Evaluating the discharge planning process

Barriers, challenges, and facilitators of timely and effective discharge for people with disability and complex needs

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Executive summary

Background

The pathway from hospital to the community for people with disability and complex needs is characterised by delayed discharges and prolonged admissions. Due to the challenges and lengthy processes associated with securing supports to re-enter the community, people with disability are at risk of entering Residential Aged Care (RAC) at the point of hospital discharge. Hence, improving the pathway from hospital to the community is the key to reducing the number of younger Australians stuck in hospital and/or discharged to RAC.

Methods

Three studies were initiated to explore and identify barriers, challenges and facilitators of timely and effective discharge for people with disability and complex needs. Firstly, a research project collecting Hospital Discharge Trajectory (HDT) data including length of stay, health and NDIS timeframes, delays to discharge and discharge destinations, was conducted. Secondly, a survey was distributed amongst clinicians working across the hospital discharge trajectory to gather their experiences of facilitating hospital discharge. Finally, routine service data were collected from the Housing Brokerage Service (HBS), a service providing secondary consultation to support teams of NDIS participants stuck in hospital due to a housing barrier.

Results

Lengthy and unpredictable timeframes associated with the approval of NDIS funding for supports and housing contributed significantly to discharge delays. Without the timely allocation of funding, clinicians were unable to facilitate efficient discharge planning for participants. Additionally, despite timeframes decreasing, the identification of NDIS participants and submission of Access Request Forms (ARF) by hospital clinicians remained lengthy. Finally, clinicians described thin housing markets, a lack of specialised support providers and challenging stakeholder interfaces to affect the achievement of timely discharge. Securing housing and supports that met the participant's needs and preferences frequently contributed to discharge delays across all studies.

Implications

Ultimately, hospital discharge occurs in a highly pressurised environment. Efficient discharges are necessary to prevent disruptions to patient flow and poor health outcomes for patients, yet delays to discharge are prevalent, placing people with disability and complex needs at risk of being discharged to RAC. When comparing the Australian aged care and NDIS support provision trajectories at hospital discharge, the differences are substantial. Aged care systems are positioned to provide comprehensive 24-hour support and housing promptly and efficiently (i.e., often within 3 days), whereas accessing housing and support through the NDIS is typically a lengthy and complex process. To improve outcomes for people with disability and complex needs in hospital, health teams should be supported to initiate early applications for NDIS funding and complete early assessments of housing needs and preferences. The NDIA should provide timely funding decisions to allow discharge preparation to commence early so that individuals can leave hospital once medically cleared to do so.

Introduction

Improving the pathway from hospital to the community is the key to reducing the number of younger Australians in RAC. However, leaving hospital and returning to the community after a traumatic accident or injury is a complex transition that requires effective coordination between the health system and the National Disability Insurance Scheme (NDIS) (Houston et al., 2020; Redfern et al., 2016). The majority of these younger people at risk of entering RAC could live in the community if their transition home could be more effectively coordinated by the health system and the NDIS (Barry et al., 2019). In order to improve this pathway, we first need to understand the barriers and facilitators to an effective hospital discharge. Accordingly, 3 projects were initiated by the Summer Foundation to address the NDIS/health interfaces. The first project is collecting Hospital Discharge Trajectory (HDT) data to evaluate the health and NDIS timeframes associated with discharge outcomes. The second project engaged with health-based clinicians through a survey to explore their experiences of hospital discharge, arranging supports for NDIS participants and navigating the NDIS, health and community interfaces. The final project is a COVID-19 response service, the Housing Brokerage Service, that aims to assist people with disability and complex needs stuck in hospital to access appropriate housing and supports necessary to leave hospital. Through these projects, we have collected data on the typical discharge trajectory of NDIS participants and prevalence and reasons for delays to hospital discharge.

Study 1: Hospital discharge trajectory data

Hospital Discharge Trajectory Data were collected from hospitals across Australia to explore the discharge pathways of NDIS participants. The below graphs highlight the length of stay, unnecessary time spent in hospital, NDIS and health timeframes, prevalence of discharge delays and discharge destinations. A requirement for inclusion in this study was that a patient has been discharged, therefore it is possible that there remain patients admitted to hospital in recent years whose data is not yet included in the report as they are still in hospital. Please note that some included graphs have used a log scale, which is a way of displaying numerical data over a very wide range of values in a compact way. Close attention to the scale on the vertical axis will be necessary when interpreting each graph. Tables providing median and range for each of these graphs have also been provided.

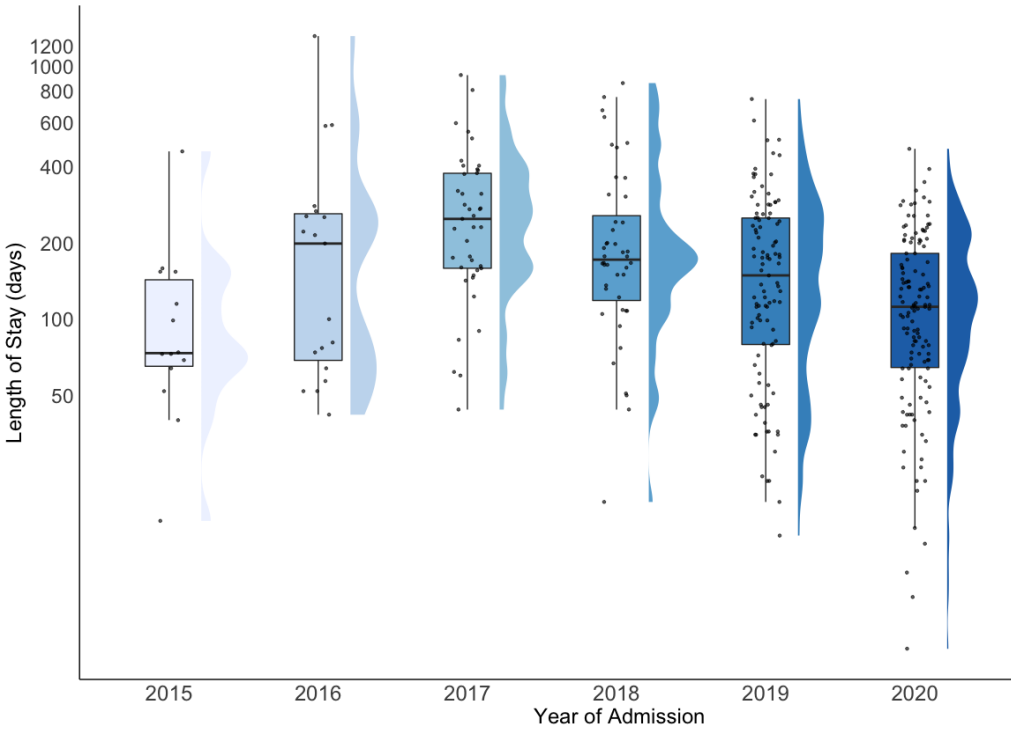
Length of stay

Length of stay was calculated for all patients from the date of admission to the date of discharge. Length of stay data is presented over different years and across different disability types. Although there are fewer extreme scores in recent years, these graphs should be interpreted with caution due to some people admitted in recent years likely remaining inpatients. The highest median length of stay was recorded in 2017 (m=249, IQR=158-382), followed by a decrease in subsequent years (table 1). Despite a reduction in length of stay since 2017, variability and extreme values were evident throughout each year of data collection (figure 1).

