LEAVING HOSPITAL WELL
COLLABORATIVE DISCHARGE APPROACH

STREAMLINING HOSPITAL DISCHARGE FOR NDIS PARTICIPANTS

COLLABORATIVE DISCHARGE APPROACH (CDA) PROJECT EVALUATION

JUNE 2020

FOR WEBSITE

SUMMER FOUNDATION

NSW GOVERNMENT

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Citation Guide

Mitsch, V. & Kelly, K. (2020). *Streamlining Hospital Discharge for NDIS Participants. Collaborative Discharge Approach Project Evaluation.* Summer Foundation and South Western Sydney Local Health District.

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EXECUTIVE SUMMARY

Introduction

The National Disability Insurance Scheme (NDIS) represents a significant change in how patients with newly acquired disability and/or change in condition are funded for their ongoing disability supports. The "Leaving Hospital Well – Collaborative Discharge Approach" project aimed to demonstrate an approach for achieving positive outcomes for participants in hospital that can be replicated across Australia. It was a partnership between South Western Sydney Local Health District, a local health district (LHD) within New South Wales, and the Summer Foundation.

Seven South Western Sydney Local Health District (SWSLHD) facilities/services participated in the Collaborative Discharge Approach (CDA) project. They include acute, sub-acute, general rehabilitation and a specialist rehabilitation unit.

Implementation

The project was implemented through a network of social work and occupational therapy champions from SWSLHD facilities/services, together with experienced support coordinators with an interest in hospital discharge planning. The local NDIS service delivery team was invited to participate in the project; however, this was not possible at the time of project implementation.

Training activities built the knowledge, skill and competences of the champions in navigating the NDIS with admitted patients, which was disseminated by champions to other staff in their site/service. Progressive practice change was supported with regular coaching and reflective support, and the development of a practice guide and supporting resources.

This project operated in 4 simultaneous focus areas to achieve improved discharge and community living outcomes for patients:

1. Getting systems working for discharge with NDIS supports
2. Articulating participant housing needs and preferences
3. Exploring housing solutions
4. Transitioning to interim and long-term housing

Evaluation

The impact of the project was evaluated through structured interviews, focus groups, surveys that yielded both qualitative and quantitative information about knowledge, skill, confidence and practice change. NDIS "waiting for what" (WFW) data from the NSW Health patient flow portal and contrasting patient case studies demonstrated changes to the efficiency of access to the right supports through the NDIS. Records of the number of staff participating in specific project activities and staff time allocations were also kept.

Results

The CDA project has fundamentally improved how admitted NDIS participants in SWSLHD are supported to access the right NDIS supports for discharge. There has been substantial and sustained improvement in NDIS champions' knowledge, skill and confidence in multiple elements of the NDIS pathway. The project resulted in effective practice change and useful resources to assist SWSLHD staff to navigate the NDIS with inpatients.

Training and project management

Each of the 7 targeted facility/specialty services had at least 2 champions - 1 from Occupational Therapy and 1 from Social Work. In practice, additional champions were recruited in temporarily or permanently as decided by each facility/service. Additional staff also participated in the capacity building training sessions.

The SWSLHD NDIS coordinator allocated **1 day per week** for the duration of the project (approximately **38 weeks**), equating to approximately **300 hours.** The health staff time commitment for training attendance equalled **589 hours** in total.

Satisfaction with training sessions

Participants rated high levels of satisfaction (≥ 7.5 of out of 10) with the 4 key training sessions: support coordination and health, train the trainer in access and planning, housing pathways, and collaboration to connect people in hospital to housing.

Specific changes in knowledge, confidence and skills

NDIS champions representing their clinical stream and teams rated their NDIS literacy and confidence in planning process as low at the start of the project within the needs analysis (May 2019). Overall confidence in NDIS moved from 4 to an 8 (out of 10) by the conclusion of the project (February 2020). This included increased understanding of the access and planning processes, housing pathways and in working collaboratively with support coordinators. Champion feedback 3 months after the project concluded (May 2020), indicated that improvements in knowledge, confidence and skills have been sustained after project activity concluded.

Practice changes

Potential participants are being identified earlier, and NDIS access and planning is being consistently commenced in the acute hospital environment. This is also the case for people who are being transferred to a rehabilitation, or other sub-acute, environment. Staff have been empowered to be more active partners in working collaboratively with support coordinators and National Disability Insurance Agency (NDIA) planners throughout the planning process, and during establishment of supports. Staff reported an improved understanding in writing to meet NDIS legislative requirements including how to demonstrate reasonable and necessary criteria.

Appropriate housing options are being considered at the beginning of the planning process, rather than the end, resulting in a reported reduction in admittance to inappropriate housing options such as residential aged care (RAC).

Efficiency of access

Efficiency of access to NDIS supports has also improved, with progressive reductions in NDIS-related wait times seen within sites able to effectively and comprehensively implement CDA principles (Hospitals A, B, C and D).

Conclusion and Future Directions

The Collaborative Discharge Approach Project has fundamentally improved how admitted NDIS participants in SWSLHD are supported to access the right NDIS supports for discharge.

The Collaborative Champions group, formed during the CDA project, continues to meet monthly to share information. This includes learning from each other's experiences and developing new

resources to support staff to work effectively in the NDIS space. The champions will remain a fundamental component to ongoing capacity building of clinical staff at SWSLHD as NDIS processes change and develop. The practice guide will continue to be a living document. The guide and supporting resources will be updated and modified by the Collaborative Champions group and in consultation with the NDIA Health Liaison Officer (funded by NDIA) for SWSLHD.

Key success factors

The CDA project was able to be successfully implemented with minimal specific resourcing within the local health district. Implementation through a champions network with executive level support made this possible. The fundamental framework required for the success of the project was:

- Executive sponsorship
- An LHD project lead
- Subject matter expertise (provided by the Summer Foundation)
- Use of project implementation methodology
- Commitment from NDIS champions throughout the project
- Champions who would internalise new information, use it to change practice, and share this knowledge with others
- Behaviour change framework strategies such as regular coaching
- Connections with experienced support coordinators

Challenges and barriers within the project

- The local NDIS Service Delivery team was not in a position to participate in the project. Involvement of NDIS representatives would have ensured that all strategies, tools and processes implemented met the needs of NDIS planning, and both LHD and NDIS processes were truly complementary
- Variability in champions' capacity to implement change within their local service/facility
- Sites with lower numbers of NDIS participants moving through the discharge pathway had limited ability to implement and practice the principles of the CDA
- Staff (champion) turnover within specific sites/services during the project limited implementation in some locations

Essential elements for streamlined discharge practice for NDIS participants

- Meaningful exploration of a person's housing goals by the hospital multidisciplinary team prior to their first planning meeting (or plan review, for people who are NDIS participants at the time of hospital admission)
- Fast and effective decisions related to eligibility for SDA, SIL and assistive technology (AT) funding
- Skilled support coordinators who collaborate early with health staff around effective hospital discharge
- Clarity of roles of health staff and support coordinators

- Access to medium term accommodation (MTA) funding with enough person-to-person support funding, even if a person does not yet have a specific long-term discharge destination
- Involvement of the same senior planner consistently across plans
- Open communication between health staff, support coordinators and NDIA planners and Health Liaison Officers (HLO)

CDA applicability outside of trial site

The CDA model could certainly be implemented in other local health districts/networks or extended further for potential state or national implementation. Key elements to be included in any replication or upscaling include:

- Executive portfolio lead
- Framework for NDIS capacity building within a health network/site
- Project co-design with health staff, NDIA staff and support coordinators
- Confirmation of the roles and responsibilities of the discharge planning process using the CDA practice guide
- Co-design of tools for comprehensive multidisciplinary reporting of functional abilities and support needs for access and planning (e.g. pre-planning tools/report formats)
- Enhanced capacity and co-designed tools to support exploration of the full range of housing options that align with a person's housing needs and preferences prior to the first NDIS plan
- Enhanced capacity and co-designed tools to support collaborative working between health staff and support coordinators
- Interim plans that align with a person's housing goals

Replication of this approach contributes to the achievement of the YPIRAC (younger people in residential aged care) targets, specifically towards no new entrants in to aged care by 2022. The NDIS is very young, with frequent changes and developments still occurring. As such, there is a need for the lessons, resources and processes developed during the CDA to adapt to the ongoing development of the scheme. Inevitable staff turnover and clinical rotation will also require that education and support within SWSLHD are ongoing and remain a priority. Feedback from champions indicates a need for further learning and development in the area of NDIS-related housing options and guidance for working collaboratively with support coordinators.

The eventual embedding of an NDIS HLO in SWSLHD, working in collaboration with the SWSLHD NDIS coordinator and SWSLHD NDIS champions, will support ongoing capacity building. This will also achieve an improved alignment between the local health district and NDIS processes to streamline discharge practice. The knowledge and confidence gained during the CDA puts SWSLHD in a strong position for effective ongoing collaboration with NDIS staff and registered providers for the best possible outcomes for NDIS participants.

INTRODUCTION

This project aimed to demonstrate an approach to assist people with newly acquired disability and/or change in condition who are participants of the NDIS to have timely discharge to community from a hospital facility and secure an appropriate long-term housing outcome.

Improving pathways from hospital back to the community is a high priority to enhance outcomes for people with newly acquired disability and/or change in condition who are NDIS participants or NDIS eligible.

Barriers to good participant discharge and housing outcomes include:

- Health facility staff knowledge of the NDIS processes (particularly key staff in discharge processes)
- Understanding the processes and timeframes of the NDIA
- Timely access to the right NDIS funding for supports, assistive technology and SDA funding
- Lack of understanding of SDA funding and suitable housing market options
- Lack of appropriate housing options

The NDIS represents a significant change in how patients with newly acquired disability and/or change in condition are funded for their ongoing disability supports. This project aimed to demonstrate an approach for achieving positive outcomes for participants in hospital that can be replicated across Australia.

The key benefits of this project for people with complex disability support and housing needs in hospital facilities are:

- Timely access to the NDIS
- Early approval of key NDIS supports, especially support coordination
- Individual assistance to specify housing needs and source housing solutions
- Develop transitional arrangements for support and housing where required

The project titled “Leaving Hospital Well - Collaborative Discharge Approach” was a partnership between South Western Sydney Local Health District (a local health district within New South Wales) and the Summer Foundation. A memorandum of understanding guided the deliverables for this project which commenced in May 2019 and was completed in February 2020.

IMPLEMENTATION

The project was implemented through a network of social work and occupational therapy champions from SWSLHD facilities/services, together with experienced support coordinators, with an interest in hospital discharge planning. The local NDIS service delivery team was invited to participate in the project; however, this was not possible at the time of project implementation.

Training activities built the knowledge, skill and competences of the champions in navigating the NDIS with admitted patients, which was disseminated by champions to other staff in their site/service. Progressive practice change was supported with regular coaching and reflective support, and the development of a practice guide and supporting resources.

The CDA aimed to improve the discharge pathway and outcomes through changing the behaviour of NDIS champions. Behaviour change interventions were incorporated within this project with consideration given to what was needed to deliver a change in practice for the NDIS champions working with complex people under 65. Consideration was given to involvement of personnel in the project that had more opportunity to interface with the NDIS and therefore had the capability and motivation for involvement in CDA project.

Further behaviour change interventions implemented included education to increase knowledge and understanding, persuasion techniques within coaching and feedback sessions, incentivisation (reward of improved patient outcomes and reduced staff frustrations), modelling, enablement and environmental restructuring (process change).

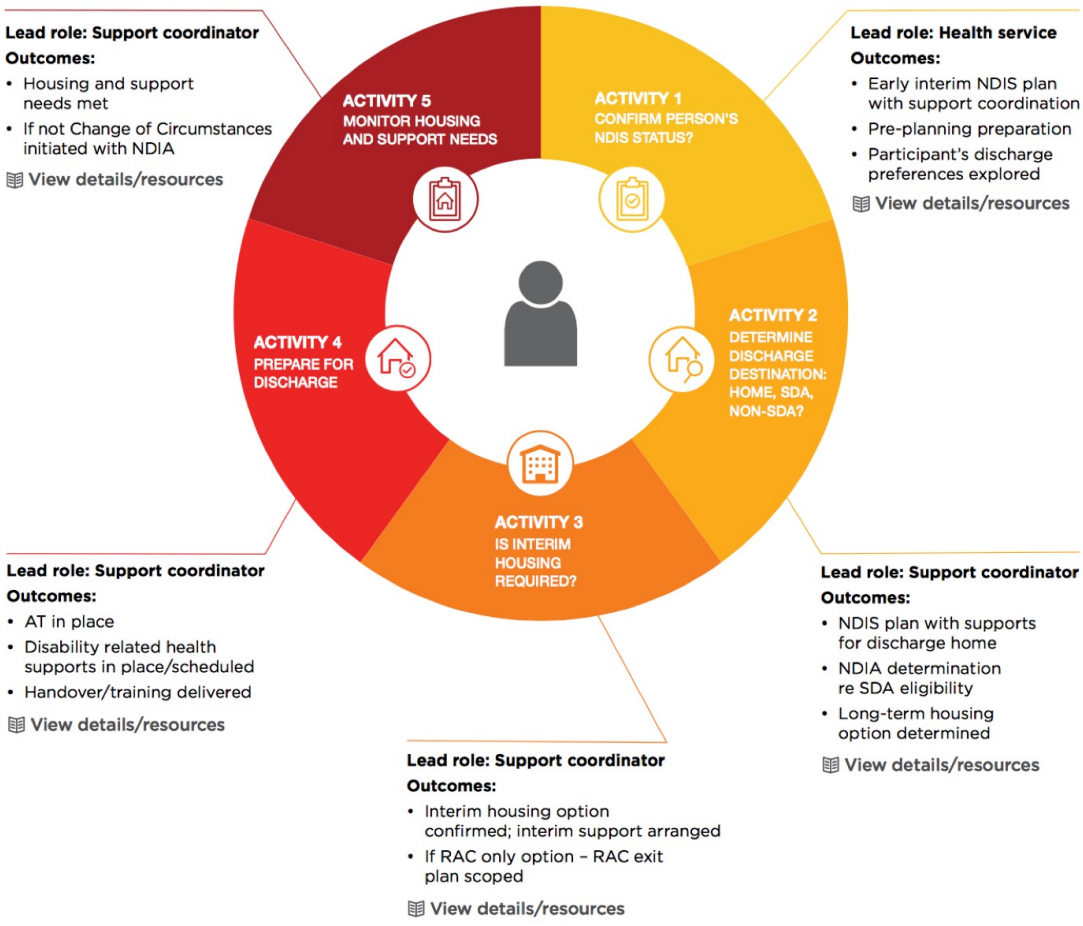
The project operated in 4 focus areas to achieve improved discharge and community living outcomes for patients. Note the focus areas were not sequential and at times operated parallel to each other.

1. Getting systems working for discharge with NDIS supports – capacity development (education and resources) for hospital staff and increased collaboration between NDIS and hospital in patient discharge planning (early collaboration with NDIS) to enhance appropriate and timely discharge with the right NDIS-funded supports. The Summer Foundation's CDA was utilised within this phase. For more information refer to document Collaborative Discharge Approach – practice guide

2. Articulating participant housing needs – supporting NDIS participants in hospital settings to develop a clear housing plan, building patient capacity to understand and identify housing needs and preferences in a way that signals requirements to potential housing providers.

3. Exploring housing solutions – where a new housing options is needed, using the participant's housing needs and preferences to explore a range of housing options that align with that need (i.e. with an SDA provider or mainstream housing providers); then offering those possible solutions to the person so they can then choose where and how they want to live (either in an existing or new SDA dwelling or a modified/customised mainstream housing option, with appropriate supports funded through an NDIS plan).
4. Transitioning to interim and long-term housing – ensuring support coordinators develop transition plans that assist participants make the transition from hospital to long-term housing, including interim and temporary solutions while long-term options are being built.

Figure 1: Collaborative Discharge Approach



Key Personnel involved in project

Executive leadership within SWSLHD was provided within the allied health directorate and a project lead from both SWSLHD and Summer Foundation (Collaborative Hospital Discharge lead).

Executive endorsement from SWSLHD allied health was secured initially in order to commence with the project. The release of allied health staff to be involved in project followed this endorsement.

The Practice Team Summer Foundation provided both administration and training support along with expert matter assistance within this project.

Seven facilities/services participated in the CDA project. They include acute, subacute, general rehabilitation and a specialist rehabilitation unit.

SWSLHD NDIS Champions

Following project sponsorship from professional leads, allied health clinicians involved in hospital discharge practice were sought to be leaders within this project. SWSLHD NDIS champions were identified in all participating sites. Champions represented the allied health profession of social work and occupational therapy and participated in all project activities included ongoing consultation for capacity building. Each facility nominated at least 1 consistent champion from each discipline, however other clinical leaders joined various capacity building, coaching and feedback sessions at the discretion of the facility.

Support Coordinators

Support coordinators were recruited via Summer Foundation's UpSkill Support Coordination Program. Support coordinators previously participated via open invitation to educate others on the health environment and hospital based discharge. A further EOI process was undertaken with this group to recruit support coordinators with particular interest in hospital-based work. Three experienced support coordinators from separately registered NDIS providers joined the project.

Project Activities

Actions identified during project activities

Actions identified within project activities were collated into themes to inform progressive project activity. The project went through an iterative process of identifying needs and actions according to the focus areas of the CDA model. Each project activity (e.g. workshop, coaching session, resource produced for trial) built on to further activities. Project activities are described according to the focus areas of the project. Focus area activities occurred concurrently, rather than in a linear fashion, and some activities addressed multiple focus areas simultaneously.

Variation was noted in how comprehensively the CDA project was implemented across sites. This was representative of factors including NDIS participant numbers for sites, number champions from each site and size of the hospital site.

