Hospital exit block

A symptom of a sick health system

2023

AMA

CLEAR THE HOSPITAL LOGJAM

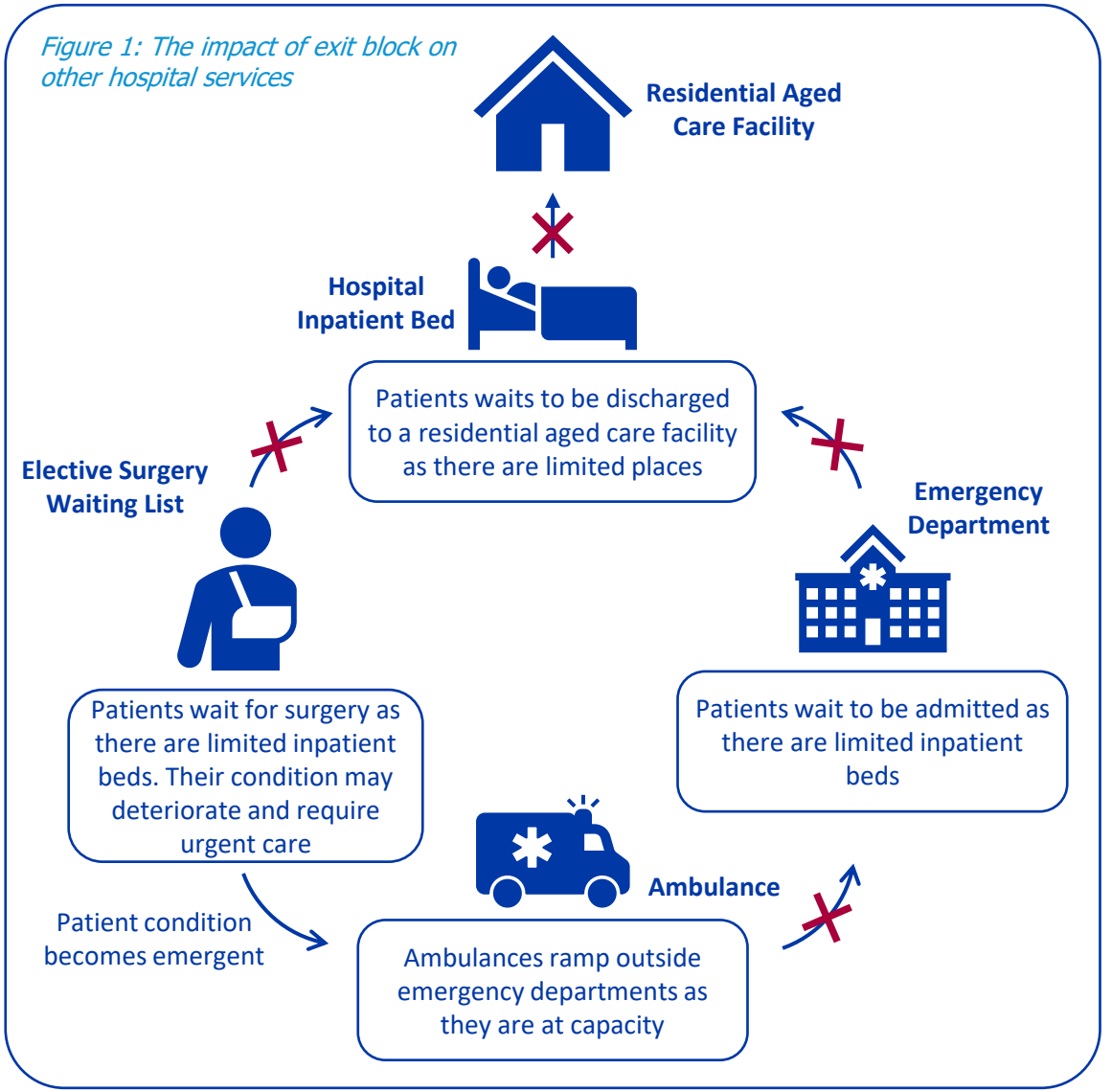
OVERVIEW

'Exit block' is a term commonly used to describe the situation when patients receiving hospital inpatient care are medically able to be discharged but have no safe destination. The most common reasons for this are that people's care needs have changed during their hospital admission, and they are now waiting for appropriate aged care (such as a place in a residential aged care facility or a home care package at the right level), or for disability care (often related to National Disability Insurance Scheme (NDIS) funding).

