COLLABORATIVE DISCHARGE APPROACH:

FOR PEOPLE AGED UNDER 65 YEARS WITH COMPLEX DISABILITIES IN HOSPITAL

WHAT IS A COLLABORATIVE DISCHARGE APPROACH?

A collaborative discharge approach describes a process to ensure that people under 65 with disability or complex support needs in hospital, can achieve an effective and timely discharge back into the community with National Disability Insurance System (NDIS) supports

WHAT IS INVOLVED IN THE COLLABORATIVE DISCHARGE APPROACH?

It involves collaboration between health clinicians, support coordinators, community, housing and support providers. All these groups work together with the National Disability Insurance Agency (NDIA) to confirm and activate NDIS supports for a person with a complex disability while they're in hospital, so they can successfully transition from hospital back to their home, or to alternative housing such as specialist disability accommodation (SDA).

The discharge process is broken down into 5 Activities:

1. Confirm person's NDIS status

2. Determine discharge destination - home, SDA, Non-SDA

3. Is interim housing required?

4. Prepare for discharge

5. Monitor housing and support needs

Each Activity has a number of actions that occur while the person with disability is in hospital. These actions are key for the person to effectively access what they need from the NDIS to achieve a timely and successful discharge. Responsibility for these actions sits with either health clinicians or support coordinators, or collaboration between these providers and others.

WHO NEEDS COLLABORATIVE DISCHARGE PLANNING?

- **Patients or NDIS participants in hospital** who are at risk of admission to residential aged care (RAC), or have a life-limiting condition where timely supports are critical
- **Patients who have had a catastrophic or life-changing event** that has resulted in a lifelong disability that requires specialist assessment for their new housing and support needs (includes potential home modifications)
- **NDIS participants with an existing disability** who have experienced a significant change in their circumstances and require specialist assessment for their new housing and support needs (includes potential home modifications)

WHY USE A COLLABORATIVE APPROACH TO DISCHARGE PLANNING?

- To prevent NDIS participants getting 'stuck' in hospital because funded supports are not available
- To avoid NDIS participants moving into RAC unnecessarily by early exploration of housing and support options funded by the NDIS
- To enable key NDIS supports to be activated for the person while in hospital, in an effective time frame before discharge

WHAT RESOURCES CAN HELP PROVIDERS WITH COLLABORATIVE DISCHARGE PLANNING?

There are a range of resources such as guides, tools and templates that can help clinicians and other providers complete key actions for discharge planning with people with disability. Links to these resources and how they're aligned with key actions are over the page.

For a more detailed guide on how collaborative discharge planning works:
Download the Collaborative Discharge Approach: Practice Guide

COLLABORATIVE DISCHARGE APPROACH

KEY FEATURES OF COLLABORATIVE DISCHARGE PLANNING – FOR PEOPLE UNDER 65 WITH COMPLEX DISABILITIES IN HOSPITAL

- An early interim NDIS plan
- Support coordinators (SC) work alongside health professionals in the hospital
- NDIS supports implemented before participant's discharge
- Early collaborative housing exploration (e.g. home modifications, SDA eligibility, interim and long-term options)

1. CONFIRM NDIS STATUS

Health tasks only

- Collaborate with patient/participant and their support person(s)
- Get patient's/participant's consent
  - Guide to NDIS decision-making
- Explore patient's/participant's discharge preferences
- Submit ARF & supporting evidence early
  - Step by Step: How to fill out the NDIS access request form
  - Urgent Access Request – cover letter
- Submit change of circumstances form early if required
  - If circumstances change
- Follow local internal/external process to escalate if needed
  - Internal and External Escalation sample guideline
- Request early interim plan with sufficient support coordination (SC) hours, specialist assessments and Medium-term accommodation (MTA)
  - Sample interim plan
- Assist patient to choose SC

2. DETERMINE LONG-TERM DISCHARGE DESTINATION – HOME, SDA, NON-SDA

Health & Support Coordinator tasks

- Collaborate with participant and their support person(s)
- Explore need for advocacy
- Explore participant's long-term discharge preferences
- Confirm disability related health needs
  - Health related supports fact sheet
- Develop pre-plan based on discharge decision
  - Getting the Language Right
- Explore housing options early The Housing Hub
- Follow local internal/external process to escalate if needed*

A. Going Home

- Follow up completion of home modifications*
- Source NDIS providers
- Coordinate plan implementation
- Deliver handover/training to NDIS providers
  - Making a training video for your support workers

B. SDA or Non-SDA

- Confirm participant's housing preferences
  - My Housing Preferences tool
- Explore available housing options
- Consider SDA requirements SDA eligibility criteria
- Complete allied health housing assessments*
  - Allied health housing assessments
- Complete Housing Plan** Housing plan tool – SDA
- Confirm SDA determination**
- Coordinate with housing and support provider
- Real world trials – AT and home environments

3. IS INTERIM HOUSING REQUIRED?

Health & Support Coordinator tasks

- Collaborate with participant and their support person(s)
- Explore available transitional housing options
  - The Housing Hub
- OT assessment of transitional option*
- Confirm MTA or SDA funding for transitional option**
- Implement NDIS plan before entering transitional housing**
- Document exit plan from transitional housing**

If residential aged care only option

- Request RAC approval to be time-limited*
- Ensure RAC means-tested fees included in NDIS plan**
  - Aged care fees for NDIS participants

4. PREPARE FOR DISCHARGE

Health & Support Coordinator tasks

- Collaborate with participant and their support person
- Ensure participant has psychological support
- Source NDIS service providers
- Coordinate installation of home modifications
- Implement AT equipment
- Implement health and disability supports
- Deliver handover/training to NDIS providers
  - Making a training video for your support workers

5. MONITOR HOUSING AND SUPPORT NEEDS

Support Coordinator tasks only

- Maintain/review delivery of NDIS supports to avoid re-admission
- Coordinate communication between participant and NDIS providers
- Request unscheduled NDIS plan review if change in participant's housing and/or support needs
  - NDIA Planning Operational Guideline

Key

AT = Assistive technology
ARF = Access Request Form
RAC = Residential Aged Care
SC = Support coordinator
SDA = Specialist disability accommodation
STAA = Short-term accommodation assistance

*Health task only

**Support coordinator task only