OUT OF HOSPITAL CARE IN AUSTRALIA

Advancing health's 'missing sector'

Prepared by Catholic Health Australia – July 2020

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Acknowledgements

This paper has been prepared by Catholic Health Australia (CHA) in collaboration with the Centre for International Economics (CIE). CHA would like to thank all CHA members for their time, expertise and high-quality evidence provided. The paper would not have been possible without these valuable contributions from CHA members.

About CHA

Catholic Health Australia is Australia's largest non-government grouping of health, community and aged care services in Australia. CHA members account for around 10 percent of public and private not-for-profit hospital-based healthcare in Australia. Members provide around 30 percent of private hospital care, 5 percent of public hospital care, 12 percent of aged care facilities and 20 percent of home care and support for the elderly.

Across all Catholic services, there is a long tradition of providing excellent, person-centred care. This care is founded in a respect for human dignity and life, while caring for the whole person in a contemporary way.

CHA looks forward to continuing to work with the government to advance health, social and public welfare for all Australians. This includes reforms across the Out-of-Hospital (OOH) sector. With members providing both public and private hospital services, the CHA membership is in a unique position to provide insight on how OOH services operate in practice.

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Acknowledgement of Country

Catholic Health Australia acknowledges and pays respect to the past, present and emerging Traditional Custodians and Elders of this nation and the continuation of cultural, spiritual and educational practices of Aboriginal and Torres Strait Islander peoples.

Definition of Out-of-Hospital care

There is no single or standard approach to OOH care. OOH care can respond to a range of conditions, deliver a range of interventions, and service a range of patient cohorts.[1] The delivery and financial systems supporting OOH care are also different depending on whether a patient is cared for within the private or public hospital system.

Throughout this paper, OOH care refers to the delivery of care by, or under the supervision of, a hospital for patients in their own home or other suitable location that is outside the hospital setting. Broadly, there are two treatment types referred to in this paper;

- OOH inpatient (admitted) care (such as Hospital in the Home) provides treatment in a patient's residence for conditions requiring clinical governance, assessment, monitoring or input that would otherwise be delivered in a traditional inpatient hospital bed, and
- OOH outpatient (non-admitted) care can assist patients to reduce the length of their hospital stay with appropriate pre-acute and post-acute care or delivery of typically hospital based sub-acute services in the comfort of their own home (e.g. rehabilitation, palliative care, geriatric evaluation). Outpatient care can also assist with limiting readmissions and prevent admissions altogether (such as through chronic disease management).

Summary

Overall, the Australian health system achieves excellent health outcomes and matches or performs better than many other comparable countries.[2] The health system is a hybrid public-private model, with public and private health services operating under different funding models with the common goal of providing high quality care to patients.

However, many factors are putting substantial pressure on the health system, particularly the public health system. For instance:

- Demand for health services is growing due to population growth, an ageing population,[3] an increase in consumer knowledge and awareness of health-related issues,[4] and an increase in chronic conditions,[5]
- health budgets have been growing at rates higher than CPI and putting the financial sustainability of the public health system under increasing pressure, and
- the reduction in the proportion of people purchasing private health insurance is shifting more healthcare costs onto the public health system

It is vital that we find new ways to improve the sustainability of the health system, and ensure equitable access to high quality healthcare into the future.

Reform opportunity with Out-of-Hospital (OOH) care

OOH models of care are an opportunity to address pressure on the health system and meet patient preferences for more flexible care. Compared to traditional in-patient care for medically stable patients, OOH care can often be more efficient and effective, with lower readmission rates, length of stay, and mortality, and increased patient satisfaction.

However, the lack of government commitment and inadequate funding, particularly for private OOH services, has often led CHA members to describe it as the 'missing sector' of the Australian health system. Private providers, Private Health Insurers (PHIs), and to a lesser extent some public OOH services, believe they face operational barriers that limit the development of OOH care, and that without reform, there will continue to be:

- limits to the capacity of OOH services to expand
- barriers to allowing or encouraging PHIs to fund OOH care services attached to private hospitals[6]
- fragmentation and underfunding of OOH services for private patients, in turn damaging the value proposition of private healthcare, and
- an unequal regulatory playing field between providers of OOH care.

The solutions proposed below are designed to address the main barriers to OOH care that have been raised in this study.

By far the greatest impediment is the lack of effective funding models for OOH care in the private sector.

The other barriers revolve around the lack of consistency, and complexity, in quality service delivery standards and a lack of good data and information upon which to design better OOH policy and strategy.

The Catholic hospital sector has significant potential and desire to expand their OOH services and deliver more holistic models of care, particularly with respect to palliative care, mental health, Hospital-in-the-Home (HITH) including in the residential aged care setting, rehabilitation, chemotherapy, postnatal care, and renal dialysis.

To achieve the vision of improved access to high quality OOH care for patients, CHA has drawn on its extensive experience delivering OOH models of care to provide the Australian Government with evidence on how OOH care currently works in practice. Case study evidence is provided to highlight where OOH care is working well in the Catholic Health sector, and the barriers that are limiting increased scale and scope of services, particularly in the private sector.

Evidence is also provided to demonstrate that delivering hospital services within a patient's home alleviates pressure on the health system and facilitates the provision of better quality of care to all Australians.

Solutions to enhance OOH care

Recognising the value of OOH Care

As outlined in this paper, OOH care – when implemented appropriately and effectively – is shown to improve health outcomes and increase patient satisfaction, as well as provide excellent value for money. Broad recognition of the benefits of OOH to Australia's health system is vital to grow this "missing sector" to its full potential.

Solution 1: Clinicians, hospital providers, health insurers and the Australian Government agree to work together to support the growth in OOH services across Australia as a vital contribution to a financially sustainable and high quality health system.

Creating effective funding models for OOH care

The funding models for OOH care are generally underdeveloped and restrictive, particularly in the private sector. Creating and facilitating appropriate funding mechanisms, particularly through changes to the *Private Health Insurance Act* 2007 and Medicare Benefits Schedule (MBS), will increase the uptake of innovative and high quality OOH models.

Solution 2: The Government should amend the Private Health Insurance Act 2007, and the rules around its implementation, to enhance the capability of PHIs and healthcare providers to form collaborative arrangements that fund OOH health services.

Solution 3: The Government should extend the current minimum default benefit to OOH services provided by, or on behalf of, private hospitals.