Exit block is a symptom of a healthcare system that is struggling to meet community demand for health and social services, however it has a significant impact on hospital logjams. Exit block means there are less beds for inpatient services, which ultimately results in increased waiting times for ambulance services, emergency department services, and essential elective surgeries (Figure 1).

> *Exit block has become a big problem. Patients requiring transition to a nursing home or to appropriate disability accommodation, when previously they had lived at home, are staying much longer in an acute hospital setting than is medically necessary. This results in bed block, which then clogs up wards like orthopaedics, general medicine, rehab beds, the stroke unit… which leads to delays in patients being admitted from the ED and the associated inherent dangers in that.*
>
> *— AMA Member*

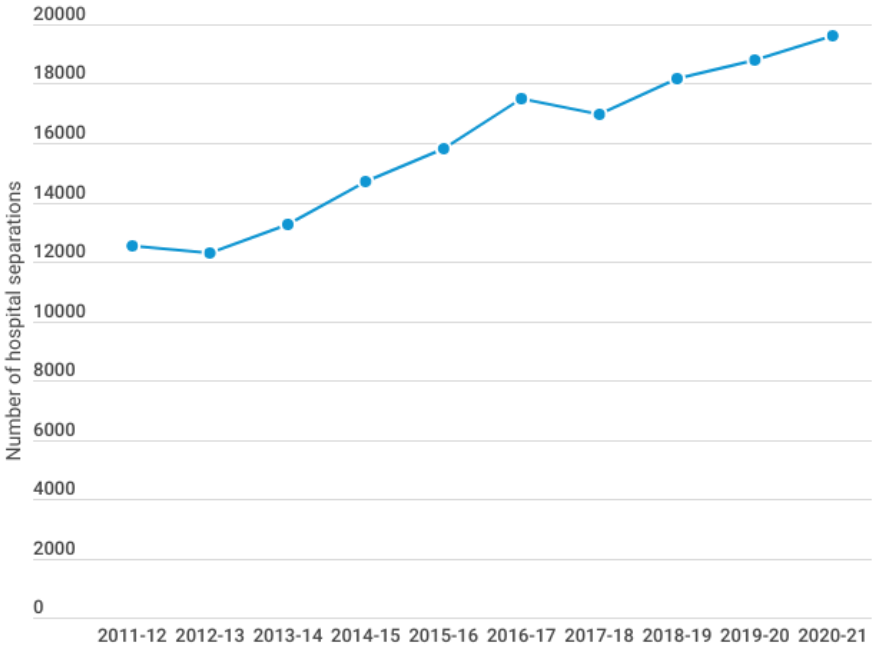
Figure 1: The impact of exit block on other hospital services



COST OF WAITING FOR AGED CARE SERVICES

In 2020–21, **19,631 public hospital separations[i] were attributed to patients waiting for aged care services nationally** (either a place in a residential aged care facility or an appropriate home care service).[1] Of these patients, around one in 10 waited more than 35 days. The number of separations, and therefore the number of patients waiting for aged care services, has been overall increasing since 2011–12 (depicted in Figure 2).

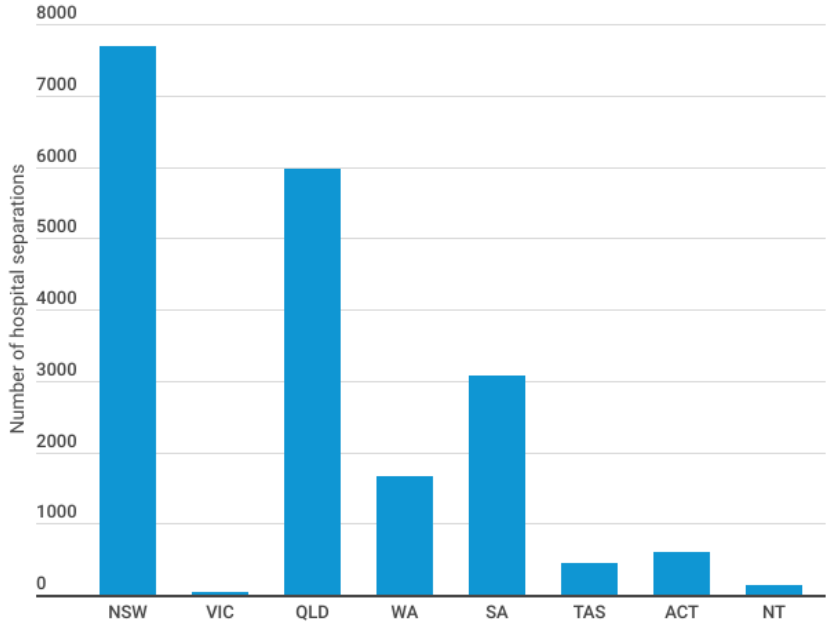
Figure 2: Public hospital separations attributed to patients waiting for aged care services (residential and home care), 2011–12 to 2020–21 [2]