Focus area 1: Getting systems working for discharge

Activities that contribute to system development included:

- Health Needs Analysis Workshop 19 May 2019, (15 participants)
- Working with people in hospitals for NDIS support coordinators, 21 May 2019 (20 participants)
- Introduction to CDA for support coordinators, 17 June 2019 (4 participants)
- Health and support coordinators - collaboration in action, 17 June 2019 (25 participants)
- Development of SWSLHD CDA - Prompts for Health and Support Coordinator
- Train the trainer (Access, pre-planning, writing for the NDIS), 17 June (30 participants)
- Development of SWSLHD CDA - Actions document- developed out of the training and capacity activities

- Bi-monthly coaching and feedback sessions with NDIS champions at each site using 'SWSLHD CDA - Prompts for Health and Support Coordinator check ins'. These capacity building sessions discussed the implementation SWSLHD actions document (key elements of the CDA). These included early identification for access, use of early interim plans, engaging early with support coordinator and early housing discussions. Coaching techniques were key to these sessions for maintaining and embedding the change.
- Mid project progress check (9 October 2019)
    - Review of elements of CDA - early interim plans, engagement with NDIA planners
    - Review of working collaboratively
- Linking SWLHD NDIS champions and NDIS coordinator to Summer Foundation Community of Practice
- End of project summation session SWSLHD NDIS champions and support coordinators. This included presentation of:
    - WFW data
    - Preliminary qualitative data
    - New resources
    - Sustainability of project

Focus area 2: Articulating participant housing needs

Once systems were established to support discharge, the focus shifted to understanding individual's housing needs and how this could be achieved within an NDIS framework. Activities focused on understanding housing options for NDIS participants and the development and trial of tools for exploring and communicating an NDIS participant's housing needs. They included:

- General housing pathways workshop 18 June 2019 (25 participants - health and support coordinators)
- SDA secondary consultation session 17 November 2019. Developing capacity within NDIS champions to consider SDA as a housing option including understanding NDIS SDA eligibility rules (15 participants)
- Bi-monthly coaching and feedback sessions with NDIS champions at each site – as for focus area 1
- Resource development specifically for housing needs and preferences. The Summer Foundation's trial Housing Needs and Preferences tool was adapted into a package of 3 templates that SWSLHD staff could use to explore and document a person's housing needs and preferences prior to a planning meeting.

Focus area 3: Exploring housing solutions

- Networking with registered housing and support providers. A collaborative session was held with SWSLHD NDIS champions, support coordinator, support providers and housing providers. In total 35 participants interacted with 7 housing providers and 5 support providers
- Workshops, coaching and resource development activities already described facilitated champions and support coordinators' capacity to explore available housing solutions that align with the NDIS participants' needs and offering those solutions to the person to choose.

Focus area 4: Transitioning to interim and long-term housing

- Consultation "clinics" were provided to each site's champions by the Summer Foundation Housing Matching Team to consider possible interim and long-term housing options for specific NDIS participants.

Evaluation

This CDA project used both qualitative and quantitative evaluation components. The qualitative component used an evaluation framework drawn from program logic methodology, with a focus on reviewing and revising practice. This included outputs such as knowledge gained in training, discharge process and relationships established with support coordinators and housing providers. Quantitative evaluation included measurements of time and resource commitment, and changes to the length of time taken for NDIS participants to progress through the NDIS pathway.

Qualitative and quantitative methods supported comprehensive evaluation across several themes.

Evaluation themes

Knowledge, confidence and skills

- Training attendance and time commitment
- Staff satisfaction level with training and resources provided
- Level of knowledge and confidence areas pre and post training
- Level of knowledge and confidence and skill reported by NDIS champions
- NDIS champions time commitment to the project

Practice change

- Early use of support coordination and private providers in the discharge continuum
- Evidence of health staff and support coordinators working collaboratively in the discharge process
- Early collaborative housing exploration (e.g. evidence of discussions on home modifications, SDA eligibility, interim and long-term options)
- Testing for SDA eligibility occurring before discharge

Efficiency of access to the right supports for discharge

- Variation in the number of potential NDIS participants identified
- Time spent in moving through the NDIS pathway (average days waited for a NDIS - related wait)
- Engagement between SWSLHD and NDIA
- NDIS supports implemented before a participant's discharge
- Interim housing options utilised before moving to a longer term housing option (e.g. use of MTA funding)
- Evidence of planning process occurring within 2 weeks from access
- Reduction in entry to RAC

Quantitative data collection

NDIS "waiting for what" (WFW)

Quantitative data was collected through the NSW Health Patient Flow Portal (PFP), a state-wide database that is in place in every hospital across NSW. The WFW functionality in the PFP allows users to add details relating to tasks and processes required throughout a person's stay to facilitate a safe discharge. Delays that could potentially be extending a person's length of stay or preventing discharge can be tracked. This system is used for all people admitted to NSW Health facilities. It does not capture data for non-admitted and community services.

The 5 NDIS wait types on the PFP allow a person's movement through NDIS-related processes to be tracked ("NDIS 1-5"). For the purpose of this project, an additional category was calculated to record the time from hospital admission to an NDIS access request being started. The 6 wait categories are therefore:

- Admission to NDIS 1 – time from admission to start of preparing NDIS access request
- NDIS 1 – Preparation & submission of access request
- NDIS 2 – NDIS eligibility decision made
- NDIS 3 – Planning meeting, plan development and approval
- NDIS 4 – Finding and establishing suitable supports (including housing)
- NDIS 5 – Approval to conduct review of NDIS plan (usually followed by another NDIS 3 wait)

WFW data was compared for 3 time periods:

- 2018 – patients admitted during the full 12 months prior to the CDA project
- 2019 pre CDA – patients admitted from January to June 2019 during the preparatory period of the project (i.e. needs analysis, capacity building etc)
- 2019 from CDA start – patients admitted from July to December 2019 following the trial implementation of the CDA

Quantitative data was collected for all sites except one which had not consistently used the WFW function on the PFP until late 2019.

Attendance and time spent

Attendance at targeted sessions and time required for specific activities was tracked. Note, this was not recorded for all activities.

Qualitative data collection

Participant case studies

The progress of 2 complex NDIS participants through the NDIS pathway was recorded for pre and post-project comparison of the impact of CDA principles and processes.

Semi-structured interviews

Group and individual interviews of SWSLHD NDIS champions and support coordinators occurred at the end of the project. Data from these interviews was collected, analysed and themed by the Summer Foundation lead. All champions at all sites were approached for interviews; see table below outlining representation. The open-ended, semi-structured interviews aimed to explore themes centred around the development of knowledge, confidence and skills within the project, practice change and efficiency of process (appendix A).

Sites Represented	Total number interviews	Total Number interviewees	Professions represented
5	9	12	Occupational therapy, social work, allied health manager, project coordinator

Table: 1 overview of interview schedule-NDIS champions

RESULTS

Knowledge, confidence and skills

Training and project management

During phase 1 of the project 6 training events occurred each addressing specific objectives within the CDA project. Content for specific training such as writing for NDIS access and pre-planning was identified within the needs analysis completed at the start of the project. Primary targets for training were NDIS champions, however selected sessions were open to additional staff members.

Each of the 7 targeted facility/specialty services had at least 2 champions - 1 from Occupational Therapy and 1 from Social Work. In practice, additional champions were recruited in temporarily or permanently as decided by each facility/service. Additional staff also participated in the capacity building training sessions.

The SWSLHD NDIS coordinator allocated **1 day per week** for the duration of the project (approximately **38 weeks**), equating to approximately **300 hours**. The role was to interface with the Summer Foundation project team; coordinate, support and develop the facility champions, assist in resource development and coordinate formal meetings, education and coaching sessions. Formal project planning and management meetings between the SWSLHD NDIS coordinator and the Summer Foundation project team totalled **more than 60 hours**.

Attendance at the training sessions is outlined in Table 2. The health staff time commitment for training attendance equalled **589 hours** in total.

Table 2.

Training name and date delivered	Number of participants	Number of completed evaluations	Duration of session(hours)	Total number of staff hours
Health Needs Analysis Workshop **20/05/2019**	15	n/a	1.5	22.5
Working with people in hospital for NDIS Support Coordinators **21/05/2019**	20 (7 health staff & 13 Support Coordinators)	n/a	4	28 (NB – health staff 7)
Introduction to CDA for Support Coordinators **17/06/2019**	4	4	2.5	n/a
Health & Support Coordinator Collaboration in Action **17/06/2019**	25 (21 health staff & 4 Support Coordinators)	5	1.5	31.5 (NB – health staff 21)
Writing for Access & Planning **18/06/2019**	30	17	5	150
Housing Pathways **03/07/2019**	25	20	4.5	112.5
Collaboration to connect people in hospital to housing **30/07/2020**	35	11	7	245
Housing Options: Specialist Disability Accommodation (SDA), Non-SDA & Supports **19/11/2019**	11	11	2	22
Total number of sessions = 8	**165**	**68**	**26.5**	**589**

Additional coaching and secondary consultation sessions occurred with champion representatives at all sites twice during the project. There were a total of 12 sessions, with at least 3 staff members attending each session, for a total of 35 staff hours. The majority of staff who attended training were occupational therapists or social workers (see Figure 2).

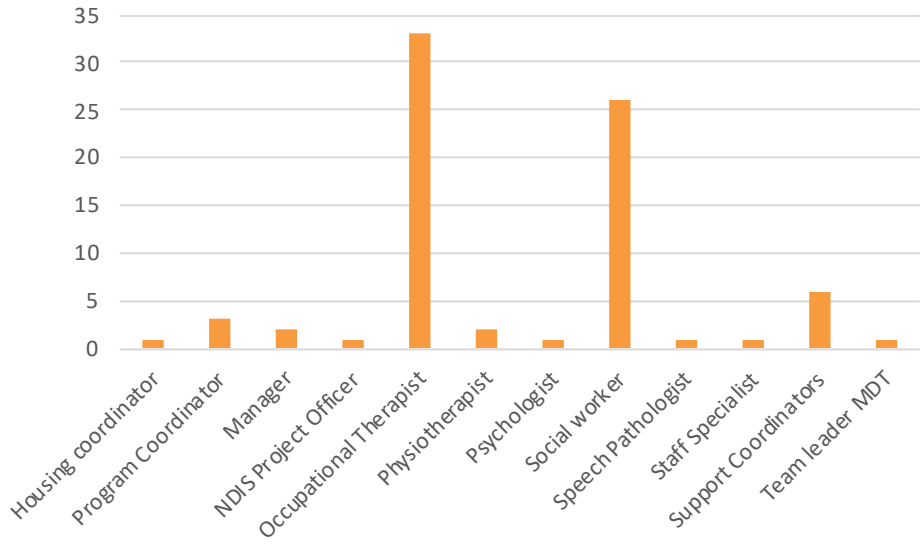


Figure 2. Training attendance by role/discipline

Time spent by champions outside of formal project activity sessions was not tracked.

Satisfaction with training sessions

Participants rated high levels of satisfaction (≥ 7.5 of out of 10) with the 4 key training sessions: Support coordination and health, train the trainer in access and planning, housing pathways, and collaboration to connect people in hospital to housing. Almost all (98%) either agreed or strongly agreed they could apply the learning in practice (Figure 3).

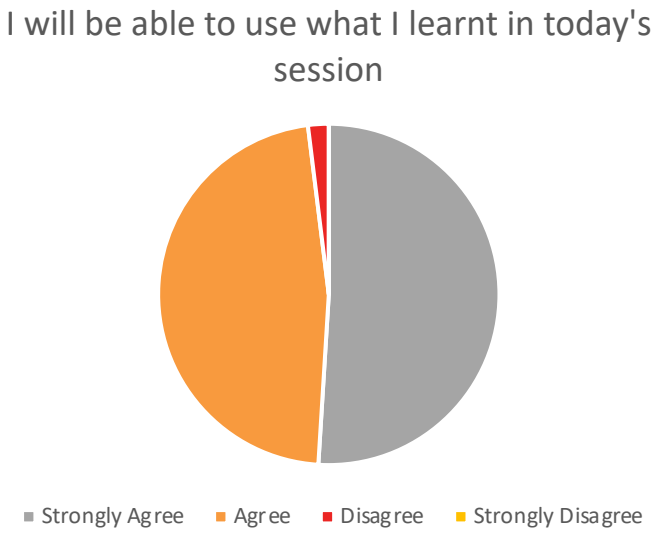


Figure 3. Applicability of training

Education provided through the CDA project was critical to the project success. This included all the training workshops, secondary consultations and the access to the online Summer Foundation Community of Practice:

"Being part of the project, I've got more resources, more tools, more confidence, more knowledge. We're getting remarkable change and success (Occupational Therapist)

Campbelltown/Camden) and the biggest change is that I actually now understand what the whole process is about. My understanding has improved." (Social Worker)

"Capacity building from Summer Foundation was essential. Thinking what could be possible. Think to the language of the Act. Made a real shift." (Project lead)

The workshops within the project provided networking opportunities that impacted on patient outcomes:

"The session from Summer Foundation from housing providers was really interesting and filled in some gaps. Following the session, I was able to develop a good working relationship with a provider. I was able to directly voice concerns and have these concerns addressed in a professional way. It was collaboration that promotes choice and control." (Social Worker)

Specific changes in knowledge, confidence and skills

NDIS champions representing their clinical stream and teams rated their NDIS literacy and confidence in planning process as low at the start of the project within the needs analysis (May 2019). Overall confidence in NDIS moved from 4 to an 8 (out of 10) by the conclusion of the project (February 2020). Confidence in planning was noted to still be variable due to variations in NDIS process across local NDIA offices. The implementation of the NDIA HLO, which is in its early beginnings, may assist with this consistency:

"Individuals at facilities were trying to negotiate this on their own within disciplines. Didn't always have a sense who was eligible who should be funnelled through NDIS. There was an early push into aged care." (Project lead)

"We used to have a passive role; we were told by planners what a person could get." (Social Worker)

Overall improvement in confidence by NDIS champions was also noted by support coordinators at completion of the project:

"Health's understanding of NDIS as a whole has improved. They are more confident when attending NDIS meetings and what they say at meetings." (Support Coordinator)

Champions' understanding of the role of support coordinators to achieve positive discharge outcomes was average (≥6.7). This increased to ≥ 8 out of 10 following the training session on Health and Support Coordinators Collaboration in Action workshop. The greatest improvements were in knowledge of the support coordinator's roles and working collaboratively to achieve positive discharge outcomes (Figure 4).

As the project progressed however, it became apparent that champions needed more formalised tools to help with establishing and maintaining effective working relationships with support coordinators.

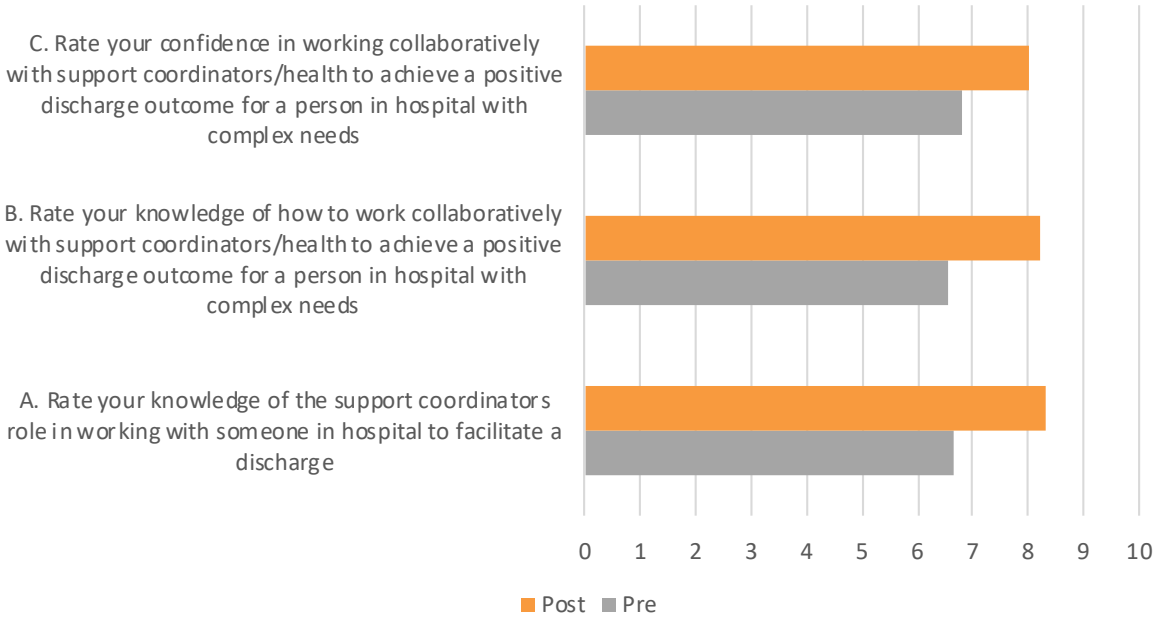


Figure 4. Knowledge and confidence changes – working collaboratively with support coordinators workshop

There was an average level of knowledge and confidence in writing evidence to support NDIS access and planning (≥6.6 out of 10), but this increased substantially following the train-the-trainer session in access and planning. The greatest improvements were in confidence to deliver training and mentoring/guidance to other health staff about the NDIS (Figure 5). Identified further learning needs included ongoing support to implement changes, periodic case consultation sessions to consolidate learnt skills and apply to real time cases and skills consolidation in writing pre-planning criteria and the use of the pre-planning tool.

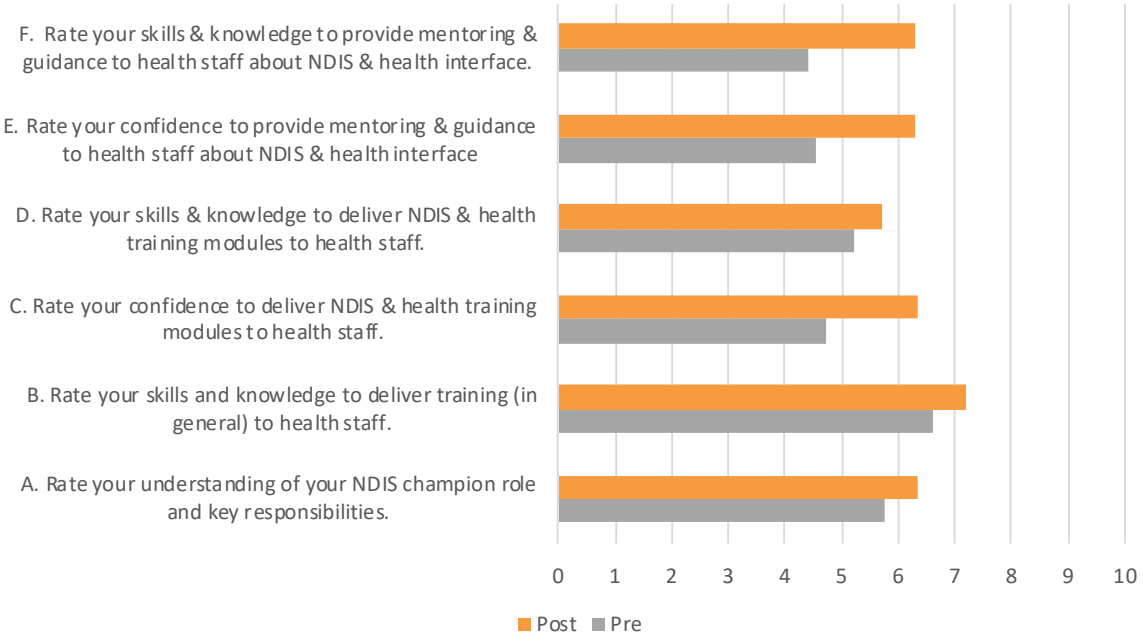


Figure 5. Knowledge and confidence changes – training others in writing for NDIS planning & access

All staff interviewed at the end of the project reported a changed NDIS knowledge, ranging from writing for access to knowledge of SDA rules. This has resulted in practice change and patient outcomes as demonstrated below:

"Seen individuals who were very anti NDIS to now 'I can do this, and I get others to do this'." (Project lead)

"More understanding of what's a realistic goal for discharge - manage expectations when guiding expectations." (Occupational Therapist)

"Hospitals understand the funding better, they understand SDA better and the use of the complex support team. We get better outcomes with this smoother process." (Support Coordinator)

"Champions understand principles, believe in it, tried and tested. This is business as you do business. We don't have to write lengthy documents, just targeted, succinct documents." (Social Worker)

Knowledge of NDIS housing pathways, especially SDA, was low prior to the Housing Pathways training. There was a noticeable increase post-training, but this was clearly an area requiring further development (Figure 6). Specific, ongoing needs identified included; further information and training on eligibility for SDA, health staff roles and responsibilities, ongoing support to implement changes, and periodic case consultation to consolidate learnt skills and apply to real time cases.

