

NSW Funding Guidelines for Rehabilitation and Extended Care 2004/2005

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Table of Contents

1. BACKGROUND	1
2. FUNDING POLICY	1
2.1 Scope of Rehabilitation and Extended Care Funding Guidelines	5
2.2 Overview of the NSW Rehabilitation and Extended Care Funding Model	6
3. SPECIFIC ISSUES IN THE DESIGN OF THE NSW REHABILITATION AND EXTENDED CARE FUNDING MODEL	8
3.1 Scope - an incremental approach to implementation	8
3.2 Classification issues	11
3.3 Funding model design	11
3.3.1 Per episode or per diem?	11
3.3.2 Trim points	12
3.3.3 Other payment issues	12
3.3.4 Costing issues	13
3.4 Data and payment issues	13
3.4.1 Consultation-liaison and how to fund it	13
3.4.2 Teaching and research and how to fund it	13
3.4.3 How to deal with inter-hospital transfers, re-admissions and program interruptions	13
3.4.4 How to pay for episodes in the AN-SNAP error class	13
3.4.5 How to deal with long episodes without a '90 day review'	14
3.4.6 Software required to implement the model	14
3.4.7 How to calculate length of stay	15
3.5 Peer Groups	16
4. NSW REHABILITATION AND EXTENDED CARE FUNDING MODEL GUIDELINES	17
4.1 Step 1 Determine In-Scope Services	17
4.1.1 Mandatory element/s	17
4.1.2 Area action - policy and management	17
4.1.3 Area action - activity analysis	17
4.1.4 Area action - financial	17
4.2 Step 2 Determine activity levels for 2004/2005	18
4.2.1 Mandatory element/s	18
4.2.2 Area action - policy and management	18
4.2.3 Area action - activity analysis	18
4.2.4 Area action - financial	18
4.3 Step 3 Determine activity budget	19
4.3.1 Mandatory element/s	19
4.3.2 Area action - policy and management	19
4.3.3 Area action - activity analysis	19
4.3.4 Area action - financial	19
4.4 Step 4 Model the implementation of Rehabilitation and Extended Care funding model	19
4.4.1 Mandatory element/s	19

4.4.2	Area action - policy and management	19
4.4.3	Area action - activity analysis	20
4.4.4	Area action - financial	20
5.	ONGOING DEVELOPMENT OF THE REHABILITATION AND EXTENDED CARE EPISODE FUNDING MODEL	22
6.	CONCLUSION.....	23
	APPENDIX 1.....	24
	NSW SNAP Implementation Steering Committee Members	24
	APPENDIX 2.....	25
	AN-SNAP classification and cost weights 2004/2005.....	25
	APPENDIX 3.....	27
	Hospitals funded under Program 4.1 and their status under the funding model	27
	APPENDIX 4.....	32
	The NSW benchmark for Rehabilitation and Extended Care and the methodology used to derive it.....	32
	APPENDIX 5.....	34
	Raw and cost-weighted hospital activity of hospitals included in the 2004/05 funding model	34
	APPENDIX 6.....	40
	Hospital cost data	40

LIST OF TABLES

Table 1	AN-SNAP class equivalents for patients treated in non-designated units	10
Table 2	AN-SNAP classification and weights	25
Table 3	Hospitals funded under Program 4.1 and their status under the funding model	27
Table 4	Benchmark cost data	33
Table 5	Reconciliation of 2002/03 activity data reported in SNAPshot and the HIE	34
Table 6	2002/03 Beddays by Case Type by Hospital.....	36
Table 7	Cost weighted admissions by hospital 2002/03	38
Table 8	Hospital costs and comparison to the 2004/05 benchmark	40

1. Background

These guidelines are the first issued by NSW Health for the episode funding of Rehabilitation and Extended Care services. Their background lies in the report of the NSW Health Council. The Health Council report recommended the implementation of a new method of funding. Funding should reflect the outputs produced by each health care unit. This principle was further reinforced by the 2003 review *Focusing on Patient Care* of the Independent Pricing and Regulatory Tribunal (IPART).

These guidelines outline the design principles of the Rehabilitation and Extended Care Episode Funding Model to be implemented in 2004/05. Like its counterpart guideline for acute inpatient episode funding, emergency department and intensive care funding, it provides guidelines designed to assist Area Health Services implement the NSW Rehabilitation and Extended Care Funding Model for their hospitals in 2004/05. It also outlines the issues that need to be addressed in refining and improving the model beyond 2004/05.

At the NSW level, the NSW AN-SNAP Implementation Steering Committee has been responsible for developing the Rehabilitation and Extended Care episode funding model. Professor Kathy Eagar, Mr Rob Gordon and Ms Janette Green from the Centre for Health Service Development at the University of Wollongong were engaged to design the actual model.

Consultation with clinicians and Area Health Services has been important in shaping the model outlined in this paper. This has largely occurred through the NSW AN-SNAP Implementation Steering Committee and through various workshops and training programs conducted over several years in relation to implementing the AN-SNAP classification. The most recent was a one day workshop in June 2004 that reviewed details of the actual model.

The model for implementation in 2004/05 is based on what can feasibly be achieved in 2004. The model will be further refined and developed over the next two years. Proposed developments are included in the paper.

2. Funding Policy

Under the Government's Action Plan for Health introduced in 2000, funding for Health Services was substantially increased and guaranteed over the next three years. This funding is allocated to Area Health Services to reflect population growth and health needs.

The Department's Resource Distribution Formula (RDF) is used to guide the allocation of three year growth funds and address historical funding inequities.

Within their population based funding allocation, Area Health Services are required to allocate funds across all program areas. This task is fundamental to achieve Area Health Plans for service delivery that reflect Government and local priorities and strategies.

From 1 July 2000, Areas were required to use episode funding to allocate budgets to hospitals to meet the cost of admissions under the acute inpatient program. This did not include rehabilitation and extended care services that are funded through a separate program (Program 4.1 – Rehabilitation and Extended Care) because the DRG system does not work well for these forms of care. Costs for patients dealt with by these services are

impacted by different factors to those typically recognised in acute episode classifications (for example, function and stage of illness). A funding model is required which recognises that the costs incurred in rehabilitation and extended care are driven by different cost drivers. This is now possible because of the progressive implementation since 1998/99 of the Australian National Sub-Acute and Non-Acute Patient (AN-SNAP) classification in NSW. Costing and data collection undertaken in recent years allows episode funding to be introduced in 2004/05 for admitted patients treated in designated units. The model will be progressively extended over time to cover all sub and non-acute care.

NSW has now introduced four episode-based funding models for different types of episodes of care:

- Acute inpatient episodes (exclusive of the Emergency Department component and/or Intensive Care component of such episodes);
- Emergency Department (ED) episodes defined as all of the care that a patient receives in an ED irrespective of whether the patient is subsequently admitted or discharged;
- Intensive Care (IC) episodes defined as all of the care that a patient receives in all designated Level 5 and 6, and some rural level 4 ICU during their inpatient stay. High dependency patients treated in these units are not included in the IC Episode Funding model.
- Rehabilitation and Extended Care episodes as defined later in these guidelines.

The principle for these funding models is to recognise the costs of caring for patients at each different phase of their episode of illness. Each of these phases is an 'episode of care'. Information about each episode of care can be bundled together to form an integrated picture of the services that the patient receives at each point along the care continuum.

Just as 'episodes of illness' vary in their duration, intensity and outcomes, so too do 'episodes of care' vary in the objectives of care, the time involved, the nature of the interventions provided, the settings of care and the outcomes of care. This requires the use of classification and costing systems that capture different settings and types of care. The overall episode of care classification schema for NSW is shown in Figure 1.

Existing methods of funding will continue for the remaining services until such time as there are standard measures of output and implementation of agreed service classifications in program areas such as mental health, community health and outpatient services.

Figure 1 NSW Episode of Care Classification Model

Setting/ Type of care	Primary & Community Care	Acute			Sub- & Non-Acute
			AR- DRGs	ICU	
Inpatient	N/A	Emergency Department			AN-SNAP
Same day	N/A		AR-DRGs with same day weights		AN-SNAP
Outpatient	N/A		Select/modify available clinic based system		AN-SNAP
Community	Progressive development of specific modules for Primary & Community Care. Linkage with SNAP & MH-CASC.				AN-SNAP

Irrespective of whether the funding model is being applied to acute inpatient episodes, ED, ICU or Rehabilitation and Extended Care episodes, the objectives are the same:

- To create an explicit relationship between funds allocated and services provided;
- To shift the focus of management to outputs, outcomes and quality;
- To encourage clinicians and managers to identify variations in costs and practices so these can be managed at local level in the context of improving efficiency and effectiveness; and
- To provide mechanisms to reward good practice and support quality initiatives.

In addition, there are specific objectives in the design and implementation of the Rehabilitation and Extended Care funding model:

- To recognise the particular features of Rehabilitation and Extended Care and the nature of their business;
- To recognise that across the system different Rehabilitation and Extended Care services will have different roles and funding requirements;
- To ensure a component of funding is related to the services delivered (or planned to be delivered) by a Rehabilitation and Extended Care service;
- To provide balanced incentives to ensure patients are appropriately dealt with across the Acute Care/Rehabilitation and Extended Care inpatient boundary;
- To take account of the information infrastructure required to implement the recommended funding model;
- To build a capacity and incentive to benchmark and improve performance; and

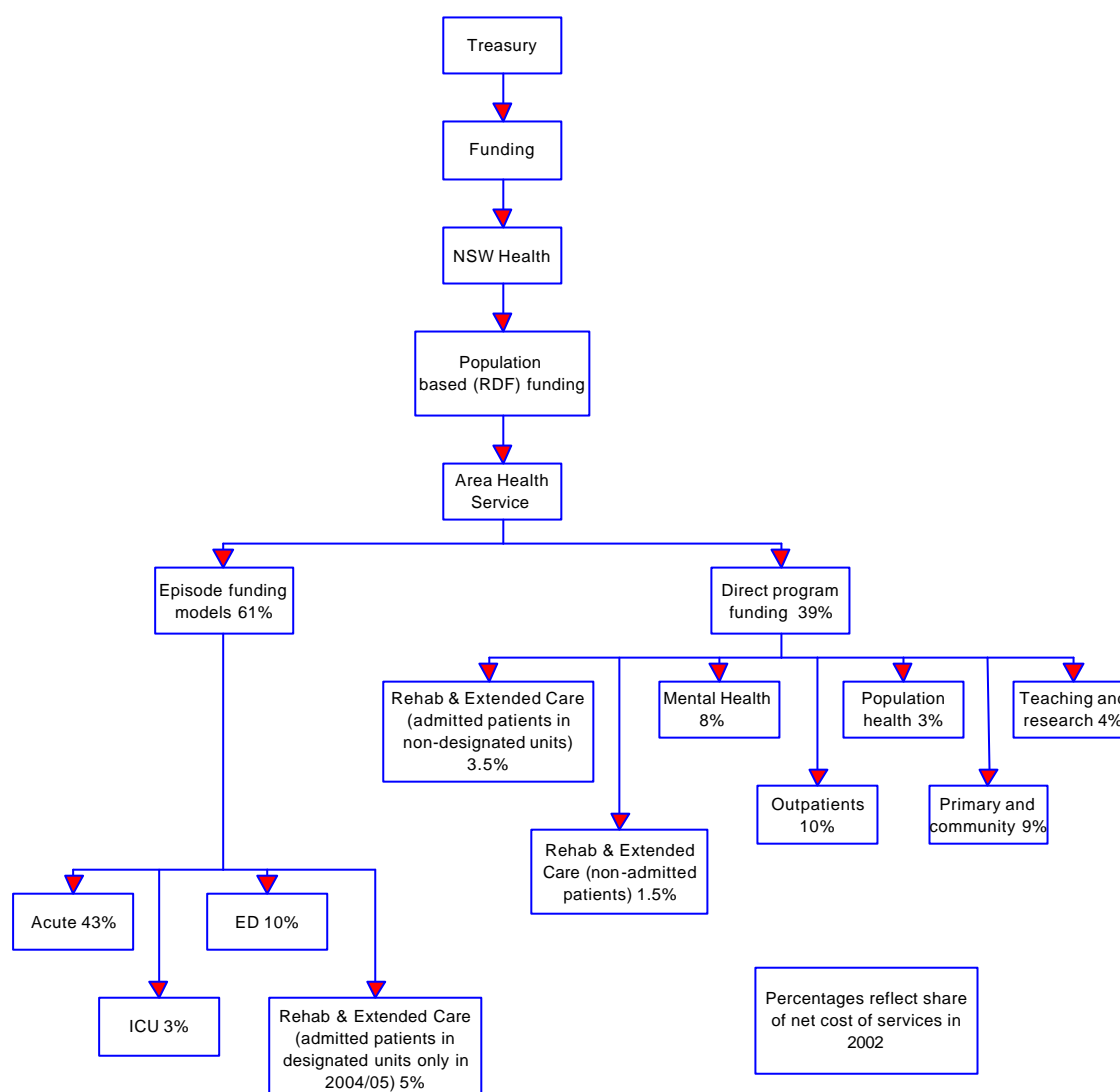
- To minimise complexity so that the model can be understood by the relevant stakeholders.

As with episode funding for acute inpatient care, the Rehabilitation and Extended Care funding model will provide capacity to benchmark costs between comparable Rehabilitation and Extended Cares. Due to limitations of current information and classification systems, benchmarking will not commence until 2005/2006. Once benchmarking is introduced, any efficiencies arising from implementing the episode funding model will be retained by Area Health Services. Area Health Services are able to use these to meet increased service demand, expand services in high priority areas, introduce better models of care and invest in research, technology and training.

The Health Department will monitor activity and performance targets within Area Health Services, particularly in the context of ensuring value in the use of enhancement funding. Area Health Services will continue to be responsible for service planning and for determining the mix of services within global activity and performance targets, subject to any Statewide planning guidelines and requirements.