Table 1 – Length of stay over time

Year of admission	*n*	Length of stay (days)	
		Median (IQR)	Range
All years	368	134.5 (*73-231)*	5 - 1312
2015	14	73.5 *(61 – 154)*	16 – 460
2016	19	199 *(64 – 267)*	42 - 1312
2017	41	249 (*158-382)*	44 - 920
2018	44	172 (*112-289)*	19 - 956
2019	103	149 (*79-251)*	14 – 740
2020	130	112 (*64-185)*	5 – 471

Figure 1 – Length of stay over time



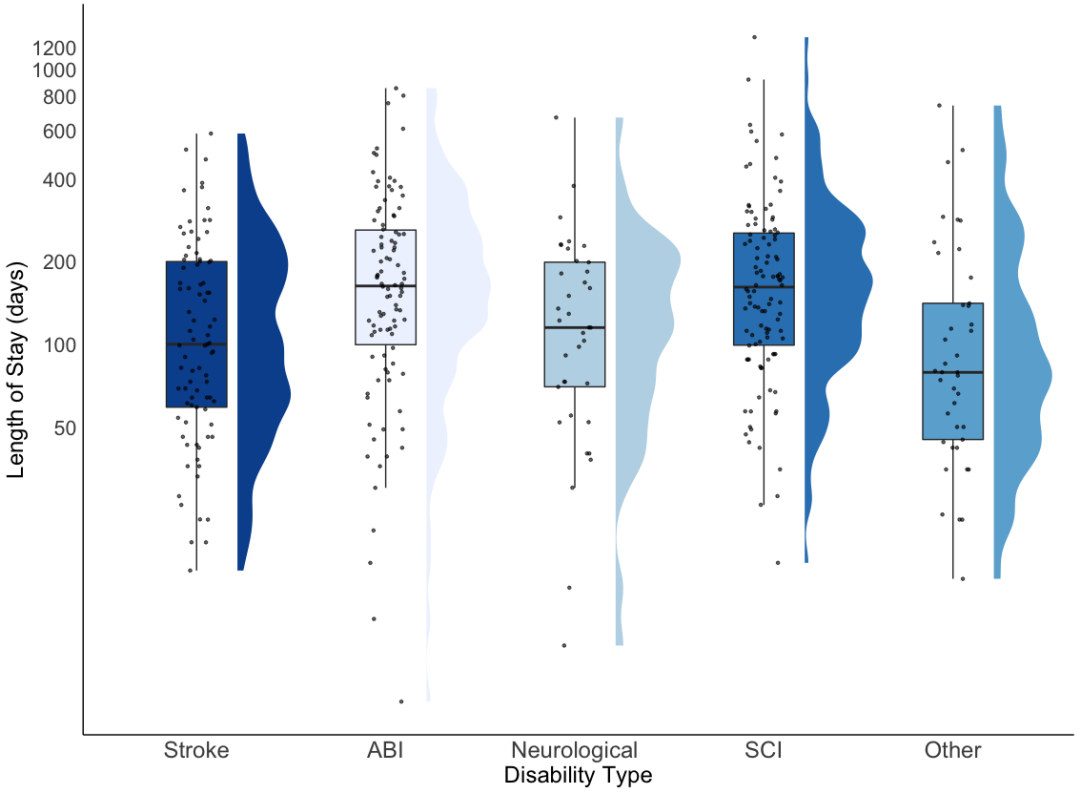
Length of stay split by disability type

Patients with brain injury experienced the longest median length of stay (m=173, IQR=109-293), followed by patients with spinal cord injury (m=161.5, IQR=99-257; SCI) and neurological disability (m=126, IQR=57-202; table 2). Patients with SCI and brain injury had the longest recorded admissions with 1312 days and 856 days respectively. Figure 2 presents a boxplot outlining the distribution of length of stay for each disability type, with overlayed individual data points representing an individual patient length of stay.

Table 2 – Length of stay split by disability type

Disability type	*n*	Length of stay (days)	
		Median (IQR)	Range
SCI	104	161.5*(99 – 257)*	16 – 1312
Stroke	97	111 *(62 – 204)*	19 – 754
Acquired Brain injury	75	173 *(109 – 293)*	16 – 856
Neurological disability	42	126 *(57 – 202)*	8 – 669
Other	44	71 *(37 – 114)*	10 – 460
Unknown	3	134 *(-)*	39 - 208

Figure 2 – Length of stay split by disability type



NDIS and health time frames

NDIS and Health time frames were recorded to explore specific time frames within the discharge trajectory. Each time frame measured represents a necessary step in the discharge trajectory that must be completed to implement supports required for discharge. Due to the fluctuating data available for eligible participants, there are varying sample sizes for each time frame.

Admission, access request form submission and eligibility determination

The total days between admission and Access Request Form (ARF) submission have decreased over time but remained lengthy, with a median of 48 days in 2020 (table 3). This is despite the vast majority of these patients ultimately gaining NDIS access during their admission. Days between ARF submission and eligibility determination by the NDIS fluctuated over time but decreased to a median of 8 days in 2020 (table 3).

Table 3 – *Admission to ARF submission and NDIS eligibility determined*

	Year of admission														
	2016			2017			2018			2019			2020		
NDIS Time frame	n	Median days (IQR)	Range	n	Median days (IQR)	Range	n	Median days (IQR)	Range	n	Median days (IQR)	Range	n	Median days (IQR)	Range
Admission to ARF submitted	7	84 (34-123)	34-434	32	95 (54-123)	32-224	20	88 (49-126)	28-323	61	55 (39-98)	20-484	85	48 (31-72)	10-218
ARF submission to NDIS eligibility determined	5	45 (32-53)	21-55	19	48 (22-102)	3-149	10	21 (10-74)	3-246	28	23 (6-55)	2-81	59	8 (6-14)	1-140

Eligibility determined and planning meeting

Days between eligibility determined by NDIS and the date of planning meeting decreased from 2018 onwards (table 4). Although this time frame has decreased, it remains lengthy as participants wait a median of 24 days (IQR=14-35) between becoming eligible for the NDIS and their first planning meeting. Variability and extreme values have also remained consistent throughout all years of data collection.

Table 4 – *Eligibility determined to planning meeting*

	Year of admission														
	2016			2017			2018			2019			2020		
NDIS Time frame	n	Median days (IQR)	Range	n	Median days (IQR)	Range	n	Median days (IQR)	Range	n	Median days (IQR)	Range	n	Median days (IQR)	Range
Eligibility to planning meeting	5	35 (10-34)	22-82	25	35 (16-59)	1-142	8	35 (25-68)	21-90	45	28 (20-40)	7-440	49	24 (14-35)	1-202

NDIS plan approval and discharge

Days between planning meetings and plan approval decreased from a median of 29 days (IQR=12-103) in 2016 to 15 days (IQR=5-33) in 2020 (table 5). Similarly, days between plan approval and discharge decreased over time to a median of 35 days (10-86) in 2020. Despite a decrease over time, variability and extreme scores were consistent throughout all years of data collection for both time frames, with some patients remaining in hospital for more than a year post plan approval in 2020 (table 5).

Table 5 – NDIS plan approval and discharge

	Year of admission														
	2016			2017			2018			2019			2020		
NDIS Time frame	n	Median days (IQR)	Range	n	Median days (IQR)	Range	n	Median days (IQR)	Range	n	Median days (IQR)	Range	n	Median days (IQR)	Range
Planning meeting and plan approval	4	29 (12-103)	6-128	12	22 (14-43)	6-158	14	29 (9-36)	0-89	33	14 (5-40)	0-177	46	15 (5-33)	1-123
Plan approval and discharge	4	120 (53-586)	41-731	15	91 (32-218)	14-535	14	83 (19-202)	2-526	33	58 (27-94)	2-187	36	35 (10-86)	3-447

Overall hospital discharge trajectory

Figures 3 and 4 present the median days for individual time frames along the hospital discharge trajectory for each year of data collection. Although individual time frames and the overall length of stay have decreased over time, some 2020 time frames remain lengthy, such as admission to ARF submission (m=48, IQR=31-72), eligibility to planning meeting (m=24, IQR=14-35), and plan approval to discharge (m=35, IQR=10-86). Figures 3 and 4 represent the median for each time frame throughout all years of data collection. Figures 5 and 6 depict the range and variability for days between eligibility being determined to planning meetings being held, and plan approval to discharge. As seen, there is significant variability in these time frames such that in 2020 there remained some people waiting months for a plan approval, and months to more than a year between their plan being approved and finally leaving hospital.

