Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2013-14, 5/6 & 7 June 2013

Question: E13-204

OUTCOME: 13 - Acute Care

Topic: Subacute Care Beds

Type of Question: Hansard Page 40, 5 June 2013

Senator: Fierravanti-Wells

Question:

Can you provide me with the link to that formula?

Answer:

See the attached 'Definitions and counting methodology for the National Partnership Agreement on Improving Public Hospital Services' document.

Definitions and counting methodology for the National Partnership Agreement on Improving Public Hospital Services

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Background and introduction

Under the 2010 National Partnership Agreement on Improving Public Hospital Services (NPA IPHS), funding has been provided from 2010-11 to 2013-14 for 1,316 'new and additional subacute care beds' or 'new and additional subacute care bed equivalents' nationally. Bed targets were agreed for each state and territory as part of the Agreement.

Schedule E of the 2010 NPA IPHS made provision for the states and territories to jointly develop and agree a nationally consistent method for measuring growth in subacute care and for the Commonwealth to 'commission an independent study to verify the rigour of the method'.

That process is now complete and four issues were identified that would need to be resolved before full funding under the 2010 NPA IPHS could be made available to the states and territories.

Professor Kathy Eagar and her team at the Australian Health Services Research Institute (AHSRI), University of Wollongong, were commissioned to achieve resolution on these four issues. This paper sets out definitions and counting methodology to resolve each of these issues.

The four issues for resolution were:

1 The definition of subacute mental health

2 How to measure and report 'additional effort'

3 Uniform and consistent definitions and measures including common conversion factors

4 Usage of new beds.

Each of these issues plus two additional issues identified in the consultation process is discussed in turn below. These two additional issues are (1) the counting methodology for the term "number of people encountered" (a term used in the 2010 NPA) and (2) the potential need to revise Implementation Plans to bring them in line with the nationally agreed conversion factors.

It is important to note at the onset that the definitions and counting methodology below have been developed by AHSRI specifically for the 2010 NPA and the consultation involved in the development of these definitions and counting methodology has been limited to key stakeholders involved in the 2010 NPA. Accordingly, the definitions and counting methodology below have not been designed for broader application. In particular, AHSRI is not suggesting that the methods adopted in the 2008 NPA be revisited. AHSRI is also not suggesting that these definitions are applicable to the development of Activity Based Funding (ABF) funding models.

A point of clarification - counting versus reporting

Before addressing each issue, it is important to draw a distinction between counting and reporting. This paper specifies definitions and counting methodology that the states and territories have agreed to adopt and implement. However, it is not proposed that reporting by the states and territories to the Commonwealth be at the level of detail set out in this paper.

Once beds and activity are counted using the methodology set out in this paper, the data will be aggregated and reported against each project specified in approved Implementation Plans.

Schedule E of the NPA IPHS sets the agreed reporting requirements. The relevant clause is as follows:

E23 Progress Reports will provide service information including identification of new beds delivered, and projects in progress, and, and in each case detailing their specific subacute care type, location, and number of people encountered over the period.

In other words, states and territories have already agreed to produce a six monthly progress report for each approved project and, consistent with Clause E23, to include in this report both the number of new and additional beds and the number of additional patients treated. AHRSI is not proposing any additional reporting to that already specified in Schedule E.

Issue One: the definition of subacute mental health

The NPA IPHS recognises four subacute care types:

- Palliative care,
- Rehabilitation care,
- Geriatric Evaluation and Management (GEM) and
- Subacute mental health care

The first three of these care types are defined in the National Health Data Dictionary (NHDD). While better definitions may be adopted in the longer-term, it is not proposed that these be amended for the purposes of the NPA. Accordingly, for the purposes of the NPA, only subacute mental health needs to be defined.

General definitions of acute, subacute and non acute care

The following concepts underpin the care types already in the National Health Data Dictionary and it is proposed that they now be applied to mental health.

Acute care

Acute care is care in which the need for treatment is driven primarily by the patient's principal medical diagnosis rather than their functional status. Acute care may be provided in any setting.

Subacute care

Subacute care is interdisciplinary or multidisciplinary[1] care in which the need for care is driven primarily by the patient's functional status and quality of life rather than the underlying medical diagnosis. It may include care for patients who have multiple diagnoses, none of which can be specified as the principal diagnosis. Subacute care may be provided in any setting.

Non-acute care

Non-acute or maintenance care is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. Following assessment or treatment the patient does not require further complex assessment or stabilisation. This care includes hospital care provided to a patient who would normally receive care in another setting e.g. at home, or in a residential aged care service, by a relative or carer, that is unavailable in the short term. Non-acute care may be provided in any setting.

