

**REHABILITATION IN THE HOME (RITH) PROGRAM GUIDELINES**

**Invitation to provide private hospitals services:**

**REHABILITATION IN THE HOME (RITH)**

**to the veteran community**

**September 2023**

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1. **Program Overview** 
   1. The DVA Rehabilitation in the Home Program (the Program) objective is to allow eligible DVA Health Card Holders (‘Entitled Persons’) the choice to access high quality functional rehabilitation care in their home.
   2. The Program will focus on the provision of functional rehabilitation directly related to medium complexity orthopaedic surgery and conditions (see attachment 1 for guidance in determining complexity level).
   3. The Program will be delivered against a planned and coordinated rehabilitation health care model including the development and implementation of a rehabilitation plan.
   4. The Entitled Person’s Consultant Physician in Rehabilitation Medicine[[1]](#footnote-1) will retain clinical oversight and supervision of care.
2. **Program Aim**
   1. The aim of the Program is to increase veteran choice over care pathways and facilitate social and mental health benefits of providing care at home.
   2. The intended benefits of the Program are to:
3. Increase the choice and flexibility in how and where an Entitled Person receives rehabilitation services;
4. Shorten length of stay in hospital, with the possibility of the Entitled Person receiving part of their rehabilitation program in their home or usual residence;
5. Support a faster return to the previous level of functioning of the Entitled Person, through tailoring therapy to the home setting; and
6. Ensure a smooth transition from hospital to the community by providing continuity of care and appropriate referrals.
7. **Program Principles**
   1. The RITH Program will operate under the following principles:
8. Access based on established clinical need with clear assessment and referral pathways;
9. Only deliver knee and hip related ambulatory rehabilitation services appropriate to restore an Entitled Persons functional ability following surgery or a trauma (e.g. an illness or accident) that has resulted in a loss of normal physical capabilities;
10. Underpinned by a client-centred, coordinated and case managed approach to rehabilitation care;
11. Services are to be multidisciplinary, in person and available 7-days per week;
12. Defined as care that would normally be provided in a hospital inpatient rehabilitation setting but which is provided to people in their own homes or in residential facilities such as hostels or other forms of supported accommodation; and
13. The Entitled person must be an admitted patient for the purposes of completion of an admission form under clause 6.2 and submission of HCP data under clause 6.9 of the Hospital Services Agreement (HSA).

*Model of Care*

* 1. The model of health care within the Program involves an ongoing partnership between the Entitled Person, their carer/s and family (where applicable), the oversighting by a Rehabilitation Physician or treating physician with expertise in rehabilitation, and a coordinated mix of at least two allied health disciplines, including access to a registered nurse, in addition to other medical professionals. Working together, this core team develops a personalised, comprehensive, multidisciplinary Rehabilitation Treatment Plan (RTP).
  2. The team will use rehabilitation treatment planning, coordination and review to focus on planned and coordinated management of the Entitled Person’s rehabilitation care with goals documented on a rehabilitation plan, which is reviewed regularly in a multidisciplinary meeting.
  3. The team should have clearly defined policies regarding the roles and responsibility of the general practitioner and the rehabilitation physician particularly concerning general medical care and after hours care.
  4. The RITH team will be familiar with the role of the Veteran Liaison Officer[[2]](#footnote-2) as outlined in section 3.3 of the HSA.
  5. The RITH is to be delivered consistently with the Guidelines for Recognition of Private Hospital-Based Rehabilitation Services[[3]](#footnote-3). A person’s rehabilitation will involve individualised, intensity, frequency and modalities of therapy as determined by the RITH team.
  6. A standard episode of care is up to 12 occasions of service over a maximum period of eight weeks post discharge.
  7. The RITH contracting entity would have authority in consultation with the Consultant Physician in Rehabilitation Medicine to deliver a further 12 occasions of service within the eight week period post discharge, if there is a likelihood of further functional gain. The Consultant Physician in Rehabilitation Medicine would be authorised to make this decision based on their assessment at completion of the initial 12 occasions of service.

