INTRODUCTION

The Collaborative Discharge Approach (CDA) has been developed to improve the experience of younger people with disability and complex support needs when needing both the National Disability Insurance System (NDIS) and the health system, particularly after a significant change in their health, functional capacity or circumstances. The approach is designed to enable effective collaboration across NDIS, health and aged care systems, support coordination and housing, and provide timely discharge through access to necessary supports.

This document steps out how the CDA works. It describes how health clinicians, support coordinators, community and housing providers can work collaboratively with the National Disability Insurance Agency (NDIA), by identifying specific actions that each needs to do. Links to resources such as guides, checklists and sample forms are also provided.

For more information regarding the development of this Collaborative Discharge Approach click here.

The electronic form of this resource is interactive. Clicking on different elements of the main CDA wheel below will take you to specific Activity Sets in the CDA process. You can also navigate between Activity Sets using the tabs along the top right of each page, or the small CDA wheel in the bottom right corner.
THE APPROACH AT A GLANCE

As featured on page 1, the diagram highlights 5 key decision points in a person’s experience from hospital back to the community, known as Activity Sets. Providers working with a person with disability and complex support needs should address each Activity Set in order to progress along the discharge continuum, towards the person leaving hospital well. The movement from one Activity Set to the next is not necessarily linear and can require providers to work across two Activity Sets at the same time, or potentially skip an Activity Set, depending on the needs of the person in hospital. For example, exploring the opportunity for a person to return home (i.e. Activity Set 2) may also require providers to explore an interim housing option (i.e. Activity Set 3) at the same time. This would occur if the person’s home or alternative housing option was not ready in the immediate term.

Activity Sets
As outlined in the Approach at a Glance map, the 5 Activity Sets in the CDA are:

1. Confirm NDIS status
2. Determine long-term discharge destination – Home, SDA, or non-SDA
3. Is interim housing required?
4. Prepare for discharge
5. Monitor housing and support needs

It’s essential that there is an identified lead role for each Activity Set, to provide consistent and effective support and information. A health team member is likely to be the lead in Activity Set 1, which shifts to the support coordinator (working within and alongside the health setting) from Activity Set 2 onwards.

There is a suggested sequence for the completion of actions by providers both inside and outside the health setting, within each Activity Set. Each action is either aligned with one provider group, or indicates the need for collaboration between groups, to achieve positive housing and support outcomes for people with complex disability support needs. Links to resources that guide the completion of specific actions are also provided.

In Activity Sets 2 and 3, the completion of level 3 and 4 assistive technology assessments and housing assessments will be a collaborative effort between health and private providers. In the absence of an early NDIS plan, providers need to lead the completion of these assessments. If there is an NDIS plan with funds allocated, private providers may lead this process. Clear agreements between health and private providers are needed to clarify expectations.

Key Outcomes
There are Key Outcomes noted for each Activity Set, which drive the actions taken by each provider at different points in a person’s hospital admission. Achieving these outcomes is indicative of progress along the discharge continuum for the person in hospital.

The presence of a support person, either informal or formal, such as a family member, trusted friend, representative from an advocacy service or appointed guardian, is essential to ensuring successful discharge from hospital. It is critical that people with communication challenges receive support to express their needs and wishes. Without this support, their discharge can be significantly delayed. To this end, where the terms ‘person’ or ‘participant’ are used throughout the document, this automatically includes their nominated representative.
ACTIVITY 1

CONFIRM PERSON’S NDIS STATUS

Lead role: Health service

KEY OUTCOMES:
• Early interim NDIS plan with support coordination
• Pre-planning preparation

1. Confirm NDIS participant status as soon as possible
   - View resources
2. Start discharge planning with early collaboration, incl. exploring person’s discharge preferences
   - View resources
3. Consider need for guardian or advocate to support decision-making
   - View resources

IS THE PERSON A CURRENT PARTICIPANT?

A. PERSON IS NOT A CURRENT PARTICIPANT

4. Establish likelihood of NDIS eligibility
   - View resources
5. Initiate access to NDIS via phone and either Access Request Form (ARF) or supporting evidence
   - View resources
6. Submit ARF via email
   - View details
7. Access approved and NDIA senior planner allocated
   - View details
7.1 If access denied
   - View details
ACTIVITY 1
CONFIRM PERSON’S NDIS STATUS

**HEALTH SERVICE**

8. [ ] Health and NDIA senior planner liaise re need for interim plan inclusive of support coordination
   - View details

9. [ ] NDIA planner approves interim plan with support coordination
   - View details

10. [ ] Assist person to choose support coordinator
    - View resources

11. [ ] Health and support coordinator meet with participant re NDIS
    - View resources

12. [ ] Start functional/home/equipment assessments
    - View resources

13. [ ] Start pre-planning preparation
    - View resources

GO TO ACTIVITY 2
ACTIVITY 1
CONFIRM PERSON’S NDIS STATUS

14. ☐ Start functional/home/equipment assessments
   View resources

15. ☐ Collaborate to determine gaps in participant’s NDIS plan
   View resources

16. ☐ If no support coordinator - alert NDIA senior planner re need for updated flexible plan with support coordination
   View resources