Solution 4: The Government should create a funding mechanism that covers OOH services through a combination of MBS rebates and PHI benefits (akin to the mechanisms used for in-hospital care), including:

- specific MBS items for OOH care provision, coordinated clinical liaison and consultation, including telehealth (for example, administration of intravenous antibiotics by a registered nurse), and
- episode of care-based payments, reflecting the services required to provide OOH care in place of traditional in-hospital admitted care, and which account for the use of consumables and multi-disciplinary teams (for example, post-surgery rehabilitation delivered primarily by an allied health team).

Solution 5: The Government should make specific provision to enable the scale-up and broad-based implementation of small-scale successful OOH programs from proof of concept into national or state-based programs, including seed or support funding until such programs become sustainable.

Promoting quality standards and improving data to grow high quality OOH care

The following solutions are proposed to improve consistency in the delivery of high quality services, improve knowledge of service delivery models through data capture, and provide the necessary reassurance to consumers that the level of care they are receiving is at the same or better level of safety and quality as the care they would receive from in-hospital treatment.

Solution 6: The Government should ensure that there is consistency in clinical standards and regulations across OOH services, including staff and training accreditation requirements, patient assessment and monitoring requirements, and information and communication standards between providers, across hospital and community providers. This would bring OOH care into line with recent changes to guidelines for mental health and rehabilitation services, with the Improved Models of Care Committee recognising this work and agreeing these guidelines are a consistent starting point for a common framework in both hospital and non-hospital services.

Solution 7: The Independent Hospital Pricing Authority (IHPA) should develop a national definition of OOH care, for both admitted and non-admitted patients, and ensure it is used to inform consistent data collection requirements across all jurisdictions.

Solution 8: The Government, healthcare providers and PHIs should publicly promote the benefits of OOH care services, and the options available for consumers to access OOH care in the home or community.

Benefits of OOH care

OOH care offers a wide range of benefits to patients, governments, healthcare providers, and PHIs by improving the efficiency and effectiveness of care, reducing readmission rates, length of stay, and mortality, and increased patient satisfaction.

OOH services can reduce costs for patients and government

For selected patients, OOH care has shown to be more efficient, and reduce the overall cost of healthcare across a range of studies by[7, 8, 9, 10, 11, 12] improving the use of inpatient beds, and enabling patients to be transferred home earlier.[13] Benefits particularly accrue to patients with mental health conditions, chronic obstructive pulmonary disease, cellulitis, pneumonia, and the aged and frail requiring care. Cost-savings were found to increase in line with the level of substitution for hospital-based care.[14]

However, OOH is not simply a cost reduction measure. The principle of OOH care is to free up the availability of hospital beds to patients requiring in-hospital care, while continuing to provide high quality services to those that can safely, and may prefer, to receive care at home. Hence, it is not about reducing hospital bed numbers, rather ensuring the best use of the beds available.

OOH improves patient health outcomes

Some hospital services and patient cohorts benefit more than others from OOH care. For example, there is evidence that elderly patients may benefit more from OOH care than younger patients, since they can experience a decline in their physical and cognitive function during hospitalisation.[15, 16] There is also evidence that home rehabilitation interventions are associated with improved health outcomes, with both improvements in physical activity following a period of care compared to in-hospital programs, and longer lasting effects as home services create lifestyle changes, as well as treatment.[17]

Across all OOH models of care, when a service is well designed and receiving appropriately referred patients, the quality of care is the same or improved, compared to traditional in-patient care.[18, 19, 20, 21, 22]

The importance of continuity of care

Patients are admitted under the care of a specialist while in hospital. At discharge, some patients are not suitable for primary care management and require ongoing specialist care as they transition back to the primary care provider. This is especially apparent for those accessing OOH services such as chemotherapy at home, wound care, and complex haematology and DVT management where the complexity of patient conditions require an ongoing high level of specialist expertise.

Under traditional models, the specialist is unable to continue providing that specialist care once the patient is discharged into the community. Allowing specialists to continue to manage their patients in the community through OOH programs maintains this important continuity of care.

OOH can reduce avoidable readmissions

Hospital readmissions are noted when a patient has been discharged from hospital and is admitted again within a certain time interval. Readmissions can be routine and necessary for clinical care, such as necessary treatments for chemotherapy or dialysis. However, they can also refer to avoidable readmissions, which detract from better health outcomes, patient safety, and the efficiency of the health system.[23]

Many OOH models of care have been found to reduce avoidable readmissions.[24, 25, 26] One study noted a large difference in readmissions compared to in-hospital service delivery for elderly patients, stating that this difference may be because patients are likely to sleep better, eat better, walk more and become less deconditioned, malnourished, and sedated.[27]

OOH improves mortality and safety

Mortality is a commonly measured outcome across healthcare literature and considered in many OOH reviews. Outcomes under these important metrics were found to improve with OOH care. For example, a meta-analysis of various OOH care models found a clinically significant reduction in mortality across all OOH models of care. They reported that OOH models of care produced a 19 percent relative reduction and a 2 percent absolute reduction in mortality, meaning the number of patients needed to be treated at home to prevent one death was 50.[28]

Safety is another metric that has been considered in many reviews of OOH care. A systematic review of three studies involving randomised control groups found that rates of adverse events and/or complications were unaffected by OOH treatment.[29]

Patients are highly satisfied with OOH care

The most frequently reported benefit to patients, family members, and carers from OOH care compared to traditional services delivered within a hospital is increased satisfaction.[30, 31, 32, 33, 34, 35]

There are various reasons why patients find OOH care more suitable and beneficial. One study of community-based elderly patients found that OOH increased satisfaction with the patient's physician, comfort and convenience of care, admission processes and the overall care experience.[36] The literature also suggests that healthcare satisfaction is higher for family members/carers.[37, 38]

Working together to grow OOH services

Solution 1: Clinicians, hospital providers, health insurers and the Australian Government agree to work together to support the growth in OOH services across Australia as a vital contribution to a financially sustainable and high quality health system.

Creating effective funding models for OOH care in the private hospital sector

The key sources of funding for the private hospital sector are the Australian Government – through funding mechanisms such as the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Schedule (PBS) – and private health insurers. Medicare pays a benefit of 100 percent for consultations provided by a General Practitioner (GP), 85 percent for other services provided by a medical practitioner in the community, and 75 percent for all services that are provided by a medical practitioner during an episode of hospital treatment when the patient is admitted as a private patient. For hospital services, private health insurers pay the remaining 25 percent of the Medicare benefit and some or all of the difference between the doctor's fee and the Medicare benefit. This amount will depend on the arrangements between the doctor and the insurer. Patients also contribute to their care in the form of out of pocket costs, also known as gap payments. This is the difference between what the doctor charges and the total benefit paid by Medicare and private health insurance.

