CROSS SECTOR DISCHARGE PLANNERS FORUM SUMMARY

JULY 2017

PREVENTING YOUNG PEOPLE UNDER 65 YEARS OF AGE ENTERING RESIDENTIAL AGED CARE

SUMMER FOUNDATION

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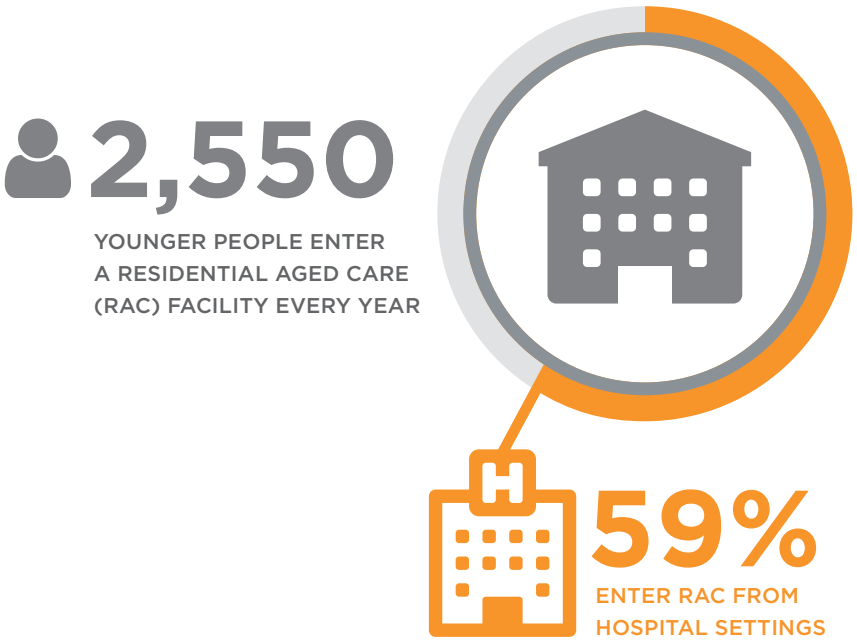
BACKGROUND



More than 2,550 Australians with disability, under 65 years of age, enter a residential aged care (RAC) facility every year (AIHW 2016 data). As a result, more than 6,200 younger Australians are currently living in nursing homes. Living in RAC is not an ordinary life for many people with disability and often results in social isolation, loneliness and boredom.

The majority of younger people enter RAC from hospital settings following a change in their health/disability status. Most (59%) of younger people are admitted to an acute or rehabilitation hospital before their first admission to RAC, with most younger people in aged care having an acquired brain injury (58%) or a late onset degenerative neurological disability such as multiple sclerosis (14%) and Huntington's disease (9%).

Leaving hospital and moving back into the community is a complex transition. For young people with complex disability, this requires a proactive, high quality discharge planning process, without which, people either remain stuck in hospital beds or are at risk of entering aged care. The challenge for the health system is evident, with the development of the National Disability Insurance Scheme (NDIS) offering a possible solution. However, although the NDIS brings a significant opportunity, it is also another complex system to navigate, along with health, aged care and housing.

Improving the pathway from hospital to the community is key to reducing the number of younger Australians in RAC. The Summer Foundation, in partnership with other leading organisations, has identified that collaboration between the NDIS and health is one of the more essential relationships required to ensure this pathway is efficient, timely and well planned. Currently most practitioners and representatives in the health, community, advocacy, housing, disability and aged care sector believe that much more work needs to be done in this area in order to prevent younger people from entering the aged care system.

THE FORUMS

The Summer Foundation, in partnership with other organisations, brought together practioners and representatives supporting young people under the age of 65 making the transition from hospital to home. This included representatives from health (acute care, allied health, rehabilitation), community, advocacy, housing, aged care, disability, National Disability Insurance Scheme (NDIS) and government.

A total of 220 participants took part in half-day forums, held in five NDIS trial sites: North East Metropolitan Melbourne (NEMA), Barwon Region in Victoria, Perth, Hunter Region in NSW, and the ACT. The evidence collated indicates diversity in the way state and territory health systems have worked with local NDIA teams through the trial period. This is particularly noticeable with higher levels of cooperation across sectors in smaller jurisdictions, where the need for an "all hands" approach has been necessary to achieve improved outcomes for those with complex support needs. This continues to be evident in the national rollout of the Scheme.

Participants shared experiences of discharge planning with young people with disability and complex needs. In particular, they reflected on what happens for young people and their families navigating their way through the health and NDIS systems as they seek access to the information, support, services and living situations they want and need.

