Delivering a **Healthy WA**

SUBACUTE CARE PLAN – WESTERN AUSTRALIA 2009-2013 NATIONAL HEALTH PARTNERSHIP AGREEMENT SCHEDULE C

Innovation and Health System Reform Division
Aged Care Policy Directorate
April 2009

Government of **Western Australia**
Department of **Health**

SUBACUTE CARE - WESTERN AUSTRALIA IMPLEMENTATION PLAN 2008-09 TO 2012-13

Department Name

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EXECUTIVE SUMMARY

There is significant potential with respect to the strengthening of subacute care services across Western Australia (WA). The combination of a relatively low population base compared to eastern seaboard states, the vast size of WA and geographically remote regional communities has led to the historical concentration of health care and hospital resources in the metropolitan area. Attachment D provides a brief environmental scan of the status of Subacute Care services across the continuum in WA and it is clear there are identified gaps in services.

In addition, within the WA metropolitan area, there has been a historical tendency to concentrate on services provided by tertiary hospital sites, with the main focus on acute service provision with linked clinical specialist services.

The strategic planning and development of subacute care services from a system wide perspective could largely be characterised as secondary to the provision of acute care services.

The 2004 Reid Review identified this fact and made a number of recommendations to build upon the strengthening of subacute care services through various avenues. The Reid Review subsequently led to the development of the WA Clinical Services Framework 2005-2015 (WA CSF) and Models of Care. These documents have informed the WA Subacute Care Plan.

The National Health Partnership Agreement (NPA) on Hospital and Health Workforce Reform – Schedule C: Subacute Care offers a significant opportunity for WA to strengthen and diversify such services. In effect, it will be instrumental in closing the gaps in the missing part of the continuum of care for older people - subacute care.

The Department of Health, through the Aged Care Policy Directorate has a strong track record in the implementation of joint commonwealth-state programs and services. Among these are the Home and Community Care Program, the COAG Long Stay Older Persons Initiative, the Aged Care Assessment Program and the Transition Care Program.

In designing the WA Subacute Care Plan (the Plan), WA has chosen not to completely restrict itself to the older population cohort of 70+, but has taken a broader approach by including chronic disease populations who require secondary and preventative approaches to their care needs. Recommendations made in the Reid Review and embodied in the WA CSF and Model of Care documents has driven this approach.

A key, central theme of these documents is the shift from the tertiary level hospital to the secondary/generalist hospital level with a strengthening of

ambulatory care and community based services, and a strong rehabilitation therapy focus in many areas.

In WA, a key vehicle for improved quality of care and microeconomic reform has been the development of alternative models of care led by senior clinicians with engagement from the community service sector and consumers.

The aim of the WA Subacute Care Plan is to expand the provision of subacute services in line with targets, employing approaches agreed to by the National Subacute Care Working Group in alignment with WA local needs, priorities, circumstances and opportunities.

Specifically, the Plan will provide increased services in the ambulatory care setting, move services to secondary hospital sites closer to where people live and will assist hospitals to be more efficient and sustainable. It is envisaged that the anticipated outcomes from the Plan will support the implementation of the Taking Pressure Off Public Hospital Plan and in particular the State “Four Hour Rule Program” in WA.

The Plan meets the requirements of Schedule C, provides accountability for funding through growth in services and allows flexibility for WA to plan and develop services to meet local needs. The Plan provides information on the state-wide strategies and approaches to improving sub-acute care services in metropolitan, regional and rural WA to ensure better access to services across the population of WA.

The Plan identifies opportunities for growth in services as well as potential risks and constraints. Service growth targets have also been established and their achievement will demonstrate improvement in access to services.

While baseline 2007-08 activity data has been used in the plan, WA would reserve the right to monitor and modify the plan over the four years, 2009 – 2013 to meet local needs and to take advantage of local opportunities.

BACKGROUND

Subacute Care Plan (the Plan) has been informed by the following evidence-based planning frameworks:

- WA Health Clinical Services Framework 2005-2015 (WA CSF), the principle planning framework for the WA Department of Health; and
- Area Health Services Clinical Services planning documents (North and South Metropolitan Health Services, WA Country Health Service).

Role delineation of health and hospital services outlined in the Area Health Services Clinical Services planning documents is linked to the requirements of the WA CSF.

An outline of the key elements of the WA CSF and how they serve to define the strategies and opportunities identified in the WA Plan, is outlined in Appendix A, including:

- Model of Care documents developed by WA Clinical Health Networks and the Aged Care Policy Directorate.

These documents each contain recommendations that apply to service development and reform across their respective domains.

A short outline of the strategic nature of the Model of Care documents, their link to the WA CSF and the fundamental importance as key drivers for strategies and opportunities outlined in the Plan over the period 2009-2013 is contained in Appendices A and C.

The National Hospital and Health Workforce Partnership Agreement presents a timely opportunity to implement the outcomes of these planning initiatives while simultaneously meeting the requirements as outlined in Schedule C.

STRATEGIES

The key strategies of the WA Plan are to:

- build and strengthen existing services based on evidence based outcomes;
- provide new services where there are identified gaps based on evidence based outcomes;
- strengthen both the allied health and clinical workforce to drive increased service delivery and improve outcomes; and
- concentrate effort on robust data collections that support increase levels of activity across subacute care services.

Table One - WA Subacute Care Plan outlines the proposed approach that WA will take over the period 2009 – 2013 in order to increase service delivery capacity across the subacute care sector. Specifically the table outlines the role of the state, statewide strategies, anticipated outcomes as per the requirements of Schedule C of the NPA.

Appendix F - WA Subacute Care Plan Annual Service Growth Targets provides key information on annual service growth targets by patient type over the four years, 2009 – 2013.

The WA Plan is based on a number of evidence based planning frameworks and consultation with the respective service sectors across the subacute care, both in the Perth metropolitan and WA Country Health Service (WACHS).

Upon approval of the WA Plan, extensive consultations with stakeholders will take place to commence implementation in a staged manner.

WA has sought to concentrate its effort in the areas of rehabilitation, psycho-geriatric services, palliative care and Geriatric Evaluation and Management (GEM). These service sectors have largely been considered as secondary in terms of their relative importance in comparison to historical acute care service investment at major tertiary hospital.

WA has a strong professional workforce base with respect to geriatrician physicians. This has been the result of initiatives over the last 10 years to attract and retain an adequate number of Advanced Trainees in Geriatric Medicine. As such, extensive GEM clinical activity occurs in the admitted and non-admitted patient settings, particularly in metropolitan hospitals, both at tertiary and secondary sites.

In this respect, WA has focused its efforts in the area of GEM services through strengthening of the geriatric clinical workforce in order that reach and depth can be extended. The comprehensive multi-disciplinary assessment and management approach provided by geriatricians enables the downstream benefits of multi-disciplinary rehabilitation therapy in the Day Therapy Centre/Day Hospital non-admitted setting. WA will seek to differentiate the current activity that occurs through GEM clinical episodes of care in the non-

admitted setting leading to multi-disciplinary rehabilitation therapy through a refinement in data collection processes.

