---|---|---|
| 13096 | Home and Community Care allied health | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13097 | Home and Community Care delivered meals | Number of meals (funding is a subsidy only) | Meals | Quarterly | Mandatory | Key output measure |
| 13099 | Home and Community Care property maintenance | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13100 | Aged research and evaluation | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 13103 | Language services | Number of occasions of service | Occasions of service | Monthly | Mandatory | Key output measure |
| 13107 | Rural small high-care supplement | Number of occupied bed days | Occupied bed days | Monthly | Mandatory | Key output measure |
| 13109 | Aged Care Assessment Service evaluation | Evaluation unit meets requirements of commonwealth conditions of grant | Rating | Yearly | Mandatory | Key output measure |
| 13131 | RDNS Home and Community Care allied health | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13155 | Dementia services | Number of contacts | Contacts | Yearly | Mandatory | Other standard measure |
| 13155 | Dementia services | Number of hours of service | Hours | Yearly | Mandatory | Key output measure |
| 13155 | Dementia services | Number of sessions | Sessions | Yearly | Mandatory | Other standard measure |
| 13156 | Seniors health promotion | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 13210 | Aged Care Assessment Service training and development | Funds expended on training needs of staff | Dollars | Yearly | Mandatory | Key output measure |
| 13223 | Home and Community Care nursing | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13226 | Home and Community Care personal care | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13227 | ACCO services – aged and home care | Development of service profile | Completed service profile | Yearly | Mandatory | Key output measure |
| 13229 | Home and Community Care access and support | Hours of client care coordination | Hours | Quarterly | Mandatory | Key output measure |
| 13301 | Aged quality improvement | Current authorisations for information exchange between the department and the: | Signed documents | Yearly | Mandatory | Other standard measure |

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
|---|---|---|---|---|---|---|
| | | • Commonwealth Department of Health and Human Services<br>• Australian Aged Care Quality Agency. | | | | |
| 13302 | SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) | Number of facility cost relief expenditure plans developed and implemented | Plans | Yearly | Mandatory | Key output measure |
| 13302 | SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) | Number of facility cost relief cluster plans developed and implemented | Plans | Yearly | Mandatory | Other standard measure |
| 13302 | SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) | Number of proprietors of assisted supported residential services that meet accountability and reporting requirements for facility cost relief | Proprietors | Yearly | Mandatory | Other standard measure |
| 13303 | SAVVI Supporting Connections | Number of clients | Clients | Yearly | Mandatory | Key output measure |
| 13352 | Victorian Seniors Festival | Number of events and participants | Events<br>Participants | Yearly | Non-mandatory | Other standard measure |
| 13354 | Elder abuse prevention and response | Number of telephone calls | Calls | Six-monthly | Non-mandatory | Other standard measure |
| 13354 | Elder abuse prevention and response | Number of professional education sessions attendees | Events participants | Six-monthly | Non-mandatory | Other standard measure |
| 13354 | Elder abuse prevention and response | Number of community education sessions | Events | Six-monthly | Non-mandatory | Other standard measure |
| 13355 | Seniors community programs | Number of projects | Reports | Quarterly | Non-mandatory | Other standard measure |
| 13356 | Information and lifelong learning | Number of information requests/contacts | Contacts | Quarterly | Non-mandatory | Other standard measure |
| 13356 | Information and lifelong learning | New programs<br>New U3As | Programs<br>U3As | Six-monthly | Non-mandatory | Other standard measure |

