

Implementing the reimbursement scheme - views of health and social care staff in six high performing sites

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Abstract

The Community Care (Delayed Discharges) Act 2003 announced a new reimbursement scheme which was intended to accelerate the downward trend in rates of delayed discharges and strengthen joint working between acute health trusts and social services. Under the new scheme hospitals and social services were to agree new inter-agency discharge planning protocols and communication systems, and to operate new legal notification systems that required hospitals to give social services formal notification at least 3 days in advance of a patient's planned discharge. Agencies were required to agree the numbers of delays each agency was responsible for each week, and acute trusts could charge local authorities for any delays for which they were responsible. Critics warned that the scheme was unsuited to the task, and that its implementation might put partnership working and patient care at risk.

This paper explores health and social care staff views on the early working of the reimbursement scheme taken from a broader study of the factors associated with low rates of delays in six sites where performance (in terms of rates of delayed discharge) was exceptionally good. Forty-three qualitative interviews were undertaken between June 2004 and March 2005 with a range of health and social care professionals responsible for, or involved in, discharge arrangements in the six sites.

For the majority of staff, the scheme has largely supported joint working; it provided substantial new funding to social services departments for joint commissioning, it has required joint implementation of new interagency notification systems, and close monitoring and interagency communication around delays. Whilst those working with new notification systems have experienced some difficulties with reaching a shared understanding of what is required, the notification system appears to have supported clear and timely communication around discharge between ward and social services staff. Impacts on patients were not clear cut, but there were concerns from some social services staff that, as a result of reimbursement, there was greater likelihood of 'hurried' discharges.

This paper offers important insights into the early working of the scheme in sites where agencies were already performing well in terms of delayed discharges. It should be of interest to those involved in implementing the reimbursement scheme or with a role in discharge arrangements.

Keywords: Delayed hospital discharge, implementing reimbursement

Introduction

This paper explores the experiences of health and social care staff with regard to the implementation and early working of the reimbursement scheme in sites where the rates of delays are already low. The findings presented in this paper are based on re-analysis of qualitative data obtained from a broader study which aimed to elicit the essence of 'what works' in sites that had already addressed delayed discharges in order that this could be shared with sites still struggling with delays (see Baumann *et al.*, 2007).

Background

Delayed discharges from hospital have posed a problem for the welfare state since its inception (Schimmel, 1964) and have provided a regularly recurring topic in the health services literature (Taraborelli, 1998). Whilst certain groups of patients such as older people, those without informal carers, those who live alone, and those with complex medical needs are most at risk of delays (Victor *et al.*, 2000) it is widely acknowledged that delays are overwhelmingly a result of organisational issues including internal hospital factors, availability of community services, and interagency communication (Victor *et al.*, 2000; House of Commons Select Committee on Health, 2002; National Audit Office, 2003; Glasby, 2004; Scottish Executive, 2004). According to one author who has, arguably, delved deeper than any into the problem of delayed discharge (Glasby, 2004; Glasby & Littlechild, 2004) interagency delays are the result of a complex range of long-standing structural, cultural, policy, legal and funding issues that stand in the way of progress.

The National Audit Office (2003) and the House of Commons Select Committee on Health (2002) also offer an holistic approach to understanding the problem of delayed discharges, emphasising:

- **Insufficient capacity** in the health and social care system;
- **Internal health system inefficiencies** such as limited or inefficient advanced discharge planning; delays in making health assessments because of shortages in occupational therapists and physiotherapists; competing priorities for time; poor coordination and communication delays in preparation of discharge medicines and poor availability of transport services;
- **Inter-agency factors** such as a lack of clear multi-agency discharge protocols, poor quality interagency communication systems and slow progress with the implementation of single assessment arrangements.

A range of initiatives has been launched since 1997, which aim to address these long-standing problems and to tackle delayed discharge (Glasby & Littlechild, 2004; Baumann *et al.*, 2007). But, by 2002, although progress was being made, rates of delays had not reduced substantially, and the government announced its intention to accelerate progress through the introduction of a reimbursement scheme based on the Swedish system (DH, 2002).

