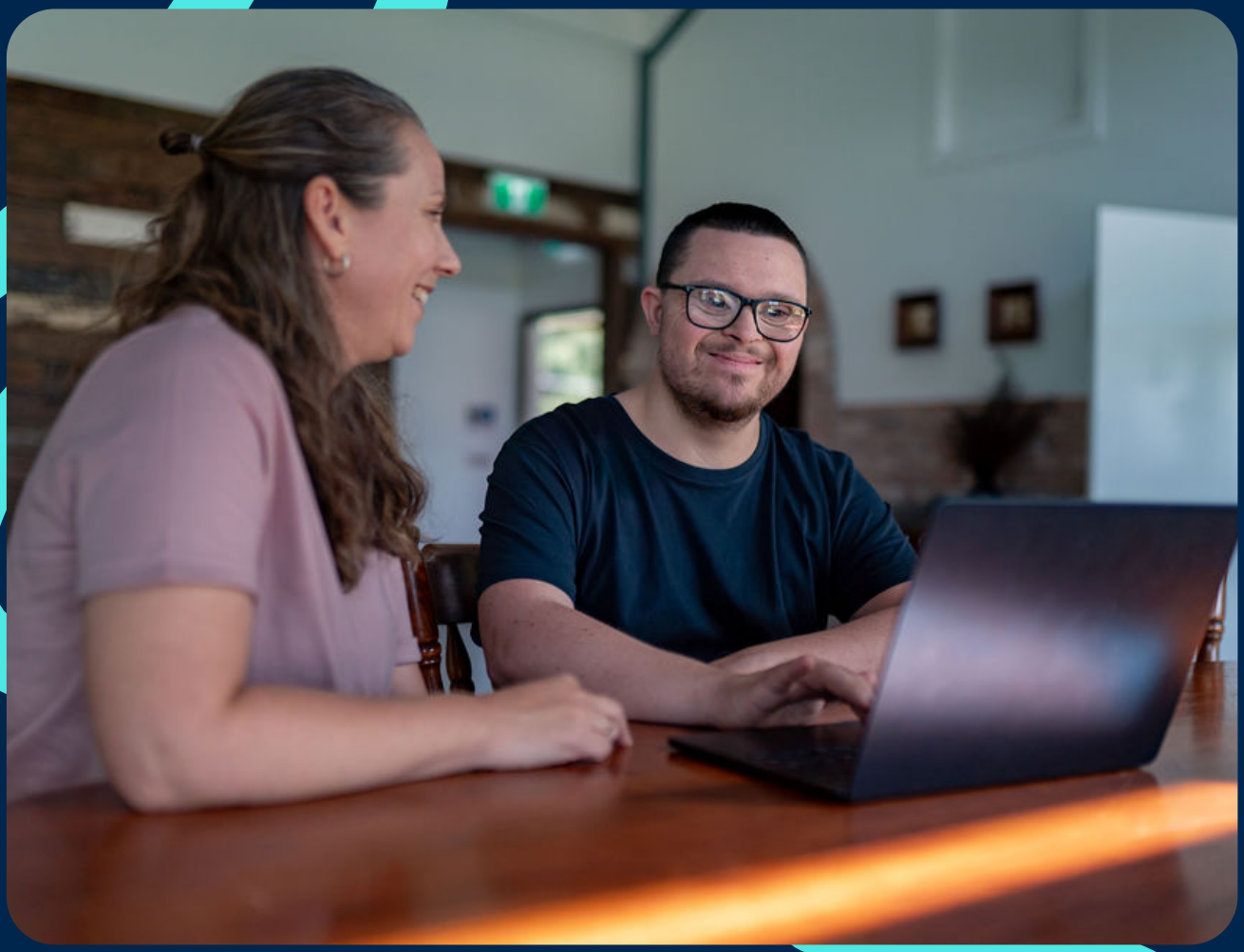

Housing Hub.

Discharge Planning for NDIS Participants

A Discharge Planning guide to help NDIS participants.

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Discharge Planning for NDIS Participants

The NDIS provides a range of housing options for people with disability. If an NDIS participant cannot be discharged home, a collaborative approach to discharge planning, which includes the person and their whole support team, is integral to a good outcome.

These resources have been designed for hospital clinicians to support NDIS participants who are stuck in hospital without a confirmed discharge destination. There are 5 resources outlining best practice for discharge planning of NDIS participants in need of housing, each with a case example based on real situations.