**Table 2.19: Ambulance Victoria performance targets and monitoring**

| Service plan | Activity | Measure description | Unit of measure | Reporting frequency | Status |
|---|---|---|---|---|---|
| Quantity – transports | Emergency road: all<br>Emergency road: metro<br>Emergency road: rural and regional<br>Non-emergency stretcher: all<br>Non-emergency stretcher: metro<br>Non-emergency stretcher: rural and regional<br>Non-emergency clinic car<br>Fixed-wing emergency<br>Fixed wing non-emergency<br>Rotary wing | Number of transports provided | Number | Monthly | Mandatory |
| Quantity – incidents | Emergency road: all<br>Emergency road: metro<br>Emergency road: rural and regional<br>Treatment without transport<br>Non-emergency stretcher: all<br>Non-emergency stretcher: metro<br>Non-emergency stretcher: rural and regional<br>Non-emergency clinic car<br>Fixed-wing emergency | Number of 000 calls or planned events to which one or more ambulance resources are dispatched | Number | Monthly | Mandatory |
| Patient experience | Patient satisfaction | Proportion of respondents to VHES survey question reporting a 'good' or 'very good' response to overall ambulance experience | Percentage | Annual | Mandatory |
| Governance leadership and culture | Safety culture | Composite of safety culture score based on eight safety culture items in the People Matter Survey | Percentage | Annual | Mandatory |
| Safety and quality | HCWI – influenza | Healthcare worker immunisation – influenza | Percentage | Annual | Mandatory |
| | Pain reduction | Adult patients who achieve a meaningful reduction in pain | Percentage | Quarterly | Mandatory |
| | Stroke patients transported | Adult patients suspected of having a stroke who were transported within 60 minutes to a health service with the capability to deliver intravenous thrombolysis | Percentage | Quarterly | Mandatory |
| | Trauma patients transported | Trauma patients transported to the highest level trauma service within 45 minutes, or transported by air directly to a Major Trauma Service | Percentage | Quarterly | Mandatory |
| | Cardiac arrest survived event rate | Adult VF/VT patients with vital signs at hospital | Percentage | Quarterly | Mandatory |

| Service plan | Activity | Measure description | Unit of measure | Reporting frequency | Status |
|---|---|---|---|---|---|
| | | Adult VF/VT patients surviving to hospital discharge | Percentage | Quarterly | Mandatory |
| Access | Response time statewide | Emergency Code 1 incidents responded to within 15 minutes | Percentage | Monthly | Mandatory |
| | | Emergency Priority 0 incidents responded within 13 minutes | Percentage | Monthly | Mandatory |
| | Response time urban | Emergency Code 1 incidents responded to within 15 minutes in centres with population > 7,500 | Percentage | Monthly | Mandatory |
| | Average response time | Average time to respond to Emergency Code 1 incidents | Minutes | Monthly | Mandatory |
| | Clearing time at hospital | Average ambulance hospital clearing time | Minutes | Monthly | Mandatory |
| | Call referral | Events where 000 caller receives advice or service from another health service provider as an alternative to emergency ambulance response | Percentage | Monthly | Mandatory |
| | 40-minute transfer | Proportion of patients transferred from paramedic care to hospital emergency care within 40 minutes of ambulance arrival | Percentage | Weekly | Mandatory |

Note: Additional measures will be developed and included in the data submissions.

**Table 2.20: Mental health service performance indicators**

| Measure or indicator | Unit | Adult report | CAMHS report | Older person report | Government target |
|---|---|---|---|---|---|
| 28-day readmission rate | per cent | Yes | No | Yes | <14<br>All age ranges |
| Pre-admission contact | per cent | Yes | Yes[9] | Yes | 60<br>All age ranges |
| Post discharge follow up | per cent | Yes | Yes[9] | Yes | 80<br>All age ranges |
| Total seclusion rate | Episodes per 1,000 bed days | Yes | Yes | Yes | <15<br>All age ranges |
| HoNOS[10] compliance – all inpatient, all ages | per cent | Yes | Yes | Yes | >85 |
| HoNOS[10] compliance – ambulatory, all ages | per cent | Yes | Yes | Yes | >85 |
| Emergency department presentations departing to a mental health bed within eight hours | per cent | Yes | No | No | 80 |
| Basis/SDQ[11] compliance | per cent | Yes | Yes | Yes | >85 |

[9] Slight variation in definition as results attributed to client's home AMHS not the separating AMHS as for adult and older person.

[10] HoNOS refers to the Health of the Nation Outcome Scale and is a key mental health consumer outcome measure that has been implemented nationally.

[11] Basis and Strengths and Difficulties Questionnaire (SDQ) are used by the consumer's and/or carer's (SDQ only) to present their views on behaviour to inform discussions with the AMHS. There are collected as part of the outcome measures suite at predefined points of time.