The government claimed that the system of payment transfers or 'cross-charging' would reduce delays by encouraging greater responsiveness from social services - a claim which was based on the Swedish experience of implementing the scheme a decade previously (see Andersson & Karlberg, 2000). Initially, only limited information about the scheme was announced; the 'one-liner' which was, unfortunately, the basis for most of the subsequent commentary, was that local authorities would be required to make payments to acute trusts for each day where a delay in discharge is a result of their failure to assess or provide services. As Henwood (2004, p.4) noted, this was

“enormously controversial” because it appeared to attribute the responsibility for delays entirely to social services, at a time when there was increasing evidence that there was a complex range of national and local, and multi-agency causes of delays.

The House of Commons Select Committee on Health, in its inquiry into delayed discharges, suggested that reimbursement would be extremely complex to implement, unlikely to succeed in addressing the various causes of delays and risked undermining interagency relationships (HCSC, 2002). For the most part, commentators agreed (Henwood, 2004) and several feared that the scheme would, in addition, have a detrimental impact on patient care and outcomes (HCSC, 2002; Glasby, 2003; Moss, 2004; Rowland & Pollock, 2004; Wilkinson, 2004).

The government responded to and allayed much of the criticism when it published detailed guidance on how the scheme would work in practice, and simultaneously announced both substantial new money for local authorities to pay for the development of services to prevent delays (or to pay acute trusts for the cost of any delays), and a

longer implementation period than initially planned (Henwood, 2004). The new guidance challenged a widespread perception that the scheme was to be used as a ‘stick to beat poor performing social services’ by making clear the responsibilities of both social services and acute trusts; in this respect acute trusts would only be able to charge social services for delays where they had provided a minimum period of notification.

The details of the notification system set out by the Department of Health (DH, 2003) are summarised in Box 1 below.

Whilst social services’ concerns appeared to evaporate as the details emerged, some anxiety about the suitability of the scheme to tackle the problem remained. Two reviews of evidence on the causes of delayed discharges concluded that the new scheme did not offer the local, multi-faceted, ‘whole systems’ approach that was needed (Glasby *et al.*, 2004; Scottish Executive, 2004). Glasby (2004) argued that fundamental change to the structure of health and social care services would be required in order to address delayed discharges.

Box 1 - Interagency notification systems

Initial notification (‘section 2’) of ‘social services’ by hospital staff

- Acute trusts are required to provide notification of ‘social services’ for assessment at least three days prior to discharge, if delays are to be ‘officially reimbursable’.
- Notification of a patient’s potential need for ‘social services’ at discharge should take place either before, or soon after, patient admission.
- Where possible acute trusts should provide an *estimated* date of discharge in the notification.

Second notification (‘section 5’) of ‘social services’ by hospital staff

- A second notification must also be provided by acute trusts of the *confirmed* date of discharge.
- This second notification must be provided to social services at least 24 hours prior to the confirmed date of discharge, and this date should be jointly agreed by the multi-disciplinary team.
- Whilst a second notification may be issued at any time after the initial notification, delays do not become reimbursable until after three full days have passed since initial notification.

The empirical evidence relating to the reimbursement scheme, which was introduced in England in January 2004, is limited. A report of the Commission for Social Care Inspection (CSCI) of progress in seven councils claimed that reimbursement had accelerated the rate of decline in delayed discharges without being divisive of interagency relations. It reported that quality of patient care was variable. In sites where existing joint working was good, and community services well developed, implementing reimbursement had required only minimal readjustment of processes and procedures. However, in other sites where the required range of services was less well developed, it claimed that work to speed up discharge in an inadequate whole health and social care system was potentially "...disempowering individuals and undermining their potential for improvement and rehabilitation" (CSCI, 2004, p.4). CSCI's follow-up investigation in the same sites reported similar findings (CSCI, 2005).

Other research commissioned by the Department of Health on the impact of reimbursement is likely to be published in coming months and will provide new information on staff experiences of using the new system in a range of sites, and systematic examination of the impact of the scheme on patients by comparing experiences in England with those of sites in Scotland where reimbursement was not implemented. In the meantime, this study offers early impressions of the working of the scheme in sites where agencies were already performing well in terms of delayed discharges.

Methods

The study reported here was conducted between June 2004 and March 2005 (a period of consolidation for the reimbursement scheme). It involved 43 qualitative interviews with a stratified sample of health and social care

professionals in six high performing sites across England.