Figure 6. Knowledge and confidence changes – NDIS housing pathways workshop

The Collaboration to Connect People in Hospital to Housing workshop was well received and connected providers of SIL and SDA housing options with champions and support coordinators within the project. There was unfortunately no pre-session evaluation, but the feedback following the session indicated above average knowledge (≥ 7 out of 10) and confidence across all topics (Figure 7).

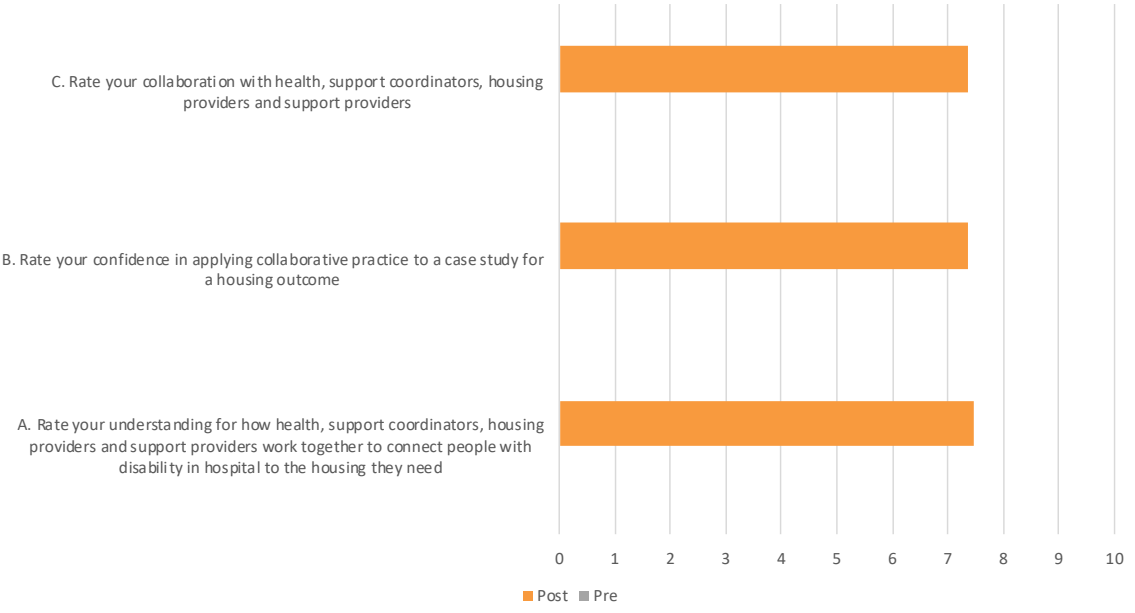


Figure 7. Knowledge and confidence – connecting people in hospital to housing workshop

The champions network adopted for this project proved successful in the development and sustainability of knowledge. There was a strong correlation with practice and change to facilities that had the highest number of champions involved in the project and implementing the knowledge gained.

Cross site/streams sharing of information and collaborating over specific NDIS clinical issues resulting in capacity building was evident in interviews.

"Champions started to talk with each other more. Made my job so much easier. The impact of my position has been magnified by the champions network" (Project lead).

"Champions understand principles, believe in it, tried and tested. 'This is business as you do business. We don't have to write lengthy documents, just targeted, succinct document" (Social Worker).

Education provided within the project led to the development of resources both at a site-specific level and within the whole of the Health district. The resource development required the commitment of the SWSLHD project lead to develop and maintain the resources for currency. A consistent location for storage and access of resources prompted the sharing of resources in practice and completed reports both resulting in increased positive patient outcomes.

The resources below were developed within the SWSLHD CDA project:

- Practice guide – "Navigating the NDIS with Inpatients"
- A document that describes the application of lessons learnt during the CDA project throughout the NDIS pathway. This document includes links to online resources and a comprehensive appendix of resources developed throughout the project. See Appendix C; Navigating the NDIS with Inpatients - A Practice Guide for Staff
- Access request cover letter template: A cover letter for an access request for staff to use to highlight an individual's complexities that make them eligible for an NDIS planner and/or the complex support needs pathway
- Pathway – ACAT assessment for a person under 65: A resource developed collaboratively with the SWSLHD Aged Care and Rehabilitation Service Manager to support staff to navigate a dual process of application to the NDIS and for ACAT assessment for RAC.
- See housing needs and preferences package – a suite of 3 resources to support staff in early exploration of a person's housing support needs and preferences so they approach a first planning meeting with a clarity on the discharge destination being proposed. The resources also help staff to assess whether eligibility for SDA should be tested and to compile information to be taken to planning meeting. See Appendix C, NDIS Participant Housing Needs and Preference Package

- Multidisciplinary pre-planning tool – a comprehensive multidisciplinary report template to compile all evidence to be presented at a planning meeting

- Tools for working collaboratively with support coordinators – a collaborative working agreement and client action plan to negotiate and support a positive working relationship with support coordinators. See Appendix C, Collaborative Working Agreement and Collaborative Working Action Plan

Appendix D notes resources that were informed by the CDA project and developed by the Practice Team Summer Foundation.

These resources, and method of storage and maintenance, were key to the success of the project assisting health staff to streamline processes and implement practice change:

"For us, having all the guidelines and templates has made it so much better (before CDA) we were completely winging it, I had no idea what I was doing. Now I would get the support coordinator to help with finding suitable accommodation." (Social Worker)

The translation of knowledge into skills was noted in using the language of the NDIS in reporting in particular when providing evidence for supports using the reasonable and necessary criteria.

"Our writing has improved. In the beginning we were writing primary disability as a medical condition e.g. stroke, needing assistance with ADLs, mobility, two people assisting. Now, we discuss it as a team and narrow down is it physical, cognitive, communication, psychosocial? What is their biggest impairment that will actually get them in (to the scheme)? And, it is not NDIS responsibility to find the evidence. It's your responsibility to find it and bring it to justify the support." (Occupational Therapist)

"We have seen a difference in what health are writing, the wording they are using in pre-plans is changing" (Support Coordinator)

The skill involved in supported goal setting within the context of the NDIS, including identifying a housing goal early, was noted for its complexity and difficulty in developing team process for this.

"The first step now is - 'where do you want to go? Breaking that down - what is realistic? …. We are upskilling staff to have case meeting together to explore housing goal. It's a challenge to have this discussion early in rehab so need to upskill staff to have that discussion early then work back from that." (Occupational Therapist)

This reported increased knowledge and skills resulted in significant changes in confidence in advocating for supports using a NDIS legislative framework within the planning meeting. This is demonstrated below:

"Staff are NDIS savvy now. What comes with expertise and advanced knowledge are changes in our expectations, and now we expect the NDIS to deliver on these expectations." (Social Worker)

"We can push back now, not just be told what to do. Going prepared, with knowledge to negotiate. This negotiation put people in a good place in the end." (Project lead)

"Confidence in advocating for patient around their goals to NDIS." (Occupational Therapist)

Sustainability of knowledge, skills and confidence

Sustainability of knowledge, skills and confidence gained within the project, in a fluid and at times transient health environment will be challenging, yet motivation for this to occur was reported.

Champion feedback 3 months after the project concluded (May 2020), indicated that improvements in knowledge, confidence and skills have been sustained after project activity concluded. On a scale of 1-10, champions indicated that:

- Understanding of the core principles of the NDIS was rated at >8
- Competence in applying for NDIS access was rated at >8
- Understanding of the NDIS planning process was rated at 8
- Competence in preparing for and participating in the NDIS planning process was rated at >7
- Understanding of NDIS related housing options was rated at >6

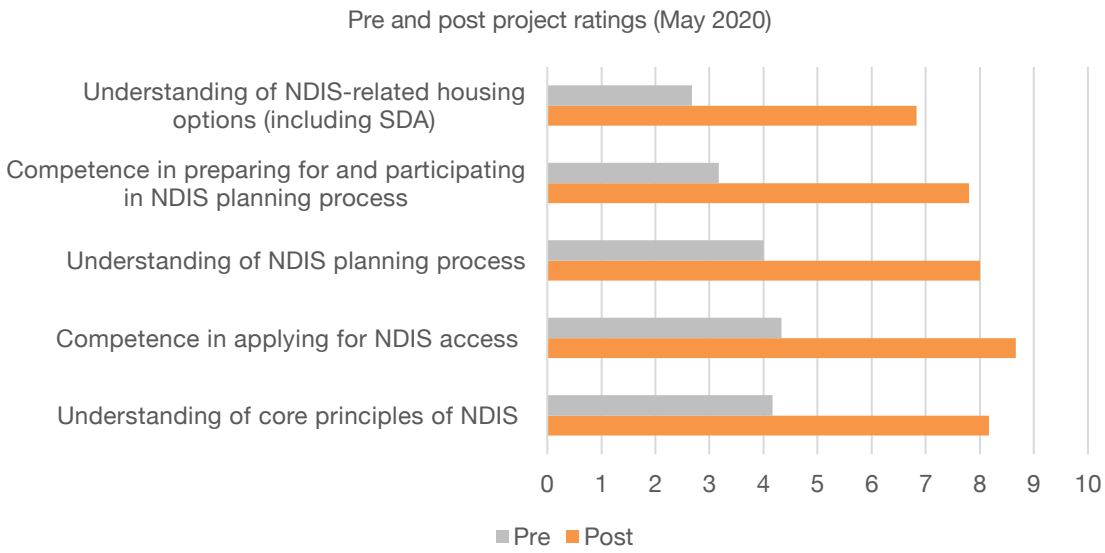


Figure 8. Champions' average ratings of knowledge, confidence and skill, 3 months pre-project and at 3 months post-project.

There remains some scope for further development in competence around planning meetings and understanding of NDIS-related housing options.

Examples of how this could be achieved included:

- Consistent implementation of the Practice Guide SWSLHD wide
- Use of multidisciplinary team for pre-planning tasks incorporated into operational processes
- Continual use of support coordinators within the planning process
- Champions continue to meet and network so to continue to be informed and teach each other
- Targeted clinical staff at each site educated on CDA principles (use of champions in this)
- Share success in SDA eligibility across sites
- Upskill staff in the role delineation between support coordinators and health
- Upskill acute staff in SDA rules and availability
- Shared provider forums with champions network and mental health champions

Practice Change

The translation of improved knowledge, skills and confidence into practice-change required both written processes (as described in the resources developed) and integration into operational process. This included multidisciplinary team meetings around the NDIS and completion of pre-planning documents within a team environment.

"Another change in our practice is that we now have fortnightly NDIS meeting where we talk about the NDIS process for these people. It's not case conference, it's a separate meeting where we talk about it; do we start access for them now? Or for others where we are up to? Do we need to escalate this? Allied health and nursing attend this meeting. It's been hard to get medical representation……. This meeting has been worthwhile because across disciplines it helps us learn and streamline things and figure out whose role is it to do what." (Occupational Therapist)

"We now have team meetings for complex NDIS patients to talk about where in the pathway they are at, identify their needs, any follow-up actions…..Change in the way reports
are being written – previously writing single discipline reports; however, now there is consistent use of templates for access and pre-planning which are contributed to by the team." (Occupational Therapist)

"As occupational therapists and social workers, we are working more closely together than we ever were." (Social Worker)

Support coordinators advocated for the use of a multidiscipline approach to pre-planning, noting who is impacted if this approach is not consistent.

"If Health don't use MDT pre-planning, it's a problem.. the risk of planner just going off the one report such as an OT report is that we get a plan that is just not adequate." (Support Coordinator)

The CDA practice guide directed emerging site-specific operational processes, resulting in increased consistency for key tasks such as access eligibility, escalation and performance indicators around these key tasks. For those sites that invested in the project a whole of site and system approach begin to emerge:

"It (CDA) gave ownership in terms of that process and guidance. We knew that if you followed CDA practices you were going to get an outcome." (Social Worker)

"There is a real commitment of staff to the NDIS purpose. We needed to change and think differently and change our reports. CDA provided a fantastic opportunity to do this." (Social Worker)

"Huge investment of time and commitment. The sites that got the best outcomes gave the biggest investment." (Project lead)

With this consistency in process came a change in the language used by champions and clinicians when writing for the NDIA. This included access request forms (ARF), supporting evidence for access, pre-planning documents and writing to evidence eligibility for SDA. Staff reported an improved understanding in writing to meet NDIS legislative requirements including how to demonstrate reasonable and necessary criteria.

The reported impact of this change in language included improved streamline processes, clarity on the role of health and expedited response from the NDIA in terms of access and planning approvals.

"Clinicians not feeling like they have to make a decision about what NDIS will or won't fund. Being really clear that the role of health is to provide the evidence to support what the person needs and what they've expressed." (Occupational Therapist)

"Using the correct language and knowing how to evidence permanency has improved timeframes, as there are fewer requests from the NDIA for further information to support access." (Occupational Therapist)

"This change is being acknowledged by planners – Some of the feedback from planning meetings of 'you've done everything and have got everything here'. We're getting feedback that we're providing such good information." (Social Worker)

The key elements of the CDA - early identification of NDIS eligibility, engaging early with a support coordinator, early exploration of housing, collaborative pre-planning, use of early interim plans - were described and detailed within interviews, champions highlighting the practice change that occurred from start to completion of the project.

Champions now reported commencing the NDIS process earlier with sites submitting ARF and any supporting documentation 10 days (on average) from identification of possible NDIS eligibility. Achieving access within 7 days (on average) from ARF submission was the result of this early identification, multidisciplinary approach and improvements in writing for the NDIS.

"Previously thought treatment had to be completed……With CDA saw that you need disability, functional impairment.

"The eligibility part is really quick. That's a massive improvement. We are no longer waiting the 21 days. We actually hear back in around 2-3 days now to get access met." (Occupational Therapist)

The SWSLHD CDA project involved engaging early with support coordinators after access had been achieved. A small number of support coordinators, both involved in the project and independent to the project, agreed to start working with the participant in hospital in a pro bono arrangement until a plan was approved. Choice and control were testified in this process and it allowed the support coordinator to meet with the participant prior to the planning meeting and collaborate with health in pre-planning process. This resulted in plans with appropriate support hours required to leave hospital and live well in the community, demonstrating the need for NDIA to fund pre NDIS supports to assist in access and planning. Working collaboratively with support coordinators gives health more confidence that the person will have a successful discharge outcome.

"The continuity, the ability to build trust and know that you have passed it onto someone who understands, and the client then feels understood, they've got someone who is on their side." (Social Worker)

"Getting SC hours early in inpatient stay means we can do the education and support early to the family on the NDIS process. We can be having those conversations early on Plan A and Plan B. There is more time to do the process probably. It's so much harder if we come in later." (Support Coordinator)

SWSLHD NDIS champions noted an enhanced understanding of the role of the support coordinator and improved understanding of an effective collaborative working relationship with support coordinators. Communication issues encountered and strategies to counteract were discussed within coaching and support sessions resulting in the resource development 'collaborative agreement'. Support coordinators reported changes in the working relationship with health following this training and towards the end of the project:

"People have had good experiences (in engaging early with SC) but things also have gone wrong. In reflection, what was at the centre of this was communication issues; 'what did you agree on when starting to work together?'…. realised that this was the missing piece. Treating them as a case manager from a government organisation. I realised I needed to help staff with how they manage this relationship and communication." (Project lead)

"Health now facilitating us connecting with the participant quicker. They are asking us for advice and to read the pre-planning document and what to say at meetings." (Support Coordinator)

Ongoing commitment is required for this practice to be sustained and extended to include a larger number of support coordinators with knowledge of CDA and how to achieve a supported transition for people leaving hospital.

Exploring a person's housing needs and preferences and options early was central to the CDA project and reinforced within training workshops (Housing Options) and coaching and feedback sessions with champions. Staff reported that early in the project it was often difficult to advocate for a person with high support needs to return home (their preferred housing option). The project focused on building knowledge and skills around communicating a person's housing goal along with reasonable and necessary clinical justification for supports within pre-planning. An achieved shift in participants being discharged home with high supports was described.

"When CDA first started you were pushing us to fight for home, but we were getting a lot of blocks. But we feel NDIA are now more on board with this." (Occupational Therapist)

The CDA has led to a change in practice by staff with early housing exploration now becoming more consistent including consideration of housing options.

"Exploring housing options in the beginning. Work needs to be done in the beginning. It really is the social model of disability. Need to explore all options not just jump to group home." (Social Worker)

"Previously we would have had a family meeting early to tell a patient you have to go to a group home, now we have family meetings where the patient can identify where they want to live." (Occupational Therapist)

NDIS champions reported a greater understanding of the separation between support and housing funding, and the significance of this. Understanding SDA, its eligibility and its potential as a discharge option was conveyed. Skills in housing exploration and how to advocate for its testing of eligibility is still a work in progress.

"It's happened around getting SDA in plans, so we are scrambling to learn about the SDA guidelines to provide justification for this using R&N criteria and SDA eligibility." (Occupational Therapist).

"Still a lot to do as (exploring hosing options early) is not embedded yet. Do that exploration housing when looking at access - do early. Just because you don't have a place to live doesn't mean you are eligible for SDA. Still need to consider the broader housing space (community housing etc) just like we used to do." (Project lead)

The use of a consistent pre-planning tool, prompting to write for reasonable and necessary legislation via a multidisciplinary approach has been a significant change and improvement for champions and other staff.

The process of sending the pre-planning document prior to the meeting to the planner is now streamlined. The below statement describes the impact of this change in process.