17. ☐ Support participant to complete/submit
   • Change of Circumstances form
     OR
   • Request plan review
     View resources

18. ☐ SC and NDIA senior planner consult re Change of Circumstances form and need for short-term plan with support coordination
      View details

19. ☐ NDIA planner approves:
    • Change of Circumstances
    • New flexible plan with support coordination
      View details
**ACTIVITY 1**

CONFIRM PERSON’S NDIS STATUS

**HEALTH SERVICE**

20. □ Assist participant to choose support coordinator
   - View resources

**SUPPORT COORDINATOR**

21. □ Meet with participant re NDIS plan
    - View details

22. □ SC and NDIA senior planner liaise re plan review meeting date
    - View details

23. □ Start preparation for plan review meeting
    - View resources
ACTIVITY 1
CONFIRM PERSON’S NDIS STATUS

The information below provides more detail on the steps for Activity 1.

1. Confirm NDIS participant status as soon as possible
   - Consider doing this when a person first enters hospital, depending on the likelihood of permanent disability

   - How can my workplace get ready for the NDIS?
   - What is the NDIS and is it for me?
   - NDIS at a glance – Useful links and resources
   - NDIS Readiness – A Toolkit for Hospitals
   - NDIS and Health – Working together

2. Start discharge planning with exploring the person’s preferences for their discharge location, and early collaboration with relevant providers
   - Specialists
   - GP
   - Support provider
   - Allied health

   - Discharge Planning Toolkit

3. Consider need for guardian or advocate to support participant with their decision-making

   - Office of the Public Advocate – Guide to NDIS decision-making

A. PERSON IS NOT A CURRENT PARTICIPANT

4. Establish likelihood of NDIS eligibility

   - NDIA – Access Checker

5. Complete NDIS Access via ‘Verbal Access Request (VAR), and either an Access Request Form (ARF) or a supporting evidence report
   - Functional language
   - Include nominated health service contact person
   - Cover letter explaining priority need (see NDIA Operational Guidelines)

   - Accessing the NDIS – Providing Support Evidence
   - Getting the Language Right
   - How to fill out the NDIS Access Request Form
   - Urgent Access Request cover letter

BACK TO ACTIVITY 1 PATHWAY
6. Submit ARF via email to NDIA National Access Team
   - NAT@ndis.gov.au
   - Note ‘PRIORITY HOSPITAL - URGENT ACCESS DECISION REQUIRED’ in subject line

7. Access approved and national office notifies appropriate NDIA local office and NDIA senior planner allocated

7.1 If access denied:
   - Contact NDIA to seek clarification re decision
   - Submit new ARF with additional supporting evidence
   - Escalate via health service escalation process
   - Request a review of a decision by NDIA
   - Contact Administrative Appeals Tribunal (AAT) for an independent review (post internal review by NDIA)

8. Nominated health service contact and NDIA senior planner liaise re need for interim plan with support coordination
   - Sample Interim NDIS Plan

9. NDIA planner approves interim plan with support coordination and other essential supports to facilitate the participant’s timely discharge from hospital

10. Assist participant to connect with and choose support coordinator
    - Support coordinator fact sheet
    - How do I choose someone to support me to make NDIS decisions?
    - Registered provider list
    - Find a registered provider information

11. Health and support coordinator meet with participant re NDIS
    Define roles and responsibilities between health and support coordinators
    - Reconnecting with the community - Key NDIS roles and how they can support you
    - Sample NDIS plans
    - Consumer and Family Carer Network
Consider and plan for functional/home/equipment assessments

- Real-world trials
- Equipment hire – required for pre-planning

Sample NDIS Pre-plan template

ACTIVITY 1

Consider and plan for functional/home/equipment assessments

- Real-world trials
- Equipment hire – required for pre-planning

Getting the Language Right

Getting ready for NDIS planning - components below:

- Disability and Health supports and how NDIS defines them
- What would a great life be for me?
- About my health - being prepared for hospital admission
- What can I get in a NDIS plan?
- My details and preferences
- About my health - being prepared for NDIS planning
- Sources (and further information)
- What do I take to my planning meeting?

Key for tasks:

- HS = Health service
- SC = Support coordinator
- N = NDIS

Sample NDIS plans
B. PERSON IS A CURRENT PARTICIPANT

14. Consider and plan for functional/home/equipment assessments
   - Real-world trials of home environment and assistive technology
   - Equipment hire – required for pre-planning

Getting the Language Right

Allied Health Housing Assessments Guide

15. Collaborate to determine gaps in participant’s NDIS plan reflecting participant’s new needs
   - Can supports be adapted or used flexibly?
   - Are home modifications or new assistive technology required?
   - Is an increase in support hours required, including support coordination?
   - When is plan due for review? Are there enough funded supports to cover changes?
     - Is Change of Circumstances form required?
   - Gather and supply evidence of the impact of participant’s capacity on daily life