[1] The terms interdisciplinary and multidisciplinary are used interchangeably in this paper.

Definition of Subacute Mental Health

Subacute mental health care is care in which the primary clinical purpose or treatment goal is improvement in function, behaviour and/or quality of life for a patient with a mental illness. This care is always evidenced by:

- interdisciplinary management and
- regular assessments against a management plan that is working towards negotiated goals within indicative time frames.

Inclusions:

- Time-limited mental health care delivered in any setting in which the primary focus of care is the patient's functional status and quality of life rather than the underlying medical diagnosis. Subacute mental health care is typically (but not always) of medium term duration (weeks to months, not years).
- The psychogeriatric care type as defined in the National Health Data Dictionary

Exclusions:

- Acute mental health care. That is, mental health care where the primary goal is reduction in severity of symptoms and/or distress associated with the recent onset or exacerbation of a mental illness. Acute mental health care is typically (but not always) of short duration (days to weeks, not months).
- Non-acute mental health care. That is, mental health care provided to a person for the purposes of maintenance of function and current health status if possible. Non-acute mental health care is typically provided to a person after an acute or subacute mental health episode and is typically of long duration (months to years, not weeks).

This definition of subacute mental health only applies for the purpose of the 2010 NPA. Further work will be required to develop a definition suitable for identifying subacute mental health for Activity Based Funding purposes. Additionally, the proposed definition is not proposed to replace the current classification of mental health beds defined in the Mental Health Establishments National Minimum Data Set and used by states and territories for annual reporting.

Issue Two: Additional effort

Background

Two recent National Partnership Agreements (NPA) have included funding for subacute care. The first is the 2008 National Partnership Agreement on Hospital and Health Workforce Reform (NPA HHWR). It will be referred to through the remainder of this document as the 2008 NPA. The definitions and counting methodology in this paper do not apply to this 2008 NPA.

The second is the National Partnership Agreement on Improving Public Hospital Services (NPA IPHS), which was agreed to by the Council of Australian Governments (COAG) in May 2010 and revised in March 2011. It will be referred to through the remainder of this document as the 2010 NPA. The definitions and counting methodology in this paper apply only to this 2010 NPA.

Funding for palliative care, rehabilitation and GEM care is included in both NPAs. Psychogeriatric care is specified in the 2008 NPA but not specified in the 2010 NPA. 'Subacute mental health' (which now includes psychogeriatric care by definition – see Issue One above) is specified in the 2010 NPA but not in the 2008 NPA.

While both NPAs include funding for new subacute care services, the measurement approach in the two NPAs is fundamentally different:

- The metric for the 2008 NPA is increased activity (specified as 5% per annum or 20% over the four years of the agreement).
- The metric for the 2010 NPA is increased subacute beds or bed equivalents (a national increase of 1,316 beds or equivalents over the four years of the agreement).

The 2010 NPA specifies that these beds or equivalent services must be additional to those funded under the 2008 NPA.

Measuring additional effort

New activity/beds that can be clearly attributed to either the 2008 or the 2010 NPA should be counted against the relevant agreement.

However, it will be difficult in some cases to attribute growth to one specific NPA. For example, a hospital may have opened ten new beds plus a home-based subacute program under the 2008 NPA and both the beds and the home program are increased under the 2010 NPA. The situation is further complicated in cases where, in addition to new services funded under a NPA, other new services have also been established or expanded, funded solely by the state or territory.

In cases such as these it will be necessary to adopt different measurement rules for reporting under the two NPAs. This is because each NPA uses a different metric. This necessarily requires a two-step method for measuring 'additional effort' under the 2010 NPA.

There are three agreed options for measuring additional effort:

- Where possible, count new activity/beds against the NPA under which the new activity/bed was funded
- Count growth under the 2008 NPA first, then count growth under the 2010 NPA
- Count growth under the 2010 NPA first, then count growth under the 2008 NPA.

Underpinning all three methods are the same core principals:

- Activity and beds can only be counted once
- To the extent that it is practical to do so, activity and beds should be attributed to the agreement under which they were funded
- If this is not possible, activity and beds are counted using a two step method that includes no double-counting.

In the steps that follow, growth under the 2008 NPA is counted first. However, in some cases it will be more logical to first count growth under the 2010 NPA and then count growth under the 2008 NPA. Both methods are permissible.

Step One

The first 5% of activity per annum or 20% in total over the four years (as measured by the 2008 NPA methodology) is counted first and reported against the 2008 NPA. This first 5% of activity excludes subacute mental health but includes psychogeriatric care approved under the 2008 NPA.

Once a total activity increase of 20% is achieved, states and territories need to maintain this level of activity for the life of the 2008 NPA and continue to report the first 20% of activity increase against the 2008 NPA.