WA is also in the unique position of providing GEM services through a dedicated sub-acute GEM unit in an acute hospital setting. This service is supported through the GEM Model of Care and where possible will be supported in the WA Plan.

The Palliative Care sector has been the recipient of significant injections of State Government and Commonwealth funding over the past fours to increase service capacity. In this context, a limited approach will be taken to provide services where gaps remain. It is recommended that there will be a small proportion of funds relative to other sectors allocated to palliative care.

OPPORTUNITIES

Key opportunities are:

<u>WA Country Health Service (WACHS) Regional Areas</u>

- Strengthening of the visiting consultant geriatrician service to WA Country Health Service (WACHS) regional resource centres with formal links to specific metropolitan aged care and stroke departments.

- To provide a visiting consultant psycho-geriatrician service to WA Country Health Services (WACHS) regional resource centres aligned with the geriatrician visiting service.

- The clinical platform of specialist clinician services will provide the “imprimatur” for a best practice comprehensive, multi-disciplinary approach to rehabilitation and geriatric evaluation and management (GEM). Downstream benefits will accrue in respect to the development of a stronger rural and regional allied health workforce.

- Sub-acute secondary rehabilitation units in major regional resource centres where population projections indicate demand.

- Establishment of rehabilitation in the home (RITH) in key WACHS regional resource centres.

- Establishment of “Day Therapy” services in key WACHS regional resource centres.

- Enhanced utilisation of tele health centres in regional areas.

Metropolitan Services

- Sub-acute secondary stroke and chronic disease services in targeted metropolitan areas where population projections indicate demand.
- Collaboration/co-location of consultant psycho-geriatrician services with geriatrician services in the metropolitan area.
- Increases in service delivery levels and diversification of ambulatory care “Day Therapy” services in the Perth metropolitan area.
- Increased RITH in the metropolitan area.
- Expanded general rehabilitation services for the younger patient (<65 years).

Statewide Services

- Expanded specialist consultant rehabilitation services for amputee patients.
- Statewide Clinical Training Unit for specialist geriatrician, psycho-geriatrician and rehabilitation physicians, rehabilitation nurses and allied health professionals. Capacity for outreach training services and professional exchange programs will occur through the Statewide Unit.

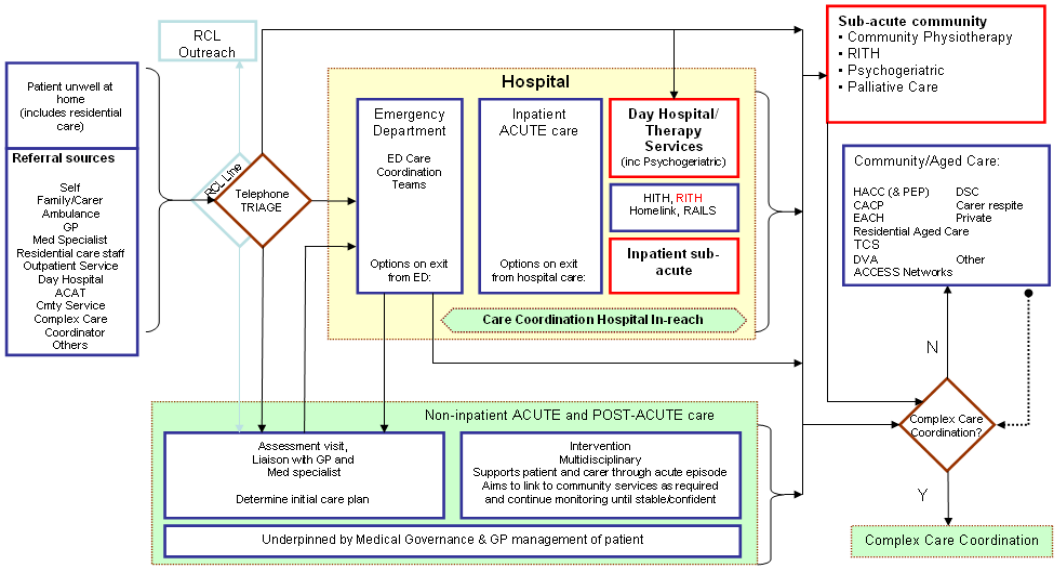
SERVICE LINKAGES

The Plan seeks to strengthen those points on the existing continuum of care that demonstrate reduced interface with the rest of the continuum. These points initially include areas of ambulatory care, community-based rehabilitation and Day Therapy/Day Hospital services.

Over the out-years of the Plan, the interfaces between the relevant points of the care continuum and subacute inpatient services (including GEM), psycho-geriatric and palliative care will be strengthened.

The strengthening of interfaces between identified subacute services and the rest of the care continuum afforded by the Plan will promote the independence of the health service user, reduce unnecessary hospital admission and enhance effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care.

Service Linkage across the care continuum:



CONSTRAINTS

1. Workforce

Planning to ensure an adequate workforce should focus on long term strategic workforce development that targets the subacute and ambulatory care workforce, both in the public hospital and diverse ambulatory care settings. It will need to involve specialist and other medical practitioners, specialist nurses and allied health workers.

Critical constraints are staff shortages that exist in the medical, allied health and nursing fields. In addition to the difficulty recruiting adequate numbers of staff, clinical leaders in allied health and nursing frequently describe challenges in attracting and retaining high quality staff.

Geriatric Consultant Physician workforce
Western Australia has been fortunate in past years to be able to progressively build the Geriatric Consultant Physician workforce.

However, full utilisation of newly trained specialists is vital for the future, to prevent 'brain drain' internationally and to the other states. There has been increasing demand for geriatricians to have greater responsibilities for liaison activities and acute medicine for older people and this has increased the need for an expanded medical workforce.

General practitioner involvement
General practitioner participation in the ambulatory care models has been minimal which has reflected both interest and training. It is clear that the opportunities to develop supportive training positions for general practice registrars are needed to services these gaps. In WA, there is now a dearth of GP training positions in geriatric medicine. There is a need to support and monitor such GP registrar positions.

Allied health
There are major problems in attracting suitable staff to fill specialist senior allied health positions and allied health support. Very often these staff have learnt on the job without support from other peers and professional clinical leaders. It is important that senior nursing and allied health positions are tied to a clinical training function to mould the clinical leaders of the future.

Western Australian Proposal

The formation of the **Geriatric/Rehabilitation Clinical Training Unit is seen as a solution to these challenges**. This unit will have a mandate to create, foster and support suitable training positions for medical (both specialist and GP), nursing and allied health through the inpatient and ambulatory care components of the subacute system of Western Australia. (This proposal is included in **Table One**).

The Unit will be responsible for assisting in the creation of training positions and liaison with the appropriate professional groups and local administrative arrangements.