[i]A hospital separation is the record of cessation of treatment and/or care and/or accommodation of a patient.

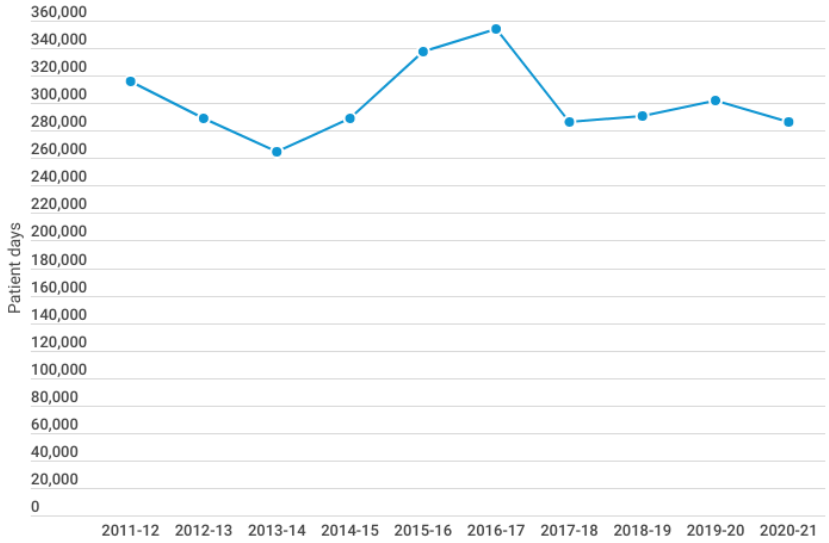
Figure 3 depicts the number of public hospital separations attributed to patients waiting for aged care services in 2020–21 for each state and territory, with New South Wales and Queensland having the highest number of hospital separations. *Note: Victoria has developed alternative care pathways for people waiting for residential aged care outside of the acute hospital system, and this is not captured in the data.*

Figure 3: Public hospital separations attributed to patients waiting for aged care services (residential aged care and home care services) for each state and territory, 2020–21 [3]



In 2020–21, **286,050 patient days**[ii] were attributed to patients waiting for a place in a residential aged care facility nationally.[4] Depicted in Figure 4, the number of patient days attributed to patients waiting for a place in a residential aged care facility reached a peak in 2016–17 before dropping in 2017–18. The number of patient days does not include the number of people waiting for an appropriate home care package, however it is understood that some patients will wait more than 12 months to receive their package.[5] It is estimated that these patients waiting for residential aged care services cost the health system **between $316.7 million and $847.6 million** in 2020–21 alone.[6]