Step Two

All activity beyond 5% of activity per annum or 20% in total over the four years is then counted. Subacute beds and activity funded by the Commonwealth under these NPAs is then reported against the 2010 NPA using the definitions and counting methodology for the 2010 NPA as specified below.

The role of the baseline

The 2010 NPA commits funding from 2010-11 to 2013-14 for subacute care beds or bed equivalents that did not exist at the baseline. The baseline is specified as 2009-10.

In practice, the process for rolling out the agreement is that each state and territory has submitted an Implementation Plan (IP) for Commonwealth approval. Each IP contains a number of discrete projects and, for each project, specifies the number of new and additional beds or equivalents. Reporting is required against each approved project.

In agreements that commit to a percentage increase in activity (such as the 2008 NPA), the baseline number of activities needs to be known so that percentage increases can be calculated.

This is not the case for agreements that commit to a specific increase in the total number of beds. In the case of the 2010 NPA, none of the new and additional beds and equivalents in approved IPs existed at the baseline.

In other words, there is no need to know the number of subacute beds that existed in 2009-10 in order to calculate the number of new and additional beds established under the 2010 NPA. All that is required is a method for counting the number of new and additional beds that were actually established[2].

The spirit of the agreement is that new and additional beds funded under the 2010 NPA are not offset by bed closures elsewhere. However, the 2010 NPA makes no mention of the need to report bed closures elsewhere in the service system and, in practice, such closures would be notoriously difficult to count.

If the reporting of bed closures were to be agreed in a future NPA, the technical difficulty would be in defining an 'offset bed'. The task is not simply one of counting any beds that close (bed numbers fluctuate daily). The task would be to only count closures that offset new beds established under the agreement. For example, it would need to be determined whether the closure of an acute bed in the same hospital constitutes an offset. Equally, it would need to be determined whether the closure of a subacute bed in one hospital offsets a bed opened in another hospital under the agreement.

Counting new and additional beds and bed equivalents for the 2010 NPA

Where new and additional activity occurs in designated subacute beds, the numbers of new and additional beds are counted as well as the activity that occurs in those beds.

[2] Note that if new and additional beds cannot be directly counted, they can be derived by taking the total number of new beds and equivalents and subtracting the number available at the baseline.

Where new and additional activity occurs in non-designated beds or in bed equivalents, the activity is counted as set out below and converted to bed year equivalents. These terms are defined below.

In converting activity in non-designated beds or in bed equivalents to beds, it is necessary to adopt a standard bed occupancy rate. A standard occupancy rate of 85% is to be used for the purpose of calculating bed year equivalents.

In doing so, it should be noted that all new services have a 'ramp up' period between commissioning and becoming fully operational. New services may not reach the equivalent of 85% occupancy immediately on opening, particularly in rural regions.

It should also be noted that the issue of a standard occupancy rate is not relevant to designated subacute inpatient beds. An available hospital bed is a hospital bed regardless of the occupancy rate. This issue is discussed further below.

Issue Three: Uniform and agreed measures including common conversion factors

Clause E16 of the 2010 NPA states that: 'Measurement of State and Territory performance under the agreement will be comparable across all States and Territories...' (our emphasis).

This was not the case with the 2008 NPA. Under the 2008 NPA, each state and territory used a different method for converting non-admitted activity to bed day or separation equivalents. The result is that the measurement of performance in relation to the 2008 NPA is not comparable across states and territories.

National agreement on consistent conversion factors for measuring performance in the 2010 NPA is necessary. One obvious implication is that performance across the two agreements cannot be compared.

Each state and territory has submitted a 2010 NPA Implementation Plan (IP), with all but one already approved by the Commonwealth. These IPs contain plans for ten types of new and additional subacute care beds and bed equivalents to be provided using funding provided under the 2010 NPA:

1 Designated subacute hospital beds
2 Subacute activity in non-designated hospital beds
3 Designated community subacute beds
4 Multidisciplinary centre-based subacute care programs and same-day subacute admissions
5 Single discipline centre-based subacute care programs
6 Subacute hospital outpatient clinic programs
7 Home-based subacute care (intensive)
8 Home-based subacute care (standard)
9 Home-based subacute care (monitoring and review)
10 Consultation/liaison and in-reach care

The practicalities of reporting

All services specified in approved IPs must be classified to one or more of these service types using the definitions set out below. **This classification process need occur only once**.

Where services provide two or more types of care, service activity is pro-rated between the types of care they provide. For example, 10% of the care provided by a home-based palliative care service may be terminal care which is classified as intensive home-based subacute care, with 50% classified as standard home-based subacute care and the remaining 40% as home-based subacute care (monitoring and review).

