



THE ACT GOVERNMENT POLICY FRAMEWORK

FOR THE

TRANSITION OF PEOPLE WITH

HIGH ONGOING SUPPORT NEEDS

FROM

HOSPITAL TO THE COMMUNITY

27 July 2010

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1. PURPOSE

This Framework draws together the principles and commitments of the key ACT Government human service agencies which provide services to people who are medically and functionally fit for discharge and who require intensive and ongoing support, and/or specialised equipment, and/or modified housing to transition from hospital to the community, and to remain in the community.

This Framework aims to:

1. Enable people with high ongoing support needs, related to disability, to resume a lifestyle in the community with essential community-based resources, services and support,
2. Reduce the risk of inappropriate long-term hospitalisation, and the associated social and financial costs to the client and family, and the health system; and
3. Ensure people with high ongoing support needs are able to transition from hospital to the community in a safe, timely and sustainable manner.

This Framework will:

1. Define the responsibilities of the key partner agencies,
2. Improve collaboration between government agencies in discharge planning and supporting the timely transition of people with complex and high ongoing support needs from hospital,
3. Identify and coordinate government agency decision-making points in relation to resource allocation; and
4. Outline procedures to assist the partner agencies to work together to achieve the Government's priorities.

2. SCOPE

This policy Framework relates to the government response to people who:

- Are aged 18 – 65,
- Are permanent residents of the ACT, including those people who can provide evidence of planning to move permanently to the ACT at the time of their admission to hospital,
- Are inpatients of Canberra or interstate hospitals,
- Have high ongoing support needs; and
- Are at risk of, or are experiencing, delayed transition from hospital to the community.

3. INTRODUCTION

3.1 BACKGROUND

National and international good practice increasingly recommends and enables people with disabilities to remain in their homes or return to their homes after hospitalisation, with the support of their natural communities and the formal services they require.

Every state and territory in Australia experiences challenges transitioning non-compensable people with complex needs from hospital to community settings. Nationwide, there are limitations to the public funding available for high-cost equipment, home modifications, housing and ongoing support needed by people with disabilities. There are challenges related to silo-ed policy and program development and delivery in the core areas of health, housing and disability services. While there are examples of collaborative interagency programs interstate which have successfully addressed the systemic and funding barriers for people with complex needs? These are targeted to people with specific conditions and are of limited application in the ACT.

In the ACT there are finite formal resources available to support people with disabilities. In some circumstances there are inadequate resources to ensure people with complex and ongoing support needs can transition out of hospital in a timely manner. The need to remain in hospital after a person is medically and functionally ready for discharge may pose specific health risks and is generally agreed to be detrimental to the wellbeing of the person and their family. There are also negative impacts on the community broadly because of the cost to the health system and reduced access for others to hospital care.

Planning for effective, safe and sustainable return from hospital to community living for people with high needs related to their health condition and disability is a joint responsibility of ACT Health and the ACT Department of Disability, Housing, and Community Services (and particularly Disability ACT and Housing ACT).

Each year a varying, though small number, of ACT residents will require an extremely high level of response and resources because of the complexity of their circumstances. For a smaller cohort within this group, they will have exceptionally intensive and therefore high cost care and support needs post discharge. The responses need to comply with a range of legal and policy frameworks and occur in the context of equitable and transparent decision making processes.

3.1.1 DEMOGRAPHIC INFORMATION

In the ACT, approximately 3.85% of the population, or around 13 000 people have a profound or severe disability.¹

The incidence of people aged 18 – 65 with a severe or profound core activity limitation is projected to increase. This is largely due to population changes resulting in growth in the 45 – 64 age group. The projected growth in the numbers of people aged 0-64 with a physical/diverse disability and an acquired brain injury (ABI) is higher than the projected

¹ABS: Disability, Ageing and Carers, Australia: Summary of Findings 2003

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growth in disability overall. The growth in incidence of disability in the working-age population, and in physical/diverse disability and ABI, will pose increasing challenges for the health and disability sectors.²

The majority of people who experience barriers in transitioning from hospital to the community have a disability sustained through an ABI including traumatic brain injury (TBI) or spinal cord injury, or experience neurodegenerative disease such as multiple sclerosis, resulting in severe or profound core activity limitation.

In the ACT the incidence of people with newly acquired disabilities, with high ongoing support needs, who are functionally and medically stable for discharge but remain in hospital because they cannot obtain the needed level of support services, is estimated to be between 6-8 each year. While numbers are comparatively low, they are unpredictable and fluctuate year-to-year.