High-performing sites were identified and selected through a multistage process. A statistical model was developed (Fernandez & Forder, 2002) to predict rates of delayed discharge using a variety of funding and services information and to identify sites that outperform the model in terms of their actual rates of delayed discharge. Sites were further short-listed with reference to information about delayed discharge performance over a four-year period, and with reference to joint review reports and star ratings. The authors' final selection of six sites in England ensured that sites represented a mix of geographical locations and local authority types (see Baumann *et al.*, 2007 for full details of the sampling process). The sites selected included:

- four southern sites, including one unitary authority (1), two shire counties (2, 3) and one London borough (6);
- two northern metropolitan boroughs (4, 5).

Interviews were undertaken with a range of health and social care professionals: social services (n=19), acute trusts (n=14), intermediate care staff (n=5) and primary care trusts (n=4). The aim was to interview the key personnel with managerial and operational responsibility for discharge arrangements in each location. Those interviewed in each site included senior strategic staff (e.g. Directors of Nursing and social services Service Managers), operational management/leads (e.g. social services Team Managers and Lead Discharge Co-ordinators in acute trusts) and operational staff (e.g. social services Care Managers and acute trust Discharge Facilitators).

Ward Nurses were not interviewed; it was believed that interviewing Discharge Facilitators, Lead Discharge Co-ordinators

and Directors of Nursing would be adequate to provide a 'health perspective'. However, the omission of nurses is regrettable since it means that the picture provided here of discharge practice is not representative of all the key stakeholders.

The sampling approach was purposive and, notwithstanding the above omission, the intention was to interview the key contacts in each agency at a strategic, team leader and operational level who were involved in the discharge process. The names and contact information for each of the stakeholders interviewed were obtained by way of a snowballing approach. In each site social services team managers were interviewed first, and the range of stakeholders involved in discharge emerged from this and subsequent interviews.

One researcher undertook the fieldwork (MP) and another undertook the analysis (MB). This division of labour was not ideal, since much of the tacit knowledge gained in fieldwork did not contribute directly to the formulation and application of the approach to analysis. However, the second researcher (MB) endeavoured to mitigate the effect of this discontinuity by sharing key interpretations with the rest of the team (including MP).

The interviews did not focus entirely on the topic of reimbursement. As explained earlier, the content of this paper is based on a broader study of good practice in relation to delayed discharge. In addressing these broader aims the interviews covered a range of factors associated with local performance including factors affecting admission rates, systems and processes relating to discharge planning and communication, and, more broadly the organisation and availability of services. In relation to reimbursement, respondents were asked to describe the implementation and impact of reimbursement locally as part of this broader discussion and, due to the timing of the interviews - which was within months of

the commencement of the scheme - discussion of reimbursement formed a substantial part of each interview.

All interviews were tape recorded and fully transcribed. Transcripts were coded (by MB) using a mixture of *a priori* and emergent themes that were agreed with the wider team. Data from each interview, on each theme, were extracted and placed in a thematic matrix, to enable both case wise and cross-case analysis. The findings from this analysis were scrutinised by the interviewer and the wider team (MP). This task was based on an approach to data analysis developed by Ritchie and Spencer (1983) known as the 'Framework Approach'. QSR Nvivo software was used for coding, sorting and retrieving data, and Microsoft Excel was used for data reduction and production of the matrix.

Results

Six main themes emerged from the data regarding the implementation and impact of reimbursement: 1) joint working and prioritisation of delayed discharges at a strategic level; 2) variation in the understanding and implementation of notification systems; 3) reorganisation of social services in some sites; 4) closer monitoring and joint agreement of delays; 5) rates of delays and experiences of cross charging and 6) patient care and outcomes.

Joint working and prioritisation of delayed discharges at a strategic level

Implementation of reimbursement was a key driver of the prioritisation of delayed discharges in all the sites. It required intensive joint work to develop protocols, implement new systems, train staff and commission new services.

In most sites, existing joint working and good relationships at a strategic level provided a positive platform for further work required to implement reimbursement.

In four sites the reimbursement funding had a high profile amongst all agencies. Staff reported positive experiences of working jointly to identify areas where the grant could be spent – such as on the further development of a range of intermediate care, on hospital services designed to prevent admissions and support the discharge process, and on funding care packages. Two of these sites in particular benefited from substantial funding.