There is no expectation that all of the following service types will be counted in each state and territory. Some states and territories are proposing to increase only one type of care while others are proposing several.

Once classified, the new and additional beds and bed equivalents at each service will be counted using the definitions and conversion factors set out below. Beds, programs and clinics will need to be flagged in state and territory information systems for this purpose.

Summary of proposed uniform and agreed measures and conversion factors

The 2010 NPA IPHS makes provision for 1,316 new and additional subacute care beds or bed equivalents nationally. These are to be counted as follows.

Type	Summary description	Per day equivalent	Per bed year equivalent
1	Designated subacute care hospital bed	Not applicable[3]	1 bed
2	Subacute activity in non-designated hospital bed	1 bed day	1 bed
3	Designated community subacute bed	Not applicable[2]	1 bed
4	Multidisciplinary centre-based subacute care programs and subacute same day admissions	2.5 occasions of service and/or same day admissions	775 occasions of service and/or same day admissions
5	Single discipline centre-based subacute care programs	6 occasions of service	1,850 occasions of service
6	Subacute outpatient clinic	8 non-admitted patient service events	2,500 non-admitted patient service events
7	Home-based subacute care (intensive)	1.5 occasions of service	465 occasions of service
8	Home-based subacute care (standard)	4 occasions of service	1,250 occasions of service
9	Home-based subacute care (monitoring and review)	6 occasions of service	1,850 occasions of service
10	Consultation/liaison and in-reach care	6 occasions of service	1,850 occasions of service

These conversion factors are based on best estimates of relative cost. The method used to determine these is set out in Attachment One.

It is important to note that 'bed equivalent' is not a measure of the number of patients treated (treatment places). A home program, for example, may care for 24 patients a day and this may be counted as only 4 bed day equivalents. This is an important distinction because some approved Implementation Plans specify the number of anticipated treatment places rather than the number of bed equivalents.

[3] If the bed is being counted under the 2010 NPA, the activity associated with that bed cannot be counted under the 2008 NPA. If the activity in that bed cannot be differentiated from other activity on that site (especially where increases are expected from both NPAs as well as new services funded solely by the state/territory) it may be necessary to count bed days in designated units and convert these to bed equivalents. In this case use 85% occupancy for new beds opened, noting lower occupancy during the establishment phase as discussed elsewhere in this document.

New and additional subacute care hospital beds

In describing each of the Types of Care below, we have provided a table that suggests how each type of care is to be counted. These tables are provided purely for the purpose of 'counting', not reporting (see page 1 of this report for the distinction between counting and reporting).

Type 1: New and additional designated subacute care beds

New and additional designated subacute care beds are beds formally designated for one or more of the four 2010 NPA subacute care types that did not exist at the baseline (2009/2010) and that:

- Are physically available to be used
- Are staffed to be used on a 24 hour basis for the relevant Care Type

Counting of designated hospital beds

New and additional designated subacute care beds are to be counted by hospital and Care Type.

Hospital:		**Reporting period**:		
Care Type	**Date/s new NPA funded beds opened**	**Number of new and additional beds opened by date**	**Separations during the period**	**Bed days during the period**
Palliative care				
Rehabilitation / GEM[1]				
Mental health				

1 Rehabilitation and GEM are reported together in recognition that some services have flexible rehabilitation / GEM beds.

Type 2: New and additional subacute activity in non-designated hospital beds

This is increased subacute activity in beds that are not formally designated for subacute care. This subacute care is provided in beds that are used flexibly depending on the need at any point in time and may accommodate acute care, subacute care or other care. These beds are typically, but not always, in small rural hospitals. For the purposes of the 2010 NPA, only new and additional subacute bed days and separations occurring in these beds can be counted.

Conversion factor for new and additional subacute activity in non-designated hospital beds

New and additional subacute bed days that occur in non-designated hospital beds will be converted to hospital bed year equivalents. A hospital bed year is a hospital bed that is available for the full year (365 days). An occupancy rate of 85% is used for the purpose of calculating bed year equivalents.

Hospital bed year equivalent = (total subacute bed days/365) * 85%

Counting of new and additional subacute activity in non-designated hospital beds

New and additional subacute care activity in non-designated beds is to be counted by hospital and Care Type.

Hospital:	Reporting period:	
Care Type	**Number of new and additional separations during the period**	**Number of new and additional bed days during the period**
Palliative care[2]		
Rehabilitation [2]		
GEM[2]		
Mental health[3]		

2 Bed days are counted using the care type item in the hospital morbidity data set

3 With the exception of the psychogeriatric care type, subacute mental health bed days cannot be reported using the care type item in the hospital morbidity data set as subacute mental health is not a recognised care type in the National Health Data Dictionary. Accordingly, any subacute mental health activity in non-designated beds will need to be manually collected.

