NDIA Hospital Discharge Journey Map

NDIS Phase	Initiate plan variation/reassessment	Planning	Implementation
Hospital Phase	**Hospital admission**	**During hospital stay**	**Hospital discharge summary**

1A — Existing participant
Patient in hospital is identified as an existing NDIS participant.

1B — Existing participant
With participant's consent, hospital staff notifies the NDIA when the participant is admitted to hospital.

2A — Prospective participant
Patient in hospital is identified as someone potentially eligible for the NDIS.

2B — Prospective participant
- With the prospective participant's consent, hospital staff assists them to lodge access request and notifies HD team of prospective participant.
- HD team completes access request within 7-10 days of being notified.

3 — Contact participant
HD team contacts the participant, prospective participant or their authorised representative within 4 days of being notified of their admission.

4 — Contact the hospital
- HLO contacts hospital staff within 4 days of being notified to discuss participant's circumstances and reassessment needs.
- HLO identifies and requests any further information to facilitate the planning activities.

5 — Hospital provides information
- Hospital staff provides information and evidence to assist HD team to understand participant needs upon discharge (Discharge Assessment template can be used for guidance and consistency).
- Health information is needed before planning meeting.

6 — Planning meeting
- HD team conducts planning meeting with the participant.
- HD team may request further information if required during the planning meeting.

7 — Home and living assessment
If required, HD team conducts home and living assessment , including Technical Advisory Branch advice. The Discharge Assessment template provides information if a home and living assessment is needed.

8 — Plan approval and implementation
- HD team prepares the plan.
- HD team approves and implements the plan, including Request For Service (RFS).

9 — Health alignment meeting
HD team notifies hospital staff of the approved plan and specific supports relevant to the hospital discharge planning.

10 — SC engagement with key people
- SC engages with participant, HLO, HD team and other key people in participant's life.
- SC understands participant's current and usual living situation, including informal supports, who they usually/may live with, and history of their living situation and suitability.

11 — Plan implementation
SC engages with the participant, scopes market options, including home and living supports and supports the participant to transition to the selected option.

12 — Discharge planning meeting
SC conducts a discharge planning meeting with the hospital staff if required, as SC transitions the particpant to their selected option.

13 — Hospital discharge summary
Hospital staff undertakes comprehensive discharge planning to facilitate exit from hospital.

14 — Discharge participant from hospital
- Supports are in place and suitable for the participant.
- HD team hands the plan back to the participants usual planner for future planning.
- SC follows up with the participant so they are stable and settled.

Legend

- Hospital
- Health Liaison Officers (HLOs)
- Hospital Discharge (HD) team NDIA
- Support Coordinator (SC)

The journey map is indicative of the full hospital discharge process as per the NDIA Hospital Discharge Operational Plan agreed at the Disability Reform Ministerial Council (DRMC) meeting in July 2022. There are many potential 'off-ramps' across the hospital discharge process which are not covered in this journey map.

NDIA and State and Territory health services share information in compliance with respective relevant privacy legislation and with the consent of participants or their authorised representatives.