**Table 2.21: Primary and dental health performance targets and monitoring**

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
|---|---|---|---|---|---|---|
| 27019 | RDHM Dental Care | Number of clients | Clients | Yearly | Mandatory | Key output measure |
| 27023 | Community Dental Care | Number of clients | Clients | Yearly | Mandatory | Key output measure |
| 28015 | FARREP | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28016 | FARREP – Health Promotion | Report against health promotion plan | Reports | Yearly | Non-mandatory | Other standard measure |
| 28018 | Family Planning – Health Promotion | Report against health promotion plan | Reports | Yearly | Non-mandatory | Other standard measure |
| 28021 | IHSHY – Health Promotion | Report against health promotion plan | Reports | Yearly | Non-mandatory | Other standard measure |
| 28048 | Language Services | Number of occasions of service | Occasions of service | Monthly | Mandatory | Key output measure |
| 28050 | Women's Health – Health Promotion | Report against health promotion plan | Reports | Yearly | Non-mandatory | Other standard measure |
| 28062 | Telephone Counselling | Number of calls answered | Calls | Quarterly | Mandatory | Key output measure |
| 28062 | Telephone Counselling | Percentage of calls answered | Calls | Quarterly | Mandatory | Other standard measure |
| 28063 | Family Planning – Education and Training | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28064 | Family Planning – Clinical Services and Training | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28066 | IHSHY | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28067 | Women's Health | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28068 | Family Planning | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28071 | Aboriginal Services and Support | Number of hours of service | Hours | Quarterly | Mandatory | Other standard measure |
| 28071 | Aboriginal Services and Support | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 28072 | Integrated Chronic Disease Management | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28076 | Refugee and Asylum Seeker Health Services | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28080 | Healthy Mothers Healthy Babies | Numbers of hours of service | Hours | Quarterly | Mandatory | Key output measure |

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
|---|---|---|---|---|---|---|
| 28081 | National Diabetes Services Scheme | Number of packs of needles and syringes | Needles and syringes | Monthly | Mandatory | Key output measure |
| 28085 | Community Health – Health Promotion | Report against health promotion plan | Reports | Yearly | Mandatory | Other standard measure |
| 28086 | Community Health | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28087 | Primary Care Partnerships | Report against PCP planning and reporting guidelines | Reports | Yearly | Mandatory | Key output measure |
| 28088 | ACCO Services – Primary Health | Development of service profile | Completed service | Yearly | Mandatory | Key output measure |
| 28090 | MDC – Community Health Nurse | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |

**Table 2.22: Public health performance targets and monitoring**

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
|---|---|---|---|---|---|---|
| 16119 | School and adult immunisation services | Number of people immunised | People | Yearly | Mandatory | Key output type |
| 16163 | Food safety education | Report against agreed objectives | Reports | Yearly | Mandatory | Key output type |
| 16203 | Regulation of ART and associated legislation | Report against agreed objectives | Reports | Yearly | Mandatory | Key output type |
| 16206 | Laboratory testing | Provision of a public health reference/testing service | Services | Yearly | Mandatory | Key output type |
| 16206 | Laboratory testing | Percentage of notifications within specified timelines | Notifications | Yearly | Mandatory | Other standard measure |
| 16206 | Laboratory testing | Provision of required testing in accordance with accredited standards | Testing | Yearly | Mandatory | Other standard measure |
| 16234 | Public Health Legislative Review | Report against agreed objectives | Reports | Yearly | Mandatory | Key output type |
| 16308 | Injury prevention | Report against agreed objectives | Reports | Yearly | Mandatory | Key output type |
| 16348 | Children's obesity | Report against agreed objectives | Reports | Half-yearly | Mandatory | Key output type |
| 16349 | Obesity – community projects | Report against agreed objectives | Reports | Yearly | Mandatory | Key output type |
| 16373 | BBV and STI – clinical services | Report against agreed objectives | Report | Annual | Mandatory | Key output type |
| 16381 | Risk management and emergency response | Report against agreed objectives | Reports | Yearly | Mandatory | Key output type |
| 16449 | Smoking information – advice and interventions | Research reports | Reports | Yearly | Mandatory | Key output type |