Disability ACT anticipates that an additional 15 people each year will enter the disability supported accommodation service and of these, eight to ten are likely to have high and complex needs and require a specific housing response.³

3.1.2 KEY THEMES

Three themes relevant to the transition of people with complex ongoing support needs from hospital to the community emerge from recent ACT Government policy and planning documents:

- Community inclusion,
- A whole of government approach; and
- Timely access to health care.

The Canberra Plan: Toward our Second Century (2008) states:

“ ... the ACT Government has a vision of Canberra becoming a place where all people reach their potential, make a contribution and share the benefits of our community....Each of the approximately 45,000 people in the ACT who report having a disability has a right to self-determination, respect, dignity and participation at all levels of the community.”

In 2004 the Disability Advisory Council and the ACT Government released *Challenge 2014: A ten year vision for disability in the ACT*. This document sets out the expectations of people with a disability including children, their families and carers. It challenges the ACT Government to have established by 2014:

“A whole of government approach to all issues affecting people with disabilities and their families; strategic planning based on accurate demographic information; a clearly understood government role ... and transparent processes around access, eligibility and funding arrangements”.

² Disability in Australia: acquired brain injury, Bulletin 55, December 2007, AIHW

³ *From House to Home-* a study into accommodation and support for people with high and complex support needs Draft Report 2009

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Access Health is a future directions document developed by the ACT Minister for Health. Timely access to health care based on clinical priority is a key priority area in Access Health. One of the key performance indicators of this priority is the reduced average length of stay for acute rehabilitation care.

ACT Government agencies fund services and individuals in a way intended to best meet the needs of the person with a disability within the resources available and within the eligibility criteria as defined by its funding agreements with the ACT Government and Australian Government.

These Agreements contain the expectation that government agencies will make the best use of all available resources and determine priorities in a fair and equitable way however they do not include the expectation that all disability needs will be met.

The ACT Government has determined that people who are medically and functionally fit for discharge from hospital are a priority for resource allocation within its' funded agencies existing program parameters. The available resources will be allocated in the manner best suited to achieve government priorities.

4. THE FRAMEWORK

4.1 LEGISLATIVE AND POLICY CONTEXT

This Framework is consistent with the goals and underlying principles of the following key ACT Government and national documents:

- Access Health (2007)
- The Canberra Plan: Toward our Second Century (2008)
- Challenge 2014: A ten year vision for disability in the ACT
- Future Directions: Towards Challenge 2014
- Caring for Carers Policy (2003)
- National Disability Agreement (2009)

This Framework is compatible with the requirements of the following legislation:

- *Aged Care Act 1997* (Commonwealth)
- *Disability Services Act 1991* (ACT)
- *Disability Discrimination Act 1992* (Commonwealth)
- *Discrimination Act 1991* (ACT)
- *Health Act 1993* (ACT)
- *Health Records (Privacy and Access) Act 1997* (ACT)
- *Home and Community Care Act 1985* (Commonwealth)
- *Housing Assistance Act 2007* (ACT)
- *Human Rights Act 2004* (ACT)
- *Mental Health (Treatment and Care) Act 1994* (ACT)
- *Public Sector Management Act 1994* (ACT)
- *Privacy Act 1998* (Commonwealth)
- *Powers of Attorney Act 2006* (ACT)
- *Public Advocate Act 2005* (ACT)
- *Public Sector Management Act 1994* (ACT)

4.2 COLLABORATIVE APPROACH

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For people whose needs exceed the capacity of their natural supports and the existing ACT Government funded accommodation and community support programs, an interagency response is required.

Collaboration is vital to achieve a safe and sustained transition from hospital for people with complex and ongoing support needs who are medically and functionally fit for discharge. The Framework will ensure that the available resources are allocated according to prioritised need, and with equity and transparency.

In relation to this priority group, the relevant programs and services funded and directly provided by the DHCS and ACT Health will work collaboratively to:

- Ensure the needs and circumstances of individuals are viewed holistically,
- Share data to plan and deliver services which meet their current and future needs,
- Ensure the smooth transition from one service system to another,
- Reduce the number of assessments and priority setting processes each individual undertakes, whilst conforming to privacy principles; and
- Ensure that assistance is provided, and resources are allocated, in the most effective, equitable and transparent way.

4.3 PRINCIPLES

4.3.1 Service Principles

- People with disabilities should be respected as equal and valued members of the ACT community,
- The person with a disability should be recognised as a person first, with attention given to their social and emotional wellbeing, as well as their physical and medical needs,
- Agencies should recognise the primacy of the person and their family in understanding their own needs,
- Services should be designed to recognise and build on the strengths of the person and their family, and to build their capacity across all domains of their life as appropriate to them,
- Service planning and implementation partnerships should begin early in the admission,
- The right services should be available at the right time and in the right place; and
- Government cannot meet all of an individual's needs related to their disability.