These funding sources, and the mechanisms behind them, work relatively well for care delivered within a physical hospital setting. However, they are not designed to accommodate OOH funding, and are therefore unnecessarily prohibitive and complicated when it comes to supporting innovative OOH services.

The following sections highlight the key impediments to effective funding models for OOH care, and identify the main changes required to PHI legislation, PHI funds and the MBS to better facilitate OOH care.

Greater flexibility needed for PHI regulations

The *Private Health Insurance Act* 2007 dictates that PHIs can fund hospital services and hospital substitute services. Generally, OOH services funded through PHIs are provided under this hospital substitution clause. The Act defines hospital substitute treatment as 'general treatment' that:

a. substitutes for an episode of 'hospital treatment'; and
b. is any of, or any combination of, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition; and
c. is not specified in the Private Health Insurance (Complying Product) Rules as a treatment that is excluded from this definition.

Through this definition, CHA members and PHIs have been able to establish various partnerships and implement OOH models of care across rehabilitation, chemotherapy, aged care, palliative care, wound care, and many more.

However the limitations within the legislation are a fundamental barrier to further developing and expanding OOH services across private hospitals, in that PHIs are prohibited from funding medical services that are provided out-of-hospital to non-admitted patients (except in designated programs).

PHI regulations through the *Private Health Insurance Act* 2007 should facilitate appropriate expansion of OOH care.

In seeking to remedy these limitations, caution is required to ensure that the fundamental principles of health care remain intact. Current shifts in industry arrangements and market structures have led PHIs to increasingly seek to be both funders and providers of care. This gradual shift to vertical integration, where an organisation spans both the funding and the provision of care, contains inherent risks in the delivery of health services and needs to be carefully managed.

There is a conflict of interest that arises from vertical integration when the provider of a service is also the beneficiary of any savings achieved in the episode of care. Disruptions in patient referral pathways and the clinical governance of vertically integrated models can jeopardise quality care, and control of patient care pathways runs the perverse risk of reducing consumer choice in providers, thereby diminishing a key principle for retaining private health insurance in Australia.

These concerns were also identified through the Senate Inquiry into 'Value and affordability of private health insurance and out of pocket medical costs' where the committee noted the redirection of patient pathways and restrictions on payments led them to oppose further expansion of PHI to out-of-hospital care until these issues were resolved.[39] The Department of Health also noted in their submission[40] that PHIs have been able to cover a wide range of alternative models to hospital treatment that include care provided in a person's home or community health care clinic.

Addressing PHI funding limitations is essential but must be addressed in a way that ensures the oversight of patient care remains with the clinician and not any funder.

Reforms should focus on facilitating partnership arrangements between PHIs and providers to further develop quality health services that are funded based on outcomes for patients.

Simplifying OOH contracts between providers and Private Health Insurers

Notwithstanding the limitations identified above, there are many services where PHIs can be a funding source for OOH care.

For an OOH care service to be funded by a PHI, an individual contract needs to exist between a patient's private health insurance fund and the private hospital. This establishes the funding amount paid by the PHI, patient eligibility criteria to receive services, and identifies the external healthcare providers within the fund's network that will deliver services.[41]

If there is no agreement in place, no claim for OOH services can be made and the service cannot be provided to the patient. This creates significant variation in the availability of OOH care services across private hospitals.

Private hospitals within the Catholic Health sector are continuing to negotiate with various private health funds to expand their OOH care services. This negotiation

process is usually highly complex and there are many new models of care that are not able to be progressed. Some of these difficulties are:

- **Artificial restrictions to access** – A common practice among private health insurers is to establish preferred supplier arrangements with service providers. Insurers state that these business partnerships are used to achieve clinical efficacy of the service, meet legal requirements related to accreditation/ registration, reduce administrative costs to the insurer, and manage member demand and the expected cost of claims. However, these business partnerships can create barriers to access OOH care. For instance, outside of these preferred supplier arrangements, patients will often incur high out-of-pocket costs. Indeed, PHIs often use these preferred supplier arrangements as an advertising tool to entice consumers that are responsive to 'no gap' services.
- **Negotiation power of smaller private hospitals** – For smaller private hospitals it is not practical to have contracts in place with PHIs because of the lengthy and costly negotiation process, where the administration costs outweigh any potential benefit. Where they do exist, they are often hindered by poor bargaining power which inevitably reflects in limits to funded services.
- **Artificial thresholds for care** – Contracts between PHIs and hospitals determine the clinical needs and thresholds to initiate a service. For example, if the hospital wants to provide rehabilitation in the home for someone that they have cared for after a joint replacement, they must convince the PHI that the person needs or warrants the rehabilitation in the home before they will approve it. This process can create a bureaucratic resource burden and a major barrier to the delivery of services – indeed, the decision for the care pathway should always remain with the clinician and patient, and not the health insurer. Often these thresholds are not clearly defined and are up to the arbitrary discretion of the PHI as to whether they will approve the service. They are not designed to be responsive to the patient or conducive to team-based models of care.

These factors make negotiating OOH care services with PHIs very difficult, and often limit OOH opportunities. There are various examples across the Catholic Health sector where a hospital has proposed to deliver a new model of care, but negotiations with PHIs became too complex and resource costs became too high.

The result of failed negotiations is felt by the patient through a lack of access to services and a lower satisfaction level. There is also an equity issue with OOH care services being available to public patients and not private patients, creating an increased burden on government funded services.

Financial incentives for private hospitals and PHIs differ

There are incentives for both private health funds and private hospitals to further expand their OOH care models. However, these incentives are often at odds.

For a private hospital, OOH services provide an opportunity to increase scale of operations and extend the hospital's healthcare footprint. A recent example is the delivery of OOH care within Residential Aged Care Facilities during COVID-19 to ensure that the individuals most at risk can practice social distancing while getting the services they need.

This increase in hospital capacity may be advantageous to a private hospital, but the overall increase in the provision of healthcare imposes additional costs on private health funds. This creates a mismatch of financial incentives and a potential conflict of interest between PHIs and private hospitals. Across the Catholic Health sector, there are many examples of OOH models of care that hospitals would like to deliver, but because of this difference in financial incentives, a funding agreement was not able to be negotiated with PHIs.

PHIs have also been hesitant to enter into OOH agreements since they often consider it as paying twice for the same episode of care. Many funding agreements between private hospitals and PHIs dictate a set payment for a procedure, which may include an agreed length of stay (LOS) associated with the payment. Under this model, there have been instances where PHIs view moving a patient into OOH care as paying twice for the same period of care, as the LOS has already been incorporated into the cost.