"We used to go to planning meetings not knowing who was going to say what, and we all brought our own reports and we all wanted to say different things to the planner. And even when we sent early the planner wouldn't always read. Now we have one pre-planning document that has everything and can be sent to the planner before the meeting." (Occupational Therapist)

"We're getting a pre-planning document together for the planning meeting. I think that's one of the biggest shifts, getting that together. That is a multi-disciplinary effort." (Occupational Therapist)

The development of collaborative relationships with planners from the local NDIA offices did occur at some of the sites leading to consistent use of key planners with knowledge of supporting a person with high support needs to leave hospital. For every positive example however, there were challenges discussed including difficulty with consistently being allocated NDIA planners rather than Local Area Coordinator (LCA) planners, variation in knowledge of planners in NDIS process and inconsistencies in what was approved.

The practice change described above has been led by a group of NDIS champion clinicians, to achieve higher numbers clinical staff changing current practices via implementing the elements of CDA; a holistic hospital approach is required. This holistic hospital approach, led by managers within the Allied Health Directorate, was suggested to promote accountability to new processes and ways of doing things. This includes managers understanding these changes, advocating for it and orientating and supervising staff around these changes.

"It's very different to how we've worked before and some of the systems we've worked in before. Getting other people on board is hard, especially if they've worked a certain way for a long time." (Occupational Therapist)

The champion network has a role in the sustainability of practice changes and the continual education of the elements of the CDA. However, a number of staff interviewed stated the importance of the NDIS coordinator position in this sustainability. Many described this position as key to sustainability of the learnings from the project, embedding the framework LHD wide. Essential roles of this position included escalation processes, stakeholder relationship management with NDIA and other providers such as housing and support.

"It's fundamental to have an NDIS coordinator position. It's helpful for advocacy and escalation. There needs to be a central point of contact for the complex patients. Someone to collate all the different experiences and know what works. Building rapport and relationships with the right stakeholders. Someone looking outward and upward…..our voice to the NDIA. It keeps us focused and grounded on what needs to be done to achieve outcomes. The link to educate executive and advocate for staff to educate them on process and time delays etc." (Social Worker)

Efficiency of access to the right supports for discharge

Quantitative NDIS WFW data demonstrated a substantial increase in the number of potential and current NDIS participants identified at Hospitals A, B and C. A modest increase was seen at Hospital D, with minimal change in Hospital E and in the Specialist Unit. Sites with the higher numbers were able to most effectively implement and practice the principles of the CDA.

The figures below show the change over time in NDIS participant numbers for sites that recorded increases in identified NDIS participants:

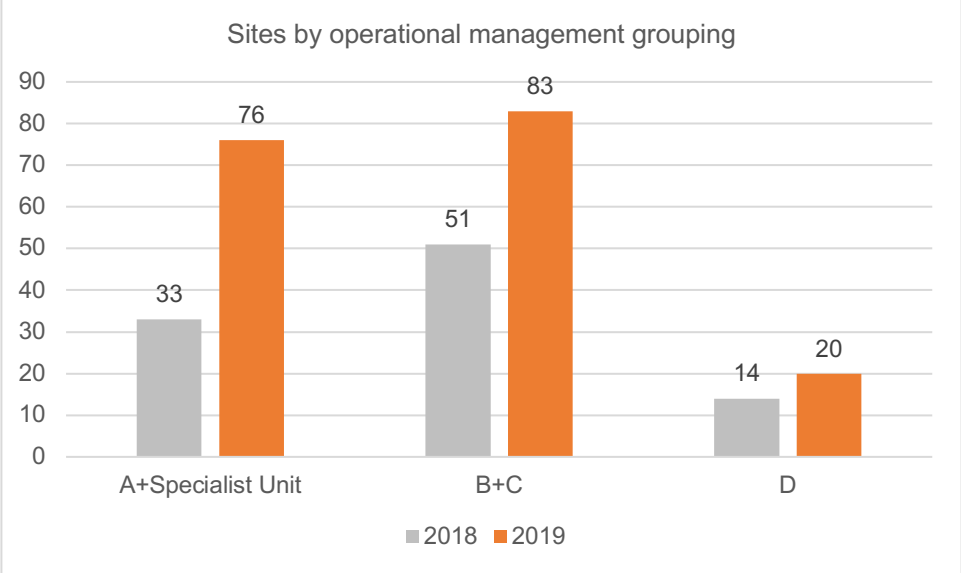


Figure 9. Increase in identification of people requiring NDIS supports for discharge – sites by operational grouping

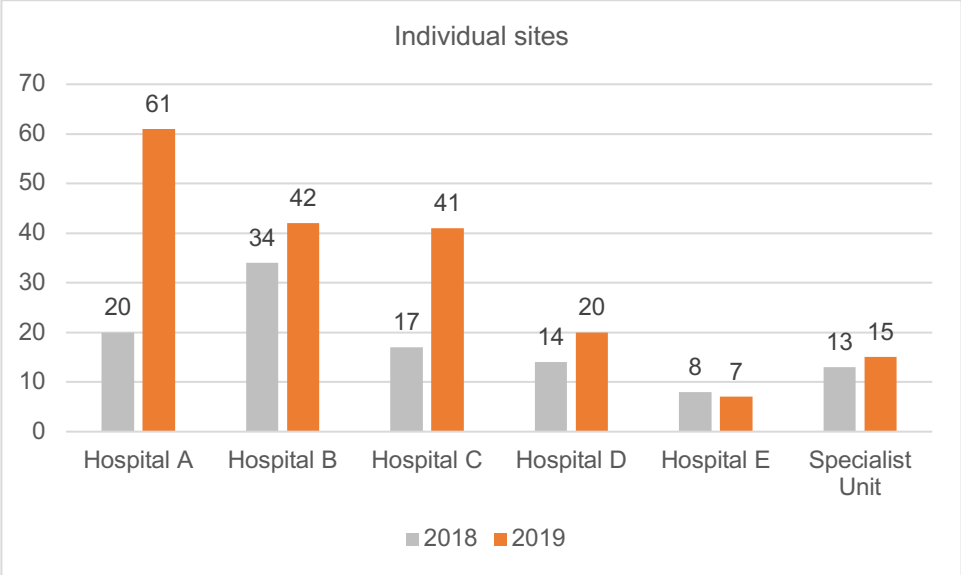


Figure 10. Increase in identification of people requiring NDIS supports for discharge – detailed site breakdown

Timeframes within the discharge process for NDIS participants featured within interviews with champions. Both timeframes related to health process as well as NDIS process. A number of clinicians reported improvements in time taken to achieve significant milestones for discharge as noted below:

"Timeframes for getting access, getting a plan, getting someone out and home is significantly different to 12 months ago. We previously had delays in getting access, and a plan whilst an inpatient and uptake of services for discharge." (Occupational Therapist).

The CDA was highlighted as the reason for this shift to timeframes, noting examples of shorter time periods between eligibility to discharge, the longer length of stay if CDA was not implemented was significant.

"Last June, 7 NDIS participants were stuck at acute neuro. Identification not good nor writing for functional impairment. Staff then taught this model…. All that were stuck when we started were then discharged using CDA." (Social Worker)

The approval of shorter, 3 month interim plans was reported in a number of sites within the CDA project. The determining factor for advocating for interim plans was often the need for funded support coordination hours quickly for housing exploration. Staff reported improvements in flagging for need for funding to test SDA eligibility within these shorter interim plans.

A shorter interim plan may be the plan that facilitates a successful and timely discharge from hospital for the NDIS participant, or the information gained within assessments, or housing exploration completed within interim plan then informed the development of the next larger plan.

"Previously we had variation, we didn't specify if 3 months or 6 months but had the same things in it. But now worked out what needs to be in that shorter plan. OT hours for functional assessment and psychology for behaviour support plan. We got better in the process. We made that first plan relevant for the next plan. We were able to communicate to the SC we have 3 months you need to do this and that." (Social Worker)

Quantitative WFW data reinforced these reported increased efficiencies; sites that were able to most effectively implement and practice the principles of the CDA saw reductions in the average days waited for many NDIS-related waits.

Figures 11-14 all note a reduction in wait days for finding supports. Of significance is Hospital A (Figure 11), a reduction from 50 average wait days to 24 days.

Gains were seen initially during the preparatory phase, as the champions' knowledge was increased, and resource development commenced. Gains then continued into the implementation phase of the project.

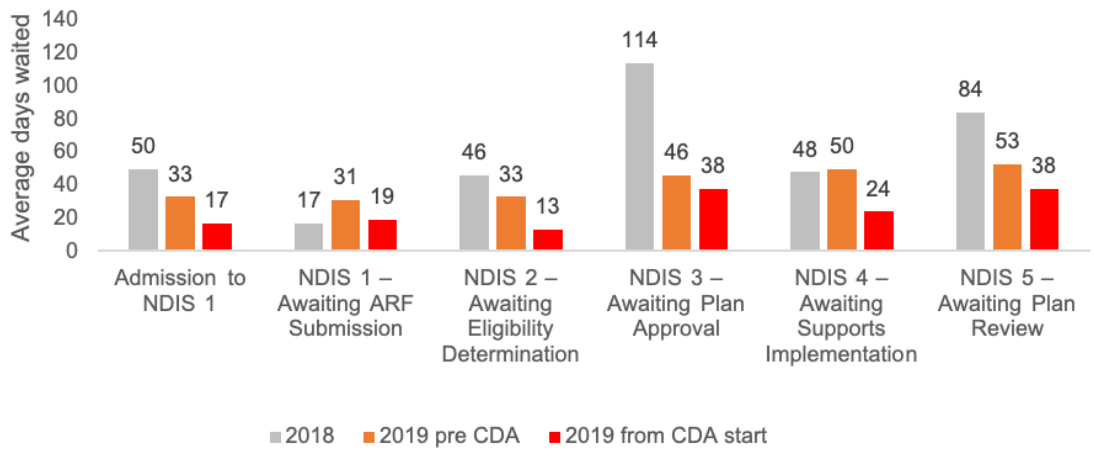


Figure 11. Changes in NDIS-related wait times – Hospital A

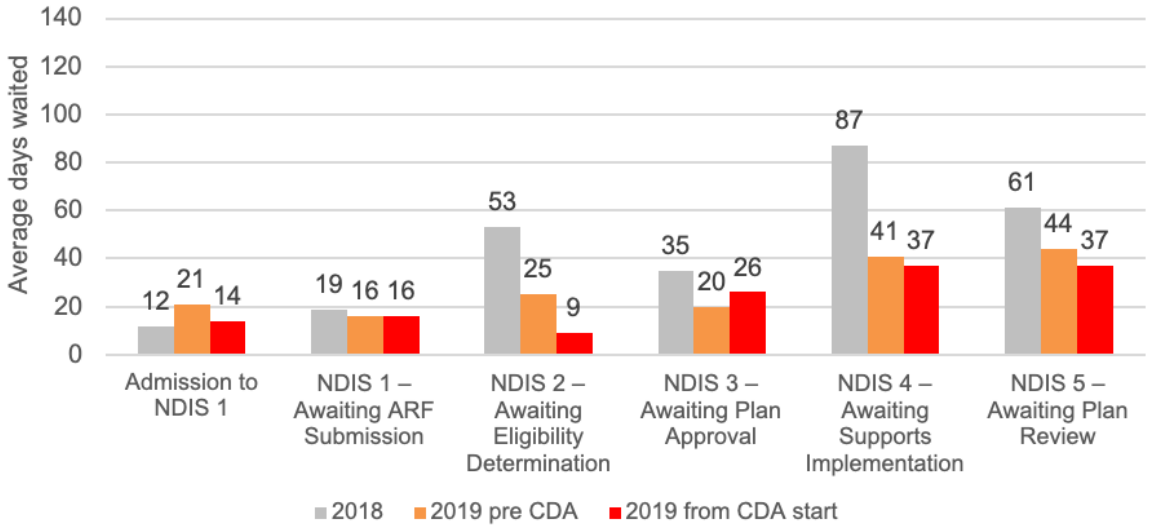


Figure 12. Changes in NDIS-related wait times – Hospital B

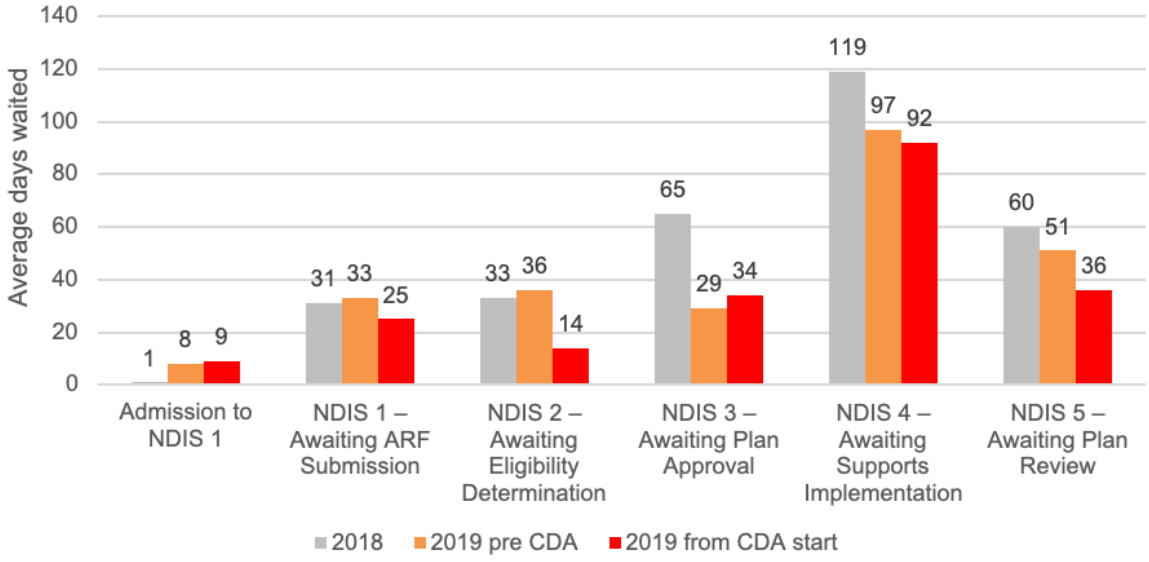


Figure 13. Changes in NDIS-related wait times – Hospital C

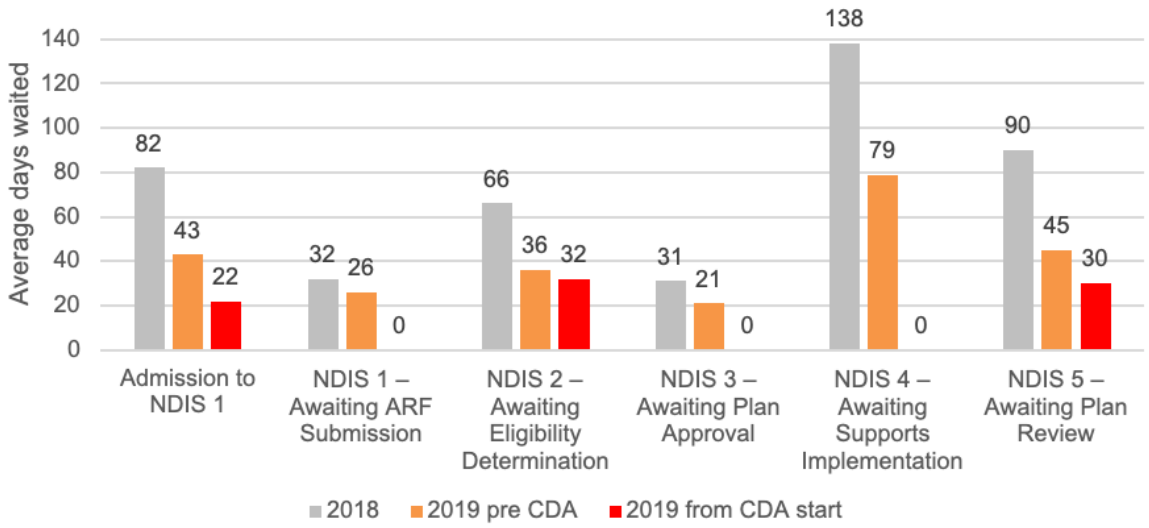


Figure 14. Changes in NDIS-related wait times – Hospital D

The same pattern was not seen at the sites (Hospital E and the Specialist Unit) where the CDA principles were unable to be implemented and/or practiced. These were the sites that saw limited or no change in the number of people recorded who required NDIS supports. It should be noted that Hospital E was working with the same 2 participants for the entire duration of the CDA project (both preparatory and implementation phases). The Specialist Unit was also challenged by substantial staff turnover during the project.

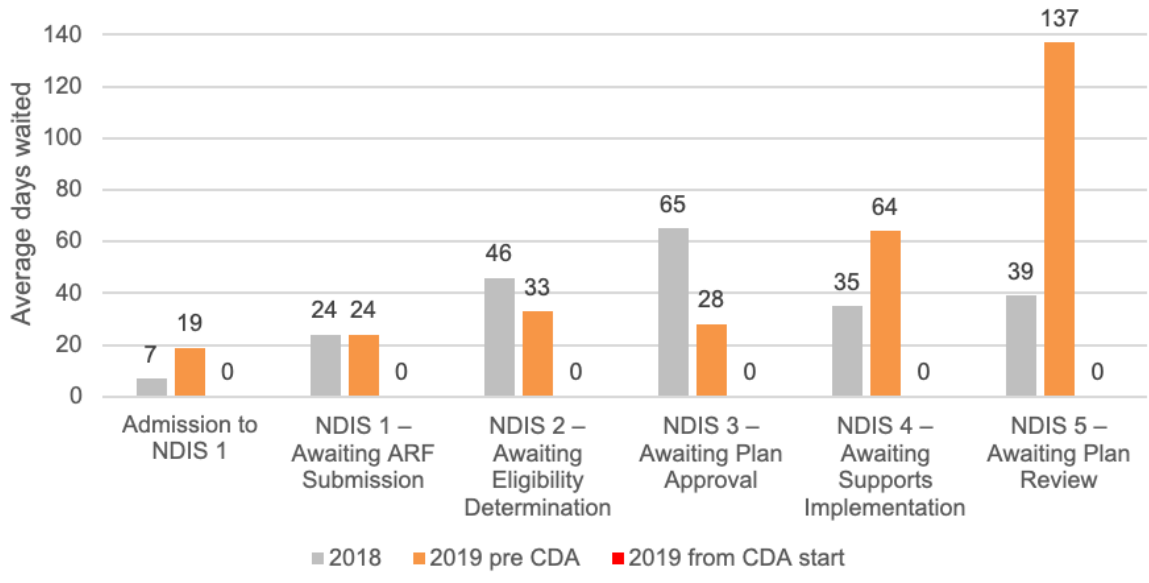


Figure 15. Changes in NDIS-related wait times – Hospital E

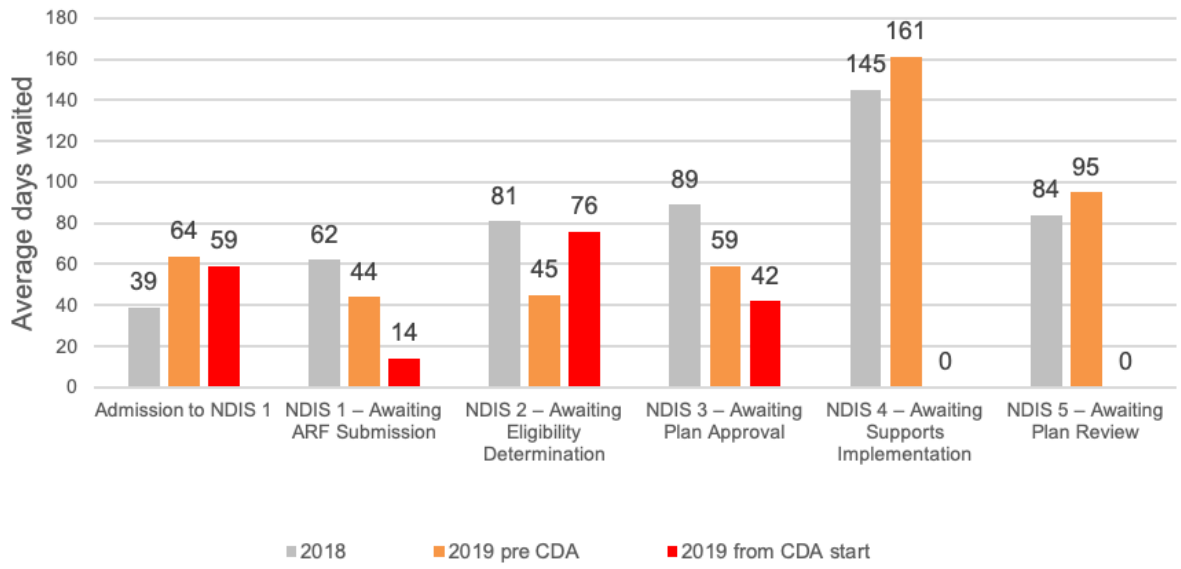


Figure 16. Changes in NDIS-related wait times – Specialist Unit

Despite improved timeframes for meeting access by the NDIA and the impact of the CDA for streamlining process, NDIS participants were still waiting in hospital while awaiting NDIS decisions for complex needs such as home modifications or SIL approval. The absence of senior planners in the planning and follow-up process, and inefficiencies and delays within the SIL approval process are possible causes of these waits.