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
|---|---|---|---|---|---|---|
| 16450 | Diabetes prevention | Report against agreed objectives | Reports | Quarterly | Mandatory | Key output type |
| 16452 | Aboriginal health advancement | Report against agreed objectives | Reports | Half-yearly | Mandatory | Key output type |
| 16453 | Aboriginal health worker support | Report against agreed objectives | Reports | Half-yearly | Mandatory | Key output type |
| 16454 | Health promotion initiatives | Report against agreed objectives | Reports | Quarterly | Mandatory | Key output type |
| 16460 | Targeted recruitment for screening programs | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output type |
| 16505 | BBV and STI – training and development | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output type |
| 16507 | BBV and STI – laboratory services | Report against agreed deliverables | Reports | Reports | Mandatory | Key output type |
| 16508 | BBV and STI – health promotion and prevention | Report against health promotion plan | Reports | Yearly | Mandatory | Key output type |
| 16509 | BBV and STI – community-based care and support | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output type |
| 16513 | Screening and preventative messages | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output type |
| 16514 | Screening service development | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output type |
| 16515 | Education and training in screening programs | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output type |
| 16516 | Screening counselling and support | Number of occasions of service | Occasions of service | Yearly | Mandatory | Key output type |
| 16517 | Cancer and screening registers | Statistical report within an agreed timeline and publicly available | Reports | Yearly | Mandatory | Key output type |
| 16518 | Cancer and screening intelligence | Report against agreed objectives | Reports | Yearly | Mandatory | Key output type |
| 16519 | Screening tests and assessments | Percentage of target population screened over an agreed period | Percentage | Yearly | Mandatory | Other standard measure |
| 16519 | Screening tests and assessments | Number of clients screened | Clients | Yearly | Mandatory | Key output type |

# Addendum 2.2: Service standards and guidelines

**Table 2.23: Small rural health services – service standards and guidelines**

| Activity no. | Activity name | Service standards and guidelines description |
|---|---|---|
| 35010 | Small rural – aged support services | *Aged Care Act 1997* as amended<br>Commonwealth Department of Health resources:<br>MyAged Care website <https://www.myagedcare.gov.au><br>Factsheets <https://agedcare.health.gov.au/publications-articles/factsheets><br>Guides and policy <https://agedcare.health.gov.au/publications-articles/guides-advice-policy><br>*mall rural health services guide 2003–04* and updates |
| 13031 | Small rural – Aged Care (Residential only) | *Aged Care Act 1997* as amended<br>Commonwealth Department of Health resources:<br>MyAged Care website <https://www.myagedcare.gov.au><br>Factsheets <https://agedcare.health.gov.au/publications-articles/factsheets><br>Guides and policy <https://agedcare.health.gov.au/publications-articles/guides-advice-policy><br>*Small rural health services guide 2003–04 and updates* |
| 35024 | Small rural – flexible health service delivery | *Small rural health services guide 2003–04* and updates |
| 35025 | Small rural – TAC[12] – acute health | *Small rural health services guide 2003–04* and updates |
| 35026 | Small rural – Department of Veteran's Affairs – acute health | *Small rural health services guide 2003–04* and updates |
| 35028 | Small rural – acute health service system development and resourcing | *Small rural health services guide 2003–04* and updates |
| 35030 | Small rural – HACC healthcare and support | *Victorian HACC program manual*<br>*Small rural health services guide 2003–04* and updates |
| 35036 | Small rural – Department of Veteran's Affairs HACC | *Victorian HACC program manual*<br>*Small rural health services guide 2003–04* and updates |
| 35042 | Small rural – drugs services | Adult AOD Screening and Assessment Tool<br>*Incident reporting instruction* (May 2013)<br>Victorian Alcohol and Other Drug Treatment Principles |

[12] TAC = Transport Accident Commission

| Activity no. | Activity name | Service standards and guidelines description |
|---|---|---|
| | | Victorian AOD Client Charter<br>*Severe Substance Dependence Treatment Act 2010*<br>*Shaping the future: the Victorian alcohol and other drug quality framework*, April 2008 |
| 35048 | Small rural – primary health flexible services | *Small rural health services guide 2003–04* and updates<br>Advice for public health and wellbeing planning in Victoria: planning cycle 2017–2021 <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/public-health-wellbeing-planning-advice-2017-2021> |
| 35052 | Small rural – specified services | *Small rural health services guide 2003–04* and updates |