Sample NDIS plans

NDIS and Health: Working together

16. If no support coordinator – alert NDIA senior planner re need for updated flexible plan with support coordination

17. Call NDIA with update on participant’s needs and gaps in current plan. Support participant to complete/submit:
   - Change of Circumstances form/Highlight gaps in participant’s current NDIS plan
   - Request plan review
   In both cases, provide additional supporting evidence re changed needs and note need for short-term plan that includes sufficient support coordination hours

If Circumstances Change

Change in Circumstances

18. SC and NDIA senior planner consult re Change of Circumstances and need for flexible plan with support coordination

Sample Interim NDIS Plan
NDIA planner approves

- Change of Circumstances
- New flexible plan with support coordination

20 Assist participant to choose support coordinator (if different provider required)

- Support coordinator fact sheet
- Registered provider list
- Find a registered provider information

21 Health and SC meet with participant re NDIS plan and inform them of the plan review process

22 SC and NDIA senior planner liaise re plan review meeting date

23 Start preparation for plan review meeting

- Liaise with health and NDIA
- Meet regularly with participant
- Confirm date of plan review meeting
- Review plan management options with participant

- Sample NDIS plans
- Getting ready for NDIS planning - components below
  - Disability and Health supports and how NDIS defines them
  - What would a great life be for me?
  - About my health - being prepared for hospital admission
  - My details and preferences
  - About my health - being prepared for NDIS planning
  - Sources (and further information)
ACTIVITY 2

DETERMINE DISCHARGE DESTINATION: HOME, SDA, NON-SDA?

KEY OUTCOMES:

- **YES** - NDIS plan with supports for discharge home
- **NO** - NDIS plan to explore housing and support needs

Lead role: Support coordinator

Complete allied health assessments and finalise recommendations for home modifications, AT requirements and participant’s support needs

2. **Complete allied health assessments and finalise recommendations for home modifications, AT requirements and participant’s support needs**
   - View resources

3. **Collaborate re participant’s allied health assessment outcomes**
   - View details

4. **Collaborate re participant’s disability related health supports**
   - View resources

5. **Collaborate on pre-planning documents**
   - View resources

6. **Collaborate re decision re participant’s ability to return to existing home**
   - View details

Health Service

Support Coordinator (SC)
ACTIVITY 2

DETERMINE DISCHARGE DESTINATION: HOME, SDA, NON-SDA?

Continued

1. **HEALTH SERVICE**

7. □ Collaborate re need for funded allied health housing needs assessment in participant’s plan
   - View resources

8. □ Collaborate re participant’s need for advocacy support
   - View resources

CAN THE PERSON RETURN TO EXISTING HOME?

- YES: START AT A
- NO: JUMP TO B

A. PERSON CAN RETURN TO EXISTING HOME

9. □ Consider need for interim housing options
   - View details

10. □ Liaise with NDIA senior planner re NDIS planning meeting
    - View details

11. □ Collaborate re attending planning meeting with participant
    - View details

BACK TO OVERVIEW
ACTIVITY 2

DETERMINE DISCHARGE DESTINATION: HOME, SDA, NON-SDA? Continued

HEALTH SERVICE

12. □ NDIA senior planner develops full NDIS plan

13. □ Review draft of full NDIS plan and recommend edits
   - View resources

14. □ Collaborate re gaps in participant’s plan and next steps
   - View details

15. □ Liaise with NDIA senior planner to finalise full NDIS plan

16. □ Collaborate re discharge plan
   - View details

17. □ Inform SC re any updates to participant’s daily support needs
   - View details

SUPPORT COORDINATOR (SC)
ACTIVITY 2

DETERMINE DISCHARGE DESTINATION: HOME, SDA, NON-SDA?

Continued

☐ HEALTH SERVICE

☑ SUPPORT COORDINATOR (SC)

18. ☐ Assist participant to choose and engage providers who can meet their daily needs
   - View resources

19. ☐ Develop support package with core support provider(s)

20. ☐ Assist participant to source and select capacity building providers (e.g. allied health)
   - View resources

21. ☐ Collaborate re handover training to any health, community, core and capacity building providers (including mainstream services)
   - View resources

22. ☐ Collaborate via case conference re discharge plan for participant returning to existing home
   - View details

23. ☐ Train core support providers
   - View resources

CONSIDER ACTIONS IN ACTIVITY 5

BACK TO OVERVIEW
ACTIVITY 2

DETERMINE DISCHARGE DESTINATION: HOME, SDA, NON-SDA?

Continued

☐ HEALTH SERVICE

☐ SUPPORT COORDINATOR (SC)

24. ☐ Health and SC liaise with NDIA senior planner re NDIS planning meeting with participant
☐ View resources

25. ☐ Collaborate re attending planning meeting with participant
☐ View details

26. ☐ NDIA senior planner updates NDIS plan
☐ View details

27. ☐ Review updated NDIS plan and recommend edits
☐ View details
DETERMINE DISCHARGE DESTINATION: HOME, SDA, NON-SDA?