Involvement from a number of sectors ensured that a range of perspectives were included in the discussion and are reflected in the ideas generated. The results of the forums, and the cooperative exchange they fostered, will inform and support collaborative work across health, NDIS and community systems to:

- Ensure a clear and unobstructed alternative path for young people leaving hospital in these circumstances
- Minimise the chances of young people being admitted to RAC
- Maximise young people's access to the support that's necessary for them to continue their lives beyond hospital care
- Advocate and take action, as a multi-sector collaboration, to establish housing alternatives centred on the wishes and needs of young people with disability and complex needs.

There are strengths in the current system. These are:

- A common recognition of the importance of getting discharge planning right for young people with disability and complex needs
- A willingness across the sector to discuss what's not working and to devise something better
- A shared commitment to working together in the interests of young people with disability and complex needs.

This common ground, and associated goodwill, provides firm foundations to build on. It will be of significant benefit in working collaboratively to make improvements that involve a number of sectors and systems. A multi-sector approach was seen by many in the forums as having the potential to ensure that the capacity of the NDIS to facilitate young people to move from hospital, or out of RAC, to home (and remain there) can be realised.

To follow is a summary of what emerged in the forums - a critical assessment of the current situation and some clear directions for change.

CURRENT CHALLENGES

As things stand, there are a number of aspects of discharge planning and practice that are leading to confusing, frustrating, negative or even harmful experiences for young people with disability and complex needs. Some of these are the result of the introduction of a new set of processes under the NDIA, which may be resolved once the Scheme is at full capacity. However there are also some practice problems that will need to be resolved during the "surge" period of the rollout so that they don't become entrenched in the mature Scheme.

Identified challenges, at various levels of service provision and systems, are detailed below.

1. LACK OF COLLABORATION ACROSS SECTORS

The extent to which the systems – health, NDIS, aged care, housing –work together effectively and cooperatively has a significant impact on hospital discharge and support for young people with disability and complex care needs. Issues raised included:

- Young people with high and complex care needs are often required to engage with multiple systems, each subject to conflicting rules, timelines and expectations. Of those systems, the hospital is likely to be the strictest, most pressured of environments.

  "One of the complications is that the timelines for what the hospital would like and the timelines that are possible with the NDIS don't necessarily match up. The hospital and the patient would like to be out as early as possible but there are often considerable delays." **(PARTICIPANT, ACT FORUM)**

- There is a mismatch between discharge turnaround expectations in the health system and time required to set up adequate supports in the disability system.

  "NDIS Plans do take a long time to get through and our preference would be to get someone their housing quite quickly but the reality is it does take months and months." **(PARTICIPANT, ACT FORUM)**

- Reasonable wait times are defined very differently by the health sector and the NDIA. This becomes apparent at various stages of the NDIS process e.g. eligibility confirmation, setting up support services, equipment provision, completion of home modifications.
- Between the sectors, there is some uncertainty about whose responsibility funding of support needs becomes - the health sector or the NDIS, or both. Some of this is now being worked out through appeals to the Administrative Appeals Tribunal of Australia (AATA), but the process can be lengthy and can leave people without access to essential equipment and services while a decision is being made (For an example, please refer to AATA 706; 14 September 2015).
- The creation of appropriate housing is not currently an NDIA or health-related responsibility.

  "Second challenge…housing, which is not really an NDIS responsibility, and yet for the health system, who have to find suitable housing such as a share house and make sure that all the tenants get on with one another…There currently is no central register for people who are willing to share with someone else nor is there an easy system to find housing." **(PARTICIPANT, HUNTER FORUM)**

- Government silos result in a lack of communication between systems and organisations and limit knowledge-sharing.

- Case management systems have been lost in the translation to the NDIS, and the scope of support coordinator roles is often unclear, particularly in addressing clinical essentials, and can be overlooked as a consequence
- While there is a lack of suitable housing options, people living with a range of multiple, chronic, functional and high dependency needs are being referred to ACATs.

Note: Before the NDIS commenced there were a high number of ACAT approvals made for young people to permanent residence RAC facilities. In the second year of the NDIS being trialled in the Barwon region the number of ACAT approvals has decreased, whilst the number of approvals for Transitional Care Programs (TCPs) has increased. This has not resulted in better outcomes for those individuals.

2. COMPLEXITY WITHIN EACH SECTOR

Individual systems that young people and their families need to negotiate can be ineffective or inappropriate in what they provide. How they work together is also critical for effective outcomes.