Figure 3 – *Hospital discharge trajectory 2016 and 2017*

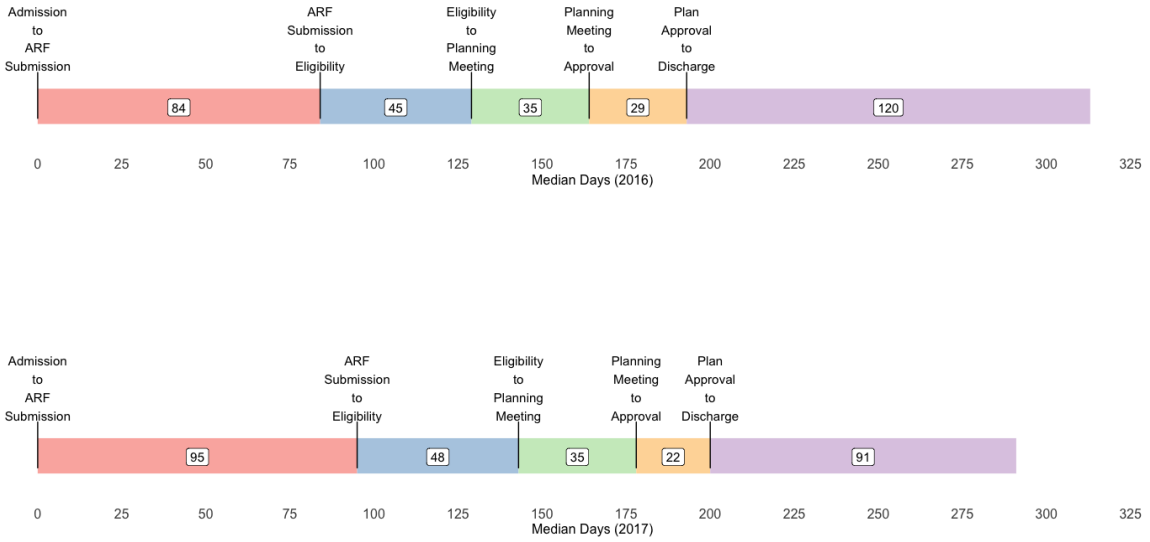


Figure 4 – Hospital discharge trajectory 2018, 2019 and 2020

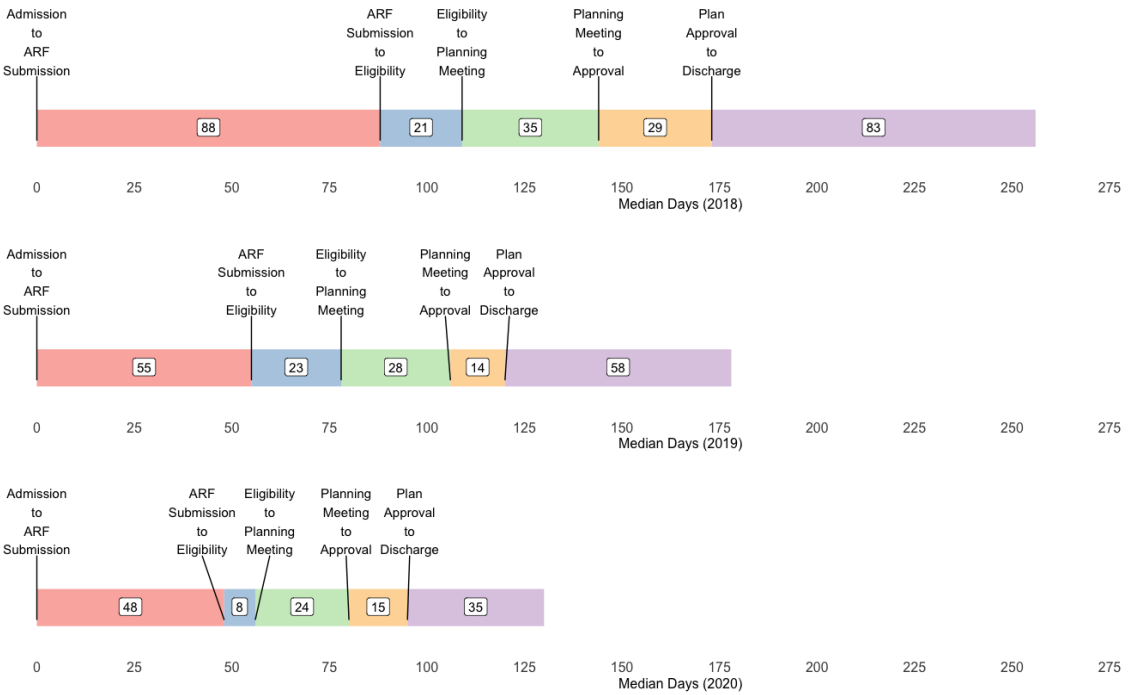


Figure 5 – Eligibility to planning meeting

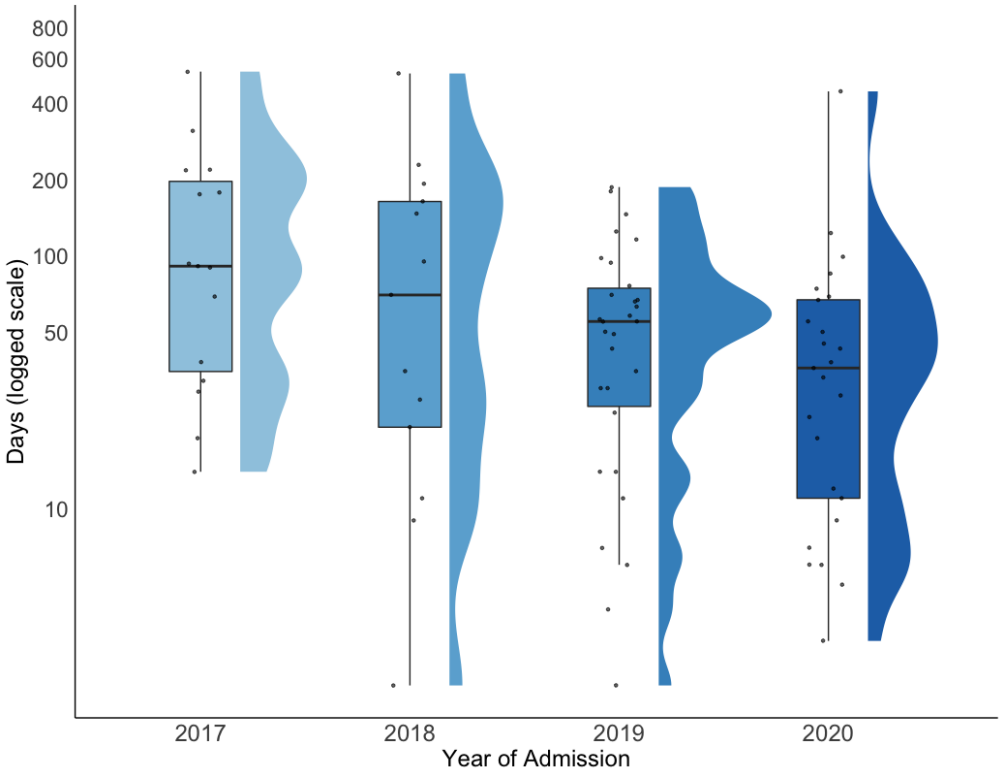
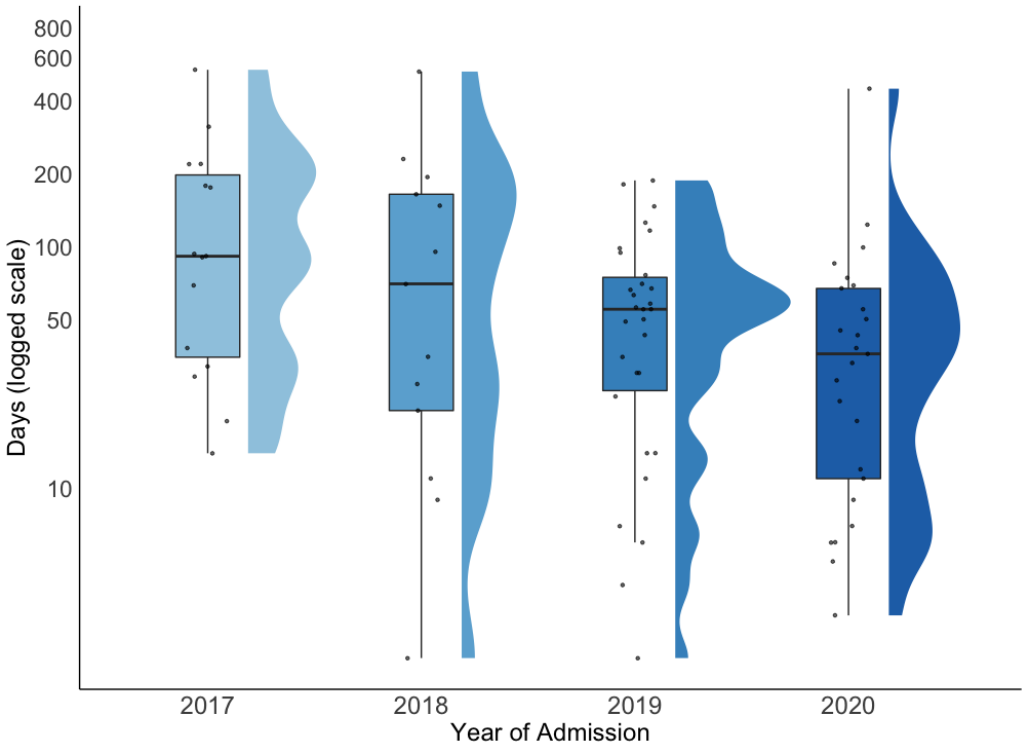