Figure 2 illustrates the role of Rehabilitation and Extended Care funding in the context of the funding model that NSW will use in 2004/05 to fund health services.

Figure 2 2004/05 funding model for NSW



Source: NSW Health Annual Report 2002-2003, with Program 4.1 splits based on the analysis reported in these guidelines.

2.1 Scope of Rehabilitation and Extended Care Funding Guidelines

These guidelines are designed to assist Area Health Services implement the Rehabilitation and Extended Care Funding Model in 2004/05. These guidelines do not concern broad strategic issues in the allocation of Area funding or in the planning and management of rehabilitation and extended care services but are designed to complement existing policies and planning guidelines prepared both by the Department and by Areas.

They are intended to be used to build up the budget allocated to each hospital and are not designed to allocate budgets to particular clinical units. The process of funding clinical units within hospitals is a matter for Area Health Services and hospitals to determine within the funding framework and incentives provided by the funding models at hospital level. The make up of the rehabilitation and extended care budget will vary between Areas and Hospitals depending on the way clinical and non-clinical supra services are organised and cross charging arrangements implemented.

It is important to recognise that, before being in a position to implement the funding model for hospitals, Area Health Services must decide on how they will allocate resources across all programs. This task is fundamental to strategic and service planning at the Area level and requires Area Health Services to take into account a range of considerations, including:

- Additional funding provided by the Government linked to specific service requirements;
- The Area's plans for strategically changing the shape of service delivery to better reflect Government and local priorities and strategies;
- The current shape of service delivery compared to State benchmarks; and
- Major service and capital developments that will impact on the level, cost and mix of services provided.

Likewise, these guidelines do not address in any detail the funding of services other than those to be funded in 2004/2005 through the Rehabilitation and Extended Care Episode Funding Model. Separate Episode Funding Guidelines are issued that address the funding of ED, ICU and acute inpatient services. From 2005/06, details of the Rehabilitation and Extended Care Episode Funding Model will be incorporated into the generic Episode Funding Guidelines.

Finally, these guidelines do not include reporting requirements except in broad terms. Minimum reporting standards will be set by the Department to meet its responsibilities with more detailed levels of disaggregation to be determined by Areas. As far as possible, the Department will use routinely reported data through SNAPshot and ISC to generate reports for monitoring targets and performance. The Department of Health's reporting requirements in terms of activity and financial management will be issued separately and Areas will be required to provide information on target level of activity for 2004/05 and the allocation of sub acute and non acute episode funding by hospital.

2.2 Overview of the NSW Rehabilitation and Extended Care Funding Model

The Rehabilitation and Extended Care Funding Model is designed to fairly share financial risk between Area Health Services and hospitals and to create incentives that are in the best interests of patients. Area Health Services will need to ensure that hospitals carry the financial risk for those factors that are within their control (eg efficiency). However, hospitals should not be required to carry all financial risk for factors outside their control (eg differences in severity or complexity between different types of patients).

As with acute inpatient services, the core feature of the Rehabilitation and Extended Care Funding Model is the allocation of a prospectively determined budget that is linked to the expected outputs of each hospital. This is a prospective funding model in which the funding for a particular hospital or service is agreed at the beginning of the financial year and does not change through the year. However, there can be changes in funding levels between years based on revisions to activity targets.

There is no intention at this stage to introduce any retrospective components into the Rehabilitation and Extended Care funding model. However, retrospective adjustments

during the year in response to actual activity levels or performance may be considered in future years.

Implementation in 2004/05 is on a shadow basis, with the model to go live from 2005/06. Funding to hospitals will include payments for both differences in costs between hospitals that can be justified and differences that cannot be justified. Justifiable cost differences are defined as the costs of providing Rehabilitation and Extended Care taking into account:

- The expected **annual volume** of patients presenting to each unit. This is by far the single biggest determinant of the costs of running a service. About 80% of costs are fixed (at least in the short-term) and those fixed costs are largely determined on an estimate of the number of expected beddays. While there are daily and seasonal fluctuations, the annual number of admissions at each facility is able to be estimated with a reasonable level of accuracy;
- The **role** of the hospital and its Rehabilitation and Extended Care units with specific reference to its role in the provision of teaching and research relative to similar hospitals;
- Differences between hospitals in their Rehabilitation and Extended Care **casemix**. The casemix measure used in the model is the Australian National Sub- and Non- Acute Patient (AN-SNAP) classification;
- **Hospital-specific factors** such as layout, scope and other factors beyond the control of the hospital itself. For example, some hospitals may be unable to recruit to essential positions on a permanent basis and thus incur unavoidable additional costs for casual staff. The definition of a justifiable hospital-specific cost is clear. If the cause of the additional cost is within the control of the hospital and its clinicians, the additional cost is not justifiable. If the factor causing the additional cost is beyond the control of the hospital and its clinicians, it is a justifiable additional cost. As with teaching and research, additional costs are assessed relative to similar hospitals. Each Area Health Service will be responsible for identifying any hospital-specific factors that warrant additional funding to cover unavoidable additional costs.

The benchmark for Rehabilitation and Extended Care Admitted Patient Care in 2004/05 is \$10,260 per case-weighted separation. This rate is standard across all peer groups. Benchmarking of Rehabilitation and Extended Care units begins in 2005/2006. From that point, if an allocation to an individual hospital cannot be justified and exceeds the State benchmark, this additional allocation will be transparently identified as a transition grant. Area Health Services will be required to phase out the transition grant within three years, beginning in 2005/06. Cost data on each hospital, and a comparison to the benchmark cost, are given in Appendix 6.

In all instances the focus will be on unexplained differences in cost between hospitals. There are justified differences in cost between hospitals and Area Health Services will have the capacity to justify variations above benchmarks for legitimate reasons at Area and facility level. Area Health Services should also take this opportunity to look at the funding for Rehabilitation and Extended Care units that are operating below benchmark to ensure the work being undertaken is recognised and funded appropriately to enable the provision of quality care. Likewise, Area Health Services have the opportunity to reward efficient hospitals that are operating at or below the benchmark for their peer group through funding of higher activity or enhanced services.

3. Specific issues in the design of the NSW Rehabilitation and Extended Care Funding Model

3.1 Scope - an incremental approach to implementation

The Rehabilitation and Extended Care Funding Model applies to services funded through Program 4.1 (Rehabilitation and Extended Care). This program represents 10% of net cost of services in NSW and, at present, 227 health facilities receive funding under this program. A list of all facilities funded under the program is included as Appendix 3.

A phased approach to the implementation of the model has been adopted.

In 2004/2005, the model will apply to:

- All admitted SNAP patients treated in designated Rehabilitation and Extended Care units that are:
 - funded under Program 4.1; and
 - currently collecting AN-SNAP data.

Designated units for inclusion in 2004/05 are those where more than 75% of patients fit into any of the SNAP Case Types, the unit has 4 beds or more and less than 75% of episodes are classified as Maintenance. Area Health Services have discretion about the inclusion of units that are on the margin. A list of the 54 facilities included in the model in 2004/2005 is in Appendix 3. These units represent approximately 60% of total Program 4.1 funding.

- All Case Types treated in these designated units and that are included in the AN-SNAP classification. That is:
 - Palliative Care,
 - Rehabilitation,
 - Psychogeriatric,
 - Geriatric Evaluation and Management (GEM) and
 - Maintenance.

The following are excluded from the model in 2004/2005:

Non-admitted patient services

The NSW AN-SNAP Implementation Steering Committee will be addressing non-admitted services as part of its work program from 2004. Funding for non-admitted patient services represents approximately 25% of total Program 4.1 funding. Ambulatory care is excluded from the model in 2004/05 except in those cases where a unit has collected AN-SNAP data on same day patients and these data are included in *SNAPshot*. In these cases, the ambulatory episodes are included.

Units with a formal designation in the F2 Peer Group (Nursing Homes)

There is no intention to bring these units into the Rehabilitation and Extended Care Funding Model. These units represent approximately 10% of total Program 4.1 funding.

Hospital units receiving Program 4.1 funding that are not currently collecting AN-SNAP data

These hospitals represent approximately 25% of total Program 4.1 funding. Table 3 on page 27 sets out the status of these hospitals under the funding model.

However, it may be that there are some units that are receiving funding which has been incorrectly allocated against Program 4.1. Accordingly, Area Health Services will need to review all such units and either:

1. Begin planning for the introduction of the AN-SNAP data collection in accordance with the timetable outlined below or
2. Transfer the funding for the unit to another program. In most cases, this will require the transfer of the funding from Program 4.1 to Program 3.1 (Acute Care). Units funded under Program 3.1 will then be included in the Acute Episode Funding Model and funded by DRG.

The timetable for the inclusion of other Program 4.1 units into the funding model is as follows:

- There are 8 hospitals that meet the criteria for inclusion but that are not collecting AN-SNAP data (or collecting it in the different format). These 8 hospitals will be brought into the funding model beginning 1 July 2005. This means that all such units will need to begin collecting SNAP data during 2004/05 and no later than 1 January 2005. A list of these units is included in Appendix 3.
- There are a further 13 hospitals receiving between \$0.5m and \$3m per annum for admitted patient services but that are reporting very low volumes of rehabilitation and extended care episodes. These 13 units need to be reviewed at an Area level to determine whether the UAR costs reported are genuinely for Rehabilitation and Extended Care. If so, they should be included in the implementation in 2005/2006. If not, relevant program adjustments will need to be made. A list of these units is included in Appendix 3.
- There are 9 hospitals that are on the margin in relation to the inclusion criteria. Areas have discretion about whether to bring these units into the funding model beginning 1 July 2006. If they are to be included, they will need to begin collecting AN-SNAP data no later than 1 July 2005. A list of these units is included in Appendix 3. These units represent a further \$7m of total Program 4.1 funding.

There are 130 units that are not proposed for inclusion in the funding model:

- F2 Peer Group – 13 nursing homes.
- F3 Peer Group – 3 multipurpose centres
- Small units in which more than 75% of beddays are for patients classified as Maintenance. 64 hospitals currently fall into this category.
- Hospitals excluded for other reasons. 50 hospitals fall into this category. These are small units in which, after removing maintenance episodes, patients meeting the criteria for inclusion occupy less than 4 beds.

Area Health Services and the NSW AN-SNAP Implementation Steering Committee will need to review these exclusions each year to determine whether any changes in role or funding mean that they meet the criteria for inclusion.

SNAP patients in non-designated units

The intention is to bring all such episodes into the Rehabilitation and Extended Care Funding Model. However, this cannot realistically be achieved across all hospitals in 2004/05.

In 2004/05, SNAP patients in non-designated units have been included in the funding model on a per diem basis. Using Case Type data (ie, episode_of_care_type) reported through the HIE, episodes in non-designated units have been costed on a per diem basis by pegging them to an AN-SNAP class regarded as typical of patients treated in non-designated units. The classes used are:

Table 1 AN-SNAP class equivalents for patients treated in non-designated units

Case Type	Class	Description	Per diem weight	Per diem cost*
Palliative Care	106	Deteriorating, RUG 4-17	0.0678	\$696
Rehabilitation	201	Admit for assessment only	0.0622	\$638
Psychogeriatric	304	HoNOS Overactive behaviour 1, HoNOS total >=30	0.0629	\$645
GEM	404	Cognition 16-35, motor 13-50	0.0532	\$546
Maintenance	505	Nursing Home Type, RUG 4-10	0.0427	\$438

* Cost refers to cost in 2004/05, based on cost in 2002/03 escalated by 6.7% to reflect cost increases over the two years.

The NSW AN-SNAP Implementation Steering Committee will be further considering this issue during 2004.

Acute episodes in designated SNAP units

Some designated units provide occasional periods of acute care. For example, a patient undergoing a rehabilitation program may become too unwell to participate in their rehabilitation. Instead of transferring the patient elsewhere, a designated unit may provide their acute care and thus remove the need to transfer the patient. The funding model needs to accommodate this care and should not provide incentives to either keep such patients on the ward or to transfer them elsewhere. The decision should be based solely on clinical criteria.

The *SNAPshot* data system allows units to register this care as an acute episode (Case Type 6). The funding model for these episodes in designated units is that the acute episode be grouped by DRG (through the HIE) and be funded at the benchmark rate for the C1 peer group. When the necessary data are not available, the default is that these episodes be pegged to AR-DRG Version 4.1 Class F63B (Venous Thrombosis W/O Catastrophic or Severe CC) and funded on a per diem rate. This class had been included in the model based on an average per diem cost of \$622 in 2003/2004.

3.2 Classification issues

Episodes included in the classification will be classified and funded using Version 1 of the Australian National Sub and Non Acute Patient (AN-SNAP) classification. This classification was developed in 1997 and no subsequent versions of the classification have been developed. Further work on the classification, leading to Version 2, is required to reflect changes in clinical practice since the original classification was developed. The most urgent priorities to resolve are the ambulatory branches of the classification and the GEM Case Type. A strategy to address these will need to be considered by the Department and the NSW AN-SNAP Implementation Steering Committee over the next year.

3.3 Funding model design

The NSW AN-SNAP Implementation Steering Committee has been responsible for developing the funding model. Several critical issues are discussed below.

3.3.1 Per episode or per diem?

After consideration, the Committee has resolved that the funding model be based on a different units of counting for different case types as follows:

- GEM, Psychogeriatric and Maintenance episodes to be built into the model on a per diem (per day) basis. Each episode is classified using the AN-SNAP classification and a per diem rate has been calculated based on the original AN-SNAP cost weights.
- Palliative care to be built into the model on a per phase basis, whereby funding is based on a cost per phase of illness. This is consistent with the AN-SNAP classification. For palliative care, a phase is equivalent to an episode.
- Rehabilitation to be built into the model on a per episode basis. This is consistent with the AN-SNAP classification.