4.3.2 Principles of Collaborative Practice

- The partner agencies demonstrate mutual trust, co-operation, professional respect and goodwill in working towards agreed goals with the person and their family,
- Information is shared appropriately between the partner agencies,
- Inter-professional and interagency learning and development, in relation to people with complex and ongoing support needs, is valued and supported,
- Innovation and continuous improvement in government processes and planning and delivery of services is valued and supported; and,

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- The partner agencies share responsibility in the relationship and accountability for the process and outcome.

4.4 THE SUPPORT AND SERVICE SYSTEM

4.4.1 Families and Natural Support Systems

Many people with high ongoing support needs, experiencing barriers to transition from hospital, have some natural support provided by family, friends and others. However for the people in the scope of this Framework, this support is not sufficient in itself to enable them to be discharged from hospital. Nevertheless, the existing natural supports must be valued, used and strengthened; and complemented but not wholly replaced by, formal supports. People with high ongoing support needs who have limited or no natural supports are more likely to experience delayed discharge than those with robust informal support networks.

4.4.2 Generic Community Services and Supports

People with high ongoing support needs are generally eligible for assistance from government funded community services, and this is the first avenue explored by the person's treating health team which is planning for their discharge. This Framework is targeted to people for whom the support available from these generic community services is insufficient, in itself, to enable discharge from hospital.

Access to accommodation provided by Housing ACT; and/or community support services funded or provided by Disability ACT are the next options explored by the treating team. In some circumstances, people need and it is appropriate for them to receive, assistance from a variety of services and programs to return safety to community living.

4.4.3 Maximum Allocation of Government Funded Resources

ACT Government cannot meet all of the costs and/or support needs of people with disabilities, their families and carers. Funding of supports and services must occur in a way which is fair, efficient and transparent.

It is appropriate that in allocating resources to enable the discharge of people with high and complex needs, and those with exceptionally high needs, the total package of direct and ongoing supports established should still be assessable for reasonableness and equity.

Reasonableness and equity, in these circumstances, relates to the general availability of resources to other people in the ACT with similar support needs (that is –those not in hospital), others with disability generally, and the potential for the assistance to have a positive impact on the person's quality of life.

In establishing support and care responses which are financially intensive, there is an expectation that the individuals and their families/legal guardians will engage, to best of their ability, in the development of supports, and potential accommodation arrangements, which are sustainable and can be delivered within the resources available. This may mean compromising; for example, considering shared support or accommodation, building informal networks to supplement formal services; and exploring environmental and technological aids to achieve sustainable arrangements.

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4.4.4 Roles and Responsibilities of Departments and Agencies in the Transition Response

The roles and responsibilities outlined below are generally consistent with the current practice of the partner agencies.

This policy framework confirms the responsibility of partner agencies for their functions and outlines some new areas of responsibility. These relate primarily to the sustainability of the support package for people with exceptionally high cost care packages.

The Framework also confirms the priority attributed, by the ACT Government, to people with complex needs at risk of delayed discharge from hospital.

ACT Health

The ACT Health system operates with an obligation to discharge people with supports appropriate to their circumstances in place. This does not negate the right of individuals to make, if they are legally able to, their own decisions in relation to how they live. Access to appropriate community health services are generally not a barrier to timely discharge.

ACT Health provides health services for people with high ongoing support needs through divisions including The Canberra Hospital, Aged Care and Rehabilitation Service, Mental Health and Community Health.

Provision of health services:

ACT Health services may be delivered in a variety of settings including hospital or community. When a person is in hospital and considered unlikely to achieve full independence, the goals of ACT Health include enabling the person to return to and remain at home, with appropriate support.

ACT Health commences discharge planning with the individual and their family/carers early in their admission; this includes undertaking a comprehensive assessment of the person and their likely level of function, their home environment and their need for equipment and modifications.

It also includes evaluation of the capacity of the person's natural supports, and early appropriate referral to formal support services able to provide for the person's additional needs, including those needs which can't appropriately be met by an unpaid carer.

ACT Health is responsible to ensure that there is early engagement with the appropriate partner agency/ies when an individual is identified as at risk of delayed discharge because of the complexity of their needs and circumstances.

ACT Health services may train paid and unpaid carers in the tasks related to supporting the person, and offer therapeutically-oriented support to the person's unpaid carers as they adjust to the caring role.

After discharge from hospital, a person may continue to receive medical, community nursing and allied health services. These are delivered in partnership with support services.

ACT Health will assist people with complex needs returning to community living to appropriately link to the private health sector, and particularly a general practitioner (GP) to assist them to manage their primary health care needs.