*Assessment*

* 1. Once the Entitled Person has been accepted to receive RITH services, the Rehabilitation Physician or treating physician with expertise in rehabilitation is to undertake a full face-to-face initial functional assessment prior to commencing the provision of the Services.
  2. Validated functional assessment tools (as indicated by the Australasian Rehabilitation Outcome Centre (AROC) ambulatory dataset (e.g. Australian Modified Lawton’s IADL scale) must be used in undertaking the comprehensive assessment of the Entitled Person’s rehabilitation needs.
  3. The outcomes of the assessment are to be used as input to the development of an individual, multidisciplinary, structured patient Rehabilitation Treatment Plan (RTP) as outlined in Criterion 5.2 of the [Guidelines for Recognition of Private Hospital Based Rehabilitation Services](https://www.privatehealthcareaustralia.org.au/wp-content/uploads/Guidelines-for-Recognition-of-Private-Hospital_Based-Rehabilitation-Services-AUGUST-2016-FINAL.pdf).
  4. Prior to receiving their first treatment in the home, the home environment will be assessed via a preliminary home risk assessment undertaken in the hospital. The preliminary assessment must be validated as accurate at the commencement of the first home visit, where a comprehensive assessment must be completed.

*Absences from RITH services*

* 1. The RITH Program is an extension of hospital based services and therefore will be subject to Section 4 - Services and Charges section of the Hospital Services Agreement. As per item 4.2.8 of the HSA, DVA will not accept financial responsibility for the payment of RITH appointments missed by Entitled Persons.
  2. If an Entitled Person is absent from RITH services for up to ten (10) calendar days, for example due to an unrelated illness or admission to an acute facility, the treating RITH team must determine if the Entitled Person continues to be medically suitable for RITH. If the Entitled Person is deemed medically suitable to continue, the treating RITH team must then determine if the current treatment plan continues or whether a new functional assessment is required.

1. **Out of Scope Services**
   1. DVA will not fund the following under the RITH Program:
2. the provision of maintenance care by allied health practitioners;
3. any modifications to the home or additional support which may be required to ensure that the place of residence of an Entitled Person is suitable for the delivery of home based rehabilitation;
4. any existing range of nursing and home care services delivered under other DVA programs, such as Veterans’ Home Care, the Rehabilitation Appliances Program and the Community Nursing Program;
5. vocational rehabilitation, psychosocial (social support) rehabilitation and medical management;
6. the replacement of any suite of ongoing community based supports through DVA that are separate to rehabilitation e.g. regular access to podiatry through the usual allied health arrangements;
7. subcontracting of RITH service delivery to community based providers.
8. **Eligibility Criteria**

5.1 To determine that the Entitled Person may be eligible for the RITH program, their treating physician must determine if the Entitled Person is medically fit to undertake rehabilitation at home prior to referral to the Program. As part of the assessment process, the hospital must provide patients and their carer/s with information to assist them to make rehabilitation care choices.

5.2 To be eligible for the Program an Entitled Person must meet ALL of the following criteria:

* 1. Be eligible for in hospital rehabilitation services as a DVA Veteran Card holder (Gold Card or White Card for accepted conditions) or has a written authorisation for treatment;
  2. Be an admitted patient of the hospital that will be delivering the in-home care;
  3. Be assessed as medically suitable for admission to the Program by the Consultant Physician in Rehabilitation Medicine overseeing RITH;
  4. Not need 24 hour nursing care during the rehabilitation episode;
  5. Have no major post-operative complications or complications that cannot be simply managed at home;
  6. Assessed as being able to tolerate a concentrated rehabilitation program;
  7. Are likely to achieve functional gains over the course of a time limited rehabilitation program;
  8. Have rehabilitation goals that are suitable for RITH;
  9. Consent to be admitted to the Program and to receive rehabilitation treatment in their home;
  10. Agree to readmission to hospital should complications occur;
  11. Be motivated and committed to participate in a rehabilitation program; and
  12. Have a home environment that is suitable for therapy.