Specifically, it had not been the practice of NDIS planners to discuss the need for SIL at the time of the first planning meeting, independently of the submission of a SIL quote by the support provider. This could result in discharge planning focusing on a discharge location for which a person is ineligible, requiring a complete re-start of the discharge planning process under an additional interim NDIS plan. SIL quote approvals were also taking more than 8 weeks for the duration of the project.

Both the improved SWSLHD practices, as well as the persistent negative impact of SIL process inefficiencies, are demonstrated in the 2 case studies in appendix B. Patient A commenced his NDIS journey prior to the CDA project. He was discharged to his own home, 7 months after meeting access and 3 months after an interim plan that directed him incorrectly to a non-SDA disability housing, for which he was ineligible. By contrast, patient B commenced the NDIS pathway while the CDA project was operating. He experienced a more streamlined process using a single NDIS plan that transferred him into a property operated by a SIL provider under medium term accommodation 3 months after meeting access. Patient B benefited from the advocacy of SWSLHD champions with stronger knowledge and confidence in the NDIS and housing pathways, but his discharge was still delayed by the extended SIL approval process.

More recent (March – June 2020) changes by the NDIS to planning timeframes and the SIL quoting and approval process have begun to address these residual delays. Further planned changes to the housing goals approval process, including SDA, MTA and SIL funding will further address delays.

A wider number of discharge options followed the increased efficiency in accessing the right supports for discharge. Champions recounted a shift in the numbers of NDIS participants being discharged to their housing preference. This included greater numbers being discharged home with high support packages versus group housing facilities and higher numbers avoiding being discharged to RAC. This is highlighted in the number of responses below.

"…. getting people home instead of aged care. That's what has changed in last 12 months…we would have advocated for aged care whilst waiting long term option from NDIS. Pushing and exploring what are the other options." (Occupational Therapist)

"Have diverted a number from RAC. Closed the gate in the option of RAC. Thinking for staff on ward is now 'don't even think of that'. Aged care is not a pathway for us. One example of a person we were working with where we investigated 10 options." (Social Worker)

"We now have a precedent of a under 65 going home with very large plan who wanted to go home - health supports, home mods, assist tech, everything. We know what's possible, it will be supported if the evidence is right. That's where we want to be." (Project lead)

Early exploration of housing needs and preferences including a recognition of choice and control over discharge destination is fundamental to the CDA and was described as being pivotal in achieving these discharge outcomes in a timely way.

"Aged care or group home, multiple examples of where we have diverted someone from aged care. A lot work on our part in reporting and justification. Back and forth. Used a lot of justification around reasonable necessary and choice and control. Anyone else (meaning NDIS participant) who didn't do this project they would be in a group home." (Occupational Therapist).

"There has been a difference, more so for patients getting discharged back to their own accommodation. Home or previous accommodation. We're getting better at it and the process is getting quicker." (Occupational Therapist)

"We are having conversations about medium term accommodation with NDIA. At first we got shut down but now we are having those conversations and participants are getting MTA in plans. It means we can get to know the person before the longer term housing option." (Support Coordinator)

Change in understanding of what's possible under NDIS led to change in discharge outcomes for patients over the course of the project.

"It's a myth that you couldn't have 24/7 within the home because it's too expensive to fund, so we didn't push for this and told patients they would have to live in group homes. Now we just had a patient funded 24/7 to return to own home. But we still needed to inform the team that this is a viable option and that we should be advocating for this." (Occupational Therapist)

Conclusion and Future Directions

The Collaborative Discharge Approach Project has fundamentally improved how admitted NDIS participants in SWSLHD are supported to access the right NDIS supports for discharge. People under 65 with various disabilities were historically directed into RAC, when community-based supports were confirmed or suspected to be insufficient for their needs. This practice continued to some degree even after the transition to the NDIS in SWSLHD, but the increase in the use of NSW Health Patient Portal to identify NDIS participants in the hospitals is showing that more people are being directed towards the right support system.

There has been substantial and sustained improvement in NDIS champions' knowledge, skill and confidence in multiple elements of the NDIS pathway. The project resulted in effective practice change and useful resources to assist SWSLHD staff to navigate the NDIS with inpatients. It was noted that a suite of resources to guide how staff communicated the needs of NDIS participants actually improved how person-centred the process was, as people were less likely to simply replicate what they had produced for the previous participant.

Potential NDIS participants are being identified earlier, and NDIS access and planning is being consistently commenced in the acute hospital environment, even for people who will be transferred to a rehabilitation or other sub-acute environment. Staff have been empowered to be more active partners in working collaboratively with support coordinators and NDIS planners throughout the planning process, and during establishment of supports. Appropriate housing options are being considered earlier in the planning process, rather than the end.

Efficiency of access to NDIS supports has also improved, with progressive reductions in NDIS-related wait times seen within sites able to most effectively and comprehensively implement CDA principles.

The Collaborative Champions group formed during the CDA project continues to meet monthly to share information, learn from each other's experiences and develop new resources to support staff to work effectively in the NDIS space. The Champions will remain fundamental to ongoing capacity building of clinical staff as NDIS processes change and develop. The practice guide will continue to be a living document. The guide and supporting resources will be updated and modified by the Collaborative Champions group and in consultation with the NDIA HLO for SWSLHD.

Key success factors

The CDA project was able to be successfully implemented with minimal NDIS-specific resourcing within the local health district. Implementation through a champions network, with executive level support made this possible. The key factors to the success of the project were:

- Executive sponsorship
- An LHD project lead
- Subject matter expertise (provided by the Summer Foundation)
- Use of project implementation methodology
- Commitment from champions through the duration of the project
- Champions who would internalise new information, use it to change practice, and share this knowledge with others
- Behaviour change framework strategies such as regular coaching
- Connections with strong support coordinators

Challenges and barriers

- The local NDIS Service Delivery team was not in a position to participate in the project. Involvement of NDIS representatives would have ensured that all strategies, tools and processes implemented definitely met the needs of NDIS planning and both LHD and NDIS processes were truly complementary.
- Variability in champions' capacity to implement change within their local service/facility
- Sites with lower numbers of NDIS participants moving through the discharge pathway had limited ability to implement and practice the principles of the CDA
- Staff (champion) turnover within specific sites/services during the project limited implementation in some locations

Essential elements for streamlined discharge practice for NDIS participants

The experiences of staff implementing the CDA within SWSLHD have helped to identify some key factors for effective and efficient transition of NDIS participants from hospital to the community. Changes made as part of the hospital discharge delays project and the COVID-19 response have been implemented as the evaluation of the CDA project was being completed, and the learnings from both are of significance for the ongoing development of the hospital discharge approach for NDIS participants.

It is recommended that these be considered as part of ongoing co-design of hospital discharge planning between health jurisdictions and the NDIA:

- **Meaningful exploration of a person's housing goals by the hospital multidisciplinary team prior to their first planning meeting (or plan review, for people who are NDIS participants at the time of hospital admission).** This includes person-led consideration of where a person wants to live, with whom, and the supports required to achieve this goal.
- **Fast and effective decisions related to eligibility for SDA, SIL and AT funding.** This fast determination results in early exploration of a number of feasible choices for living in the community.
- **Skilled support coordinators are fundamental for effective hospital discharge.** Hospital discharge planning for people with newly acquired disability (or a sudden change in function) is a highly complex process. Many participants and families are completely new to the NDIS and are still adjusting to substantial changes to their lives. Early support by a person with intimate knowledge of the NDIS function and supports is essential through the transition from hospital to the community and beyond.
- **Clarity of roles of health staff and support coordinators.** Negotiation and clarification of the respective responsibilities of the hospital multidisciplinary team and a person's support coordinators is important to ensure all tasks are completed in a timely fashion, no tasks are missed and there is no duplication of effort. While the proposed NDIS Support Coordination framework is pending, the working relationship between the hospital multidisciplinary team and the support coordinator must be negotiated and established for every new participant.
- **Access to medium-term accommodation, even if a person does not yet have a specific long-term discharge destination,** has been extremely beneficial for helping people to leave hospital. It allows for people with newly acquired disability (or a sudden change in function) time and flexibility to identify their long-term housing goals from the community, rather than in the artificial, pressured and more institutional environment of a hospital.
- **Involvement of the same senior planner consistently across plans** has contributed to substantially more streamlined discharge planning.
- **Open communication between health staff, support coordinators and NDIA planners and health liaison officers.** Person-centred, safe and efficient hospital discharges have been facilitated by the further evolution of open communication between health staff, support coordinators, NDIS planners and HLOs. The additional presence of a senior planner for Mainstream in SWSLHD has magnified the positive impact of the HLO. Both have further developed the capacity of the LHD staff to work effectively within the NDIS space, and it is hoped that this arrangement can continue.

CDA applicability outside of trial site

The CDA model could certainly be implemented in other local health districts/networks or extended further for potential state or national implementation. Key elements to be included in any replication or upscaling include:

- Executive sponsorship
- Framework for NDIS capacity building within a health network/site. This includes governance structures for NDIS processes, tools and templates, education and training plan and operational process for collaborative discharge planning
- Project co-design with health staff, NDIA staff and support coordinators
- Confirmation of the roles and responsibilities of the discharge planning process using the CDA practice guide
- Co-design of tools for comprehensive multidisciplinary reporting of functional abilities and support needs for access and planning (e.g. pre-planning tools/report formats)
- Enhanced capacity and co-designed tools to support exploration of the full range of housing options that align with the person's housing needs and preferences, prior to the first NDIS plan (e.g. home ownership, rental, public/community housing, SIL - provider operated properties, individual living options, specialist disability accommodation)
- Enhanced capacity and co-designed tools to support collaborative working between health staff and support coordinators
- Interim plans that align with a person's housing goals

The NDIS is very young, and further changes are to be expected. As such, there is a need for the lessons, resources and processes developed during the CDA in SWSLHD to adapt to the ongoing development of the scheme. Inevitable staff turnover and clinical rotation will also require that education and support within SWSLHD is ongoing. Feedback from champions indicates a need for further learning and development in the area of NDIS-related housing options and guidance for working collaboratively with support coordinators.

Although postponed due to the initial NSW health response to the COVID pandemic, the SWSLHD NDIS coordinator/project officer is collaborating with the Mental Health Pathways for Community Living (PCLI) project officer to pilot a training symposium for support coordinators working with participants in SWSLHD. It will provide training on the hospital environment, some specialist clinical groups (e.g. mental health, brain injury) and principles for working effectively together.

The eventual embedding of an NDIS HLO in SWSLHD, working in collaboration with the SWSLHD lead and SWSLHD NDIS champions, will support ongoing capacity building and even better alignment between the LHD and NDIS processes to support the discharge of NDIS participants. The knowledge and confidence gained during the CDA puts SWSLHD in a strong position for effective ongoing collaboration with NDIS staff and registered providers for the best possible outcomes for NDIS participants.

APPENDIX A: END OF PROJECT INTERVIEW SCHEDULE

How would you describe your practice with regards to discharge of young people with complex needs now?

Do you think there has been any difference in your practice compared to early last year?

- Writing and language
- Would you have considered early plans prior to this project?
- Would you have considered SDA prior to this project?
- Would you have engaged with a support coordinator prior to this project?
- Is there any difference to how you are engaging with support coordinators now?

How would you describe the outcomes you are getting for young people with complex needs?

- Would this have been occurring prior to May last year?
- What made a difference/what changed?

Do you think there has been a change in where young people are being discharged to?

- Do you feel you have diverted a patient from RAC?
- How did they do this?
- What helped with this/what supported your work to achieve this outcome?
- SDA?

Give example of a recent success story.

What looks different (if anything) for your site post the CDA project?

What made the most difference? (e.g. big ticket items)

How do you sustain this? What does it look like going forward (scale up)?

- Further support
- NDIS lead position
- Champions model

What continues to be a barrier for people leaving hospital who need NDIS supports?

What's your plan/what do you need to do to address these?

APPENDIX B: CONTRASTING PATIENT JOURNEYS

Patient A – Pathway commenced pre-CDA project

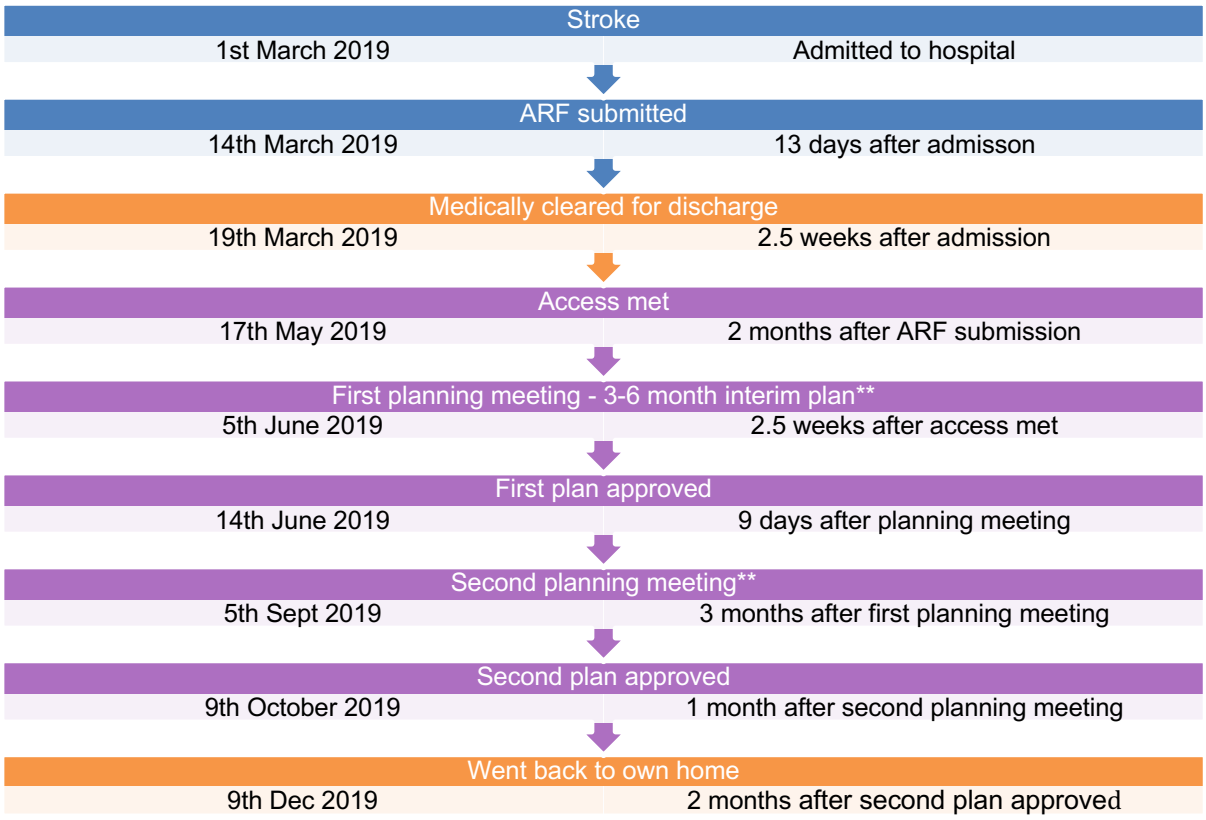
54-year-old male admitted following a stroke with pre-existing schizophrenia and history of substance abuse resulting in psychosocial & cognitive disabilities.

In the assessment it was found he was a victim of financial exploitation – he would draw money and buys drinks for acquaintances and give them cash when asked. He was verbally aggressive towards others on the ward and needed to be 'security specialled' for most of his admission to keep himself and others safe. He lived alone in Department of Housing Public Housing where there is evidence of damage to the unit such as holes and damage to cupboards. The home was very dirty and unkept.

** Following the first planning meeting, allied health team understood from the planner that the first plan was created with the intention of exploring non-SDA disability housing in a shared living environment with social & community participation. All subsequent assessments and discharge planning followed this expectation. At the second planning meeting, a new planner indicated that he was ineligible for SIL funding and a plan should be created to transition him back to his own home. All discharge planning completely changed direction.