Implementation also necessitated the design and interagency agreement of a discharge protocol and notification system that would meet the requirements set out in government guidance. Whilst challenging, in the limited time available for preparation for reimbursement, joint working was, in most sites, positive. Either a joint group oversaw the work or it was undertaken by one agency on behalf of both. In just one site each agency oversaw its own requirements separately, and here agencies had still not agreed the protocol 10 months after implementation of reimbursement.

Variation in the understanding and implementation of protocol and notification systems

Discharge notification systems had been redesigned, based on government guidance, but understanding and implementation varied considerably amongst individual members of staff within and between sites.

This variation in understanding was particularly apparent amongst operational staff. Some ward staff (in sites 1 and 5) provided initial notification (section 2s) of ‘social services’ soon after admission, as detailed in the guidance. Whilst this was largely helpful, social services staff complained that some nurses who sent notifications for assessment at admission did not then communicate with social services until sending final notifications (section 5s) of confirmed date of discharge which could be sent as late as a day before

discharge. As a result social services staff had either to keep chasing ward staff for details of the discharge date in order to avoid any last minute surprises, or they had to be prepared to ‘drop everything they were doing’ at the last minute to finalise the discharge arrangements when they came through:

You get the referral early here, which is great compared to before, but the problem is that nursing staff then think that you are arranging the discharge. But you can't until all the treatment and assessments have been done.

(Care Manager, Social Services, Site 1)

In other sites (2, 3, 4 and 6) initial and follow up notification timescales varied. Some nurses were sending initial notifications well in advance but, according to social services staff, many nurses still provided initial notification as late as three days before discharge. Social services staff in site 4, who commonly received initial and follow up discharge notifications within a day of each other, were not involved in setting discharge dates and staff here were regularly trying to make arrangements within 24 hours of notification from nurses of an intention to discharge:

the pressure we're under is not sustainable, we're going to have to go back to the Trust and get them to work under reimbursement criteria. ... We can't be getting people discharged the same day...

(Team Manager, Social Services, Site 4)

Social services respondents in site 3 reported that late arrival of initial notification was not a problem for them as staff were always involved in setting actual discharge dates with trust staff.

The use of ‘estimated date of discharge’ was new to most sites, and its inclusion in initial notifications (section 2s) was inconsistent. Where it did happen, the reported benefits

were that both health and social care staff who were notified of the date could plan their assessments and services accordingly, and discharge teams could more easily monitor progress. Health and social care staff in all but one site (site 3) reported that ward staff had only a limited understanding of what was required of them under the new notification system, despite support from discharge teams and local training opportunities:

I mean we're still struggling out on the wards 'cause you'll go up on the wards now even 18 months down the line and you'll ask "have you completed your section 5?" and they'll say "what's a section 5?" despite huge amounts of training". (Discharge Process Manager, Acute Trust, Site 6)

It may be that, whilst arranging discharge is the key role of many of the staff we spoke to, it is just one part of the work of a nurse and, with such large numbers of nurses, compared to care managers or discharge facilitators, it is perhaps unsurprising that the arrangements were taking a longer time to become embedded in nursing practice.

Reorganisation of social services in some sites

In sites 2, 3 and 4 social services teams based in the hospitals were responsible for arranging post-discharge care for all clients (both new and existing) who were referred by ward staff. In these sites proximity and familiarity with the pace of hospital working and with the staff involved meant that a relatively rapid social services response could be provided to any notification for assessment from ward staff.

Prior to reimbursement, in sites 1, 5 and 6, hospital teams were only responsible for arranging discharge of clients who were new to social services. Where a client was already known to social services, hospital teams had to pass on the notification to

community teams who would then come to the hospital to assess the patient and arrange discharge. Community teams were reportedly unable to respond as quickly as hospital staff but it was believed that they provided continuity of care which was valued by patients. Following reimbursement's implementation, these arrangements were reviewed. In sites 5 and 6, due to the need to speed up the pace of work to avoid having to make payments, hospital social services teams now took on all referrals from the wards and community teams were no longer involved until the discharge had been arranged. Furthermore, care managers in these sites had been assigned to specific wards with the aim of providing improved team working. In site 1 restructuring along these lines was being considered.