Further, **ambulatory care hubs** will be established to further expand and enhance undergraduate and postgraduate allied health training and development. These hubs will link in closely with the Clinical Training Unit to ensure appropriate modules and experiential learning. It is proposed to have a number of hubs to be supported by the subacute care strategy.

There will be capacity for outreach training services to WACHS regional resource centres with professional exchange programs at identified sites. The services offered by the Clinical Training Unit will particularly benefit the "ambulatory care hubs" as there is much opportunity for outreach training services across the WACHS allied health sector.

Rural Western Australia
At present the development of training opportunities is hindered by the lack of a specialised workforce. It is now proposed that the new positions in the major rural centres will have a training function from the outset and will allow the development of local clinical leaders, who will be supported by the Clinical Training Unit.

2. Cultural constraints to practice change

Education and training across the sub-acute care rehabilitation sector will be an effective solution in addressing cultural constraints to practice change. In addition, the availability of additional in-patient allied health resources, and a focus on early supported discharge programs with adequate resourcing will diversify the type of rehabilitation services in WA.

3. WA Hospital building programs

The WA Subacute Care Plan has been developed in parallel with the WA Clinical Services Framework 2005-2015 and the building programs contained within this framework. No new building programs with an impost to the state have been identified for the WA Subacute Care Plan. Funding will be targeted to support existing programs and services and using existing infrastructure particularly with respect to in-patient hospital beds. Minor equipment and refurbishment improvements will occur on a case by case basis.

The Subacute Care Plan will inject additional workforce resources into existing programs and services. It is anticipated that this will support equity of access to the $48.6 million over the four year timeframe, and contribute to extend the capacity of the funding as much as possible.

This strategy will also support an effective in timely achievement of the commitments made in the WA Plan.

REPORTING AND ACCOUNTABILITY REQUIREMENTS

WA Data Collection Improvement Initiatives

This section describes the WA strategies to meet the quality and data improvements.

In submitting the WA Subacute Care Plan, WA recognises there are a range of issues relating to the quality of some data collections related to rehabilitation activity across the continuum of care.

Admitted, inpatient data collections are well developed across the WA public health system. Electronic reporting occurs in a systematic and well-coordinated manner, according to standard definitions required by the WA Hospital and Morbidity Data System.

Strengthening the area of accurate definitions of an inpatient acute care episode and the point in transition to a subacute rehabilitation care episode will be the focus of the improving accountability requirements of the WA Plan.

The area of non-admitted patient data collection will require a co-ordinated effort to improve. Data collection platforms vary and there are inconsistencies in data definitions.

There are discrete data collection systems for specific rehabilitation programs that collect data relevant to the required Key Performance Indicators under the National Health Partnership Agreement. It will be a key focus of the WA Plan to develop such collections in a co-ordinated and systematic way.

In view of the constraints with respect to data collection, WA has established a strong platform for in-patient rehabilitation activity. This is supported by a department wide “Operational Directive” which describes the mandatory reporting requirements for rehabilitation episodes of care in WA public hospitals and outlines the program approach for rehabilitation care services.

In addition the “Operational Directive” outlines the reporting requirements for functional outcome measures using the Functional Independence Measure (FIM), Functional Assessment Measure (FAM) and a version of the Barthels Index.

It includes guidelines for the management, classification, costing, and functional measurement of rehabilitation episodes. WA Functional Impairment Groups (WAFIG) is included in the collection and reporting processes streamlined.

These reporting requirements are mandatory for all public hospitals, and for services provided on a contract basis to public rehabilitation patients in private hospitals.

WA rehabilitation services have commenced in part to electronically record agreed multidisciplinary care plans. This initiative will be supported through the WA Plan to promote quality and continuity of care for patients.

This will serve as strong starting point in which to meet the Key Performance Indicators as required under Schedule C of the National Health Partnership Agreement.

Through funding allocated through the National Health Partnership Agreement, WA will also employ additional staff to concentrate on the improvement of non-admitted data collections across the public health sector. Such resources will be utilised to develop systems to report at national level in a timely manner.

Contribution to Collaborative Jurisdictional Work

This section describes WA's proposed contribution to collaborative jurisdictional work to developing national measurement protocols, benchmarks, definitions and performance indicators in subacute care as per the requirements of Schedule C.

TABLE 1. SUBACUTE PLAN – DEPARTMENT OF HEALTH WESTERN AUSTRALIA

Key Performance Benchmarks of Schedule C

Annual increase in provision and improved mix of subacute care services for hospital and out-of-hospital care.

Role of State	Key Deliverables for State Implementation Plan	Timing	Expected effects on Performance Benchmarks
REHABILITATION			
Deliver enhanced provision of subacute care services in both hospital and community settings	Increase in service delivery levels and diversification of ambulatory care "Day Therapy" services in 9 metropolitan sites, this will also include rehabilitation services for the younger patient (<65 years)	Service expansion 2009-10 for full enhancement by 2013	WA Health's rehabilitation services in both hospital and community settings will contribute towards achieving the performance benchmark of 5% service level annual growth in each year commencing in 2009-10
	Increased rehabilitation in the home (RITH) in metropolitan area	Service expansion 2009-10 for full enhancement by 2013	The performance improvement will be measured by an increase in activity for the following years across the state.
	Expand specialist medical services for amputees	Commence 2009-10	2009/10 13,180 00S 2010/11 28,996 00S 2011/12 36,904 00S 2012/13 42,176 00S

	Support the development of secondary stroke units in North and South Metropolitan Area Health Services using existing infrastructure with the provision of additional dedicated allied health, physician support with commitment to early discharge program into the community Establish a visiting consultant geriatrician/neuroscience specialist service for Parkinson's Disease for Bentley Hospital Re-establish Parkinson's Disease inpatient service at SMAHS (Fremantle Hospital) Expand community allied health services to support chronic disease models of care; for example COPD, Stroke, Heart Failure, Diabetes, Falls and Spinal Pain Establish community allied health primary care services from the 2 jointly funded "Super Clinics" at Midland and Wanneroo to support ambulatory rehabilitation and chronic disease utilising the Models of Care	Commence 2010-2012 for full implementation by 2013 Commence 2010-2011 Commence 2009-10 Commence 2011-12 Commence 2012-13	An improvement in patient outcome measures using existing functionality measures of (FIM, FAM or Barthels Index) as per DOH Operational Directive An improvement in patient quality and continuity of care (measured by evidence of agreed multidisciplinary care plans) will continue to be expanded across metropolitan Area Health Services and WACHS