In the case of both Palliative Care and Rehabilitation, the funding model adopted is a blended payment model that has three components:

- Episode component – this is condition-specific and represents the case complexity of the casemix class.
- Per diem component – this is standard across all episodes and represents all ‘core hospital costs’. It represents approximately 40% of the average bedday cost for SNAP-type care.
- Outlier component – this is for episodes with an atypically long or short length of stay.

The blended payment model is being used because, with an average length of stay of 19 days, the financial risks in the standard episode payment approach used to fund acute care are much higher. Further, the concept of ‘swings and roundabouts’ that underpins most DRG (episode) funding models does not work well with small volumes because the risks are higher. The CHSD modelled the impact of introducing a per episode model and concluded

that the risks to both funding agencies and hospitals are very high. The blended payment model reduces the financial risks to all parties¹.

3.3.2 Trim points

Given the use of the blended payment model for both rehabilitation and palliative care, it is necessary to identify 'trim points' or the points at which an episode is judged to have an atypically long or short length of stay. The calculation of trim points for the other three Case Types is not required as these episodes are funded on a per diem basis.

Most casemix funding models use a formula based on a standard deviation but this is not the approach adopted in the blended payment model. The reasons are discussed in detail in the 1999 report already referenced. Instead, the trim points used are:

- **Rehabilitation** – the short stay outlier threshold is 7 days or the average length of stay minus 13, whichever is the larger value and average length of stay plus 13 days defines the high outlier threshold. Only 3 days of an Assessment Only episode (Class 201) are included in the blended payment model. Any days beyond three are treated as outlier days.
- **Palliative care** – the short stay outlier threshold is the average length of stay minus 7 days and the average length of stay plus 7 days defines the high outlier threshold. Only 1 day of a Bereavement episode (Class 111) is included in the blended payment model. Any days beyond one are excluded for funding purposes.

3.3.3 Other payment issues

Paying for outcomes

The NSW AN-SNAP Implementation Steering Committee considered whether or not to build in an element of outcome-based payment, at least for rehabilitation, into the model. Under such a model, units that achieved better patient outcomes would be rewarded in the funding model. The Committee considered the incentives (positive and negative) that such a model may create when such a model is applied at both the patient level or the unit level. Such an approach at the patient level would pay more for patients who improve the most. When applied at a unit level, the model would pay more to units who achieve the most improvement. After consideration, the Committee resolved that outcomes should not be built into the model because the potential perverse incentives outweighed the potential positive incentives.

Fixed and activity payments

The acute, IC and ED funding models are all based on two elements - a fixed infrastructure payment and an activity payment. The NSW AN-SNAP Implementation Steering Committee could see no need to separately identify these elements in the Rehabilitation and Extended Care funding model as the funding model is prospective and there is one benchmark across all peer groups.

¹ Further details of the model can be found in Eagar K, Green J, Gordon R. (1999) *A national classification system and payment model for private rehabilitation services*. Centre for Health Service Development, University of Wollongong. http://www.health.gov.au/pubs/circfin/consult/fin_rep_prwg_ke.pdf

3.3.4 Costing issues

The benchmark cost for 2004/05 is based on a sample of 29 hospitals. They are listed in Appendix 4. These hospitals were selected because they had both good quality activity and cost data.

The cost data used were based on 2002/03 UAR costs reported by Areas. In some cases, Areas were able to refine their costing data and these data were used instead of the UAR data. Combo cost data were also reviewed where available. Activity data were extracted from SNAPshot and reconciled against HIE data.

3.4 Data and payment issues

A range of data and payment issues were considered by the NSW AN-SNAP Implementation Steering Committee in developing the 2004/05 model. They include:

3.4.1 Consultation-liaison and how to fund it

In 2004/05, these costs have not been separately identified and have been built into the benchmark cost. Further work at the hospital and Area level is required on the fractionation of rehabilitation and extended care cost centres.

3.4.2 Teaching and research and how to fund it

These costs have been separated out by Areas as part of preparing their 2002/03 UAR return and have been funded through Program 6.1 (Teaching and research).

3.4.3 How to deal with inter-hospital transfers, re-admissions and program interruptions

No special approach has been taken with respect to transfers as they are adequately dealt with under the outlier arrangements.

The question of whether there should be special rules to deal with re-admissions and program interruptions has been considered in some detail. No such approach has been taken in the 2004/05 model but the NSW AN-SNAP Implementation Steering Committee will be undertaking further work on this issue that may have an impact on the 2005/06 model.

3.4.4 How to pay for episodes in the AN-SNAP error class

In the acute DRG funding model, episodes assigned to an error class are given a cost weight of 0.00 and are therefore not funded in the model. This approach was judged to be too harsh in the early years of the Rehabilitation and Extended Care Funding Model. Instead, episodes in the AN-SNAP error class are paid on a per diem basis at a rate equivalent to the cheapest AN-SNAP per diem cost (Class 511 with a per diem weight of 41% of the average bedday rate). Under this rule, hospitals have a clear incentive to ensure that every episode is classified to a valid AN-SNAP class. The longer-term intention is to assign error class episodes a cost weight of 0.00.

3.4.5 How to deal with long episodes without a '90 day review'

The business rules for AN-SNAP have been in place for several years. One such rule is the '90 day' rule. It is of particular importance in sub-specialty rehabilitation areas such as brain and spinal injury where a length of stay of a year is not uncommon. But the rule applies to all Case Types and impairment groups.

Under this rule, episodes with a length of stay greater than 90 days are reviewed each 90 days and the episode artificially ended with a code of '90 day review' recorded as the reason. A new episode, with a begin reason of '90 day review', is started and new clinical data recorded. Thus, a patient in continuous care for a year would have 4 episodes in SNAPshot, each of which will attract its own payment.

The question to be considered in the funding model is how to pay for episodes that have a length of stay greater than 90 days because they have not had a '90 day review'. In these cases, the approach adopted is to:

- Split the episode into 2 episodes by ending the first episode at 90 days. The second episode consists of all days beyond 90.
- Episode 1 is assigned to its correct AN-SNAP class.
- All days in Episode 2 are assigned to the lowest paying maintenance class (Class 511) and are paid at the per diem rate for that class (0.41 per diem).

This approach provides a clear incentive for hospitals to ensure that the 90 day rule is strictly applied.

3.4.6 Software required to implement the model

Almost all designated Rehabilitation and Extended Care units in scope for the funding model in 2004/05 are routinely collecting and entering AN-SNAP activity data into an information system known as *SNAPshot*. The *SNAPshot* system allows episode and clinical data items to be recorded for each of the five AN-SNAP Case Types and has a grouper function that assigns episodes to individual AN-SNAP classes. *SNAPshot* data should be used for the purposes of compiling a Rehabilitation and Extended Care activity data set as outlined in Section 4.2.

A new version of *SNAPshot*, Version 3.6, will be available from 1 July 2004. This version includes a HIE extract function that enables certain data items to be uploaded to the HIE through a batch process. Training in the SNAP HIE batching process was provided to Area Health Services in May 2004. Ongoing support will be provided by the Department during 2004/05. The inclusion of *SNAPshot* data in the HIE should greatly assist Area Health Services staff in accessing Rehabilitation and Extended Care activity data.

It is not compulsory for hospitals to use the *SNAPshot* system for collecting Rehabilitation and Extended Care activity data. It is, however, critical for all facilities to be able to group episodes to AN-SNAP classes, to calculate cost weights for the purpose of determining Rehabilitation and Extended Care budgets and to undertake a range of data analyses related to the funding model. Hospitals not using the *SNAPshot* software will need to carefully consider their capacity to manage the overall implementation of the funding model in this context.

As outlined in Section 4.3, Area Health Services will also need to calculate a shadow budget based on projected case weighted activity for each hospital and the standard NSW benchmark payment of \$10,260 per Rehabilitation and Extended case weight. To assist in this process, Table 7 on page 38 provides 2002/03 cost weighted activity data.

For 2004/05, Areas wishing to project case weighted activity using more recent data should contact the Centre for Health Service Development at the University of Wollongong for assistance². Software requirements for use from 2004/05 will be considered by the NSW AN-SNAP Implementation Steering Committee during 2004/05.

3.4.7 How to calculate length of stay

The AN-SNAP cost weights used in the Rehabilitation and Extended Care Episode Funding Model are based on the following definition of length of stay:

'End date minus begin date minus leave days plus one'.

That is, an episode that begins on Monday and ends on Friday is recorded as having a length of stay of 5 days.

The length of stay calculation in the current version of *SNAPshot* is correspondingly based on this definition, as are the activity data presented in Appendix 5.

For this reason, this definition will be used in calculating budgets for the Rehabilitation and Extended Care Episode Funding Model in 2004/05. Although there is a sound argument for the retention of this definition in subsequent years, it is recognised that this definition is not the National and NSW standard which is:

'End date minus begin data minus leave days'.

Under the national definition, an episode that begins on Monday and ends on Friday is recorded as having a length of stay of 4 days.

This national definition will be applied to all activity data collected after 1 July 2004. *SNAPshot* Version 3.6 will incorporate the amended definition. Revised cost weights and trim points based on this definition will also be developed for use in the 2005/06 funding model.

However, a key issue yet to be resolved is how to calculate the length of a palliative care phase. The problem is best illustrated by example:

A patient is admitted on Monday and is discharged on Friday. The patient is classified to the Unstable Phase on Monday. They are reclassified to the Stable Phase on Thursday before being discharged on Friday.

Using the current definition ('End date minus begin data minus leave days plus one') this patient has a total length of stay of 5 days. Phase 1 has a length of stay of 3 days. Phase 2 has a length of stay of 2 days, making 5 days in total.

Using the national definition ('End date minus begin data minus leave days') this patient has a total length of stay of 4 days. Phase 1 has a length of stay of 2 days. Phase 2 has a

² Contact either Janette Green or Rob Gordon on 0242214411.

length of stay of 1 days, making 3 days in total. The practical outcome is that a patient loses a day at each change of phase.

The NSW AN-SNAP Implementation Steering Committee will need to resolve this issue during 2004/05.

3.5 Peer Groups

NSW has a well-established system for classifying hospitals into peer groups. This peer grouping is based on the hospital's role and inpatient activity as measured by the DRG classification and, in the acute inpatient episode funding model, different benchmarks are set for different peer groups.

A key issue considered during the development of the current guidelines was whether Rehabilitation and Extended Care benchmarks should be based on these existing peer groups or on the delineated role of each Rehabilitation and Extended Care unit (which is strongly correlated with peer group) or on some other criterion.

A review of both raw and casemix-adjusted costs indicated no systematic differences in costs between hospital peer groups. Accordingly, there is one benchmark cost that applies to all hospitals. However, the C2 and D peer groups were not adequately represented in the sample. This is not a particular problem in 2004/05 as, in the main, hospitals in these groups will not come into the model until after 2005.

4. NSW Rehabilitation and Extended Care Funding Model Guidelines

These guidelines describe 4 steps required to implement the Rehabilitation and Extended Care funding model within an Area Health Service. These 4 steps are:

- Step 1 Determine in-scope services
- Step 2 Determine activity levels for 2004/2005
- Step 3 Determine activity budgets for 2004/2005
- Step 4 Implement

Each of these steps is described below. In each case, the guidelines define the issue to be addressed and identify those elements that are mandatory within the Rehabilitation and Extended Care Funding Model. Decisions and actions that are required at the Area level are identified in relation to:

- Policy and management,
- Service planning and activity analysis, and
- Financial planning and analysis.

4.1 Step 1 Determine In-Scope Services

4.1.1 Mandatory element/s

The Rehabilitation and Extended Care funding model is to apply to all hospitals shown in the 2004/05 implementation group in Appendix 3.

4.1.2 Area action - policy and management

The Rehabilitation and Extended Care role of all hospitals should be reviewed in the context of the relevant planning exercises.

4.1.3 Area action - activity analysis

Assemble a Rehabilitation and Extended Care activity data set for analysis. Appendix 5 to this paper includes relevant data for 2002/2003 for those units collecting AN-SNAP data. Include all admitted patients who were treated within a designated Rehabilitation and Extended Care unit.

Contact the Department if assistance with assembling this data set is required. For 2004/05, Areas wishing to project case weighted activity using more recent data than that shown in Appendix 5 should contact the Centre for Health Service Development at the University of Wollongong for assistance³. Software developments discussed on page 14 of these guidelines will assist Areas with this task in subsequent years.

4.1.4 Area action – financial

Assemble a financial data set for analysis that includes a total operating budget for each Rehabilitation and Extended Care unit, including their share of both Area and hospital overheads. This should reconcile with the hospital's program allocation under Program 4.1 (Rehabilitation and Extended Care). Appendix 3 shows UAR data for 2002/03 that can be

³ Contact either Janette Green or Rob Gordon on (02) 42 214411.

used as a starting point. However, Program 4.1 may need to be purified to ensure that it correctly includes the cost of all in-scope Rehabilitation and Extended Care services and excludes the cost of out of scope services.

The Rehabilitation and Extended Care funding file should include all Rehabilitation and Extended Care cost centres, Rehabilitation and Extended Care overhead costs (both Area and hospital). The Rehabilitation and Extended Care fraction of other direct cost centres such as resident medical officers should be excluded from the acute episode funding file and added as separate line items to the Rehabilitation and Extended Care funding file.

Note that the Rehabilitation and Extended Care funding file will contain two types of costs. Most will be the direct costs of Rehabilitation and Extended Care that form a Rehabilitation and Extended Care budget at the hospital level. But the file will also contain other Area and hospital costs (overheads, RMOs etc) that will not necessarily be passed on to the hospital or from the hospital to the Rehabilitation and Extended Care unit.

4.2 Step 2 Determine activity levels for 2004/2005

4.2.1 Mandatory element/s

Under the Rehabilitation and Extended Care funding model, the Rehabilitation and Extended Care funding budget is built up based on expected activity in 2004/05.