Health

Processes within hospitals can work against a young person's interests and needs:

- The provision of community based rehabilitation and slow stream rehabilitation for people with complex brain injuries is a gap in the service system, particularly now in Victoria, with the progressive withdrawal of the ABI: Slow to Recover program. Once the acute phase of someone's rehabilitation, has been provided by the health system, the provision of ongoing rehabilitative supports is rarely available in the public system. Meaningful, contextualised and episodic rehabilitation in a person's home and community is now recognised as best practice and the appropriate model for this is thought to be delivered through a combined health and disability framework.
- Communication in hospitals between health professionals and discharge planners can be poor. Often discharge planners are the last to know when a person is being discharged so the application for the NDIS is delayed.
- In an effort to avoid residential aged care placement, young people experience unduly long stays in hospital where their disability support needs are not being addressed.

> *"It doesn't matter if there is a multidisciplinary team or lots of nurses, or that the system does not want to institutionalise the person; the hospital is set up like an institution. A length of stay of a year or more makes a person feel institutionalised and they lose the ability to make decisions. They end up relying on others to make them for them..."* **(PARTICIPANT, ACT FORUM)**

- Communication with the person and their family can also be poor. People have experienced being assessed as medically ready for discharge when they are not ready in any broader sense (supports set up; appropriate home to move to; equipment sourced).
- There can be confusion about various plans, their purpose and what they cover. The NDIS plan and the discharge plan are often not distinguished in the minds of staff and the individual, resulting in NDIA-funded supports not actually being in place at the time of discharge. Similarly, the person may have a plan at discharge and feel that all is in place for them to leave, however services and supports have not been set up to meet their needs

- While young people might benefit from Transition Care Plans, they are mostly only available to people over 65 years of age and for a period of 12 weeks.
- Diversity across states and territories in how the health system works in general and the discharge planning process in particular, needs to be accounted for. Improved cooperation between the NDIA and aged care is essential.

NDIS

Almost all young people in aged care and young people with disability and complex support needs will be eligible for the NDIS. There are, however, inconsistencies in how the NDIS responds to and supports them, and what funded support includes and excludes. The following specific issues were raised:

- There can be poor understanding by the NDIA that people with acquired brain injury have varying levels of recovery in the acute or inpatient setting which can make it difficult to know their functional status at the time of application. NDIS application timelines do not always take account of this and application and planning processes can either be rushed or delayed.
- There have been some reported instances of NDIS "reneging" on decisions about eligibility and provision of specialised equipment.
- NDIS funding is provided without case management or case coordination being automatically included, therefore plans are approved but not implemented, as the person themselves doesn't have capacity to do this.
- NDIS plans vary in their quality and effectiveness due to inconsistency and varied skill levels of NDIA planners. This means having a good plan in place can be more the result of good luck than good management.
- While NDIS funding is not capped and allows for choice and control to address people's needs, the NDIS actuaries do undertake reference packaging to determine what funding might be likely for a particular group. This can work against individual outcomes, particularly for those with complex needs who require a highly customised approach to address a number of concurrent issues, many of which have lifetime implications for support and costs.
- The new era of NDIS hasn't fully "arrived" meaning that we are still in a period of transition which has a real impact on the lives of individuals with disability and complex support needs.
- Inconsistencies in decisions about eligibility may be isolated examples of the variation which occur in the practice of implementing the scheme rather than changes in NDIS policy or directives.
- Currently two NDIS trial sites exist in Western Australia (WA) – one known as the NDIS and the other as WA NDIS (formerly My Way). Both are located in two diverse regions of WA - one regional and the other metropolitan. It is not certain as to which model, or if both, will continue with the full rollout due in July 2017.

Aged Care

There are no age limitations defined within the current aged care act so referrals for young people can and are accepted. However, RAC facilities are not set up for young people, and do not work well for them. Issues include:

- Physical environments in RAC are often unsuitable. Most facilities still have shared rooms for residents, limiting privacy for young people. There is very little space per room, and building stock is often old and not always fit for purpose. Financial imperatives work against creating suitable living environments. To be viable there needs to be 120 beds onsite. Bigger rooms need a bigger site and less beds mean a facility is less financially viable.
- Young people can have large amounts of equipment, which often doesn't fit in the space.
- Daily routines are often driven by rosters and staff efficiency. Despite best intentions, this can limit person-centred support.
- Staff skill mix is not optimal. The majority of staff in RAC are personal care attendants with frequently only one primary registered nurse available at a time, often to oversee more than 100 residents. This means access to medical or nursing or diagnostic expertise for young people is limited or nor non-existent. Early detection and intervention for common secondary health conditions (eg. pressure care, UTIs, chest infections) is therefore essential for this group of people.
- There can be a lack of clarity and knowledge within RAC about the highly specialised equipment needs of some young people.
- There is limited access to clinical assessment, particularly where recovery from traumatic injury or episodes of neurological disease can be intermittent and unexpected.
- The aged care system is also undergoing major reform, which needs to be considered alongside changes to the disability system introduced by the NDIS.

