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A Review of the Private Sector Outreach Services Legislation

Executive Summary

Introduction

The *Health Legislation Amendment Act No 1 2001*, was passed in Parliament and granted Royal Assent in March 2001. This Act changed the *National Health Act 1953* and the *Health Insurance Act 1973* and when it came into effect on 8 June 2001, it enabled registered health benefit organisations (hereinafter referred to as private health insurers) to:

- fund alternative models of health care delivery which directly substituted for in-hospital care for admitted patients (ie outreach services) from their hospital tables, AND
- claim against the reinsurance arrangements for covered outreach services.

Section 5D of the *National Health Act 1953* states that:

The Minister must cause an independent review of the operation of the private sector outreach services legislation, and that the report of this independent review would be tabled in Parliament by no later than 30 June 2003.

PricewaterhouseCoopers was engaged by the Commonwealth Department of Health and Ageing ('The Department') to conduct this independent review.

Aims of this Project

The terms of reference for this independent review of the private sector outreach services require the reviewer to assess the operation of the extension of the *National Health Act 1953* and the *Health Insurance Act 1973*. The research questions developed in consultation with the Department are:

- What private sector outreach services have been developed since the introduction of the legislation? [location of providers, number of providers, range of available services, number of services, number of patients, private health insurer participation]
- Are the types of private sector outreach services which are operating, or which are planned, consistent with the intention of the legislation?
- Has the criteria for provider approval and the approval/notification process been developed and applied in a manner which is consistent with the intention of the legislation?
- Are the private sector outreach services being delivered in a manner which is consistent with the intention of the legislation? [Provider aspects (informed consent, care processes)][Private health insurer aspects (informed consent, product design, member communication)]
- Are the private sector outreach services being monitored in terms of safety, quality and outcomes? Are stakeholders satisfied with the monitoring

processes? Are stakeholders satisfied with the safety, quality and outcomes being achieved by the private sector outreach services?

- Has the financial impact of introducing private sector outreach services been inflationary? [impact on private health insurance benefit expenditure, impact on Medicare, any real or potential cost shifting]

Methodological Approach

Due to a lack of data on private sector outreach services and a short project timeframe, the review relied on qualitative methods to obtain information in relation to the research questions. The two methods used were:

- the collection and review of documentary evidence; and
- the collection of stakeholder perceptions using a structured interview tool.

The stakeholder sample included approved providers, private health insurers, the Department, the Private Health Insurance Ombudsman and a range of professional bodies and industry organisations.

Findings and Conclusions

Overall, there appears to be ongoing support by all stakeholders for the concept of private sector outreach services which are a genuine substitution of in-hospital care for admitted patients and which are delivered in a safe and cost effective manner. Our remaining findings and conclusions are presented under each research question as follows:

What private sector outreach services have been developed since the introduction of the legislation? [location of providers, number of providers, range of available services, number of services, number of patients, private health insurer participation]

- There are twenty-three approved private sector outreach service providers which are primarily located in Victoria, South Australia and Western Australia. All approved providers are licensed private hospitals with the exception of one public hospital. Eleven hospitals are approved for psychiatric services, eleven are approved for medical/surgical services, and one is approved for palliative care services.
- The private health insurers interviewed feel that the number of approved providers and service utilisation has been lower than expected. While the approved providers reported that utilisation had exceeded their expectations. The stakeholders generally believe that utilisation will continue to grow.
- Private health insurer participation with approved private sector outreach services ranges from no participation to participation with most approved providers.

Are the types of private sector outreach services which are operating, or which are planned, consistent with the intention of the legislation?

- The approved provider respondents believe that the types of private sector outreach services that they are offering are consistent with the intention of the legislation.
- The private health insurers interviewed generally believe that the types of services, which have been developed appear to be consistent with the intention of the legislation; however, the majority are concerned that the actual utilisation of the approved services does not always meet the substitution criterion of the legislation. They are concerned that some services which may have been previously delivered on an outpatient basis and funded through Medicare or State funding arrangements, are now being provided in private sector outreach programs.

Has the criteria for provider approval and the approval/notification process been developed and applied in a manner which is consistent with the intention of the legislation?

- The Department has implemented new structures and processes to operationalise the private sector outreach legislation.
- **Criteria:** Based on the available evidence and stakeholder responses, it appears that the criteria for provider approval has been developed and implemented in a manner consistent with the intention of the legislation.
- **Approval Process:** Based on the available evidence and stakeholder responses, it appears that the approval process has been developed and implemented in a manner consistent with the intention of the legislation. Both approved providers and private health insurers acknowledge that the legislation stipulates that the Minister must approve outreach services, however, most believe that the Department should not have an ongoing role in outreach service approval.
- **Notification Process:** From the evidence available, the notification process implemented by the Department does not satisfy the intention of the legislation. The legislation specified that an outreach service was any service deemed to be such by the Minister. The Department's notification process does not provide the industry with sufficient detail about the specific services which have been approved. As a result, the private health insurers feel exposed to claims for outreach services which are not consistent with the legislation or with the admission and exclusion criteria for the approved outreach service.

Are the private sector outreach services being delivered in a manner which is consistent with the intention of the legislation? [Provider aspects (informed consent, care processes)] [Private health insurer aspects (informed consent, product design, member communication)]

- The stakeholders believe that the private sector outreach services are being delivered in a manner consistent with the intention of the legislation.

Are the private sector outreach services being monitored in terms of safety, quality and outcomes? Are stakeholders satisfied with the monitoring processes? Are stakeholders satisfied with the safety, quality and outcomes being achieved by the private sector outreach services?

- The private sector outreach services are primarily being monitored internally by the approved providers using a range of quality and performance indicators, and externally by the Private Sector Outreach Services Working Party. The stakeholders are currently satisfied with these monitoring processes, although some private health insurers feel that 'cost-effectiveness' needs to be included as a key performance measure.
- There were no concerns reported by the stakeholders with regards to the safety, quality and outcomes of the approved private sector outreach services.
- The lack of data on private sector outreach services is a problem which needs to be rectified in order to enable the evaluation of service utilisation and patient outcomes.

Has the financial impact of introducing private sector outreach services been inflationary? [impact on private health insurance benefit expenditure, impact on Medicare, any real or potential cost shifting]

- At a macro-level, the stakeholders do not believe that the private sector outreach services have been inflationary as utilisation has been insignificant.
- At a micro-level, the approved providers do not believe that the private sector outreach services have been inflationary because they have been a direct substitution of in-hospital care for admitted patients and because the negotiated rates for outreach services have been less than the agreed in-hospital rates. Some private health insurers believe that they are being charged for new services which are not a direct substitution and that these are inflationary. Some private health insurers also felt that the introduction of a Ministerial Default Benefit (\$145) had had an inflationary effect as the amount exceeded rates which had already been negotiated with many approved providers and prompted them to seek renegotiation to this new floor price. The introduction of the Ministerial Default Benefit also reportedly had the consequence of raising the agreed rates for related services.
- The stakeholders do not have any evidence to suggest that the private sector outreach services have had an inflationary impact on Medicare. The majority of the private health insurers are concerned about the potential for cost shifting onto the private health insurers should there be an influx of approved public hospitals providing services which have traditionally been funded on an outpatient basis.

1 Introduction

1.1 Project Overview

The *Health Legislation Amendment Act No 1 2001*, was passed in Parliament and granted Royal Assent in March 2001. This Act changed the *National Health Act 1953* and the *Health Insurance Act 1973* so that when it came into effect on 8 June 2001, it enabled registered health benefit organisations (hereinafter referred to as private health insurers) to:

- fund alternative models of health care delivery which directly substituted for in-hospital care for admitted patients (ie outreach services) from their hospital tables, AND
- claim against the reinsurance arrangements for covered outreach services.

Section 5D of the *National Health Act 1953* states that:

The Minister must cause an independent review of the operation of the private sector outreach services legislation, and that the report of this independent review would be tabled in Parliament by no later than 30 June 2003.

PricewaterhouseCoopers was engaged by the Commonwealth Department of Health and Ageing ('The Department') to conduct this independent review.

The aims of this independent review are to determine if the private sector outreach services are operating in a manner consistent with the intent of the legislation. The intent of the legislation, as documented in the Hansard Transcript dated 7 February 2001 and the explanatory notes, may be summarised as follows:

- programs are to be approved at the discretion of the Minister for Health and Ageing for a defined period;
- approved programs must deliver services which are a substitution of in-hospital care for admitted patients;
- private health insurance is not extended to out of hospital medical services (ie medical practitioner services) which attract an 85% rebate;
- the patient remains under the jurisdiction of the hospital while receiving private sector outreach services;
- approved programs must deliver safe and high quality services; and,
- programs are not to be inflationary in terms of health costs.

1.2 A Brief History of Outreach Services

Outreach services began emerging in the public hospital sector in Australia during the 1980's. These hospitals, faced with increasing patient demand for limited beds, sought to provide flexible, cost-effective, and evidence-based healthcare services to patients in their home environment. Australian private hospitals began to establish outreach services in the mid 1990's. Private hospitals in the not-for-profit hospital sector and those with a focus on specialty areas such as rehabilitation, psychiatry and palliative care were particularly interested in this option. The key drivers for private hospitals to establish outreach services were:

- the desire to establish innovative, evidenced-based, alternative models of healthcare delivery;
- pressure on available beds and opportunities to increase throughput and revenue; and
- clinician and patient demand for private sector outreach services.

Despite the interest of both private hospitals and private health insurers in establishing outreach services, there were legislative barriers to funding the services. The existing *National Health Act 1953* and the *Health Insurance Act 1973* precluded private health insurers from extending benefits for out of hospital care for members with hospital cover, and benefits for outreach services could only be provided to members with ancillary cover. Without changes to the legislation:

- there were financial disincentives for the private health insurers since ancillary benefits cannot be claimed against the reinsurance arrangements;
- privately insured members could benefit only if they had both hospital and ancillary cover; and
- paying for hospital-related services under ancillary cover was inconsistent with the intended product design.

These barriers to more innovative health care delivery models were identified in the Productivity Commission's Report No. 57 on Private Health Insurance (1997). The Commission's report recommended a range of reforms to ensure a viable future for private health insurance by enabling the private health insurers to fund new and proven models of healthcare delivery.

Beginning in the mid 1990s, the Government demonstrated its commitment to promoting efficiency in the private sector, containing the cost of acute care and improving the private health insurance product by progressively establishing six (6) Early Discharge/Hospital in the Home Trials.

Health Management Advisors completed the formal evaluation of the Trials in 2000. According to their findings, the private sector outreach services were:

- safe;
- delivered care using sound clinical practices;
- were well accepted by service providers, consumers and carers; and
- were cost effective.

1.3 Private Sector Outreach Service Legislation

The *National Health Act 1953* defines an **Outreach Service** as:

any service specified in a determination under section 5D¹ of the Act², that is provided to a patient by, or on behalf of, a hospital or day hospital facility, but does not include service provided by a medical practitioner that would attract a Medicare benefit of 85% of the scheduled fee.

The *Health Legislation Amendment Act No 1 2001* also resulted in the following changes to the *National Health Act 1953* and the *Health Insurance Act 1973*:

- the definition of 'patient' was expanded to include a person who receives an outreach service;

¹ Section 5D: (1) The Minister may, by written determination, specify services provided by, or on behalf of, a specified hospital or day hospital facility for the purposes of the definition of outreach service.

² *National Health Act 1953*

- the definition of ‘hospital treatment’ was expanded to include reference to the provision of outreach services;
- the Federal Minister of Health was given the power to approve private outreach services for a specified time period and to revoke a determination to provide outreach services; and
- the Federal Minister of Health was required to cause an independent review of the operation of the extension of the *National Health Act 1953* and the *Health Insurance Act 1973* in relation to outreach services. A copy of the review report must be tabled in Parliament by no later than 30 June 2003.