New and additional subacute care hospital bed equivalents

For the specific purpose of the 2010 NPA, there are eight types of new and additional subacute care bed equivalents:

- Designated community subacute bed
- Multidisciplinary centre-based subacute care programs and same-day subacute admissions
- Single discipline centre-based subacute care programs
- Subacute hospital outpatient clinic programs
- Home-based subacute care (intensive)
- Home-based subacute care (standard)
- Home-based subacute care (monitoring and review)
- Consultation/liaison and in-reach care

Each is discussed in turn.

Type 3: Designated community subacute beds

Community subacute care beds are beds in a non-hospital setting that are designated for subacute care and that:

- Are physically available to be used
- Are staffed appropriately on a 24 hour basis for the care type

Conversion factor for community beds

One community bed = one hospital bed

Counting of community beds

New and additional subacute community beds are to be counted by location and Care Type.

Location:		Reporting period:		
Care Type	**Date/s new NPA funded beds opened**	**Number of new and additional beds opened by date**	**Separations during the period**	**Bed days during the period**
Palliative care				
Rehabilitation / GEM[4]				
Mental health				

4 Rehabilitation and GEM are reported together in recognition that some services have flexible rehabilitation / GEM beds.

Type 4: Multidisciplinary centre-based subacute care programs and subacute same day admissions

An occasion of subacute service provided to a non-admitted patient in a designated subacute care centre, a community health centre or similar that is delivered as part of a comprehensive subacute care program OR a subacute same day admission.

A multidisciplinary occasion of service is an occasion of service delivered by more than one discipline and that is of at least two and a half hours duration.

Conversion factor for multidisciplinary centre-based subacute care programs and subacute same day admissions

2.5 multidisciplinary occasions of service = one hospital bed day

2.5 same day admissions = one hospital overnight bed day

775 multidisciplinary occasions of service = one hospital bed year

775 same day admissions = one hospital bed year

A hospital bed year is a hospital bed that is available for the full year (365 days). An occupancy rate of 85% is to be used for the purpose of calculating bed year equivalents.

Counting of multidisciplinary centre-based subacute care programs and subacute same day admissions

Centre-based subacute care programs and subacute same day admissions are to be counted by location and Care Type.

Service/location:	Reporting period:
Care Type	**Number of new and additional multidisciplinary OOS and/or same day admissions**
Palliative care	
Rehabilitation	
GEM	
Mental health	

Type 5: Single discipline centre-based subacute care programs

An occasion of subacute service provided to a non-admitted patient in a designated subacute care centre, a community health centre or similar that is delivered as part of a comprehensive subacute care program.

A single discipline occasion of service is an occasion of service delivered by one discipline and/or is of less than two and a half hours duration.

Conversion factor for single-discipline centre-based subacute care programs

6 single discipline occasions of service = one hospital bed day

1,850 single discipline occasions of service = one hospital bed year

A hospital bed year is a hospital bed that is available for the full year (365 days). An occupancy rate of 85% is to be used for the purpose of calculating bed year equivalents.

Counting of single-discipline centre-based subacute care programs

Centre-based subacute care programs are to be counted by location and Care Type.

Service/location:	**Reporting period:**
Care Type	**Number of new and additional single discipline centre-based OOS**
Palliative care	
Rehabilitation	
GEM	
Mental health	

Type 6: Subacute outpatient clinic

A subacute service event provided to a non-admitted patient in a hospital outpatient clinic or similar. This includes group sessions.

Conversion factor for outpatient clinic care

8 non-admitted patient service events = one hospital bed day

2,500 non-admitted patient service events = one hospital bed year

A non-admitted patient service event has been adopted as the new measure of activity for non-admitted hospital care (but not community care) and is being implemented from July 2011. A non-admitted patient service event is an interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record. For the purposes of the 2010 NPA, a non-admitted patient service event is equivalent to an occasion of service.

A hospital bed year is a hospital bed that is available for the full year (365 days). An occupancy rate of 85% is to be used for the purpose of calculating bed year equivalents.

Counting of outpatient clinic programs

Outpatient clinic subacute care programs are to be counted by hospital and Care Type.

Hospital:	Reporting period:
Care Type	**Number of new and additional non-admitted patient service events**
Palliative care	
Rehabilitation	
GEM	
Mental health	

Type 7: Home-based subacute care (intensive)

An occasion of interdisciplinary care provided to a non-admitted patient as a direct substitute for an inpatient admission and with the same level of clinical intensity as care on an inpatient unit. This care is typically provided as a component of a broader program and typically includes care:

- by more than one discipline
- of at least three hours duration and
- that is provided in the person's usual place of accommodation or similar.