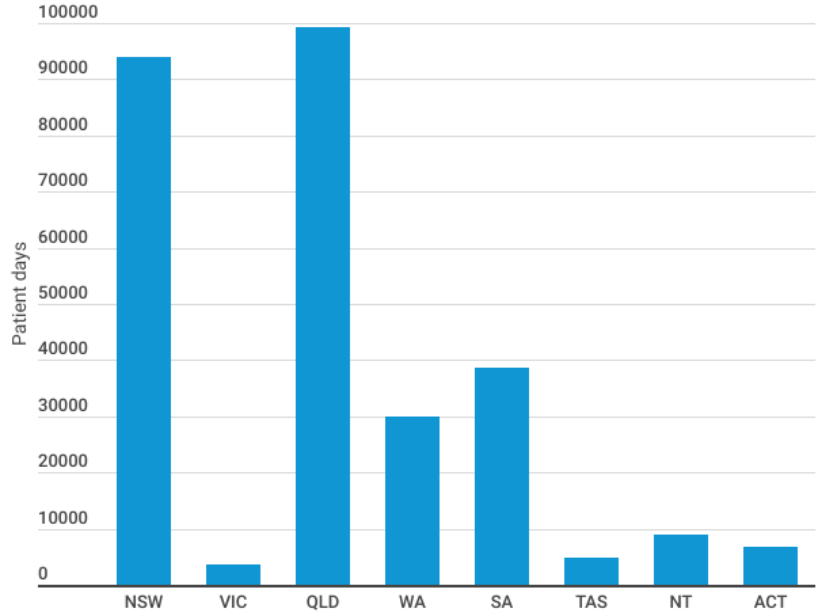
Figure 4: Patient days attributed to patients waiting for residential aged care nationally, 2017–18 to 2020–21 [7]



[ii]Patient days are the total number of days for all patients who were admitted for an episode of care and who separated during a specified reference period.

The number of patients days attributed to patients waiting for residential aged care is concerning, as there is significant variability between the states and territories. Figure 5 depicts the number of patient days attributed to patients waiting for residential aged care in 2020–21, with Queensland having the highest number of patients waiting for aged care services in hospital, and Victoria having the lowest number (as outlined previously, Victoria has developed alternative care pathways for people waiting for residential aged care outside of the acute hospital system which may explain this low number of patient days).[8]

Figure 5: Patient days attributed to patients waiting for residential aged care for each state and territory, 2020–21 [9]



COST OF WAITING FOR DISABILITY CARE

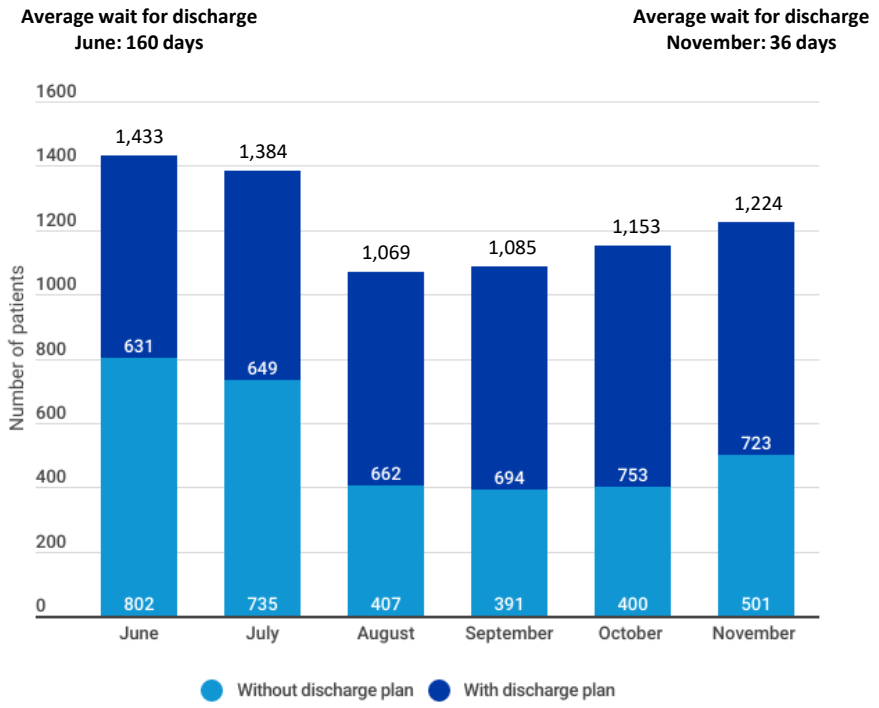
In June 2022, the Minister for the NDIS announced a new agreement with state and territory governments to improve the hospital discharge process for NDIS-eligible patients. The operational plan includes:

- increasing the number of dedicated hospital discharge staff supporting each state and territory, with 52 Hospital Liaison Officers (HLOs) and 54 hospital discharge planners
- the development of transition plans to support NDIS-eligible patients transition from hospital to long-term accommodation
- increasing the delegation of those staff and streamlining processes to facilitate quicker decision-making
- a commitment from the National Disability Insurance Agency (NDIA) to contact every NDIS participant (or their authorised representative or nominee) within four days of being notified of their admission
- a commitment from the NDIA that an NDIS discharge plan will be approved within 30 days
- enhanced data collection and reporting to measure progress against these commitments and identify reasons for any delay.[10]

While there is currently no regular publicly available reporting of the number of NDIS-eligible patients waiting for disability services through the NDIS, data sourced from the NDIA reveals that the operational plan has overall improved discharge planning for NDIS-eligible patients (Figure 6).