Work towards achieving annual service growth targets, with a particular focus on the types of subacute care most needing expansion; and on regional areas with the greatest need for enhanced services	Establish rehabilitation in- patient services in Bunbury, Kalgoorlie and Geraldton using existing infrastructure with the provision of additional allied health, physician support with commitment to early discharge program into the community Establish a RITH service selected WACHS centres of Bunbury and Geraldton Establish "Day Therapy" services in key WACHS regional resource centres Geraldton, Bunbury, Kalgoorlie and Albany Expand the visiting consultant geriatrician service to WACHS. Included in the expansion will be psycho-geriatrician, rehabilitation nurse and allied health professionals Establish a Geriatric/Psycho-geriatric Rehabilitation Clinical Training Unit to create, foster and support training positions for medical, nursing and	Commence 2010-12 full implementation by 2013 Commence 2010-12 full implementation by 2013 Commence 2010-11 full implementation by 2013 Service expansion 2010 full implementation by 2013 Commence 2011-12 full implementation by 2013	As above

	allied health. In addition a work rotation placement will be built into the Unit Establish a 'hub' at WACHS regional resource centres supported by Rehabilitation, Geriatric and Psychogeriatric metropolitan 'hubs' to provide expertise, training and professional support	 Commence 2010-11	
Actively participate in national coordination of this initiative and support governance structures	WA currently reports national minimum dataset information on rehabilitation services WA has nominated a participant as a member of the Subacute Care Measurement Working Party WA is a participant on the National Health Information Statistics and Standards Committee and through this group will work with all jurisdictions to resolve definitional matters around subacute non admitted care WA is a participant in the National Subacute Care Working Group	 Commence July 2009 for completion December 2009 Commence February 2009 completion 2013	WA has demonstrated its agreement to the targets and will participate in the national benchmarking exercise WA has agreed to publicly report on its performance against the annual growth targets

Role of States	Key Deliverables for State Implementation Plan	Timing	Expected effects on Performance
GERIATRIC EVALUATION & MANAGEMENT (GEM)			
Deliver enhanced provision of subacute care services in both hospital and community settings	Increase in service delivery levels and diversification of ambulatory care "Day Therapy services in 9 metropolitan sites, this will provide the opportunity GEM services to be delivered in an outpatient setting Support the establishment of a GEM inpatient unit in South Metropolitan Area Health Service using existing infrastructure with additional allied health and physician support with commitment to early discharge program into the community	Service expansion 2009-10 for full enhancement by 2013 Establish 2011-12	WA Health's GEM services in hospital and community settings will contribute towards meeting the performance benchmark of 5% in each year commencing in 2009-10 The performance improvement will be measured by an increase in the following years in the metropolitan area 2009/10 2,976 00S 2010/11 6,547 00S 2011/12 8,333 00S 2012/13 9,523 00S An improvement in patient outcome measures using existing functionality measures of (FIM, FAM or Barthels Index) as per DOH Operational Directive

			An improvement in quality and continuity of care (measured by evidence of agreed multidisciplinary care plans) will continue to be expanded across the metropolitan Area Health Services and WACHS
Actively participate in national coordination of this initiative and support governance structures	WA currently reports national minimum dataset information on GEM services WA has nominated a participant as a member of the Subacute Measurement Working Party WA is a participant on the National Health Information Statistics and Standards Committee and through this group will work with all jurisdictions to resolve definitional matters around subacute non admitted care WA is a participant in the National Subacute Care Working Group	Commence July 2009 for completion December 2009	WA has demonstrated its agreement to the targets and will participate in the national benchmarking exercise WA has agreed to publicly report on its performance against the annual growth targets

Role of States	Key Deliverables for State Implementation Plan	Timing	Expected effects on Performance Benchmarks
PYSCHOGERIATRIC **Deliver enhanced provision of subacute care services in both hospital and community settings**	Co-location of psycho-geriatric beds with Parkinson's Disease beds in SMAHS (Fremantle Hospital) Psycho-geriatric services will be included in the Rehabilitation Training Unit that will foster and support training positions for medical and mental health nurses and allied health staff	Commence 2009-10 Commence 2011-12 full implementation by 2013	WA Health's psychogeriatric services in both hospital and community settings will contribute towards meeting the subacute benchmark of 5% in each year commencing in 2009-10 The performance improvement will be measured by an in increase for the following years across the state 2009/10 2,682 00S 2010/11 5,901 00S 2011/12 7,510 00S 2012/13 8,583 00S
Work towards achieving annual service growth targets, with a particular focus on the types of subacute care most needing expansion; and on regional areas with the greatest need for enhanced services	Psycho-geriatrician services will be included in the Consultant Geriatric visiting service to WACHS Senior Mental Health professions with skills and expertise in older mental health conditions will form part of the 'hub' at WACHS regional resource centres	Commence 2010 with full implementation by 2013 Commence 2010-11	As above

Actively participate in national coordination of this initiative and support governance structures	WA currently reports national minimum dataset information on mental health services of which psychogeriatric care is a sub set WA has nominated a participant as a member of the Subacute Care Measurement Working Party WA is a participant in the National Subacute Care Working Group	Commence July 2009 for completion December 2009	WA has demonstrated its agreement to the targets and will participate in the national benchmarking exercise WA has agreed to publicly report on its performance against the annual growth targets

Role of State	Key Deliverables for State Implementation Plan	Timing	Expected effects on Performance Benchmarks
PALLIATIVE CARE **Deliver enhanced provision of subacute care services in both hospital and community settings** **Work towards achieving annual service growth targets, with particular focus on the types of subacute care most needing expansion; and on regional areas with the greatest need for enhanced services**	Implementation of an evidence-based training package for palliative care that focuses on the transition between hospital to residential care and from residential care to hospital. This will occur state-wide through established palliative care networks in the metropolitan area and WACHS Support the training of community palliative care Registrar position in NMAHS. This will support adequate specialist palliative care medical workforce in WA and allow other specialists in training to experience community care e.g. oncology trainees	Commence 2010 with full implementation 2012 Commence 2009-10	WA Health's palliative care services in both hospital and community settings will contribute towards meeting the subacute benchmark of 5% in each year commencing in 2009-10 The performance improvement will be measured by an increase in the following years across the state 2009/10 2,809 00S 2010/11 6,180 00S 2011/12 7,865 00S 2012/13 8.989 00S
Actively participates in national coordination of this initiative and support governance structures	WA currently reports national minimum dataset information on palliative care services WA has nominated a participant as a member of the Subacute	Commence July 2009 for completion	WA has demonstrated its agreement to the targets and will participate in the national benchmarking exercise WA has agreed to publicly report on its performance against the annual growth

	Care Measurement Working Party WA is a participant in the national data collection of the Palliative Care Outcomes Collaboration (PCOC) WA is a participant in the National Subacute Care Working Group	December 2009	targets

APPENDIX A

WA CONTEXT FOR REFORM IN SUBACUTE CARE SERVICES IN WA

BACKGROUND

Existing Planning Frameworks

1.1 WA Health Clinical Services Framework 2005-2015

The Clinical Services Framework (CSF) is the strategic planning framework for the development and provision of health care services for WA over the period 2005-2015. It has been developed on the basis of a rigorous population projection analysis and identified areas of need for services.

