ST VINCENT'S HEALTH AUSTRALIA

Serving, Seeing, Striving for something greater

To	Department of Health PHI Consultation
Topic	SVHA Response – Private Health Insurance Reforms – second wave
Date	Monday 8th February 2021
SVHA Contact	Judith Day, Director Health Funding and Negotiations Angela Souter, Group Manager – Funder Relations

Consultation 2: Expanding home and community based rehabilitation care

Proposed policy: Development of a rehabilitation plan that includes out of hospital care

SVHA supports expanding the variety of care modalities for patients including community or at home rehabilitation as it enables clinicians to prescribe the most appropriate level of care for a patient.

Expanding Out of Hospital (OOH) care should not be seen as a replacement for current inpatient or admitted same day rehabilitation but as a valuable tool to provide alternative options for patients who are clinically appropriate for this type of care.

It also brings the private sector into line with what has been provided in the public sector for some time.

Crucial to making this work is consistency across all funds and hospitals in order to support systemic reform.

There should also be standardised funding for this model of care in the form of default rates. Accredited providers need this type of surety to be able to invest in OOH services and ensure they are available for patients. A default rate will also ensure insurers, should they continue to be allowed to be both funders and providers, do not just channel patients through their own services and shut out other providers from delivering theses services.

Review of the Medicare Benefits Schedule (MBS) should also be undertaken so that there are suitable mechanisms to fund development of the proposed Rehabilitation Plan by a suitable medical professional, multidisciplinary team meetings in order to review the progress of the plan and handover to the GP at the completion of the program.

It is also crucial to include telehealth as an ongoing mechanism to provide OOH care so that the PHI funding of this is consistent and not piecemeal.

The Government should ensure that there is consistency in clinical standards and regulations across OOH services, including staff and training accreditation requirements, patient assessment and monitoring requirements, and information and communication standards between providers, across hospital and community providers.

SVHA response to questions in the consultation paper

1. **Which procedures and/or MBS item numbers should have a rehabilitation plan?**

SVHA do not believe that this initiative should be restricted to any specific procedure or MBS Item number

Patients with a broad range of conditions could benefit from access to OOH care.

For example, hip and knee arthroplasty may seem like a logical inclusion due to the high volume of these procedures being undertaken however patients who are undergoing chemotherapy and reconditioning rehabilitation concurrently have far better outcomes than those not undergoing rehabilitation.

This cohort of patients would also benefit from having this service at home or even by telehealth.

Therefore, all current rehabilitation modalities should be included for patients requiring:

- Orthopaedic lower
- Orthopaedic upper
- Spinal surgery
- Reconditioning post major surgical or medical interventions
- Reconditioning as part of cancer treatments
- Stroke rehabilitation

2. **How prescriptive should the plan be, regarding the type of care services to be included? What exemptions if any should be available?**

The plan itself should have 2 parts:

- The referral from the treating surgeon/physician or GP
- The rehabilitation plan that would determine what treatment is required and for how long.

    This should be devised by clinical experts in this area in conjunction with the patient i.e. a Rehabilitation Physician in conjunction with Allied Health Specialists or Specialist Nursing staff.

    Plans should be individualized and meet the individual need of the patient and care should be as widely available as possible, including inpatient rehabilitation, pre-habilitation and same-day rehabilitation programs, with the ability to move the patient across the continuum of care as assessed on clinical needs and individualized rehabilitation goals. This means that funding sources should be

flexible to facilitate this care (e.g. removal of the strict 3-hour rule for same-day rehabilitation programs when not prescribed in the rehabilitation program).

SVHA cannot see where there would need to be exemptions to this service.

3. **What mechanisms should be in place to ensure compliance with developing and reviewing a rehabilitation plan?**

Clinical review of agreed goals and assessment of how the patient is meeting those goals is crucial to reviewing the effectiveness of the plan.

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?**

The plan should be shared amongst the treating clinicians.

The fact that a plan has been created should be shared with the funder. It needs to be noted that funders should not be determining the type of rehabilitation that a patient receive. There are instances where funds under the current model stating such things as "the patient does not require inpatient rehabilitation and could be treated in a same day capacity." This is not the remit of the fund.

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?**

By publicly promoting OOH rehabilitation services across all levels of insurance and limiting products with exclusions for OOH care.

6. **What transition arrangements and timeframe would be appropriate to implement this reform?**

Education should be provided to referring doctors both GPs and Specialists so that they are aware of the option to refer to providers

7. **What are appropriate metrics for measuring the impact of this proposal?**

Greater referrals to OOH based rehabilitation and a reduction in overnight admitted inpatient rehabilitation.

What is clear that consumers expect to be covered for treatment if their doctor wants to admit them to hospital (bearing in mind their level of cover). There would be a higher sense of satisfaction and value of PHI if there was not perceived to be a "he said – she said" battle between hospitals and funds every time a patient needs to have an infusion for example.

8. **What is the regulatory burden associated with this proposal?**

This will need to be thought out as part of the review as current reporting mechanisms (for example measures collated by AROC) would not adequately address this type of admission. Also HCP may not be appropriate for OOH if the patient is not admitted.

9. **What services would you deliver under this proposal?**

Rehabilitation in the Home / Prehabilitation / Same Day Rehabilitation / Telehealth / Admitted overnight services.