**Table 2.24: Drug services – service standards and guidelines**

| Standards and guidelines description | Activity name |
|---|---|
| *Alcohol and other drug program guidelines* | 34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34074, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34057, 34060, 34061, 34062, 34066, 34069, 34070, 34078, 34079, 34082, 34084, 34200, 34202, 34203, 34205, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| *Alcohol and other drug withdrawal practice guidelines* (2018) | 34050, 34056, 34064, 34203, 24204, 34214, 34303, 34310 |
| *Alcohol in the workplace: guidelines for developing a workplace alcohol policy* | 34009 |
| Assessment and intervention tool for youth alcohol and drug treatment services (prepared by Turning Point Alcohol and Drug Centre Inc. for the Department of Human Services) 2004 | 34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34075, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34309, 34310 |
| Adult AOD intake and assessment tools | 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34057, 34060, 34061, 34062, 34066, 34069, 34070, 34078, 34079, 34082, 34084, 34200, 34202, 34203, 34205, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| *Child Wellbeing and Safety Act 2005* | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| *Children, Youth and Families Act 2005*<br>*Commission for Children and Young People Act 2012*<br>*Working with Children Act 2005*<br>Protocol between drug treatment services and child protection for working with parents with alcohol and drug issues | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| *Clinical treatment guidelines for alcohol and drug clinicians: co-occurring acquired brain injury/cognitive impairment and alcohol and drug use disorders* | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, |

| Standards and guidelines description | Activity name |
|---|---|
| *National comorbidity guidelines* | 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| *Clinical treatment guidelines for methamphetamine dependence and treatment* | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| Code of practice for running safer music festivals and events | 34004 |
| *Cultural diversity guide* | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| *COATS, Community Correctional Services and Drug Treatment Services protocol* (2016) | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34309, 34310 |
| *Drugs, Poisons and Controlled Substances Act 1981* | 34061, 34308, 34070 |
| *Health Complaints Act 2016* | 34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34074, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34057,34060, 34061, 34062, 34066, 34069, 34070, 34078, 34079, 34082, 34084, 34200, 34202, 34203, 34205, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34302, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| *Incident reporting instruction* (May 2013) | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| *Client incident management guide* | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| Interagency protocol between Victoria Police and nominated agencies | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, |

| Standards and guidelines description | Activity name |
|---|---|
| | 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34309, 34310 |
| *Management response to inhalant use: guidelines for the community care and drug and alcohol sector* (2003) | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34309, 34310 |
| Victorian AOD client charter | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| *Victorian policy for maintenance pharmacotherapy for opioid dependence* (2016)<br>*National guidelines for medication-assisted treatment of opioid dependence* (2014) | 34047, 34057 |
| *The Victorian hepatitis C strategy 2016–2020*<br>*The Victorian hepatitis B strategy 2016–2020*<br>*The Victorian HIV strategy 2017–2020*<br>*Eighth national HIV strategy 2018–2022*<br>*Fourth national sexually transmissible infections strategy, 2018–2022*<br>*Fifth national Aboriginal and Torres Strait Islander blood-borne viruses and sexually transmissible infections strategy 2018–2022*<br>*Third national hepatitis B strategy 2018–2022*<br>*Fifth national hepatitis C strategy 2018–2022* | 34070, 34308 |
| *National needle and syringe programs strategic framework 2010–2014* | 34070, 34308 |
| *Medically supervised injecting room performance monitoring framework* | 34308 |
| *National Ice Action Strategy 2015* | 34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34074, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34057, 34060, 34061, 34062, 34066, 34069, 34070, 34078, 34079, 34082, 34084, 34200, 34202, 34203, 34205, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| *National Drug Strategy 2017* | 34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34074, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34057, 34060, 34061, 34062, 34066, 34069, 34070, 34078, 34079, 34082, 34084, 34200, 34202, 34203, 34205, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |

| Standards and guidelines description | Activity name |
|---|---|
| *Service specification for the delivery of selected non-residential alcohol and drug treatment services in Victoria 2015* | 34300, 34301, 34302, 34303, 34304 |
| *Rainbow eQuality Guide* | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| *Severe Substance Dependence Treatment Act 2010* | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| *SHPA standards of practice for Australian poisons information centres* | 34003 |
| *Victorian needle and syringe programs operating policy and guidelines*, Department of Health (revised November 2008) | 34070, 34308 |