Misalignment of interest between PHIs and private hospitals acts to the detriment of expanding OOH services.

Notwithstanding the above, there are also many aligned incentives between the PHIs and private hospitals. For instance, both PHIs and private hospitals would like to expand OOH care to increase patient choice and satisfaction. There are also benefits for both stakeholders to divert people away from models of healthcare delivery within hospitals that are costly and unsustainable.

Examples such as this highlight the need to amplify the common benefits for OOH models to facilitate new partnerships.

Need for economies of scale

OOH care is only financially sustainable when services are provided at a sufficient volume to minimise travel distances between patients, and maximise the utilisation of staff and resources. For example, St John Of God's Healthcare at Home program was initially provided across metropolitan Melbourne, however, large distances made the service inefficient and unsustainable, and the service was limited to patients within the hospital catchment area to increase the number of patients that could be seen by each caregiver. Without funding certainty, there are limited incentives for service providers to invest in efficient processes and systems to scale up and improve operations.

OOH care is only financially sustainable when economies of scale can be achieved.

Government funding of OOH care

Private hospitals

Some OOH services are funded under the Medicare Benefits Schedule (MBS). Under this model, patients in the private system can receive OOH care services for items covered under the MBS. However, this framework is restrictive. There are many examples where the MBS does not cover the costs of OOH care delivery, or restricts when MBS is available, such as:

- **Clinical consultation** – unless the specialist physically provides the OOH service, they cannot access MBS. For example, if a nurse providing a wound care service in the home has concerns about the grafting and wants to check in with the specialist, the specialist is not reimbursed for this consultation. This lack of recognition of the role of the specialist and their input to ongoing OOH care is a disincentive for the specialist using OOH services.
- **Consumables** – when OOH care is provided under a PHI contract, or care is provided in a hospital setting, the costs of consumables (such as wound dressings) are covered. However, when the same care is provided outside a hospital under MBS, consumables are not covered. This creates a disincentive for the hospital and clinician to provide OOH services as they are not able to seek reimbursement for consumables. This can result in clinicians admitting patients into the hospital instead of providing OOH care.

These shortcomings in the MBS also manifest in very few outpatient clinics in private hospitals.

Off-site models of care would create significant operational efficiencies. For instance, under the current funding system, if a specialist cannot undertake a medical consultation within their private practice, they may need to refer the patient to a hospital, even though the patient could receive a suitable service within a clinic setting. This particularly relates to procedures that have consumables or disposables, since there are no means for these items to be reimbursed outside of the hospital. Once admitted, there are significant overheads associated within the hospital environment, resulting in an expensive service.

There are significant benefits in enabling clinic-based models of care for private hospitals including:

- economies of scale that are required for OOH models of care to be financially sustainable
- accessibility benefits to patients as it avoids unnecessary costs and time associated with travelling to a hospital, and
- clinical benefits from off-site delivery of care that draws on experienced hospital staff, hospital standards and medical governance.

Funding limitations are particularly paramount for private OOH care, undermining the value proposition of private health.

Public hospitals

In contrast to the issues identified in the private sector, funding of OOH care for public patients in public hospitals is much more straightforward. OOH care is funded under the same principles as patients who attend hospital for admitted acute or sub-acute care or as outpatients (for non-admitted care). For example, all acute admitted episodes of care (whether provided in-hospital or OOH) are within the scope of the acute admitted activity-based funding (ABF) stream.[42] For this reason, funding models are not generally considered a barrier to OOH care in public hospitals.

Identifying funding sources and beneficiaries for new OOH programs

The existing funding systems within Australia's health system are designed around three sectors of health: primary, secondary and community. However, many OOH care models do not clearly fit within one of these sectors and this lack of clarity causes inconsistencies and uncertainty in OOH care funding sources. For example, an OOH GP-led service, designed to prevent emergency admissions to a hospital from a nearby aged care home, could be funded by the Commonwealth Government (being largely responsible for funding of aged care services), the Primary Health Network (in support of the GP-led model of care), PHIs (as they are benefiting from fewer admissions) or the aged care provider.

This often results in service providers finding it difficult to navigate the funding environment and secure ongoing funding for successful programs. Service providers respond to this by negotiating funding partnerships with jurisdictions and sometimes need to partner with multiple funders. However, it can be very difficult to secure funding partnerships, as the benefits and activities are not always aligned to one of the three health sectors, and funders can be reluctant to support programs that are not directly within their existing funding models. When the benefits do not completely align to one funding base, this also makes assessing the impact and clearly articulating the benefits to individual funders difficult.

There is a lack of clarity and accountability of government funding.

Within the Catholic Health sector, one example of this lack of clarity and accountability of government funding was experienced by Calvary. Calvary piloted the publicly funded Geriatric Rapid Acute Care Evaluation Service (GRACE) in the ACT for a period of 16 months, with funding temporally provided through a partnership between Calvary and the ACT PHN. Although the pilot was successful and achieved positive health and financial outcomes, the PHN was not able to provide ongoing funding for the service. ACT Health recognised the benefits created by the program and stepped-in to provide ongoing funding. This is enabling the service to be scaled and made available to all residential aged care facilities (RACF) in the ACT. Even though the GRACE pilot has proved successful in both the ACT and NSW, it is not clear which funding partner is most suitable within each jurisdiction.

This lack of assurance and identification of a clear funding partner makes it difficult for health providers to adequately invest and commit to innovative service models, such as OOH care. There is an expectation on the innovator to develop innovative models of care, demonstrate that it is a good model (including health outcomes and financial benefits), and then convince people to fund it. Available funding to implement these improved models of care that demonstrate improved health outcomes and sustainability is consistently lacking. This paucity of clarity in funding for OOH care means there is not a sustainable foundation for innovators to invest in new OOH care models, nor the opportunity to facilitate or promote increased scope.

Hospital providers find it difficult to enhance OOH care services within the traditional funding model and regulations.

Creating effective funding models for OOH care

Solution 2: The Government should amend the Private Health Insurance Act 2007, and the rules around its implementation, to enhance the capability of PHIs and healthcare providers to form collaborative arrangements that fund OOH health services.

Solution 3: The Government should extend the current minimum default benefit to OOH services provided by, or on behalf of, private hospitals.

Solution 4: The Government should create a funding mechanism that covers OOH services through a combination of MBS rebates and PHI benefits (akin to the mechanisms used for in-hospital care), including:

- specific MBS items for OOH care provision, coordinated clinical liaison and consultation, including telehealth (for example, administration of intravenous antibiotics by a registered nurse), and
- episode of care-based payments, reflecting the services required to provide OOH care in place of traditional in-hospital admitted care, and which account for the use of consumables and multi-disciplinary teams (for example, post-surgery rehabilitation delivered primarily by an allied health team).