Figure 6 – Plan approval to date of discharge

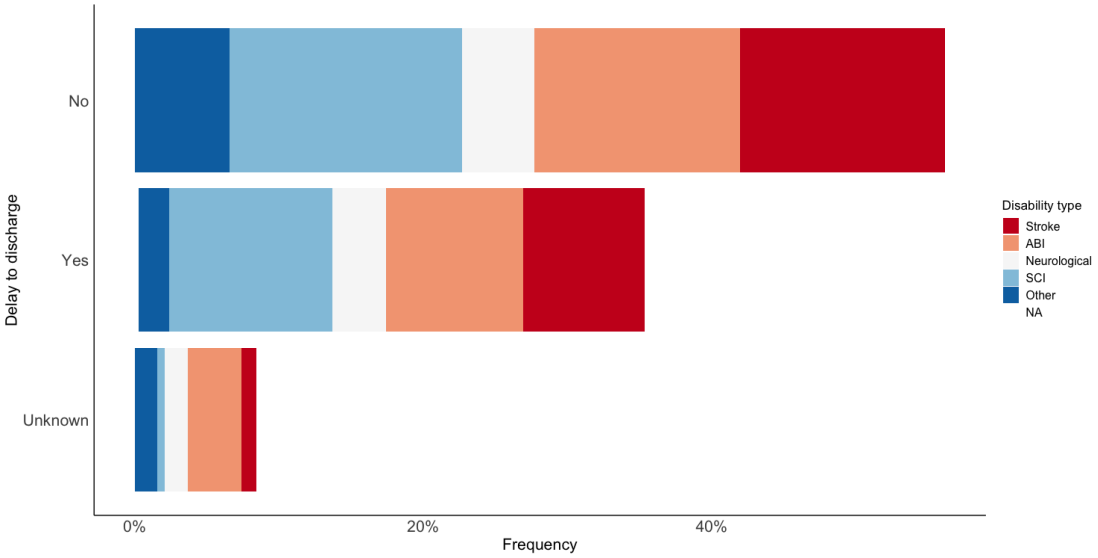


Discharge delays

Prevalence of discharge delays

More than a third (34.5%, n=134) of all patients experienced a delay to discharge. Discharge delays were most frequently experienced by patients with SCI (32.1%, n=43), ABI (26.9%, n=36) and stroke (23.9%, n=32). Figure 7 depicts the frequency of discharge delays and is colour coded to demonstrate how much each disability type was represented in this delay data.

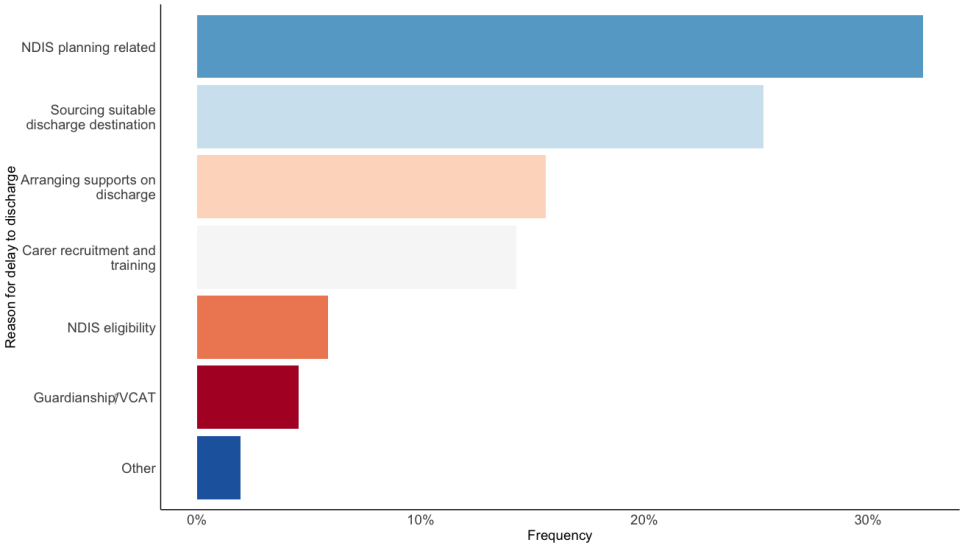
Figure 7 – Prevalence of discharge delays



Reason for discharge delays

The most common reasons for discharge delays were NDIS planning related delays (33%), sourcing a suitable discharge destination (25%), and arranging supports on discharge (16%; figure 8).

Figure 8 – Reason for discharge delays



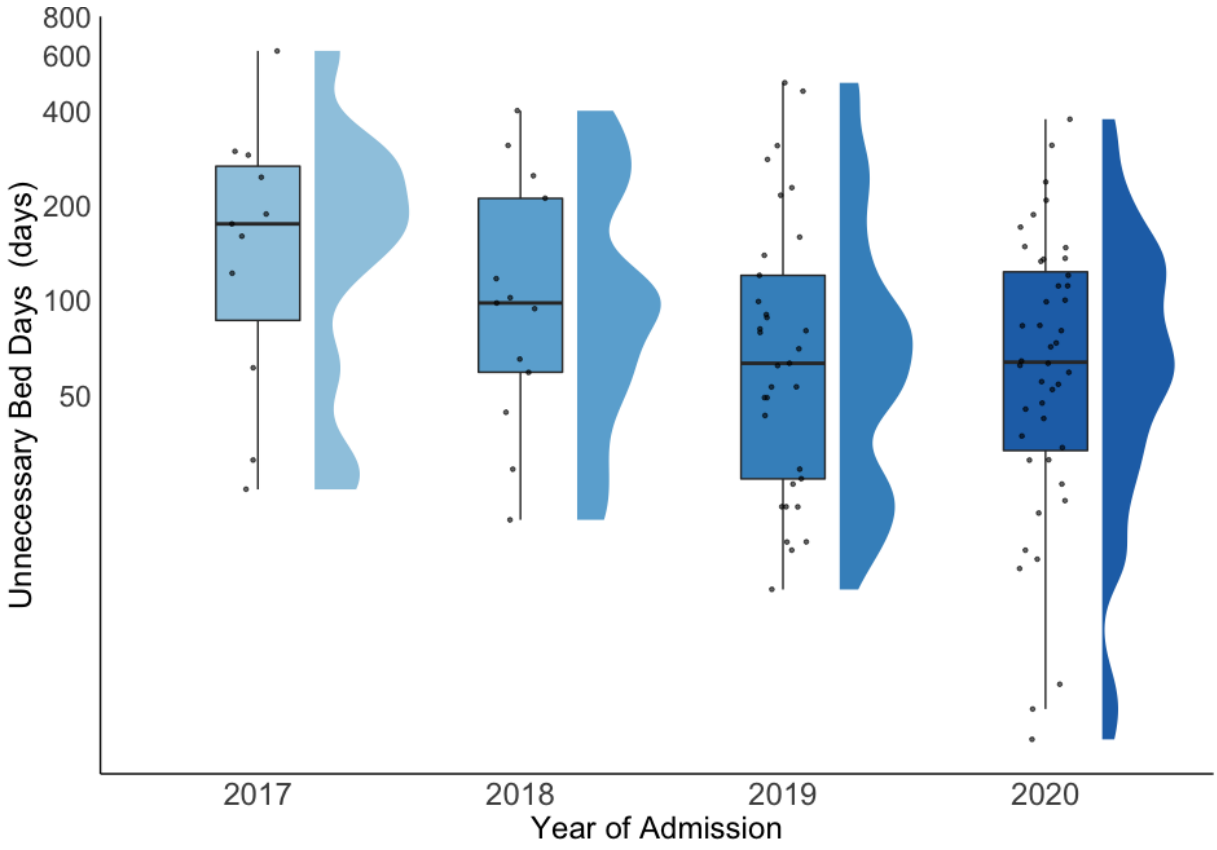
Days between being clinically ready for discharge and actual discharge (unnecessary bed days)

Unnecessary bed days were calculated from the date the patient was clinically ready for discharge to the date of actual discharge. Although there was a decrease in median unnecessary bed days over time, some patients spent months to more than a year in hospital beyond the time that they medically needed to be an inpatient (table 5). Figure 9 presents the variability and distribution of unnecessary bed days split by year of admission.