Continued

☑ HEALTH SERVICE

☐ SUPPORT COORDINATOR (SC)

28. SC liaises with NDIA senior planner to finalise updated plan

29. Explore non-SDA housing options prior to SDA options
    - View resources

30. Collaborate re available non-SDA housing options
    - View resources

31. Collaborate re participant trialling potential non-SDA housing option
    - View details

32. Collaborate via case conference for decision re suitable non-SDA housing
    - View details
ACTIVITY 2

DETERMINE DISCHARGE DESTINATION: HOME, SDA, NON-SDA?

Continued

A. NON-SDA IS SUITABLE

SC liaises with NDIA senior planner to confirm NDIS planning meeting with participant

33.

Circle

Jump to B. if SDA suitable

34.

☐ Collaborate re attending planning meeting with participant

View details

35.

☐ NDIA senior planner drafts full NDIS plan

36.

☐ Review draft of full NDIS plan and recommend edits

View resources

37.

☐ SC liaises with NDIA senior planner to finalise full NDIS plan

38.

☐ Coordinate plan implementation

View resources

HEALTH SERVICE

SUPPORT COORDINATOR (SC)
ACTIVITY 2
DETERMINE DISCHARGE DESTINATION: HOME, SDA, NON-SDA?

Continued

☑️ HEALTH SERVICE

☑️ SUPPORT COORDINATOR (SC)

B. SDA EXPLORATION

39. Collaborate re participant’s functional capacity and support needs for likelihood of SDA eligibility
   - View resources

40. Collaborate re need to source private allied health providers if required
   - View resources

41. If SDA seems likely, start full exploration of available SDA housing options
   - View resources

42. Collaborate re connecting participant to housing matching service
   - View resources

43. Support participant to preview SDA options
   - View details

44. Health complete allied housing assessments – in collaboration with private providers if required
ACTIVITY 2

DETERMINE DISCHARGE DESTINATION: HOME, SDA, NON-SDA?

45. Collaborate re completing housing plan
   - View resources

46. SC liaises with NDIA senior planner re NDIA planning meeting to present evidence for SDA determination
   - View details

47. Collaborate re attending planning meeting with participant
   - View details

48. NDIA senior planner submits SDA evidence to NDIA central SDA panel
   - View details

49. NDIA central SDA panel makes determination for SDA eligibility
   - View details

HEALTH SERVICE

SUPPORT COORDINATOR (SC)
ACTIVITY 2

DETERMINE DISCHARGE DESTINATION: HOME, SDA, NON-SDA? Continued

☐ HEALTH SERVICE

☐ SUPPORT COORDINATOR (SC)

50. NDIA senior planner drafts full NDIS plan including SDA funding
   - View details

51. Collaborate re reviewing draft of NDIS plan and recommend edits
   - View details

52. SC liaises with NDIA senior planner to finalise full NDIS plan with SDA and supports

53. Support participant to choose SDA provider and develop transition plan

54. Collaborate re need for interim housing option – Activity Set 3

55. Coordinate plan implementation
   - View resources

BACK TO OVERVIEW
ACTIVITY 2
DETERMINE DISCHARGE DESTINATION: HOME, SDA, NON-SDA?

The information below provides more detail on the steps for Activity 2.

1. Collaborate and consult with participant regarding their preferences for the discharge destination

2. Complete allied health assessments (e.g. OT, psychology, neuropsych) and finalise recommendations for home modifications, AT requirements and address person’s current and ongoing emotional support needs
   - Health recommend level 1 and 2 minor modifications and AT recommendations
   - Health collaborate with private providers to complete level 3 and 4 major modifications and AT recommendations (funds available), or assess participant for behavioural intervention support (BIS) plan

3. Collaborate re assessment outcomes and impact of these on participant’s discharge preferences and NDIS plan

4. Collaborate re participant’s disability related health supports. Arrange NDIS funded services to address participant’s short and long-term health related needs attributable to disability e.g. nursing, consumables such as continence care and wound care etc

Key for tasks:

| HS | = Health service |
| SC | = Support coordinator |
| N  | = NDIS |

Getting the Language Right
Allied Health Housing Assessments Guide
Providing assistive technologies and home modifications

Delivering disability related health supports - a guide for providers

BACK TO ACTIVITY 2 PATHWAY
Collaborate on completing pre-planning documents in preparation for NDIA planning meeting

- Participant’s statement
- Participant’s current support and housing needs
- Consider participant’s health needs related to their disability and establish funding sources (e.g. community nursing, consumable items, equipment, etc)
- Support coordinator collates information for NDIA planning meeting e.g. assessment reports, overall support needs recommendations, recommended SC and allied health hours for exploring housing, and plan management decision

Sample NDIS Pre-plan template

Getting ready for NDIS planning – components below:

- Disability and Health supports and how NDIS defines them
- What would a great life be for me?
- About my health - being prepared for NDIS planning
- About my health - being prepared for hospital admission
- Sources (and further information)

Sample Pre-Planning Tools For PwD in RAC

Collaborate on decision re participant returning to existing home (or not)

Collaborate re the need for allied health housing needs assessment to be funded within participant’s NDIS plan – if required. Health may complete this assessment.