Solution 5: The Government should make specific provision to enable the scale-up and broad-based implementation of small-scale successful OOH programs from proof of concept into national or state-based programs, including seed or support funding until such programs become sustainable.

Ensuring service delivery standards are consistent

OOH care provided by hospital operators is delivered under high clinical standards and governance

For both the private and public hospital systems, patients being treated through an OOH care model operated by the hospital operator are still regarded as hospital patients. Generally this means that clinical responsibility and accountability remains with the hospital clinician overseeing the care. It is the clinician's role to ensure that the care provided to the patient is up to the hospital standards required.

Because of this, patients receiving OOH care through hospital operators benefit from the same standards and regulations as in-patient care, and the clinician with medical governance has assurance that:

- services are generally provided by clinicians including nurses, doctors and allied health professionals. This overlap helps to provide continuity of care and ensures that healthcare professionals have diverse workplace experiences
- there is clinical documentation for the lead clinician to easily follow the patient's progression and the services that have been provided
- services are provided in line with the hospital governance structures and have accreditation status aligned with the National Quality and Safety Standards, and
- the hospital structure allows for recourse if issues arise with the delivery of care.

These clinical and governance standards exist within the hospital setting to support patients with higher acuity needs. It also creates a high level of trust and willingness for clinicians to refer patients to their hospital's OOH care services.

Outside of the hospital system there are many organisations providing services that can constitute OOH care.

These providers may not be aligned to the hospital system or bound by the same standards and governance systems. Although these providers will meet individual sector standards, they do not necessarily operate under the same quality standards, clinical governance and oversight standards as the hospital operator provided services.

This difference in standards and governance systems may sometimes deter hospital clinicians from referring patients to non-hospital services. Clinicians will only refer patients to services in which they have trust and trust is reduced if inconsistent standards and governance structures apply across hospital and non-hospital providers. Clinicians need to have confidence that their referred service provider will maintain high levels of clinical standards and keep the flow of communication high. For example, they need to be aware if the patient's position deteriorates. Clinicians also require assurance that the skills of nurses are clinically appropriate when providing the service at home.

Any lack of trust creates an incentive to retain the patient in the hospital where they can ensure oversight and control of services. In some cases, this can occur even when admission is not necessary.

Inconsistent standards and regulations across hospital and non-hospital providers reduce referrals to OOH care.

To overcome this and to ensure that high-quality clinical standards are being maintained, both hospital and non-hospital providers should comply with a consistent set of safety and quality standards for equivalent services. This could include a universal requirement of OOH care quality standards, staff and training accreditation requirements, patient assessment and monitoring requirements and information and communication standards between providers. Patients are not always aware that a service they receive from a hospital substitute service providers could provide care that is not of the same quality as that which they would receive in an OOH program from their hospital provider.

A consistent approach to patient safety would provide various benefits across the OOH care sector. For instance, it would ensure that there is a consistent process to respond to the deterioration of the patient's condition, ensure a high level of clinical governance and that clinical records/continuity of care is maintained.

Promoting quality standards for OOH care

Solution 6: The Government should ensure that there is consistency in clinical standards and regulations across OOH services, including staff and training accreditation requirements, patient assessment and monitoring requirements, and information and communication standards between providers, across hospital and community providers. This would bring OOH care into line with recent changes to guidelines for mental health and rehabilitation services, with the Improved Models of Care Committee recognising this work and agreeing these guidelines are a logical starting point for a common framework in both hospital and non-hospital services.

Better information is needed for improved OOH care policy and strategy.

OOH care data collection

Data collection systems for hospital services delivered within a hospital are very mature. There are clear national guidelines on how to collect and report data and there are clear national definitions and coding. This mature system ensures that consistent data is being collected nationally, which helps to reduce administrative burden of healthcare providers.

However, the data collection system supporting OOH care is not mature and creates a significant administrative burden for healthcare providers. For an OOH service to be funded through ABF, the provider needs to prove that the

activity occurred. However, standards and data collection requirements are not consistently applied across government jurisdictions. Each jurisdiction enforces different levels of detail and data required to validate OOH activities and associated funding.

There can also be inefficiencies in the collection and reporting of OOH care data. For example, services undertaken by private providers cannot be directly entered into the government data systems. Providers are required to collect service activity data under their own system, then reformat to meet government jurisdictional requirements. This reformatting imposes an additional resource burden onto providers and health departments which also need to enter the data into their system.

Inconsistent data collection requirements and definitions across government jurisdictions create administrative burden and poor data quality.

There is an opportunity to collect more robust and nationally consistent data within OOH care. By increasing the consistency and transparency of public and private data collections, the effort required to collect the data will be reduced and evidence based decision making will be enabled across the whole sector.[43] But this can only be supported through better identification and consistent definitions of what constitutes OOH care. As mentioned previously, this includes a clear national definition of hospital substitution services to clearly define what is in scope and out of scope for OOH care.

Understanding OOH care is important for its growth

Solution 7: The Independent Hospital Pricing Authority (IHPA) should develop a national definition of OOH care, for both admitted and non-admitted patients, and ensure it is used to inform consistent data collection requirements across all jurisdictions.

Solution 8: The Government, healthcare providers and PHIs should publicly promote the benefits of OOH care services, and the options available for consumers to access OOH care in the home or community.

OOH Care across the Catholic health sector

Current OOH care services

Across the Catholic Health sector, there is a significant amount of OOH care services provided, including palliative care, mental health, rehabilitation, chemotherapy, post-natal care, renal dialysis, aged care, intravenous antibiotics, infusions and wound management. These services are being provided across both public and private hospitals.

As flagged in this paper, the most significant opportunities to increase the scale of services or establish new services in OOH models of care are within the private sector. There are opportunities across all models of care, with chemotherapy, palliative care, mental health and aged care of particular interest to the Catholic Health sector.

The case studies below show the range of OOH care models that are currently being delivered by the Catholic Health sector. These serve as 'exemplars' of service, which draw upon vertical or horizontal partnerships along the care pathway that ultimately improve outcomes for patients.