4.2.2 Area action - policy and management

Decide on the cost weighted volume of services to be delivered by each hospital in 2004/2005. Start with existing levels, then increase/decrease in line with strategic service development plans, waiting time management strategies, activity forecasts based on historic trends and population growth, government initiatives and so on. Unless there are major service changes in progress, there is a high level of predicability in the demand for these services. Include any expected acute beddays in this projection. Acute bed days are captured in *SNAPshot* as Case Type 6.

4.2.3 Area action - activity analysis

Modify the existing activity file to incorporate changes in expected case weighted volumes for 2004/2005. Note that the level of proposed activity is tentative only at this point as the final volumes will need to be refined in the final steps to match funding levels and activity levels.

4.2.4 Area action – financial

Calculate the total quantum of funding to be distributed through the Rehabilitation and Extended Care funding model in 2004/2005. Start with the 2003/04 Rehabilitation and Extended Care program allocation and expenditure budget (incorporating the recurrent allocation and revenue budget estimate). Exclude the expenditure budget allocated to out of scope hospitals and out of scope services.

This will need to include funding for projected acute beddays. If DRG data are available, they should be used. If not, the default is that these episodes be pegged to AR-DRG Version 4.1 Class F63B (Venous Thrombosis W/O Catastrophic or Severe CC Not DC) and funded on a per diem rate. This class is equivalent to a SNAP per diem weight of 0.0614.

For funding purposes, remove Area overhead costs, any costs covered by other programs and Teaching and Research costs from the pool of funds that will be distributed through Rehabilitation and Extended Care funding to hospitals. If depreciation is not passed onto

hospitals, exclude it from the pool of funds. The hospital will receive funding for Teaching and Research costs through the hospital's T&R program allocation.

4.3 Step 3 Determine activity budget

4.3.1 Mandatory element/s

Each hospital with a designated Rehabilitation and Extended Care unit is to be funded through the allocation of a prospective budget to each hospital that includes funding for both activity and infrastructure.

4.3.2 Area action - policy and management

Nil.

4.3.3 Area action - activity analysis

Nil.

4.3.4 Area action – financial

Calculate the shadow budget based on projected case weighted activity for each hospital and the standard NSW payment of \$10,260 per Rehabilitation and Extended Care case weight.

4.4 Step 4 Model the implementation of Rehabilitation and Extended Care funding model

4.4.1 Mandatory element/s

Rehabilitation and Extended Care funding is on a shadow basis in 2004/05 and will apply for the 2005/2006 financial year. Areas that have not already done so need to bring together clinicians, hospital managers, and area staff to review the implementation of Rehabilitation and Extended Care funding at an Area and hospital level. Area Health Services are expected to continue to involve clinicians in the process of determining and monitoring Rehabilitation and Extended Care funded activity and budgets.

4.4.2 Area action - policy and management

- Model the implementation of the Rehabilitation and Extended Care Funding model.
- As part of a Funding Service Agreement with each hospital, include an explicit agreement about reporting arrangements, specify the amount to be allocated to the hospital for Rehabilitation and Extended Care services and the target level of activity in 2004/05. This should identify the difference between the amount allocated to the hospital for Rehabilitation and Extended Care services and the amount that would be calculated through applying the benchmark rate;
- Provide information on target levels of activity for 2004/05, the allocation of Rehabilitation and Extended Care funding by hospital and the difference between the amount allocated to the hospital and the amount that would be calculated through applying the benchmark rate;
- Develop a work program to better understand Rehabilitation and Extended Care costs and to more precisely calculate justifiable infrastructure grants from 2005/2006;

- Develop costing capacity to provided quarterly reporting and monitoring of activity on costs by the Rehabilitation and Extended Care Funding stream consistent with other Programs;
- If relevant, undertake further analysis to understand the difference between the amount allocated to the hospital and the amount that would be calculated through applying the benchmark rate;
- A process of quarterly reporting through the year estimates of expenditure by the Rehabilitation and Extended Care Funding stream will be initiated from 2004/05. In recognition that the costing capacity in some Health Services is not sufficiently advanced to accurately provide this information, the quarterly reporting requirements will only apply to Health Services with such capacity. All Health Services will have 2004/05 to put systems in place to undertake quarterly reporting and monitoring of activity on costs by the Rehabilitation and Extended Care Funding stream for implementation in 2005/06. Guidelines will be issued during 2004/05 to assist all Health Services build this capacity.
- Some Area Health Services have developed broader performance agreements with hospitals. While such performance agreements are not mandatory, they are seen as good practice since they clarify joint responsibilities of the Area and its facilities in meeting health system requirements and can do so using the NSW Health's Framework for Managing the Quality of Health Services.

4.4.3 Area action - activity analysis

Agree on activity flow and monitor on a shadow basis throughout the year.

4.4.4 Area action – financial

Areas must ensure that the proposed allocations are within the expenditure that can be funded from their 2004/05 budget allocation and revenue estimates. If this is not the case, review the proposed activity levels and funding components in line with available funds.

Appendix 6 provides relevant information to assist with the budget build up process for the 36 hospitals included in the second phase of the benchmark costing study. As discussed in Appendix 4, some hospitals are included in Table 8 that have known data errors. Nevertheless, it provides a starting point.

It shows, for each hospital:

1. The budget for in-scope patients that the hospital would receive based on the 2004/05 benchmark cost. This is based on casemix-adjusted activity in 2002/03. It needs to be adjusted for expected changes in activity from 2002/03 to 2004/05.
2. Designated unit expenditure. This is expenditure after removing the costs of SNAP episodes in non-designated units as per the method outlined in Appendix 4. Expenditure data are as reported in the UAR unless revised costs were provided by the Area Health Service. Expenditure costs have been inflated to reflect costs in 2004/05.
3. The difference between the benchmark budget and expenditure in 2002/03 inflated to 2004/05 costs.
4. Expenditure on SNAP days in non-designated units inflated to 2004/05 costs. This expenditure was removed from the calculation of the benchmark price. It needs to be built back in to build up a total budget for each unit after adjusting for expected changes in activity from 2002/03 to 2004/05.

5. Expenditure on acute care days in designated units, as reported in *SNAPshot*, inflated to 2004/05 costs. This expenditure needs to be built back in to build up after adjusting for expected changes in activity from 2002/03 to 2004/05.

In addition, funding from other programs such as Program 6.1 (Teaching and Research) and for non-admitted services funded under Program 4.1 needs to be included in the final budget build up. Combine the various elements to form a funding allocation for each hospital. Agree on cash flow and allocate on a shadow basis.

5. Ongoing development of the Rehabilitation and Extended Care Episode Funding Model

The model to apply in 2004/05 has been limited to what is feasible within the timeframe and capacity of the NSW health system. The Rehabilitation and Extended Care episode funding model will evolve in future years in response to feedback from Area Health Services, clinicians and managers.

A range of issues have already been identified that will be progressed over the course of 2004/2005 and 2005/06 at both the departmental and Area levels:

- Resolve data and software issues as outlined in Section 3 of these guidelines;
- Build capacity to support activity planning and target setting for Rehabilitation and Extended Care Episode Funding;
- Develop standard reports in HIE and Business Objects that will support episode funding at hospital and Area level, and allow for ease of reporting;
- Share information on methods for monitoring, evaluating and benchmarking;
- Develop and undertake training programs on the episode funding;
- Improve data quality;
- Give greater priority to processes for classification development and extension of activity funding to other programs in order to deal with incentives to shift funds between programs; and
- Actively seek feedback from clinicians to assess any unintended impact of episode funding that should be corrected.

6. Conclusion

Successful implementation of Rehabilitation and Extended Care funding requires Area Health Services to identify the mix of staff, skills and resources that have to be devoted to achieve implementation in 2004/2005 and initiate discussion at facility level with senior managers and clinicians about the practical implementation of Rehabilitation and Extended Care funding.

The Department will continue to work with Area Health Services to provide the data, information and support required. Areas are also encouraged to share experience and expertise to assist those Health Services that face a difficult task to build the capacity to implement episode funding.

Area Health Services are encouraged to feedback comments and issues that arise during the implementation process so that they can be taken into account in refining the model to apply from 2005/2006. These comments can be directed to Eui-Soo Choi on tel: 9391 9879 or e-mail at ECHOI@doh.health.nsw.gov.au.

Appendix 1

NSW SNAP Implementation Steering Committee Members

Name	Position	Organisation
Prof Kathy Eagar	Director, Centre for Health Service Development	University of Wollongong
Dr Jeff Rowland	Director of Aged Care	Liverpool Hospital
Prof Daniel Chan	Director of Aged Care and Rehabilitation	Bankstown Hospital
Ms Beth Monk	Area Manager of Aged and Extended Care	Southern Area Health Services
Dr Friedbert Kohler	Director of Rehabilitation	Braeside Hospital
Mr Stuart Campbell	Decision Support Coordinator	South Eastern Area Health Service
Prof Ian Cameron	Director of Aged Care and Rehabilitation	Northern Sydney Area Health Service
Dr Chris Poulos	Director of Aged and Extended Care Service	Illawarra Area Health Service
Dr Peter Henke	Director of Rehabilitation	Balmain Hospital
Dr Doug Sabau	Director, Aged Care Psychiatry	Greenwich Hospital
Dr Andrew Dorigo	Director of Palliative Care	St Joseph Hospital
Ms Sharon Smith	Occupational Therapist	St Joseph Hospital
Prof Ben Marosszeky	Director of Rehabilitation Medicine	Westmead Hospital
Ms Eui-Soo Choi	Senior Analyst Casemix Policy Unit	NSW Health
Mr Rob Gordon	Senior Research Fellow, Centre for Health Service Development	University of Wollongong
Ms Sharyn Wilson	Casemix Officer	Hunter Area Health Service
Ms Maree Banfield	Manager, Palliative Care	Calvary Hospital

Appendix 2

AN-SNAP classification and cost weights 2004/2005

Table 2 *AN-SNAP classification and weights*

Case Type	Class	Description	Episode weight	Per diem weight	Outlier weight
Palliative care	101	Stable, RUG 4	0.1192	0.0402	0.0529
Palliative care	102	Stable, RUG 5-17	0.2463	0.0402	0.0623
Palliative care	103	Stable, RUG 18	0.3339	0.0402	0.0728
Palliative care	104	Unstable, RUG 4-17	0.2053	0.0402	0.0630
Palliative care	105	Unstable, RUG 18	0.2126	0.0402	0.0800
Palliative care	106	Deteriorating, RUG 4-17	0.2174	0.0402	0.0678
Palliative care	107	Deteriorating, RUG 18, age <=71	0.2638	0.0402	0.0848
Palliative care	108	Deteriorating, RUG 18, age >=72	0.1673	0.0402	0.0773
Palliative care	109	Terminal, RUG 4-16	0.1732	0.0402	0.0805
Palliative care	110	Terminal, RUG 17-18	0.1382	0.0402	0.0878
Palliative care	111	Bereavement	0.0926	0.0402	0.1328
Rehabilitation	201	Admit for assessment only	0.0973	0.0402	0.0622
Rehabilitation	202	Brain, Neuro, Spine and MMT, FIM 13	3.3645	0.0402	0.0985
Rehabilitation	203	All other impairments, FIM 13	0.9111	0.0402	0.0751
Rehabilitation	204	Stroke and Burns, motor 63-91, cognition 20-35	0.3189	0.0402	0.0577
Rehabilitation	205	Stroke and Burns, motor 63-91, cognition 5-19	0.5619	0.0402	0.0658
Rehabilitation	206	Stroke and Burns, motor 47-62	0.4378	0.0402	0.0564
Rehabilitation	207	Stroke and Burns, motor 14-46, age >=75	0.6491	0.0402	0.0618
Rehabilitation	208	Stroke and Burns, motor 14-46, age <=74	0.9949	0.0402	0.0637
Rehabilitation	209	Brain Dysfunction, motor 71-91	0.3190	0.0402	0.0587
Rehabilitation	210	Brain Dysfunction, motor 29-70, age >=55	0.3766	0.0402	0.0559
Rehabilitation	211	Brain Dysfunction, motor 29-70, age <=54	0.8896	0.0402	0.0657
Rehabilitation	212	Brain Dysfunction, motor 14-28	1.9141	0.0402	0.0728
Rehabilitation	213	Neurological, motor 74-91	0.1425	0.0402	0.0489
Rehabilitation	214	Neurological, motor 41-73	0.3730	0.0402	0.0581
Rehabilitation	215	Neurological, motor 14-40	0.6946	0.0402	0.0649
Rehabilitation	216	Spinal Cord Dysfunction, motor 81-91	0.1300	0.0402	0.0498
Rehabilitation	217	Spinal Cord Dysfunction, motor 47-80	0.5712	0.0402	0.0615
Rehabilitation	218	Spinal Cord Dysfunction, motor 14-46	1.7696	0.0402	0.0776
Rehabilitation	219	Amputation of limb, motor 66-91	0.1696	0.0402	0.0473
Rehabilitation	220	Amputation of limb, motor 47-65	0.5458	0.0402	0.0567
Rehabilitation	221	Amputation of limb, motor 14-46	0.7620	0.0402	0.0628
Rehabilitation	222	Pain Syndromes	0.1506	0.0402	0.0498