Based on decision for participant returning to existing home or not

- Support coordinator documents proposed housing and support needs (including health related to disability) for NDIS planning meeting

Allied Health Housing Assessments Guide
ACTIVITY 2
Continued

8. Collaborate re exploring participant’s need for advocacy support

- Explore options with participant’s consent
- Connect participant to advocate

What are advocates and how can they help me?
Guardians and administrators: What can they do and who decides if I need one?
What is a Power of Attorney and how can they support me?

A. PERSON CAN RETURN TO EXISTING HOME

9. Consider need for interim housing options if major home modifications required (see Activity 3)

10. Liaise with NDIA senior planner re NDIS planning meeting with participant/their representatives

- Support coordinator sends copy of pre-planning document to senior planner

11. Collaborate and consult with participant re attending their planning meeting to provide support

12. NDIA senior planner develops full NDIS plan

13. Review draft of full NDIS plan and recommend edits

NB this is a newly developing practice

Sample NDIS plans

14. Collaborate re any gaps in participant’s plan. Decide on next steps

Key for tasks:

HS = Health service
SC = Support coordinator
N = NDIS

BACK TO ACTIVITY 2 PATHWAY
ACTIVITY 2 Continued

15 Liaise with NDIA senior planner to finalise full NDIS plan

16 Collaborate re discharge plan

17 Inform SC re participant’s daily support needs, i.e. completed community living plan

18 Assist participant to choose and engage support providers who can meet their daily needs. Outline participant’s needs in detail to support provider eg. outline roster needed for scheduled support

Plan Management
Find a Registered Provider information
Registered Provider list
NDIS Booklet #3

19 Develop support package with core support provider(s)

20 Assist participant to source and select capacity building providers (e.g. allied health)

21 Collaborate re handover training to any health, community, core and capacity building providers (e.g. private OT) noted in participant’s plan

This includes services both within and outside the person’s NDIS plan
• Community rehabilitation
• Health related needs (e.g. wound care, oxygen)

Implementation: Useful links and resources
Find a Registered Provider information
Registered Provider list

Key for tasks:
HS = Health service
SC = Support coordinator
N = NDIS
ACTIVITY 2

Collaborate via case conference re discharge date for participant returning to existing home, including all involved service providers. This is dependent on support plan outlining daily support implementation date.

Collaborate re training core support providers while participant is in hospital.

NB May not happen prior to discharge - health still required to provide post discharge.

Making a Training Video for your Support Workers
Supporting the Person’s Thinking and Communication

B. PERSON CAN’T RETURN TO EXISTING HOME

Health and SC liaise with NDIA senior planner re NDIS planning meeting with participant to recommend updating plan for SC and allied health hours to explore housing and support options.

Living More Independently

Collaborate and consult with participant re attending their planning meeting to provide support.

NDIA senior planner updates NDIS plan including additional SC and allied health related to housing.

Review updated NDIS plan and recommend edits. NB this is a newly developing practice.

SC liaises with NDIA senior planner to finalise updated plan.

Key for tasks:

HS = Health service
SC = Support coordinator
N = NDIS

BACK TO ACTIVITY 2 PATHWAY

BACK TO OVERVIEW
Explore non-SDA housing options prior to SDA options, taking into account the participant’s support needs and preferences

Housing Hub
My Housing Preferences tool
A Successful Transition to More Independent Living
Living Like Everyone Else
The Housing Toolkit

Collaborate re available non-SDA housing options
Mainstream Housing Options guide
My Housing Preferences tool

Collaborate re participant trialling potential non-SDA housing option e.g.
- Visit to property
- Functional activity within property

Collaborate via case conference for decision re suitable non-SDA housing
Move to option A if non-SDA is suitable. If non-SDA is not suitable move to option B to explore SDA

A. NON-SDA IS SUITABLE

SC liaises with NDIA senior planner to confirm NDIS planning meeting with participant re participant’s support needs and home modifications

Collaborate and consult with participant re attending planning meeting to provide support
ACTIVITY 2

Continued

35 NDIA senior planner drafts full NDIS plan

36 Review draft of full NDIS plan and recommend edits

\textit{NB This is a newly developed process}

Sample NDIS Plans

37 SC liaises with NDIA senior planner to finalise full NDIS plan

38 Coordinate plan implementation including assisting participant with provider selection

Plan Management

Registered Provider list

Find a Registered Provider information

Clickability

IDEAS

Boosted

B. SDA EXPLORATION

39 Collaborate re participant’s functional capacity and support needs for likelihood of SDA eligibility

SDA Eligibility Criteria

Allied Health Housing Assessments Guide

Getting the Language Right

40 Collaborate re need to source private allied health providers relating to housing, if required. Health may also complete these assessments

Housing Plan Tool – SDA

41 If SDA seems likely, start full exploration of available SDA housing options and discuss with health evidence required for SDA determination