**Table 2.25: Ageing, aged and home care service standards and guidelines**

| Activity no. | Activity name | Service standards and guidelines description |
|---|---|---|
| 13004 | Aged Care Assessment – Projects | *Aged Care Act 1997*, as amended |
| 13004 | Aged Care Assessment – Projects | *My Aged Care National Education and Training Strategy (2018–2020)* |
| 13004 | Aged Care Assessment – Projects | *Aged Care Act 1997*, as amended |
| 13005 | Aged Care Assessment | *My Aged Care Assessment Manual – for Regional Assessment Services and Aged Care Assessment Teams (2018) and addendums* |
| 13005 | Aged Care Assessment | *Aged Care Act 1997*, as amended |
| 13005 | Aged Care Assessment | *My Aged Care National Education and Training Strategy (2018–2020)* |
| 13005 | Aged Care Assessment | *Aged Care Assessment Program Style Guide*, April 2016 (Commonwealth Department of Health) |
| 13005 | Aged Care Assessment | Protocol Between Aged Care Assessment Services and the Office of the Public Advocate, 2011 |
| 13005 | Aged Care Assessment | Protocol between Victorian Aged Care Assessment services and Aged Persons Mental Health, 2008 (Department of Human Services) |
| 13005 | Aged Care Assessment | *Strengthening access to Aged Care Assessment Services for Aboriginal consumers* |
| 13015 | HACC Linkages Packages | *Victorian HACC program manual* |
| 13019 | Personal Alert Victoria | *Personal Alert Victoria program and service guidelines*<br>*Personal Alert Victoria response service guidelines* |
| 13023 | HACC Service Development | *Victorian HACC program manual* |

| Activity no. | Activity name | Service standards and guidelines description |
|---|---|---|
| 13024 | HACC Assessment | *Victorian HACC program manual* |
| 13026 | HACC Domestic Assistance | *Victorian HACC program manual* |
| 13027 | HACC Respite | *Victorian HACC program manual* |
| 13031 | Public Sector Residential Aged Care Supplement | *Aged Care Act 1997*, as amended<br>*Commonwealth Department of Health resources:*<br>MyAged Care website <https://www.myagedcare.gov.au><br>Factsheets <https://agedcare.health.gov.au/publications-articles/factsheets><br>Guides and policy <https://agedcare.health.gov.au/publications-articles/guides-advice-policy> |
| 13035 | Support for Carers | *Carers Recognition Act 2012*<br>*A Victorian charter supporting people in care relationships and information kit*<br>*Program guidelines – Support for Carers Program*<br>*Victorian HACC program manual* |
| 13038 | HACC Service System Resourcing | *Victorian HACC program manual*<br>*SRS Service Coordination and Support Program service activity report, guidelines and pro forma* |
| 13043 | HACC Flexible Service Response | *Community Connection Program quality standards framework and data collection guidelines*, 2001<br>*Victorian HACC program manual*<br>*SRS Service Coordination and Support Program service activity report, guidelines and pro forma* |
| 13053 | Victorian Eye Service | *Victorian Eye Service program guidelines*, 2015 (interim) |
| 13056 | HACC Planned Activity Group – Core | *Victorian HACC program manual* |
| 13057 | HACC Planned Activity Group – High | *Victorian HACC program manual* |
| 13063 | HACC Volunteer Coordination | *Victorian HACC program manual* |
| 3082 | Low Cost Accommodation Support | *Community Connection Program quality standards framework and data collection guidelines*, 2001<br>*Flexible Care Fund guidelines for the Older Persons High Rise Support Program*, August 2002<br>*Older Persons High Rise Support Program submission guidelines*, 2001<br>*Housing Support for the Aged Program submission guidelines*, 2000<br>*SRS Oral Health initiative service model specifications*, 2011 |
| 13096 | HACC Allied Health | *Victorian HACC program manual* |
| 13097 | HACC Delivered Meals | *Victorian HACC program manual* |
| 13099 | HACC Property Maintenance | *Victorian HACC program manual* |
| 13109 | Aged Care Assessment Service Evaluation Unit | *My Aged Care Assessment Manual – for Regional Assessment Services and Aged Care Assessment Teams (2018) and addendums* |
| 13109 | Aged Care Assessment Service Evaluation Unit | *Aged Care Act 1997*, as amended |
| 13109 | Aged Care Assessment Service Evaluation Unit | *My Aged Care National Education and Training Strategy (2018–2020)* |

