

# 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.



# COLLABORATIVE DISCHARGE APPROACH

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

- 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 to liaise with the NDIA
- Explore patient's/participant's discharge preferences
- Submit ARF
  - 📖 [Accessing the NDIS – Providing Support Evidence](#)
  - 📖 [Urgent Access Request – cover letter](#)
- Submit change of situation form early if required
  - 📖 [If circumstances change](#)
- Follow local internal/external process to escalate if needed
  - 📖 [Internal and External Escalation sample guideline](#)
- Request a plan that is in line with the person needs and preferences. It may include, sufficient support coordination (SC) hours, specialist assessments and medium-term accommodation (MTA)
  - 📖 [Guide to NDIS Pre-Planning](#)
- Assist patient to choose SC
- Collaborate with participant and their support person(s)
- Explore need for advocacy
- Explore participant's long-term discharge preferences
- Confirm disability related health needs
  - 📖 [Disability related health supports](#)
- Develop pre-plan based on discharge decision
  - 📖 [Guide to NDIS Pre-Planning](#)
  - 📖 [Getting the Language Right](#)
- NDIS discharge templates (disseminated by HLO)
- Explore housing options early 📖 [The Housing Hub](#)
- Follow local internal/external process to escalate if needed

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

#### Health & Support Coordinator tasks

#### A. Going Home

- **Health** – 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](#)
- **Health** – Complete allied health housing assessments 📖 [Allied health housing assessments](#)
- **SC** – Complete Housing Plan
  - 📖 [Housing plan tool – SDA](#)
- Confirm SDA determination
- Coordinate with housing and support provider
- Real world trials – AT, home and other housing 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](#)
- **Health** – OT assessment of transitional option
- **SC** – Confirm MTA or SDA funding for transitional option
- **SC** – Implement NDIS plan before entering transitional housing
- **SC** – Document exit plan from transitional housing

### 4. PREPARE FOR DISCHARGE

#### Health & Support Coordinator tasks

- Collaborate with participant and their support person
- Source NDIS service providers
- Coordinate installation of home modifications
- Provide prescribed AT
- 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 changing your plan](#)

#### Key

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