NSW Funding Guidelines for Rehabilitation and Extended Care 2004/2005

Case Type	Class	Description	Episode weight	Per diem weight	Outlier weight
Rehabilitation	223	Orthopaedic conditions, motor 74-91	0.0751	0.0402	0.0455
Rehabilitation	224	Orthopaedic conditions, motor 58-73	0.1878	0.0402	0.0501
Rehabilitation	225	Orthopaedic conditions, motor 52-57	0.3058	0.0402	0.0533
Rehabilitation	226	Orthopaedic conditions, motor 14-51	0.4785	0.0402	0.0583
Rehabilitation	227	Cardiac	0.2784	0.0402	0.0544
Rehabilitation	228	Major Multiple Trauma	0.6452	0.0402	0.0688
Rehabilitation	229	All other impairments, motor 67-91	0.1329	0.0402	0.0484
Rehabilitation	230	All other impairments, motor 53-66	0.2689	0.0402	0.0547
Rehabilitation	231	All other impairments, motor 25-52	0.3954	0.0402	0.0588
Rehabilitation	232	All other impairments, motor 14-24	0.5198	0.0402	0.0584
Psychogeriatric	301	HoNOS Overactive behaviour 4,5	NA	0.0699	NA
Psychogeriatric	302	HoNOS Overactive behaviour 2,3, ADL 5	NA	0.0717	NA
Psychogeriatric	303	HoNOS Overactive behaviour 2,3, ADL 1-4	NA	0.0603	NA
Psychogeriatric	304	HoNOS Overactive behaviour 1, HoNOS total \geq 30	NA	0.0629	NA
Psychogeriatric	305	HoNOS Overactive behaviour 1, HoNOS total \leq 29	NA	0.0531	NA
Psychogeriatric	306	Long term care	NA	0.0346	NA
GEM	401	Cognition \leq 15, motor 13-43	NA	0.0572	NA
GEM	402	Cognition \leq 15, motor 44-91, age \geq 84	NA	0.0485	NA
GEM	403	Cognition \leq 15, motor 44-91, age \leq 83	NA	0.0461	NA
GEM	404	Cognition 16-35, motor 13-50	NA	0.0532	NA
GEM	405	Cognition 16-35, motor 51-77	NA	0.0458	NA
GEM	406	Cognition 16-35, motor 78-91	NA	0.0405	NA
Maintenance	501	Respite, RUG 15-18	NA	0.0529	NA
Maintenance	502	Respite, RUG 5-14	NA	0.0450	NA
Maintenance	503	Respite, RUG 4	NA	0.0358	NA
Maintenance	504	Nursing Home Type, RUG 11-18	NA	0.0486	NA
Maintenance	505	Nursing Home Type, RUG 4-10	NA	0.0427	NA
Maintenance	506	Convalescent care	NA	0.0499	NA
Maintenance	507	Other Maintenance, RUG 14-18	NA	0.0795	NA
Maintenance	508	Other Maintenance, RUG 4-13	NA	0.0490	NA
Maintenance	509	Long term care, RUG 17-18	NA	0.0338	NA
Maintenance	510	Long term care, RUG 10-16	NA	0.0303	NA
Maintenance	511	Long term care, RUG 4-9	NA	0.0227	NA

Appendix 3

*Hospitals funded under Program 4.1 and their status under the funding model***Table 3** *Hospitals funded under Program 4.1 and their status under the funding model*

Code	Peer Group	Name	Total Rehabilitation and Extended Care: Admitted Patients (Program 4.1.00.1)	Total Rehabilitation and Extended Care: Non-Admitted Patients (Program 4.1.00.2)	Total
Included in the 2004/05 funding model					
B221	F6	Royal Rehabilitation	\$25,310,178	\$1,716,536	\$27,026,714
D213	F8	St Joseph's	\$15,698,655	\$426,805	\$16,125,460
C202	F5	Calvary Kogarah	\$13,615,754	\$10,883,613	\$24,499,367
C208	A1a	Prince of Wales	\$12,979,193	\$7,655,014	\$20,634,207
K751	F2	Lourdes Dubbo	\$12,317,351		\$12,317,351
D224	A1a	Westmead	\$12,311,132	\$13,568,616	\$25,879,748
A209	F5	Sacred Heart	\$12,145,485	\$2,019,246	\$14,164,731
P206	F8	Port Kembla	\$10,621,544	\$8,700,414	\$19,321,958
D209	A1	Liverpool	\$10,460,606	\$6,661,698	\$17,122,304
C214	B1	Sutherland	\$10,261,882	\$6,806,847	\$17,068,729
B208	F8	Greenwich	\$9,849,046	\$1,544,382	\$11,393,428
D228	F8	Braeside	\$9,759,971	\$566,363	\$10,326,334
C213	A1	St. George	\$9,234,828	\$939,155	\$10,173,983
Q215	F2	Rankin Park	\$8,201,345	\$2,526,820	\$10,728,165
C206	F6	Waverly War Memorial	\$7,782,106	\$1,679,003	\$9,461,109
R219	B2	Wagga Wagga	\$7,522,525	\$0	\$7,522,525
M201	B2	Albury	\$7,215,110	\$0	\$7,215,110
D227	B1	Bankstown	\$6,410,215	\$7,378,545	\$13,788,760
N216	F8	St John of God Goulburn	\$6,352,910	\$3,363,134	\$9,716,044
J216	B2	Tamworth	\$6,213,935	\$213,267	\$6,427,202
M212	F8	Mercy Albury	\$6,129,106	\$0	\$6,129,106
B210	B1	Hornsby	\$6,051,545	\$5,276,988	\$11,328,533
D210	A1b	Nepean	\$5,559,049	\$8,360,792	\$13,919,841
Q211	A3	Newcastle Mater	\$5,042,058	\$2,009,516	\$7,051,574
P203	F8	Coledale	\$4,864,743	\$936,738	\$5,801,481
B206	B1	Wyong	\$4,792,631	\$830,843	\$5,623,474
D215	B1	Macarthur	\$4,752,154	\$6,045,978	\$10,798,132
H222	F6	St. Vincent's (Lismore) Public Rehab	\$4,406,545	\$6,457,926	\$10,864,471
B214	B1	Mona Vale	\$4,402,848	\$762,441	\$5,165,289
B203	D2	Woy Woy	\$4,357,069	\$627,684	\$4,984,753
D203	B1	Blacktown	\$4,320,716	\$2,163,152	\$6,483,868
A201	F8	Balmain	\$4,262,268	\$8,186,861	\$12,449,129
L216	B2	Orange	\$4,224,325	\$2,115,395	\$6,339,720
Q213	A3	Royal Newcastle	\$4,177,057	\$56,184	\$4,233,241
D218	B1	Mount Druitt	\$4,126,089	\$3,915,123	\$8,041,212
P291	F8	David Berry	\$3,767,955	\$6,736	\$3,774,691
L201	C1	Bathurst	\$3,611,675	\$1,764,584	\$5,376,259
A202	B1	Canterbury	\$3,198,425	\$65,383	\$3,263,808
H221	C2	Murwillumbah	\$3,159,271	\$1,512,723	\$4,671,994
B209	F5	Neringah	\$2,941,893	\$575,286	\$3,517,179
D204	C2	Blue Mountains	\$2,478,050	\$5,569,763	\$8,047,813
J225	B2	Manning River	\$2,431,116	\$0	\$2,431,116
P207	C1	Shoalhaven	\$2,393,631	\$1,026,692	\$3,420,323
B218	A1a	Royal North Shore	\$2,377,137	\$4,776,647	\$7,153,784
B212	B1	Manly	\$2,210,615	\$3,903,642	\$6,114,257
B224	B1	Ryde	\$2,191,848	\$1,409,590	\$3,601,438
H208	B2	Coffs Harbour	\$2,096,690	\$86,948	\$2,183,638
J226	D2	Manning, Wingham	\$1,988,782	\$1,670,106	\$3,658,888

NSW Funding Guidelines for Rehabilitation and Extended Care 2004/2005

Code	Peer Group	Name	Total Rehabilitation and Extended Care: Admitted Patients (Program 4.1.00.1)	Total Rehabilitation and Extended Care: Non-Admitted Patients (Program 4.1.00.2)	Total
Q206	C1	Maitland	\$1,890,288	\$3,255	\$1,893,543
H212	C2	Kempsey	\$1,881,895	\$0	\$1,881,895
J201	C1	Armidale	\$1,608,312	\$30,134	\$1,638,446
N210	F8	Mercy Young	\$1,593,479	\$1,695,108	\$3,288,587
Phase 1 implementation group			\$335,389,036	\$152,371,655	\$487,760,691
Implementation 2005-2006					
A237	A1a	Concord	\$8,971,507	\$2,241,265	\$11,212,772
H210	C1	Grafton	\$2,697,590	\$1,612,627	\$4,310,217
R205	C1	Griffith	\$1,705,395	\$0	\$1,705,395
N219	C1	Bowral	\$1,511,867	\$1,057,003	\$2,568,870
J222	D2	Werris Creek	\$1,094,426	\$12,987	\$1,107,413
Q217	C2	Singleton	\$1,086,894	\$281,957	\$1,368,851
J208	C2	Inverell	\$737,788	\$12,772	\$750,560
N206	C2	Cooma	\$532,230	\$0	\$532,230
Phase 2 implementation group			\$18,337,697	\$5,218,611	\$23,556,308
Other possible inclusions in 2005-2006 implementation, subject to Area review of activity and costs					
B202	A1b	Gosford	\$2,794,360	\$789,416	\$3,583,776
A208	A1a	Royal Prince Alfred	\$1,933,950	\$673,149	\$2,607,099
S201	C1	Broken Hill	\$2,406,195	\$1,317,605	\$3,723,800
N215	C2	Queanbeyan	\$1,893,252	\$0	\$1,893,252
M205	F4	Culcairn	\$1,697,279	\$0	\$1,697,279
M215	F4	Tumbarumba	\$2,045,564	\$12,206	\$2,057,770
K221	F4	Warren	\$3,050,802	\$41,094	\$3,091,896
K219	F4	Trangie	\$1,371,402	\$212,017	\$1,583,419
L215	F4	Oberon	\$1,368,890	\$43,246	\$1,412,136
L212	F4	Lake Cargelligo	\$1,149,483	\$70,946	\$1,220,429
L219	F4	Parkes, Trundle	\$837,651	\$0	\$837,651
R210	F8	Coolamon/Ganmain	\$1,264,028	\$0	\$1,264,028
D214	D1	Springwood	\$1,413,711	\$20,306	\$1,434,017
Other possible inclusions in 2005-2006			\$23,226,567	\$3,179,985	\$26,406,552
Inclusion in 2006-2007 or at Area discretion					
M207	C2	Deniliquin	\$1,999,946	\$0	\$1,999,946
M216	D2	Wentworth District	\$1,486,004	\$271,682	\$1,757,686
N202	C2	Bega	\$878,520	\$0	\$878,520
N211	C2	Moruya	\$302,901	\$0	\$302,901
N214	D1	Pambula	\$282,103	\$0	\$282,103
N204	D2	Boorowa	\$100,692	\$0	\$100,692
N203	D2	Bombala	\$33,347	\$136,832	\$170,179
Phase 3 possible inclusions			\$5,083,513	\$408,514	\$5,492,027
Excluded from funding model - MPS					
H213	F3	Kyogle	\$1,787,607	\$106,161	\$1,893,768
K207	F3	Baradine	\$1,561,066	\$70,279	\$1,631,345
M213	F3	McCaughey Memorial Urana	\$1,260,454	\$0	\$1,260,454
H205	F3	Campbell Coraki	\$416,638	\$117,023	\$533,661
N205	F3	Braidwood	\$349,823	\$0	\$349,823
Excluded from funding model - MPS			\$5,375,588	\$293,463	\$5,669,051
Excluded from funding model - more than 75% Maintenance					
R211	D1	Leeton	\$3,414,191	\$0	\$3,414,191
R209	D2	Junee	\$2,803,235	\$0	\$2,803,235
B204	D2	Long Jetty	\$2,637,256	\$1,066	\$2,638,322

NSW Funding Guidelines for Rehabilitation and Extended Care 2004/2005

Code	Peer Group	Name	Total Rehabilitation and Extended Care: Admitted Patients (Program 4.1.00.1)	Total Rehabilitation and Extended Care: Non-Admitted Patients (Program 4.1.00.2)	Total
M206	D1	Corowa	\$2,427,079	\$0	\$2,427,079
K218	D2	Nyngan	\$2,027,923	\$65,966	\$2,093,889
M210	D2	Holbrook	\$1,937,811	\$0	\$1,937,811
K213	D2	Gilgandra	\$1,821,633	\$145,793	\$1,967,426
K220	D1	Walgett	\$1,800,399	\$564,859	\$2,365,258
H224	F3	Urbenville	\$1,766,222	\$0	\$1,766,222
L208	D2	Eugowra	\$1,680,922	\$4,262	\$1,685,184
K201	D1	Bourke	\$1,662,050	\$85,426	\$1,747,476
L202	D2	Blayney	\$1,643,103	\$9,257	\$1,652,360
J224	D2	Gloucester Soldiers' Mem	\$1,638,620	\$0	\$1,638,620
L210	F4	Grenfell	\$1,614,402	\$14,536	\$1,628,938
L214	D2	Molong	\$1,605,426	\$0	\$1,605,426
J214	D2	Prince Albert Tenterfield	\$1,584,530	\$56,808	\$1,641,338
R206	D2	Gundagai	\$1,574,373	\$0	\$1,574,373
K209	D2	Coonamble	\$1,508,917	\$2,669	\$1,511,586
Q205	C2	Kurri Kurri	\$1,481,531	\$249,835	\$1,731,366
R207	D2	Hay	\$1,429,735	\$0	\$1,429,735
K202	D1	Cobar	\$1,357,020	\$27,617	\$1,384,637
J218	D2	Vegetable Creek	\$1,338,317	\$15,303	\$1,353,620
J203	D2	Bingara	\$1,309,736	\$0	\$1,309,736
L218	D2	Parkes, Peak Hill	\$1,235,771	\$8,565	\$1,244,336
M204	D2	Berrigan War Memorial	\$1,197,569	\$0	\$1,197,569
J204	D2	Boggabri	\$1,196,631	\$35,601	\$1,232,232
Q214	C1	Belmont	\$1,190,235	\$0	\$1,190,235
J217	D2	Inverell Tingha	\$1,188,719	\$0	\$1,188,719
K204	D2	Collarenebri	\$1,182,530	\$120,335	\$1,302,865
L221	D2	Rylstone	\$1,181,703	\$84,114	\$1,265,817
J202	D2	Barraba	\$1,153,732	\$56,217	\$1,209,949
J219	D2	Walcha	\$1,030,190	\$56,171	\$1,086,361
M209	D2	Henty	\$994,303	\$0	\$994,303
M214	D2	Tocumwal	\$962,037	\$0	\$962,037
Q219	D2	Wilson Memorial Murrurundi	\$957,598	\$0	\$957,598
R213	D2	Lockhart	\$952,744	\$0	\$952,744
K205	D2	Coolah	\$947,986	\$0	\$947,986
J207	F8	Guyra	\$946,700	\$21,859	\$968,559
K217	D1	Narromine	\$927,486	\$195,224	\$1,122,710
N207	D1	Crookwell	\$891,862	\$0	\$891,862
H223	C1	Tweed Heads	\$869,651	\$1,375,013	\$2,244,664
K210	D2	Gulgambone	\$866,453	\$0	\$866,453
K212	D2	Dunedoo	\$861,654	\$0	\$861,654
R208	D2	Hillston	\$810,219	\$0	\$810,219
M202	D2	Balranald	\$792,755	\$134,555	\$927,310
R202	D1	Batlow	\$769,441	\$0	\$769,441
M203	D2	Barham & Koondrook Memorial	\$733,199	\$46	\$733,245
J211	D2	Manilla	\$729,370	\$72,283	\$801,653
H216	C2	Macksville	\$722,128	\$0	\$722,128
L203	D1	Canowindra	\$706,392	\$209,155	\$915,547
K215	D1	Gulgong	\$650,572	\$26,648	\$677,220
J220	D2	Warialda	\$639,145	\$51,625	\$690,770
Q208	D2	Merriwa	\$611,182	\$8,731	\$619,913
Q210	D2	Muswellbrook, Denman Subsidiary	\$564,776	\$0	\$564,776
J221	D1	Wee Waa	\$543,896	\$66,256	\$610,152
P204	F8	Kiama	\$474,167	\$469,940	\$944,107
L223	D2	Tottenham	\$412,203	\$52,523	\$464,726
Q216	D1	Scott Memorial Scone	\$348,322	\$0	\$348,322