Housing

There continues to be a significant lack of suitable alternative housing for people with high and complex needs in the community, making discharge to RAC more likely. Issues raised include:

- The urgent need to evaluate the suitability of current housing, and determine what new accessible and affordable housing is required.
- There are long wait periods for suitable and appropriate housing.

3. SLOW PROCESSES AND LIMITED STAFF RESOURCES

NDIS application requirements and processes, and the pressures created by competing demands on hospital services can make it difficult to successfully plan and carry out discharge from hospital. Often processes are neither timely nor person-centred, and the outcomes are shaped instead by organisational constraints and requirements. Issues identified included:

- Young people in acute or inpatient settings need to be properly informed and have time to fill in an NDIS application, to have their plan approved, and to arrange support and services including home modifications before being discharged. Pressures on hospital staff to discharge patients, change wards or change staff teams can work against this.
- The process of applying for, planning and setting up support with the NDIS is slow. This can include: the time and labour-intensive job of gathering documentation required on application; waiting for a person's functional status to be declared permanent while in recovery (obstructing necessary planning for the individual, even when the need is clear); lengthy wait times between the various steps in the NDIS process (e.g. confirming eligibility, planning, provision of equipment, home modification, ensuring funded support is successfully in place in the home).
- The time required by various other application and referral processes that need considering, such as applying to a Transitional Care Program (TCP), an Aged Care Assessment Team (ACAT), or to a specific organisation for interim housing. Information requirements vary with each and these take time to meet.

A lack of trained and experienced staff in the workforce can add to these difficulties. There are often not enough support workers and allied health professionals available, particularly in regional areas, and allied health professionals are not available full time, and often have waiting lists. At worst, as raised in the forums, it can be "easier to give up on achieving best outcomes" when the processes, and what a young person wants and needs, seem out of reach. Motivation of staff as well as the young person and family can be eroded by seemingly insurmountable time and resource constraints.

4. LIMITED KNOWLEDGE AND AWARENESS OF ISSUES

There is a lack of knowledge about services for people with complex needs, and how to navigate through service systems. This is the case for all involved: families and carers, hospital directors/executives and manager, doctors (GPs) and staff in aged care facilities, many of whom are not familiar with, or do not have a good understanding of what's available or what the issues are. Limited awareness about the NDIS is common, and includes:

- Mistakenly interpreting the NDIA as a health system. Rather, the NDIA serves to provide funding for necessary and reasonable support for the person to be able to live in the community.
- NDIS connection for young people with disability and complex support needs doesn't necessarily equate to preventing that person's admission into aged care nor does it equate to them leaving aged care.
- Lack of knowledge and access to information about the NDIS, particularly what is included and what is excluded.
- Individuals being incorrectly advised by people in the health system that they have NDIS funded supports when in fact they are not eligible.
- Low awareness in the primary health care sector about the NDIS and who might be eligible, as well as about their role in a young person's path to securing support through the NDIS.

Lack of information, or awareness about how other aspects of the system work has also negatively affected outcomes for young people. This includes:

- Despite being at considerable risk of entering residential aged care (RAC), young people and families often don't have information and guidance about how to assess and choose RAC facilities before they are discharged
- Perhaps due to not recognising the importance of review planning meetings, and what may be at stake, the young person, their carer or their family members may not attend discharge planning meetings. This can lead to goals and expectations not being recognised, translated or met across systems or sectors.

5. YOUNG PEOPLE WITH COGNTIIVE DISABILITY AND COMPLEX SUPPORT NEEDS

The complexity of the experiences and situations of young people with disability and complex support needs, as well as of the service system and funding environments, need to be acknowledged and taken into account in any collaborative work to make improvements. These complexities include:

- Social isolation can lead to a young person's expectations and opportunities being limited. Similarly, lack of motivation to set goals can be the result of long term institutionalisation, in any setting, including long stays in hospital.
- Young people's capacity to make informed decisions regarding services or housing options can be limited due to their cognitive-communicative capacity, requiring considerable work to ensure their decision-making is supported. Levels of competency to make decisions can be difficult to assess, and changes occur during recovery that will alter the young person's decision-making capacity while they are an inpatient.
- Young people with high and complex needs, particularly those with chronic conditions, are not necessarily able to predict their progress or future functioning, while they are awaiting discharge, making an application to the NDIS difficult to complete.
- All the potential sources of funding (NDIA, TAC, aged care, superannuation) that a young person may require have guidelines which must be adhered to and criteria which must be met.
- As one participant put it there are "complexities all round". It is a challenge to balance the complex situations and needs of young people with cognitive disability with the complexities in the health and service systems.