Patient A lived in hospital for 9 months from admission:

- 8 months after being medically discharged
- 7 months after meeting access



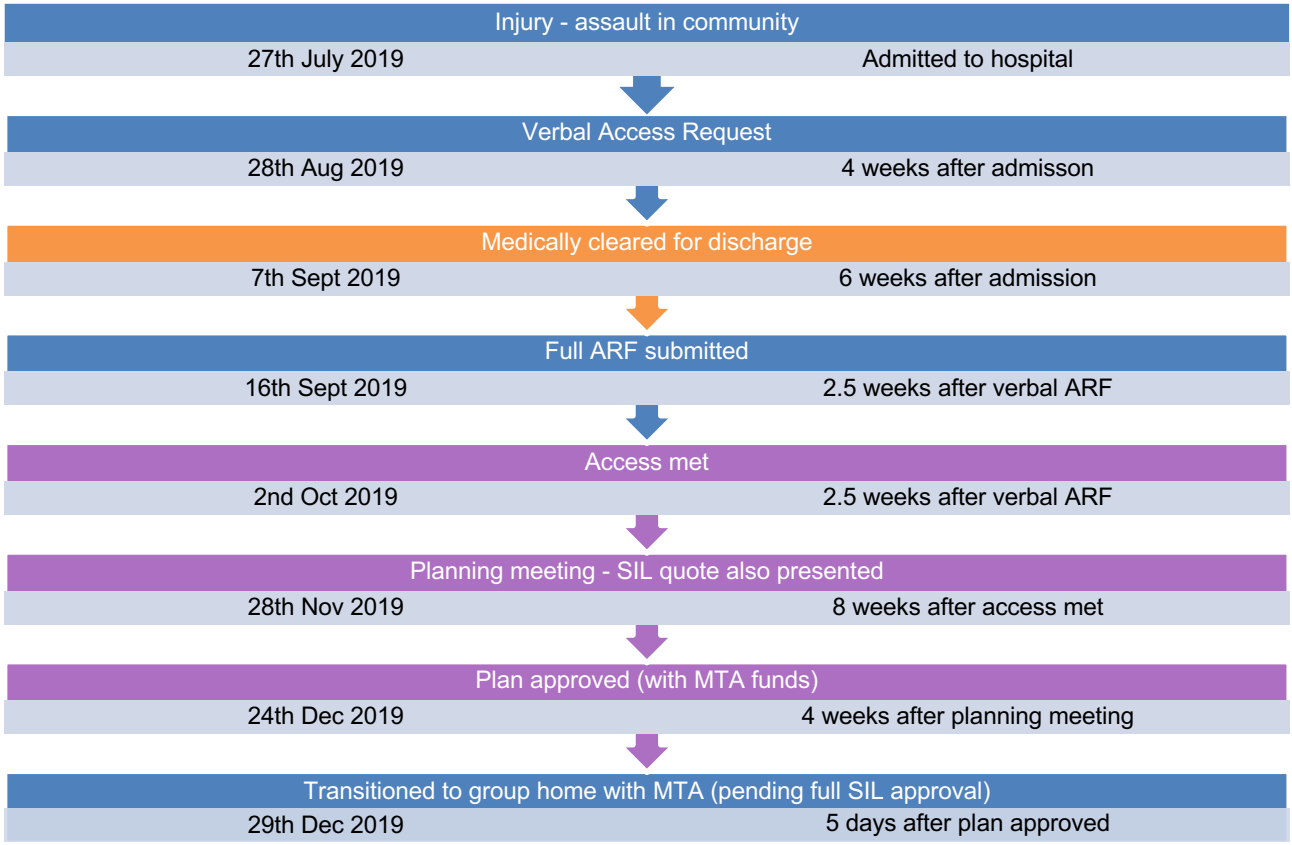
Patient B – During CDA project

28-year-old male admitted to hospital following an assault in the community.

He has multiple diagnoses of brain injury, treatment resistant schizoaffective disorder, substance abuse & forensic behaviour.

Patient B lived in hospital for 5 months from admission:

- 3 months after being medically cleared for discharge
- 3.5 months after meeting access



APPENDIX C: SWSLHD TRIAL PRACTICE GUIDE AND SUPPORTING RESOURCES

Please see following pages.

Health
South Western Sydney
Local Health District

Navigating the NDIS with Inpatients

A practice guide for staff

February 2020

South Western Sydney Local Health District

Version 1 – February 2020

transforming your experience

Background

This is an overarching practice guide for supporting NDIS participants in SWSLHD admitted facilities. It is acknowledged that specific facilities may develop their own detailed practice guidelines to establish additional local processes.

This resource is combines elements of the Summer Foundation Collaborative Discharge Approach, guidance from the NSW Ministry of Health, information from the National Disability Insurance Agency, and the personal experiences of SWSLHD staff and patients. The Summer Foundation Collaborative Discharge Approach can be viewed at:
https://www.summerfoundation.org.au/?s=collaborative+discharge+approach

This is a living document that is intended to be modified and updated as NDIS-related processes change.

Please contact SWSLHD-NDISProject@health.nsw.gov.au if you identify any inconsistencies or outdated information in this document.

Contents:

1. Prepare and submit an access request

Start preparing the access request as soon as it is apparent the person will need NDIS supports and meets the eligibility criteria. Important points to consider before starting:

- Does the person have a home to return to?
- Can the person return home while the NDIS process is ongoing?
    - If yes, could the Local Area Coordination (LAC) partner St Vincent de Paul assist with the ongoing access process?
- Could SASH supports help the person go home while they are awaiting an access decision?
- Could the person return to their previous home with substantially increased NDIS person-to-person and/or assistive technology supports?
- Will a guardianship application be needed to progress?
- Have you started exploring the person's housing (community living) preferences?
    - Consider the least restrictive options first
    - If considering referral for ACAT assessment, consult the "Request for ACAT assessment for people under 65" resources

Useful resources:

- ***Access request form (ARF)***
- ***Professional report template***
- ***Example professional report template***
- ***Consent form***
- ***Access request cover letter***
- ***NDIS website – "Mental Health and the NDIS" -*** https://www.ndis.gov.au/understanding/how-ndis-works/mental-health-and-ndis
- ***"Getting the language right" - Summer Foundation -*** https://www.summerfoundation.org.au/wp-content/uploads/2018/04/getting-the-language-right-web.pdf
- ***NAT-related information – NDIA resource***
- ***SWSLHD pathway - "Request for ACAT assessment for people under 65"***

- ***NDIS participant booklet "Understanding the NDIS" –*** https://www.ndis.gov.au/applying-access-ndis

- ***Summer Foundation presentation – "Access"***

1. Gain the consent of the person/their representative to make an NDIS access request.

2. Create a wait on the patient flow portal under "NDIS 1 – Awaiting ARF submission".

3. Contact the NDIA to begin the registration process:

    - Call 1800 800 110, together with the person/their representative to make a verbal access request, or
    - Contact the National Access Team via NAT@ndis.gov.au for a registered access request form

4. Complete the written portion of the access request. Compile:

    - Access request form (ARF)
    - Professional report template
    - Consent form
    - Proof of identity, address and citizenship
    - Access request cover letter

If the person has a psychosocial disability arising from a mental health condition, the **NDIS evidence of psychosocial disability form** may also be used, and is accessed via: file:///C:/Users/25127109/Downloads/FM%20Evidence%20of%20Psychosocial%20Disability%20PDF.pdf

Note that it is important to use appropriate disability-related language to describe the person's disability, impairments and functional support needs. This is to meet the disability requirements (section 24) of NDIS ACT 2013, which can be viewed at: http://www5.austlii.edu.au/au/legis/cth/consol_act/ndisa2013341/s24.html.

You do not need all clinical reports noting details of all support needs at the time of the ARF submission if the ARF is completed in detail; these can be sent through later (if required) or incorporated within pre-planning documents

LHD staff cannot sign the ARF on the person's behalf. The ARF must be signed by one of the following:

- The person
- A person responsible
- A legally appointed guardian
- The public trustee
- A person who has power of attorney

- A representative named in an advance health care directive

Attach evidence of guardianship, power of attorney or the advance care directive when submitting the ARF.

Highlight throughout the access request whether a person has complex support needs as part of the access request. Explain how and why this is a complexity for this individual. This should help them be streamed appropriately in their journey through the NDIS.

What are complex support needs?*

Challenging behaviour: intense, frequent or persistent behaviour that threaten the quality of life and/or physical safety of the individual or others and is likely to lead to restrictive or exclusionary responses. Positive behaviour support is an approach that seeks to understand the relationships between the person's behaviour and his/her ecology from a biological, psychological and social perspective.

Decision-making is a fundamental human right involving the act of choosing between two or more courses of action. Some people, including those with intellectual disability, require additional assistance (e.g., communication aids, different formats, longer timeframes, reminders of previous decisions, greater explanation of implications) to make and express choices.

Family circumstances: refers to the social, cultural and economic factors that impact on family relationships. For example, on the coping or stress levels of carers.

Mental illness: is a general term for a group of illnesses affecting thinking, emotions and/or behaviour. A mental illness can be mild or severe, temporary or prolonged.

Complex communication needs: communication involves the exchange of information between two or more people. People with complex communication needs may have communication problems associated with a wide range of physical, sensory, cognitive and environmental causes which restrict or limit the person's ability to participate independently in society. People with complex communication may need significant support from their communication partners for their messages to be understood. Augmentative and alternative communication strategies may be used (e.g., alphabet boards, sign language, voice generating devices.)

Physical location: relates to the interplay between an individual and their physical environment that creates disadvantage. Geography can create access barriers, such as in rural and remote locations, and social barriers, such as lack of opportunity or social capital. Physical location includes poor living conditions, such as overcrowding or squalor, and placements at risk of breakdown.

Complex medical/physical/sensory needs: includes profound, severe or long term physical or medical impairment or sensory disability that requires continuous support, high cost equipment and access to various mainstream services. The

complexity of need may relate more to the complexity of services and systems than the complexity of an individual's disability.

Socio-economic disadvantage: refers to hardship or inequality in a person's standard of living, well-being, capabilities or other life opportunities. Socio-economic disadvantage is considered to be broader than poverty, as it reflects multiple types of social inequality.

Social isolation: refers to a person's lack of meaningful, extended relationships and intimacy leading to feelings of having no one to turn to during a crisis. The risk of social isolation is increased by family violence, ill-health and disability, living alone, unemployment, ageing and lack of transport.

Substance misuse: refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Substance misuse may cause an individual to experience social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence.

*"Being a planner with a person with disability and complex support needs" (p. 13), University of NSW

5. Submit the ARF and supporting documents to the National Access Team at NAT@ndis.gov.au and cc: cassie.hammond@ndis.gov.au with the email subject line:

   URGENT Access Decision required, health discharge pending,<*insert person's first and last name*> , <*insert name of hospital*>".

   Send any outstanding reports to the National Access Team in a second email once they are completed, with the email subject line:

   "URGENT Access Decision required, health discharge pending,<*insert person's first and last name*>, <*insert name of hospital*>".

   IF THERE IS NO RESPONSE WITHIN 5 DAYS - contact Cassie Hammond on [redacted]

6. Email the local NDIA team on enquiries.nswact@ndis.gov.au to alert them that the request is coming.

7. Close the "NDIS 1 – Awaiting ARF submission" wait on the patient flow portal. Create a new wait under "NDIS 2 – Awaiting plan approval".

8. Enter the NDIS participant status on the eMR as "NDIS – Non participant (Awaiting NDIS Eligibility Approval)".

2. Explore housing needs and preferences

Useful resources:

- ***SWSLHD Housing needs and preferences package***
- ***Department of Communities and Justice – "Housing & homelessness" -*** https://www.facs.nsw.gov.au/housing
- ***Department of Communities and Justice – "Find a specialist homelessness service" -*** https://www.facs.nsw.gov.au/housing/help/ways/services
- ***NDIA presentation – "A New Approach to Housing"***
- ***NDIS website – "Individual Living Options" -*** https://www.ndis.gov.au/providers/housing-and-living-supports-and-services/housing/individual-living-options
- ***"My Supports" website – " Individual Living Options" -*** https://mysupports.com.au/independent-living-options-ilo
- ***Summer Foundation presentation – "Housing Pathways"***
- ***SDA eligibility decision tools – Summer Foundation -*** https://www.summerfoundation.org.au/?s=SDA+eligibility
- ***NDIS website – "Specialist Disability Accommodation" -*** https://www.ndis.gov.au/providers/housing-and-living-supports-and-services/housing/specialist-disability-accommodation
- ***Allied Health Housing Assessments – Summer Foundation -*** https://www.summerfoundation.org.au/resources/allied-health-housing-assessments/

The goal of the NDIS is for a person to live in as "ordinary" a living situation as possible. Options may include:

- Living in a the home owned/rented (including public housing) by the person with comprehensive supports
- Independent living options (ILOs)
- Supported independent living options (SIL) – for people who need intensive person-to-person support (even with assistive technology) for approximately 24 hours a day. May be provided in a registered SDA property or a non-registered property operated by a SIL provider.

- Specialist disability accommodation (SDA) – for people who need specialised physical builds due to extreme functional impairment and/or very high support needs

It is the person's goals/preferences and evidence of the support required that influences the housing option chosen. The first preference is always for a person to return to the home they already have (if they have one).

Not having a home to go to (homelessness) does <u>not</u> automatically make someone eligible for SIL (in a group home) or SDA. The role of the NDIS is not to address homelessness, but to provide the appropriate supports according to the evidence provided through planning. If a person is homeless, but does not require intensive 24-hour care/specialist disability accommodation, investigate appropriate homelessness services and public/community housing options. The NDIS can then fund the necessary care in one of these environments.

Only after multiple other options have been eliminated (with clear rationales) should supportive disability-related housing models be pursued. The NDIA requires this specific information to build a plan that supports disability-related housing. If this information is not provided early, it is possible that the person will receive multiple interim plans for the purpose of doing this work.

It is essential that a person's housing needs and preferences are explored <u>early</u> as they influence all subsequent planning and assessment work.

1. Explore the person's long term discharge preferences and options.
    - Does the person have a home they could return to?
    - Could the person return to their previous home with substantially increased NDIS person-to-person and/or assistive technology supports?
    - What supports would the person need to meet their goals and live in the community?
    - If the person does not have a home to go to, can they access another housing option (e.g. private rental, public housing etc) if they receive more supports than they have now?
    - Would the person be interested in an independent living option?
    - If there is a clinical need for specialist disability accommodation, what are the person's housing needs and preferences?

2. If a new housing arrangement is to be pursued, use the **Housing Needs and Preferences package** to:
    - Discuss the person's living preferences
    - Consider their eligibility for SDA
    - Compile a housing seeker profile that can be shared (with consent) with Support Coordinators and providers during a housing search

3. Await an access decision

NB: Awaiting an access decision and pre-planning should occur simultaneously.

Urgent access requests should receive a decision within 5 days.

Non-urgent access requests should receive a decision within 21 days.

If no response has been received in the above timeframes, contact Cassie Hammond in the National Access Team via [redacted] to follow up.

Once the access decision is confirmed:

Not accepted:

1. Change the NDIS participant stats on the eMR to “NDIS – Non-participant (Eligibility Declined)”.
2. Review the reasons given and determine appropriate next steps.

Accepted:

1. Change the NDIS participant status on the eMR to “NDIS – Participant” and enter the NDIS number.
2. Close the “NDIS 2 – Awaiting plan approval” wait on the patient flow portal. Create a new wait under “NDIS 3 – Awaiting plan approval”.
3. Add an “NDIS Participant” status to the person’s electronic medical record.

4. Requesting a plan review for an existing NDIS participant

Useful resources:

- ***NDIS website – "Change in Circumstances" -*** https://www.ndis.gov.au/participants/using-your-plan/changing-your-plan/change-circumstances

1. Identify whether the person has a Support Coordinator.

2. If there is a Support Coordinator, work with them to request a plan review. If there is no Support Coordinator, contact the LAC and work with them to request a plan review.

    - If within 3 months of plan end date – contact planner to request plan review
    - If more than 3 months until plan end date – lodge a "change of circumstances" request.

3. Create a new wait on the patient flow portal under "NDIS 5 – Awaiting plan review".

4. If a planning meeting remains outstanding for an extended period, the facility escalation representative may make an escalation to Mainstream Interfaces according to the specific escalation guidelines.

5. Follow the processes outlined under "4. Pre-planning".

6. Once the plan is received, close the "NDIS 5 – Awaiting plan review" wait on the patient flow portal. Create a new wait under "NDIS 4 – Awaiting supports implementation".

5. Pre-planning

Useful resources:

- ***SWSLHD Housing needs and preferences package***
- ***SWSLHD Multidisciplinary pre-planning report template***
- ***NDIS participant booklet "Planning" –*** https://www.ndis.gov.au/applying-access-ndis
- ***Sample interim plan – Summer Foundation -*** https://www.summerfoundation.org.au/?s=sample+interim+plan
- ***Summer Foundation presentation – "Pre-planning"***
- ***"Getting the language right" - Summer Foundation -*** https://www.summerfoundation.org.au/wp-content/uploads/2018/04/getting-the-language-right-web.pdf
- ***NDIS website – "How the planning process works" -*** https://www.ndis.gov.au/participants/how-planning-process-works

1. Revisit the person's long term discharge preferences and options – this should have been started during the "Explore housing needs and preferences" stage.

2. Determine whether the first plan will be:
   - **To explore more complex support and/or housing options.** A 3 or 6 month interim plan with Support Coordination, allied health assessment hours, community access, assistive technology and behavioural intervention supports (combination as appropriate for the person) will be required.
   - **To immediately transition back to existing accommodation in the community.** Depending on the complexity of the supports, the person may need an interim plan (as above) or the first plan may be able to establish all the supports they need to return home.

3. The multidisciplinary team, the person (and Support Coordinator, if involved) and their family work collaboratively to compile the **multidisciplinary pre-planning report and provide any other appropriate supporting documentation**. Work with the Support Coordinator if the person has one.

All stakeholders **should be very clear on what supports are to be recommended/requested before going into a planning meeting**.

Ensure that there is **written evidence to support all requests made during the planning meeting**. Verbal requests made without written evidence are unlikely to be reflected in the final NDIS plan.

Notification of a planning meeting

A planning meeting date should be received soon after access.

The participant or carer may be contacted before the nominated clinician – check with them first if the planning meeting date is still outstanding.

If notification is not received:

- Email the local NDIA team via enquiries.nswact@ndis.gov.au to request a planning meeting, using the subject line **"NSW Health Transitioning Participant <*insert name of hospital*>, access met, planning meeting required".**
- The facility escalation representative may make an escalation as per the specific escalation guidelines.

Where complex supports and/or housing exploration is required, an NDIA planner (ideally senior) is preferred to planning conducted by the LAC. If an LAC is allocated to planning, the facility escalation representative may make an escalation to Mainstream Interfaces outlining the specific rationale (complexities) for requiring a planner.