1. **Staff Qualifications and Competencies** 
   1. All treatment will be delivered in the home by a Registered Nurse and/or allied health professional who is suitably qualified, credentialed and appropriately trained in the delivery of rehabilitation in a home environment.
   2. RITH services will be provided by hospital or hospital contracted staff. The delivery of services under the Program must not be outsourced to a third party.
   3. All members of the workforce who interact with DVA clients are to be registered by the appropriate authority to work with vulnerable adults.
2. **Coordination and Continuity of Care** 
   1. A nominated RITH team health professional in conjunction with other RITH team professionals delivering in home care will coordinate patient care.
   2. Patients must be referred to suitable allied health services where risk factors such as psychological distress, malnutrition or other lifestyle risk factors are identified. As part of the discharge process the patient’s General Practitioner must be kept informed about the patient’s treatment, care and referrals to other services.
   3. Carers are expected to be involved in the patient journey, including actively participating in the development of rehabilitation treatment plans and the discharge summary. Additionally it is expected they are provided with information and education to assist them in offering support to the patient throughout their treatment.
   4. As the Program is an extension of existing hospital services, patients must continue to have access to 24-hour support or treatment if required. The Entitled Person must be provided with details of how to access after-hours arrangements.
   5. Transitions between in-home and hospital based care must be managed seamlessly and discharge planning should be undertaken by the Contracting Entity pursuant to Sections 6.4 and 6.5 of the Hospital Services Agreement.
3. **Governance Requirements** 
   1. The hospital must ensure that appropriate governance and clinical policies for in-home based services are in place. This will include, but is not limited to:
4. Policies and procedures for in-home assessment;
5. Maintenance and delivery of treatment plans;
6. Care escalation;
7. Discharge planning;
8. Home visit safety;
9. Security of records;
10. Risk management;
11. Incident management; and
12. Continuous improvement.
    1. DVA reserves the right to request documentary evidence of the Hospital’s governance arrangements and clinical policies related to the delivery of the Program.

*Quality and Performance Management*

* 1. The RITH Program is an extension of hospital-based services and therefore will be subject to the Quality and Performance Measures contained in Section 5 of this Hospital Services Agreement.
  2. The contracted entity must have a rigorous clinical governance framework in place to support safety, quality and continuous improvement.
  3. Contracting entities will consistently deliver the RITH Program in line with relevant clinical aspects of the:

1. [*Standards for the Provision of Rehabilitation Medicine Services in the Ambulatory Setting*](https://www.racp.edu.au/docs/default-source/advocacy-library/ambulatory-standards.pdf), 2014 (Australasian Faculty of Rehabilitation Medicine (AFRM)).
2. [*Guidelines for Recognition of Private Hospital-based Rehabilitation Services*](https://www.privatehealthcareaustralia.org.au/wp-content/uploads/Guidelines-for-Recognition-of-Private-Hospital_Based-Rehabilitation-Services-AUGUST-2016-FINAL.pdf), August 2016, noting DVA’s Hospital Services Agreement requires contracting entities to comply with the 2016 Guidelines.
   1. DVA recognises that while the AFRM Ambulatory Rehabilitation Standards will be used as the broad platform for the RITH Program, the Standards are general standards for non-inpatient programs and may need to be tailored for a home-based rehabilitation model.
3. **Licences**
   1. The Contracting Entity must have, and maintain any, and all necessary licences, permits, approvals, consents or authorisations to enable it to lawfully provide Rehabilitation Medicine Services in the Home to Entitled Persons pursuant to section 4.24 of the Hospital Services Agreement.
4. **Evaluation** 
   1. The Contracting Entity must provide to DVA, at no additional cost, an Evaluation Report after one year of operation of the RITH program which must include the following:

* number of referrals;
* number of occasions of service;
* average waiting time between assessment of a DVA patient being accepted into RITH and when they start treatment;
* percentage of patients with a multidisciplinary care plan within 7 days of acceptance into RITH;
* aggregated data on functional improvement;
* in-home patient clinical outcomes compared to outcomes for patients accessing day ward services;
* completion rate and the number of Entitled Persons who withdrew from RITH and the reason for their withdrawal;
* pre- and post-treatment Patient Satisfaction analysis to determine whether patient expectations were met, and where appropriate, the carer experience was positive;
* evaluation of the effectiveness of the transition of care from hospital to home and from the home to the hospital if required;
* number of readmissions to hospital related to an original admission and continuous improvement strategies implemented to prevent readmissions occurring in the future;
* number and analysis of safety incidents including continuous improvement strategies implemented to prevent incidents from occurring in the future;
* evaluation of the effectiveness of care coordination throughout the Program including referrals to other services; and
* evaluation of the effectiveness of the transition of care upon discharge.