Barriers to discharge

The term 'housing' is often used to describe the barrier to discharge. However, barriers are usually more complex than this. Understanding the real barrier to discharge is critical. View resource

Collaborative discharge planning

It can be difficult to navigate a complex discharge with multiple stakeholders. Being able to work together effectively will assist with smooth discharge planning. View resource

Making sense of NDIS funding

It is useful to understand how a person's NDIS funding can be used to support discharge. It is important to identify early if more funding is needed. View resource

Supporting a good transition

Poor transitions can result in re-admissions to hospital and adverse outcomes for the person. A good transition plan to support the move into new housing is essential. View resource

Escalation pathways

To avoid NDIS decision timeframes delaying discharge, ensure you know how to escalate decisions appropriately within your team and with the NDIA. View resource

Barriers to Discharge

The terms 'housing' and 'the NDIS' are frequently used as reasons for discharge delay for people in hospital.

However, discharge barriers are usually more complex than this. If 'housing' is the barrier - what is it about housing that's causing challenges? Being as specific as possible when identifying the barrier to discharge will provide a better understanding of the required next steps.

A Housing Hub survey of hospital clinicians in 2023 found that the housing market is one of six common barriers to discharge for NDIS participants stuck in hospital. The other barriers include:

1. Communication between stakeholders
2. Understanding roles and responsibilities
3. Report writing and evidence requirements
4. Inconsistencies in NDIS decision-making
5. Lengthy decision making timeframes

Top Tricks and Tips

- Consider why a person cannot return home, or why they can't discharge to an interim setting. The answer will usually lead you to identify discharge barriers other than a lack of 'bricks and mortar' housing.
- Consider what information or resources a provider needs to confidently provide housing and support to your participant.
- It's never too early to start. Don't wait until someone is 'discharge ready' to explore housing options.

Case Study

Amir and his support team were having trouble finding housing for discharge. Despite having Supported Independent Living (SIL) funding, applications for vacant properties kept being rejected.

When the occupational therapist followed up with one provider to query why the application was rejected, the provider reported being concerned about managing behaviours of concern, as there was no Behaviour Support Plan (BSP) in place. The hospital team did not think a BSP was required, because there were no restrictive practices being used in the hospital setting. As a result, there was no funding in the NDIS plan for positive behaviour support.

The multidisciplinary team needed to submit new evidence to the NDIA for a plan review to include behaviour support funding. By the time the BSP was completed, discharge had been delayed by 3 months.

Collaborative Discharge Planning

Misunderstanding of roles and responsibilities is a key issue faced by many teams during complex discharge planning.

The involvement of many different stakeholders can lead to confusion, particularly when multiple tasks are being completed at the same time.

It is important to always define roles and responsibilities of each stakeholder, and clarify these throughout the discharge process.

Regular meetings and the circulation of meeting minutes enables all stakeholders to receive updates and clear actions. Having these in writing promotes accountability and prevents progress from stalling. Clear responsibilities and actions will also ensure NDIS funded stakeholders such as support coordinators can use their available hours in the most efficient and effective manner.

Refer to the Collaborative Discharge Approach for more information.

Top Tricks and Tips

- Don't assume a support coordinator has worked with a hospital team before.
- Roles and responsibilities can differ between hospitals. Always take the time to explain yours.
- Frequent, short meetings reduce the need for complex long email chains, and are more effective than a single 90-minute meeting.

Case Study

Mei was admitted to hospital with significant functional decline as a result of early onset Alzheimer's disease. Her multidisciplinary team included a neurologist, occupational therapist (OT), social worker, support coordinator, behaviour support practitioner and family members. Weekly meetings of 15-30 minutes were arranged to share updates on progress toward discharge, and enabled stakeholders to share ideas and concerns in a timely way.

These meetings were chaired by the hospital social worker, who was also responsible for ensuring actions and tasks were assigned during the meeting, and documented on an action log with time frames. Once the discharge date was confirmed, the OT was responsible for arranging hire equipment, the support coordinator ensured all community supports were in place prior to discharge, and the behaviour support practitioner arranged education of Supported Independent Living (SIL) support staff prior to Mei transitioning to their care.

Making Sense of NDIS Funding

NDIS funding does not always directly align with what was requested, or with a person's stated housing needs and preferences. However, NDIS funding can often be used flexibly to meet expectations.

When reviewing NDIS outcomes, it is important to consider the dollar figure instead of the description of support. Then, ask housing and support providers the minimum funding they need to meet the person's needs. A provider may be able to work within the person's current NDIS budget, saving you from needing to go to a plan review prior to discharge. If the dollar figure in the person's plan significantly falls short of what the provider needs, you will likely need to apply for more funding.