Conversion factor for intensive home-based subacute care

1.5 occasions of service = one hospital bed day

465 occasions of service = one hospital bed year

A hospital bed year is a hospital bed that is available for the full year (365 days). An occupancy rate of 85% is to be used for the purpose of calculating bed year equivalents.

Counting of intensive home-based subacute care

Home-based subacute care (intensive) is to be counted by location and Care Type.

Service/location:	Reporting period:
Care Type	**Number of new and additional intensive home-based OOS**
Palliative care	
Rehabilitation	
GEM	
Mental health	

Type 8: Home-based subacute care (standard)

An occasion of interdisciplinary care provided to a non-admitted patient as a component of a program that directly substitutes for an inpatient admission. This typically includes care:

- by more than one discipline
- of at least one hours duration and
- that is provided in the person's usual place of accommodation or similar.

Conversion factor for other home-based subacute care

4 occasions of service = one hospital bed

1,250 occasions of service = one hospital bed year

A hospital bed year is a hospital bed that is available for the full year (365 days). An occupancy rate of 85% is to be used for the purpose of calculating bed year equivalents.

Counting of new and additional home-based subacute care

Home-based subacute care (standard) is to be counted by location and Care Type.

Service/location:	Reporting period:
Care Type	**Number of new and additional standard home-based OOS**
Palliative care	
Rehabilitation	
GEM	
Mental health	

Type 9: Home-based subacute care (monitoring and review)

All other new and additional home-based subacute care that does not meet the criteria for classification as either intensive or standard home-based subacute care. This includes home visits for monitoring the patient's progress and for purposes such as a medication review and other home visits of less than one hour duration.

Conversion factor for other home-based subacute care

6 occasions of service = one hospital bed

1,850 occasions of service = one hospital bed year

A hospital bed year is a hospital bed that is available for the full year (365 days). An occupancy rate of 85% is to be used for the purpose of calculating bed year equivalents.

Counting of new and additional other home-based subacute care

Home-based subacute care (monitoring and review) is to be counted by location and Care Type.

Service/location:	Reporting period:
Care Type	**Number of new and additional monitoring & review home-based OOS**
Palliative care	
Rehabilitation	
GEM	
Mental health	

Type 10: Consultation/liaison and in-reach care

Consultation/liaison and in-reach care is subacute care provided to an acute admitted patient under the care of another clinician/team. For example, a rehabilitation team may begin rehabilitation while the patient is still in intensive care or a palliative care team may begin providing palliative care while a patient is still receiving acute care and under the clinical management of an oncologist. This includes a 'second opinion'; advice on a particular problem; case review; patient/carer education and/or therapy. The other service, and not the subacute care service, is

the primary provider for this episode and the patient is admitted under the care of the primary provider.

For the purposes of the 2010 NPA, the subacute care that the patient receives is classified and counted as a non-admitted occasion of service (i.e., the same way as home-based care).

Conversion factor

6 occasions of service = one hospital bed

1,850 occasions of service = one hospital bed year

A hospital bed year is a hospital bed that is available for the full year (365 days). An occupancy rate of 85% is to be used for the purpose of calculating bed year equivalents.

Counting of consultation/liaison and in-reach care

Consultation/liaison and in-reach care is to be counted by hospital and Care Type.

Hospital:	**Reporting period:**
Care Type	**Number of new and additional consult liaison OOS**
Palliative care	
Rehabilitation	
GEM	
Mental health	

Issue Four: Usage of new beds

Two issues have been agreed in relation to measuring the usage of new beds.

Services provided for only part of a year

Beds and services opened during a financial year are to be pro-rated in proportion to the number of weeks opened in the year:

New and additional beds = (number of new and additional beds x weeks opened) / 52

In interpreting this, it should be recognised that all new services have a 'ramp up' period between commissioning and becoming fully operational. New services may not reach the equivalent of 85% occupancy immediately on opening, particularly in rural regions. This will be an important consideration in assessing progress in the early years of the program.

For this reason, in addition to reporting total new beds and bed equivalents, states and territories have agreed to report the number of new and additional beds and equivalents at the end of each reporting period.

Standard bed occupancy rates for the purpose of converting activity to hospital beds

A hospital bed year is a hospital bed that is available for the full year (365 days). An occupancy rate of 85% is used for the purpose of calculating bed year equivalents. This only applies to non-designated beds and bed equivalents.

