Consultation 2: Expanding home and community based rehabilitation care

Bupa Submission

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Context

A range of publications in the academic literature demonstrate that most patients get better clinical outcomes with in-home rehabilitation at a lower cost than rehabilitation provided in hospital (for example, Buhagiar et al, 2017; Langhorne & Baylan, 2017 Naylor et al 2017; Onggo et al 2018). Support in dealing with day-to-day tasks, in the patients' own environment, is demonstrably better in most cases than simulated, in-hospital rehabilitation with some exceptions, such as people who are particularly frail and have no family support. Unnecessary and prolonged hospital admissions also increase the risk of adverse events and hospital acquired infection.

The Royal Australian College of Surgeons (2018) has also noted the lack of evidence for inpatient rehabilitation following knee and hip replacement/revision, and Naylor and colleagues concluded a 2019 paper stating:

> *that current practice in Australia is not primarily guided by the available evidence or need and is likely provided at a far greater cost than it would be if the best available evidence were adopted. Resolving this evidence-practice gap should be a priority for all stakeholders.*

Yet overall in-patient rehabilitation rates following knee and hip replacements and revisions vary widely between states, hospitals and surgeons. Schilling et al (2018) found huge variation between surgeons who referred for inpatient rehabilitation of 0-100% and that this variation is driven mostly by provider characteristics rather than patient characteristics (75% vs 25%); with hospital related factors making the largest contribution to variation (47%). The huge variation found by Schilling et al (2018) is also evident in our data with rates of 10% - 92% and some hospitals transferring as many as 80-90% of patients to overnight, hospital-based rehab.

In other jurisdictions, the practice is following the evidence, and in-hospital rehabilitation is declining. In Australian public hospitals, for example, the rates of transfer to inpatient rehabilitation following a knee or hip replacement/revision is approximately 20-30%.

In the 12 months to Feb 2020, Bupa funded over 16,200 hip and knee joint replacement/revision episodes for over 15,500 members. Using public hospital transfer rates as a benchmark, our data indicates over 1,700 in-patient rehab episodes that could potentially have been provided equally safely and more cost effectively at home or in a community setting.

Problem definition

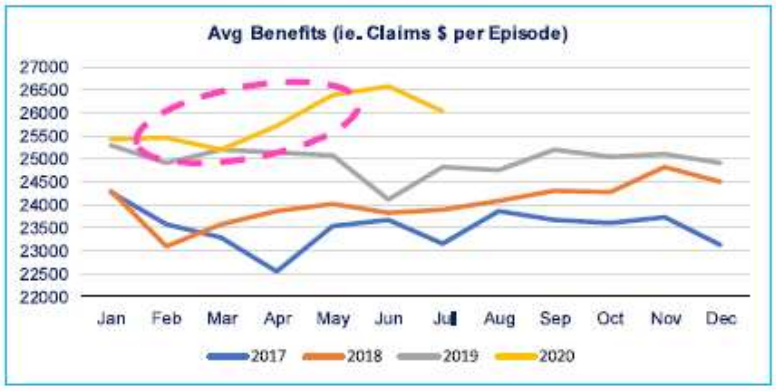
While we agree with the assessment of the Private Health Ministerial Advisory Committee's Improved Models of Care (IMOC) Working Group that in most cases the regulation does not appear to present a barrier for [providing or offering] alternatives to in hospital rehabilitation, there most certainly are financial incentives inherent in current regulations that limit the take-up of such alternatives.

These financial incentives include:

- Generous payments for in-patient rehabilitation has resulted in a proliferation of hospital delivered rehabilitation centres and an associated drive by hospitals to fill these rehabilitation beds. Acute hospitals which have corporate ownership of rehab centres often have in-patient rehabilitation rates up to five times what we see at other hospitals for the same acute admission types.
- Hospitals can self-define rehabilitation admission criteria, as well as the services provided, and the providers utilised for those services. For example, members are often admitted to the rehab hospital before the rehab physician has seen or assessed them, negating potential home or day program rehab options.

- Medical practitioners can only charge MBS fees for services provided face to face and hospital-based in- and out-patient services are therefore more convenient and the preferred setting for them.
- There is no requirement to certify that the services claimed for were provided in full.
- Poor or inappropriate guidance on 'Type C' certification for rehabilitation and no review process for day programs that often continue once functional improvement has tapered off.

In addition to deviating from the evidence on the most appropriate care setting, these financial incentives also impact the ongoing affordability of PHI. As the chart below demonstrates, average benefits paid per hip and knee episode continue to grow each year along an unsustainable trajectory and contribute to increasing premiums.