Table 5 – Unnecessary bed days

	Year of admission														
	2016			2017			2018			2019			2020		
NDIS Time frame	n	Median days (IQR)	Range	n	Median days (IQR)	Range	n	Median days (IQR)	Range	n	Median days (IQR)	Range	n	Median days (IQR)	Range
Unnecessary bed days	7	93 (47-113)	27-436	11	175 (61-290)	250-622	13	98 (52-230)	20-401	33	63 (27-130)	12-492	44	64 (32-130)	4-377

Figure 9 – Unnecessary bed days

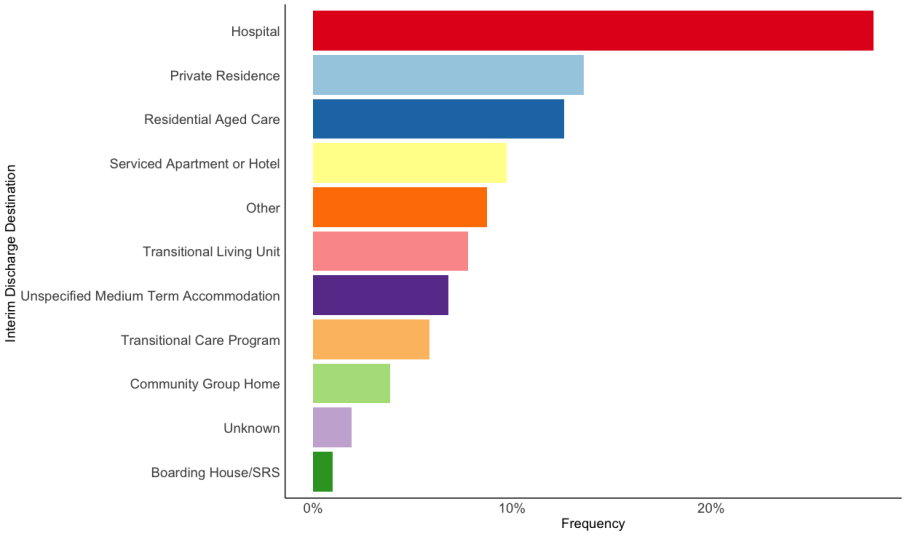


Discharge destination

Interim discharge destinations

Interim discharge destinations were defined as temporary housing for patients who could not go directly to their final discharge destination from hospital. The frequency of discharges to interim destinations is presented in Figure 10, which shows 26% (n=102) of all patients were discharged to interim discharge destinations. Of those who went to RAC, 54% (n=7) had experienced a stroke; 23% (n=3) had an SCI; and 23% (n=3) had a neurological disability. All patients discharged to a Transitional Living Unit had a brain injury (100%, n=8). More than half of discharges to Medium-Term Accommodation (MTA) were for people with SCI (59%; n=10).

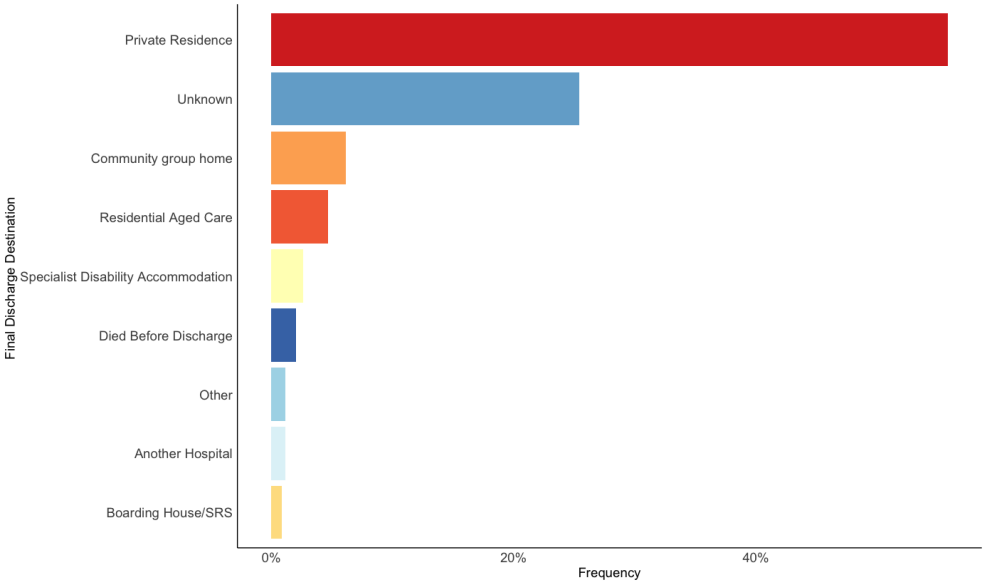
Figure 10 – Interim discharge destination



Final discharge destinations

Final discharge destinations were defined as a long-term housing or living arrangement a patient was discharged to following hospital admission. As seen in Figure 11, more than half of all patients (56%) were discharged to private residences, and more patients went to RAC (5%) than SDA (3%). Of those discharged to RAC; 38% had ABI; 25% had stroke; and 13% had SCI, neurological disability, and other disability respectively.

Figure 11 – Final discharge destination



Summary

Over time, there has been substantial variability in the hospital length of stay, unnecessary time spent in hospital and the NDIS and health milestones. Despite an overall improvement in these variables, it is evident that there are components of the hospital discharge trajectory that require attention to improve discharge outcomes and support people to leave hospital when they are clinically ready to do so. Early identification of patients who are likely to be eligible for the NDIS, and submission of an ARF early in the hospitalisation will likely result in enhanced capacity to complete planning in a timelier fashion. The main barriers to hospital discharge are NDIS planning issues and sourcing adequate housing and disability supports. This interface is complex, requiring costly specialist support to navigate. There is a need for NDIS funding decisions to be made quickly, with some flexibility to enable people with disability and complex needs to leave hospital faster, and in a way that reduces the likelihood of discharge to inappropriate housing such as RAC.

Conclusion

Although hospital length of stay for NDIS participants is decreasing over time, the HDT data presents opportunities to reduce admissions further and prevent discharge delays. Early engagement with the identification of NDIS participants and the submission of ARF forms, combined with timelier NDIS funding decisions, and increased availability of NDIS housing and supports, would likely decrease hospital length of stays, prevent discharge delays and disrupt pathways to RAC for younger people with disability.

Study 2: Clinicians' perspectives of arranging NDIS supports

A survey was completed with members of the Summer Foundation Leaving Hospital Well Community of Practice. The Community of Practice (COP) is an online platform designed to facilitate communication and knowledge sharing amongst clinicians involved in hospital discharge for NDIS participants. The aim of the survey was to explore clinician's experiences of arranging support for NDIS participants throughout their transition from hospital to the community. A total of 89 clinicians participated in the survey: 84% worked in the hospital setting and almost half of all respondents were allied health professionals (49%). The role of survey respondents are presented in Table 6.

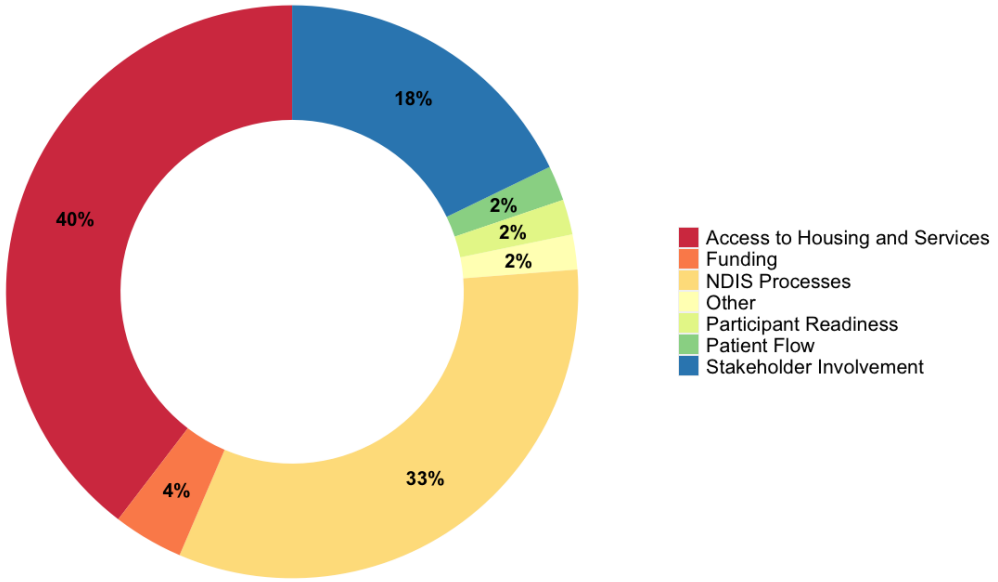
Table 6 – Role of survey respondents (N=89)

Respondent role	*n* (%)
Project or policy work	13 (14.6)
Allied health clinician	44 (49.4)
Occupational therapist	22 (50)
Social worker	15 (34.1)
Psychologist	1 (2.3)
Clinical lead	4 (18.2)
Physiotherapist	2 (4.5)
Manager or Director	9 (10.1)
Disability liaison officer	13 (14.6)
Support coordinator	2 (2.2)
Housing coordinator/officer	4 (4.5)
Community engagement officer	2 (2.2)
ACAS	1 (1.1)
Unknown	1 (1.1)

Findings

Survey respondents were asked to describe challenges faced when supporting NDIS participants to access housing and supports. A total of 169 challenges were identified by 84 survey respondents. Following thematic analysis, seven main challenges emerged: access to housing and supports, NDIS processes, stakeholder involvement, funding, patient flow, participant readiness, and other (covid restrictions, consent, and general time constraints; Figure 12). The findings presented below describe the 3 most frequently reported challenges: access to housing and services, NDIS processes and stakeholder involvement.