The WA Department of Health has remained committed to the long term reform process outlined in the CSF since the final recommendations of the Health Reform Committee (the "Reid Review") were published in 2004.

One of the key drivers in the work of the Health Reform Committee (HRC) was the trend in the increasing number of aged care patients and patients with chronic and complex conditions and their increased care needs both in the medium to longer term.

The Committee highlighted the need for innovative models that concentrated on shifting health care away from the acute hospital setting to secondary and ambulatory care settings where appropriate.

1.2 WA Health Clinical Services Framework Role Delineation

The WA CSF identifies role delineation and service level definitions for tertiary, secondary, general and rural hospital services. The role and service type for each health service in WA is based on the application of the following principles and data including:

- providing care closer to where people live
- ensuring accessibility across the metropolitan area and country regions
- developing networked clinical services across the metropolitan area, with rural links
- supporting the Area Health Service concept
- projected future demand for services
- projected future population growth and demographic trends
- impact of reform initiatives

1.3 Hospital Delineation - Metropolitan

In the metropolitan area, the WA CSF identifies four levels of hospitals; tertiary hospitals, general or secondary hospitals, specialist hospitals and other hospitals.

General Hospitals
In the context of subacute care, this level of hospital incorporates general medical and geriatric services, some rehabilitation and mental health services and a centre for diagnostics, treatment and ambulatory care.

Specialist Hospitals
This level of hospital will focus on mental health, aged care and rehabilitation services. They will also retain some day/ambulatory medical and surgical services.

The WA CSF has defined the roles for these levels of hospitals and as such, the WA Subacute Care Plan has largely been defined and informed by this role delineation. The focus of the WA Plan will, thus, be aligned with future service provision and activity designed for General Hospitals and Specialist Hospitals.

A key strategy identified in the CSF is the strengthening of hospital in the home and other ambulatory care programs to improve access and the range of health services offered to the community in order to decrease demand on inpatient care.

1.4 Hospital Delineation – WA Country Health Service (WACHS)

The basis for the planning for health services in regional areas of WA is a network of health services based on a "hub and spoke" concept with Regional Resource Centres as the centres for acute services.

The Regional Resource Centres will provide outreach services to lower level Integrated District Health services. Health services in smaller towns and communities have been designed to provide age care and appropriate community-based services.

The development of WA Subacute Care Plan has taken account of this configuration of service delivery.

1.5 Clinical Health Networks and Models of Care

The reform process identified in the Reid Review called for the development of "appropriate models of care" and 'a more defined continuum of care across levels of care"[1], either for specific clinical areas and/or population groups.

[1] Page 2, WA Health Clinical Services Framework 2005-2015. Department of Health. WA. 2005.

In WA, a key vehicle for the development of alternative models of care has been the establishment of Clinical Health Networks and the development of “Models of Care” across the continuum.

WA has been pro-active in the establishment of Clinical Health Networks and is now in the fortunate position to utilise the completed the Models of Care to inform the development of the WA Subacute Care Plan 2009-2013.

The Model of Care documents that align with the provision of subacute care service delivery are at Appendix C.

APPENDIX B: REPORTING AND ACCOUNTABILITY REQUIREMENTS

As agreed in the National Partnership Agreement on Hospital and Health Workforce Reform, Western Australia will:

1. review this plan at least at least biannually to take account of emerging issues (unless otherwise agreed nationally);

2. participate in national arrangements established to address:
   - enhanced provision and mix of subacute care services, with a particular focus on the types of subacute care most needing expansion and on regional areas with the greatest need for enhanced services;
   - quality and data improvements through agreed models of care, including improved data collection and reporting arrangements; and
   - strengthened capacity of the multi-disciplinary subacute care workforce; including improved geographical distribution, an increase in the supply of the workforce and development new workforce models.

3. provide agreed data to the to the Commonwealth—including performance information as set out in the National Partnership agreement—and participate in work with national data collection agencies to collect and evaluate data on subacute care;

4. publicly report (in a nationally agreed format) on its performance against the annual growth targets for subacute care published in this plan. The first report will measure the first 6 months of progress (June-December 2009) while subsequent reports will measure progress over a full financial year. The report will be published on the WA Health website.

Western Australia will work with the other States and Territories and the Commonwealth to achieve national agreement on improved measurement and data for subacute care including an auditable method for measuring growth in service provision for subacute care.

Western Australia will nominate and support representatives on a Subacute Care Measurement Working Party to steer the following stages.

1. Define the measures and data required to report the Subacute NPA performance indicators;

2. Develop and agree data item definitions;

3. Undertake a cost study to establish suitable conversion ratios to enable annual growth in services to be measured for:

   - both hospital and community-based services,
   - each of the four care types; and
   - subacute care as a whole.

The conversion study is to develop resource weightings to be used to:

- establish new baselines for reporting from 1 July 2010; and
- measure growth against those baselines.

4. Identify suitable benchmarks for all subacute care types.

5. Develop business cases for the addition of new data items to existing National Minimum Data Sets (NMDSs) for ongoing reporting.

APPENDIX C:
MODELS OF CARE

WA Department of Health - Model of Care Documents Sourced

Aged Care Health Network

- Rehabilitation and Restorative Care Services for the Older Person
- Geriatric Evaluation and Management
- Ortho-geriatric Care Services for the Older Person
- Parkinson's Disease Services
- Amputee and Rehabilitation Services for the Older Person
- Dementia Model of Care
- Delirium Model of Care

Falls Network

- Falls Model of Care

Neurosciences and Senses Network

- Stroke Model of Care for Western Australia

Diabetes and Endocrine Health Network

- Diabetes Model of Care

Cardio-vascular Health Network

- Heart Failure Model of Care

Respiratory Health Network

- Chronic Obstructive Pulmonary Disease

Palliative Care Network

- Palliative Care Model of Care

Musculo-skeletal Health Network

- Spinal Pain Model of Care

APPENDIX D:
SUBACUTE CARE SERVICES – WA ENVIRONMENTAL SCAN

General Statement

The following narrative outlines the scope of services provided in the subacute care sector across the continuum of inpatient, outpatient and ambulatory and community care services.

They are described in the context of the National Health Partnership Agreement, Schedule C; rehabilitation, GEM, psycho-geriatric care and palliative care.

Health Services across the state, have developed step down and rehabilitation services to varying degrees in order to reduce length of stay, prevent admission and provide supported discharge to reduce rates of re-admission. A shift towards ambulatory and community based services in recent years has demonstrated a sustainable and clinically reliable service.

1. Community based sector – Home and Community Care Program

1.1 Wellness Approach to Community Care

The primary focus of the WA HACC Program continues to be the provision of basic support and maintenance services to the HACC target group.

However, since 2006 the WA HACC Program has adopted the concept of a wellness approach to community home care as its policy position for future growth in service delivery. The WA HACC Program has continued with the wellness approach to home care as an underlying element to all aspects of the Program.