When applying for funding, be clear on exactly what is being requested. The terms 'Specialist Disability Accommodation' (SDA) and '24/7' are too general and unlikely to result in adequate funding, as the NDIS will likely default to the most cost-effective option. Providing specific recommendations aligned to a person's goals is more likely to result in funding that provides practical options for discharge.

Top tips and tricks

- Speak with the Support Coordinator or Health Liason Officer (HLO) to help with understanding funding in an NDIS plan.
- Not all SDA funding is the same. Make sure you understand and request the design category, build type, and occupancy.
- Use the NDIS SDA Price Calculator to understand the shortfall between a person's ideal and current SDA funding.
- The Housing Needs and Preferences to Support Discharge guide and template helps to break down a person's support requirements.

Case Study

Margaret had funding in her NDIS plan for Supported Independent Living (SIL). This support was funded at a 1:3 ratio; meaning 1 support worker is shared between 3 NDIS participants. Margaret's goal was to continue living with her partner, but the team thought she would need to live in a shared home due to her 1:3 funding.

After speaking with their hospital NDIS navigator, the team learnt about a housing option where a set of 4 single-occupancy villas shared 1 onsite support worker. The social worker called the provider and confirmed the 1:3 SIL funding was sufficient for this arrangement, and Margaret was able to move in and live with her partner in their own villa.

Supporting a Good Transition

Locating a housing option for discharge is only a part of the discharge planning process. Once a housing option is confirmed, planning for a transition from hospital should include frequent communication with both the housing and support providers.

Support providers will seek to understand the person's support needs, and may request documents including OT (occupational therapist) reports, medication charts and continence information. For those needing specialised care, such as behaviour support or specialised manual handling techniques, specific training is recommended and often required by the provider. Participant-led training videos are a useful way to do this.

Other items regularly associated with moving such as furniture, linen and first food shop also need to be organised. It is important to allocate these tasks to a member of the care team well in advance. When this is left to the last minute, discharge can be delayed several days to ensure the basics are in place.

Top Tricks and Tips

- Include housing and support providers in regular stakeholder meetings leading up to discharge.
- Shadow shifts in the hospital are ideal to provide thorough training of new support workers.
- The Moving to a New Home Checklist is a helpful resource for transition planning.

Case Study

Five days after discharge to a new SDA (Specialist Disability Accommodation), Josh was readmitted to hospital. The reason for admission was because the new support workers workers found it challenging to provide adequate support, and the support provider complained they had not been fully informed of Josh's specific needs.

An investigation found that prior to discharge, no carer training or comprehensive handover had been completed between the hospital team and the support provider. As a result, the arrangement broke down and Josh returned to the hospital via ED (emergency department). The care coordinator spoke to the provider, who agreed they would be willing to support Josh once carer training and a written handover had been provided. Josh then needed to be admitted to a ward for 5 days so this could be completed.

Escalation Pathways

The NDIS website outlines their commitment to supporting the timely discharge of NDIS participants in hospital, including expected decision making timeframes. Escalation should occur as soon as these timeframes have been exceeded, or when the NDIS has made a decision that does not align with the person's needs for discharge, so this decision can be reviewed.

The first point of escalation should always be via your health liaison officer (HLO). Your HLO can also assist in determining what additional evidence is required to support an ideal funding outcome.

Most hospital networks have NDIS navigators or similar roles to support with NDIS processes, who often act as the nominated representative for contact with the HLO. Your NDIS navigator may also be able to assist with further escalation to the health interface branch if needed.

Still Need Support

- Disability liaison officers (DLO) play a useful role in health service accessibility for people with a disability, however do not typically play a role in discharge planning and escalations.
- Multiple and Complex Needs Initiative (MACNI) may offer gap funding while awaiting outcomes and have their own escalation pathways with the NDIA.
- DFFH Housing Crisis Line for those facing homelessness or escaping family violence.
- Marathon NDIS Crisis Service when NDIS supports break down.

Case Study

Despite the need to live alone, Daniel was funded for Specialist Disability Accommodation (SDA) in a 3-resident house. Daniel's care team located an appropriate 1-resident apartment, and then provided updated evidence to the NDIA via their HLO in order to request an increase to his funding.

The new evidence was reviewed by the Home and Living panel, who changed Daniel's funding to SDA, 1 resident villa/duplex/townhouse. Despite this seeming like good news, the hospital team realised that the funding was still not sufficient for the housing option they'd identified for Daniel. The HLO recommended they provide evidence of their housing search to the NDIA, and as a result, Daniel's funding was updated to allow him to move into a 1-resident apartment.

Discharge Planning for NDIS Participants

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