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Information:

ACT Health collects information relating to the health, functional and social needs of people at risk of, or experiencing, barriers to transition to the community, and shares this appropriately with partner agencies. More broadly, ACT Health gathers and analyses service users' casemix data, including diagnostic related groups, lengths of stay and bed utilisation rates.

Policy

ACT Health develops policy to support the implementation of evidence based practice for managing the health needs of people with high support needs.

Provision of Equipment and Aids

A wide range of equipment is available from the ACT Equipment Service, funded by ACT Health. Canberra residents who utilise this scheme will not be financially disadvantaged as all equipment is now fully funded and no contribution is required. Low income earners and some self funded superannuants who do not hold a health care card will now be eligible for supply under the ACT Health Equipment Schemes dependent only on their income level.

Community Services

ACT Health funds and directs community support services through the Home and Community Care (HACC) Program, a key provider of community care services to frail aged people and younger people with disabilities, and their carers.

The overall objective of the HACC Program is to enhance the independence of people in these groups and to avoid their premature admission to long term residential care. The Program aims to:

- Provide a comprehensive, coordinated and integrated range of basic maintenance and support services for frail aged people, people with a disability and their carers,
- Support these people to be as independent as possible at home and in the community, thereby enhancing their quality of life and/or preventing their inappropriate admission to long term residential care; and
- Provide flexible, timely services that respond to the needs of consumers.

The Program is intended to provide basic maintenance and support services that are cost effective and meet the needs of individuals so they can remain in the community. This can include a range of services such as advocacy, case management, respite, personal care and domestic assistance, delivered through a range of community organisations.

Some individuals require a comprehensive package of services and supports from other programs and their carers to enable them to achieve to safe and sustainable community living arrangements. Agencies will work together, within existing resources, to establish appropriate packages of support around the individual.

The Department of Disability, Housing and Community Services (DHCS)

Provides services for people with a disability through its business units of Disability ACT, Therapy ACT, Community Services and Housing ACT.

Disability ACT

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Disability ACT funds services and individuals in a way intended to best meet the needs of the person with a disability, within the resources available and within the eligibility criteria as defined by its funding agreements with the ACT Government and the Australian Government. These agreements do not include the expectation that all disability needs will be met. They do contain the expectation that Disability ACT will make the best use of all available resources and determine priorities in a fair and equitable way. Access to specialist disability services is limited, and is prioritised to people who are assessed as being the most likely to gain most benefit from them. People at risk of delayed discharge are identified as a core priority for response. Disability ACT is responsible for:

Policy

Ensuring that the circumstances and aspirations of people with complex and ongoing support needs and their families are considered in government policy. Liaison with other agencies and governments, including the Australian Government, to develop, implement and monitor service responses.

Planning

Researching and collation of information about people with complex and ongoing support needs and their families. Gathering data about the current levels of service delivery, unmet need and service system gaps.

Community awareness

Promoting the right of people with complex ongoing support needs, to be accepted into, and supported to be active participants in, community life.

Information

Providing information relevant to the support of people with complex and ongoing needs to families, carers, community agencies and other government agencies. Educating community agencies about available services and supports. Collating and maintaining an accessible database of information on services and service access. Assisting people with complex and ongoing support needs and their families.

Service coordination

Planning, sourcing and coordinating the ongoing services which provide individualised and practical assistance to the person and their family and informal networks, to maintain the best possible quality of life.

Assessments, prioritisation and allocation

Of funding and other formal resources to those with known need and those in emergency need.

Accommodation support

Providing accommodation support or supported accommodation, for people with high and complex needs, when the person's family or formal supports are not able to provide the level of support required. Developing new service models to respond to growth in demand.

Housing ACT

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Housing ACT provides public housing and related services to eligible people with complex and ongoing support needs.

For new tenants of Housing ACT

Identifying and allocating a suitable property, and completing any modifications that may be required to make the property suitable.

For existing tenants of Housing ACT

Where possible, completing the modifications required to make the existing property suitable. Where that is not possible, identifying and allocating another suitable property and completing any modifications that may be required to make that property suitable.

Respond to prioritised need

Along with a suite of supplementary principles, Housing ACT prioritise applicants who are able to demonstrate a range of complex needs with evidence of significant risk factors that would be addressed or substantially alleviated through the early allocation of public housing, including:

- Formally diagnosed mental health issues, including the effects of past trauma and torture;
- Other serious and chronic health issues
- Disability including frail-aged, where natural supports have broken down, or are at serious risk of breaking down;

A waiting list of no more than 150 applicants in priority need is maintained. Applicants need to demonstrate that they can sustain their tenancies; this means any housing allocation will be coordinated with the developed package of community health and other supports and, as appropriate, Disability ACT's confirmation of a sufficient and recurrent resource allocation.