Before the operational plan was implemented in June 2022, there were 1,433 NDIS-eligible patients in public hospitals waiting to be discharged, with patients waiting around 160 days — over five months — for appropriate supports to be put in place through the NDIS so they could leave hospital.[11,12] Of these 1,433 patients, 44 per cent had a discharge plan in place.[13] These **1,433 NDIS-eligible patients cost the health system an estimated $253.8 to $679.4 million** in the 160 days they were waiting to be discharged.[14]

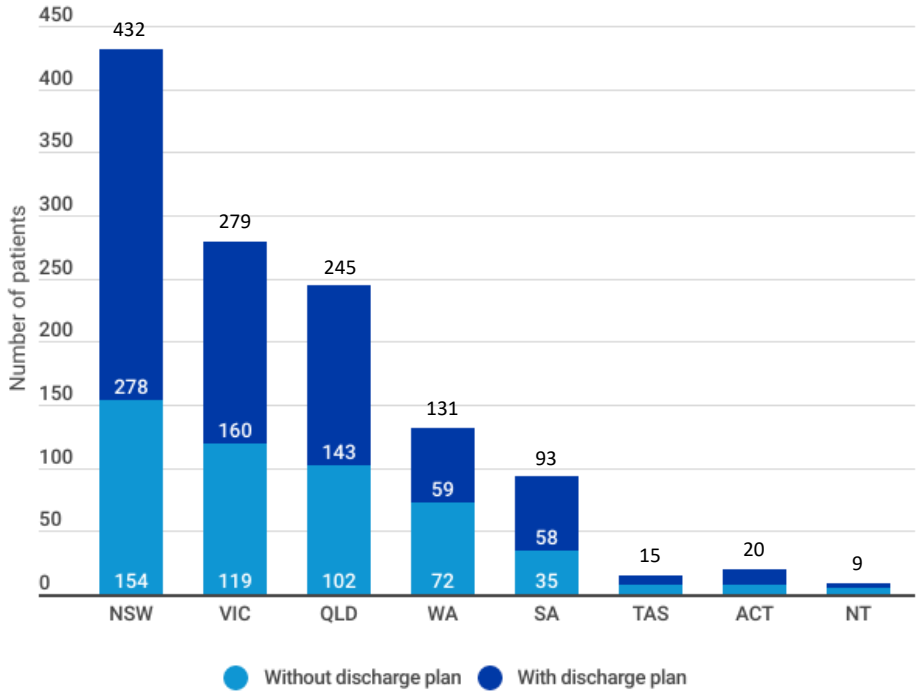
Figure 6: Discharge plan status for NDIS-eligible patients who are medically ready for discharge June – November 2022 [15]



In the latest reporting period (November 2022), there were 1,224 NDIS-eligible patients in public hospitals waiting to be discharged, with patients now waiting only 36 days — just over one month — for appropriate NDIS supports.[16] These 1,224 NDIS-eligible patients cost the health system an estimated $48.8 to $130.6 million in the 36 days they were waiting to be discharged.[17] Of these 1,224 patients, 59 per cent had a discharge plan in place. Depicted in Figure 7, in the latest reporting period (November 2022), New South Wales had the highest number of NDIS-eligible patients who were medically ready for discharge, whereas the Northern Territory had the lowest number.