Staff from both health and social services reported improved relations between ward staff and care managers as a result of these changes and, in site 5, multi-disciplinary team (MDT) meetings were now frequently occurring, where previously they had not:

The ward staff like it a lot better ... they used to complain that they might have six or seven social workers coming on the ward every day, they didn't know who was who ... So now there are dedicated workers the ward know exactly who the workers are. And a lot of wards are now having weekly multi-disciplinary team meetings to consider complex cases.

(Team Manager, Social Services, Site 5)

Closer monitoring and joint agreement of delays

The need for close monitoring and joint agreement of delays is a key requirement of the reimbursement scheme. Social services and hospitals reported that since reimbursement they had started monitoring patient discharge progress on a daily basis. In addition, in almost all sites weekly meetings (at team leader level) were held to

agree formally the numbers of delays and the agency responsible. In sites 1 and 6, staff also commented that these meetings provided a positive basis for identifying and preventing risk of delays.

Staff reported that agreeing responsibility for delays was generally straightforward; both the notification protocols that had been developed and the Department of Health guidance around reporting weekly delays provided a firm basis for deciding which agency was responsible. For example:

if there's a debate or dispute [the Deputy Director] will get involved and she will involve her counterpart in Social Services and they'll decide, but even that would rarely be the case. ... There's an understanding of what the rules are. (Director of Nursing, Acute Trust, Site 3)

Rates of delays and cross charging

Staff in four sites (2, 3, 5 and 6) believed that there had been a fall in numbers of social services delays since implementation of the reimbursement scheme but it was often mentioned that rates of delays were already low (or falling).

The responsibility for low/falling delays was commonly attributed to existing good communication and working relationships and well developed health and social care infrastructure but there was a perception that the risk of charges (sites 2 and 5) and the extra resources provided by reimbursement grant (especially sites 2 and 3) had also made a contribution.

Social services and health staff in a number of sites reported that, as a result of the notification protocols and reimbursement money, the only delays remaining were those that were the responsibility of the acute trust:

Well I think we're finding very little now ... it's changed a lot. Now the

reimbursement money has been put in, there's very little reimbursable delay. In other words, most of it is health delay but, yes, there's not much delay full stop. (Senior Management, Acute Trust, Site 3)

Patient care and outcomes

There was some discussion in staff interviews of patient care and outcomes. In three sites (2, 3 and 6) reimbursement was praised for providing additional funds for service development. Some staff commented that newly developed intermediate care services meant patients now had a greater chance of returning home than previously.

In most sites people with mental health problems were, according to staff, most likely to experience long delays due to the limited number of psychiatric staff available to make assessments, and the limited availability of post-acute health and social care for this group. In Site 3, however, a substantial (£1m) reimbursement grant had been used specifically to develop a range of community-based services for older people with mental health problems, enabling significant progress to be made with backlogs of delays for this group.

Some social services staff in three of the sites stressed that the reimbursement scheme had increased the pressure on care management staff to work more quickly with patients on arranging discharge. Some social services staff felt that this pressure did not allow them to support patients adequately in regard to key decisions about their future living arrangements and care needs:

but it's this very quick turnover that I can't get to grips with, especially for placements, because ... you've got to work with families; to come to terms with that ... it just doesn't seem to be good practice. We're rushing people into

making decisions. (Operational Staff, Social Services, Site 2)

In two sites, there were some fears amongst social services staff that some patients had been discharged too early, although these respondents were not sure if this was a systematic trend.

Discussion

Like the CSCI studies (CSCI, 2004; CSCI, 2005) we found that reimbursement had not undermined relationships in our study sites. At a strategic level the introduction of reimbursement has provided new opportunities to work together in commissioning new services and in designing the new notification systems. At an operational level the notification system is largely perceived to be a step in the right direction towards further clarifying responsibilities and enabling staff to communicate effectively and in a timely manner regarding discharge. However, greater exposure and engagement with the guidance on discharge could be helpful for nurses whose interpretation and understanding of the guidance is reportedly inconsistent.

The payments system has prompted closer monitoring of delays and joint working amongst health and social care staff at team manager level to avoid delays. The notification system has been helpful to the process of agreeing the attribution of responsibility for delays between hospitals and social services and, in these sites, has largely been accompanied by a growing recognition amongst health staff that most delays are 'health delays' rather than a result of delay by social services. Glasby (2004) has also highlighted the growing evidence that a substantial proportion of delays are the result of 'internal hospital inefficiencies' in his review of the hospital discharge literature. In this respect, the reimbursement scheme appears to have

provided a long overdue system of arbitration.