1.4 Distinguishing Features of Private Sector Outreach Services

The term ‘Private Sector Outreach Service’ is currently synonymous with the term ‘Hospital in the Home’ (HITH).

For a full list of terminology please refer to the glossary in Appendix A.

According to the explanatory notes and advice from the Department, the key distinguishing features of these private sector outreach or HITH services are:

- The patient’s home, or the home of the patient’s carer, is legally viewed as within the jurisdiction of the hospital – a virtual ward of the hospital;
- The patient has not been formally discharged from the hospital and, as an admitted patient, legally remains the responsibility of the hospital when treated within the hospital’s approved private sector outreach program;
- The hospital, in conjunction with the admitting medical practitioner, is responsible for the case management of the patient and for coordinating the delivery of care;
- The services which the hospital provides directly, or on a sub-contracted basis, must be a substitute for in-hospital care for an admitted patient in a private or public hospital, and must deliver the same level of care that the patient would otherwise have received in the hospital. As such, the services typically include clinical treatment delivered by a multidisciplinary team as well as domiciliary care; and
- Only those medical practitioners who have admitting privileges to the approved private sector outreach hospital can raise charges for treatment provided to a patient receiving outreach services. Their charges are reimbursed by Medicare as if the patient was an admitted patient of the hospital.

It is the combination of these key distinguishing features which differentiate the approved private sector outreach services (HITH) from other types of healthcare services which are provided to a patient in their home (eg early discharge programs, community nursing).

1.5 Aims of this Project

1.5.1 Project Scope

The terms of reference for this independent review of the private sector outreach services require the reviewer to assess the operation of the extension of the *National Health Act 1953* and the *Health Insurance Act 1973* with regard to:

- private health insurance is not extended to out of hospital medical services;
- approved programs operate for a defined period;
- programs are not inflationary in terms of health costs; and
- programs deliver safe, quality care.

The terms of reference specifically direct the independent review to examine and report on how the private sector outreach programs are operating in practice with regard to:

- types of services provided;
- uptake of services by hospitals, private health insurers and patients;
- application arrangements and requirements;
- approval arrangements and requirements including the criteria and standards to be met;
- patient admission criteria;
- operating guidelines and procedures;
- care planning and provision;
- discharge planning;
- informed consent;
- measures to assure safety;
- measures to assure quality;
- performance monitoring and reporting;
- costs of services and financial arrangements for patients;
- what inflationary impact, if any, the programs have had on health benefits;
- what impact, if any, the services have had on Medicare.

In response to these scope requirements, the following research questions were developed by PricewaterhouseCoopers and endorsed by the Department:

What private sector outreach services have been developed since the introduction of the legislation? [location of providers, number of providers, range of available services, number of services, number of patients, private health insurer participation]

Are the types of private sector outreach services which are operating, or which are planned, consistent with the intention of the legislation?

Has the criteria for provider approval and the approval/notification process been developed and applied in a manner which is consistent with the intention of the legislation?

Are the private sector outreach services being delivered in a manner which is consistent with the intention of the legislation?

[Provider aspects (informed consent, care processes)]

[Private health insurer aspects (informed consent, product design, member communication)]

Are the private sector outreach services being monitored in terms of safety, quality and outcomes? Are stakeholders satisfied with the monitoring processes? Are stakeholders satisfied with the safety, quality and outcomes being achieved by the private sector outreach services?

Has the financial impact of introducing private sector outreach services been inflationary? [impact on private health insurance benefit expenditure, impact on Medicare, any real or potential cost shifting]

1.5.2 Project Scope Exclusions

According to the terms of reference established by the Department, the independent review is excluded from examining the following aspects of the private sector outreach services:

- any barriers for participation in the program;
- analysis of national data (which are not currently available for outreach services); and
- matters relating to contract negotiations between private health insurers and hospitals (including service payment rates or additional health fund approval processes).

1.5.3 Project Limitations

In considering this report there are five important constraints on the project to bear in mind. These constraints are:

- the project had only a short time frame.
- there is no readily available private sector outreach services data.
- stakeholder perceptions and documentary evidence from the Department were the only sources of information used to answer the research questions.
- stakeholder perceptions were provided on a voluntary basis and
- no quantitative methods (eg audit or data analysis) were utilised to validate the stakeholder responses.

As a consequence of these constraints this project did not include:

- an evaluation of clinical efficacy and patient safety;
- clinical audits (eg to determine if the outreach services have been a direct substitution of in-hospital care for admitted patients);
- process audits on the service delivery (eg to evaluate the processes of informed consent, discharge planning, 24 hour support, etc);
- quality/safety/outcome assessment of the approved programs;
- financial audits to determine inflationary impact on the private health insurers and Medicare;
- utilisation review studies;
- direct patient and/or medical practitioner surveys;
- an expert clinician's evaluation of the criteria and guidelines which have been developed by the Private Sector Outreach Services Working Party; or,
- an expert clinician's evaluation of the program approval recommendations made to date by the Private Sector Outreach Services Working Party.

1.5.4 Lack of Data

As mentioned above, there is a lack of data on private sector outreach services and this limited the type of evaluation that could be performed.

Data are not available as:

- Most approved outreach providers are not billing outreach services in a manner which allows the private health insurers to accurately identify and record the services (i.e. the outreach services appear on the bill as in-hospital care).
- Private health insurers are reportedly not receiving data on private sector outreach services via the Hospital Casemix Protocol (HCP) data submissions even though data item 36 of the protocol is available to record days in a hospital in the home program.
- Since the private health insurers are not receiving data on private sector outreach services, the HCP dataset provided by the private health insurers to the Department does not include this information.

2 Methodology

In view of the lack of data to undertake a quantitative evaluation, the review relied on qualitative methods to obtain information in relation to the research questions. The two methods used were:

- the collection and review of documentary evidence; and
- the collection of stakeholder perceptions.

Each method is detailed below.

2.1 Documentary Evidence

The documentary evidence was collected with the assistance of the Department. The documents collected and reviewed included:

- the legislation and the explanatory notes to the legislation;
- the Hansard transcript dated 7 February 2001;
- the Department's HBF/PH circulars;
- the Department's Guidelines for the Establishment and Development of Private Sector Outreach Services and the Application Form;
- National Evaluation of Private Sector Based Early Discharge and Hospital in the Home Trials (July 2000);
- the renewal applications for selected approved providers.

2.2 Stakeholder Perceptions

2.2.1 *The Stakeholders*

The Stakeholders were identified as:

- the approved private sector outreach providers;
- the private health insurers;
- the Department of Health and Ageing;
- the Private Health Insurance Ombudsman;
- the Private Health Insurance Advisory Council; and
- selected key industry bodies/associations which represent the private hospitals, the private health insurers, medical practitioners, and consumers.

2.2.2 *The Sampling Approach*

A sampling framework was prepared to ensure that all significant aspects of the private sector outreach services were covered in the review. PricewaterhouseCoopers selected the approved provider and private health insurer samples, while the Department assisted in identifying the other stakeholder bodies/associations that should be consulted for the project.

The provider sample included:

- providers across the range of approved services (medical, surgical, psychiatric, and palliative care);
- providers which had been approved for at least several months;
- providers which participated in the Early Discharge/Hospital in the Home Trials;
- providers of various size;
- providers with licensed accident and emergency rooms; and
- the only rural and public hospital provider.

Private hospital perceptions were also sought from the Australian Private Hospital Association and Catholic Health Australia.

The private health insurer sample covered the top six (6) insurers which account for approximately 77% of the market. Private health insurer perceptions were also sought from the Australian Health Insurance Association, the Health Insurance Restricted Membership Association of Australia (HIRMAA), and the Australian Health Services Alliance.

The full sample can be found at Appendix B, and the response rate which was achieved is detailed in Chapter 3.

2.2.3 The Stakeholder Interview Process

All stakeholders in the sample were sent a letter by the Department to advise them of the independent review of the operation of the private sector outreach services legislation and to confirm that PricewaterhouseCoopers had been appointed to conduct the review. PricewaterhouseCoopers also wrote to all stakeholders in the sample to request their voluntary participation and to provide them with a copy of the interview guide to inform their decision.

Stakeholder perceptions were collected via face-to-face interview, telephone interview and self-completion of the interview guide (details are found at Appendix B). A standard interview guide was developed based on the research questions, and was slightly modified to effectively collect the required information from the approved providers, the private health insurers, and the other key stakeholder groups. Refer Appendix C for copies of the interview guides.

All interviews were conducted by at least one senior manager from PricewaterhouseCoopers, and most were conducted by two PricewaterhouseCoopers representatives. All interviews were documented, and then reviewed by the second interviewer, where applicable, to ensure accuracy and completeness. The information collected via the stakeholder interviews was then consolidated into thematic summaries for reporting.

3 Findings

The findings are presented in two sections:

1. **Evidence of Private Sector Outreach Services Operation:** This section details the evidence of the structures and processes that have been implemented to enable the legislation to operate effectively.
2. **Stakeholder Perceptions:** This section contains the perspectives and opinions of approved providers, private health insurers and other stakeholders regarding the operationalisation of the legislation.

3.1 Evidence of Private Sector Outreach Service Operation

Following Royal Assent, the Department developed the structures and processes necessary to ensure the legislation was enacted as intended. A summary of the initiatives of the Department are listed below.

3.1.1 Notification of Legislation

On 29 March 2001, the Department issued Circular HBF 698/PH 437 which advised all stakeholders that the *Health Legislation Amendment Bill (No.1)* 2001 had been passed by Parliament and granted Royal Assent. The Circular advised that a full copy of the legislation and the Department's explanatory memorandum were available on the Parliament House website.

3.1.2 Operation of the Legislation

To enable the operationalisation of the legislation, the Department:

- developed the Private Sector Outreach Service Guidelines;
- developed the Private Sector Outreach Service Application Form;
- developed the Private Sector Outreach Services Approval and Notification Process; and
- established the Private Sector Outreach Services Working Party.

Private Sector Outreach Services Guidelines

The Department, with reference to the intention of the legislation, developed the Private Sector Outreach Services Guidelines (refer copy at Appendix D). A comprehensive evidence base that included existing public sector hospital in the home guidelines and public and private sector evaluation reports also informed the Guideline development. The primary focus of the Guidelines is on the processes and infrastructure that an approved provider must have in place.

The Department implemented a comprehensive consultation process for the Guidelines which included:

- seeking public comment via the Department's website, and
- seeking industry stakeholder comment via a direct mail-out.

All stakeholder feedback was compiled by the Department and incorporated where possible and appropriate. A final draft of the Guidelines was circulated to industry stakeholders for comments.

Private Sector Outreach Services Application Form

The Private Sector Outreach Services Application Form was an agreed outcome of the consultation process (a copy is found at Appendix E). Private hospital stakeholders requested that a standardised application form be developed which clearly articulated the requirements to be addressed in the application. The Department developed the application form from the final draft of the Guidelines.

Private Sector Outreach Services Approval and Notification Process

The Private Sector Outreach Services approval and notification process was developed by the Department in response to the legislative requirement for the Minister to provide approval for private sector outreach services. A flowchart of the approval process is included in Appendix F.

The notification process includes written notification to the individual provider and industry notification via the Department's Circulars. Currently the extent of industry notification is limited to the name of the approved provider. Copies of the determinations are available upon request from the Department and contain the type of approved service (e.g. psychiatric, palliative care, medical/surgical). The Department advised that to date, only one private health insurer has requested a copy of the determinations. The Department does not make available the final approved hospital submissions to the private health insurers as they are provided to the Department on a commercial in confidence basis. The Department advised that their website is currently being updated so that all approved providers will be listed along with the type of service for which they have been approved.

Private Sector Outreach Services Working Party

To complete the application review component of the approval process, the Minister approved the establishment of the Private Sector Outreach Services Working Party. In October 2001, the Department wrote to all industry stakeholder organisations advising them of the establishment of the Working Party and seeking a representative to be nominated from their organisation. This was a transparent process and gave all major stakeholder groups a single representative for future consultation. The current composition of the Working Party is available in Appendix G. The role of the Working Party includes:

- reviewing applications against the Guidelines and making recommendations to the Minister; and
- reviewing the Private Sector Outreach Services Guidelines as required.