By reducing the number of days NDIS-eligible patients are waiting to be discharged, the **operational plan has resulted in an estimated saving of $205.0 to $548.8 million since it was implemented**.[18] Assuming the operational plan continues to be effective at reducing the number of days an NDIS-eligible patient waits for discharge (i.e. no days waiting for discharge), the **health system would have saved an estimated $495.0 million to $1.32 billion annually**.[19]

Figure 7: NDIS-eligible patients who are medically ready for discharge with a discharge plan in progress or complete by state and territory, November 2022 [20]



SOLUTION TO EXIT BLOCK

Public hospitals cannot afford to keep operating at this level of exit block, particularly as our public hospitals already have limited capacity and are struggling to meet demand. The Commonwealth and state and territory governments need to work together to refine the current arrangements around transitioning people out of inpatient wards into appropriate care.

A new hospital agreement

The current funding model for our health system is not fit for purpose. It's only focused on the number of procedures that hospitals provide and does not adequately account for the fact that Australia's population is growing, ageing, and developing more complex health needs. It also doesn't fund hospitals to keep people out of hospital through preventative and community care. The AMA's four point plan for hospital reform proposes targeted reforms to stem the crisis in public hospitals, funded through new partnership between the Commonwealth and state and territory governments:

1. Improve performance
Reintroduce funding specifically for performance improvement, with the goal of at least reversing the decline in public hospital performance.

2. Expand capacity
Fund extra beds and staff in a partnership between the Commonwealth and states and territories so that hospitals have a chance of ending ambulance ramping, meeting community demand and improving treatment times.

3. Address demand
Fund more out-of-hospital care, so that people whose needs can be better met in the community, can be treated outside hospital. Programs that work with general practitioners throughout design and implementation to address avoidable admissions and readmissions should be prioritised.

4. Increase funding and remove funding cap
An increase in the Commonwealth's contribution to 50 per cent for activity, with state and territory governments required to reinvest the 5 per cent of 'freed-up' funds on improving performance and capacity. Eliminate the artificial 6.5 per cent cap on growth, so funding can meet community demand for hospital services. Moving to 50-50 funding and removing the 6.5 per cent cap would represent investment of $20.5 billion over four years between 2022-23 and 2025-26.[21]

Invest in primary healthcare

Explored further in the AMA's report *Putting health care back into aged care*, residential aged care facilities often fail to provide an adequate level of clinical care for older people, resulting in residents being frequently taken to hospital. During this time, both the government and resident continue to pay for the place in the aged care facility. By adequately investing in aged care and improving clinical care in nursing homes, the Commonwealth government could remove some of the burden from the public hospital system while making substantial savings. The AMA estimates that $4.4 billion could be saved every year in potentially preventable hospitalisations from older people in the community and in residential aged care facilities by investing in better primary care.[22]

Improve data on exit block to support targeted initiatives

As outlined in the AMA's submission on data and information needs in aged care, there are issues with data transparency and availability at both a national and state and territory level that make it difficult to properly understand the scale of exit block. This was also a finding and recommendation in the Aged Care Royal Commission Final Report.[23] There is also currently no publicly available information on the number of NDIS-eligible patients waiting for appropriate NDIS supports.

To properly address exit block, regular data on the number of patients waiting for aged care services or disability care will need to be gathered and made available. Additionally, there needs to be improved use of the My Health Record and interoperability between other systems (such as My Aged Care) to improve care coordination. This will require the Commonwealth and state and territory governments to collaborate as hospitals are managed by state and territory governments whereas most disability and aged care services are managed by the Commonwealth government.

Implement national solutions that address exit block

Reporting of data on patients waiting in hospital for aged care services and disability care will enable governments to implement targeted solutions that address exit block at a national level. The NDIS operational plan, including the increased number of dedicated hospital discharge staff with increased delegation, is an example of a solution that improves the discharge process for NDIS-eligible patients. There is an opportunity for this type of program to be expanded to include aged care patients.

Programs that support discharge should be implemented alongside out-of-hospital initiatives that provide patients with transition care, temporary supports or accommodation while they wait for appropriate aged care services or disability care. While a national program exists that provides patients with transition care for older Australians waiting for aged care services (the Transition Care Programme), there are limited programs that support transition for NDIS-eligible patients. One model that has reported success is the Western Australian pilot program "From Hospital 2 Home" that provides NDIS-eligible patients with transition accommodation and services while longer term arrangements are made through their NDIS Plans. Victoria also has a similar program *Pathways to Home* which provides NDIS-eligible patients transition care while they wait for disability services.