A BETTER APPROACH

How we achieve better outcomes for young people with disability and complex needs leaving hospital is important. Having taken a multi-sector approach to reflecting on the current situation, it's important that collaboration and coordination are at the foundation of our work to make identified improvements.

Discussion at the forums identified a range of ways in which things could be improved. A number of common goals about what needs changing, and what a better approach might look like, emerged. These included ideas about: shared values for collaboration; education and awareness; skills, personnel and key roles; planning and decision making; and resources.

1. EFFECTIVE COLLABORATION, RESPONSIVENESS AND ACCOUNTABILITY ACROSS SECTORS

The NDIS interface with both health and aged care has been poorly developed so far. In practical terms an individual is not concerned which sector is responsible for services and supports that are required to live a good life, but they need to be delivered efficiently and effectively. Entry to the NDIS and effective planning has been achieved for individuals across these two sectors through one-on-one support and strong advocacy. However, this has mostly been achieved through dedicating resources in short term projects that are not sustainable and would require additional resources if they are to be made available across Australia.

Preventing new entries to residential aged care requires information and continuing education at the coal face of discharge planning about alternative options to aged care. Effective liaison roles are needed that can oversee the smooth transition of supports between sub-acute health and the community, with a capacity to resource and inform the NDIS planning process.

A cross-system commitment to preventing young people with high and complex needs from entering RAC was discussed at each forum and included the following points:

- Cross-system commitment to the principles of the NDIS, including the benefit for young people with high and complex needs
- A holistic approach to the management of a person with high and complex needs, that incorporates the person's functional, clinical and community goals and needs
- Cross-government partnerships that can work on changes or foster co-commitment
- Memorandum of Understandings (MOUs) between rehabilitation units and acute hospitals to include the NDIS
- Processes for notifying NDIA about which patients are in the acute or sub-acute system to enable early intervention
- Protocols for clear guidance of external support staff entering hospitals
- Appointment of an inter-agency coordinator for young people with high and complex needs is necessary to build cooperation across health, mental health and disability sectors. Experience indicates this role needs to be funded across all systems, or it is at risk of being lost in future cost-cutting in individual sectors
- Better communication between key stakeholders with clear guidance on which sectors are responsible for funding needed supports and services
- The NDIS doesn't provide all supports, so the health system will still need to provide some supports that the person requires, and the two systems will need to cooperate in the interests of young people seeking support.

2. ACCESS TO DEDICATED ADVOCACY

Young people with complex disability support needs, whether they are in an acute phase after illness or injury, or have required additional supports due to changes in their circumstances, struggle greatly to independently navigate across health, housing, aged care and disability systems. Accessing support through the NDIS currently requires a dedicated person to lead, coordinate, educate and facilitate on their behalf, so that timely and effective outcomes can be achieved, while the individual's skills and capacity are being developed or re-established.

Examples of this type of dedicated advocacy are:

- In ACAS: Staff working to advocate for innovative housing and support options to be made available.
- In health: Discharge teams identifying the people who need more than three hours of support per day in order to link them to the NDIS early on, and to strongly advocate for them to remain in the health system until they can receive adequate supports, aimed at avoiding entry into the residential aged care system.
- In health: Social work is an essential role in achieving positive outcomes for young people with complex needs in hospital by: leading the team in applying for the NDIS as early as possible; supporting and educating families and carers regarding the NDIS and NDIS processes and making informed decisions; facilitating the young person and their family or carer to begin exploring support provider options in preparation for NDIS plan implementation.
- In health: A key liaison or support worker is need in the acute or inpatient setting to coordinate communication, services and supports between systems (discharge planners and NDIA planners), and to clearly understand and explain the roles of each team member.
- Across systems: A key liaison or support person who coordinates services and supports between the health and disability systems or a specialist clinical panel or group (discharge planners and NDIA planners) who clearly understand and outline roles within the multidisciplinary team, timelines in discharge and NDIS processes and what's needed to meet them.
- Across systems: The identification of individuals within each system ("champions") who are able to focus on ensuring best practice and collaboration among all stakeholders.
- Across systems: Have someone who can assume an advocacy role but not necessarily an advocacy organisation, for example a family member or friend. This is particularly crucial in working with the NDIA through application, planning, allocation of funding and setting up of supports. Young people with severe communication impairment or cognitive-communication impairment require support in order to participate in the NDIS process meaningfully. Young people with cognitive –communication impairment and executive impairment can often present with their challenges masked, and can therefore receive less support than they actually require.