1. **Termination, Extension and Scope** 
   1. DVA may, at its absolute discretion, for any reason and at any time, alter the scope of the RITH Program or terminate the Program by providing written notice to the Contracting Entity stating the effective Termination Date. If DVA elects to terminate the RITH Program, the Contracted Entity must work with DVA on a Transition Out Plan for existing Program clients.
   2. The Contracting Entity may, at its absolute discretion, terminate the RITH Program by issuing written notice to DVA, where the effective Termination Date shall be the date that is immediately after the date of expiry of the Notification Period. If the Contracted Entity elects to terminate the Program, the Contracted Entity must work with DVA on a Transition Out Plan for existing RITH Program clients.
2. **Payment for Services** 
   1. The payment structure for RITH will include a per diem based amount per occasion of service with a separate fee for the initial in home comprehensive assessment. An occasion of service may include multiples sessions provide by different nursing and allied health professionals per day.
   2. The per diem fee is to reflect: direct face-to-face service delivery, as well as the costs of hospital/patient liaison, travel time, case management, transportation, report writing, professional development, patient education, and usual business overheads.
   3. Services delivered under the RITH program must be claimed using the designated RITH Program item numbers detailed in Table 2 - Funded Services.

#### Table 2: Funded Services

|  |  |  |
| --- | --- | --- |
| **Service** | **DVA Item #** | **Fee $** |
| Rehabilitation in the Home (RITH) Program – Initial comprehensive in-home assessment (claimable only once). | HX… |  |
| Rehabilitation in the Home (RITH) Program - Standard  (1-12) in home occasions of service provided by nursing and/or allied health practitioners. | HX… |  |
| Rehabilitation in the Home (RITH) Program – Supplementary  (13-24) in home occasions of service provided by nursing and/or allied health practitioners. | HX… |  |

**Please note**:

The Item is inclusive of hospital/patient liaison, travel time, case management, transportation, report writing, professional development, patient education, and usual business overheads.

The comprehensive assessment of home is billed when the initial assessment of the home is completed to ensure suitability for treatment and safety of nursing and allied health practitioners.

Each occasion of service will comprise of between 1 and 5 sessions with nursing and/or allied health practitioners in the Eligible Persons Home.

Program length is not expected to exceed 12 occasions of service however if the Eligible Persons has been assessed by the Consultant Physician in Rehabilitation Medicine to require further treatment, an additional 12 occasions of service can be funded within the eight week period post discharge

Fees are not fixed. The fee per item will be negotiated with Providers directly. Providers are encouraged to provide a summary of costs as outlined in Attachment 2 - **.** Guidelines for proposals for rehabilitation in the home.

**Attachment 1: Guidance in determining complexity level for RITH eligibility**

DVA RiTH Services are to be offered only to Entitled persons determined to require a medium-complexity level of rehabilitation therapy. Rehabilitation/ treating Physicians are encouraged to use a risk stratification model in determining the clinical appropriateness of offering rehabilitation in the home.

The following factors should be considered by the rehabilitation/ treating Physician in determining RITH eligibility.

**Patient preoperative factors:**

* Independent mobility with or without gait aid prior to surgery
* History of another condition affecting mobility
* Concurrent medical illness / co-morbidities which may impact on the Entitled Persons ability to participate in RITH
* Medical and psychiatric stability
* Identified cognitive issues.
* Continence
* Ability to independently conduct personal activities of daily living.
* Need to receive personal care services.

**Patient operative factors**

* Primary (initial) replacement
* Unilateral surgery
* Non-complex revision surgery. Revision surgery can be considered non-complex in situation where patella button insertion in a total knee replacement (TRK), exchange of modular implants which are not fixed to bone - tibial tray insert in TKR, exchange of acetabular liner +/-femoral head components in total hip replacement (THR). Conversion of Unicondylar knee replacement (UKR) to TKR may also be considered non-complex in a medically fit patient expected to rehabilitate as for a primary TKR following revision.
* Revision surgery requiring extensive soft tissue dissection and debridement, exchange of all components fixed to bone +/- structural bone loss management are not considered suitable for RITH.
* Bilateral surgery should only be considered for suitability in medically fit patients, (ASA grade 1-2) who have had uncomplicated surgical and anaesthetic episodes. Rehabilitation would be anticipated as for a primary unilateral arthroplasty within reason considering bilateral surgery.
* Functional recovery post-surgery is within expected parameters with early mobilisation and acceptable functional mobility status on discharge from hospital.