6. Planning

Useful resources:

- ***SWSLHD Housing needs and preferences package***
- ***SWSLHD Multidisciplinary pre-planning report template***
- ***NDIS participant booklet "Planning" –*** https://www.ndis.gov.au/applying-access-ndis
- ***Sample interim plan – Summer Foundation -*** https://www.summerfoundation.org.au/?s=sample+interim+plan
- ***Summer Foundation presentation – "Pre-planning"***
- ***"Getting the language right" - Summer Foundation -*** https://www.summerfoundation.org.au/wp-content/uploads/2018/04/getting-the-language-right-web.pdf
- ***NDIS website – "How the planning process works" -*** https://www.ndis.gov.au/participants/how-planning-process-works

1. Work with the person to identify who will be present at a planning meeting.

2. Participate in planning meeting.

    - If pursuing an interim plan, ask the planner whether (on the basis of information provided) they will support a plan to return the person home, or whether they are more likely to support a transition to a supportive housing model. This will help inform the direction of ongoing work.

3. NDIA planner builds a plan according to evidence presented at the planning meeting. Plan is approved by appropriate delegate.

4. If a plan remains outstanding for an extended period, the facility escalation representative may make an escalation to Mainstream Interfaces according to the specific escalation guidelines.

5. Once the plan is received, close the "NDIS 3 – Awaiting plan approval" wait on the patient flow portal. Create a new wait under "NDIS 4 – Awaiting supports implementation".

7. Working with a Support Coordinator

Useful resources:

- ***SWSLHD Support Coordination referral/handover form***
- ***SWSLHD Collaborative Working Agreement template***
- ***SWSLHD Collaborative Working Action Plan template***

The role of Support Coordination*

- Support implementation and identify options for all supports in the plan, including informal, mainstream and community, as well as funded supports.
- Strengthen and enhance the participant's abilities to coordinator supports and participate in the community, reach decisions and develop agreements with support providers.
- Ensure mainstream services meet their obligations (i.e. housing, education, justice, health).
- Build capacity of the participant to achieve greater independence, self-direct supports in the longer term and understand funding flexibility.
- Be available – to ensure new support arrangements endure and in times of 'crisis'.
- Provide NDIA with reports on outcomes and success indicators within agreed reporting frequency.

The role of Support Coordinators in exploring housing options

Collate all supporting information including assessments and provide a final report to the NDIA and include the following information:

1. Identified suitable housing solutions and support needs. If SDA has been identified, consider SDA rule 4.3 – determining the design category.
2. Advise of any completed housing applications.
3. Complete a life transition plan: identify likely supports required to ensure a smooth transition into the identified housing solution.

4. Complete a capacity building/skill development plan, identifying likely supports to meet the identified housing solution.
5. Where applicable, justification for inclusion of additional reasonable and necessary funded supports to meet the identified housing solution, including an estimation of required hours and advise how the expected outcomes will be met and how they will be measured.

*"An Overview of Housing Supports for People with a Disability" – NDIA Community & Mainstream Branch Presentation, February 2020

Support Coordinators are employed by different businesses that are registered NDIS providers. They are not employees of the NDIA. Each support coordination provider will have different ways of working. It is essential to establish a positive collaborative working relationship with a Support Coordinator from the beginning.

1. Assist the person to choose a Support Coordinator if they would like help doing so. Alternatively a Support Coordinator may be appointed by the NDIA.

2. Provide a summary of the person's situation to the Support Coordinator using the **Support Coordination referral/handover form**.

3. Establish a mutual agreement (using the **Collaborative Working Agreement template**) with the Support Coordinator for how they will communicate and work together with the multidisciplinary team, including:
    - Will there be a key worker/primary contact within the MDT that primary contact will occur through?
    - How frequently will information be exchanged?
    - How many hours per week is the Support Coordinator funded to work for the person?
    - Will information and updates be exchanged via email, phone, in person?
    - What is the expected timeframe for LHD staff and the Support Coordinator to respond to communications?
    - What contingencies exist if the Support Coordinator or LHD staff are unavailable? e.g. on planned / unplanned leave, whether the Support Coordination business has shutdown periods
    - How will issues be resolved if either the LHD staff or Support Coordinator do not observe the pre-negotiated expectations?

    N.B: Meeting face to face with the support coordinator is the recommended practice

4. Use the **Collaborative Working Action Plan template** to plan and monitor the work to be shared with the Support Coordinator and other registered NDIS providers.

8. Interim plan – exploration of support and housing needs

Useful resources:

- ***SWSLHD Housing needs and preferences package***
- ***SWSLHD multidisciplinary pre-planning report template***
- ***NDIA presentation – "A New Approach to Housing"***
- ***NDIS website – "Individual Living Options" -*** https://www.ndis.gov.au/providers/housing-and-living-supports-and-services/housing/individual-living-options
- ***"My Supports" website – " Individual Living Options" -*** https://mysupports.com.au/independent-living-options-ilo
- ***NDIS website - "Assistive Technology" -*** https://www.ndis.gov.au/participants/home-equipment-and-supports/assistive-technology-explained
- ***NDIS website – "Providing Home Modifications" -*** https://www.ndis.gov.au/providers/housing-and-living-supports-and-services/providing-home-modifications
- ***Summer Foundation presentation – "Housing Pathways"***
- ***SDA eligibility decision tools – Summer Foundation -*** https://www.summerfoundation.org.au/?s=SDA+eligibility
- ***NDIS website – "Specialist Disability Accommodation" -*** https://www.ndis.gov.au/providers/housing-and-living-supports-and-services/housing/specialist-disability-accommodation
- ***Allied Health Housing Assessments – Summer Foundation -*** https://www.summerfoundation.org.au/resources/allied-health-housing-assessments/
- ***The Housing Hub*** - https://www.thehousinghub.org.au/
- ***Nest*** – https://www.gonest.com.au

- ***Disability Housing*** - https://www.disabilityhousing.com.au/
- ***Ideas*** - https://www.ideas.org.au/
- ***SWSLHD Pathway - "Request for ACAT assessment for people under 65"***
- ***NDIS participant booklet "Using Your NDIS Plan" –*** https://www.ndis.gov.au/applying-access-ndis

This stage will occur for participants who receive an interim plan. LHD staff and the Support Coordinator must collaborative actively and consistently through this process.

SWSLHD staff discussing and documenting the person's support and housing needs and preferences commences this process (see SWSLHD housing needs and preference package).

See earlier comments about establishing a mutual working agreement with the Support Coordinator.

1. Collaborate with the Support Coordinator to use supports in the plan to explore housing and support needs. Things to consider and negotiate include:

    - Which tasks will be completed by the Support Coordinator and which by LHD staff?
    - Which allied health assessments will be completed by NDIS-registered providers and which by LHD staff? e.g. support needs assessments, assistive technology assessments, home modification assessments, behavioural support assessment and planning
    - What is the target timeframe for achieving all assessments?
    - What are the person's housing needs and preferences? Can the person return home, or will a supportive housing model be pursued?
    - Is the person interested in / appropriate for an Individual Living Option?
    - Will eligibility for Specialist Disability Accommodation be tested?

2. Support Coordinator engages NDIS-registered providers as negotiated.

    - It is suggested that a similar mutual working agreement be established between LHD health professionals and NDIS-registered providers, especially if they will be sharing tasks

3. LHD staff collaborate with Support Coordinator and NDIS-registered providers to establish a mutual working agreement for how they will work together. Things to consider and negotiate include:

    - Will there be a key worker/primary contact within the MDT that NDIS-registered providers will liaise with?
    - How frequently will information be exchanged?
    - Will information and updates be exchanged via email, phone, in person?

- What is the expected timeframe for LHD staff and the NDIS-registered providers to respond to communications?
- What contingencies exist if the NDIS-registered providers or LHD staff are unavailable? e.g. on planned / unplanned leave, provider shutdown periods
- How will issues be resolved if either the LHD staff or NDIS-registered providers do not observe the pre-negotiated expectations?

4. LHD staff, Support Coordinator and NDIS-registered providers complete assigned tasks according to mutually negotiated timeframes. This may include (but is not limited to):
    - Assessments
    - Reports
    - Locating available housing options
    - SIL quotes
    - Home / accommodation visits

Information to include in functional capacity assessments for housing*:

- What types of housing solutions and support needs have been considered or tried in the past and why were they unsuitable?
- How the identified housing solution and/or supports will assist to facilitate the participant's independence, social and economic participation
- What are the risks associated with the participant's current living arrangement, informal care support, level of independence, social and economic participation?
- Provide recommendations to mitigate any potential risks including how the recommended housing solution will mitigate these identified risks
- Identify suitable interventions, programs, strategies or skills development/capacity building opportunities that will enhance the participant's ability to maintain their current living arrangement, support them until a suitable home or dwelling becomes available
- How will capacity building and skill development programs for the proposed housing solution be monitored and progress provided in relation to the participant's progress/measurable outcomes
- Identify the participant's housing and support needs considering their capacity to live with others, behaviours of concern, physical, cognitive and sensory support needs, proposed and previously funded home modifications and aides/equipment
- Consider any additional support needs that may be required as a result of the recommended housing solution and risks e.g. choice of location may result in social isolation from community, informal support network and local services and supports

- Identification of “best fit” providers to match individual participant needs and assist the participant to pursue goals and objectives in their plan. Include the skills and training requirements of the support staff.

*”An Overview of Housing Supports for People with a Disability” – NDIA Community & Mainstream Branch Presentation, February 2020

5. LHD staff, Support Coordinator and NDIS-registered providers collaborate with the person and their family to compile a **multidisciplinary pre-planning report and provide any other appropriate supporting documentation** (e.g. SIL quotes, reports, assistive technology requests, home modification requests).

    - Consider whether to request Medium Term Accommodation (MTA) funds will be requested to allow the person to leave hospital while:
        - Home modifications are completed – an alternative accommodation location with quote should be brought to the planning meeting
        - SIL quote is negotiated
        - Preferred SDA build is finalised - an alternative accommodation location with quote should be brought to the planning meeting
    - If MTA is being pursued, the amount in core supports may need to be increased for the duration of MTA, as MTA funds only cover the accommodation, not the care provided.

6. LHD staff and Support Coordinator collaborate to request a plan review meeting.
    - If within 3 months of plan end date – contact planner to request plan review
    - If more than 3 months until plan end date – lodge a “change of circumstances” request.

7. Once the request for plan review is made, close the “NDIS 4 – Awaiting supports implementation” wait on the patient flow portal. Create a new wait under “NDIS 5 – Awaiting plan review”.

9. Plan review

1. Work with the person to identify who will be present at a planning meeting.

2. Participate in planning meeting.

    - If pursuing an interim plan, ask the planner whether (on the basis of information provided) they will support a plan to return the person home, or whether they are more likely to support a transition to a supportive housing model. This will help inform the direction of ongoing work.

3. NDIA planner builds a plan according to evidence presented at the planning meeting. Plan is approved by appropriate delegate.

4. If a plan remains outstanding for an extended period, the facility escalation representative may make an escalation to Mainstream Interfaces according to the specific escalation guidelines.

5. Once the plan is received, close the “NDIS 5 – Awaiting plan review” wait on the patient flow portal. Create a new wait under “NDIS 4 – Awaiting supports implementation”.

10. Supports implementation and planning for discharge

This process is completed in close collaboration with the Support Coordinator. Scheduled case conferences/planning meetings are recommended.

Useful resources:

- *NDIS participant booklet "Using Your NDIS Plan" –* https://www.ndis.gov.au/applying-access-ndis

1. Collaborate on:
   - Completion of home modifications
   - Scripting, supply and delivery of assistive technology equipment
   - Training of support providers
   - Transition to supportive housing
   - Handover to NDIS-registered providers who will provide ongoing care
   - Need for ongoing contact with LHD staff / facility after transition to the community
   - Provision of health-related handover to relevant parties

2. When the person leaves hospital, notify the NDIA of their transfer into the community via enquiries.nswact@ndis.gov.au. Include details of their new address if not returning to their previous home.

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11. Appendix of resources

This appendix contains copies of resources listed in the “Useful resources boxes” that are not available on the internet.

Electronic copies of these resources are also available on the SWSLHD NDIS intranet page.

1. Access request form (ARF)
2. Professional report template
3. Example professional report template
4. Consent form
5. ARF cover letter
6. NAT-related information
7. Pathway – Request for ACAT assessment for a person under 65
8. Summer Foundation “Access” presentation
9. SWSLHD Housing Needs and Preferences Package
    a. Factsheet
    b. Questionnaire
    c. Evidence to test SDA eligibility
    d. Housing seekers profile
10. Support Coordinator referral/handover form
11. Collaborative Working Agreement template
12. Collaborative Action Plan template
13. Multidisciplinary pre-planning document
14. Summer Foundation “Pre-planning” presentation
15. Summer Foundation “Housing Pathways” presentation
16. NDIA “A New Approach to Housing” presentation
17. SWSLHD escalation resources
    a. Guidance for facility escalation representatives
    b. Guidance for staff
    c. Escalation form

NDIS Participants Housing Needs and Preferences

The National Disability Insurance Scheme (NDIS) aims to give people with a disability choice and control over where they live.

The NDIS Participant Housing Needs and Preferences Package is a resource for clinical staff working with NDIS participants who are searching for appropriate housing.

It is designed to help identify:

- the individual's preferences for housing
- their support needs related to housing
- eligibility for specialist disability accommodation (SDA)

It also gathers information that can be shared (with consent) with potential housing and supported independent living (SIL) providers during the housing search.

Package Components

1. **NDIS Participant Housing Needs and Preferences Interview**

   This tool is used to guide a detailed discussion with an NDIS participant and/or their representatives about their housing needs and preferences.

2. **Eligibility for Specialist Disability Accommodation (SDA)**

   This tool helps determine whether a person may be eligible for SDA based on extreme functional impairments (in at least one domain) and the need for very high person-to-person support needs. Note that it is the NDIA that actually determines whether a person is eligible for SDA on the basis of evidence provided.

   The tool includes guidance on SDA eligibility according to the SDA rules and examples of how to write for SDA.

   It can be used to create a report for the NDIA to help test a person's eligibility for SDA. The appendix should be removed prior to submission as a report.

3. **Housing Seeker Profile**

   This tool collates the information collected by the previous two tools.

   Once written consent is secured from the participant, this profile can be shared with potential housing or SIL providers during the housing search.

Consent

The NSW Health Consent to Release Health Information form should be signed by the participant / their representative before any information is shared with external providers.

Data Collection

These tools provide an opportunity to collect data on the extent of NDIS participants' housing needs within South Western Sydney.

Please forward any completed Housing Needs and Preferences Packages to SWSLHD-NDISProject@health.nsw.gov.au to assist with this data collection.

NDIS Participant Housing Needs and Preferences Interview

Participant Name:
DOB:
MRN:
NDIS Number:

Housing history/journey

What was your most recent housing situation before entering hospital?

- ☐ Owned own home
- ☐ Private rental
- ☐ Public housing – shared support or other
- ☐ Group home
- ☐ Individual living option
- ☐ Other

Housing provider details (if relevant):

What area did you live in and why?

Who did you live with?

Would you like to return to your previous living arrangement?

What supports do you need to return to your previous living arrangement?

If no/not possible, what is the reason?

Risks associated with returning to previous housing:

Other factors preventing return to previous housing:

Provide details of other previous housing types, flatmates, family and locality that you liked or disliked and reasons why:

General housing preferences

Once you have been discharged from hospital who would you like to live with?

- Alone
- Family - Provide details: _____
- Friends - Provide details: _____
- Share with another person with disability - Provide details: _____

If you would prefer to live with others, how many people would you like to live with and what age/gender? Preferred number: _____ Gender: _____

Preferred number of bedrooms? _____

Preferred maximum number of bedrooms? _____

Would you require an additional area/bedroom for an overnight support worker?

- YES
- NO

If yes, provide details:

Do you have any additional requirements for equipment/work/study/hobbies – e.g. storage, shed, yard, study area?

- YES
- NO

If yes, provide details:

Preferred housing types

- Separate housing
- Townhouse/villa
- Apartment

If applicable, provide further details:

What are your requirements for vehicle accommodation and access for vehicle parking (level for wheelchair access, undercover etc.)?

Describe some of the activities you would like to be able to do when settled in Specialist Disability Accommodation: *This could include in home activities, social contact and activities, work/study related activity.*

What are some of the activities your ideal home would allow you to do?

Describe who and what is important to you and will influence where you would like to live:

Housing geographical location preference

Describe your preferred locations and why (for example: close to hospital, shops, transport, family, schools, university, work etc.):
1.
2.
3.

Is there an area you would not like to live in? (Due to, for example: family or other violence, negative impact on wellbeing for some other reason)

Please provide any other information you feel may be relevant:

Checklist of accessible housing features

Outline whether specific features are required due to the nature of the disability

(e.g. climate control due to autonomic dysregulation, strengthened build due to behaviours of concern, lift access due to wheelchair use)

- Wheelchair accessible (e.g. no step entry, accessible features on at least one level - wide doorways, large bathroom with grab rails, accessible kitchen)
- Accessible features (e.g. less than 3 steps, non-slip flooring, bathroom with grab rails)
- Ceiling Hoist
- Automated doors
- Strengthened walls, doors, glass and soundproofing because my behaviours can lead to me damaging myself or my house
- Lift access
- Outdoor area – fenced?
- Study
- Intercom to entry
- Alarm System
- En-suite
- Dishwasher
- Built-in wardrobes
- Floor coverings - type
- Broadband internet available
- Ducted heating
- Ducted cooling
- Split-system heating
- Split-system air conditioning
- Evaporative cooling
- Gas heating
- Any further remarks on climate control
- Solar power panels
- Solar hot water
- Water tank
- Car parking
- Garage required
- I want to have a pet – type, size
- I want a home that is furnished
- I want to be allowed to smoke indoors

ELIGIBILITY FOR SPECIALIST DISABILITY ACCOMMODATION (SDA)

Participant Name:
DOB:
MRN:
NDIS Number:

Evidence of an extreme functional impairment in one or more of the following areas:

Self-care

<*Name*> has an extreme functional impairment in self-care based on:

(*identify source assessment and documentation or describe here)*

Self-management

<*Name*> has an extreme functional impairment in self-management based on:

(*identify source assessment and documentation or describe here)*

Mobility

<*Name*> meets the criteria of having an extreme functional impairment in mobility based on:
(*identify source assessment and documentation or describe here*)

AND

<*Name*> has very high person-to-person support needs when undertaking that or those activity/activities listed above.

Justification for SDA response:

<*Name*> meets the requirements of needing an SDA housing response for the following reasons:

An SDA response is likely to more likely to support <*Name*> to achieve their goals as stated within their NDIS plan than any other type of non-SDA housing.

An SDA response would likely improve life outcomes and enhance <*Name*>'s capacity in the following ways:

An SDA response would mean <*Name*> would be able to participate in their local community because:

An SDA response would mean <*Name*> would be able to fulfil their life roles of _____ by living in SDA and:

An SDA response would mean <*Name*> would have shared on-site support which is immediately available or shared on-site support in the dwelling constantly available.