In some sites reimbursement has precipitated a change to the balance of work undertaken by care managers in hospital and community teams. Due to reimbursement, social services teams based in hospitals now tend to arrange all discharges (both new and existing clients), transferring responsibility to community teams only for follow up and ongoing care management. This represents a more efficient way of dealing with discharge arrangements and appears to have positively affected interagency relationships (through supporting closer interagency working), but there were concerns amongst social services staff that this efficient discharge had been achieved with a cost to continuity of care management. The value attributed by patients to continuity of care is highlighted by the CSCI report which found that "... older people really appreciated having a single named person to oversee, monitor and adjust care services in response to their changing needs" (CSCI, 2005, p.5). That reimbursement may be undermining this is of concern.

Whilst there was comment from some social services staff about an increased likelihood for 'hurried' discharge this was not something that hospital staff spoke about. Glasby (2004, p.597) has argued that health and social care agencies "operate according to competing notions of good practice" in which hospitals prioritise efficient throughput and social care practitioners emphasise the importance of adequately supporting patients to make difficult decisions about their future care. The difference of opinion found in this study regarding whether discharge is 'timely' or 'hurried' is surely a reflection of the different mindsets underpinning good practice in health and social care.

Social care and health staff however expressed concerns about the lack of impact the scheme would have on speeding up

discharge of those patients excluded from it such as patients with mental health problems who often stay in hospital for prolonged periods while they wait for assessment or available community-based services. Whilst this outcome was foreseen by commentators (Moss, 2004), the exclusion of these patients was perhaps a recognition on the part of the government that addressing the shortages of psychiatric staff and developing good quality community-based services across the country would take time and substantial funding. And, in this respect, it was perhaps an acknowledgement of the limitations of the reimbursement scheme.

There are limitations to this study as noted earlier and it is helpful to recapitulate some of these before moving on to draw conclusions. Firstly, the results are taken from a much broader review of the factors supportive of timely discharge in high performing sites. It is not a representative study of the implementation of reimbursement in a broad range of sites. As we have already noted, this limits the conclusions we can draw on the implementation of reimbursement. A second issue, linked to this, is that the interviews did not focus entirely on the topic of reimbursement – our findings relating to reimbursement are based on what respondents chose to talk about. Had the interviews systematically covered the full range of issues relating to staff perceptions of the implementation of reimbursement, the study findings would be based on a more comprehensive analysis. Since this was not the case it was not always possible to find information on all the main themes from the interview data. A third issue is the omission of interviews with nurses. Although interviews with a range of health staff were undertaken, it would have been valuable to examine nurses' perspectives on factors affecting their discharge planning especially given the research evidence in the literature (Payne *et al.*, 2002) and from the present study, which suggests that nurses' limited

understanding of discharge issues is sometimes a key factor hampering efficient discharge communication.

Conclusion

Staff views from these high performing sites may reflect some of the experiences of staff in other sites in England but, since these sites are anomalies by virtue of their pre-existing success in tackling delayed discharges, care should be taken in making inferences from this small study. Indeed, because existing relationships were, by and large, good in these sites, it may be that reimbursement has been easier to implement than in sites where relationships are less well established.

The implementation of reimbursement in these sites has provided a sound basis for continued positive joint working at both strategic and operational levels. There was very little evidence to suggest that its implementation has had a negative effect on interagency relationships. The clarity brought by new protocols, regarding the balance of responsibilities between agencies, and the extra resources provided to sites for implementation of the scheme, may have been fundamental in supporting joint working. Operational efficiency appears to have made some gains, but further work is needed to ensure that nurses, who are key drivers of discharge, fully understand the system.

Whilst, in general, it appears that patients are more likely to receive timely discharge from hospital as a result of the new scheme and that monies provided through reimbursement had in a number of sites been used to develop new services, there is also some evidence that suggests that reimbursement may have had some negative impacts on some patients, by reducing the time available to them to consider their options and by affecting the continuity of their care. The ongoing issue of delayed discharge for people with mental health

problems has largely been unaffected by reimbursement due to their exclusion from its provisions.

Further research (described earlier) has been commissioned by the Department of Health specifically to explore the impact of reimbursement and we expect that this research will shortly provide a full account of its implementation, including its impact on patient care and outcomes.

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