Two key objectives were identified for the development and implementation of the wellness approach:

- to facilitate, across the WA HACC sector, a reorientation from a predominantly dependency based service model towards a wellness service model.
- to ensure that the model could be implemented by service providers regardless of their organisational structure.

The successful implementation of a wellness approach requires a change in mind set in the way in which many HACC service providers deliver their home care services. This process not only encompasses changes in work processes and practices, but also the enhancement and development of staff skills to be able to implement and operate effectively within a wellness service model.

The wellness model reflects two main principles:

- People want to retain autonomy and build capacity, which in turn has a positive impact on their self esteem and ability to manage day to day life; and
- "Independence" is not limited to physical functioning but extends to social and psychological functioning.

Since early 2006, The Aged Care Policy Directorate has contracted the training arm of the HACC program to provide training to service providers on this approach.

The "WELLNESS" team at Community West has worked closely with a number of WA HACC service providers to support them to effect change and implement wellness. This has included the development of formal training, ongoing peer support and practical resources to enhance staff skills.

1.2 Personal Enablement Packages

PEP is an innovative service delivery model within the HACC program. It commenced as a pilot in January 2003 and is now mainstreamed. The service aims to achieve a positive outcome for the HACC client by maximising their level of independence following an acute episode of care in a metropolitan hospital.

Rather than providing maintenance care the service achieves these outcomes by moving from a purely maintenance model to an enabling care model. The service is only available to HACC eligible clients and provides individually tailored therapy based packages delivered in the client's home.

The benefits of PEP include:

- ability to put required services in place at short notice (including allied health, nursing & home care);
- ability to plan and negotiate decreasing service requirements over the period of the package;
- dependable mode of delivery;
- an ability to increase and decrease service levels based on clients condition and progress; and
- an ability to build client confidence back to independence.

For 2006/2007, a total of **1417** clients were provided with an Enablement Package. For 2007/2008, a total of **1,692** clients received an Enablement Package.

The program contributes to the reduction in the length of stay in the hospital sector and reduction in the demand for long-term care.

2. Residential Aged Care Sector Transition Programs

2.1 Transition Care Program

WA has been pro-active in the progressive implementation of the Transition Care Program across the state. This has been largely characterised by the implementation in the metropolitan region in the early years, with a progressive move to gradual implementation in rural regions of WA.

The WA Transition Care Program 2007 - 08 to 2011-12 approved by the Australian Government, incorporates the essential elements of the continuum of services for older people and focuses on their transition from hospital to home.

The program reflects the directions of the Reid Review, with recommendations relating to Transition Care Services subsequently incorporated within the WA Clinical Services Framework 2005-2015. It also reflects considerations of the *National Framework for the Care of Older Australians* developed by the Australian Health Ministers Advisory Council's Care of Older Australians Working Group.

Private providers, subcontracted to the WA Department of Health have been selected through an open tender process to provide the service across metropolitan and rural areas.

Mandatory criteria dictate the use of a multi-disciplinary team approach with the core disciplines of GP, Nursing, Physiotherapy and therapy assistants, Occupational therapy and therapy assistants, and Social work.

Prior to the 2007/08 - 2011/12 allocation, there were 178 Transition Care Service (TCS) places in WA of which 60 are in the rural regions of the South West, Great Southern and Midwest.

WA received an additional of 186 places over the four years 2007/08 to 2011-12, the first 18 of which are now operational.

2.2 Care Awaiting Placement Program – redirection to rehabilitation focus.

Since 2001, WA has operated a Care Awaiting Placement Program for elderly patients who have been assessed as being eligible for a residential aged care place. The total number of places for this program reached 254 in 2008/09 with funding totalling $25 million.

The Aged Care Policy Directorate is now moving towards redirecting the focus of this program to an extended transition care program to offer a pathway for those older people who can benefit from the maintenance and therapeutic aspects of transition care and who are required to wait for permanent residential care.

The policy framework that supports this approach includes:

- Appropriate discharge planning, with good communication between hospitals, general practitioners (GP), community care providers and family enables older people to be discharged from hospital to community with adequate support; and

- Access to rehabilitation and an appropriate level of community support to enable a return to independent living may avoid unnecessary placement in residential care, or, if unavoidable, at a lower level of care need.

3. Ambulatory and Community Care Programs – Rehabilitation Focus

3.1 Day Hospital Centres/Therapy Centres

The majority of Day Hospitals/Therapy Centres operating in WA are managed by, and located in, metropolitan Departments of Geriatric Medicine. A smaller number of Day Therapy services in rural regions operate under the aegis of Primary Health within the local health service.

WA Day Hospital/Therapy Centres provide specialised and generic rehabilitation services to an outpatient or non-admitted population using both individual and small-group client service delivery models.

Day Hospitals/Therapy Centres service clients with a broad range of care acuity levels, ranging from those who are recently post-acute with intensive rehabilitation needs, to those with chronic diseases requiring education and time-limited step-down rehabilitation. Clients are drawn primarily from the 65 years and over age group.

Assessments and treatment interventions are provided in a centre-based setting, and in a significant number of cases provide a diversion from acute care. Services are led by consultant geriatricians, senior registrars, while the multi-disciplinary care plan is implemented through the assistance of registered and enrolled nurses, physiotherapists, occupational therapists, therapy assistants, social workers, speech therapists, dieticians and podiatrists. The majority of referrals come from GP’s and from acute hospital services.

Currently this type of GEM activity is not differentiated in the data collection processes and is contained in the total non-admitted rehabilitation activity. WA will seek to improve this process.

There are nine Day Hospitals/Therapy Centres currently operating in WA; eight in the Perth metropolitan area, and 1 in rural WA.

Day Hospital/Therapy Centre activity in the 2008 calendar year included 53,463 attendances. Evidence is also now available to demonstrate that an increasing referral pattern to such centres is now occurring directly from Emergency Department Care Co-ordination Teams referrals. These Teams are funded through the COAG Long Stay Older Patient Initiative in WA.

A recent review of Day Hospital /Day Therapy Centres conducted by the Aged Care Policy Directorate indicates potential for expanded and diversification of services offered from these sites.

3.2 Rehabilitation in the Home Program – RITH

The RITH program in WA is confined to the metropolitan area with a dedicated program focus in the south metropolitan region area health service (SMAHS). Some similar services are provided in the north metropolitan region, but are in the developmental stage.

The SMAHS RITH program is an early discharge, hospital substitution allied health service that has 2 tertiary hospital bases. The program accepts referrals from all hospitals in the SMAHS and also accepts cross referrals from the North Metropolitan Area Health Service for clients living in the SMAHS catchment area.

Therapy is provided to clients in their own home by physiotherapists, occupational therapists, speech therapists, social workers, dieticians, clinical psychologist and therapy assistants. Clinical governance is provided through a consultant geriatrician and senior registrar input.