In February 2002, the Working Party met for the first time in Canberra. The Working Party meets every 2-3 months or as required. All meetings are now held via teleconference.

3.1.3 Evidence of Approvals

As at 28 May 2003:

- 2 hospital providers were undergoing approval;

- 23 hospital providers had received approval;
- 7 of the original 8 approved providers covering 14 hospitals had re-applied;
- No provider approvals had been revoked; and
- One provider application had been rejected as the service was outside the legislative criteria.

Table 1 details the providers who have been approved, their approved service type and their approval time periods.

Name of Approved Provider	Type of Private Sector Outreach Service Provided	Ministerial Approval Date	Ministerial Reapplication Date
Victoria			
The Melbourne Clinic Private Hospital, (including: the Geelong Clinic, the Victoria Clinic, and Northpark Private Hospital)	Psychiatric	1 July 2002	30 June 2003
The Albert Road Clinic	Psychiatric	1 July 2002	30 June 2003
Epworth Private Hospital	Medical & Surgical	1 July 2002	30 June 2003
St Frances Xavier Cabrini Private Hospital	Palliative	1 July 2002	30 June 2003
Wangaratta District Base Hospital	Medical & Surgical	1 July 2002	30 June 2003
Pinelodge Clinic Private Hospital Dandenong	Psychiatric	1 Nov 2002	31 Oct 2003
Delmont Private Hospital	Psychiatric	1 Nov 2002	31 Oct 2003
South Australia			
Adelaide Community Healthcare Alliance, (including: the Ashford Hospital, the Memorial Hospital, Western Hospital, Ashford Community Hospital (South West Campus), Flinders Private Hospital)	Medical & Surgical	1 July 2002	30 June 2003
Ramsay Health Care Australia Pty Ltd (including: The Adelaide Clinic, Kahlyn Private Hospital and Fullarton Private Hospital)	Psychiatric	1 Nov 2002	31 Oct 2003
Western Australia			
Bethesda Hospital	Medical & Surgical	31 May 2002	30 June 2003
St John of God Health Care – Subiaco	Medical & Surgical	31 May 2002	30 June 2003
New South Wales			
Sydney Adventist Hospital Limited	Medical & Surgical	1 Feb 2003	31 Jan 2004
Australian Capital Territory			
Calvary Health Care ACT Inc	Medical & Surgical	1 Nov 2002	31 Oct 2003
Queensland			
Toowong Private Hospital	Psychiatric	1 Nov 2002	31 Oct 2003

3.2 Stakeholder Perceptions

This section includes:

- the stakeholder response rate;
- how stakeholder responses have been reported;
- stakeholder perceptions recorded against each research question.

3.2.1 Response Rate

A wide range of industry stakeholders were approached to participate in the review including approved providers, private health insurers, professional associations and industry bodies.

- 8 approved providers covering 14 hospitals were invited to participate and all 8 contributed.
- 6 private health insurers were invited to participate and all 6 contributed.
- 10 other stakeholders were invited to participate and 6 contributed.

A detailed list of participants is available for reference in Appendix B.

3.2.2 Reporting of Stakeholder Responses

For ease of reporting, the perspectives of the Australian Private Hospitals Association (APHA) and Australian Health Insurance Association (AHIA) have been incorporated into the approved provider and private health insurers sections respectively. Due to the minimal response from other stakeholders, only responses that are inconsistent or offer a new insight have been reported separately.

3.2.3 Developed Private Sector Outreach Services

This section addresses the research question ‘What private sector outreach services have been developed since the introduction of the legislation?’.

3.2.3.1 Approved Provider Perspective

Current Private Sector Outreach Services

Most providers noted that the uptake of private sector outreach services had been far greater in Victoria, South Australia and Western Australia than elsewhere.

Providers identified that only the larger private hospitals with high occupancy rates have a business case to develop outreach services. Many of the providers noted that outreach services alone are not necessarily commercially viable. However, these providers were committed to delivering continuity of care using healthcare delivery models which offer medical practitioners and their patients alternatives to in-hospital care.

The types of private sector outreach services being delivered under the legislation include:

- Medical: including cellulitis, deep venous thrombosis, oncology and cardiology;
- Surgical: post-operative care, including wound care and infection management;

- Psychiatric: mother and child, adult and psycho-geriatric services; and
- Palliative Care.

All providers advised that they do not intend to develop any further outreach services at this stage due to:

- the need to maximise efficiencies and streamline care processes of the current services;
- the unexpectedly high demand for current services;
- the difficulties servicing patients from a wide geographical area; and
- staffing resource shortages.

Service Delivery Models

Different service delivery models have been developed and implemented for private sector outreach services. These include:

- **In-house:** employees of the approved provider deliver outreach services. The admitting medical practitioner maintains clinical management of the patient. An Outreach Service Manager is appointed to coordinate the service delivery.
- **In-house with Medical Director of Outreach Services:** operates as per the in-house model except the admitting medical practitioner hands-over the clinical management of the patient to the Medical Director of Outreach Services. The admitting medical practitioner can remain informed of the patient's progress if desired.
- **Out-sourced:** this is identical to the in-house model except that the approved provider sub-contracts the service delivery component of the outreach service to an external provider.

Referral Sources

The following sources of referral were reported during the review:

- Referral of an admitted patient from the provider's hospital;
- Referral from provider hospital's accident and emergency department;
- Referral of a non-admitted patient by a medical practitioner with admitting rights; and
- Referral from another hospital.

Utilisation of Private Sector Outreach Services

Most providers advised that the patient utilisation of private sector outreach services has exceeded their expectations and cited overwhelming support from the medical profession as the primary contributing factor. Providers also advised that as the services become better known and trusted, increased referrals from the medical profession were expected.

Private Health Insurer Participation

The majority of providers advised that they were satisfied with the support and funding arrangements negotiated with the private health insurers.

Funding of Private Sector Outreach Services

The providers reported that services are primarily funded on a per diem basis (ie a daily rate). Where outreach services are provided in relation to admissions which are covered under a case payment, the hospital does not charge or receive benefits for outreach services until the patient has exceeded the outlier threshold.

3.2.3.2 Private Health Insurer Perspective

Current Private Sector Outreach Services

The majority of respondents reported that the number of approved providers is lower than expected. The reasons cited for the lower than expected take-up rate were nominated as:

- most hospitals find it is too expensive to set up an outreach service;
- there is no business case for a hospital unless it is under pressure for beds and/or its accident and emergency department is strained by demand;
- some hospitals are having issues with their own liability insurers who are unwilling to extend the hospital's liability cover to the patient's home;
- hospitals are having difficulties getting the necessary staffing to treat patients outside of the hospital;
- it is too difficult for the major private hospitals to serve their large geographical area; and,
- the intensive approval process is too costly and long in duration.

There is a noticeable absence or lack of providers in New South Wales, Queensland, and Tasmania. Private health insurers speculated that this may be a consequence of the slower adoption by the public sector of outreach services in these States.

In addition to the reasons listed above, it was suggested that a small number of the approved programs might not be offering any services because they were not able to negotiate agreed rates with a significant number of private health insurers. (*Note: PricewaterhouseCoopers learned of one such hospital during the course of the review.*)

Utilisation of Private Sector Outreach Services

According to private health insurer respondents, the patient numbers have been relatively small and utilisation of outreach services has primarily been for:

- the administration of IV antibiotics;
- the administration of low molecular weight heparin;
- wound management; and
- psychiatric services.

Growth in utilisation has apparently been the strongest in psychiatric services and some respondents noted that this was correcting the lack of access to publicly funded community services for the privately insured.

Private Health Insurer Participation

Private health insurer participation ranges from no participation to participation with most of the approved programs. The reasons for non-participation with an approved program included:

- negotiations underway;
- negotiation of agreed rates failed;
- services are not believed to be a substitution of in-hospital care for admitted patients;
- private health insurers are unwilling to negotiate agreed rates with approved public hospitals; and
- low activity levels with the approved hospitals.

Funding arrangements

The private health insurer respondents confirmed that most funding of private sector outreach services is on a per diem basis. Where private sector outreach services are provided in connection with an admission that is covered under a case payment, the outreach services are not funded separately until the outlier threshold has been exceeded and the outlier per diem rates apply. Some private health insurers reported that they are considering different case payment rates for admissions that involve outreach services. One hospital group reportedly provides psychiatric services, including outreach services, under a capitation funding arrangement.

It is noteworthy that one hospital group is currently seeking to negotiate fee for service arrangements for their outreach services. This type of funding arrangement appears to be incongruous to the intention of the legislation which specifies that the services must be a substitution of in-hospital care for an admitted patient. We also note that in the explanatory notes of the legislation the expectation is that private sector outreach services will be funded on a per diem basis. The Ministerial Default benefit has been structured accordingly.

3.2.3.3 A Case Study

The most developed arrangements between a private health insurer and an approved provider, which were identified during the review, are detailed in the case study on the following page.

Case Study: A Collaborative Approach to Private Sector Outreach Services

The most developed approach identified during the review involved a major private health insurer, and a large private hospital which provides medical and post-operative outreach services.

Key features

The key features of this approach included:

- it was highly collaborative and high levels of trust existed between the parties;
- a one year trial was agreed;
- prior to the commencement of the trial, both parties reached agreement on the patient admission/exclusion criteria and the type of services that would be eligible for funding;
- actual utilisation was closely monitored during the trial;
- the private health insurer conducted comprehensive satisfaction surveys with patients and treating medical practitioners which revealed very high levels of satisfaction;
- the private health insurer conducted an in-depth cost-benefit analysis which revealed that the service was cost effective;
- a comprehensive evaluation and clinical audit was conducted at the end of the first year.

Outcome

Both parties viewed the trial as a success. The results were consistent with the intention of the legislation and fit with each parties' own business objectives.

3.2.4 Types of Services

This section addresses the research question ‘Are the types of private sector outreach services which are operating, or which are planned, consistent with the intention of the legislation?’

3.2.4.1 Approved Provider Perspective

All providers advised that their private sector outreach services are consistent with the intention of the legislation.

3.2.4.2 Private Health Insurer Perspective

Half of the private health insurers interviewed believe that the types of services which have been developed and approved are consistent with the intention of the legislation.

The majority of the private health insurers are, however, concerned that the *actual utilisation* of the approved programs is not always in accordance with the intention of the legislation. They gave examples of IV antibiotics, the treatment of deep vein thrombosis and palliative care. Prior to the introduction of the legislation, these services were usually treated on an outpatient basis. Now privately insured patients are increasingly being treated in a more costly outreach services program. As a consequence, many of those interviewed believe that these are new services which do not meet the substitution criterion as set out in the legislation. There is concern that the availability of these new services will create a demand from patients who have been happy to be treated on an outpatient basis up until now.

The provision of psychiatric outreach services was also raised by some of the private health insurers who suggested that they were not always a direct substitution, and were more accurately described as preventative case management (ie keeping people out of hospital). The availability of these services was generally viewed as a positive way to provide psychiatric care in a manner which is evidenced-based.

3.2.4.3 The Department’s Perspective

The Department’s response to the private health insurer stakeholder views outlined in 3.2.4.2 above was as follows:

“The services which the private health insurers are concerned about are consistently identified in the national and international literature as falling within the accepted boundaries of hospital in the home. In addition, the Private Sector Outreach Services Working Party carefully scrutinises applications to ensure that only those proposed services that directly substitute for in-hospital care for admitted patients are recommended for approval by the Minister.”

3.2.5 Criteria and Notification Process

This section addresses the research question ‘Has the criteria for provider approval and the approval/notification process been developed and applied in a manner which is consistent with the intention of the legislation?’

3.2.5.1 Approved Provider Perspective

The Criteria

All providers advised that the criteria for provider approval was developed and applied in a manner that is consistent with the intention of the legislation.