3. INCREASE AFFORABLE, ACCESSIBLE AND INNOVATIVE HOUSING

There is clear potential for the NDIA's Specialist Disability Accommodation framework to stimulate the housing market, and create suitable innovative alternatives to RAC. However, the marketplace is still emerging as understanding of that framework develops, and it will be at least a decade before demand can be fully addressed. In the short term the following priorities have been identified:

- The health sector working with the state government department of housing to identify appropriate housing that will be purpose built to get people out of hospital.
- Provision of appropriate housing options in the community, with diversity in range and scale.
- Creation of a "matching service" for housing options and individuals seeking housing.
- Greater collaboration between the disability and housing sectors to ensure current housing meets the demand.

4. TARGETED EDUCATION AND TRAINING FOR HEALTH & AGED CARE PERSONNEL

A better system includes highly skilled, highly motivated and highly engaged people, whose roles cross the varied systems, sectors and settings. While this was an underlying theme at the forums, there were a number of specific points raised about strengthening education and awareness across systems used by young people with disability and complex support needs. Connected to improving education and awareness, forum participants generated ideas about what skills and staffing across sectors would improve the discharge and NDIS application process. These included:

- Targeted education regarding the NDIS process for: service providers, families, general practitioners, aged care services and any relevant stakeholders located outside of the trial sites
- Producing a step-by-step manual about discharge planning and NDIS application
- Training more experienced clinicians in assessments required to determine NDIS eligibility.
- More education and better communication between allied health and medical teams in the hospital for people with complex disability and co-morbidities.
- Set up programs in the acute setting to review the individual's functional improvement over a period of time. If so, they can go onto intensive rehabilitation in the inpatient setting and can have 2-3 opportunities to make improvements before being discharged.
- A multidisciplinary/interdisciplinary rehabilitation team that provides training to service providers before the young person is discharged
- More skilled RAC staff are needed for optimal support provision (particularly primary registered nurses).

5. IMPROVE EFFECTIVE DISCHARGE PLANNING

Ideas were raised about planning and decision-making covered discharge planning processes and NDIS planning; how these work together; the timeliness of planning processes; and the basis of planning informed and supported decision-making with the young person and their family or carers. Suggested improvements included:

- Setting goals as early as possible (however limited) to achieve positive outcomes that will ensure the person moves back into the community. Recognising that, although rehabilitation goals for young people with high and complex needs may be hard to articulate while still in the acute phase, it is crucial to work on goal-setting.
- Starting applications, referrals to and engagement with the NDIS as early as possible following medical stability to make certain a person's goals are achieved.
- Making early and clear identification of NDIS funding limits in order to assist young people and their families in making informed decisions.
- Ensuring that all the people needed to contribute to and support the person and family to make the required decisions are in attendance at discharge planning meetings.
- Providing all possible information, communicated in a way that works for the person, to support their decisions.
- Having multiple face-to-face meetings with the family during the inpatient stay, including regular planning and review meetings with individual and family. Having the family present sometimes uncovers "surprising" options not previously considered.
- Having discharge plans that can be flexible to meet contingencies, ensuring changing patient and family expectations can be met. Plans should include approximate dates for discharge.
- Having hospital-based meetings for early identification of people who are at risk of becoming long-stay complex needs patients.
- Providing strong family advocacy and Transitional Care Planning support in planning processes.
- Organising early NDIS pre-planning and planning that ideally occurs while the young person with high and complex needs is in hospital. This should be detailed, thorough and include all aspects of support and care required; inclusive of contingency options (e.g. Plan B); based on the premise of "potential and hope" where entering residential aged care is the "last resort"; inclusive of all representatives from all sectors and all stakeholders; informed by interdisciplinary Care Plans written by specialist teams of allied health professionals.
- Dealing with the high and complex needs group requires specialist skill and experience, including NDIS planners who are skilled and experienced in working with diagnostic complexities.
- That there is the commitment and skilled support to enable the person to make decisions (about services, housing etc.), and ensuring that they remain at the centre of those decisions, particularly in situations where there are communication and cognitive impairments.
- Setting up a good support package and addressing equipment needs for a person with high and complex needs prior to going into the community is important and will often result in more positive health outcomes.
- Being persistent and leading the discharge planning team meetings to ensure that this patient group's preferred place to live in the community can be identified and delivered.