In the 2008 financial year:

- the major referring specialities included General Medicine (22%), Geriatrics (21%) Neurological/Stroke/NSRG (17%) and Orthopaedics (20%)
- the age of clients ranged from 33% under 65 years to 66% over 65 years
- the top five occasion of service DRG's were stroke, falls, fractured NOFs, TKR and general fractures.

Over the 2008 financial year the RITH program provided rehabilitation therapy to 2673 patients with an average representation rate to hospital of 6.67%.

3.3 Community Physiotherapy Services (CPS) - Perth Metropolitan Area

The Community Physiotherapy Services (CPS) provides rehabilitation programs designed to maximise functional ability and minimise the impact of chronic disease and related secondary complications.

Programs are developed for chronic conditions that have been identified in the research literature as benefiting from physical activity and/or specific rehabilitation programs. Clinical interventions follow condition specific evidence based best practice guidelines.

Programs include falls prevention /balance and mobility, orthopaedic rehabilitation (pre and post intervention), functional rehabilitation which emphasises slow steam rehabilitation and maintenance to prevent functional decline, stroke and Parkinson's disease, cardio-vascular and respiratory rehabilitation.

New program development is aligned with recommendations included in the Clinical Health Networks Model of Care.

All programs are group based, staffed by Senior Physiotherapists and located in community venues throughout the Perth metropolitan area.

Referrals are generated from the following sources:

- Tertiary and secondary hospital discharges
- Outpatient clinics
- Non-inpatient services (hospital in the home (HITH) and rehabilitation in the home (RITH)
- Chronic Disease Management Teams
- ABHI projects
- Divisions of General Practice
- Private and public medical and allied health practitioners

A completed Community Physiotherapy Services Referral/Medical form is required to participate in the program.

In 2007-2008 CPS activity indicated there were:

- 5000 clients
- 1713 new referrals
- 180 classes per week across the metropolitan area
- 35% of clients had multiple chronic conditions and complex needs

In 2007-2008, there was a demonstrated trend in increasing numbers of referrals from tertiary hospital emergency department departments through the COAG Long Stay Older Patients Initiative.

4. Dedicated Inpatient Aged Care Services Sub-acute Care Programs

4.1 Geriatric Evaluation and Management (GEM)

The GEM inpatient unit at Royal Perth Hospital (RPH) provides the only dedicated inpatient GEM model of care in Western Australia. This unit has been successfully operating since 22 July 2002 when the service commenced as part of a National Demonstrations Hospital Pilot (NDHP) Phase 4.

The distinguishing feature of this model is the early application of the principles of geriatric care during the inpatient care continuum. The role of the geriatrician and the multi-disciplinary team is involved at a much earlier stage.

Potential patients are referred to GEM from most acute areas of the hospital after their acute problem is resolved or are in the process of resolving (this usually is 1-3 days after the medical condition has stabilised). Referrals are mostly made by medical staff and increasingly by physiotherapists and occupational therapists.

Suitability of the patient for the GEM unit is determined following assessment of the older person by a Geriatrician, a GEM Unit Registrar or GEM Clinical Nurse Specialist in consultation with a Geriatrician or Registrar. It is also possible that a suitably experienced occupational therapist and/or physiotherapist is also able to carry out the assessment.

The key aims of the clinical pathway are:

- to provide rapid and early access to rehabilitation for elderly people
- increased access to geriatric inpatient care for elderly people across the hospital
- improved liaison with other specialists and General Practitioners
- improved discharge planning with linkages to the community care sector and outpatient based patient services.

As geriatric assessment, treatment and rehabilitation are core to the unit, the team includes the following components:

- geriatrician (registrar and resident medical officer/intern),
- nursing coordinator
- social worker.
- registered and enrolled nurses
- physiotherapist
- occupational therapist

Other professionals are consulted to assist with specialist needs. This may include but is not limited to speech therapy, dietician, podiatry and psychiatry.

In rural and remote areas where access to geriatricians and geriatric trained staff may be limited due to the use of technology, video and telephone conferencing can be utilised to access geriatric and rehabilitation specialist input. This access can support an established dedicated medical team in providing the treatment and management philosophy and skills needed for the model.

The RPH NHPR demonstration pilot 2004 demonstrated a reduction of 14 days in average length of stay from admission to discharge from a secondary level aged care rehabilitation unit with a GEM intervention.

A reduction in the average length of stay of 7 days was also demonstrated for those who were discharged directly from the GEM unit and did not progress to a secondary level aged care rehabilitation unit.

RPH continues to achieve reductions in average length of stay for assessed patients suitable for GEM intervention.

4.2 In-patient sub-acute rehabilitation

Rehabilitation services are provided at all hospitals across WA. The bulk of the activity occurs in the metropolitan area across eleven hospital sites. Activity data is collected for each of the sites for all rehabilitation episodes, with specific activity for fractured neck of femur and stroke.

Apart from specialist rehabilitation at a dedicated tertiary level hospital site, dedicated rehabilitation units/programs are not available for the bulk of stroke, amputee and orthogeriatric episodes at secondary level hospitals, but are incorporated in a general rehabilitation service offered at the hospital.

Where possible, inpatient units strive to provide specific condition related rehabilitation services.

For 2007-2008, WA HMDS DRG data indicates that for rehabilitation DRG's related to orthopaedic/amputee rehabilitation, neurological/stroke rehabilitation, general rehabilitation and conditions that require rehabilitation (for example; chronic obstructive airways disease, knee replacement and reattachment) consistently appear in the top five DRG groupings for lengths of stay ranging from 4 days to 36+ days. (This DRG activity relates to the 65+ and ATSI 45+ years age groups).

Research evidence utilised for the development of Models of Care documents also indicates that a large proportion of rehabilitation for rural patients from WA Country Health services occurs in the metropolitan area. This is particularly so for amputee rehabilitation, stroke and ortho-geriatric rehabilitation where access to specialist clinician services are necessary.

The WA Subacute Care Plan 2009-2013 will seek to strengthen these gaps in services and link them to downstream rehabilitation related programs.

5. Psycho-geriatric Care

There are large gaps in the WA's existing psychogeriatric services. These services are not sufficient or appropriately distributed to meet existing needs or the needs of a rapidly expanding population of older adults.

In areas where well-functioning psychogeriatric services are collocated with ACATs or geriatric medicine departments there are widely recognized clinical and systemic benefits (see RANZCP guidelines/position statement) achieved through clinical collaboration and cross consultation.

In areas where psychogeriatric services are absent or inadequate the clinical burden of managing behavioural disturbances in dementia, depression, delirium and other mental disorders falls mainly to primary care, general hospitals, aged care and residential care providers rather than adult mental

health services. There are then adverse effects on patient flow (e.g. increased ED attendances and lengths of stay in general hospitals) as well as increased morbidity and mortality.

The key gaps in sub-acute psychogeriatric services in WA are:

1) Most rural and remote regions have negligible human resources allocated to psychogeriatric care. This is despite the southwest region, for instance, having an elderly population of 17,614 in 2006, which would justify a full multidisciplinary team (6.0 FTE) in a metropolitan area.