The Approval Process

All providers advised that the approval process was developed and applied in a manner consistent with the intention of the legislation. While the providers understood that the legislation required the Minister's approval of an outreach service, most questioned the appropriateness of the Department having an ongoing approval role. They based this assessment on the fact that the Department does not approve any other private sector healthcare services to this degree, and that the licensing of other healthcare services remains a State responsibility.

All providers commented on the comprehensiveness and rigour of the approval process, as well as on the high level of resource commitment required to complete the application. A few providers highlighted this high level of resource commitment as a possible disincentive for small providers to apply.

The Notification Process

Some respondents experienced very timely notification while others felt the process took too long to complete.

(Note: According to the Department lengthy delays were experienced during the early stages of implementation. This situation has now been improved as processes have been progressively streamlined.)

3.2.5.2 Private Health Insurer Perspective

The Criteria

The majority of the private health insurers feel that the criteria for provider approval are consistent with the legislation. One private health insurer does not believe the criteria are consistent, while one was unsure.

Most private health insurers commented that the criteria is focused on the processes surrounding the administration of outreach services. While the processes are important, the critical issue is getting the patient admission and exclusion criteria right and correctly applied. They acknowledged that legislation does not have the capacity to define outreach patient services versus in-hospital services for an admitted patient categorically, and as a result, the private health insurers feel this exposes them to gaming practices. They indicated that this situation creates constant tension between the private health insurers, the approved providers and the admitting medical practitioners. Some private health insurers stated that the Department's role ends with the approval of a provider, and the legislation does not provide for the Department to have an ongoing monitoring or enforcing role of the actual activities of approved providers.

The Approval Process

The majority of the private health insurers feel that the approval process has been applied in a manner which is consistent with the intention of the legislation;

however, more than half of the respondents stated that they do not believe that the Department should have an ongoing role as the approving body. These private health insurers believe that it should now be left up to them to determine the programs that they approve/fund on behalf of their members just as they currently do with special care units and special programs (ie psychiatric and rehabilitation programs). The majority view is that the approval arrangements are over-regulated.

The Notification Process

Several private health insurers stated that they do not feel that the notification process has been applied in a manner consistent with the intent of the legislation. The private health insurers are reliant on the Department to notify them of the services that have been deemed by the Minister as approved outreach services. Currently, the Departmental Circulars and the Commonwealth of Australia Special Notices Gazettes do not include sufficient information on the precise details of the approved services including the unique patient admission/exclusion criteria developed by the provider and approved by the Department. As a consequence, the private health insurers feel exposed to claims which do not meet the intention of the legislation or the admission criteria approved by the Department. The majority of private health insurer respondents recommended that the notification process be changed to address these issues.

3.2.6 The Manner of Delivery of Outreach Services

This section addresses the research question ‘Are the private sector outreach services being delivered in a manner which is consistent with the intention of the legislation?’ These include the aspects of informed consent and care processes instituted by the providers and the aspects of informed consent, product design and member communication required by the private health insurers.

3.2.6.1 Approved Provider Perspective

Provider Aspects of Service Delivery

All providers advised that their private sector outreach services were being delivered in a manner consistent with the intention of the legislation. They noted that they provide supporting documentary evidence in their approval applications.

Private Health Insurer Aspects of Service Delivery

Most providers expressed satisfaction with the private health insurers’ involvement in private sector outreach services. One provider expressed concern that the eligibility and benefit approval process with inter-state private health insurers can be a lengthy and demanding process. Some private health insurers apparently require a detailed letter from the admitting medical practitioner to determine benefit eligibility. The turn-around time for this approval has reportedly taken up to 3 weeks and as a consequence the patients remain in the hospital for a longer period.

3.2.6.2 Private Health Insurer Perspective

Provider Aspects of Service Delivery

The majority of respondents feel that the approved providers are delivering the services in a manner which is consistent with the legislation. This assessment is

primarily based on the fact that member complaints have been rare. One respondent suggested that the providers are being very diligent in their administration of the programs because they only get a one year approval, and have made a considerable investment in infrastructure to gain that approval.

Private Health Insurer Aspects of Service Delivery

Of the private health insurers interviewed, only one reported making process or product changes as a result of the legislation. In this example, product changes were made in relation to the application of the front-end deductible to outreach services.

Communication with members has been limited to generic magazine articles about the benefits of being treated outside a hospital setting. The private health insurers expect the hospitals and the medical practitioners to identify and communicate with the patients who they feel are suitable for the outreach service programs.

3.2.6.3 Other Stakeholders

The Private Health Insurance Ombudsman advised that only one formal complaint had been received in relation to private sector outreach services. This complaint was about the informed financial consent process. There were no issues regarding the safety and/or quality of care. Specifically, the member complained because they thought that being treated in their home would be cheaper, and were unhappy to learn that their admission had been billed at full, shared room overnight hospital rate. They had selected what they thought would be a cheaper option because their hospital cover had a \$500 front-end deductible. The Private Health Insurance Ombudsman is continuing to investigate this complaint with the private health insurer and the approved provider involved.

3.2.7 Safety, Quality and Outcome Issues

This section addresses the research questions ‘Are the private sector outreach services being monitored in terms of safety, quality and outcomes?’ ‘Are stakeholders satisfied with the monitoring processes?’ and ‘Are stakeholders satisfied with the safety, quality and outcomes being achieved by the private sector outreach services?’

3.2.7.1 Approved Provider Perspective

All providers advised that private sector outreach services are being monitored in terms of safety, quality and outcomes. Many commented that outreach services had been integrated into the hospital’s existing quality improvement cycle with outcomes and incidents reviewed regularly.

All providers indicated that satisfaction amongst stakeholders (patients/clients, carers, clinicians and staff) was very high. The increasing support and utilisation of private sector outreach services is evidence of this.

The safety and quality monitoring tools currently used by providers included:

- GP, patient, staff and referring clinician satisfaction and complaint management processes;
- Australian Council on Healthcare Standards (ACHS) Hospital in the Home Clinical Indicators;
- ACHS EQulP Accreditation;

- OH&S assessment and incident reporting;
- risk management review; and
- monthly key performance indicators (clinical, human resources, financial).

3.2.7.2 Private Health Insurer Perspective

Of those respondents who commented, most noted that they rely on the Private Sector Outreach Services Working Party to evaluate the outreach programs in respect of safety, quality and outcomes as part of the approval process and again when the hospitals report their key performance indicators. Those who responded were satisfied with this level of program evaluation. Only one private health insurer reported doing extensive member and provider satisfaction surveys which revealed that both member and provider satisfaction was 'very high'. Some private health insurers noted that measurement must extend to the cost-effectiveness of the programs to meet with the intent of the legislation.

Accurate data is a significant and relevant issue and only one private health insurer reported that they are able to track utilisation of outreach services. As noted in Chapter 1, it appears that most hospitals are billing for outreach services in a way which does not allow the services to be identified from the claim/account; therefore, most private health insurers cannot perform even basic utilisation review activities (eg track readmissions following outreach services). Some private health insurers recommended a 'type change' for patients on outreach services, so that these services can be tracked via the Hospital Casemix Protocol (HCP) data.

(We note that the HCP does include data item 36 for recording days in a hospital in the home program, but apparently this is not being used.)

3.2.8 Financial Impact

This section addresses the research question 'Has the financial impact of introducing private sector outreach services been inflationary?'

3.2.8.1 Approved Provider Perspective

Impact on Private Health Insurance

All providers maintained that the implementation of private sector outreach services had not been inflationary at an industry level due to the adherence to the criterion which requires substitution for in-hospital care for admitted patients.

Half of the providers indicated that they had had to renegotiate their agreed rates with the private health insurers prior to the contract renewal date because they had underestimated the costs associated with establishing and running the outreach service. They did not feel that this was inflationary since the renegotiated rates were still below the rates that would have applied if the patient had remained within the hospital.

Impact on Medicare

All providers advised that the impact on Medicare would be neutral or would possibly result in savings as medical practitioners do not visit outreach patients as often as they would visit a patient within the hospital.

3.2.8.2 Private Health Insurer Perspective

Impact on the Private Health Insurance

Most private health insurers do not feel that the private sector outreach services have been inflationary at the macro-level as the utilisation is still insignificant.

At a micro-level, only the private health insurer that is actively tracking utilisation and working closely with two approved outreach providers stated that the programs had proven to be cost-effective to date. The representative of this private health insurer attributed this result to tight controls and a trusting working relationship between the parties. *(It should be noted that this example occurred in a State where case payments are not widely implemented and therefore the impact on cost-effectiveness may be more readily apparent.)*

Most of the private health insurers interviewed are concerned that some hospitals are seeking rates for outreach services which are equal to the agreed overnight hospital rates. If the services were a true substitution, then the result would be cost-neutral at best and not necessarily cost-effective as was intended by the legislation. As previously stated, the majority of the private health insurers are also concerned that new services are being charged that were previously not charged to a private health insurer (i.e. services which were previously treated on an outpatient basis) and as a result, the funding of these services at any price is inflationary.

Some private health insurers also noted that the introduction of a Ministerial Default Benefit of \$145 had been inflationary as the amount exceeded the rates which had already been negotiated with many approved providers and prompted the approved providers to seek renegotiation to this new floor price. The introduction of the Ministerial Default Benefit also reportedly had the consequence of raising the agreed rates for related services.

Impact on Medicare

Most private health insurers do not believe that there is any evidence that there has been cost-shifting to Medicare. Instead, they are more concerned that there could be cost-shifting onto the private health insurers through the funding of services which have historically been funded on an outpatient basis through Medicare or through the State funding arrangements.

4 Conclusions

Overall, there appears to be ongoing support by all stakeholders for the concept of private sector outreach services which are a genuine substitution of in-hospital care for admitted patients and which are delivered in a safe and cost effective manner. Our remaining conclusions are presented under each research question as follows:

What private sector outreach services have been developed since the introduction of the legislation? [location of providers, number of providers, range of available services, number of services, number of patients, private health insurer participation]

- There are twenty-three approved private sector outreach service providers which are primarily located in Victoria, South Australia and Western Australia. All approved providers are licensed private hospitals with the exception of one public hospital. Eleven hospitals are approved for psychiatric services, eleven are approved for medical/surgical services, and one is approved for palliative care services.
- The private health insurers interviewed feel that the number of approved providers and service utilisation has been lower than expected. While the approved providers reported that utilisation had exceeded their expectations. The stakeholders generally believe that utilisation will continue to grow.
- Private health insurer participation with approved private sector outreach services ranges from no participation to participation with most approved providers.

Are the types of private sector outreach services which are operating, or which are planned, consistent with the intention of the legislation?

- The approved provider respondents believe that the types of private sector outreach services that they are offering are consistent with the intention of the legislation.
- The private health insurers interviewed generally believe that the types of services, which have been developed appear to be consistent with the intention of the legislation; however, the majority are concerned that the actual utilisation of the approved services does not always meet the substitution criterion of the legislation. They are concerned that some services which may have been previously delivered on an outpatient basis and funded through Medicare or State funding arrangements, are now being provided in private sector outreach programs.

Has the criteria for provider approval and the approval/notification process been developed and applied in a manner which is consistent with the intention of the legislation?

- The Department has implemented new structures and processes to operationalise the private sector outreach legislation.
- **Criteria:** Based on the available evidence and stakeholder responses, it appears that the criteria for provider approval has been developed and implemented in a manner consistent with the intention of the legislation.
- **Approval Process:** Based on the available evidence and stakeholder responses, it appears that the approval process has been developed and implemented in a manner consistent with the intention of the legislation. Both approved providers and private health insurers acknowledge that the legislation stipulates that the Minister must approve outreach services, however, most believe that the Department should not have an ongoing role in outreach service approval.
- **Notification Process:** From the evidence available, the notification process implemented by the Department does not satisfy the intention of the legislation. The legislation specified that an outreach service was any service deemed to be such by the Minister. The Department's notification process does not provide the industry with sufficient detail about the specific services which have been approved. As a result, the private health insurers feel exposed to claims for outreach services which are not consistent with the legislation or with the admission and exclusion criteria for the approved outreach service.