NSW Funding Guidelines for Rehabilitation and Extended Care 2004/2005

Code	Peer Group	Name	Total Rehabilitation and Extended Care: Admitted Patients (Program 4.1.00.1)	Total Rehabilitation and Extended Care: Non-Admitted Patients (Program 4.1.00.2)	Total
D201	B1	Auburn	\$346,994	\$2,606,034	\$2,953,028
H206	C2	Casino	\$314,766	\$309,236	\$624,002
K206	D1	Coonabarabran	\$298,841	\$0	\$298,841
H217	C2	Maclean	\$280,624	\$455,561	\$736,185
H215	D2	Lismore, Nimbin	\$279,069	\$167,691	\$446,760
Excluded from funding model - more than 75% Maintenance			\$73,828,047	\$7,826,781	\$81,654,827
Excluded from funding model - other reasons					
H201	C2	Ballina	\$1,126,309	\$1,494,957	\$2,621,266
M211	D2	Jerilderie	\$1,004,499	\$0	\$1,004,499
J205	D1	Glen Innes	\$876,599	\$0	\$876,599
L226	D2	Wyalong	\$717,795	\$0	\$717,795
J206	C2	Gunnedah	\$690,079	\$406	\$690,485
Q202	C2	Cessnock	\$681,744	\$1,094,053	\$1,775,797
R216	D1	Temora	\$667,811	\$0	\$667,811
H214	B2	Lismore	\$613,358	\$1,763,706	\$2,377,064
L220	D2	Portland	\$568,683	\$0	\$568,683
L206	C2	Cowra	\$561,555	\$588,581	\$1,150,136
L209	C2	Forbes	\$547,017	\$210,052	\$757,069
L217	C2	Parkes	\$461,379	\$1,075,508	\$1,536,887
K216	C2	Mudgee	\$455,843	\$477,866	\$933,709
C238	A2	Sydney Children's	\$422,779	\$757,475	\$1,180,254
J213	D1	Narrabri	\$421,929	\$15,130	\$437,059
K222	D1	Wellington	\$392,938	\$377,396	\$770,334
R221	D1	Cootamundra	\$376,387	\$0	\$376,387
J215	D1	Quirindi	\$375,698	\$101,887	\$477,585
R218	D1	Tumut	\$360,292	\$0	\$360,292
J212	C2	Moree	\$344,804	\$4,925	\$349,729
Q203	D2	Dungog	\$318,462	\$0	\$318,462
R215	D1	Narrandera	\$293,600	\$0	\$293,600
L213	C2	Lithgow	\$282,067	\$813,975	\$1,096,042
L205	D1	Condobolin	\$277,503	\$131,798	\$409,301
M208	D1	Finley	\$270,943	\$0	\$270,943
N201	C2	Bateman's Bay	\$251,394	\$0	\$251,394
H220	D1	Mullumbimby	\$213,814	\$93,279	\$307,093
K203	D1	Cobar	\$204,786	\$50,946	\$255,732
L224	D2	Tullamore	\$198,073	\$41,602	\$239,675
N213	D2	Murrumburrah-Harden	\$195,055	\$0	\$195,055
N217	D1	Yass	\$174,488	\$0	\$174,488
J223	D1	Bulahdelah	\$160,628	\$0	\$160,628
H203	D1	Bellingen River District	\$148,781	\$0	\$148,781
N218	C2	Young	\$122,217	\$0	\$122,217
C201	A3	Royal Hosp for Women	\$113,984		\$113,984
H225	D1	Wauchope	\$101,130	\$0	\$101,130
K211	B2	Dubbo	\$98,625	\$0	\$98,625
Q209	C2	Muswellbrook	\$76,814	\$21,592	\$98,406
D206	B1	Fairfield	\$58,488	\$2,307,843	\$2,366,331
C205	F8	Lord Howe Is.	\$44,640		\$44,640
H204	D1	Byron Bay	\$36,455	\$8,136	\$44,591
Q225	D1	Nelson Bay Polyclinic	\$32,616	\$988,079	\$1,020,695
N208	F4	Delegate	\$32,004	\$0	\$32,004
P208	A1b	Wollongong	\$29,963	\$0	\$29,963
H209	F4	Dorrigo	\$29,006	\$0	\$29,006
P202	C2	Bulli	\$25,120	\$0	\$25,120
H207	D1	Casino, Bonalbo	\$17,523	\$12,075	\$29,598

NSW Funding Guidelines for Rehabilitation and Extended Care 2004/2005

Code	Peer Group	Name	Total Rehabilitation and Extended Care: Admitted Patients (Program 4.1.00.1)	Total Rehabilitation and Extended Care: Non-Admitted Patients (Program 4.1.00.2)	Total
P205	C2	Milton-Ulladulla	\$9,424	\$372,749	\$382,173
P211	C1	Shellharbour	\$4,569	\$0	\$4,569
N209	C1	Goulburn	\$2,873	\$0	\$2,873
Excluded from funding model - other			\$15,492,543	\$12,804,016	\$28,296,559
Excluded from funding model – F2 Nursing Homes					
D755	F8	Lottie Stewart	\$9,893,752	\$7	\$9,893,759
C791	F2	Garrawarra	\$13,061,228		\$13,061,228
Q791	F2	Allandale	\$10,440,018		\$10,440,018
N752	F2	Murrumburrah-Harden	\$7,555,146	\$177,625	\$7,732,771
Q758	F2	Wallsend	\$7,150,147		\$7,150,147
D758	F2	Queen Victoria Thirlmere	\$6,400,287		\$6,400,287
D753	F2	Carrington	\$6,057,963		\$6,057,963
D754	F2	Governor Phillip	\$5,227,995		\$5,227,995
N751	F2	Mount St. Joseph's Young	\$2,389,157	\$667,677	\$3,056,834
B751	F2	Graythwaite	\$1,725,836		\$1,725,836
J751	F2	Gloucester - NH unit	\$1,118,221		\$1,118,221
Q759	F2	Muswellbrook	\$1,014,347		\$1,014,347
D751	F2	Bodington	\$352,440		\$352,440
Excluded from funding model - nursing homes			\$72,386,537	\$845,309	\$73,231,846
Total			\$550,616,056	\$183,081,146	\$733,697,202

Appendix 4

The NSW benchmark for Rehabilitation and Extended Care and the method used to derive it

The cost data used were based on 2002/2003 UAR costs reported by Areas. The cost file included general ledger expenditure only, with no revenue offsets. Combo cost data were also reviewed where available. Activity data were extracted from SNAPshot and reconciled against HIE data.

In the first stage of the costing, the costs of the 54 units currently collecting SNAP data were calculated and reviewed. After review, 18 were excluded from the costing study. In most cases, this was because of problems with their activity data, their cost data or both. In some cases, the hospital was excluded because 2002/03 was an atypical year because of reasons such as a change in role.

The next stage involved a more thorough review of the 36 remaining units. A raw cost per episode and a casemix-adjusted cost per episode was calculated for each hospital. The rules used in the costing are summarised in Section 3.1.

If necessary, Area Health Services and hospitals were contacted to review the data and, in some cases, were able to provide more accurate cost data. In some cases, problems with either cost or activity data were identified that could not be rectified in time for inclusion in the benchmark costing group. Such hospitals were trimmed from the data set. Table 8 provides the cost and activity data for all 36 units, including those with known data errors.

Adjustments were made for:

- The cost of any acute beddays in designated SNAP units that were recorded in *SNAPshot* as Case Type 6. The *SNAPshot* data system allows units to register this care as an acute episode (Case Type 6). In the absence of DRG data, the default approach was used and these days were pegged to AR-DRG Version 4.1 Class F63B (Venous Thrombosis without Catastrophic or Severe CC) and funded on a per diem rate. This class had an average per diem cost of \$583 in 2002/2003.
- SNAP beddays in non-designated units in those hospitals whose UAR data included the cost of both designated and non-designated units. The method used is summarised in Section 3.1 on page 10.

The benchmark cost for 2004/05 was based on a final sample of 29 hospitals that were considered to have good quality cost and activity data. They are shown in Table 4 below.

In summary, the benchmark set for 2004/05:

1. Is based on 2002/2003 data.
2. Includes all of the direct costs of providing rehabilitation and extended care.
3. Includes a share of Area and hospital overhead costs.
4. Includes depreciation.
5. Includes superannuation and workers compensation for all hospitals, including those where these items are retained at the Area level.
6. Excludes all costs associated with teaching and research that are held in Program 6.1.
7. Include a cost escalation factor of 4.61% from 2002/03 to 2003/04 and 2.0% from 2003/04 to 2004/05.

Table 4 *Benchmark cost data*

Code	Peer Group	Name	Average weight						Casemix adjusted episode cost	Raw episode cost
			Pall Care	Rehab	Psych Ger	GEM	Maint	All		
D224	A1	Westmead (BIU only)	0.00	3.45	0.00	0.00	0.16	3.44	\$13,214	\$45,475
D209	A1	Liverpool (BIU only)	0.00	3.87	0.00	0.00	0.00	4.04	\$12,387	\$50,016
B208	F8	Greenwich	0.28	1.08	0.00	0.87	1.29	0.40	\$11,946	\$4,783
D218	B1	Mount Druitt	0.47	0.00	0.00	0.00	0.00	0.48	\$11,844	\$5,641
Q211	A3	Newcastle Mater	0.29	0.00	0.00	0.00	0.00	0.29	\$11,776	\$3,439
Q213	A3	Royal Newcastle	0.00	1.48	0.00	0.00	1.06	1.67	\$11,002	\$9,199
B221	F6	Royal Rehabilitation	0.00	2.42	0.00	0.73	2.45	2.43	\$10,987	\$26,698
B214	B1	Mona Vale	0.00	1.01	0.00	0.60	0.00	1.00	\$10,498	\$10,550
M212	F8	Mercy Albury	0.74	1.55	1.92	1.20	2.13	1.41	\$10,340	\$14,593
C206	F6	Waverly War Mem	0.46	1.23	0.00	0.00	0.49	1.20	\$10,147	\$12,215
A209	F5	Sacred Heart	0.52	1.34	0.00	0.00	0.00	0.61	\$10,106	\$6,194
A202	B1	Canterbury	0.45	0.00	0.00	0.00	0.00	0.46	\$10,105	\$4,656
D213	F8	St Joseph's	0.40	1.62	2.37	0.00	1.26	0.84	\$9,665	\$8,076
P206	F6	Port Kembla	0.66	1.54	0.00	0.00	1.75	1.32	\$9,656	\$12,709
A201	F8	Balmain	0.00	1.39	0.00	0.00	0.00	1.42	\$9,634	\$13,705
Q206	C1	Maitland	0.00	1.64	0.00	0.00	1.53	1.62	\$9,507	\$15,446
C208	A1	Prince of Wales	0.00	2.18	0.00	0.00	1.34	2.14	\$9,485	\$20,280
B206	B1	Wyong	0.00	1.28	0.00	0.00	0.00	1.29	\$9,171	\$11,834
L201	C1	Bathurst	0.00	1.55	0.00	0.00	0.00	1.57	\$8,997	\$14,134
D227	B1	Bankstown	0.00	1.28	1.83	0.00	0.00	1.37	\$8,981	\$12,347
Q215	F2	Rankin Park	0.00	2.15	0.00	0.00	1.58	2.07	\$8,961	\$18,519
C202	F5	Calvary Kogarah	0.54	1.22	0.00	0.00	0.00	0.74	\$8,601	\$6,380
P291	F8	David Berry	0.42	1.59	0.00	0.00	0.66	0.74	\$8,270	\$6,139
B203	D2	Woy Woy	0.00	1.51	0.00	0.00	0.00	1.52	\$8,093	\$12,273
J216	B2	Tamworth	0.00	1.65	0.00	0.13	0.40	1.63	\$8,086	\$13,165
D215	B1	Macarthur	0.35	1.50	0.00	0.97	0.54	0.78	\$7,960	\$6,201
L216	C1	Orange	0.00	1.48	0.00	0.00	0.00	1.49	\$7,635	\$11,406
D228	F8	Braeside	0.51	1.50	1.87	0.00	0.00	0.99	\$7,221	\$7,150
P203	F8	Coledale	1.39	1.49	0.00	0.00	1.17	1.34	\$7,137	\$9,539
Grand Total			0.4285	1.6202	2.0247	1.1169	1.4702	0.9951	\$9,566	\$9,519
Benchmark for 2004/05									\$10,260	

The benchmark for 2004/05 of \$10,260 is based on the mean casemix-adjusted episode cost of the hospitals in the benchmark costing study. These hospitals had an average weight of 0.9951. The benchmark is for a cost weight of 1.00, escalated to reflect cost increases since 2002/03.