Initiatives that provide sub-acute and rehabilitation care, out-of-hospital care (in particular mental health and palliative care), as well as support transition to social housing, should also be investigated. Additionally, ensuring that there are enough aged care and NDIS services available is key to addressing exit block.

It is evident that the current approach to addressing hospital exit block is piecemeal and fragmented. As exit block is a national issue, there is an opportunity for governments to work together and expand existing successful programs so there is a national approach to addressing exit block that includes patients waiting for aged care, disability, and social services. **The analysis performed in this report reveals that targeted programs that address exit block could save an estimated $811.6 million to $2.17 billion a year.**

In designing programs to address hospital exit block, effort should be made to co-design these programs with hospitals to ensure they meet the needs of care providers and the patient. Programs should explore how existing infrastructure can be modified to meet the out-of-hospital needs of patients, and ensure new infrastructure meets appropriate standards. Mechanisms to ensure assessment and approval processes are efficient and effective should also be implemented, including appropriate accountability mechanisms, performance indicators, and continuous monitoring and evaluation.

Keep aged care assessments within the public system

Under the current aged care reforms, there is a plan outlined by the Commonwealth Government to privatise aged care assessments. An older person would still be in public hospital, but instead of the assessment being done by the hospital team that is already there, they would have to wait for an external team of assessors to perform the assessment. There is real fear among the medical profession that privatised aged care assessments will result in exclusion of medical specialists from the assessments, resulting in further fragmentation of care for older people. Additionally, the external assessors would need be provided access to the patient and potentially their clinical data, which is not readily available to those outside the hospital.

Ultimately, this change would be to the detriment of the public hospitals and patients, and would likely result in increased and prolonged hospital stays for older people. It has been the AMA's ongoing position that the aged care assessment service for older people with complex health and aged care needs must remain with state and territory health services.

REFERENCES

[1] Australian Government Productivity Commission (2023). *Report on Government Services 2023: Chapter 14 aged care services.* Retrieved 24/01/2023 from: https://www.pc.gov.au/ongoing/report-on-government-services/2023/community-services/aged-care-services

[2] Australian Government Productivity Commission (2023). *Report on Government Services 2023: Chapter 14 aged care services.* Retrieved 24/01/2023 from: https://www.pc.gov.au/ongoing/report-on-government-services/2023/community-services/aged-care-services

[3] Australian Government Productivity Commission (2023). *Report on Government Services 2023: Chapter 14 aged care services.* Retrieved 24/01/2023 from: https://www.pc.gov.au/ongoing/report-on-government-services/2023/community-services/aged-care-services

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[5] DPS Publishing (2021). *Aged Care Guide: Options while waiting for a home care package.* Retrieved 21/10/2022 from: https://www.agedcareguide.com.au/information/options-while-waiting-for-a-home-care-package

[6] The cost of a hospital bed per day for a patient waiting for aged care or disability care services is challenging to estimate, as the cost depends on a variety of factors (such as location, the patient and their care requirements etc.).

The most reliable national data on the cost of a hospital bed per day for patients waiting for aged care or disability services was the Independent Hospital and Aged Care Pricing Authority (IHACPA) National Hospital Cost Data Collection (NHCDC) Public Hospitals Report – Round 24 (financial year 2019–20).

Under the Australian National Subacute and Non-Acute Patient Classification, the category "non-acute care" (also referred to as "maintenance care") was used as an indicator for patients waiting for aged care or disability services, as it relates to care which the *"…primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition. Following assessment or treatment the patient does not require further complex assessment or stabilisation. Patients with a care type of maintenance care often require care over an indefinite period."*

There are several classes for admitted non-acute patients, and the costs of each of these classes vary depending on length of stay, frailty, and age. The National Hospital Cost Data Collection reports an "average length of stay" and "average cost per separation" for each class of maintenance care, which were used to estimate a per day hospital bed cost range of $1,107-$2,963. While this is only an indicative per day hospital bed cost, this range is consistent with other studies, including:

- Western Australia Office of the Auditor General's 2022 report *Management of Long Stay Patients in Public Hospitals* which estimated the average cost of a hospital bed in Western Australia at $2,370 per day
- Palliative Care Australia and KPMG's report *Investing to save* which estimated the average cost of a hospital bed at $1,286 per day

Independent Hospital and Aged Care Pricing Authority (2021). *Australian National Subacute and Non-Acute Patient Classification Version 5.0.* Retrieved 20/21/2022 from: https://www.ihacpa.gov.au/resources/australian-national-subacute-and-non-acute-patient-classification-version-50

The range for the average cost of a hospital bed per day was then multiplied by the number of patient days (302,150).