2) Some of the rural areas have a fly-in psychogeriatric service supplemented by teleconferencing, but these arrangements are patchy and inconsistent with no consistent model of care, linkages to metropolitan resources or sustainable funding.

3) Patients from WACHS regions who require admission to specialist psychogeriatric facilities in the metropolitan area have difficulty accessing beds partly because there is a lack of local psychogeriatric services and partly because there is not a clear relationship between metro and rural services with respect to inpatient admissions.

4) Several of the existing metropolitan psychogeriatric services are not collocated with geriatric medicine or ACAT services as recommended by the joint position statement by RANZCP and Australian Society of Geriatric Medicine Physicians. This results in inadequate integration of the psychogeriatric services with mainstream healthcare and lost opportunities for collaboration and optimization of service delivery and continuity of care.

5) Psychogeriatric expertise is not available in some of the key aged care services where there is need for patient-centered collaboration: e.g. memory clinics and Parkinson's disease clinics and day therapy services.

The WA Plan recommends that that the most strategic use of additional funds for sub- acute care in psychogeriatric care would be to provide sustainable psychogeriatric services in rural and remote regions and clear processes for psychogeriatric admissions from rural areas.

6. Palliative Care

The public health cancer care sector has been the recipient of targetted funding of $6 million per year over the last 4 years through state government funding streams. Included within this strategy has been the enhancement of palliative care services.

A recurrent budget commitment of $7 million has also been made for 2009/2010. On this basis, WA has chosen to direct funding from the National Hospital and Health Workforce Partnership Agreement to areas of need where additional resourcing is required and therefore only limited areas of need are therefore targetted.

In addition, the Silver Chain Nursing Association has received increased state only funding over the last 2 years for community based palliative care services.

APPENDIX E: WA COAG NHPA SUBACUTE CARE PLAN BASE LINE ACTIVITY 2007-08 DATA

National Partnership Agreement on Hospital and Health Workforce Reform : Schedule C - Subacute care

Template for subacute care baseline activity, using 2007-08 data

	Type of care				
	Rehabilitation	Psychogeriatric	Geriatric Evaluation and Management	Palliative	Totals
Patient days (volumes)	***Admitted (#)***				
Hospital based	148778	34363	5713	23144	211998
Hospital in the Home	20839	na	na	na	20839
Combined Hospital based & HITH	169617	34363	5713	23144	232837
Other (please specify)					
Total admitted patient days	169617	34363	5713	23144	232837
Separations (patients)					
Hospital based	8773	716	617	2619	12725
Hospital-in-the-home	1690			na	1690
Combined Hospital based & HITH	10463	716	617	2619	14415
Other (please specify)					
Total admitted separations	10463	716	617	2619	14415

			Non-admitted		
Occasions of service (volumes)					
Centre based	395266	53991	na	na	449257
Home based	utd	10393	na	70448	80841
Combined Centre & Home based	395266	64384	na	70448	530098
Other (please specify)					
Total occasions of service	395266	64384	na	70448	530098
Episodes (patients)					
Centre based	utd	4987	utd	na	4987
Home based	utd	2083	utd	4498	6581
Combined Centre & Home based	utd	5041*	utd	4498	9539**
Other (please specify)	utd	utd	utd	utd	utd
Total episodes	utd	5041*	utd	8996	9539**
Total group sessions	utd	17431	utd	utd	17431

Notes and definitions

Note: The data should include only the care types specified. Do not include Transition Care or Maintenance care.

Please do not record services as both group and individual services.

Where possible it is expected that the National Health Data Dictionary V14 Definitions will be used.

NHDD v14 definitions are at http://www.aihw.gov.au/publications/hwi/nhddv14/nhddv14.pdf

Data item	Meteor ID or other definition
	Admitted
Admitted patient	268957
Separations	270407
Care type	270174
Patient day	270045
Hospital-in-the-home	327308
	Non-admitted
Non-admitted patient	268973
Episode Group Session	As a first draft, see Victorian definitions at http://www.health.vic.gov.au/hdss/vinah/2007-08/vinah_sect2.pdf
Care type	270174
Occasion of Service	313837

Notes:

1. All data are preliminary and subject to change. See Note 7 in regard to non-admitted data.
2. utd - unable to be determined
3. na - not available or not applicable
4. # Admitted data also includes public patients at private hospitals under contractual arrangements in addition to public hospital activity. Inpatient data are sourced from the WA Health inpatient data Collection (Hospital Morbidity Data Collection).
5. * Patients may be included in both centre based and home based counts but the Total episode count includes each patient only once.
6. ** See previous comment. Total patients includes each psychogeriatric patient once only.
7. Non-admitted rehabilitation data are sourced from counts information only and have not been validated through comparison with unit records. Therefore data may be subject to significant change and should not be considered to be of sufficient accuracy to be even indicative of the correct figure.

NATIONAL PARTNERSHIP AGREEMENT ON HOSPITAL AND WORKFORCE REFORM -- Subacute Care Reform
Plan to enhance subacute care services

Year	Patient Type	Admitted		Non-admitted		Combined totals	
	Unit of measure for services	Patient days	Equivalent OOS	Occasions of service		(OOS equivalents) (**)	
2008-09	2007-08 used as proxy	232,837	465,674	530,098	A	995,772	
2009-10	Targeted growth for year	1,012	2,024	19,623		21,647	
	Targeted growth %	0.4%	0.4%	3.7%		2.2%	
	Services in 2009-2010	233,849	467,698	549,721		1,017,419	
2010-11	Targeted growth for year	2,227	4,454	43,170		47,624	
	Targeted growth %	1.0%	1.0%	8.1%		4.7%	
	Services in 2010-2011	235,064	470,128	573,268		1,043,396	
2011-12	Targeted growth for year	2,834	5,668	54,944		60,612	
	Targeted growth %	1.2%	1.2%	10.4%		6.1%	
	Services in 2011-2012	235,671	471,342	585,042		1,056,384	
2012-13	Targeted growth for year	3,239	6,478	62,793		69,271	
	Targeted growth %	1.4%	1.4%	11.8%		7.0%	
	Services in 2012-2013	236,076	472,152	592,891		1,065,043	
	Total growth	9,312	18,624	180,530		199,154	**20.0%**

(**) Weighting between admitted patient days and non-admitted occasions of services = 2.0

Notes: Targeted growth for the year is the growth from the levels in the base year and targeted growth % is growth as a % of the base year.

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SIGNED FOR AND ON BEHALF OF THE GOVERNMENT OF WESTERN AUSTRALIA, DEPARTMENT OF HEALTH BY

(Signature)

Hon. Dr. KIM HAMES
DEPUTY PREMIER
MINISTER FOR HEALTH

___ April 2009

Delivering a **Healthy WA**

Government of **Western Australia**
Department of **Health**