| Activity no. | Activity name | Service standards and guidelines description |
|---|---|---|
| 13109 | Aged Care Assessment Service Evaluation Unit | *Aged Care Assessment Program Style Guide*, April 2016 (Commonwealth Department of Health) |
| 13109 | Aged Care Assessment Service Evaluation Unit | Protocol between Aged Care Assessment Services and the Office of the Public Advocate, 2011 |
| 13109 | Aged Care Assessment Service Evaluation Unit | Protocol between Victorian Aged Care Assessment Services and Aged Persons Mental Health, 2008 (Department of Human Services) |
| 13109 | Aged Care Assessment Service Evaluation Unit | *Transition Care training handbook for Aged Care Assessment Teams*, 2006 (Commonwealth Department of Health and Ageing) |
| 13109 | Aged Care Assessment Service Evaluation Unit | *Strengthening access to Aged Care Assessment Services for Aboriginal consumers* |
| 13130 | HACC Volunteer Coordination – Other | *Victorian HACC program manual* |
| 13131 | RDNS HACC Allied Health | *Victorian HACC program manual* |
| 13155 | Dementia Services | *Carers Recognition Act 2012*<br>*Program guidelines: Support for carers of people with dementia including younger people with dementia guidelines* (updated 2013)<br>Support and Links Service program statement |
| 13156 | Seniors Health Promotion | *Victorian HACC program manual*<br>*Older Persons High Rise Support Program guidelines* |
| 13210 | ACAS Training and Development | *Aged Care Assessment Programme national training strategy*, January 2012 |
| 13223 | HACC Nursing | *Victorian HACC program manual* |
| 13224 | Department of Veterans' Affairs HACC | *Victorian HACC program manual* |
| 13226 | HACC Personal Care | *Aged Care Act 1997* (as amended) |
| 13227 | Aboriginal Community-Controlled Organisations Services – Aged and Home Care | *Victorian HACC program manual* |
| 13229 | HACC Access and Support | *Victorian HACC program manual* |
| 13301 | Aged Quality Improvement | *Aged Care Act 1997*, as amended<br>Commonwealth Department of Health resources:<br>MyAged Care website <https://www.myagedcare.gov.au><br>Factsheets <https://agedcare.health.gov.au/publications-articles/factsheets><br>Guides and policy <https://agedcare.health.gov.au/publications-articles/guides-advice-policy> |
| 13302 | Supporting Accommodation for Vulnerable Victorians Initiative | *SRS supporting accommodation for vulnerable Victorians guidelines*, 2012 |
| 13303 | SAVVI Supporting Connections | *SRS supporting accommodation for vulnerable Victorians guidelines*, 2012<br>*SAVVI Supporting Connections flexible funds guidelines*, 2010<br>*SAVVI Supporting Connections services specifications*, 2008 |
| 13352 | Victorian Seniors Festival | *Victorian Seniors Festival Community Grants Program guidelines* |
| 13354 | Elder Abuse Prevention and Response | *Contract guidelines and schedules* |
| 13355 | Seniors Community Programs | *Funded program guidelines* |

| Activity no. | Activity name | Service standards and guidelines description |
|---|---|---|
| 13356 | Information and Lifelong Learning | *Funded program guidelines* |
| 13303 | SAVVI Supporting Connections | *SRS supporting accommodation for vulnerable Victorians guidelines*, 2012<br>*SAVVI Supporting Connections flexible funds guidelines*, 2010<br>*SAVVI Supporting Connections services specifications*, 2008 |

**Table 2.26: Public health service standards and guidelines**

| Service standards and guidelines description | Activity no. |
|---|---|
| Advice for public health and wellbeing planning in Victoria: planning cycle 2017–2021 <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/public-health-wellbeing-planning-advice-2017-2021> | 28085 |
| *Community Health Integrated Health Promotion Program: Planning Guidelines 2013–17* | 16454 |
| *Community Health and Women's Health Integrated Health Promotion: Reporting Guidelines 2013–17* | 16454 |
| *Guide to Municipal Public Health and Wellbeing Planning*, 2013 (including the Environments for Health Framework) | 16454 |
| *BBV/STI Program Guidelines for Funded Agencies* (current edition) | 16373<br>16377<br>16505<br>16506<br>16507<br>16508<br>16509 |