Are the private sector outreach services being delivered in a manner which is consistent with the intention of the legislation? [Provider aspects (informed consent, care processes)] [Private health insurer aspects (informed consent, product design, member communication)]

- The stakeholders believe that the private sector outreach services are being delivered in a manner consistent with the intention of the legislation.

Are the private sector outreach services being monitored in terms of safety, quality and outcomes? Are stakeholders satisfied with the monitoring processes? Are stakeholders satisfied with the safety, quality and outcomes being achieved by the private sector outreach services?

- The private sector outreach services are primarily being monitored internally by the approved providers using a range of quality and performance indicators, and externally by the Private Sector Outreach Services Working Party. The stakeholders are currently satisfied with these monitoring processes, although some private health insurers feel that 'cost-effectiveness' needs to be included as a key performance measure.
- There were no concerns reported by the stakeholders with regards to the safety, quality and outcomes of the approved private sector outreach services.
- The lack of data on private sector outreach services is a problem which needs to be rectified in order to enable the evaluation of service utilisation and patient outcomes.

Has the financial impact of introducing private sector outreach services been inflationary? [impact on private health insurance benefit expenditure, impact on Medicare, any real or potential cost shifting]

- At a macro-level, the stakeholders do not believe that the private sector outreach services have been inflationary as utilisation has been insignificant.
- At a micro-level, the approved providers do not believe that the private sector outreach services have been inflationary because they have been a direct substitution of in-hospital care for admitted patients and because the negotiated rates for outreach services have been less than the agreed in-hospital rates. Some private health insurers believe that they are being charged for new services which are not a direct substitution and that these are inflationary. Some private health insurers also felt that the introduction of a Ministerial Default Benefit (\$145) had had an inflationary effect as the amount exceeded rates which had already been negotiated with many approved providers and prompted them to seek renegotiation to this new floor price. The introduction of the Ministerial Default Benefit also reportedly had the consequence of raising the agreed rates for related services.
- The stakeholders do not have any evidence to suggest that the private sector outreach services have had an inflationary impact on Medicare. The majority of the private health insurers are concerned about the potential for cost shifting onto the private health insurers should there be an influx of approved public hospitals providing services which have traditionally been funded on an outpatient basis.

5 Reference List

Commonwealth Department of Health and Ageing (2001) *Guidelines for the Establishment and Implementation of the Private Sector Outreach Services*, Canberra

Commonwealth Department of Health and Ageing (2001) *Application for the Establishment and Implementation of the Private Sector Outreach Services*, Canberra

Healthcare Management Advisors (July 2000) *Evaluation of Private Sector Based Early Discharge and Hospital in the Home Trials: Report of the National Evaluation*, Commonwealth Department of Health and Aged Care, Canberra.

Productivity Commission (28 February 1998) *Report No 57 on Private Health Insurance*, Australia Government Publishing Service, Canberra

A Appendix:

Glossary

Ancillary cover	Covers services such as dental, prescribed optical appliances, physiotherapy, chiropractic, hearing aids, and speech therapy. These services do not require referral from a medical practitioner for private health insurance cover.
Case Payment	An single payment for hospital treatment which covers the episode of care and which is based on the patient's clinical classification.
Hospital	means a recognised hospital, a private hospital, or a hospital that is declared by the Minister, by writing or signed by him or her, to be a hospital.
Hospital Treatment	means accommodation and nursing care, whether provided for the purpose of permitting the provision of professional attention or, in the case of a nursing-home type patient, as an end in itself.
Outlier Threshold	The pre-determined length of stay which is the upper limit of the case payment parameters. Once the outlier threshold is exceeded, per diem payments apply.
Private Sector Outreach Services	Any service specified in a determination under section 5D ³ of the Act ⁴ , that is provided to a patient by, or on behalf of, a hospital or day hospital facility, but does not include service provided by a medical practitioner that would attract a Medicare benefit of 85% of the scheduled fee.
Per Diem	Per Day
Reinsurance	A system for sharing the hospital costs of high risk members among private health insurers. ⁵

³ Section 5D: (1) The Minister may, by written determination, specify services provided by, or on behalf of, a specified hospital or day hospital facility for the purposes of the definition of outreach service.

⁴ *National Health Act 1953*

⁵ Productivity Commission (28 February 1998) Report No 57 on Private Health Insurance, Australia Government Publishing Service, Canberra

B Appendix:

Stakeholder Sample and Response Rate

Approved Provider	Type of Interview Conducted
Epworth Private Hospital <i>Victoria</i>	Face to Face
St Frances Xavier Cabrini Private Hospital <i>Victoria</i>	Face to Face
The Albert Road Clinic <i>Victoria</i>	Face to Face
St John of God Health Care <i>Western Australia</i>	Phone
Bethesda Hospital <i>Western Australia</i>	Phone
Adelaide Community Healthcare Alliance <i>South Australia</i>	Phone
Wangaratta District Base Hospital <i>Victoria</i>	Phone
Ramsay Health Care Australia: The Adelaide Clinic <i>South Australia</i>	Phone
Private Health Insurers	Type of Interview Conducted
Medibank Private	Face to Face
Medical Benefits Fund of Australia (MBF)	Face to Face
BUPA (AXA)	Face to Face
HCF	Face to Face
HBF	Phone
NIB	Phone
Other Stakeholders	Type of Interview Conducted
Private Health Insurance Ombudsman	Face to Face
Commonwealth Department of Health and Ageing	Phone
Australian Private Hospitals Association (APHA)	Postal Survey
Australian Health Insurance Association (AHIA)	Postal Survey
Committee of Presidents of Medical Colleges	Postal Survey
Catholic Health Australia	Declined Response
Private Health Insurance Advisory Council	Declined Response
Consumer's Health Forum	Declined Response
HIRMAA	Declined Response
Australian Health Service Alliance	Postal Survey

C Appendix: Interview Guides

Department of Health & Ageing – Review of Outreach Services Legislation Questionnaire for Health Insurers

Completed by:
Date:

Question	Answer
The intention of the Private Sector Outreach Services legislation includes: • replacement of an inpatient bed day • patient remains under the jurisdiction of the hospital • private health insurance is not extended to out of hospital medical services • approval to provide services is limited to a defined period • programs are not inflationary in terms of health costs • services are delivered with ‘desirable features’ (informed consent, safety, clinical practice) in line with trial services (post operative, psychiatric, rehabilitation, palliative care).	
Section 1: Private sector outreach service development and experience	
Are the types/range of private sector outreach services which have been developed (or which are planned) consistent with the intention of the legislation? Prompt: Psych? Rehab? Palliative Care? Hospital in the Home? Wound Management?	
Is the number of available private sector outreach programs consistent with your fund's expectations? If not, prompt for: More? Less? Reasons why?	
What private sector outreach services are you funding on a fee for service basis or per diem?	
Are you tracking private sector outreach service utilisation? If so, are you able to provide an indication of: - the number of services covered (by type of service) - the number of members covered for the 12 month period ending 31 January 2003.	
Has utilisation of the private sector outreach services been consistent with your fund's expectations? If not, prompt for: More? Less? Reasons why?	
Part 2: Criteria for approval and Approval/Notification Process	
Has the criteria for provider approval been developed and applied in a manner which is consistent with the intention of the legislation? Prompt: Seek recommended solution is problems are identified	

Has the provider approval/notification process been developed and applied in a manner which is consistent with the intention of the legislation?	Prompt: Seek recommended solution if problems are identified
Part 3: Private sector outreach service delivery and evaluation	
Are the approved providers delivering the private sector outreach services in a manner which is consistent with the legislation?	Aspects: Informed consent? Patient selection? Home assessment where required? Discharge planning? 24/7 support for patients/carers? Care plan development and ongoing monitoring? Carer needs/issues incorporated into care plan? Staffing of service? Etc.
	Prompt: Seek recommended solution if problems are identified
How are the private sector outreach services being evaluated in terms of safety, quality and outcomes?	Prompt: including patient and provider satisfaction? Any issues/concerns?
Is your fund currently satisfied with the safety/quality/outcomes of the approved private sector outreach services?	
What has your fund done in response to the introduction of the private sector outreach legislation in regards to:	• product design • member communication • informed financial consent and eligibility processes?
Part 4: Financial Impact	
Has the financial impact of introducing benefits for private sector outreach services been inflationary?	Prompt: If answer yes prompt for details regarding extent of inflationary impact.
Has any real cost-shifting resulted from the introduction of private sector outreach services? Any potential cost-shifting? Specifically, has there been any cost-shifting in respect of Medicare?	
Part 5: Additional Comments	
Any final or closing comments?	

Department of Health & Ageing – Review of Outreach Services Legislation Questionnaire for Approved Providers

Completed by:
Date:

Question	Answer
The intention of the Private Sector Outreach Services legislation includes: • replacement of an inpatient bed day • patient remains under the jurisdiction of the hospital • private health insurance is not extended to out of hospital medical services • approval to provide services is limited to a defined period • programs are not inflationary in terms of health costs • services are delivered with ‘desirable features’ (informed consent, safety, clinical practice) in line with trial services (post operative, psychiatric, rehabilitation, palliative care).	
Section 1: Private sector outreach service development and experience	
What type of private sector outreach services are being provided by your hospital? Are any additional outreach services being developed?	
Are all implemented and planned services consistent with the intention of the legislation?	
What private sector outreach services are you being funded for on a fee for service or per diem basis?	
What private health insurers are providing benefits for your private outreach services? Which are not and why?	
Are you tracking private sector outreach service utilisation? If so, are you able to provide an indication of: - the number of services (by type of service) - the number of patients - the number of participating doctors for the 12 month period ending 31 January 2003.	
Has the utilisation of your hospital’s private sector outreach services been consistent with your expectations?	
If not, prompt for: More? Less? Reasons why?	
Part 2: Criteria for approval and Approval/Notification Process	
Has the criteria for provider approval been developed and applied in a manner which is consistent with the intention of the legislation?	
Has the provider approval/notification process been developed and applied in a manner which is consistent with the intention of the legislation?	

Part 3: Private sector outreach service delivery and evaluation	
Are you delivering the private sector outreach services in a manner which is consistent with the legislation?	Prompt: Informed consent? Patient selection? Home assessment where required? Discharge planning? 24/7 support for patients/carers? Care plan development and ongoing monitoring? Carer needs/issues incorporated into care plan? Staffing of service? Etc.
How are the private sector outreach services being monitored in terms of safety, quality and outcome? Do you believe this is a sufficient level of monitoring?	
Prompt: including patient and provider satisfaction? Any issues/concerns?	
Have any changes been made to the private sector outreach services you offer in response to the safety/quality/outcome evaluations?	
Are the stakeholders currently satisfied with the safety/quality/outcomes of your approved private sector outreach services?	
Prompt: including patient and provider satisfaction. If answer is no, pursue why?	
Are you satisfied with the fund's response to the introduction of the private sector outreach legislation in regards to:	
• product design • member communication • informed financial consent and eligibility processes?	
Part 4: Financial Impact	
Has the financial impact of introducing benefits for private sector outreach services been inflationary? If so, how?	
Has any real cost-shifting resulted from the introduction of private sector outreach services? Any potential cost-shifting? Specifically, has there been any cost-shifting in respect of Medicare?	
Part 5: Additional Comments	
Any final or closing comments?	