Appendix 5

Raw and cost-weighted hospital activity of hospitals included in the 2004/05 funding model

Table 5 *Reconciliation of 2002/03 activity data reported in SNAPshot and the HIE*

Code	Peer Group	Name	HIE count	SNAPshot count	Merged count	SNAPshot coverage	% matching	Coverage and matching rate >90%
M201	B2	Albury	252	500	285	100.00%	100.00%	Yes
J201	C1	Armidale	146	49	47	33.56%	95.92%	
A201	F8	Balmain	320	309	292	96.56%	94.50%	Yes
D227	B1	Bankstown	486	556	344	100.00%	61.87%	
L201	B2	Bathurst	282	226	222	80.14%	98.23%	
D203	B1	Blacktown	457	419	414	91.68%	98.81%	Yes
D204	C1	Blue Mountains	246	156	155	63.41%	99.36%	
N203	D2	Bombala	12	6		50.00%		
N204	D2	Boorowa	6	18	1	100.00%	5.56%	
D228	F8	Braeside	879	901	763	100.00%	84.68%	
C202	F5	Calvary Kogarah	1290	1254	1253	97.21%	99.92%	Yes
H205	F3	Campbell , Coraki	39	40	38	100.00%	95.00%	Yes
A202	B1	Canterbury	323	330	317	100.00%	96.06%	Yes
H208	B2	Coffs Harbour	105	68	65	64.76%	95.59%	
P203	F8	Coledale	299	527	306	100.00%	58.06%	
P291	F8	David Berry	423	411	421	97.16%	100.00%	Yes
D206	B1	Fairfield	555	526	504	94.77%	95.82%	Yes
B208	F8	Greenwich	723	560	569	77.46%	100.00%	
B210	B1	Hornsby & Ku-Ring-Gai	634	933	802	100.00%	85.96%	
Q230	A1	John Hunter	455	410	409	90.11%	99.76%	Yes
H212	C2	Kempsey	122	76	69	62.30%	90.79%	
D209	A1	Liverpool	65	89	60	100.00%	67.42%	
K751	F2	Lourdes Nursing Home- Dubbo	288	288	297	100.00%	100.00%	Yes
Q206	C1	Maitland	142	95	82	66.90%	86.32%	
B212	B1	Manly	249	118	116	47.39%	98.31%	
J225	B2	Manning River	88	48	38	54.55%	79.17%	
M212	F8	Mercy Care Centre, Albury	462	416	476	90.04%	100.00%	Yes
N210	F8	Mercy Care Centre, Young	319	305	309	95.61%	100.00%	Yes
B214	B1	Mona Vale	501	382	373	76.25%	97.64%	
D218	B1	Mount Druitt	246	291	184	100.00%	63.23%	
H221	C2	Murwillumbah	282	259	271	91.84%	104.63%	Yes
D210	A1	Nepean	223	121	120	54.26%	99.17%	
B209	F5	Neringah Home of Peace	393	317	323	80.66%	100.00%	
Q211	A3	Newcastle Mater	478	424	416	88.70%	98.11%	Yes
L216	B2	Orange	284	218	231	76.76%	100.00%	
P206	F6	Port Kembla	791	752	754	95.07%	100.00%	Yes
C233	A1	Prince of Wales	581	547	551	94.15%	100.00%	Yes
Q213	A3	Royal Newcastle	289	117	112	40.48%	95.73%	
B218	A1	Royal North Shore	258	814	47	100.00%	5.77%	
B221	F6	Royal Rehabilitation	496	523	511	100.00%	97.71%	Yes

NSW Funding Guidelines for Rehabilitation and Extended Care 2004/2005

Code	Peer Group	Name	HIE count	SNAPshot count	Merged count	SNAPshot coverage	% matching	Coverage and matching rate >90%
B753	F3	Royal Rehab. Weemala	25	60	13	100.00%	21.67%	
B224	B1	Ryde	250	644	293	100.00%	45.50%	
A209	F5	Sacred Heart	834	815	827	97.72%	100.00%	Yes
P207	C1	Shoalhaven	156	129	129	82.69%	100.00%	
N216	F8	St John of God Goulburn	372	380	368	100.00%	96.84%	Yes
D213	F8	St Joseph's	1077	1049	1054	97.40%	100.00%	Yes
C213	A1	St. George	326	217	208	66.56%	95.85%	
H222	F6	St. Vincent's (Lismore) Public Rehab	346	341	338	98.55%	99.12%	Yes
H306	PH	St. Vincent's Private - Lismore		340				
C214	B1	Sutherland	519	467	461	89.98%	98.72%	
J216	B2	Tamworth	318	290	264	91.19%	91.03%	Yes
R219	B2	Wagga Wagga	204	183	196	89.71%	100.00%	
C206	F6	Waverly War Memorial	532	521	533	97.93%	100.00%	Yes
D224	A1	Westmead	828	396	281	47.83%	70.96%	
B203	D2	Woy Woy	392	358	349	91.33%	97.49%	Yes
B206	B1	Wyong	419	390	410	93.08%	100.00%	Yes
Grand Total			21087	20298	17808	94.65%	89.23%	

Table 6 2002/03 Beddays by Case Type by Hospital

Code	Peer Gp	Name	Total Pall days	Pall days in designated unit	Total Rehab days	Rehab days in designated unit	Total Psych-ger	Psych-ger days	Total GEM	GEM days in designated unit	Total Main.	Main. Days in designated unit	Total SNAP days	Total in designated SNAP units	% of episode in designated units
M201	B2	Albury	138	0	5741	5539	0	0	0	0	1513	532	7392	6071	82.1%
J201	C1	Armidale	185	6	2149	1536	0	0	1	0	1580	396	3915	1938	49.5%
A201	F8	Balmain	7	0	10330	6821	0	0	0	0	522	258	10859	7079	65.2%
D227	B1	Bankstown	361	94	8020	7299	242	241	218	68	2079	1274	10920	8976	82.2%
L201	C1	Bathurst	4	0	2167	2165	0	0	0	0	345	286	2516	2451	97.4%
D203	B1	Blacktown	0	0	8908	8858	49	0	0	0	1347	1333	10304	10191	98.9%
D204	C2	Blue Mountains	612	25	4099	4076	0	0	87	86	114	40	4912	4227	86.1%
N203	D2	Bombala	2	0	0	0	0	0	0	0	4982	4935	4984	4935	99.0%
N204	D2	Boorowa	23	0	27	0	0	0	0	0	4520	4487	4570	4487	98.2%
D228	F8	Braeside	6808	6153	12809	11736	5009	43	0	0	0	0	24626	17932	72.8%
C202	F5	Calvary Kogarah	12169	12082	13273	13269	0	0	0	0	0	0	25442	25351	99.6%
H205	D2	Campbell Coraki	127	127	0	0	0	0	0	0	1008	1008	1135	1135	100.0%
A202	B1	Canterbury	4334	4289	1839	0	0	0	0	0	0	0	6173	4289	69.5%
H208	B2	Coffs Harbour	6	0	3797	2869	0	0	0	0	82	0	3885	2869	73.8%
P203	F8	Coledale	16	16	7017	7017	0	0	0	0	408	408	7441	7441	100.0%
P291	F8	David Berry	2167	2158	4946	4946	0	0	0	0	544	544	7657	7648	99.9%
B208	F8	Greenwich	5298	5289	8454	8402	6323	0	0	0	351	351	20426	14042	68.7%
B210	B1	Hornsby	0	0	12195	12142	0	0	0	0	1786	394	13981	12536	89.7%
Q230	A1	Rankin Park (John Hunter coded)	0	0	12708	12692	106	106	270	65	2215	851	15299	13714	89.6%
H212	C2	Kempsey	281	0	2144	2144	0	0	0	0	1578	26	4003	2170	54.2%
D209	A1	Liverpool	63	0	7381	5125	226	0	147	0	2	0	7819	5125	65.5%
K751	F2	Lourdes Dubbo	945	941	5043	5043	0	0	1469	1469	1461	1461	8918	8914	100.0%
Q206	C1	Maitland	211	0	2649	2627	0	0	199	152	996	327	4055	3106	76.6%
B212	B1	Manly	6	6	4379	4324	3133	0	0	0	1645	242	9163	4572	49.9%
J225	B2	Manning River	913	215	0	0	0	0	0	0	2972	166	3885	381	9.8%
J226	D2	Manning Wingham	0	0	4593	4590	0	0	0	0	112	112	4705	4702	99.9%
M212	F8	Mercy Albury	1012	1010	2038	2038	139	139	3150	3150	5765	5765	12104	12102	100.0%
N210	F8	Mercy Young	711	710	2019	2019	6	6	1551	1551	1305	1290	5592	5576	99.7%
B214	B1	Mona Vale	333	0	7630	7630	0	0	0	0	1356	512	9319	8142	87.4%
D218	B1	Mount Drutt	2030	2022	0	0	0	0	0	0	7377	7375	9407	9397	99.9%
H221	C2	Murwillumbah	673	6	7073	7073	0	0	0	0	197	0	7943	7079	89.1%
D210	A1	Nepean	3189	4	7270	6582	0	0	32	0	713	66	11204	6652	59.4%
B209	F5	Neringah	4627	4606	88	88	0	0	0	0	12	12	4727	4706	99.6%
Q211	A3	Newcastle Mater	4915	4899	0	0	0	0	91	12	1583	1199	6589	6110	92.7%
L216	B2	Orange	16	0	1904	1903	0	0	0	0	257	45	2177	1948	89.5%
P206	A1	Port Kembla	3945	3940	14185	14185	0	0	0	0	397	397	18527	18522	100.0%
Q213	A3	Royal Newcastle	0	0	8905	7642	0	0	29	1	1224	1056	10158	8699	85.6%
B218	A1	Royal North Shore	16	0	1657	10	0	0	63	18	1912	533	3648	561	15.4%
B221	F6	Royal Rehabilitation	0	0	25533	25527	0	0	0	0	34224	22903	59757	48430	81.0%
B224	B1	Ryde	0	0	3938	3912	0	0	0	0	0	0	3938	3912	99.3%
A209	F5	Sacred Heart	13677	13663	4680	4679	0	0	0	0	0	0	18357	18342	99.9%
P207	C1	Shoalhaven	0	0	3446	3426	0	0	0	0	192	126	3638	3552	97.6%
N216	F8	St John of God Goulburn	901	901	3375	3375	12	12	1422	1422	4703	4703	10413	10413	100.0%
D213	F8	St Joseph's	6585	6572	13235	13231	4723	4593	0	0	813	812	25356	25208	99.4%

NSW Funding Guidelines for Rehabilitation and Extended Care 2004/2005

Code	Peer Gp	Name	Total Pall days	Pall days in designated unit	Total Rehab days	Rehab days in designated unit	Total Psych-ger	Psych-ger days	Total GEM	GEM days in designated unit	Total Main.	Main. Days in designated unit	Total SNAP days	Total in designated SNAP units	%of episode in designated units
C213	A1	St. George	720	6	10903	7258	430	1	2631	45	3072	115	17756	7425	41.8%
H222	F6	St. Vincent's (Lismore) Public R	0	0	10635	10635	0	0	0	0	0	0	10635	10635	100.0%
C214	B1	Sutherland	1493	56	8827	7549	225	0	1366	1	10547	1682	22458	9288	41.4%
J216	B2	Tamworth	888	887	4984	4936	5602	5601	7	7	136	126	11617	11557	99.5%
R219	B2	Wagga Wagga	194	0	7562	4809	1414	0	4938	0	2407	215	16515	5024	30.4%
C206	F6	Waverly Memorial	5	5	10882	10879	0	0	0	0	313	313	11200	11197	100.0%
D224	A1	Westmead	2318	2031	14294	11633	146	0	0	0	1950	1022	18708	14686	78.5%
B203	D2	Woy Woy	0	0	9466	9359	0	0	0	0	2820	54	12286	9413	76.6%
B206	B1	Wyong	0	0	8818	8814	0	0	0	0	39	6	8857	8820	99.6%
Grand Total			82924	72719	338015	312412	27785	10742	17671	8047	115476	69758	581871	473678	81.4%

Source: SNAPshot and HIE

Includes only those hospitals in the funding model in 2004/05.