Palliative Care

There are significant gaps in access to community based palliative care services including both specialist palliative care and palliative care provided by other health professionals.[44] For instance, over half of Australians die in hospitals, approximately a third die in residential aged care and only a quarter in their own homes.[45, 46, 47] This occurs despite evidence that most people have a preference to die at home.[48] The gaps in availability are partly caused by structural and funding barriers to the provision of palliative care for people living in 'homes' that are not personal residences, including: age discrimination; under-provision of health services due to cross-sector issues such as disability care or aged care, Medicare funding requirements, the lack of a regular GP and lack of access to culturally appropriate services.[49]

St Vincent's Private Hospital Brisbane has been delivering their Community Specialist Palliative Care Service (CSPCS) for both public and private patients. The service alleviates physical symptoms and provides psychosocial and spiritual support for people with a terminal illness and their families. The service is operated by clinical nurses, doctors, and counsellors, where clinical nurses are case coordinators. The program includes access to specialist palliative care advice/ home visits twenty-four hours per day and access to an inpatient palliative care unit if needed.

The program offers specialist palliative care, assessment and care planning; 24/7 support access for patients, carers and families; intensive support at home; and direct access to their specialist inpatient unit if in-hospital care is required. After initial assessment and development of a patient's care plan, follow-up consultations are used to monitor the patient's progress and help them to remain at home.

Referrals to the CSPCS are accepted for both privately insured and state funded patients residing within the Brisbane City Council geographic boundary. The service provides the same standard of care to all patients and carers regardless of funding.

Public patients are eligible for the service if they receive a life limiting diagnosis. Over the past 2 years, 1,251 public patients have received this service. However, public patients are generally placed on a waiting list to receive palliative care, which can be significant and can result in a patient not receiving the required care within an appropriate time-frame.

Within the private practice, access to services is dependent on an individual's PHI and their eligibility requirements. Currently the hospital has individual service agreements with Bupa and Medibank. Bupa patients are eligible if they are diagnosed with a life limiting diagnosis with an estimated prognosis of six months of less. Medibank patients are eligible if they are at the end of life (estimated 30-day program duration).

Over the two-year trial, there have been 338 patients participating in the program through this private stream.

An evaluation of this program found that high rates of home death (as preferred by program participants) and low rates of hospital deaths are achievable with this model. The study also found that those participating in the program had a greater likelihood of wanting to die at home. The study concluded that an effective partnership between a palliative care provider and a private health insurer can facilitate end-of-life care.

For this program to be a success, St Vincent's needed to manage various risks, such as:

- maintaining a financially viable service. For example, access to capital is difficult,
- the non-standardised PHI funding arrangement and service delivery expectations. For example, Bupa's funding excluded the service being delivered in aged care facilities, citing regulatory barriers, and
- the geographic scope/reach of the service to ensure the efficiency of staff as travel time is unfunded.

Addressing these barriers would support St Vincent's to expand this model of care.

Mental Health

Across the CHA membership, mental health services are currently being provided through community outreach programs. For example, the St Vincent's Mental Health Strategy 2019-2021 listed strengthening community-based services as a priority within public services in Sydney.[50] This priority included the expansion of Crisis Assessment and Home Treatment in the medium term. This team provides crisis mental health assessment for adults who require an urgent response and are likely to require the support of the adult community or inpatient mental health services. This team also provides short-term follow-up for new users and home-based treatment as an alternative to hospital admission. Community outreach programs have proven to be effective for mental health services.[51, 52]

There is interest within the Catholic Health sector to consider additional private and public OOH mental health models. For instance, both St John of God and Cabrini would consider building their current capacity to deliver new or additional mental health services if barriers were reduced. This includes services ranging from low, medium and complex healthcare needs.

However, despite this interest to expand OOH models of care, PHIs are not able to fund health services provided outside a hospital which have an MBS item. This occurs even though evidence suggests that many mental health services for high-prevalence conditions can be effectively provided in the community.[53, 54] In addition to this, co-payments associated with private mental health services provided in the community are a significant disincentive for consumers to access these services even when they have been appropriately referred and the services are available.[55] This creates a perverse incentive for the patient to be admitted in order to avoid out of pocket expenses. Adopting a more flexible approach to funding private mental health would allow health providers to deliver care in more appropriate settings.

Addressing these barriers would significantly support CHA member negotiations with PHIs to provide additional mental health services through OOH models of care.

Hospital in the Home

St John of God provides private OOH services through the St John of God Healthcare at Home program. Home intravenous antibiotic therapy, complex wound care and anticoagulation therapy are provided within Western Australia and Victoria. In 2019, over 7,000 home visits were provided for these services.

These services would have ordinarily been provided in a hospital if no HITH was available. The care is delivered by a registered and enrolled nurse with patients remaining under the medical governance of their treating doctor. Where needed, wound and other specialty consultants may support care.

Strong integration of these services to St John of God's hospitals enable a greater continuity of care across the continuum of acuity. For example, HITH services have been able to better leverage hospital programs that support patients' needs and prevent readmissions, engage with hospital avoidance programs and better target programs to address patients with frequent admissions.

However, there are operational and financial barriers that impact on the service scale, such as the current definition of hospital substitution within the *Private Health Insurance Act* 2007. The definition is unclear and open to interpretation. This places limitations on the scope of services that can be made available, adding to the complexity of funding and differing interpretations of what services can be funded. Because of this, each PHI funds OOH care differently and this adds significant complexity and administrate burden to funding negotiations.

Chemotherapy

Mater has been committed to providing the community with leading cancer care services for more than 100 years. The Mater Cancer Care Centre (MCCC) recognises that small comforts can make a significant difference to a patient's wellbeing in difficult times. Because of this, the MCCC partnered with the Mater's home visiting team (Mater at Home) to provide public patients standard access to the following services in the home:

- Chemotherapy disconnection
- Subcutaneous chemotherapy (Azacitidine), and
- Some chemotherapy infusions.

Before the establishment of the Mater's OOH cancer service, MCCC patients needed to come into the MCCC centre or, if on weekends, the oncology ward to receive relatively simple cancer care procedures, such as chemotherapy disconnection. This often required long driving distances for the patients and necessitated the hospital to increase ward staffing levels on weekends. As Mater at Home had an established home-visiting nursing team, providing HITH and post –acute services to the community, it was decided that the service offerings of this mobile team could safely be extended to include services to specific MCCC patients. Under the Mater's OOH chemotherapy model, clinical governance remains with the treating specialist.

Public MCCC patients on these programs can also receive the following home services as part of holistic care:

- Physiotherapy – maintenance/restoration of condition, strength and movement
- Occupational therapy – functional adjustments
- Dietetics – post/during treatment – prevention of malnutrition
- Psychology – adjustment therapy, survivorship and mindfulness
- Social work – psychosocial assessment and supportive needs assessment
- Speech pathology – management of swallowing difficulties due to treatment

The MCCC found that their OOH care programs reduced anxiety for their patients who are potentially quite unwell during treatment. For instance, patients receiving chemotherapy disconnection services at their home stated that the service assisted in reducing stress and logistic complexities in managing family life while undergoing repeated chemotherapy cycles.