Note: A strategy adopted by an inpatient facility which has made uptake of the NDIS more successful is cross-collaboration through fortnightly meetings organised with the team leader from the NDIA and the senior discharge planner. This has contributed to establishing strong and trusting working relationships and a shared understanding of each other's operating constraints

6. STREAMLINE NDIS PROCESSES

The steps needed for leaving hospital and securing NDIS support in the community need to facilitate rather than obstruct the young person's pathway to returning home to supported living. Suggestions about improving these processes included:

NDIS application, approval, planning and funding

- New NDIA specialty disability teams working within the health sector to establish planning pathways prior to discharge**
- The more information regarding diagnoses and functional profile that can be provided in the application to the NDIS, the better
- Supplying a covering letter outlining the supporting worker's role can enable better lines of communication
- Online or electronic forms allow for quicker application and approval within the NDIS process
- It's important for the person, the family and supporting professionals to be prepared for a lot of questioning, and to be clear about recommendations for care and support
- Comprehensive reports provided by a multidisciplinary/interdisciplinary rehabilitation team, including recommendations, information and education to NDIA planners and service providers, should be provided before the young person is discharged
- Plans incorporating advice from the hospital treating team and the residential aged care nurse, in close consultation with the person and family, can strengthen an application
- A timely and streamlined process for approval and access to NDIS funding and planning. Shorten hospital length of stay by reducing wait time in approving eligibility for NDIS and arranging supports (NDIA officially have 21 days to make a decision regarding eligibility)
- A separate stream within the NDIS (perhaps a different coloured Access Request Form [ARF] and online access to ARFs) which processes applications for people in hospital
- An identifiable NDIA representative to discuss complex situations with and who will advocate for timely processing of ARFs
- Include NDIS planners in the process while the person is in hospital, taking on an educative role if required, and hold planning meetings with the NDIS and the multidisciplinary team in the hospital setting
- Consistency in planning approaches from the NDIS planners and assistance to implement the plan
- "Uncapped" resources allocated according to need: specialised equipment, home modifications, support worker hours
- Timely and responsive NDIS funding of interim housing and support (for example private rental while awaiting completion of home modifications)
- Facilitating timeliness of home modifications and equipment approval, so the individual can be discharged more quickly
- Developing strategies, training and support structures that enable the individual to move on to a long term living option of their choice.

**Note: A comparison with the no-fault compensation schemes operating across Australia, indicates major injury divisions have been set up to deal with those with more complex support needs. In contrast the NDIS continues to favour a more generic approach to planning, making it difficult in many localities to offer the skill base required for this group that addresses short term priorities more efficiently and can reduce lifetime care costs

ACAT, RAC and Disability Services assessment and applications

- Early completion of the disability services departmental housing applications while identifying eligibility for NDIS funding can be an advantage for some young people, depending on their situation and which jurisdiction they are located in.
- Regular meetings with disability services and NDIA in relation to housing funding, identified vacancies and possible alternative funding options.
- If the person is to have an ACAT done, provide them with information about the process, particularly that the process only takes one hour maximum
- Ensure transitions from the acute or sub-acute setting into RAC facilities are planned in a unified way (right time, right people). The person and family member or carer should be provided with information on their options before admission to RAC as well as being able to choose which facility they want to live in.

Hospital discharge

- Early assessment for discharge, having the right people available at the right time to make the necessary decisions, and estimating an approximate date of discharge to commence funding application processes.
- Recognising that a primary driver for health is the high cost of acute and emergency beds. Flexible stay options need to be created to work around required application processes, as well as the process of setting up housing and supports once deemed NDIS-eligible.