**Table 2.27: Primary, community and dental health service standards and guidelines**

| Activity name | Activity no. | Service standards and guidelines description |
|---|---|---|
| Dental health | 27010<br>27011<br>27017<br>27019<br>27020<br>27023<br>27024<br>27025<br>27026<br>27028<br>27029 | Dental health <https://www2.health.vic.gov.au/primary-and-community-health/dental-health> |
| Community health | 28033<br>28043<br>28069<br>28074<br>28080<br>28084<br>28085<br>28086 | Community health integrated program guidelines: direction for the community health program <https://www2.health.vic.gov.au/primary-and-community-health><br>Advice for public health and wellbeing planning in Victoria: planning cycle 2017–2021 <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/public-health-wellbeing-planning-advice-2017-2021><br>*Victorian Aboriginal affairs framework* (VAAF) standards <https://www.vic.gov.au/aboriginalvictoria/policy/victorian-aboriginal-affairs-framework.html> |

| Activity name | Activity no. | Service standards and guidelines description |
|---|---|---|
| Maternal health | 28080<br>28085<br>28086 | Community health integrated program guidelines: direction for the community health program <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Community-Health-Integrated-Program><br>Healthy Mothers, Healthy Babies Program <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/children-youth-and-families/healthy-mothers-healthy-babies> |
| Child health | 28082<br>28085<br>28086 | *Child health services: Guidelines for the community health program*<br>Child health teams <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/children-youth-and-families> |
| Young people | 28021<br>28066<br>28085<br>28086 | Community health integrated program guidelines: direction for the community health program <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program><br>Child, youth and family health <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/children-youth-and-families><br>Innovative Health Services for Homeless Youth (IHSHY) <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/children-youth-and-families> |
| Women's health | 28015<br>28016<br>28018<br>28050<br>28063<br>28064<br>28068<br>28067<br>28085<br>28086 | Women's health <https://www2.health.vic.gov.au/about/populations/womens-health><br>Health promotion <https://www2.health.vic.gov.au/public-health/population-health-systems/health-promotion> |
| Aboriginal health | 28071<br>28085<br>28086 | Community health integrated program guidelines: direction for the community health program <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Community-Health-Integrated-Program---CHIP---guidelines><br>Various other publications <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health> |
| People with chronic disease | 28072<br>28074<br>28081<br>28085<br>28086 | *Community health integrated program guidelines: direction for the community health program* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Community-Health-Integrated-Program---CHIP---guidelines><br>Early intervention in chronic disease <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/integrated-chronic-disease-management/icdm-in-victoria><br>Integrated chronic disease management <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/integrated-chronic-disease-management/icdm-in-victoria> |
| Culturally and linguistically diverse groups | 28048<br>28076<br>28085<br>28086 | Refugee health <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/refugee-health-program><br>Includes:<br>*Guide to asylum seeker access to health and community services in Victoria.* These standards should be referenced until superseded;<br>*Guide for the Refugee Health Nurse Program;*<br>*Refugee and asylum seeker health services- Guidelines for the community health program* |

| Activity name | Activity no. | Service standards and guidelines description |
|---|---|---|
| | | Refugee and asylum seeker health and wellbeing <https://www2.health.vic.gov.au/about/populations/refugee-asylum-seeker-health>, includes the *Refugee and Asylum Seekers Health Action Plan 2014–18*<br>*Cultural Responsiveness Framework: guidelines for Victorian health services* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Cultural-responsiveness-framework---Guidelines-for-Victorian-health-services> outlines the government's approach to cultural responsiveness in health services focusing on four key areas: organisational effectiveness, risk management, consumer participation and effective workforce<br>*Language services policy* <https://www.dhhs.vic.gov.au/publications/language-services-policy-and-guidelines><br>Health Translations Directory <https://www.healthtranslations.vic.gov.au> |
| Partnerships and system support | 28054<br>28087 | Primary Care Partnerships (PCPs) <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships><br>Primary Care Partnerships 2013–2017 planning and reporting requirements <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships/pcp-reporting><br>Service coordination <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships><br>General practice and private providers <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/general-practice-private-providers><br>Working with general practice: position statement and resource guide <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/working-with-gps-resource-guide-2008><br>Integrated health promotion <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships> |

Note: Organisations that receive funds associated with activity 28085 and 28086 should note that these funds can be applied flexibly across the broad range of programs and initiatives to meet the needs of the local community.