However, there is potential for the MCCC to further develop this model of care for privately funded patients. CHA members highlighted chemotherapy as having

the most potential for future OOH care for private patients receiving certain chemotherapy drugs. This could include privately insured patients whose specialist deems safe for OOH therapy and who:

- are receiving cycles of chemotherapy for colorectal/pancreatic cancer and requiring frequent pump disconnections
- are receiving certain types of subcutaneous chemotherapy
- are deemed eligible for OOH chemotherapy. That is, they have:
  - previously received specified chemotherapy infusions in hospital with no adverse reaction
  - reside within the hospital catchment area, and
  - consent to treatment.

Expanding services to private patients is expected to have a significant impact to the delivery of care at Mater. It is anticipated that there will be 250 private patients who would receive services across the above treatment plans, resulting in the avoidance of 2,172 hospital presentations for cancer care per year. This would move services out of the hospital setting, with service provided in the home by appropriately credentialed clinical nurses, and allied health professionals, under the governance of the treating oncologist.

However, there are various legal and regulatory barriers preventing MCCC from expanding this service and creating additional capacity within their hospital beds. These barriers include:

- the lack of Medicare rebates for allied health limit the ability of PHIs to fund services through alternative models,
- the unclear description of hospital substitution within the *Private Health Insurance Act* 2007 has led to inconsistent definitions of OOH care across funders and sectors, and
- the lack of financial incentives to increase access to integrated models where care is provided in the most appropriate setting.

Postnatal care

OOH postnatal services are provided through the St John of God Healthcare at Home program. This service provides advice and care during the first few days, weeks or months after a mother returns home, depending on the needs of the patient. The service is undertaken by experienced midwives and certified lactation consultants from the St John of God Healthcare at Home service. Workforce is leveraged from the hospital services with some caregivers working at both the hospital and Healthcare at Home service.

The home service includes; advice on baby and mother health and wellbeing, general and health checks support, and communication and coordination with other health professionals, such as obstetricians, paediatricians, child health nurses and GPs.

Postnatal OOH care is available in metropolitan Perth (extending from Secret Harbour in the south to Quinns Rocks in the north) and Mandurah and its surrounding suburbs.

Currently postnatal services are available for private patients. Antenatal services are provided by the hospitals.

For private and public patients, there are various operational barriers that needed to be overcome for this service to be successful. These barriers included:

- understanding the complexity of funding and identifying what services are funded and what are not
- given the low financial margin of the services, operations need to be efficient and cost effective, and
- good discharge planning and ongoing communication with medical staff.

Aged care

A growing and ageing population has been increasing the number of aged care facility residents being admitted to hospital over the past decade. However, this is not always the best outcome for patients, as older patients that are admitted are more likely to experience adverse events while in care.[56]

The Interim Report of the Royal Commission into Aged Care, found significant concerns with the delivery of aged services and considers the sector in need of significant reform.[57] The interim report identified a clear and present danger of declining function, inappropriate hospitalisation, carer burnout and premature institutionalisation because necessary services are not provided. The Royal Commission expressed concern that the express wishes of older people to remain in their own homes for as long as possible, with the supports they need, is downplayed with an expectation that they will manage.

CHA supports the Royal Commission's view that older people should receive the home care services they need to live safely at home, with funding provided by the Australian Government to ensure the timely delivery of these services. New models of care are required to address the concerns raised by the Royal Commission, increase the quality of care provided and to meet an increasing demand for services.

Across the CHA network, there are various examples of high quality and effective aged care services being delivered out of the hospital settings. Two of these examples have been provided below.

Calvary's Geriatric Rapid Acute Care Evaluation Service (GRACE) model

In the ACT, Calvary provides an in-reach model of care for acutely unwell RACF residents called the Geriatric Rapid Acute Care Evaluation Service (GRACE).

The GRACE model of care was originally developed by the Hornsby Ku-ring-gai Health Service. Under the model, hospital staff work in collaboration with general practitioners and aged care facilities to improve the journey of aged care facility residents.[58] The main aim of the GRACE model of care is to improve access to hospital services at home by supporting general practitioners and aged care facilities with enhanced hospital resources.

The GRACE Service was piloted in the ACT for a period of 16 months (October 2017 – January 2019) covering 450 RACFs beds and addressed falls, infections (skin, urinary tract, respiratory tract) wound care, PEG/catheter care and pain control.

Compared to the baseline activity data for the corresponding pre-pilot period, Calvary experienced the following benefits from the pilot:

- improved quality of care provided to acutely unwell RACF residents
- 22 percent decrease in unnecessary transfer into EDs
- 21 percent decrease in unnecessary hospital admissions, and
- 15 percent reduction in ED average length of stay and 8 percent reduction in ward average length of stay.

The success of the ACT program promoted a second pilot program to be undertaken in SA. The experience and outcomes being achieved are consistent to the ACT pilot.

However, Calvary has encountered various barriers to the expansion of this successful program. Some of these include:

- as GRACE staff are hospital-employed, they are subject to the same clinical and corporate governance/standards as other care staff. This creates a different cost structure to other non-hospital based providers that operate under different regulations and standards making it difficult to compete for services as service quality varies,
- independent prescribing for nursing staff is jurisdictionally regulated, making a nationally consistent model difficult,
- funding models are segmented and unclear across government jurisdictions, resulting in shifts between State and Commonwealth Governments. For instance, the ACT pilot was funded as a partnership between Calvary and the ACT PHN. Although the pilot received positive outcomes, the ACT PHN was not able to support ongoing funding for the program. Recurrent funding was subsequently provided through ACT Health, and
- PHI regulations limit scope of involvement in OOH model of care development and trials.

Aged care is an OOH model of care identified by CHA members as a potential area for growth. However, barriers such as those identified above, are limiting CHA members' ability to expand services within this area.

Mater's older person continuum of coordinated care model

Since 2015, Mater South Brisbane Emergency Department has been experiencing a significant increase in Emergency Department (ED) presentations of frail and older people. To address this increasing demand for services, a Mater team designed and implemented an effective home first model for frail older people.

This model of care is a specialist nurse-led, ED physician championed team that provides frontload assessment, care coordination, stakeholder communication (including but not limited to the patient and their family/care givers, primary and secondary health care providers, facility staff) and appropriate discharge planning. The team focus on all presentations from aged care facilities as well as older people from the community who are identified as frail via screening on presentation to the ED.