SDA Payments guide

Using SDA to Buy Your Own Property

Housing Hub

Housing Plan Tool – SDA

Hunter Housing and Support Demonstration Project booklet

Allied Health Housing Assessments Guide

Key for tasks:

\begin{align*}
\text{HS} & = \text{Health service} \\
\text{SC} & = \text{Support coordinator} \\
\text{N} & = \text{NDIS}
\end{align*}
Collaborate re connecting participant to housing matching service, for support with SDA housing options

Support participant to preview existing SDA options through coordinating with health staff and/or private providers

Complete allied health housing assessments in collaboration with private providers if required

Collaborate re completing housing plan including collating evidence from hospital and private allied health assessments and arranging housing assessments with private allied health providers

SC liaises with NDIA senior planner re NDIA planning meeting to present evidence for SDA determination (e.g. housing plan and support needs)

Collaborate and consult with participant re attending planning meeting to provide support related to SDA application

NDIA senior planner submits SDA evidence to NDIA central SDA panel for decision re SDA eligibility

NDIA central SDA panel makes determination for SDA eligibility and advises local NDIA team
ACTIVITY 2

NDIA senior planner drafts full NDIS plan including SDA funding (e.g. includes design category, occupancy, building type, location)

Collaborate re reviewing draft of full NDIS plan and recommend edits

NB This is a newly developing practice

SC liaises with NDIA senior planner to finalise full NDIS plan with SDA and supports

Support participant to choose SDA provider and develop transition plan

Collaborate re need for interim housing option – Activity Set 3

Coordinate plan implementation including assisting participant with provider selection

Plan Management

Registered Provider list

Find a Registered Provider information
**ACTIVITY 3**

**IS INTERIM HOUSING REQUIRED?**

Lead role: Support coordinator

**KEY OUTCOMES:**
- Interim housing option confirmed; interim support arranged
- If RAC interim option required - RACF staff trained; RAC exit plan scoped

**HEALTH SERVICE**

1. Consult with housing providers re all available interim options
   - View resources

2. Collaborate re interim housing options preferred/explored
   - View details

3. OT home assessment of interim housing option
   - View resources

4. Collaborate re participant previewing interim housing option

5. Collaborate via case conference re decision on interim housing discharge location

6. Collaborate re completion of home modifications for interim location

**SUPPORT COORDINATOR (SC)**
**Activity 3**

**Is interim housing required?**

**Health Service**

1. Refer to ACAT/ACAS - recommend time-limited permanent approval
   - View resources

2. ACAT/ACAS assessment for residential aged care (RAC) as time-limited interim option

**Support Coordinator (SC)**

3. Collaborate re consultation with RAC providers
   - View details

4. Collaborate re NDIS plan including RAC means tested fees
   - View resources
11. Collaborate re handover training to RAC staff – equipment and care needs
   - View details

12. Collaborate re meeting with participant re exit plan

13. Liaise with RAC staff re participant’s exit plan to the community

14. SC liaises with NDIA senior planner re participant’s exit plan from RAC and NDIS plan review date
ACTIVITY 3
IS INTERIM HOUSING REQUIRED?

The information below provides more detail on the steps for Activity 3.

1. Consult with housing providers re all available interim options
   - Housing Hub
   - Mainstream Housing Options guide
   - Additional housing search option: Nest

2. Collaborate re interim housing options explored and highlight participant’s preferred options
   - HS
   - SC

3. OT home assessment of interim housing option for accessibility, e.g.
   - Portable accessible ensuites
   - Modular ramping systems
   - Showering units
   - Allied Health Housing Assessments Guide

4. Collaborate re participant previewing interim housing option
   - HS
   - SC

5. Collaborate via case conference re decision on interim housing discharge location
   - HS
   - SC

6. Collaborate re completion of home modifications for interim location
   - HS
   - SC

Key for tasks:
- HS = Health service
- SC = Support coordinator
- N = NDIS
**IF RESIDENTIAL AGED CARE (RAC) REQUIRED**

7. Refer to ACAT/ACAS - recommend time-limited permanent approval
   - Follow the local ACAT/ACAS process for under 65s
   - Ensure NDIS plan is implemented and RAC exit plan is documented

Aged Care Assessment Toolkit

8. ACAT/ACAS assessment for residential aged care (RAC) completed; approval for time-limited interim option

9. Consult with various RAC providers re their room availability and anticipated discharge date

10. Collaborate re RAC means tested fees being included in participant’s NDIS plan, noting anticipated discharge date
    Support coordinator – assist participant to collate relevant documentation to ensure fees are covered in their NDIS plan

Moving into residential aged care

NDIS and Aged Care Fees

Financial considerations of moving in to RAC

11. Collaborate re handover training to RAC staff including participant’s care and equipment needs
ACTIVITY 3

Collaborate and consult with participant re their RAC entry/exit plan

Liaise with RAC staff re participant’s exit plan to the community

SC liaise with NDIA senior planner re participant’s exit plan from RAC and NDIS plan review date

Key for tasks:

