RMSANZ
Rehabilitation Medicine Society of Australia and New Zealand

18 November 2022

Dear Dr Freeland and committee,

Thank you for taking the time to consider this submission from the Rehabilitation Medicine Society of Australia and New Zealand (RMSANZ) on the long COVID and Repeated COVID infections. This submission will address items 1,2 and 6 of the terms of reference.

Who are we and what do we do?

The Rehabilitation Medicine Society of Australia and New Zealand (RMSANZ) is the peak body representing rehabilitation physicians and trainees in Australia and New Zealand and is affiliated with the International Society of Physical and Rehabilitation Medicine and World Health Organisation (WHO). A major role for the Society is to serve as a medium for advocacy on behalf of rehabilitation physicians in Australia and New Zealand to improve health, function and quality of life of people living with disabilities, with a dedicated and clear focus that is independent and unconstrained by competing interests[1].

The WHO defines rehabilitation as - *set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment…… Anybody may need rehabilitation at some point in their lives, following an injury, surgery, disease or illness, or because their functioning has declined with age.*[2]

The RMSANZ published a position statement in Sept 2022 on the role of rehabilitation medicine physicians in the management of COVID 19 patients[3].

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Recommendations:

1) The RMSANZ recommends that the Federal government enhance the capacity and scale of work that is currently done within the existing infrastructure in rehabilitation medicine departments in Australian public hospitals, in order to accommodate the extra clinical load required to assist those suffering from long COVID.
2) That vocational rehabilitation services be funded for long COVID patients enrolled in comprehensive rehabilitation programs in the public sector. Further, that patients suffering from long COVID have access to funded vocational rehabilitation services in both the community and private sectors.
3) That educational resources are provided for patients in terms of self-management and a general understanding of the condition. Further that training resources be developed for General Practitioners, Allied health professionals and medical specialists regarding the diagnosis and management of long COVID.
4) That the federal government consider extending the number of allied health episodes of care included in the extended care plan from five to sixteen episodes of care for those suffering from long COVID.
5) That the government encourage private health insurers to include those diagnosed with long COVID as being covered by their insurance policies for reconditioning rehabilitation as day only rehabilitation patients.
6) RMSANZ recommends a tiered approach to service delivery for long COVID matching services to patient needs and health care workers skills.
7) RMSANZ recommends the development of combined hospital based long COVID clinics in which rehabilitation physicians and respiratory or acute physicians work together to manage complex patients, offer support to GPs and allied health in the community and act as a centre of excellence for a particular area health service or state.

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8) RMSANZ recommends that the federal government establish a registry of all long COVID sufferers who present to the health system together with an outcomes centre to track outcome trajectories and identify improvement, develop quality improvement processes, and collect data on patient reported experience and outcomes during treatment for long COVID.
9) That the federal government encourage state governments to reinstate the lost rehabilitation bed base and capacity so that hospital-based rehabilitation services are able to meet the business-as-usual demands for inpatient rehabilitation as well as prepare to cope for further services required by long COVID patients suffering stroke, ischaemic heart disease and deconditioning.
10) RMSANZ recommends that the federal government establishes an advisory group in long COVID of experts in the management of loss of function, community care of those with temporary loss of independence as well as those with experience in return to work and the psychosocial phenomena associated with loss of function.

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Rehabilitation medicine is a subacute specialty developed in the USA following the epidemics of Polio and TB in 1921. Sister Elizabeth Kenny developed rehabilitation techniques in Australia for the victims of poliomyelitis virus in Queensland in 1930. In Australia, the discipline of rehabilitation medicine was developed following WW2 (1947) to manage disability and prolonged symptoms of returning soldiers. Rehabilitation Medicine responded similarly to natural disasters including the HIV epidemic, the Christchurch earthquakes and most recently to the pandemic COVID. It focuses on treating people after their acute medical or surgical illness to assist them to return to work, usual activities and to maximise their normal functioning.

Rehabilitation physicians manage patients of all ages (including children and the elderly) with medical, musculoskeletal, neurological and deconditioning sequelae of illness or injury. As such, they are integrally involved in the management of patients suffering from prolonged symptoms, loss of independence and cognitive impairment following infectious diseases, medical illness and surgery. Rehabilitation physicians treat people in all settings inpatients, outpatient, in the home and virtually. They work in teams of colleagues including allied health professionals, healthcare assistants and nurses, in a defined framework of goal achievement and consumer involvement.