Department of Health & Ageing – Review of Outreach Services Legislation

Questionnaire for Other Stakeholders

Completed by:

Date:

Question	Answer
The intention of the Private Sector Outreach Services legislation includes: • replacement of an inpatient bed day • patient remains under the jurisdiction of the hospital • private health insurance is not extended to out of hospital medical services • approval to provide services is limited to a defined period • programs are not inflationary in terms of health costs • services are delivered with ‘desirable features’ (informed consent, safety, clinical practice) in line with trial services (post operative, psychiatric, rehabilitation, palliative care).	
Section 1: Private sector outreach service development and experience	
Are the types of private sector outreach services which have been developed (or which are planned) consistent with the intention of the legislation?	
Part 2: Criteria for approval and Approval/Notification Process	
Has the criteria for provider approval been developed and applied in a manner which is consistent with the intention of the legislation?	
Has the provider approval/notification process been developed and applied in a manner which is consistent with the intention of the legislation?	
Part 3: Private sector outreach service delivery and evaluation	
Are the approved providers delivering the private sector outreach services in a manner which is consistent with the legislation? Aspects: Informed consent? Patient selection? Home assessment where required? Discharge planning? 24/7 support for patients/carers? Care plan development and ongoing monitoring? Carer needs/issues incorporated into care plan? Staffing of service? Etc.	
How are the private sector outreach services being evaluated in terms of safety, quality and outcomes?	
Is your organisation currently satisfied with the safety/quality/outcomes of the approved private sector outreach services? Prompt: including patient and provider satisfaction. If answer is no, pursue why?	

Part 4: Financial Impact	
Has the financial impact of introducing benefits for private sector outreach services been inflationary? Prompt. If answer yes prompt for details regarding extent of inflationary impact.	
Has any real cost-shifting resulted from the introduction of private sector outreach services? Any potential cost-shifting? Specifically, has there been any cost-shifting in respect of Medicare?	
Part 5: Additional Comments	
Any final or closing comments?	

D Appendix:

**Commonwealth Department of Health and
Ageing Guidelines for the Establishment and
Implementation of Private Sector Outreach
Services**

Guidelines for the Establishment and Implementation of The Private Sector Outreach Services

Introduction

These Guidelines have been developed with reference to a comprehensive evidence base that included existing public sector hospital in the home guidelines and public and private sector evaluation reports. The Guidelines have evolved with a generic focus to enable accommodation of all stakeholders who wish to establish an Outreach Service. The Guidelines must be satisfied in order for an Outreach Service to be approved.

The Outreach Service Guidelines will assist the Minister for Health and Ageing (or the nominated Delegate) to select (and approve) those outreach services that meet the Guidelines. Approval will be granted for a specified period. Approved outreach services will need to reapply to the Minister, or the Minister's delegate, if they wish to continue the service beyond the specified period, before the existing approval expires. Reapplication forms will be available from the Department of Health and Ageing, by either visiting the website or contacting the Department on (02) 6289 9826.

It is recognised that the majority of hospitals, including those currently offering outreach services already have in place protocols and policies that would be similar to the Guidelines. Therefore these guidelines will compliment each other.

Reports of the National Evaluation (Stage One and Two) indicated that outreach trials for private patients were:

- ◆ safe;
- ◆ sound clinical practice;
- ◆ accepted by all levels of the profession;
- ◆ supported by carers;
- ◆ beneficial for patients;
- ◆ able to demonstrate cost efficiencies, or at least be no more costly; and
- ◆ a genuine substitution for in-hospital care.

A copy of these Reports is available on the Private Health Industry Web-site. The address is: <http://www.health.gov.au/privatehealth/providers/imc.htm>

If required, a copy of the *Health Legislation Amendment Act (No.1) 2001* is available from the Australian Government Information Shop.

Under the Act, hospitals seeking to provide outreach services to private patients will be required to gain Ministerial approval before providing an outreach service. Only approved services will be covered by hospital table insurance arrangements. The Guidelines will determine whether an outreach service should be specified under the new section 5D of the *National Health Act 1953*.

In addition to satisfying the Guidelines, any facility seeking approval as an outreach service provider must:

- (i) have a State or Territory licence or registration certificate, and/or
- (ii) be declared by the Commonwealth minister for health to be either:
 - a private hospital under subsection 23E(1) of the *Health Insurance Act 1973*; or
 - a day hospital facility under subsection 5B(1) of the *National Health Act 1953*.
- (iii) be an accredited facility with a recognised accreditation agency with no areas of high priority recommendations.

State/territory public hospitals that have been issued with a Commonwealth provider number are eligible to apply.

A Patient's Admission into the Outreach Service

Patients admitted to the Approved Outreach Services, regardless of how they enter the program, are **admitted patients of the hospital, and therefore remain under the jurisdiction of the hospital** until discharge.

Patients may be admitted to an approved outreach service following an episode of in-hospital care, that is, their admitted patient status simply continues for the duration of their care. Alternatively, patients may be admitted to an outreach program (and hospital simultaneously) without having to have been physically admitted to the hospital itself. For example, he/she may be assessed as suitable in their place of residence, at their GP's surgery, or in the Accident and Emergency Department of the approved hospital. The patient must satisfy the admittance/ eligibility criteria for the program and belong to a participating health fund if they wish to claim benefits from their hospital table.

Applications From Outreach Services Seeking Approval

Applications from hospital(s) seeking approval for their proposed outreach services will be required to provide sufficient detail and documentation to satisfy the minimum criteria and standards specified in the Guidelines.

The outreach service is a voluntary program. It is not mandatory for hospitals to participate. Hospitals should consult with relevant health funds in the development of their applications and seek agreement from participating health funds prior to submitting their applications. Proposals should include in-principle agreements from participating health funds

It is recommended that benefits paid for outreach services (which are commercial in confidence agreements) be determined between the providers and funders and that these are negotiated with regard to the complexity and cost-effectiveness of implementing the outreach program.

It is also recommended that proposals for new outreach service delivery in the private sector take into account the viability of the proposed service.

As Ministerial approval will be time limited, it will be a requirement that those programs previously approved report on the results of a review of the outreach service prior to additional approval being granted.

Additional approval from the Minister or his/her delegate will be necessary if a new or substantially different service is developed with a view to this being offered as part of the outreach program.

The Department should be notified within 30 days if the participating parties to the original proposal change during the period of approval. A standard form for notification of changes will be available from the Department.

As the legislation underpinning these outreach services requires an independent review and a report to Parliament of this review before 30 June 2003, each approved outreach service will be required to provide a mid term progress report to the Commonwealth, through the Department, noting progress against objectives and outcomes. Once the Outreach Service in the approved organisation is established progress reporting will be required annually.

Under the Act, the Minister has the power to revoke an outreach service's approval and this may occur if he/she believes that these minimum guidelines are not being satisfied.

Summary of Guidelines for Outreach Services under the *Health Legislation Amendment Act (No 1) 2001*

1. Informed Consent of Patients Receiving Outreach Services
2. Informed Consent of Carer Participating in the Outreach Service
3. Patient Selection into the Outreach Service
4. Care Planning for Outreach Services
5. Discharge Planning Procedures
6. Effective and clear communication
7. Responsibilities of the general practitioner and the hospital
8. Staff competency including skill levels and continuing education
9. Staff Safety
10. Patient and Carer Safety

In addition to the above, the following best practice principles and practices should be in place.

11. Informed Financial Consent
12. Simplified Billing
13. Quality management and clinical guidelines

1. Informed Consent of Patients Receiving Outreach Services.

Patients of outreach services *must* be provided with an opportunity to make an informed choice about their participation in an outreach service. Patients should receive the full and appropriate information about their condition, treatment and ongoing management. To ensure this principle is maintained there should be:

- 1.1 Arrangements requiring the written consent of the patient and, if appropriate or relevant, their carer. This consent must be based on an explicit explanation and agreement to the plan of care between the providers, patient and (if involved) the carer.
- 1.2 Included in the consent form information about the rights and responsibilities of all parties.
- 1.3 A requirement that the consent form must be signed before admission to the program.
- 1.4 Information for patients and carers that includes an explanation of the concept of outreach care.
- 1.5 An explanation of specific problems which may be encountered whilst receiving hospital treatment under the outreach care program.
- 1.6 A consent form in community languages and/or provision for an interpreter
- 1.7 An acknowledgment in the consent form that the hospital can withdraw the option of outreach treatment if the medical condition or social situation of the patient changes and if continued provision of such services would be inconsistent with safe or appropriate outreach care.
- 1.8 Recognition that the patient maintains the same rights as those of a hospital in-patient, and that their participation is voluntary and can be terminated at the patient's (or carer's) request or at the discretion of outreach staff. The hospital will ensure that the patient can become admitted back to the facility at any time deemed necessary for the ongoing provision of care of the patient.
- 1.9 Agreement by the patient and the patient's carer to the measures necessary to facilitate safe outreach care and to ensure safe access to the home and the patient.
- 1.10 Appropriate training available to patients which includes information and training (in plain English) that enables them to deal with emergencies if they should arise.
- 1.11 Information given to the patient about who they should contact in an emergency, or if they have problems, questions or if they require additional attention.
- 1.12 An understanding by all parties, especially the patient and carer, that the patient is an **admitted patient of the hospital while receiving outreach services and not a patient of their GP.**

Evaluation: That there is documented evidence of consent criteria, program policies and procedures that reflect, at a minimum, the above points.

2. Informed Consent of the Carer Participating in the Outreach Service.

To ensure that both the patient *and* the carer have the opportunity to give their informed consent, and where a carer is involved in the provision of care to that patient, there should be:

- 2.1 Carer agreement to *their* role in the management of the patient.
- 2.2 A clear explanation, and documentation, of the role of the carer in the management of the patient in the service
- 2.3 Agreement by the carer to the transfer of the patient into outreach care, when a carer is involved in providing support to the patient.
- 2.4 Appropriate training available to carers which includes information and training (in plain English) that enables them to deal with emergencies if they should arise.
- 2.5 Information given to the carer about who they should contact in an emergency, and who to contact if they have problems, questions or if they require additional attention or information.
- 2.6 The provision for an interpreter so that carers are able to access further information should they require it.
- 2.7 Documentation in the progress notes that the carer has consented to participating in the patient's care.
- 2.8 In the case of a patient who does not require or request carer support eg., psychiatric patients not requiring carer intervention due to the sensitive nature of their illness, the above Carer consent criteria is not applicable.

Evaluation: That there is evidence of consent criteria, program policies and procedures that reflect, at a minimum, the above points.

3. Patient selection into the outreach program

To ensure that the selection of participating patients is based primarily on clinical considerations there should be:

- 3.1 Protocols for patient selection based on an objective, accurate and comprehensive assessment of each patient's suitability.
- 3.2 Criteria for ensuring that the provision of care is appropriate and the patient's clinical condition is amenable for outreach services and that the care provided meets the needs and requirements of the patient.
- 3.3 Where a carer is involved, that the patient and carer understand that the patient's condition can be managed in an appropriate setting with the assistance of the carer.
- 3.4 A clear patient diagnosis, a stable condition and a definitive prognosis.
- 3.5 A care environment that is appropriate for outreach care.
- 3.6 Evidence that a carer is available (where appropriate and/or necessary).
- 3.7 A telephone that is connected within the patient's home environment and is easily accessible in all instances.
- 3.8 A requirement that the patient is able to communicate his or her needs effectively, at all times and, if necessary through an interpreter.
- 3.9 A requirement that public safety be considered as part of the patient assessment process. This includes safe storage of medication and any equipment used by the patient and carer (if applicable).
- 3.10 An assessment of the patient's home environment, where appropriate, as part of the initial referral/assessment process. It is recognised that for some clinical areas within outreach services that an on-site inspection of the patient's home will not be required.

- 3.11 Included as a component of assessment for suitability of outreach services, an assessment of the equipment requirements for the patient's home (where applicable).

Evaluation: evidence that programs ensure consistent and comprehensive assessment against admission criteria and are able to provide appropriate documentation on the application of admission criteria.