HS = Health service
SC = Support coordinator
N = NDIS
**Activity 4**

**Prepare for Discharge**

*Lead role: Support coordinator*

**Key Outcomes:**
- Non-SDA - home modifications completed; support arranged
- SDA - home modifications completed; support arranged

**Health Service**

1. Provide psychological support to participant
   - View details

2. Collaborate re completion of home modifications
   - View resources

3. Collaborate re scripting, supply and delivery of all AT equipment

4. Collaborate re documenting participant’s core support needs
   - View details

5. Collaborate re arrangement of NDIS funded services to address participant’s short and long-term disability related health supports
   - View resources

**Support Coordinator (SC)**

*View details*
6. Collaborate re selection of all providers

7. Collaborate re handover training to community, core, capacity building providers and/or mainstream services

8. Liaise with housing and support providers re discharge date

9. Liaise with NDIA senior planner re NDIS plan review date

10. Update participant’s GP
ACTIVITY 4
PREPARE FOR DISCHARGE

The information below provides more detail on the steps for Activity 4.

1. Provide psychological support to participant as required
   
2. Collaborate re home modifications, if required
   
3. Collaborate re scripting, supply and delivery of all AT equipment
   
4. Collaborate re documenting participant’s core support needs i.e. completed community living plan
   
5. Collaborate re arrangement of NDIS funded services to address participant’s short and long-term disability related health supports e.g. nursing, consumables such as continence care and wound care etc
   
6. Collaborate and consult with participant re selection of all providers

Support coordinator coordinates support package with core support provider

Key for tasks:

- HS = Health service
- SC = Support coordinator
- N = NDIS

NDIS and Health: Working together
Delivering disability-related health supports - a guide for providers
7. Collaborate re handover training to community, core, capacity building providers and/or mainstream services. This includes services both within and outside the person’s NDIS plan.
   - Community rehabilitation
   - Health related needs (e.g. wound care, oxygen)
   - Provide handover package to support providers

8. Liaise with housing and support providers re discharge date

9. Liaise with NDIS senior planner re participant’s NDIS plan review date

10. Update participant’s GP

Key for tasks:
- HS = Health service
- SC = Support coordinator
- N = NDIS
ACTIVITY 5
MONITOR HOUSING & SUPPORT NEEDS
Lead role: Support coordinator

KEY OUTCOMES:
- Housing and support needs met
- Change of Circumstances initiated with NDIA if not

☑️ NDIS PROVIDERS

1. □ Maintain and review delivery of NDIS funded supports
   - View resources

☑️ SUPPORT COORDINATOR (SC)

2. □ Confirm participant’s preferred method of communication and support
   - View resources

3. □ Collaborate via regular case conference meetings with participant

4. □ Establish any new housing and support needs for participant throughout 12-month plan
   - View resources

5. □ Support participant to request unscheduled NDIS plan review if new housing and support needs not meet

6. □ SC liaises with NDIA senior planner re NDIS plan review date

BACK TO OVERVIEW
ACTIVITY 5

MONITOR HOUSING & SUPPORT NEEDS

The information below provides more detail on the steps for Activity 5.

1. Maintain and review delivery of NDIS funded supports
   - NDIS Providers (NP)

2. Confirm participant’s preferred method of communication and support
   - Support coordinator (SC)
   - Supporting the Person’s Thinking and Communication

3. Collaborate via regular case conference meetings with participant
   - Support coordinator (SC)
   - NDIS Providers (NP)

4. Establish any new housing and support needs for participant throughout 12-month plan
   - Support coordinator (SC)
   - The Housing Toolkit

5. Support participant to request unscheduled NDIS plan review if new housing and support needs not meet
   - Support coordinator (SC)

6. SC liaises with NDIA senior planner re NDIS plan review date
   - Support coordinator (SC)
   - NDIS (N)
More than 2,000 young Australians with disability enter Residential Aged Care (RAC) every year. As a result, more than 5,800 young Australians with disability live in RAC, a life characterised by loneliness and isolation. The goal of the Collaborative Discharge Approach (CDA) is to halve the number of young people with complex disability support needs discharged from hospital into RAC by 2020. A further goal is to reduce the length of hospital stay for these young people as prolonged hospital admissions often result in poor health and behavioural outcomes for the person, impacting on access to housing options.

The CDA has been developed to improve the experience of younger people with disability and complex support needs when needing both the National Disability Insurance System (NDIS) and the health system, particularly after a significant change in their health, functional capacity or circumstances. The approach is designed to enable effective collaboration across NDIS, health and aged care systems, support coordination and housing, and provide timely discharge through access to necessary supports.

The approach aims to enable younger people with disability and complex needs to return to their homes or to suitable housing in the community, with supports in place, and without unnecessary delay in their hospital discharge thus avoiding the person having to live in aged care. The CDA will also facilitate essential increases to people’s supports when a change of circumstances occurs, and prevent unnecessary readmission to hospital.

This document provides an overview of the CDA. It describes how health clinicians and managers, support coordinators, community and housing providers can work collaboratively with the National Disability Insurance Agency (NDIA) to achieve desired outcomes. It summarises key features of the CDA and identifies specific actions that each of the providers need to do. Links to resources such as guides, checklists and sample forms, are also provided.