Figure 12 – Challenges supporting NDIS participants to access housing and supports



Access to housing and services

Survey respondents reported difficulties with housing and support providers as the most frequently experienced challenges accessing housing and services for NDIS participants.

Housing

Of survey respondents who experienced challenges accessing housing and services, 71% reported difficulties in securing housing for NDIS participants. Challenges associated with arranging housing supports frequently resulted in delayed discharges and prolonged admissions for NDIS participants in hospital. Challenges associated with lengthy delays in NDIS decisions regarding housing were frequently described (see section below on NDIS Processes). Survey respondents reported a thin and competitive housing market, with available housing often not meeting the accessibility requirements of NDIS participants. Interim and long-term housing options in the preferred location of the NDIS participant were also rarely available. More specifically, securing housing in rural areas was a particular challenge due to severely limited options. Group homes were often the only housing option available for people with an urgent need for accessible housing.

Support providers

Difficulties securing support providers was the second most frequently reported challenge when supporting NDIS participants to access housing and services. In the hospital setting, survey respondents reported that finding and engaging with providers in a timely manner was challenging. Finding appropriate providers in a timely fashion is particularly important in the hospital setting due to pressures to free up hospital beds and prevent prolonged admissions. Survey respondents reported that potential service providers often lacked specialised knowledge about people with disability and complex needs, and/or were restricted in their capacity to provide support due to staffing constraints. For example, when arranging disability housing, survey respondents reported difficulties in securing adequately qualified providers with experience in supporting people with complex support needs. Again, those in rural areas reported difficulty sourcing suitably located service providers, including providers in remote areas with cultural links to communities.

NDIS processes

NDIS processes were identified by 33% of survey respondents as a challenge when accessing housing and supports for NDIS participants. NDIS decisions and approvals, and evidence and eligibility were reported as the most frequent challenges encountered with NDIS processes.

NDIS decisions and approvals

Survey respondents reported that NDIS decisions and approvals, including the time waiting for NDIS plans and plan review approvals, impacted their ability to support NDIS participants to secure housing and supports. Housing-related outcomes, such as outcomes of Home and Living Supports Request Forms, were reported to often involve extended and unpredictable waiting periods. One survey respondent reported that appealing Home and Living decisions further contributed to existing delays. Survey respondents speculated that extensive delays associated with Home and Living outcomes were related to the tightening of funding for housing and support by the NDIA.

Evidence and eligibility

Acquiring evidence to secure funding for necessary supports was challenging for many survey respondents. Having the correct evidence and providing the level of detail required to meet NDIS criteria to secure funding was difficult and time consuming. For example, arranging for an Occupational therapist (OT) to complete a housing assessment for an SDA report was reported as a tedious process, as it involves identifying an appropriate OT, completing an SDA assessment, developing the report, and submitting to the NDIA. Moreover, survey respondents highlighted how NDIS processes did not align with the flexibility required by NDIS participants as they transitioned from hospital to the community. Hospital-based clinicians reported that the NDIS had unrealistic expectations in their ability to accurately predict the long-term support needs of NDIS participants, given that participant support needs were likely to change once living in the community. The requirement to secure a long-term housing option prior to being able to obtain funding for Medium Term Accommodation was considered unnecessary, and typically resulted in prolonged hospital admissions.

Stakeholder involvement

Collaboration and communication between stakeholders and knowledge of stakeholders were identified by respondents to challenge the efficient organisation of supports.

Collaboration and communication

Navigating multiple interfaces between health, NDIS and community-based providers, was a challenge for survey respondents. Although survey respondents reported that they aimed to foster productive and collaborative relationships between health and disability services, relationships between stakeholders could be fraught, thus impacting the quality of support provided to NDIS participants. A lack of willingness for collaboration between the NDIA and health was identified as a challenge. Communicating with external support providers was identified as complex, particularly when developing detailed care plans and evidence to justify supports required.

Knowledge of stakeholders

The knowledge of participating stakeholders was identified as a challenge for survey respondents. One respondent reported that acute and sub-acute staff members lacked knowledge of NDIS processes. Conversely, another respondent reported inconsistencies in the knowledge of support coordinators, particularly in relation to housing, available supports and an understanding of hospital pressures and demands. Hospital-based clinicians reported having to compensate for the lack of knowledge of support coordinators, resulting in an unnecessary increase in their workload. Other survey respondents reported a need for more opportunities for all clinicians to increase their knowledge of housing for NDIS participants.

Summary

Clinicians working with NDIS participants in the context of hospital discharge reported experiencing multiple challenges when arranging housing and supports. Initial phases of discharge planning involved navigating time-consuming NDIS processes to access funding for supports. Time frames associated with NDIS outcomes such as eligibility, plan approval and Home and Living Request forms were unpredictable and lengthy. Further, clinicians were often required to submit evidence predicting the long-term support needs of NDIS participants, despite uncertainty regarding peoples' recovery potential. Once the required funding was obtained to purchase supports, clinicians faced thin housing markets, a lack of specialised community-based supports and limited staffing availability across service providers. This frequently resulted in a lack of choice for the NDIS participant with regards to their housing and support arrangements. Concurrently, as clinicians arranged the roll out of supports, challenges occurred at the interface between health, NDIS, housing, and community service providers, due to significant variability in stakeholder knowledge and a lack of collaboration between providers.

Conclusion

Clinicians have identified a continuum of factors that individually and collectively prolong hospital admissions and increase the likelihood of discharge delays. The findings of this survey highlight a need for increased specialised housing and support providers. Currently, the NDIS market is not meeting the needs of people with disability, thus affecting their ability to choose to live in preferred locations with specific support arrangements. Moreover, existing processes to gain funding to purchase supports do not align with the needs of people with complex support needs at the point of hospital discharge. Timely access to funding to purchase short-term supports would likely expedite hospital discharge and decrease the workload of clinicians involved, ultimately reducing hospital length of stays.

Study 3: Housing Brokerage Service

The Housing Brokerage Service (HBS) was developed to address the increasing bed-pressure caused by the COVID-19 pandemic by facilitating the discharge of people with disability stuck in hospital due to a housing barrier. The HBS was delivered through a secondary consultancy approach wherein HBS coordinators provided guidance and developed the capacity of the support team of people with disability stuck in hospital. The HBS provided 3 primary interventions including the identification of the housing needs and preferences of the person with disability, the provision of feedback and advice on written evidence for submission to the NDIS, and the completion of an intensive and innovative search for potential interim and long-term housing options. The data below were collected as routine clinical and quality assurance measures for 199 people with disability referred to the HBS. Due to variation in availability and quality of data from each site and referral, there is variation in sample sizes for each variable.