Rehabilitation physicians are specialist physicians who are fellows of the Australasian Faculty of Rehabilitation Medicine, itself a Faculty of the Royal Australasian College of Physicians. Rehabilitation medicine has been recognised as a non-age-related specialty by the medical board of Australia since 1976[4]. Its training program is under the auspices of the Australasian Faculty of Rehabilitation Medicine and the Royal Australasian College of Physicians. The post graduate speciality training for qualified doctors involves all forms of rehabilitation in all settings, takes 4 years to complete and has an extensive qualification process.

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What is our expertise in managing the Long COVID population including first nation's people?

Rehabilitation medicine has taken a key role in many states of Australia in responding to the pandemic and long COVID. In NSW Prof Faux[5] established the COVID community of practice with NSW Health's Agency of Clinical Innovation (ACI) and produced a number of documents regarding ways to manage functional decline following acute COVID[6] he also established the first rehabilitation led acute care ward for those suffering functional decline as a result of acute COVID. In Victoria, Prof Khan and Dr Murphy established acute rehabilitation wards to respond to acute COVID in working age and older adults at Royal Melbourne Hospital and St Vincent's Melbourne, respectively. Prof Crotty established a rehabilitation led service to respond to acute COVID and the impact on people's capacity to return to normal function at Flinders Medical Centre in Adelaide. In Queensland Dr Graham established the RACP's education program leading with talks to teach physicians and general practitioners about the functional decline seen with acute COVID among other topics.

In NSW and South Australia rehabilitation physicians have been critical to the establishment of long COVID clinics (eg St Vincent's Sydney, Flinders Medical Centre Adelaide, Orange Base Hospital, Nepean Base hospital). Dr Gounden in Orange has established the first long COVID clinic for rural and remote people including the largest single cohort of first nations people in the country.

The RMSANZ has published a position statement in Sept 2022 on the role of rehabilitation medicine physicians in the management of COVID 19[3]. This document highlights importance of rehabilitation medicine in disaster response and in particular to the response to COVID which includes a substantial role in the management of Long COVID patients.
This statement is based on local and international experience on the role of rehabilitation medicine for the treatment of long COVID.

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Established infrastructure for rehabilitation in Australia and scalability opportunities for long COVID.

Every state of Australia has established departments of rehabilitation medicine in metropolitan and large regional hospitals. Each department has similar models of service, which include outpatient rehabilitation and telerehabilitation as well as inpatient rehabilitations on a rehabilitation ward. There are over 500 such departments nationwide (AROC) and of NSW's 9000 hospital beds over 1280 are subacute including rehabilitation.

In NSW a clear model of care has been established since 2015 (updated in 2019) that includes inpatient, inreach, outpatient clinics, community rehabilitation in the home and tele rehabilitation, models of care. Variations of these models have been adopted in all states of Australia. This includes hub and spoke models of service delivery for people living in rural settings who receive treatment from both their local rural hospital with support or from their larger regional centre or networked city hospital.

Each department has an integrated team structure with allied health, healthcare assistants and nurses working in an established framework of regular case conferences, goal setting and admission and discharge criteria. Communication with referrers and general practitioners are integral to many internal processes including discharge planning and community follow up.

Recommendation 1 :

The RMSANZ recommends that the Federal government enhance the capacity and scale of work that is currently done within the existing infrastructure in rehabilitation medicine departments in Australian public hospitals, in order to accommodate the extra clinical load required to assist those suffering from long COVID.

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Established experience in vocational rehabilitation, return to work and financial/social supports for the unemployed

Much of the work of rehabilitation physicians and departments of rehabilitation medicine relate to community integration of those suffering from reduced functional levels following illness or injury. This involves, assisting people in returning to driving, returning to work, returning to their roles within families as partners, parents and more.

Allied health professionals and other members of the rehabilitation team will regularly engage with employers and design acceptable return to work programs, develop and train patients in work task practices and advocate for entitlements relating to sick leave, retraining or redeployment if required. A large part of the training of rehabilitation physicians relate to vocational rehabilitation so that rehabilitation physicians are familiar with local legislative processes for assisting people back to work.

Evidence shows that up to 13% of those suffering from long COVID have had to change jobs or have not returned to work within 12 months[7] due to persistent symptoms following COVID and as such would benefit from multidisciplinary rehabilitation including the assistance offered by social workers so that government financial entitlements available to the unemployed and or disabled can be sought. This is crucial as much of the rehabilitation can take prolonged periods and patients face significant financial pressure during this time often with physical and cognitive challenges that prevent their capacity to register for benefits.

Unfortunately, access to these services are generally restricted to compensable patients who can access these services in the private sector. There are extremely limited vocational rehabilitation services available to patients in the public sector, non-compensable patients or those being cared for by the NDIS.[8]

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Recommendation 2:

That vocational rehabilitation services be funded for long COVID patients enrolled in comprehensive rehabilitation programs in the public sector. Further, that patients suffering from Long COVID have access to funded vocational rehabilitation services in both the community and private sectors.