The consultation paper's stated aim of providing "*greater scope for developing and offering out of hospital services*" will not address the issue of the inappropriate overuse of inpatient rehab. Bupa, along with other health funds, already offer high quality out of hospital rehabilitation services and are investing in the development of alternative models of care. What is required is the removal of outdated financial incentives which promote practices that deviate from the evidence and waste health system resources.

About Bupa's rehabilitation offerings

Around one in every seven patients having a knee or hip replacement/revision in Australia is a Bupa member. We work hard to support our customers to communicate with their treating doctor and choose the most appropriate rehabilitation option based on their individual circumstances. We do this by making available multiple rehabilitation options for our customers, including:

1. Rehabilitation in hospital: We fund overnight and same day rehabilitation delivered by hospitals.
2. Rehabilitation at home: Through our Bupa Rehab Choices program, Bupa funds home-based rehabilitation delivered by two national home rehab providers. Services include nursing, physiotherapy, occupational therapy, personal care, home support, meals and equipment.
3. Digitally enabled rehab: We have partnered with 360 MedCare to, when clinically appropriate, provide customers, the option of a surgeon prescribed, digitally enabled, physio supported home rehab program.

As this shows, health insurers already offer customers alternatives to hospital delivered rehabilitation. In our experience, the reasons why hospital delivered rehabilitation rates are not decreasing is not due to a lack of other options, but to the other factors noted above.

Insurers already have clear incentives aligned to offering and funding in home and out of hospital rehabilitation. The introduction of an obligation to fund or the setting of minimum benefits is completely unnecessary and will only undermine our ability to ensure quality care by contracting with specialised, non-hospital providers. It would also undermine the intent of the reform, further entrenching the financial incentives for unnecessary, non-evidence based in and out-patient rehab.

The proposed policy

It is our view that the proposed policy represents little change to the status quo and is unlikely to result in the desired changes to current practice and take-up rates.

Unless accompanied by reforms to address the perverse financial incentives, the proposed policy risks further increasing unnecessary utilisation and over-servicing. For example, driving the replacement of clinically appropriate community physiotherapy accessed under ancillary cover, with in-home rehabilitation at a higher price, rather than the desired substitution of hospital based rehabilitation.

Recommendations

- There are currently no criteria to determine the most appropriate place for rehab to occur. Working with rehab physicians to develop these guidelines and criteria must be a priority.
- It should be a requirement that rehabilitation plans be based on published and broadly accepted clinical guidelines. For example, use of tools such as the RAPT (Risk Assessment Prediction Tool), which is done pre-joint replacement surgery. RAPT results indicate whether hospital delivered rehab may be required and therefore it's a good way to assess whether patients are receiving rehab in the most appropriate setting for them. The development and application of other clinical guidelines to determine the appropriate rehab setting for other rehabilitation types should also be a priority.
- Rehabilitation plans should be required for all patients requiring rehab following an acute hospital admission. These should be made available to all parties including patients, providers and insurers.
- The development of rehabilitation plans must involve more than simply an extra administrative step documenting current practice. For example:
    - Care plans must be completed pre-admission;
    - Care plans must be completed by the patients' treating physician, rather than hospital staff;
    - The assumption should be that home rehabilitation is appropriate and will occur as the default option unless the medical practitioner completing the care plan provides reasons why in or out-patient rehab is necessary for that patient – and this will ensure intensive rehab settings are reserved for patients with specific clinical and social needs; and
    - The most suitable rehab option should be established pre-surgery for the patient based on the established clinical guidelines outlined above. Patients should be advised of this so that they can make informed choices based on their unique clinical and social circumstances. The patients' preferred location of rehabilitation setting should be considered and documented pre-surgery and should form part of this decision making process. Departures from the pre-surgery documentation should be fully documented as an amendment to the care plan.
- Informed consent requirements to apply to the development and certification of rehabilitation plans, clarifying that there is no obligation for the rehab to be associated with the hospital where surgery is performed. Patients should be provided with comprehensive information about all care setting options from multiple providers.
- Supporting amendments should be made to the *Private Health Insurance (Benefit Requirements) Rules 2011* changing the definition of "rehabilitation patient" to require that a patient in hospital for rehabilitation must receive a minimum standard of care in line with the Royal Australasian College of Physicians (RACP) Australasian Faculty of Rehabilitation Medicine (AFRM) Standards, and instituting a certification process for approval of in-patient or out-patient rehabilitation as a departure from rehabilitation in the community as accepted best practice.
- Rescind Department of Health PHI Circulars 37/17, 75/18 and 02/19, which have been used by some providers to deny health funds the ability to audit rehabilitation claims.