Length of stay and barriers to discharge

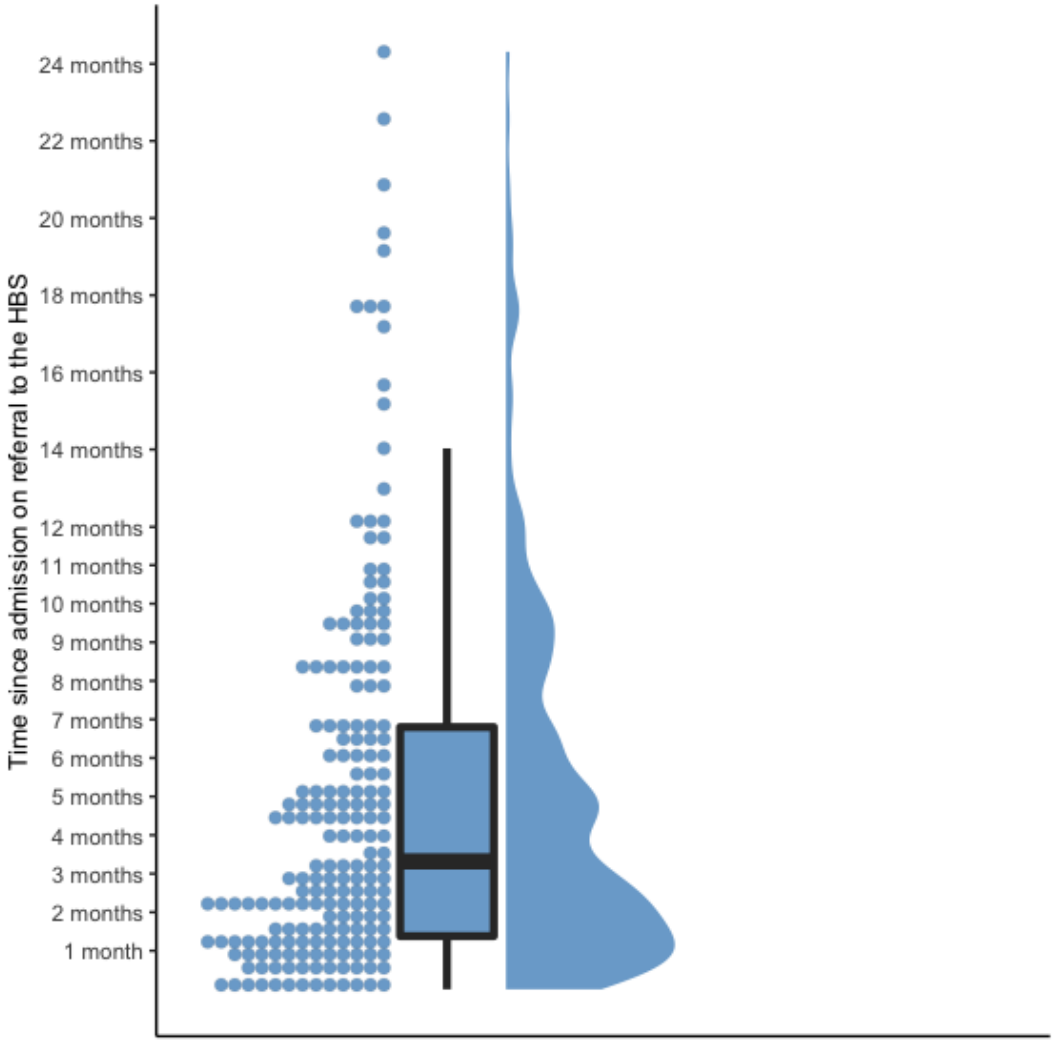
Length of stay on referral

The most frequent primary disability types experienced by NDIS participants referred to the HBS were ABI (29%), psychosocial disability (25%), degenerative neurological disease (11%) and intellectual disability (10%). Table 7 summarises time spent in hospital prior to referral to HBS for each disability type. On median, participants with a psychosocial disability had the longest hospital length of stay prior to referral followed by those with “other neurological condition” and chromosomal syndrome (Table 7). Figure 13 depicts the time spent in hospital before referral to HBS for participants who had spent up to 3 years in hospital. As can be seen, the majority of participants had been in hospital between 1 and 6 months prior to HBS referral; however, a cohort of participants had much longer admissions of up to 22 months.

Table 7 – Length of stay on referral to HBS

Primary disability	Days since admission to HBS referral			
	N	Mean (*SD*)	Median	Range
ABI	58	162 (132)	136	2 to 635
Amputation	4	39 (11)	38	27 to 52
Autism	6	54 (75)	22	3 to 197
Cerebral Palsy	4	63 (92)	22	7 to 200
Chromosomal syndrome	3	146 (141)	149	4 to 285
Degenerative neurological disease	22	99 (124)	62	0 to 537
Developmental disability	20	104 (90)	74	7 to 328
Other neurological condition	7	214 (191)	151	6 to 462
Other physical disability	12	157 (167)	100	18 to 597
Psychosocial disability	50	444 (747)	184	7 to 3781
SCI	8	144 (101)	130	14 to 288
Total	199	212 (410)	107	0 to 3781

Figure 13 – Length of stay on referral to HBS



Note. Five long-term inpatients with hospital stays ranging from 3 to 10 years were excluded to improve visual clarity. All excluded patients had a diagnosed psychosocial primary disability.

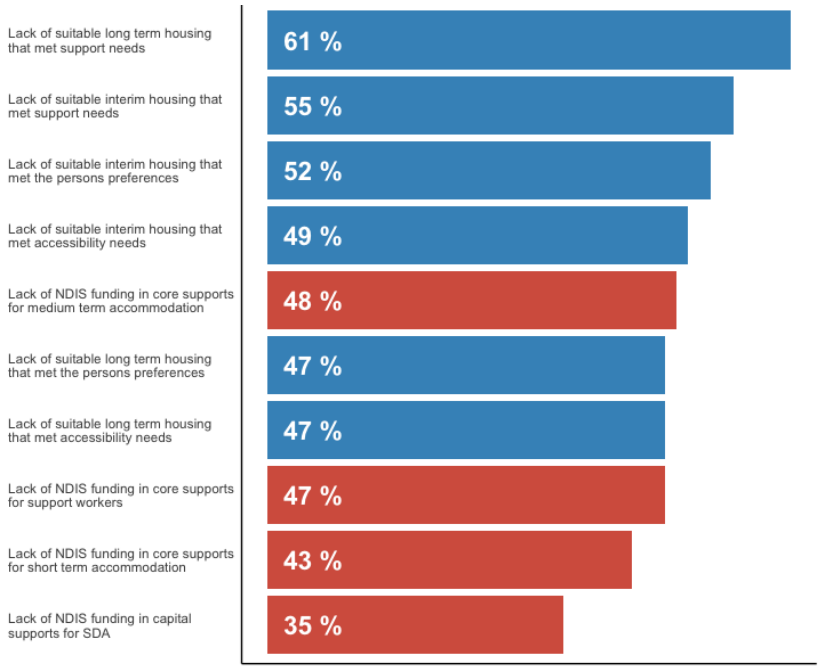
Barriers to discharge

Barriers to discharge are routinely collected as part of HBS service delivery. Table 8 presents the prevalence of barriers to discharge reported upon referral to HBS, with the most common barrier related to difficulties sourcing housing and lack of available NDIS funds to allow for safe and effective discharge. Please note that many participants experienced multiple barriers to discharge, hence the percentages add up to over 100%. Figure 14 provides a visual representation of the top 10 barriers to discharge. Barriers related to housing supply are coloured blue and barriers related to NDIS funding are coloured red.

Table 8 – Barriers to discharge on referral to HBS

Barrier to Discharge	Count	%
Lack of suitable long-term housing that met support needs	46	61 %
Lack of suitable interim housing that met support needs	41	55 %
Lack of suitable interim housing that met the person's preferences	39	52 %
Lack of suitable interim housing that met accessibility needs	37	49 %
Lack of NDIS funding in core supports for medium term accommodation	36	48 %
Lack of NDIS funding in core supports for support workers	35	47 %
Lack of suitable long-term housing that met accessibility needs	35	47 %
Lack of suitable long-term housing that met the person's preferences	35	47 %
Lack of NDIS funding in core supports for short term accommodation	32	43 %
Lack of NDIS funding in capital supports for SDA	26	35 %
Insufficient informal support	25	33 %
Lack of NDIS funding in capital supports for home mods	22	29 %
Lack of NDIS funding in capital supports for equipment	21	28 %
Lack of NDIS funding in capacity building supports for therapy	19	25 %
Lack of NDIS funding in capacity building supports for support coordination	18	24 %
Delayed support worker recruitment (formal supports)	14	19 %
Informal supports needing training	12	16 %
Formal supports needing training	11	15 %
Waiting for equipment to be sourced or delivered	11	15 %