Level of education of health professionals and Health literacy of the population

- RMSANZ and AFRM (RACP) have run a number of workshops to engage with health professionals about the identification treatment and follow-up of those with long COVID[8]. These have been well attended but despite these there is little in the way of available resources for the upskilling and education of specialists and general practitioners in the rehabilitation management of those with persisting symptoms. Some state governments have attempted to develop healthcare pathways[9] projects for the upskilling of general practitioners but these are not uniformly followed.

Further with resources stretched to manage the business as usual load attending rehabilitation outpatient clinics, many allied health and rehabilitation physicians have little time to train or indeed any capacity to accept a new stream of patients with persisting symptoms that require multidisiciplinary approaches.

Further the general health literacy of the public is variable at best, and in order to assist people to live with the uncertainty of the prognosis of long COVID, it is paramount to improve their general understanding of long COVID, its management and prognosis. Further skills need to be taught regarding pacing of activities and living with a measure of uncertainty, that is associated with long COVID.

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Recommendation 3

That educational resources are provided for patients in terms of self-management and a general understanding of the condition. Further that training resources be developed for General Practitioners, Allied health professionals and medical specialists regarding the diagnosis and management of long COVID.

Rehabilitation in the community led by General Practitioners and in the private sector led by community based Rehabilitation Physicians

Multi-disciplinary rehabilitation can be delivered in the community led by general practitioners and utilising allied health services. Medicare item numbers 735, 739 and 743[10] together with an extended care plan (ECP) and or a mental health management plan (MHMP), support the general practitioner and the allied health interventions in delivering a community based rehabilitation program. However, there are only five episodes of service that can be delivered though the ECP in the community and this means that the service is extremely limited or will require the patient to pay for additional services as out of pocket expenses. All rehabilitation programs are tailored to the needs of patients however, those with fatigue or cognitive impairment preventing them from returning to work are likely to need at least 8 – 12 weeks of regular twice weekly allied health input to improve functioning and return to work. This will mean that at least 16 episodes of physiotherapy or occupational therapy may be required which is well in above the 5 available through the Extended Care Plan (ECP) item number.

In the private sector those covered by private health insurance have access to day rehabilitation programs operated by private hospitals. Patients who suffer deconditioning following medical illness or surgical procedures are eligible for day hospital services for up

to 20 days depending on the type of insurance product they have purchased and the company from whom they have purchased the insurance product. For some insurers the day rehabilitation (same day rehabilitation) that is available for deconditioned patients can only be activated if the person is admitted to hospital for the medical illness or surgical procedure that causes the deconditioning, and the rehabilitation needs to commence shortly after the hospitalisation. The WHO definition of long COVID indicates that the symptoms associated with the condition must persist for greater than 3 months (this is often long after their hospitalisation (if any) has occurred). As such, those with private health insurance can not always access day rehabilitation services funded by the insurers despite being deconditioned and having persistent symptoms for which rehabilitation is the best practice and the treatment of choice.

Recommendation 4:

That the federal government consider extending the number of allied health episodes of care included in the extended care plan from five to sixteen episodes of care for those suffering from long COVID.

Recommendation 5:

That the government encourage private health insurers to include those diagnosed with long COVID as being covered by their insurance policies for reconditioning rehabilitation as day only rehabilitation patients.

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Recommendation 6:

RMSANZ recommends a tiered approach to service delivery for long COVID matching services to patient needs and health care workers skills.

Model of Care for multidisciplinary rehabilitation of patients with long COVID

RMSANZ encourage a tiered model for multidisciplinary rehabilitation for persistence of symptoms following COVID. This will allow appropriate resources and treatments to be applied to people with different severity of illnesses from mild to severe[11]. It will also accommodate those living in different parts of the country with different access to resources.

Tier one – should include web based self-management tools and information modules for those able to manage their own symptoms. This is likely to assist those with mild symptoms, reasonable educational standards and adequate health literacy. Information would need to be provided in formats accessible by CALD and first nations populations.

Tier two – should include patients being able to be managed in the community by their general practitioners and allied health professionals with online support through health pathways and other education material directed at health professionals. Telephone or virtual support from specialists' clinics (tier three) should be provided to offer clinician to clinician education support and advice. This telephone support is critical, so that people in rural and remote areas can receive state of the art treatment.