4. Care Planning for Outreach Services

A clearly understood multidisciplinary care plan is required. It should be developed in partnership with the medical practitioner, nursing, allied health professionals, the patient and their carer. An inclusion of the General Practitioner will be required in the care planning in relation to discharge planning or when the General Practitioner is the **attending hospital doctor**. To ensure sound care planning there should be:

- 4.1 Inclusion in care plans of sound assessment procedures and the development of individualised care/treatment plans in conjunction with the treating specialist, service provider(s), patient and, as appropriate the patient's carer.
- 4.2 Treatment/care plans which actively take account of the individual patient's clinical, social and emotional needs.
- 4.3 Treatment/care plans which actively take account of carer needs (where applicable).
- 4.4 Ongoing assessment processes by a multidisciplinary team which involves service providers, the medical practitioner under whom the patient is admitted, the patient and, as appropriate, the patient's carer.
- 4.5 A multidisciplinary team to monitor clinical care provided and the outcomes, modify the service delivery approach as necessary, which in turn will lead to patient discharge at the appropriate point in the patient's treatment.
- 4.6 Documentation of expected patient outcomes that have been agreed to by the patient/carers.
- 4.7 A service delivery approach that is capable of responding to patient needs. For patients' experiencing psychiatric requirements, the staff delivering the service should be matched to the patient **where possible**.
- 4.8 Recognition that carer issues are likely to be different to those identified by patients and an understanding that service providers must respond differently to these needs.
- 4.9 Criteria and protocols in place for patient transfer to hospital if required.
- 4.10 Documentation of patient review protocols.
- 4.11 Ongoing updating and monitoring of care plans and clinical needs.
- 4.12 Processes for the treating medical practitioner, outreach nurse or allied health professional to liaise and communicate as necessary with the other members of the team.
- 4.13 Consideration of the significant administrative/non-patient contact requirements of outreach services, particularly travel, in the care planning (indirect care requirements).

- 4.14 A requirement that the coordinated care plans compiled by the relevant staff in conjunction with the patient and carer remain with the patient while the patient is admitted to the outreach service. Treatment notes to be held by the organisation or by the patient when agreed to by the said organisation.
- 4.15 A copy of the care plan should be made available to the general practitioner upon the Patient's discharge or within a suitable time frame after discharge.

Evaluation: Evidence of specific care management plans and evidence that the care plans were followed. Evidence that variations are made to standardised care plans to cope with individual and specific patient needs, and evidence that care plans reflect agreed (patient/carers) treatment approaches/ outcomes.

5. Discharge Planning Procedures

Comprehensive discharge planning processes should be in place to ensure client and carer participation and agreement. Prior to discharge the patient and carer should be prepared for any ongoing management and continuity of care requirements between the outreach service and community care. To ensure the appropriate processes are in place:

- 5.1 The process of discharge planning should be commenced at the beginning of the outreach service, as would be the case with admitted patients.
- 5.2 Discharge planning should involve the appropriate health professionals, the patient and carer and the patient's GP (where appropriate).
- 5.3 There should be an ongoing patient assessment process that leads to the patient's discharge from the outreach program at the appropriate point in the patient's treatment.
- 5.4 For 'Acute Care' patients, the patient's GP should be advised of the patient's admission to the service, their progress and the approximate date of discharge. Within a suitable time frame ie forty eight hours after discharge from the service, the patient's GP should be sent a discharge summary of the patient's outreach treatment, their medications and any follow-up plan. In the case of psychiatric care, due to the sensitive nature of the information, the patients discharge summary should only be sent to General Practitioners if agreed to by the patient.
- 5.5 There should be a process for ensuring follow-up with appropriate referral services following discharge from outreach care, if required.
- 5.6 Patient and carer should receive education for the post discharge care aspect of the discharge planning process.

Evidence: That appropriate discharge, referral and post-discharge strategies are in place for outreach patients, where required, and that there is evidence of discharge plans or procedures being followed.

6. Effective and Clear Communication

Clearly establish and indicate to the patient the hospital's medical responsibilities, the lines of responsibility in managing the patient's care and the responsibilities of other health care providers. For example, guidelines and processes must be in place to ensure that:

- 6.1 As an admitted patient of the hospital, the patient remains under the care of the hospital and the attending hospital medical practitioner and the patient is fully aware and understand this.
- 6.2 Clear communication takes place between all the parties and includes the treating medical practitioner who is involved in the patient's care.
- 6.3 All parties understand that under the *Health Legislation Act (No.1) 2001*, outreach service means any service specified in a determination under section 5D of the *National Health Act 1953*, that is provided to a patient by, or on behalf of, a hospital or day hospital facility, as a direct substitute for hospital treatment that would otherwise be provided in a hospital or day hospital facility, **but does not include a service provided by a medical practitioner that would attract a Medicare benefit of 85% of the scheduled fee**

Evaluation: That there is evidence of program policies and procedures that reflect the above points.

7. Responsibilities of the general practitioner and the hospital

The respective roles and responsibilities of the patient's general practitioner and the hospital should be made clear to the patient and the carer. This information should include the following principles and practices:

- 7.1 Outreach patients are *admitted* patients of the hospital until they are discharged from both the outreach program and the hospital.
- 7.2 Outreach care must be a direct substitute for the treatment the patient would otherwise receive if the patient were an admitted patient of the hospital.
- 7.3 The patient's GP would not be directly involved in the Outreach/Acute patient's care (whilst they are a patient of the service). Unless, a patient's GP is an attending physician at the hospital providing services as part of the outreach program or is contracted by that hospital to provide medical services as part of its outreach program.
- 7.4 Recognition of, and protocols for, the establishment of early linkages and communication with the patient's general practitioner prior to and shortly after the patient's discharge.
- 7.5 The patient's GP to be included (where appropriate) in the discharge planning process from the outreach program
- 7.6 Should the admitted patient develop a new medical problem, he or she should communicate this to their contact at the hospital, not their general practitioner unless, as under 7.3, the patient's general practitioner is involved with the admitted care of the patient.

Evaluation: Evidence that the patient's GP is informed of the patient's admission to the program within 48 hours of admission and that the GP receives a discharge summary within 48 hours of the patient's discharge from the outreach program. There should be evidence, where appropriate, that the patient's GP is included in the discharge planning process.

8. Staff competency including skill levels and continuing education

To ensure staff competency the service delivery arrangement should maintain experienced and appropriately qualified staff such that:

- 8.1 Staff providing outreach care have the appropriate and relevant health qualifications for the targeted outreach patient needs.
- 8.2 Staff providing outreach care have the necessary knowledge and skills relevant to the services provided by the outreach programs.
- 8.3 Staff have access to ongoing education regarding specific outreach acute care skills.
- 8.4 Appropriate orientation and in-service programs are in place to facilitate safe, quality levels of care and outcomes for patients.
- 8.5 Staff have access to education programs to update and acquire those skills necessary and relevant to provide the acute care needs of outreach patients.
- 8.6 Outreach programs recognise the need for a wide range of health professionals including nursing, allied health, and others to be available as appropriate for outreach programs.
- 8.7 The facility should have in place:
 - (i) policies and protocols to facilitate and ensure that any individual working in the hospital is appropriately qualified and experienced to fulfil their responsibility safely and effectively, including:
 - credentialling procedures;
 - ongoing monitoring of staff performance and systems to continuously improve performance in clinical practice; and
 - peer review mechanisms linked to hospital credentialling.
 - (ii) mechanisms to review and adjust staff skills to meet the needs of patients
 - (iii) systems in place to ensure staff satisfaction /feedback is regularly sought and acted upon.

Evaluation: That there is evidence of program policies and procedures being in place that reflect the above points.

9. Staff Safety

Staff safety features should encompass ongoing staff safety education programs and service delivery protocols and should include:

- 9.1 The development and implementation of appropriate protocols and procedures for ensuring staff security and safety.
- 9.2 The development of safety guidelines for home visits and travelling in cars, particularly when medication may be being carried.
- 9.3 Implementation of infection control and hazard management policies and protocols in outreach programs.
- 9.4 Manual handling and lifting protocols and policies.
- 9.5 Access to appropriate equipment to prevent potential injury.
- 9.6 Mandatory standard requirements of a means of immediate communication, for example, mobile phones, for outreach staff who are working alone.

Evaluation: That there is evidence of program, policies and procedures that reflect the above points.

10. Patient and Carer Safety

Patients/carers should have access to a 24-hour contact point to obtain support from service providers at times of concern. A clearly defined protocol for advising the patient/carer and arranging for appropriate clinical intervention should be implemented as necessary. To ensure this, there should be:

- 10.1 Availability of 24-hour backup support for patients in the program. Patients and carers must be fully aware of all contact numbers and advised of what to do in an emergency.
- 10.2 Emergency backup policies and protocols and evidence that they are adequate and appropriately applied.
- 10.3 Information provided to the patient and carer so that they are aware of the signs and symptoms of any deterioration of health status and of the action they need to take.
- 10.4 Patient education concerning the safe handling and storage of medications and use of equipment.
- 10.5 Procedures to ensure appropriate assessment of the patient's home environment as part of the initial referral/assessment process.
- 10.6 Recognition that for some clinical areas within outreach services that an on-site inspection of the patient's home will not be required.
- 10.7 A telephone that is connected and is easily accessible for all accepted outreach patients (and/or a functioning UHF radio, where in the rural areas this is part of the normal communication arrangements).
- 10.8 Appropriate processes for dealing with adverse incidents, analysis of and recording of the incidents, and appropriate documentation of the actions taken.

Evaluation: That there are emergency backup policies and protocols in place, and evidence that they are adequate and appropriately applied. That there is documented evidence of patient and carer safety protocols. That there is documented evidence of monitoring of adverse events, recording of these and of the action taken.

The following four Guidelines are consistent with best practice principles. It is expected that any hospital providing outreach services would have in place practices that comply with these more general requirements.

11. Informed Financial Consent

Hospital Gaps

This guideline requires an explanation of what the patient's health fund covers and does not cover and the expenses the patient is likely to incur. To ensure the patient is fully informed the facility should have:

- 11.1 Procedures in place to inform a patient, or nominee, in writing, of what hospital charges, health fund benefits and out-of-pocket costs (where applicable) are expected in respect of the hospital or outreach service treatment. The patient or nominee must be informed of these expected costs in respect of:
- scheduled admissions, at any time before admission for the hospital treatment; or
 - unplanned admissions – as soon after the admission as the circumstances reasonably permit.

Medical Gaps

Where possible the patient should be given:

- 11.2 Clear information about what the health funds provide in terms of cost coverage. Currently, health funds can provide above MBS payments to contributors where services are provided either under a negotiated gap agreement, or a Ministerially approved gap cover scheme. The *National Health Act 1953* requires that medical practitioners who charge a patient an additional amount above the benefit provided by the health fund under these circumstances must inform the patient of this cost.

12. Simplified billing

In accordance with the *Health Insurance Act 1973*, the facility should:

- 12.1 provide patients, with 1 month after the patient has been discharged from the hospital, with a single account, where possible, in respect of that hospital treatment. It must cover all hospital services and related services (not necessarily including professional services); and
- 12.2 have processes in place that would allow the inclusion of in-hospital medical bills in a simplified billing arrangement.

The facility may also issue interim accounts where an episode of hospital treatment exceeds 7 days and where the patient to which the admission applies has been advised that this will occur.

13. Quality Management and Clinical Guidelines

The outreach service should promote best practice and be linked to the hospital's overall quality improvement and service evaluation plans.

The facility should support the implementation of clinical practices that are based on best available evidence, supported by a cycle of ongoing review and measurement. This would include where available, the use of, and implementation of clinical pathways where supported by an evidence base. The facility should have in place processes and policies that are consistent with safe and quality use of medication.

As part of the ongoing quality management of outreach services, regular patient, staff and medical practitioner satisfaction surveys should be conducted.

References

The development of the Guidelines has been informed by the following publications.

1. Report of the National Evaluation, July 2000, Evaluation of the Private Sector Based Early Discharge and Hospital in the Home Trials, Health Management Australia, A Consultancy for the Commonwealth Department of Health and Ageing.
2. Consultancy to Progress in the Home Care Provision, July 1999, Final Report Centre for Health Economics Research and Evaluation, A Consultancy for the Commonwealth Department of Health and Ageing.
3. Program Standards and Guidelines for Hospital in the Home, March 2000, Victorian Centre for Ambulatory Care Innovation.
4. Hospital in the Home 1997/98 Service Audit Final Report, June 1999 KPMG report to the Department of Human Services.