Australian Government Productivity Commission (2022). *Report on Government Services 2022: Chapter 14 aged care services.* Retrieved 29/10/2022 from: https://www.pc.gov.au/ongoing/report-on-government-services/2022/community-services/aged-care-services

[7] Australian Government Productivity Commission (2023). *Report on Government Services 2023: Chapter 14 aged care services.* Retrieved 24/01/2023 from: https://www.pc.gov.au/ongoing/report-on-government-services/2023/community-services/aged-care-services

[8] Australian Government Australian Institute of Health and Welfare (2022). *National Healthcare Agreement: PI 27–Number of hospital patient days used by those eligible and waiting for residential aged care, 2022.* Retrieved 23/12/2022 from: https://meteor.aihw.gov.au/content/740822

[9] Australian Government Productivity Commission (2023). *Report on Government Services 2023: Chapter 14 aged care services.* Retrieved 24/01/2023 from: https://www.pc.gov.au/ongoing/report-on-government-services/2023/community-services/aged-care-services

[10] National Disability Insurance Agency (2022, September 15). *Faster hospital discharge for NDIS participants.* Retrieved 06/01/2022 from: https://www.ndis.gov.au/print/pdf/node/8190

[11] Data sourced from the NDIA.

[12] Prior to October 2022, the NDIA did not receive data on the average number of days between notification that a NDIS-eligible patient is medically ready for discharge and the actual date of discharge. The average figure of 160 days is being used by NDIA as a baseline, based on a survey of 21 hospitals in Victoria.

National Disability Insurance Agency (2022, December 21). *NDIS legacy appeal cases slashed.* Retrieved 04/01/2022 from: https://www.ndis.gov.au/news/8559-ndis-legacy-appeal-cases-slashed

The Sydney Morning Herald (2022, May 19). *Disabled Victorians forced to wait in hospital beds due to NDIS delays.* Retrieved 04/01/2022 from: https://www.smh.com.au/national/disabled-victorians-forced-to-wait-in-hospital-beds-due-to-ndis-delays-20220519-p5amlv.html

The NDIA has since sourced this data for October and November 2022.

[13] Data sourced from the NDIA.

[14] The range for the average cost of a hospital bed per day (see reference 6 for details on calculation) was multiplied by the number of NDIS-eligible patients waiting in June 2022 (1,433) and the average number of days these patients waited to be discharged (160, see reference 12).

[15] Data sourced from the NDIA.

Note: See reference 12 for details on average wait for discharge.

[16] Data sourced from the NDIA.

[17] The range for the average cost of a hospital bed per day (see reference 6 for details on calculation) was multiplied by the number of NDIS-eligible patients waiting in November 2022 (1,224) and the average number of days these patients waited to be discharged (36, see reference 12).

[18] Estimated saving is the difference between the June 2022 estimate for the 1,433 NDIS-eligible patients waiting an average of 160 days ($253.8 to $679.4 million) and the November 2022 estimate for the 1,224 NDIS-eligible participants waiting 36 days ($48.8 to $130.6 million).

[19] Estimated annual saving was calculated by taking an average of the number of NDIS-eligible patients medically ready for discharge between June and November 2022 (1,225) and multiplying this by the range for the average cost of a hospital bed per day (see reference 6 for details on calculation), multiplied by 365 to determine an annual figure.

[20] Data sourced from the NDIA.

[21] Australian Medical Association (2022). *AMA Pre-Budget Submission 2022-23.* Retrieved 31/10/2022 from: https://www.ama.com.au/articles/ama-pre-budget-submission-2022-23

[22] Australian Medical Association (2021). *Putting health care back into aged care.* Retrieved 31/10/2022 from: https://www.ama.com.au/articles/report-putting-health-care-back-aged-care-0

[23] Royal Commission into Aged Care Quality and Safety (2021). *Final Report: Care, Dignity and Respect.* Retrieved 31/10/2022 from: https://agedcare.royalcommission.gov.au/publications/final-report

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