- Review the accreditation standards for standalone rehabilitation hospitals, consistent with the AFRM Standards.
- Expand reimbursement arrangements for medical practitioners, via a single claimable MBS item number, to:
    - Fund them to 'own' rehabilitation care plans for their patients. This would include creation, maintenance, and oversight of care plans for their patients, and responsibility to sign off upon the patient's discharge from rehabilitation; and
    - Reduce disincentives for medical specialists to refer to rehab in the home. This could mean while the creation of the care plan needs to happen face-to-face between clinician and patient, the oversight and maintenance of the care plan as the patient goes through rehabilitation could happen virtually.

Other areas to consider

- Ensure quality across non-hospital providers of rehabilitation by requiring these providers to go through an accreditation certification process.
- Rehabilitation plans to require the collection and reporting of health outcomes and longer term follow up (including PROMs).
- Compliance mechanisms could include:
    - The MBS item is only payable to the medical practitioner when a plan is in place and signed by the patient, with the same requirement when its reviewed;
    - RAPT (or equivalent beyond joint replacement surgery) collected as part of the rehabilitation care plan;
    - Rehabilitation setting indicated in care plan is the rehabilitation setting received unless certified otherwise;
    - A code of conduct audit process to promote consistency across insurers; and
    - Monitoring of hospital delivered rehabilitation rates.
- Evaluation mechanisms to inform the evolution of this reform could include:
    - Collection of an aggregate tally of rehabilitation rates (to ensure that this reform does not have the unintended consequence of increasing rehabilitation rates);
    - Deidentified RAPT (or equivalent beyond joint replacement surgery) scores collected at an aggregate level along with acute admission and setting of rehab, to monitor variation across jurisdictions and hospitals;
    - Collection of practitioner transfer rates to inpatient rehab, hospital transfer rates to inpatient rehab, practitioner transfer rates to home based rehab, and hospital transfer rates to home based rehab, to monitor variation; and
    - Patient reported health and experience outcomes.

TABLE 1: CONSULTATION QUESTIONS REFERENCE SUMMARY	
1. Which procedures and/or MBS item numbers should have a rehabilitation plan?	In-home rehabilitation is often appropriate in a variety of clinical and social circumstances. Rehabilitation plans should be required for all patients who may require rehab of any type following an acute hospital admission.
2. How prescriptive should the plan be, regarding the type of care services to be included? What exemptions if any should be available?	The development of rehabilitation plans must involve more than simply an extra administrative step documenting current practice. • Care plans must be completed pre-admission. • Care plans must be completed by the patients' treating physician, rather than hospital staff. • The assumption should be that home rehabilitation is appropriate and will occur as the default option unless the medical practitioner completing the care plan provides reasons why inpatient or out-patient rehab is necessary for that patient. This will ensure intensive rehab settings are reserved for patients with specific clinical and social needs. • Patients should be advised of the most suitable rehab option, so they can make informed choices based on their unique clinical and social circumstances. The patients' preferred location of rehabilitation setting should be considered and documented pre-surgery and should form part of this decision making process.
3. What mechanisms should be in place to ensure compliance with developing and reviewing a rehabilitation plan?	Compliance mechanisms could include: • MBS item only payable to the medical practitioner when plan in place and signed by the customer, with the same requirement when its reviewed • RAPT (or equivalent) collected as part of the rehabilitation care plan • Rehabilitation setting indicated in care plan is the rehabilitation setting received • A code of conduct audit process to promote consistency across insurers • Monitoring of hospital delivered rehabilitation rates.
4. It is expected that the plan would be developed in consultation with the patient and potential rehabilitation providers. Which parties should the rehabilitation plan be made available to once created?	Rehabilitation plans should be completed by the patients' treating physician. Patients should be provided with comprehensive information about all care setting options from multiple providers. Once created, plans should be made available to all parties including patients, providers and insurers.
5. What arrangements, if any, should be in place to assist medical practitioners identify appropriate home or community based rehabilitation services and oblige insurers to fund these services?	Health insurers already have clear incentives to offer and fund in home and out of hospital rehabilitation and we already do offer and fund alternatives to hospital delivered rehabilitation for our customers. The introduction of any obligation to fund or the setting of minimum benefits is completely unnecessary and will only undermine our ability to ensure quality care by contracting with specialised, non-hospital providers. It would also undermine the intent of the reform, further entrenching the financial incentives for unnecessary, non-evidence based in and out-patient rehab.