An SDA response would mitigate the following risks:

An SDA response would mitigate the following impairments by:

And SDA response would improve <*Name*>'s functional capacity by:

Without an SDA response, <*Name*>'s skills and overall wellbeing will deteriorate in the following ways:

Signature:

Heath Professional Name
Profession
Contact Details

Appendix: Guidance on SDA eligibility Delete if completing template as a report

SDA Rules

3.5 A participant has an extreme functional impairment if:
(a)the impairment results in an extremely reduced functional capacity of the participant to undertake one or more of the following activities:
Self-care

- Do they have an extreme functional impairment in self-care
  i.e. do they need person- to-person support to complete all or some personal care tasks
- What types of self-care activities can they do independently?
- What types of activities do they need set up for?
- What types of activities do they need verbal prompting/physical assistance/supervision for?

Self-management:

- Do they have an extreme functional impairment in self management i.e. paying bills, banking, shopping, finances, legal, organising and life/activity planning?

Mobility:

- Do they have an extreme functional impairment in mobility i.e. are they unable to walk?
- Do they use a wheelchair? If so, which type, where and how?
- How do they transfer?
- Is their current transfer method safe or does the occupational therapist recommend that, if they were living in a different place, they should actually be transferring via a different method?

AND

Very high support needs

The participant has a very high need for 1:1 support in undertaking the activity even with assistive technology, equipment or home modifications.

- How much constant, person-to-person physical assistance, do they need every day and what do they require assistance with?
- How much 1:1 support, immediately available in the same dwelling/house do they need?
- How much 1:1 support immediately available on-site (around 5 to 10 minutes away) do they need?
- How would on-site shared support best meet their needs? What would they need it for? How often might they use it?
- How would they call or contact the on-site support worker? Have they been doing something similar currently?
- If not, does a professional say they have the capacity to develop this potential? Is so, in what time frame? Would it be within the next 3 to 6 months?

AND

3.6 The participant requires an SDA response if, when compared to other supports alone, combined SDA and other supports:

a) would be likely to better assist the participant to pursue the goals, objectives and aspirations in the participant's statement of goals and aspirations
b) would be likely to be more effective and beneficial, having regard to current good practice, including because of the extent to which it would, where possible:

- mitigate or alleviate the impact of the participant's impairment on their functional capacity-prevent the deterioration of their functional capacity-improve their functional capacity-maintain or promote the participant's ability to build capacity, including in the medium or long term; or
- maintain or enhance the participant's opportunities to develop skills

c) would represent better value for money; and
d) would promote stability and continuity of supports, particularly for participants currently residing in SDA

- Why does mainstream non-SDA housing + core supports not meet their housing and support needs?
- Why do they need SDA more than other housing and supports?
- How will it:
  - Help them achieve their goals?
  - Mitigate deterioration and risks?
  - Support them to build their capacity?
  - Be value for money?
  - Allow them to participate socially and economically in society?
  - Build their skills?

SDA Design Categories

Every SDA has to be classified as one of these categories.

Basic - No specialist design features e.g. existing stock that is only included in a plan if a person is already living there or as an interim housing option.

Improved Liveability - Reasonable physical access and enhanced provision for people with sensory, intellectual or cognitive impairment.

Fully Accessible – High level of physical access e.g. wheelchair accessible, power supply to doors and blinds.

Robust – Resilient housing reducing risk to the person e.g. High impact wall lining, secure window and doors, sound proofing.

High Physical Support – High level of physical access and requiring very high levels of support e.g. ceiling hoist, 950mm door widths.

SDA Building Types

There are five SDA building types.

Apartments – Self-contained units, as part of a larger building.

Duplexes, Villas and Townhouses -Separate but semi-attached properties, for 1, 2 or 3 people to live in.

Houses – Detached low-rise dwellings.

Group Homes – Houses with 4 or 5 people living there.

Sample SDA Eligibility

Ms G.

35 year old female with C4 Spinal Cord Injury.

Ms G has been in hospital for 6 months and has completed rehabilitation. Ms G's goal on her NDIS plan is to leave hospital and live independently in her own home.

Mobility: Independent in a power wheelchair indoors and outdoors.
Transfers: Ms G requires a hoist transfer for all transfers. In the hospital she is using a ceiling hoist and will require this ongoing.

Self-Care: Ms G uses a tilt-in-space commode for all personal care. Ms G requires assistance with all aspects of her showering, drying and dressing. Ms G needs assistance with eating as she is unable to bring the food to her mouth.

Self-Management: Ms G is able to manage her own finances and uses the apps on her phone with head control to complete online shopping. Ms G does require assistance with cooking, cleaning and accessing the community. A 24 hour care plan has been completed by Mrs G and her treating team at the hospital and it identifies that Ms G requires 7 hours of person to person support every day. Outside of that time, Ms G would be able to use her jelly switch on her wheelchair to call for assistance for incidental care needs and support that is immediately available but not in her dwelling. Before coming into hospital Ms G lived in a private rental with a flatmate. Due to her admission, Ms G had to give up this rental and is now homeless.

Considering the SDA eligibility criteria for Ms G, she has an **extreme functional impairment** in mobility and self-care.

Ms G has a **very high need for person to person supports** related to the extreme functional impairment (ie. 7 hours of 1:1 support + immediately available support for when she is alone).

A SDA response would best meet Ms G's needs and support her to achieve her NDIS goals which are to:

Leave hospital
Live independently in her community
Socialise with family and friends
Return to work

The SDA design category which would best accommodate all these needs is **high physical support.**

Mr S

Mr S is a 44 year old male who has Down Syndrome and was admitted to hospital following a functional decline. Mr S was previously living at home with his 89-year-old mother who has said she can no longer support him.

Mr S has been reviewed by his health team and has been diagnosed with early onset dementia.

Mobility: Mr S transfers and walks independently without any aids or equipment.

Personal Care: Mr S requires prompting with going to the toilet and minimal assistance with his daily shower. Mr S also requires assistance in preparing daily meals. Before coming in to hospital, Mr S would call out to his mother if he needed anything or if he needed to go to the bathroom.

Community Access: Mr S enjoys going out to the shops and movies and requires someone to come with him to do this.

Mr S's goal is to live in a home where he can feel safe and supported.

Mr S enjoys being around other people, however also likes time on his own. Mr S can become frustrated at times when he feels overwhelmed and responds to this by removing himself from where he is and going to a quiet place.

Mr S's neuropsychology report states that he is at risk of wandering away when he feels overwhelmed and that he has a behaviour support plan which identifies triggers that Mr S might be feeling this way. A recommendation from the neuropsychologist is for Mr S to have routine throughout the day where he has time with other people and time alone in his room or home. Mr S is safe to be alone as he is able to call for assistance as he requires. This routine reduces Mr S's risk of wondering away alone which would place him at high risk of becoming lost or injured whilst crossing the road.

Mr S is ready to leave the hospital as his team feel he has no further rehabilitation goals.

Mr S has ***very high support needs*** most appropriately met by an SDA response as it will support him achieving his goals, reduce his risk to himself with becoming frustrated and wandering away. An SDA response would also prevent further deterioration to his function that could occur if he remained in hospital or went into residential aged care. The SDA design category which would best accommodate Mr S's needs would be ***improved liveability***.

Susie

Susie is a 44 year old female who has recently been admitted to hospital after a fall at home which resulted in a fracture of her left neck of femur. Susie had a total hip replacement and is recovering well.

Susie has autism and prior to her fall, was living in a group home. Susie's group home have said that they are unable to have Susie back as her needs can no longer be met there.

The hospital Social Worker has supported Susie to liaise with the group home to ensure that they are acting in her best interest and that she was protected by her tenancy rights. The outcome of this remains the same and Susie requires another housing option.

Susie has lived in a number of group homes since she turned 18 and has no other informal support networks.

Susie uses non-verbal communication methods to express her basic needs, including signing and visual charts.

Susie is hypersensitive to sound and can be triggered by a loud sound, specifically a truck horn outside or a doorbell ringing. When this does occur, Susie becomes anxious and agitated and tries to escape the noise by screaming and running in the opposite direction. Susie also responds to this hypersensitivity by scratching herself and others around her. In these moments, Susie is not aware of her surroundings and often hits into objects and people around her environment. This has included breaking glass windows in her previous homes.

Susie has a behaviour support plan that was completed by the neuropsychologist and outlines positive behaviours and strategies that would support her. This includes being able to live in an environment where large sounds can be reduced and where Susie and her staff can spend time apart both for sensory regulation and safety for herself and staff.

Susie's OT and Physio have reported on her function:

> **Mobility**: Susie walks independently without any aids or equipment. The OT and physiotherapist have recommended that Susie have someone with her when she is walking in the hospital, due to unknown and unexpected obstacles that Susie will not respond to. The OT and PT have observed Susie walking in a safe and controlled environment and report that she is independent there.
>
> **Self-Care:** Susie requires assistance with all elements of her self-care. This includes initiating toileting and her daily shower. The OT has trialled strategies for Susie to initiate going to the toilet which are working 70% of the time, however in the hospital environment Susie shares a bathroom with other patients so she cannot always go when her alarm goes off.
>
> **Self-Management:** Susie requires assistance with all elements of self-management. This includes accessing the community, cooking and cleaning. According to Susie's behaviour support plan, she also benefits from having company and support to regulate her behaviours and support her with her daily tasks.

Susie has an ***extreme functional impairment in self-management and self-care*** *and* ***very high support needs*** most appropriately met by an SDA response as it will support her to achieve her goals and reduce the risks to herself and others. An SDA response would also prevent further deterioration to her function that could occur if she remained in hospital or went into residential aged care. The SDA design category which would best accommodate Susie's needs would be ***robust***.

+Date completed:

Name of person completing profile:

Personal details

Name:

Telephone number:

Email:

Date of birth:

Age:

Gender:

Marital status:

Dependents: Yes / No

If yes, how many? _____

Decision making capacity:

Awaiting NCAT hearing: Yes / No

If yes, provide hearing date:

Appointed decision maker - health, accommodation and service provision

Contact name: _____ Phone number: _____

If yes, provide hearing date:

Appointed decision maker - administration

Contact name: _____ Phone number: _____

Describe the best way to communicate with the person:

☐ Directly
Provide details:

OR

☐ Other methods
Provide details:

Financial details

Pension type:

Customer Reference Number:

Other income/superannuation: _____

Significant assets or liabilities: _____

Employment details and/or study history (if applicable):

- ☐ Part time
- ☐ Full time

Provide details:

Hospital admission details

Hospital name and ward:

Date admitted to hospital:

Reason for admission:

Main contact person at hospital & contact details:

Date suitable for discharge:

Perceived barriers to discharge:

From individual/family perspective:

From a medical perspective:

Medical/health related conditions:

Supports required to manage the following conditions (include all required):

- ☐ Pressure area care
- ☐ Asthma management
- ☐ PEG management
- ☐ Epilepsy
- ☐ Tracheostomy management
- ☐ Diabetes management
- ☐ Catheter care
- ☐ Other

Additional information/comments:

Disability information

Primary disability:

Secondary disabilities:

NDIS status

NDIS participant: Yes / No

NDIS reference number:

Awaiting access: Yes / No

Awaiting first planning meeting: Yes / No

Current plan: Yes / No

Dates of current plan:

Copy provided/viewed: Yes / No

List the goals of NDIS plan:

Core supports:

Capital supports:

Has SDA been secured? Yes / No

If yes, please provide the following details:

Design Category: _____

Building Type: _____

Occupancy: _____

Location: _____

On-site overnight assistance (OOA) required? Yes / No

Are you currently waiting for NDIA determination of SDA? Yes / No

If relevant, please provide further detail:

Are you *not* eligible for NDIS because of disability or injury due to an accident? Yes / No

Are you eligible for other funding? Yes / No

If not NDIS eligible – give reason :

Other funding applicable:

- ☐ Department of Veterans' Affairs
- ☐ Lifetime Care and Support Scheme
- ☐ WorkCover

Case manager/Rehabilitation coordinator details:

Current support network

Informal supports:

NDIS-funded supports:

Mainstream allied health, service providers:

Current functional capacity

NOTE: Please describe functionality in terms of the following:

- Level of independence
- How much 1:1 physical assistance, supervision, verbal/physical prompting, set up support is required for tasks
- Whether support needs to be *with* the person constantly available or *in* the same dwelling, *on-site* immediately available, *on-call* not immediately available (provide details of any relevant strategies)
- **Current** (in hospital)/**predicted** (on discharge)/**potential** (with capacity building after 3 to 6 months)

Cognitive skills and executive functioning skills:

(Defined as the ability to identify and solve problems independently, know when to call for help and the ability to call for help)

Communication abilities and skills:

Self-care ADLs

Mobility and physical skills

Mobility inside the home:

_____

_____

Mobility outside the home:

_____

Self-management IADLs

Ability to prepare own meals:

Ability to use assistive technology:

Psychosocial capacity (mental health):
(Describe current functioning and any supports required and provided/organised)

Impact of impairments, disability and adjustment to injury on behaviour: (Describe any behaviours of concern):

Has a behaviour support plan been developed? Yes / No

If yes, provide the following details:

Date: Author(s) & contact details:

Does this plan include restrictive practices? Yes / No

If no, provide details of the reasons why:

Provide details of any known risks:
(Risks could be related to returning to previous housing and support and/or related to future housing and support)

Summary of support required

(Note, detailed information is required)

- ☐ Daily person-to-person support hours
- ☐ On-site (in same dwelling) support hours required
- ☐ On-site (not in same dwelling) support hours required
- ☐ Overnight support required: (active or inactive; in same room, dwelling or on-site)

If applicable, please provide further details – attach timetable of supports from pre-planning document

Equipment required (both current and predicted):

Individual Living Options

Would the person like to pursue one of the Individual Living Options (ILO)?

See: https://www.ndis.gov.au/providers/housing-and-living-supports-and-services/housing/individual-living-options

- ☐ Co-residency
- ☐ Host arrangement
- ☐ Living alone
- ☐ Living together
- ☐ Not appropriate for this person
- ☐ Does not want an ILO

Housing design requirements

If NDIA has not determined SDA, potential SDA eligibility (as per document "Eligibility for Specialist Disability Accommodation")

- ☐ Likely
- ☐ Maybe
- ☐ Not likely

Accessibility and other design requirements - attach documents:

1. **NDIS Participant Housing Needs and Preferences Interview**
2. **Eligibility for Specialist Disability Accommodation**

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NDIS Support Coordinator Referral / Handover Form

Participant Name		**NDIS Number**	
Age		**MRN**	
Gender		**DOB**	
NDIS Participant **Please circle**	Yes Awaiting access	**Short term accommodation to be pursued**	Yes / No If yes – for how long:
Primary Disability **(per professional report template)**		**SIL to be pursued**	Yes / No
Secondary Disabilities **(per professional report template)**		**SDA approval to be pursued**	Yes /No Improved livability / Fully Accessible / High Physical Support / Robust
Medical Diagnoses		**Requires home modifications**	Yes / No
Behaviours of concern		**Equipment & assistive technology required**	Yes / No Brief summary:
Guardianship	Yes / No Authority to exchange information: Brief summary:	**Requesting SC involvement in pre-planning**	Yes / No

Current progress through NDIS pathway (tick as many as apply):

☐ **ARF in progress**	☐ **Plan received**
☐ **ARF submitted**	☐ **Housing option identified (if needed)**
☐ **Pre-planning & awaiting planning meeting**	☐ **Awaiting supports implementation**
☐ **Planning meeting completed, awaiting plan**	☐ **Awaiting plan review**

Please attach:

- ☐ **Completed professional report template**
- ☐ **Written consent to exchange information with Support Coordinator**
- ☐ **Any other relevant documents**

SWSLHD Contact Person (Name & Role)		Contact No Email address	

Collaborative Working Agreement
SWSLHD staff and NDIS providers

This agreement is established to support a collaborative and effective working relationship between SWSLHD staff and registered NDIS providers for:

Participant name: _____

Participant DOB: _____

This agreement is made between:

SWSLHD staff name:_____

SWSLHD staff role:_____

SWSLHD staff contact details: _____

Provider staff name:_____

Provider staff role:_____

Provider staff contact details: _____

Provider organisation name: _____

We have discussed and agreed upon the following:

Topic	Agreed actions and information
Primary contacts in SWSLHD and the provider organisation	*Delete in final version – document names, roles and all relevant contact details*
Backup contacts in SWSLHD and the provider organisation	*Delete in final version – document names, roles and all relevant contact details*
Frequency of updates exchanged between SWSLHD and the provider organisation	*Delete in final version – How often will each organisation share updates with the other? Consider the amount of funding available to the NDIS-registered provider to negotiate an appropriate and cost-effective timeframe.*

South Western Sydney Local Health District
ABN 46 738 965 845

Liverpool Hospital Eastern Campus
Locked Bag 7279 Liverpool BC 1871
Tel 612 8738 6000 Fax 612 8738 6001

General Correspondence
Email: SWSLHD-ESU@health.nsw.gov.au
Website: www.swslhd.health.nsw.gov.au

Roles and responsibilities of SWSLHD staff	*Delete in final version - what are SWSLHD staff responsible for?*
Roles and responsibilities of provider staff	*Delete in final version - what are the provider staff responsible for?*
Mode of communication between SWSLHD and the provider organisation (e.g. email, regular meetings, teleconferences, videoconferences)	*Delete in final version – How will each organisation share regular updates with the other? Will you have regular case conferences, teleconferences, videoconferences, email exchanges? Consider the amount of funding available to the NDIS-registered provider to negotiate a cost-effective option.*
Expected response time to communications	*Delete in final version – within what timeframe should there be a response to an email or a phone message sent by staff of either organisation*
Contingency plans if contacts are on leave or provider organisation has a shutdown period	*Delete in final version – what plans will you make to cover periods of unavailability?*
Resolution of issues	*Delete in final version – how will you resolve any issues, where either organisation may not be observing the collaborative working agreement?*
Collaborative Working Agreement review frequency	*Delete in final version – how frequently will you review and update the Collaborative Working Agreement?*
Action Plan	*Complete the Collaborative Working Action Plan template and add as an appendix to the Collaborative Working Agreement*
Insert new topic/ delete as appropriate	
Insert new topic/ delete as appropriate	

Date of agreement: _____

_____ _____

SWSLHD staff signature Provider staff signature

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Local Health District

Collaborative Working Action Plan

This action plan will document and track collaborative action by SWSLHD staff and registered NDIS providers for:

Participant name: _____

Participant DOB: _____

Action Item	Detailed actions required	Person & Organisation Responsible	Target Date

Date of action plan: _____

Action plan review date(s): _____

APPENDIX D: SUMMER FOUNDATION RESOURCES INFORMED BY CDA PROJECT

- CDA practice guide
- CDA poster
- Capacity Building Framework Training Manual