E-Poster

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Funding of Hospital-Based Rehabilitation Needs to Consider its Cost Savings

Topic: Economics

Steven Faux[1], Jane Wu[2]

[1]*Department of Rehabilitation Medicine, St Vincent's Hospital, UNSW, Sydney, Australia*
[2]*St Vincents Hospital, UNSW, Sydney, Australia*

BACKGROUND

In-reach rehabilitation teams are typically multidisciplinary and provide evidence-based interventions to patients in the acute care setting in a coordinated fashion. These 'high-quality' rehabilitation services can be defined by measurable functional gains and increase home discharge rates.

An ideal payment system for rehabilitation should promote efficient, high quality rehabilitation practice. We will use our hospital as a case study to highlight how the current funding incentives rehabilitation services need to change as it is not promoting this goal. St Vincent's Hospital Sydney (SVHS) is 400 bed tertiary hospital with specialised transplantation and trauma services. It has an onsite inpatient rehabilitation unit. It has an in-reach rehabilitation team which can treat 6-8 patients at any one time while they are having acute care.

In-reach rehabilitation models of care have been in operation for more than a decade (ACI 2019) and there is excellent data generated by in-reach teams for improving care measured by activities of daily living independence (FIM measures), expediting early discharge, avoiding hospital aquired complications and decreasing length of stay in rehab wards. The traditional two stage model for rehabilitation care is also reinforced by case-mix (or activity-based) funding rules, which provide separate payments for the acute and the subacute episodes. There is currently no case-mix model in Australia that provides a payment for rehabilitation occurring in parallel with acute care, even though this may be the most appropriate clinical course in many patients.

This paper discusses alternative costing models and funding options to remunerate the rehabilitation units who provide in reach rehabilitation for the added value that they offer acute care and hospital based. Gaming of data to conceal waste of financial resources are discussed as well as incentives to allow for funding of early rehabilitation. An accreditation process and the collection of quality assurance data is also presented.

CONCLUSION

An ideal payment system for rehabilitation should promote efficient, high quality rehabilitation services. The current rehabilitation funding model has been a factor inhibiting the uptake of in-reach rehabilitation to date despite evidence of efficacy. Alternative funding options are presented

Statement of Disclosures

None

Corresponding Author:
Steven Faux
Department of Rehabilitation Medicine, St Vincent's Hospital, UNSW, Sydney, Australia
Email: Sfaux@stvincents.com.au

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