A cost benefit analysis was externally commissioned in 2017 and demonstrated a 10:1 benefit.

Further evaluation of the program in 2019 showed:

- a 38 percent increase between 2017–2019 in 75 years or older presenting to ED
- primary and secondary health care providers were very satisfied with the program
- average length of stay for Aged Care Facility residents decreased from 6.9 days in 2014 to 3.8 days in 2019
- 72 percent of presentations were being discharged from ED with a 24 percent reduction in hospital admission rates, and
- this reduction in admissions was supported by a 220 percent increase in referrals to the Mater at Home service, which provided coordinated multidisciplinary care to people in their own homes to enable them to function independently and with optimal capacity.

Mater at Home was integral to the continuum of care and the success of the program. This service provides personalised community-based allied health and nursing services designed to minimise risk of hospital related harm and support alternatives to hospitalisation through strong links to community care providers. The service provides access to a team who delivery interdisciplinary speciality care, having the function to coordinate this care across specialist community-based services, primary health care and hospital ED if necessary.

The Mater older person continuum of coordinated care model is predicated on a community-based program tailored to meet population health needs, rather than an adjunct to hospital care that is primarily reactive to acute health needs.

Conclusion

The Catholic Health sector has developed this paper to provide the Australian Government with advice on enhancing the OOH care sector, evidenced with case studies which show how OOH models work in practice and where the major barriers lie.

With appropriate changes, particularly to the regulatory side, there is enormous potential for OOH care to transform from the "missing" sector into a flourishing and highly effective sector which is a major contributor to health outcomes across Australia as well as the financial sustainability of our health system.

Because there is no single or standard approach to OOH care, there are a wide range of stakeholders that need to be engaged in implementing these recommendations. These stakeholder groups include; patients, healthcare professionals, clinical staff, families and carers, PHIs, home and community health workers, general practitioners, health economists, and government funders.

Catholic Health Australia and the entire Catholic Health sector looks forward to working with the Australian Government to deliver on these important reforms.

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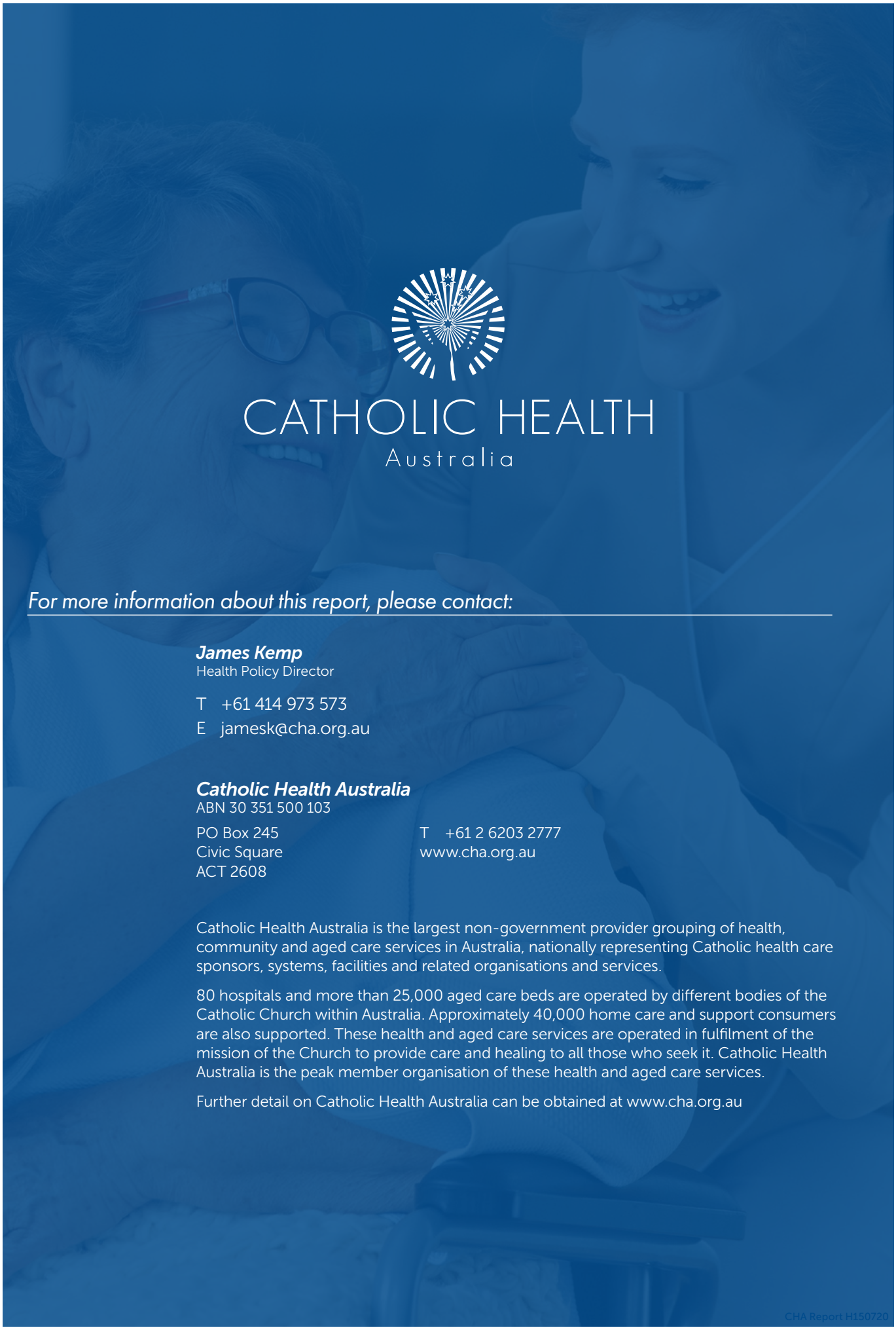

CATHOLIC HEALTH
Australia

For more information about this report, please contact:

James Kemp
Health Policy Director

T +61 414 973 573
E jamesk@cha.org.au

Catholic Health Australia
ABN 30 351 500 103

PO Box 245
Civic Square
ACT 2608

T +61 2 6203 2777
www.cha.org.au

Catholic Health Australia is the largest non-government provider grouping of health, community and aged care services in Australia, nationally representing Catholic health care sponsors, systems, facilities and related organisations and services.

80 hospitals and more than 25,000 aged care beds are operated by different bodies of the Catholic Church within Australia. Approximately 40,000 home care and support consumers are also supported. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to all those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services.

Further detail on Catholic Health Australia can be obtained at www.cha.org.au

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