Issue Five: Counting "number of people encountered"

The 2010 NPA specifies the quantitative reporting that the parties have agreed on and there is no suggestion by AHSRI that these be changed. The quantitative reporting specified in the agreement is limited to new and additional subacute beds and the "number of people encountered over the period" (E23).

The sections above deal with the methodology for counting new and additional subacute beds. This section addresses the other quantitative reporting requirement – that the number of people encountered be reported for each approved project. This is necessary because the term "the number of people encountered" is not defined and differences have emerged in the consultation process about how the term is being interpreted.

In the case of admitted patient episodes, the counting methodology is straightforward. The logical interpretation is that the number of people encountered is the number of additional separations during the reporting period. These additional separations are counted using the methods outlined in the section on measuring additional effort (page 4).

In the case of non-admitted patient episodes, the methodological issues are more difficult. IT systems are generally more rudimentary in the non-admitted setting and national minimum data set requirements (where they exist) specify the reporting of occasions of service or service events rather than the number of people. In the case of community alternatives to inpatient care, only mental health has a relevant national minimum data set. There are also significant differences between states and territories in their own internal reporting requirements.

The implication is that, in the non-admitted setting, existing routine data collections typically capture occasions of service or service events rather than the number of unique patients treated.

Accordingly, for the purposes of the 2010 NPA, the "number of people encountered" in the non-admitted setting is to be interpreted as a count of:

(1) additional patient episodes of care where this information can be captured in existing information systems or

(2) occasions of service or service events if patient-level counting is not possible.

As with admitted activity, patients / occasions of service are counted using the methods outlined in the section on measuring additional effort (page 4).

Issue Six: Activity counts in existing Implementation Plans

Each state and territory has submitted a 2010 NPA Implementation Plan (IP) that specifies what will be implemented by year, including the number of new and additional beds and bed equivalents. In preparing these IPs, most states and territories used the conversion factors they used in the 2008 NPA. These conversion factors differ from each other and from the conversion factors agreed and described in this document.

Once these nationally consistent conversion factors are adopted, it will be necessary for some states and territories to recalculate the number of new bed equivalents specified in their IP. Given that these plans will be public documents, states and territories may need to include an explanation of why the numbers specified in previous plans have now been changed. This could include, for example, a statement that, while the number of treatment places has not changed, the number of bed equivalents has because of changes in the counting methods. This would help to alleviate any public concern that plans already announced appear to have been changed. The Commonwealth and the states and territories will need to agree on a process by which IPs can be so revised.

Attachment One

A brief description of the method used to determine conversion factors

Step One – classify initiatives in approved Implementation Plans

The first step involved classifying each of the initiatives in approved Implementation Plans (IPs). A provisional list was first developed based on activity funded under the 2010 agreement. This classification was then reviewed against the information in each written IP. This resulted in some modifications. This modified list was then subsequently reviewed in consultations with each state and territory and further refinements were made. The outcome is the identification of 10 types of care being funded under the 2010 NPA as summarised in the table below.

Type	Summary description
1	Designated subacute care hospital bed
2	Subacute activity in non-designated hospital bed
3	Designated community subacute bed
4	Multidisciplinary centre-based subacute care programs and subacute same-day admissions
5	Single discipline centre-based subacute care programs
6	Subacute outpatient clinic
7	Home-based subacute care (intensive)
8	Home-based subacute care (standard)
9	Home-based subacute care (monitoring and review)
10	Consultation/liaison and in-reach care

Step Two – map the state specific conversion factors in the 2008 NPA to the 10 service types being funded in the 2010 NPA

The states and territories produced a document in December 2010 entitled "A nationally consistent method for measuring subacute care growth". While this document did not meet the requirements set out under Schedule E[4], it nevertheless contained very useful data that was used in Step Two.

This information is summarised below, as is the mapping between it and the 10 types of services proposed above. The mapping in this table is not comprehensive but is a summary based on information in IPs and in consultations with each jurisdiction.

State/ Territory	State / Territory conversion factor	Care Type specific	Description of care by State / Territory	Maps to AHSRI type/s	Comment
ACT	1.64-2.23	Yes	Outreach	Home-based subacute care	ACT is resubmitting its IP. Its initial IP was only for beds so conversion factors were not relevant.
NSW	8.4		Outpatient	Outpatient	While NSW proposed a conversion factor in the state/territory document, the NSW IP is only for designated and non – designated beds and so conversion factors are not relevant.

[4] As determined by the independent study commissioned by the Commonwealth under Schedule E.