Tier three – multidisciplinary clinics in metropolitan or regional hospitals which could be doctor, nurse or allied health led to offer multidisciplinary assessments of patients. These

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assessments could offer a treatment plan for general practitioners to refer to for cases in which the general practitioner is unable to achieve necessary goals in the community alone. Tier four – one clinic per state or per area health service should operate as a reference clinic and be run by specialists in Rehabilitation medicine and Respiratory medicine or acute medicine. These clinics could act as a reference clinic providing virtual and face to face contact with patients with severe symptoms and/or clinicians struggling to offer adequate management to their patients. Further these clinics could be seen to offer up to date advice on emerging research, advanced management techniques and have referral pathways to specialist inpatient and outpatient rehabilitation and acute medical services. These clinics would also be able to share resources and collaborate nationally with clinics in other states, through the sharing of data, expertise and research findings.

As most of those with symptoms of long COVID have more than one symptom, which include cognitive, physical and psychological symptoms, the RMSANZ believe that most of the sufferers will require multidisciplinary coordinated services including medical, allied health and nursing. The condition is by definition subacute and as such Rehabilitation Medicine departments are most suited to deliver goal directed multidisciplinary rehabilitation with the focus of return to normal functioning.

Medical clinics are not likely to have adequate resources in allied health and are likely to refer to multidisciplinary rehabilitation clinics to assist in returning patients to normal functioning. Single discipline allied health practitioners are likely to identify some symptoms that are outside of their training to manage such as cognitive impairment for physiotherapists, swallowing and speech disorders for occupational therapist and nutritional loss for psychologists. Single discipline allied health therapists are likely to refer to colleagues when unable to manage alone but will have difficulty preventing fragmentation

of service delivery. In these situations, often rehabilitation medicine departments are able to assist.

Recommendation 7:

RMSANZ recommends the development of combined hospital based long COVID clinics in which rehabilitation physicians and respiratory or acute physicians work together to manage complex patients, offer support to GPs and allied health in the community and act as a centre of excellence for a particular area health service or state.

Best Practice in the definition, diagnosis and treatment of long COVID

RMSANZ and AFRM (RACP) have together sought to promote and encourage best practice in the management of loss of function and disability in all Australians.

To illustrate how long we have been doing this, in 1995 to 1997 the AFRM was represented on the Commonwealth convened the National Sub-Acute and Non-Acute Casemix Committee, whose role was to achieve national agreement on the development of a classification for sub-acute and non-acute care, including medical rehabilitation. With the goal of establishing an agreed national classification for use by 1997-1998, the National Steering Committee facilitated the National Sub-Acute and Non-Acute Casemix Classification Study, the outcome of which was the Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP), which makes use of the Functional Independence Measure (FIM) as the standard measure of functional status for rehabilitation. The Australian Clinical Casemix Committee subsequently endorsed the recommendation to adopt AN-SNAP as the national classification and the AFRM formally endorsed it.

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In 1997 the then Casemix Branch of the Commonwealth Department of Health and Family Services provided an $86,000 grant to the AFRM following a proposal by the AFRM to develop a national Australian Minimum Data Set for Rehabilitation Medicine. The final report submitted in February 1999 included the FIM as the agreed standard national outcome measure. In March 1999 the Commonwealth Department of Health and Aged Care provided a further one-off grant of $50,000 to the AFRM to obtain the licensing contract from UDS_{MR} in America for education, training and development of the FIM in Australia. In 2000 the Private Rehabilitation Working Group (PRWG) adopted the AN-SNAP classification across the whole of the private sector and the collection of the Australian Minimum Data for Medical Rehabilitation in the private sector. Significantly, Australia now had a uniform agreement to use the same rehabilitation classification model and data set across the majority of the public system and all private rehabilitation service facilities.

The AFRM proposed to establish the Australasian Rehabilitation Outcomes Centre (AROC), that would develop a national database to be used for reporting and research with the aim of improving clinical rehabilitation outcomes in both the public and the private sectors. The Commonwealth Department of Health and Aged Care agreed to fund a planning phase for the establishment of AROC. To this end, a Working Group was set up with representatives from all the stakeholder groups – providers, payers, Commonwealth and State Governments as well as the AFRM. With the support of its industry partners, AROC was established by the AFRM and officially commenced operation on 1 July 2002. The purpose and aims of AROC were established as, and continue to be:

- Develop a national benchmarking system to improve clinical rehabilitation outcomes in both the public and private sectors.
- Produce information on the efficacy of interventions through the systematic collection of outcomes information in both the inpatient and ambulatory settings.

- Develop clinical and management information reports based on functional outcomes, impairment groupings and other relevant variables that meet the needs of providers, payers, consumers, the States/Commonwealth and other stakeholders in both the public and private rehabilitation sectors.
- Provide and coordinate ongoing education, training and certification in the use of the FIM and other outcome measures.
- Provide annual reports that summarise the Australasian data.
- Become a research and development centre that seeks external funding for its research agenda.