Barriers to effective participant discharge and identification of housing outcomes include:

- Health facility staff knowledge of NDIS language and processes
- Timeliness of access and planning processes by the NDIA
- Timeliness of approval to NDIS funding for essential supports, assistive technology, home modifications and housing options
- Lack of understanding of housing pathways and options, including Specialist Disability Accommodation (SDA) by health, housing and support coordination providers
- Lack of skilled support coordination available to facilitate the transition from hospital to home

The CDA offers a solution to achieving this transition more efficiently and effectively, and avoiding unnecessary entry or re-entry to residential aged care.
DEFINING THE TARGET GROUP

The CDA is relevant to people aged from 18 to 65 who:

- Have a disability and complex support and care needs
- Are using or likely to need hospital and community-based health services

Typical conditions include acquired brain injury, spinal cord injury, amputation, sensory failure, cerebral palsy, and progressive neurological diseases such as Multiple Sclerosis, Parkinson’s or Huntington’s. People with these conditions are expected to experience lifelong impairments as a result and have complex care needs. These needs often require coordination of health, disability and housing supports.

The CDA assumes, as a starting point, a major change in a person’s circumstances which necessitates a hospital admission. This may be, for example:

- An accident or injury which results in a serious permanent disability
- A significant worsening of a person’s disability due to progress of the underlying medical condition meaning that current care arrangements are no longer tenable
- The breakdown of a care arrangement, for instance through a serious illness to a parent carer

People who experience a health change requiring hospitalisation that does not result in significant lifelong change to their care or support needs are not expected to require this approach.

ESSENTIAL PRINCIPLES

There are a number of fundamental principles that underpin the success of the CDA. These are:

- **Person with disability and their family are central decision-makers**
  The younger person with complex disability support needs and their families/representatives are supported to be central to decision-making, incorporating input from clinicians experienced in framing a successful discharge.

- **Collaboration is expected**
  Key expectations of collaboration include having shared vision and commitment; open and timely communication; having the right people involved; and understanding each other’s context and challenges.

- **Early contact with the NDIA**
  Wherever possible, communication between health and the NDIA is best initiated early in a person’s stay in hospital, depending on the likelihood of permanent disability. This should lead to the implementation of an NDIS plan with approval for support coordination as early as possible. Early contact between health, ACAT/aged care, and community and housing providers will also help avoid unnecessary entry into or long-term stay in RAC.
• **Early housing exploration**
  Exploring a person’s long-term support and housing needs is required early in the discharge planning process. This is essential for more person-centred housing outcomes and accommodating the long lead times required to explore, secure and sometimes build suitable housing.

• **Building on health expertise and knowledge**
  Health holds expertise and responsibilities in health care, rehabilitation and discharge planning. The CDA assumes the ongoing completion of up-to-date discharge planning practice.

• **Core roles and responsibilities are identified and maintained**
  Health, the NDIA, support coordination, ACAT, RAC and housing providers need clear definition of their roles and scope of responsibilities at specific points throughout the person’s admission and discharge to the community.

• **Building capacity where required**
  Training and education is needed for providers working with young people with complex disability support needs, particularly support coordinators. Training will include case studies of types of support models, NDIS plans and positive housing outcomes.

• **Best available evidence**
  This approach is informed by best available evidence in reducing unnecessary costs to the health setting, and achieving optimal discharge and housing outcomes for young people with complex disability support needs. The earlier a young person can leave hospital and begin living their life with support in the community, the greater the opportunity they have to achieve social and economic participation.
BACKGROUND DEVELOPMENT

This approach is the culmination of a number of projects undertaken at the Summer Foundation, in collaboration with people with disabilities and providers across Victoria, New South Wales, ACT and Queensland. These projects include:

- Cross Sector Discharge Planners Forums (2015-16) – View resource
- Department of Health and Human Services (DHHS) Victoria: Rapid response model and bringing health into NDIS planning (October 2017-June 2018)
- William Buckland Project: Collaborative Hospital Discharge (April 2017-March 2020)
- Information, learning and capacity (ILC) NDIA project: Hospital Readiness and ILC Aged Care (July 2017-Dec 2018)
- Support Coordination Flagship program (current)
- Tenancy Matching Service (current) – View resource
- The Housing Hub (current) – View website
- Abbotsford and Hunter housing demonstration projects - support provider reviews (April 2018 – current)

Methodology used within these projects included:

- Comprehensive key stakeholder engagement across all mainstream services including health, NDIA, support coordination, ACAT, RAC and housing
- Co-design principles which included consultation, workshops, synthesizing insights and testing prototypes of processes and tools to guide practice
- Journey mapping based on consultations with younger people with disability and other stakeholders

The NDIS continues to evolve in response to evidence being collected on outcomes for people with disability. As the rollout progresses across Australia, the way it interfaces with other sectors such as health will require updating, this model is also expected to continue to adapt in response. We welcome feedback to ensure best possible outcomes can be achieved.