State/ Territory	State / Territory conversion factor	Care Type specific	Description of care by State / Territory	Maps to AHSRI type/s	Comment
NT	4		Various	Outpatient and home-based care	NT noted that conversion factors were preliminary pending agreed national definitions of subacute care categories. However, the NT IP is only for beds so conversion factors are not relevant.
QLD	2		Multidisciplinary team outreach	Multidisciplinary centre-based subacute care	
SA	2		Various	Multidisciplinary home-based care	Projects requiring conversion in the SA IP are subacute mental health projects that were not within scope of the 2008 NPA. SA. Accordingly, conversion factors from the 2008 NPA are not applicable.
TAS	2		Not specified	Not applicable	The Tasmanian IP is only for beds so conversion factors are not relevant.
VIC	1.55-3.34	Yes	Various	Mostly multidisciplinary centre-based subacute care and home based care	
WA	2		Various	Several types but mostly outpatient	WA did not participate in the preparation of the state and territory document as the WA government was not a signatory to the agreement at that point.

Step Three – compare conversion factors proposed by states and territories by service type

The conversion factors proposed by states and territories were then compared by service type. For example, Queensland proposed a conversion factor of 2 for multidisciplinary centre-based subacute care while Victoria proposed conversion factors ranging between 1.55 and 3.34 depending on care type and setting. The NSW conversion factor of 8.4 differed significantly from the others and was based on a costing study undertaken for the purpose. However, this conversion factor was for outpatient services only.

Once the type of service was understood, the differences between the conversion factors proposed by states and territories largely disappeared. The initial differences were more to do with converting different types of services than inherent differences between states.

Step Four – calculate AHSRI conversion factor

The final stage involved the calculation of the proposed AHSRI conversion factor:

1. Using a notional subacute bed day cost of $700, we calculated the cost of each activity using the conversion rates nominated by the states and territories. For example, with a conversion rate of 2, Queensland was indicating that the relative cost of one occasion of multidisciplinary centre-based subacute care was $350; South Australia was indicating that the relative cost of one home visit was also $350 while an outpatient visit in NSW was $83.
2. Calculating a provisional national conversion factor by comparing these results to each other and to existing subacute care data already held by AHSRI.
3. We then worked with people with expertise in the various models of care to agree on what would typically be provided in terms of both staff mix and time and allocated a realistic cost based on staff time and other expected costs (e.g., travel for home visits).
4. We also requested that states and territories provide us with any cost data they held and sought feedback on the face validity of each proposed conversion factor. While most states and territories were in a position to provide feedback on face validity and some such as NSW had already undertaken costing studies to calculate their earlier conversion factors, Victoria

had the most extensive data and was able to test each of the provisional conversion factors against their own data. This resulted in some refinements in the final stage of the project.

The result of this process is summarised by state and territory in the table below. It will be seen that, in cases where the conversion factors in the state/territory reports were detailed, the results are very similar.

State/ Territory	State / Territory conversion factor	Maps to AHSRI type/s	AHSRI conversion factor
ACT	1.64-2.23	Home-based subacute care	1.5-6 depending on type
NSW	8.4	Outpatient	8
NT	4	Outpatient and home-based care	8 for outpatient, 1.5-6 depending on type of home visit
QLD	2	Multidisciplinary centre-based subacute care	2.5
SA	2	Home-based care	1.5-6 depending on type
TAS	2	Not stated	Not applicable
VIC	1.55-3.34	Multidisciplinary centre-based subacute care and home based care	1.5-6 depending on type
WA	2	Several types but mostly outpatient	1.5-8

These same results are presented in relative (not absolute) dollar terms below. These costs are relative to a notional $700 a day hospital bed day or, assuming 85% occupancy rates, $217,175 per bed year. They would be different if a different dollar value was used as the cost of a typical subacute bed day.

In considering these relative costs, it is important to reiterate that bed-based care is for 24 hours a day (equivalent to $29 per hour for a notional $700 a day bed). This is not the case with most other services.

Type	Notional cost
Designated subacute care hospital bed	$700
Subacute activity in non-designated hospital bed	$700
Designated community subacute bed	$700
Multidisciplinary centre-based subacute care programs and subacute same day admissions	$280
Single discipline centre-based subacute care programs	$117
Subacute outpatient clinic	$88
Home-based subacute care (intensive)	$467
Home-based subacute care (standard)	$175
Home-based subacute care (monitoring and review)	$117
Consultation/liaison and in-reach care	$117

Our assessment is that the costing information available for use in the calculation of conversion factors is very poor. Accordingly, the development of the proposed conversion factors has necessarily involved elements of judgement as well as quantitative analysis. Nevertheless, on the matters requiring judgement, there was a surprisingly high level of agreement between those we consulted and the experts in our own team. Our overall assessment is that, in the absence of nationally consistent and detailed cost data, the proposed conversion factors are defensible. They have face validity and are based on the best information available.