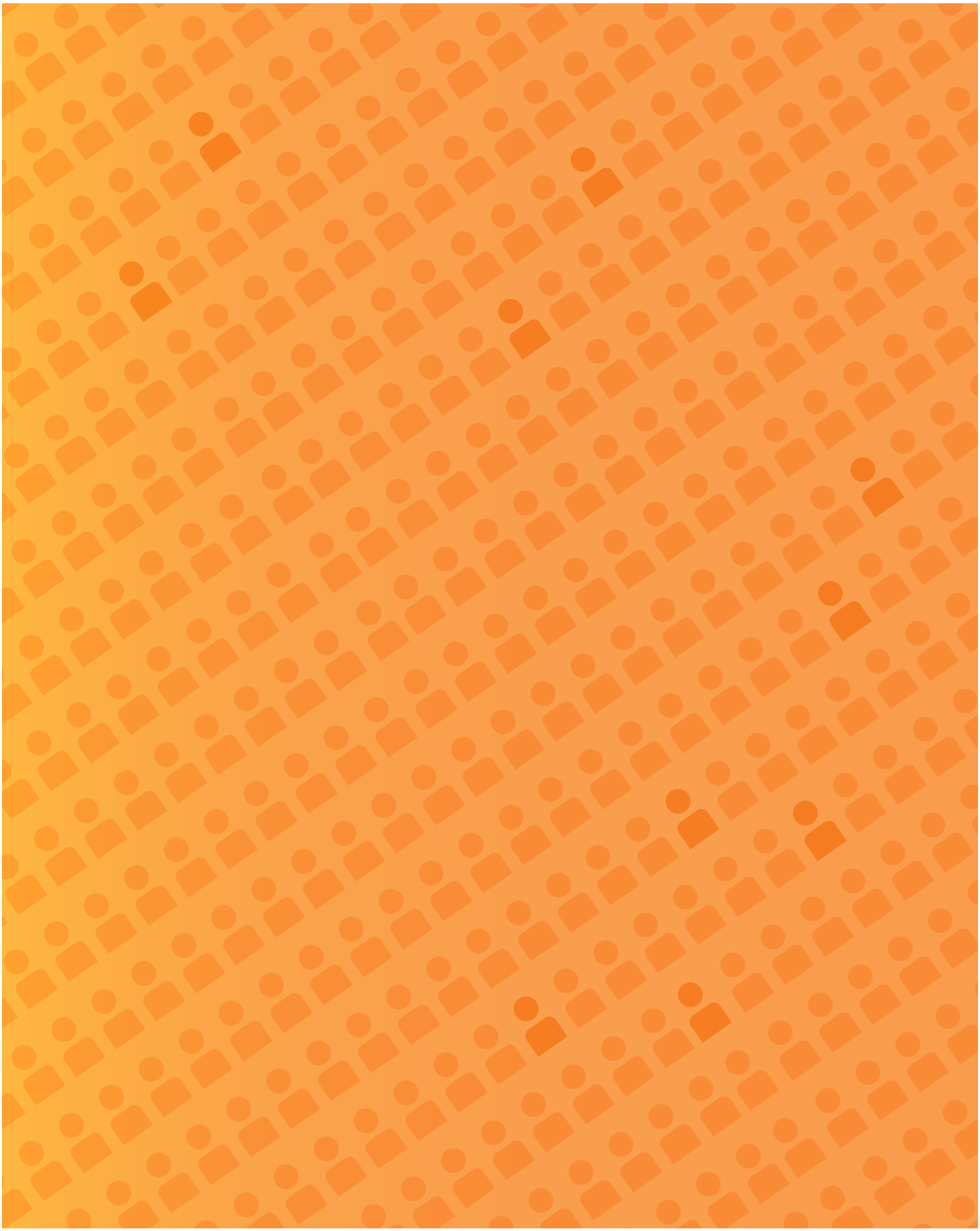
7. TRANSITION CARE

- Availability of temporary, age-appropriate restorative/transition care allowing the hospital time to organise funding and support while waiting for NDIS decisions to be made (not a residential aged care facility).
- ACAT working with hospital staff for the young person with high and complex needs to access residential respite care as they wait for home modifications to be completed (emphasis is made that this is to be a temporary solution and not a path to permanent admission to residential aged care).
- More interim housing is needed post discharge for those waiting for NDIS services/supports.
- Temporary respite locations prior to full discharge, with support provision.

8. SHARED VALUES AND COMMITMENT

Shared values and commitments identified at the forums included:

- Realisation across systems that this population needs lifelong support, that is, support that doesn't stop once the person is discharged or enters a RAC facility
- A shared perspective of hope on the part of all services and professionals - a "can-do attitude"
- A common understanding of dignity of risk and person-centred support
- A commitment to keeping the consent and choice of the person with disability foremost in the process, while providing the time and support with decision-making where needed
- A common goal to build a shared and comprehensive understanding of the person
- Consideration throughout to the emotional needs of the person and family, in hospital and in transition from hospital, acknowledging that this is an overwhelming and distressing time in their life.
- "Thinking outside the square" and working to ensure there is flexibility and responsiveness in the system, not following procedure for procedure's sake.



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