Table 7 Cost weighted admissions by hospital 2002/03

Code	Peer Group	Name	Pall Care	Rehab	Psych Ger	GEM	Maint	Sub Total	Error Cost Weights	Grand Total
M201	B2	Albury		322.39				322.39	9.73	332.12
J201	C1	Armidale		64.33			6.37	70.70	1.72	72.42
A201	F8	Balmain		432.33				432.33	10.07	442.40
D227	B1	Bankstown		594.67	164.46			759.13	2.54	761.67
L201	C1	Bathurst		335.31				335.31	4.04	339.35
D203	B1	Blacktown		534.25			41.41	575.66	8.14	583.80
D204	C1	Blue Mountains		186.02				186.02	0.52	186.54
N203	D2	Bombala					2.04	2.04	1.84	3.88
N204	D2	Boorowa					78.83	78.83	17.98	96.81
D228	F8	Braeside	410.73	622.21	281.91			1314.85	36.82	1351.67
C202	F5	Calvary Kogarah	816.12	759.33				1575.45	7.53	1582.98
A202	B1	Canterbury	308.43					308.43	8.07	316.50
P203	F8	Coledale	4.16	423.45			308.79	736.40	0.05	736.45
P291	F8	David Berry	180.57	261.27			19.93	461.77	2.90	464.67
B208	F8	Greenwich	497.00	317.65		0.87	2.58	818.10	6.28	824.38
B210	B1	Hornsby & Ku-Ring-Gai		951.29		0.37	31.56	983.22	24.89	1008.11
D209	A1	Liverpool		405.93				405.93	26.12	432.05
K751	F6	Lourdes Dubbo	165.55	574.28		150.96	83.80	974.59	78.13	1052.72
D215	B1	Macarthur	162.32	417.96		8.74	5.37	594.39		594.39
Q206	C1	Maitland		134.53			21.44	155.97		155.97
B212	B1	Manly		171.36				171.36		171.36
M212	F8	Mercy Albury	63.63	47.96	7.68	212.57	260.37	592.21	0.54	592.75
N210	F8	Mercy Young	42.13	119.28		77.92	59.46	298.79	6.44	305.23
B214	B1	Mona Vale		366.93		0.60		367.53	0.29	367.82
D218	B1	Mount Druitt	193.04					193.04	3.67	196.71
D210	A1	Nepean		242.10				242.10	7.73	249.83
L216	C1	Orange		324.55				324.55	2.61	327.16
P206	F6	Port Kembla	232.58	928.01			35.02	1195.61	2.13	1197.74
C233	A3	Prince of Wales		1328.19			40.14	1368.33		1368.33
Q215	F6	Rankin Park		830.44			113.90	944.34	2.15	946.49
Q213	A3	Royal Newcastle		191.16			6.34	197.50	28.25	225.75
B221	F6	Royal Rehabilitation		1251.09		2.20	626.99	1880.28	5.37	1885.65
B224	B1	Ryde		247.05				247.05	39.92	286.97
A209	F5	Sacred Heart	907.35	293.81				1201.16	0.59	1201.75
P207	C1	Shoalhaven		191.96			3.54	195.50		195.50
N216	F8	St John of God Goulburn	61.61	172.80	52.49	74.02	169.72	530.64	14.08	544.72
D213	F8	St Joseph's	523.79	746.82	284.99		55.58	1611.18	12.29	1623.47

NSW Funding Guidelines for Rehabilitation and Extended Care 2004/2005

Code	Peer Group	Name	Pall Care	Rehab	Psych Ger	GEM	Maint	Sub Total	Error Cost Weights	Grand Total
C213	A1	St. George		337.50				337.50	3.17	340.67
H222	F6	St. Vincent's Lismore Public Rehab		608.21			10.52	618.73		618.73
H306	PH	St. Vincent's Lismore Private	257.90					257.90	3.26	261.16
C214	B1	Sutherland		449.48			57.31	506.79	0.36	507.15
J216	B2	Tamworth		308.49		0.64	0.80	309.93	5.94	315.87
R219	B2	Wagga Wagga		300.98				300.98	2.74	303.72
C206	F6	Waverly War Memorial	0.46	613.29			10.84	624.59	1.38	625.97
D224	A1	Westmead	187.31	437.77			0.31	625.39	5.85	631.24
B203	D2	Woy Woy		537.02				537.02	1.38	538.40
B206	B1	Wyong		516.44				516.44	6.12	522.56
Grand Total			5014.68	18899.89	791.53	528.89	2052.96	27287.96	403.63	27691.59

Source: SNAPshot collection

Appendix 6

Hospital cost data

Table 8 Hospital costs and comparison to the 2004/05 benchmark

Code	Peer Group	Name	Average weight						Casemix adjusted episode cost	Raw episode cost	Benchmark budget for in-scope patients (see note 1)	In scope cost (see note 2)	Difference from current budget (see note 3)	As percentage of current cost	Add funding for SNAP days in non-designated units (see note 4)	Add funding for acute care days in designated units (see note 5)
			Pall Care	Rehab	Psych Ger	GEM	Maint	Average all								
D224	A1	Westmead (BIU only)	0.00	3.45	0.00	0.00	0.16	3.44	\$13,214	\$45,475	\$4,553,855	\$6,259,362	-\$1,705,507	-27.2%	\$0	\$0
M201	B2	Albury	0.00	1.50	0.00	0.00	0.00	1.43	\$15,633	\$22,379	\$3,406,864	\$5,539,799	-\$2,132,935	-38.5%	\$478,537	\$1,680,187
R219	B2	Wagga Wagga	0.00	1.64	0.00	0.00	0.00	1.66	\$13,649	\$22,654	\$3,115,631	\$4,423,495	-\$1,307,864	-29.6%	\$3,603,039	\$0
B212	B1	Manly	0.00	1.27	0.00	0.00	0.00	1.27	\$12,901	\$16,375	\$1,757,758	\$2,358,726	-\$600,969	-25.5%	\$748,079	\$0
L216	C1	Orange	0.00	1.48	0.00	0.00	0.00	1.49	\$7,635	\$11,406	\$3,355,948	\$2,665,229	\$690,719	25.9%	\$0	\$0
D209	A1	Liverpool	0.00	3.87	0.00	0.00	0.00	4.04	\$12,387	\$50,016	\$4,431,958	\$5,710,301	-\$1,278,343	-22.4%	\$0	\$46,655
B208	F8	Greenwich	0.28	1.08	0.00	0.87	1.29	0.40	\$11,946	\$4,783	\$8,456,502	\$10,508,302	-\$2,051,799	-19.5%	\$0	\$0
Q211	A3	Newcastle Mater	0.29	0.00	0.00	0.00	0.00	0.29	\$11,776	\$3,439	\$4,392,257	\$5,379,876	-\$987,619	-18.4%	\$0	\$0
K751	F2	Lourdes Dubbo	0.95	1.90	0.00	1.37	1.78	1.66	\$11,701	\$19,428	\$10,798,765	\$13,142,614	-\$2,343,848	-17.8%	\$0	\$0
D218	B1	Mount Druitt	0.47	0.00	0.00	0.00	0.00	0.48	\$11,844	\$5,641	\$2,017,908	\$2,486,011	-\$468,102	-18.8%	\$0	\$0
Q213	A3	Royal Newcastle	0.00	1.48	0.00	0.00	1.06	1.67	\$11,002	\$9,199	\$2,315,729	\$2,650,012	-\$334,283	-12.6%	\$0	\$217,721
B221	F6	Royal Rehabilitation	0.00	2.42	0.00	0.73	2.45	2.43	\$10,987	\$26,698	\$19,342,932	\$22,105,908	-\$2,762,976	-12.5%	\$0	\$0
L201	C1	Bathurst	0.00	1.55	0.00	0.00	0.00	1.57	\$8,997	\$14,134	\$3,480,974	\$3,257,569	\$223,405	6.9%	\$0	\$0
B214	B1	Mona Vale	0.00	1.01	0.00	0.60	0.00	1.00	\$10,498	\$10,550	\$3,773,046	\$4,120,095	-\$347,049	-8.4%	\$577,744	\$0
M212	F8	Mercy Albury	0.74	1.55	1.92	1.20	2.13	1.41	\$10,340	\$14,593	\$6,080,331	\$6,539,756	-\$459,425	-7.0%	\$0	\$0
C206	F6	Waverly War Mem.	0.46	1.23	0.00	0.00	0.49	1.20	\$10,147	\$12,215	\$6,421,202	\$6,777,249	-\$356,047	-5.3%	\$0	\$35,457
A209	F5	Sacred Heart	0.52	1.34	0.00	0.00	0.00	0.61	\$10,106	\$6,194	\$12,327,536	\$12,959,232	-\$631,697	-4.9%	\$0	\$0
A202	B1	Canterbury	0.45	0.00	0.00	0.00	0.00	0.46	\$10,105	\$4,656	\$3,246,699	\$3,412,719	-\$166,021	-4.9%	\$1,118,011	\$0
D213	F8	St Joseph's	0.40	1.62	2.37	0.00	1.26	0.84	\$9,665	\$8,076	\$16,653,482	\$16,742,379	-\$88,897	-0.5%	\$0	\$0
P206	F6	Port Kembla	0.66	1.54	0.00	0.00	1.75	1.32	\$9,656	\$12,709	\$12,286,385	\$12,339,665	-\$53,280	-0.4%	\$0	\$0

NSW Funding Guidelines for Rehabilitation and Extended Care 2004/2005

Code	Peer Group	Name	Average weight						Casemix adjusted episode cost	Raw episode cost	Benchmark budget for in-scope patients (see note 1)	In scope cost (see note 2)	Difference from current budget (see note 3)	As percentage of current cost	Add funding for SNAP days in non-designated units (see note 4)	Add funding for acute care days in designated units (see note 5)
			Pall Care	Rehab	Psych Ger	GEM	Maint	Average all								
A201	F8	Balmain	0.00	1.39	0.00	0.00	0.00	1.42	\$9,634	\$13,705	\$4,538,128	\$4,547,840	-\$9,712	-0.2%	\$2,217,349	\$0
Q206	C1	Maitland	0.00	1.64	0.00	0.00	1.53	1.62	\$9,507	\$15,446	\$1,599,961	\$1,582,117	\$17,845	1.1%	\$651,461	\$434,821
C233	A1	Prince of Wales	0.00	2.18	0.00	0.00	1.34	2.14	\$9,485	\$20,280	\$14,036,330	\$13,848,799	\$187,531	1.4%	\$1,260,763	\$0
B206	B1	Wyong	0.00	1.28	0.00	0.00	0.00	1.29	\$9,171	\$11,834	\$5,360,458	\$5,113,737	\$246,721	4.8%	\$16,175	\$0
D227	B1	Bankstown	0.00	1.28	1.83	0.00	0.00	1.37	\$8,981	\$12,347	\$7,813,116	\$7,298,755	\$514,362	7.0%	\$1,028,854	\$0
Q215	F2	Rankin Park	0.00	2.15	0.00	0.00	1.58	2.07	\$8,961	\$18,519	\$9,709,093	\$9,049,803	\$659,290	7.3%	\$0	\$0
C202	F5	Calvary Kogarah	0.54	1.22	0.00	0.00	0.00	0.74	\$8,601	\$6,380	\$16,238,098	\$14,528,010	\$1,710,088	11.8%	\$0	\$0
P291	F8	David Berry	0.42	1.59	0.00	0.00	0.66	0.74	\$8,270	\$6,139	\$4,766,665	\$4,100,548	\$666,117	16.2%	\$0	\$0
B203	D2	Woy Woy	0.00	1.51	0.00	0.00	0.00	1.52	\$8,093	\$12,273	\$5,522,920	\$4,648,993	\$873,928	18.8%	\$0	\$0
J216	C1	Tamworth	0.00	1.65	0.00	0.13	0.40	1.63	\$8,086	\$13,165	\$3,240,166	\$2,725,075	\$515,091	18.9%	\$0	\$0
D215	B1	Macarthur	0.35	1.50	0.00	0.97	0.54	0.78	\$7,960	\$6,201	\$6,097,358	\$5,048,154	\$1,049,204	20.8%	\$0	\$22,394
B224	B1	Ryde	0.00	0.68	0.00	0.00	0.00	0.49	\$7,638	\$3,715	\$2,943,818	\$2,338,702	\$605,116	25.9%	\$3,783	\$0
D228	F8	Braeside	0.51	1.50	1.87	0.00	0.00	0.99	\$7,221	\$7,150	\$13,865,244	\$10,413,889	\$3,451,355	33.1%	\$0	\$0
P203	F8	Coledale	1.39	1.49	0.00	0.00	1.17	1.34	\$7,137	\$9,539	\$7,554,425	\$5,608,063	\$1,946,361	34.7%	\$0	\$0
B210	B1	Hornsby	0.00	0.99	0.00	0.01	0.52	0.90	\$6,003	\$5,542	\$10,341,255	\$6,456,999	\$3,884,257	60.2%	\$0	\$0
N210	F8	Mercy Young	0.43	1.13	0.00	1.08	0.85	0.88	\$5,201	\$4,588	\$3,131,013	\$1,693,750	\$1,437,263	84.9%	\$6,492	\$0
Grand Total			0.44	1.53	2.02	0.67	1.38	1.01	\$9,591	\$9,649	\$248,973,811	\$248,381,532	\$592,279	0.2%	\$11,710,287	\$2,437,235

1. This is the budget for in-scope patients that the hospital would receive based on the 2004/05 benchmark cost.

2. This is expenditure after removing the costs of SNAP episodes in non-designated units as per the method outlined in Appendix 4. In total, \$12m was removed for SNAP episodes in non-designated units was removed using this method. Expenditure data are as reported in the UAR unless revised costs were provided by the Area Health Service. In most cases, revised cost data from Areas had the cost of SNAP episodes already removed and thus they are not shown in this column. Expenditure costs have been inflated to reflect costs in 2004/05.

3. This is the difference between the benchmark budget and expenditure in 2002/03 inflated to 2004/05 costs.

4. This is funding for SNAP days in non-designated units inflated to 2004/05 costs. This expenditure was removed from the calculation of the benchmark price. It is built back in to build up a total budget for each unit.

5. This is funding for acute care days in designated units, as reported in *SNAPshot*, inflated to 2004/05 costs. This expenditure is built back in to build up a total budget for each unit. In addition, funding from other programs such as Teaching and Research and for non-admitted services funded under Program 4.1 need to be included in the budget build up.