For the past 20 years AROC has collected data on all patients with loss of function managed in rehabilitation hospitals and outpatient clinics in the country (metropolitan, regional and rural centres, public and private centres and inpatient and ambulatory service delivery) and currently have almost 2 million episodes of individual patients who have improved in their function through the delivery of rehabilitation services. Further, data from AROC is regularly submitted confidentially to individual hospitals and rehabilitation departments with data driven feedback on their performance against national benchmarks. In this manner rehabilitation units have been able to continuously improve their service delivery. In some states (NSW) this data is used in activity based funding.

Since the outbreak of COVID AROC has responded by facilitating the collection of COVID related data with monthly service audits measuring the impact of COVID on service delivery, introduced a national adjunct COVID data collection monitoring rehabilitation provided to patients with COVID, and has modified current datasets to facilitate the collection of rehabilitation episodes where the reason for the rehabilitation is because of COVID, or the rehabilitation has been impacted by COVID by way of comorbidity or complication. As such AROC is well placed to collect and monitor outcomes of patients with long COVID.

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Established in February 2015 and born out of the AFRM, RMSANZ's major objective is to facilitate a more targeted, responsive, and effective advocacy model for rehabilitation medicine, rehabilitation physicians, and their patients. Long COVID is a condition characterised by a loss of function due to persistent symptoms and while rehabilitation plays a central role in returning people to work, normal functioning and their families, data collection is key to developing evidence based treatments and identifying waste and also exemplar services. AFRM is a strong advocate for AROC and the establishment of best practice models in the definition, diagnosis and treatment of long COVID and the ongoing measurement and benchmarking of rehabilitation outcomes following long COVID.

Recommendation 8:

RMSANZ recommends that the federal government establishes a registry of all long COVID sufferers who present to the health system together with an outcomes centre to track outcome trajectories and identify improvement, develop quality improvement processes and collect data on patient reported experience and outcomes during treatment for long COVID.

Reinstating of rehabilitation beds lost during acute COVID to continue the management of business as usual rehabilitation cases.

The Australasian Rehabilitation Outcomes Centre (AROC) has been routinely surveying inpatient rehabilitation services throughout Australia to accurately record and map the impact of COVID on these services. By March 2022, the vast majority of services surveyed (70/85 or 82 %) had reported being impacted by COVID 19 and only a small number (17/70 or 24 percent) reporting that they were starting to return to pre-pandemic levels (Alexander, 2022). By October 2022, AROC noted 77% of total beds among services

impacted by COVID had been returned to pre-COVID levels (report yet to be published). It is concerning that there is still a significant gap between current and pre-COVID rehabilitation beds number levels.[12]

Recommendation 9:

That the federal government encourage state governments to reinstate the lost rehabilitation bed base and capacity so that hospital based rehabilitation services are able to meet the business as usual demands for inpatient rehabilitation as well as prepare to cope for further services required by long COVID patients suffering stroke, ischaemic heart disease and deconditioning.

Ministerial advisory services for those with persisting symptoms due to Long COVID

As long COVID is a subacute illness characterised by a variety of persistent symptoms that affect functioning, RMSANZ believe that ATAGI with its acute focus and knowledge of illness prevention, and vaccination efficacy may not have the experience to advise the government on issues to do with temporary loss of function, disability and psychosocial phenomena associated with recovery. This experience is best sought from experts in the management of temporary and permanent loss of function, a clear understanding of interpretation of data on functional decline and a scientific understanding of research in the subacute fields of recovery and rehabilitation.

RMSANZ believes that the health minister and the government need a specific advisory service with experts in the use of rehabilitation services and community care of those living with loss of function.

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Recommendation 10:

RMSANZ recommends that the federal government establishes an advisory group in long COVID of experts in the management of loss of function, community care of those with temporary loss of independence as well as those with experience in return to work and the psychosocial phenomena associated with loss of function. Further that these experts be appointed for their expertise and knowledge of the evidence base rather than simply as representatives of industry or professional bodies. That this group meet regularly, assess captured data and review the literature in an attempt to advise the minister with up to date evidence based information and opinion on the prevention, management and outcomes of long COVID.

Thank you for taking the time to read this submission, which has been ratified by the Board of RMSANZ.

Dr Zoe Adey-Wakeling
RMSANZ President

Dr Richard Seemann
RMSANZ Vice President

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Prof Steven Faux

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Presentation 1 Epidemiology and rehabilitation research.

Presentation 2 – AROC's new rehabilitation outcome strategies and directions

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