**Patient postoperative factors**

* Consideration of discharge notes that indicate complications from surgery such as infection, dislocation, blood clots, failure to relieve pain, injury to blood vessels, need for blood transfusion, hip fracture, delirium.
* Incidence of falls in the acute phase.
* Pain control and need for a written plan to wean analgesia that is communicated to the patient and their GP.

**Attachment 2: Guidelines for proposals for rehabilitation in the home**

DVA welcomes and encourages providers to submit proposals that may improve health outcomes in the veteran population. Refer to Hospital Services Agreement clause 4.32 of Part A.

To facilitate evaluation of proposals for a Rehabilitation in the Home programme please complete the proforma below when preparing proposals.

**Details of Proposals RITH Programmes**

|  |  |
| --- | --- |
| **Criterion** | **Description** |
| **Name of Hospital** |  |
| **Contact Person** | Name:  Position:  Telephone:  Email: |
| **Title** | Programme Name (in hospital) |
| **Program Aims and Principals** | Summarise how the proposed RITH programme will meet the aims and principals outlined in the invitation documentation.  Include research evidence and evidence of identified need  (i.e. how many DVA-patients in the catchment area). |
| **Evidence** | Provide evidence that the programme represents best practice. This will usually be from peer-reviewed journals. |
| **Staffing** | Qualifications, skills and experience of staff who will provide the programme. |
| **Competency** | Evidence that the provider has the skills and capabilities to provide the RITH programme, including any examples of the hospital delivering the programme, or similar programmes, to other clients. |
| **Outcomes** | Details of clinical outcomes expected for DVA clients, including how they will be measured and reported. See invitation documentation. |
| **Programme outline** | Taking into account the invitation documentation include a detailed outline of the structure of the programme and relevant care pathways that will be used (e.g. number of contact hours, mode of delivery, number of participants, duration). |
| **Timetable** | Provide details of projected timetable for delivery and critical milestones (e.g. length of programme and frequency of treatment). Programmes must be time limited. Where an Entitled Person has a longer-term or ongoing requirement for treatment, it is DVA’s expectation that the hospital will refer the patient to a community‑based provider. |
| **Privacy**  **Ethics approval** | Any privacy issues likely to be encountered in the programme or reports should be addressed, including any requirement for Human Research Ethics approval. |
| **Evaluation** | This area should address how qualitative and quantitative data will be utilised to evaluate the effectiveness of the evidenced based intervention and improved clinical outcomes. It should also address how patient satisfaction will be measured. See invitation documentation. |
| **Costs** | Detailed analysis of all costs associated with provision of the service. Include details of any costs to DVA for any partially completed service and any elements that have not been costed. |
| **Cost effectiveness** | Evaluation or analysis of value for money by comparing outcomes to costs of provision of the service. |
| **Alternatives** | Information about similar or alternative services already available. Highlight any implications if the service is not approved. |

1. Defined in Criteria 2: [Guidelines for Recognition of Private Hospital Based Rehabilitation Services AUGUST 2016](https://www.privatehealthcareaustralia.org.au/wp-content/uploads/Guidelines-for-Recognition-of-Private-Hospital_Based-Rehabilitation-Services-AUGUST-2016-FINAL.pdf) [↑](#footnote-ref-1)
2. **“Veteran Liaison Officer” (VLO**) means a Hospital staff member whose role is to provide assistance to Entitled Persons in order to enhance the treatment and services provided to Entitled Persons during their Hospital episode. Additional information about the role of the VLO can be found at: [↑](#footnote-ref-2)
3. [Guidelines for Recognition of Private Hospital Based Rehabilitation Services AUGUST 2016](https://www.privatehealthcareaustralia.org.au/wp-content/uploads/Guidelines-for-Recognition-of-Private-Hospital_Based-Rehabilitation-Services-AUGUST-2016-FINAL.pdf) [↑](#footnote-ref-3)