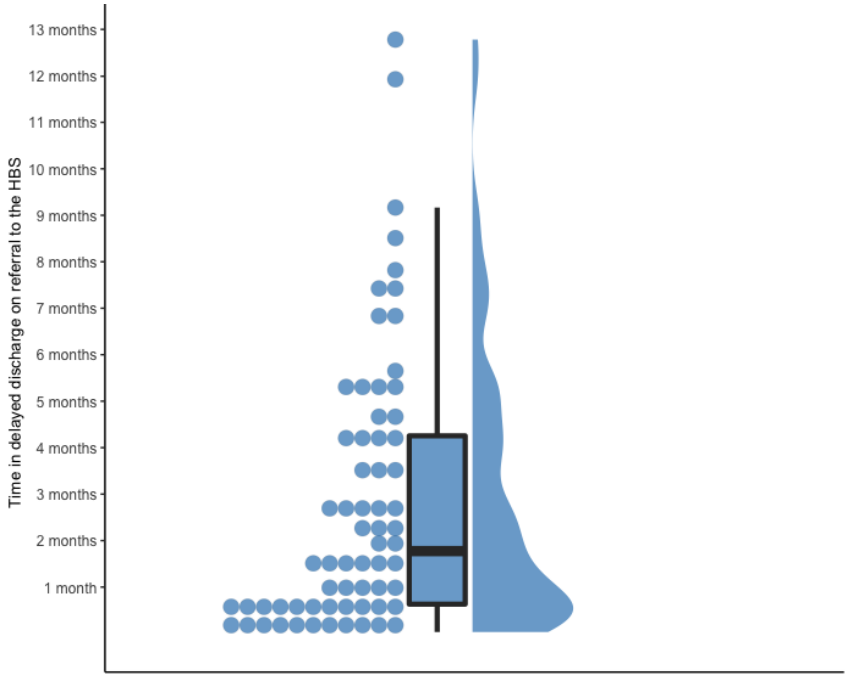
Figure 14 – Barriers to discharge



Unnecessary time spent in hospital (unnecessary bed days)

Figure 15 illustrates the time spent unnecessarily in hospital where this information has been able to be recorded (n = 67). Unnecessary time spent in hospital is defined as days between the date the patient was clinically ready for discharge to the date of actual discharge. Each point represents one NDIS participant, and their location in the figure represents how long they spent in hospital despite being clinically ready for discharge. For many people with disability, this was between 1-3 months; however, there was substantial variation with some people spending months (up to 2 years) unnecessarily in hospital.

Figure 15 – Unnecessary days in hospital



Note. For visual clarity 1 person who has been medically ready for discharge for 2 years has been excluded from the graph.

Summary

HBS service data has highlighted that securing accessible housing that meets support needs and aligns with the participant's housing preferences is a significant challenge for participants stuck in hospital with housing barriers, particularly those with complex support needs. NDIS participants often faced delays and difficulties in securing funding for housing; funding approval to purchase home modifications, equipment, support, and therapies; and funding packages for disability supports necessary to facilitate a successful transition from hospital to the community. Participants often required interim options while awaiting long-term housing options to become available, however due to limited short and medium-term accommodation funding, participants were forced to remain in hospital, unnecessarily extending their admissions and using hospital resources.

Conclusion

To reduce lengthy hospital admissions for NDIS participants, there is a need for quick and responsive funding decisions and availability of housing that meets the reasonable and necessary needs and preferences for people with disability and complex needs. Funding should be provided quickly and flexibly to support the timely discharge back into the community rather than taking many months, leaving people with disability spending unnecessary time in hospital which, aside from the social costs, places pressure on already stretched health systems.

Report summary

The combined findings of these studies highlight the complexities in navigating the interface between hospitals, NDIS and housing sectors. The hospital discharge trajectory for NDIS participants comprises multiple milestones that must be completed in a linear fashion to obtain necessary supports and discharge with appropriate housing and supports. Unfortunately, this means that a delay in the achievement of 1 milestone will likely impact the entire discharge trajectory. At hospital admission, the time taken to identify NDIS participants and submit the ARF remains lengthy throughout all years of data collection. Given that NDIS planning was highlighted as the most frequent reason for delays to discharge, the delayed identification of eligible participants and ARF submission likely exacerbates existing pressures to arrange supports and quickly discharge participants from hospital. Early submission of NDIS applications and early assessment of housing needs and preferences represent opportunities for hospitals to improve hospital discharge trajectories. Such findings have been previously reported in published literature (Housten et al., 2020).

The 3 studies identified NDIS planning processes (i.e., providing sufficient and timely access to funding for housing and supports) as a key driver to lengthy and unnecessary hospital delays. NDIS approvals and determinations following the submission of evidence or appeals were characterised by delays. Decisions relating to housing outcomes such as Home and Living Request Forms were reported to be particularly lengthy and unpredictable. The outcome of such extended waiting periods ultimately resulted in clinicians being unable to arrange timely discharge supports, and NDIS participants having to remain in hospital without established discharge plans. Both timeframes have the potential to impact the overall length of stay and contribute to unnecessary days in hospital, yet also present as tangible opportunities to increase efficiencies and reduce hospital length of stay for NDIS participants. Ultimately, even where hospitals have efficient processes for their side of the hospital discharge trajectory, delays from the NDIA result in prolonged hospital admissions.

The findings of this report also highlight that current NDIS processes and methods of funding allocation do not align with the needs of NDIS participants at hospital discharge, contributing to delayed discharges. Although support needs are typically subject to change throughout the transition from hospital to the community, clinicians reported having to submit evidence for long term supports for participants in hospital. Consequently, producing quality evidence with the input of specialist stakeholders to obtain long-term supports was described as a time consuming and challenging process that did not always lead to obtaining the funding required for discharge supports. One contributor to this was the absence of clear guidelines on what quality evidence looks like from the perspective of the NDIA. Similarly, HBS referrers reported challenges in securing funding for interim supports such as STA and MTA, even if a long-term housing option had been identified. To expedite hospital discharge and prevent lengthy admissions, a more flexible and responsive approach should be considered in the allocation of funding to purchase discharge supports.

All 3 studies identified challenges in accessing and securing supports in a timely manner. A thin NDIS housing market with a lack of appropriate housing options was frequently reported in all studies. Not only were there limited numbers of available housing options, but houses were often inaccessible or did not meet the preferences of NDIS participants, as participants were often forced to consider moving to areas away from their family, friends and communities due to the lack of suitable housing. Not only did limited housing options impact NDIS participants' ability to choose where they lived, but they also complicated discharge planning for clinicians, due to the intensive searches required to identify and secure appropriate housing. Moreover, arranging supports on discharge further contributed to discharge delays. Specialised and appropriately experienced support providers were challenging to find, and there was often limited staffing availability amongst service providers. Clinicians also reported experiencing difficulties in arranging supports in a manner that facilitated a timely hospital discharge.

Implications

It is evident from the findings of these 3 studies that the interface between health, NDIS and housing for people with disability and complex needs is characterised by delays at various milestones that have serious implications for those stuck in hospital with insufficient funding for housing and supports. Lengthy hospitalisations place people at risk of further health complications and poor quality of life, as well as having broader financial and patient flow implications for hospitals. Previously, RAC was an efficient but unsatisfactory option for quick hospital discharges (Barry et al., 2019; Oliver et al., 2020); however, the YIPRAC strategy asserts that hospitals should no longer be discharging individuals under 65 to RAC. In order to solve the problem of young people with disability remaining in hospital for months to years after being clinically ready for discharge, the following is necessary:

1. Hospitals should implement early alert systems for people who are either NDIS participants or likely to be eligible for NDIS. This would allow an early Access Request Form to be submitted, and for early assessment of likely housing needs and preferences to be undertaken. Early NDIS access and assessment of needs and preferences may facilitate more timely housing searches and implementation of required supports when the person becomes medically ready for discharge.
2. NDIA should provide timely and flexible funding for people with disability and complex needs who are in hospital. Currently, people requiring permanent housing in a RAC facility can have funding and support decisions made within 3 days; however, the funding and support decisions for people under 65 with disability can take weeks to months. Further, there is little guidance or feedback on funding decisions that have been made, meaning that appeals and plan reviews add to these delays. Faster and more transparent funding decisions would allow timelier purchasing of equipment and home modifications needed for discharge, earlier housing searches if new housing is needed and the ability to recruit and train support workers needed to leave hospital once medically ready for discharge.
3. NDIA personnel (e.g., planners, local area coordinators) supporting people with disability and complex needs who are in hospital require a working knowledge of the specific needs and preferences of this cohort. For example, people with acquired brain injury who are stuck in hospital often have co-morbid psychosocial disability and behaviours of concern. People with neurodegenerative disorders will likely have fluctuating needs over time, requiring flexible and responsive funding decisions from the NDIA to proactively plan for changing needs as well as prevent re-hospitalisation and admission to RAC as the disease progresses. A flexible and responsive system with dedicated staff with expertise would likely reduce hospital discharge delays and result in more effective hospital discharges.

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