E Appendix:
 **Commonwealth Department of Health and
 Ageing Application Form to Provide Private
 Sector Outreach Services**

DEPARTMENT OF HEALTH AND AGED CARE

Application Form Private Sector Outreach Services

Introductory Information

The Federal Government is committed to the development of innovative services in the private sector. The Government sees considerable merit in the development of high quality and cost-effective acute care services that offer an alternative to in-hospital treatment. In this regard, the Department of Health and Aged Care has worked with private health funds and private hospitals to develop and evaluate six hospital outreach trials that have tested innovative and flexible models of care that substitute for in-hospital care.

The Guidelines have been developed with reference to a comprehensive evidence base that includes existing public sector hospital in the home guidelines and public and private sector evaluation reports.

It is recognised that the majority of hospitals, including those currently offering outreach services already have in place protocols and policies that would be similar to the Guidelines, therefore the Guidelines will compliment each other.

The Report of the National Evaluation (Stage One) supports the *Health Legislation Amendment Bill (No.3) 2001*, which was passed by Parliament on 7 March 2001. Now known as *Health Legislation Amendment Act (No.1) 2001* (the Act), it enables the private health industry to provide approved outreach services that directly substitute for in-hospital care for admitted patients, and to claim reinsurance (where eligible).

Under the Act, hospitals and insurance funds seeking to provide outreach services to private patients will be required to gain Ministerial approval before providing an outreach service. Only approved services will be covered by hospital table insurance arrangements. To gain approval, hospitals will be required to meet the Guidelines. The Guidelines will determine whether an outreach service should be specified under the new section 5D of the *National Health Act 1953*.

Electronic copies of the application form and guidelines can be obtained from the Department of Health and Aged Care's website
(www.health.gov.au/privatehealth/providers/circulars01-02/index.htm)

Hard copies of the application form and guidelines can be obtained from:

Private Sector Outreach Services
Private Health Services Reform Section
Private Health Industry Branch
Mail Drop Point 86
GPO Box 9848
Canberra ACT 2611

Enquiries about the application form should be directed to the above address or by telephone (02) 6289 9853 (24 hour answering machine) or E-mail the enquiry to PrivateHealth@health.gov.au

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Applications for Outreach Services

(Additional space may be required, please add more pages as necessary).

Name of Participating Hospital/Clinic:

Address of Facility:

Telephone:

Facsimile:

Email address:

Postal Address of Facility:

Names of Participating Health Funds:

Address of Health Funds:

Telephone:

Facsimile:

Email address:

Postal Address of Health Funds:

Date of proposed commencement of Service (if applicable):

Date of reapplication of ongoing Service:

Proposal Details

Please give a summation of the project outline ie. services proposed, population targeted (DRGs etc), staffing, catchment area.

Key features of the program:

What key performance indicators will be used to monitor the outcomes and effectiveness of this program?

How will your facility monitor adverse events, ie infection control, wound management, patient satisfaction etc?

Accreditation information

Has the facility received accreditation?

Did you receive any recommendations to address?

If recommendations were addressed what has been the outcome?

Admission Criteria and information provided to patients and carers.

Do all parties understand that under the *Health Legislation Act (No.1) 2001*, Outreach Service means any service specified in a determination under section 5D of the *National Health Act 1953*, that is provided to a patient by, or on behalf of, a hospital or day hospital facility, as a direct substitute for hospital treatment that would otherwise be provided in a hospital or day hospital facility, **but does not include a service provided by a medical practitioner that would attract a Medicare benefit of 85% of the scheduled fee?**

Do you have consent criteria, program policies and procedures that reflect the practice of the organisation's health care providers in relation to the provision of care of the patient?
Please provide evidence of this.

Do you have consent criteria, program policies and procedures that reflect the involvement of the patient's carer (where applicable)?
Please provide documented evidence.

Have you developed admission criteria for the Outreach Service?
From this criteria are you able to obtain relevant data to monitor outcomes from the health services provided?

Have you developed information on the Outreach Service for your patients and carers (if applicable)?

Does this information include instructions related to care of the patient in an emergency and how to contact the relevant health personnel?

Care Planning and Discharge Planning for the Outreach Service

Do you use multidisciplinary care plans in the formulation of care for your patients? Is the care planning performed in consultation with your patients and how often are they reviewed? Please give a brief description of your clinical pathways.

Is the discharge planning approach to care provided on admission to hospital and at separation into Outreach Services and how is this service provided?

How do you monitor the compliance of the multidisciplinary team in completing the Care Plans?

Do the care plans reflect agreement between health care provider/patient and (if applicable) carer? Give an example.

Are appropriate discharge strategies in place on patient separation from the Outreach Service when required? Please give examples.

Are procedures in place to facilitate notification (within 48 hours) to the General Practitioners of **admission to hospital**? Please give examples. If notification procedures are not in place give reasons why.

Are procedures in place to facilitate early notification (within 48 hours) to the General Practitioner of patient **discharge** from the Outreach Service? What are these procedures? If there are no notification procedures in place please give reasons why.

Staff Competency, Continuing Education and Safety

Do the staff in the Outreach Program have relevant health qualifications for the patients needs? Please give examples ie psychiatric diploma, wound management certificate, pharmacy certificate.

Do you provide ongoing education and professional development to all staff caring for patients in the Outreach Program? Give examples of programs offered.

Is there a credentialling program/process in place and who is responsible for overseeing the process?

What mechanisms do you have in place to determine the staff's level of competence and their ongoing professional development requirements?

Do you provide regular staff satisfaction surveys and staff appraisals and how often are they implemented? What are the results/outcomes?

Do you have protocols, policies and standards in place for the staff, to address all safety aspects of the Outreach Service as mentioned in the Guidelines ie adequate communication, manual handling and lifting protocols and policies? Give examples.

Do you have protocols, policies and standards in place for patients and carers (where applicable), to address all safety aspects of the Outreach Service as mentioned in the Guidelines ie access to a telephone and storage of medication at the patient's home? Please give examples.

Additional Comments

Please provide any further information you feel relevant to this application:

I have read the above and I acknowledge and accept that this application and/or its contents will be made available to those people who will consider it for the purpose of advising the Minister for Health and Aged Care.

Signature of Responsible Officer:

Signature

Signed by (please print)

Date:

Signature of Health Fund:

Signature

Signed by (please print)

Date:

Lodgment of application

Applications should be lodged directly with the Private health Services Reform Section. The Department can only accept responsibility for the confidentiality of material in this document when it is lodged directly with the Department of Health and Aged Care. The completed application form should be forwarded together with any supporting documentation to:

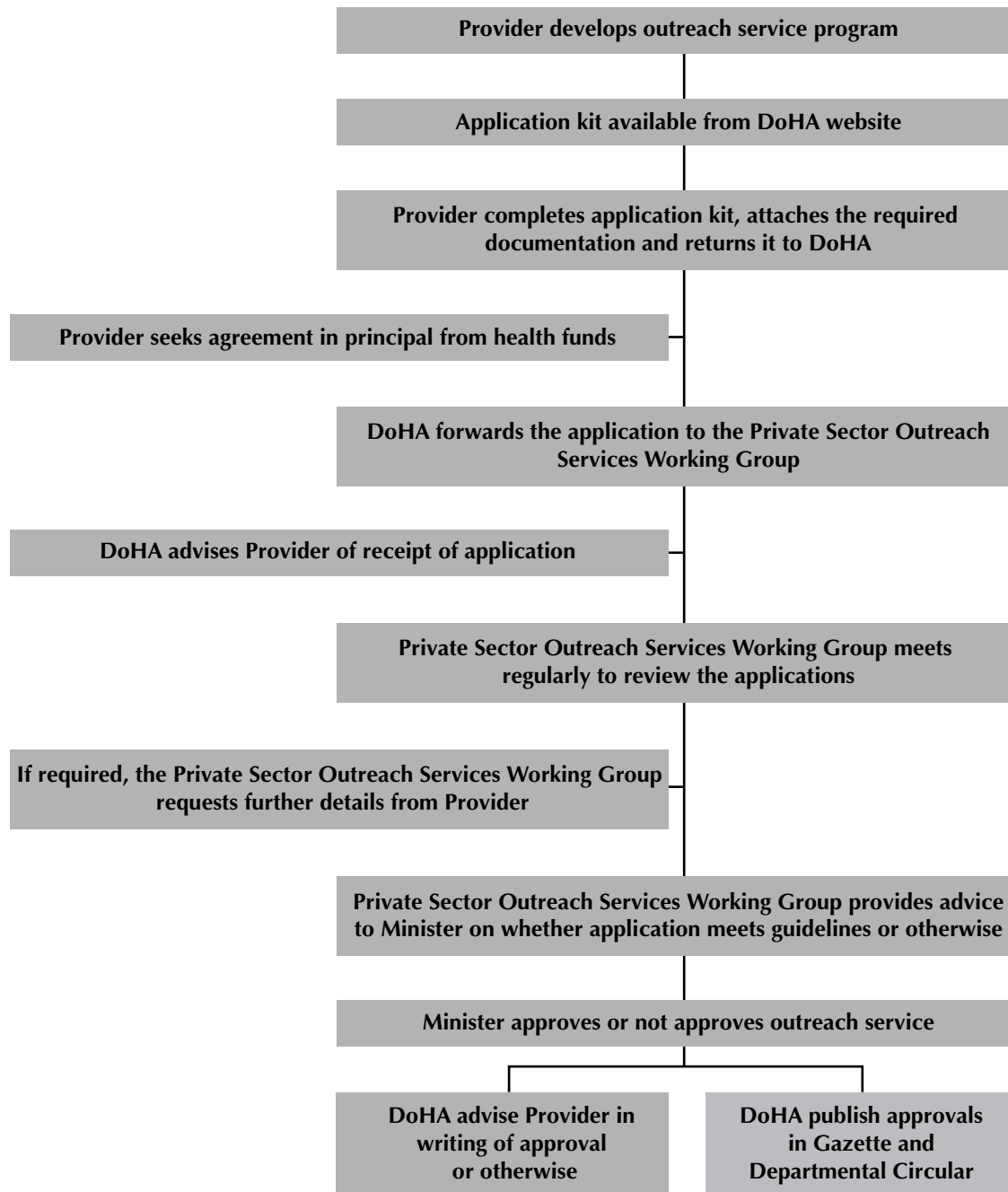
Private Sector Outreach Services
Private Health Services Reform Section
Mail Drop Point 86
GPO Box 9848
Canberra ACT 2611

CHECK LIST

Make sure you have:

- ✓ Provided contact details (Section 1)
- ✓ Read and acknowledged the fact that the information will be used when considering your application (Section 7)
- ✓ Provided additional information where and when necessary, including documentation.

F Appendix: Private Sector Outreach Service Application and Approval Process



G Appendix:

Private Sector Outreach Services Working Party

Name	Organisation Represented	Position
Ms Sonya Walmsley	Australian Private Hospitals Association Ltd	Director of Clinical Services
Professor Robert Goldney	Committee of Presidents of Medical Colleges	Professor of Psychiatry
Mr Matthew Blackmore	Consumers Health Forum of Australia	Consumer Representative
Mr Mark Avery	Catholic Health Australia	Private Health Policy Advisor
Mr Russell Schneider (Ms Peg Higginbottom representing)	Australian Health Insurance Association Ltd	Chief Executive
Ms Peg Higginbottom	Australian Health Insurance Association	Nominated Representative
Mr Nick Santamaria	Ambulatory Care Australia	Principal Research Scientist
Mr Keith McCulloch	Royal College of Nursing Australia	Health Service Manager, Kenmore Hospital - Southern Area Health Service, NSW