4.5 GOVERNANCE

Responsibility for the implementation, monitoring and evaluation of this policy framework sits with the Chief Executives of ACT Health and the Department of Disability, Housing and Community Services.

5. IMPLEMENTATION

Implementation of the Framework is to commence in 2010 and will involve:

- The development and agreement of a Service Partnership Agreement to operationalise the Transition Response (below),
- Development and implementation of joint procedures and guidelines to support the continuous improvement and broad application of the Policy Framework,
- Nomination of an Executive Officer from each agency, with authority to prioritise and allocate resources, to the Transition Response Panel; and
- Dissemination of the policy Framework to government and funded community services and publication on the ACT Government Internet site.

5.1 COLLABORATIVE MECHANISMS

The collaborative mechanisms underpinning the Framework are to be codified and operationalised through the establishment of an Service Partnership Agreement between the relevant ACT Government departments and partner agencies.

5.1.1 TRANSITION RESPONSE TEAM

The Transition Response Team will operationalise the Framework to enable people with high ongoing support needs to transition from hospital to the community in a safe, timely and sustainable manner.

The Transition Response team will:

- Engage early in planning to identify and respond to needs where transition to the community is likely to be resource intensive, complex or delayed,
- Confirm which agency will undertake lead agency responsibility for the coordination of responses and resources,
- Determine appropriate and prioritised service responses within all available resources and confirm agency responsibility for the different components of the response,
- Ensure the coordinated and collaborative delivery of services for individual clients across agencies and programmes,
- Individual agency representatives will undertake usual internal procedures if the determined response is outside of usual program guidelines, existing budgets or their own delegated authority,
- Facilitate appropriate submissions (for example, for new funding to respond to an extraordinary need or set of needs),
- Will identify and address service capacity, eligibility criteria, funding arrangements and reporting mechanisms that contribute to fragmentation and service gaps; and or effective transition,
- Provide a forum to identify areas for interagency strategic planning, and policy and service development; and

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- Provide advice to the Relevant Senior Officers in relation to:
 - significant service gaps that cannot be resolved by the identified responsible agency; and/or
 - Significant systemic issues impacting on the ability of an individual or cohort, to transition from hospital to appropriate community living arrangements.

Membership

The Transition Response Team will include senior representatives, with resource allocation and prioritisation authority, from:

- Disability ACT
- Housing ACT
- Representatives of the appropriate policy and clinical divisions of ACT Health

Chair

The Chair of the Transition Response Team will:

- Be selected by the Executive Directors,
- Confirm the responsible agency for responses identified in the individual's agreed care plan; and
- Provide advice to the Executive Directors in relation to:
 - significant service gaps that cannot be resolved by the identified responsible agency; and/or
 - significant systemic issues impacting on the ability of an individual or cohort to transition from hospital to an appropriate community living arrangements.
- Provide specific advice and/or options to the Executive Directors in relation to the most appropriate response to individual or systemic areas of unmet need referred to the team.

5.1.2 EXECUTIVE DIRECTORS' FORUM

The partnership agencies involved in the transition response, recognise that for an individual with high ongoing support needs, there may not be suitable services or resources to enable safe and sustainable transition to the community in a timely manner.

The Executive Directors will operate in accordance with its Terms of Reference; and will:

- Provide the avenue of escalation from the Transition Response Team if the responsible agency/ies are not able to resource a required component of the care plan,
- Facilitate and/or support, any necessary budget submissions,
- Provide advice to the Chief Executives on responses and resources for referred individuals; and
- Make recommendations and implement consequential strategic policy and program reform.

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Implementation of Agreed Transition Plan

To effectively transition the individual from hospital to appropriate community living, a transition plan will be developed by the transition response team.

The nominated lead agency will be responsible for developing and managing the transition plan. Detailed in the plan will be:

- The support each ACT Government agency will provide on a sustained basis,
- The contact name of key liaison personnel in each area,
- The record management responsibilities; this includes consent details and what information is able to be shared,
- Any reporting measures,
- Communication arrangements with the person in hospital and/or their legal guardian and between partner agencies and the lead agency; and
- The expected outcomes and timeframes for actions agreed.

5.2 EVALUATION

The effectiveness of this policy Framework to facilitate the desired outcomes will be jointly evaluated two years after implementation by the two partner agencies of ACT Health and the Department of Disability, Housing and Community Services.

GLOSSARY OF TERMS AND ACRONYMS

DISABILITY:

The *ACT Disability Services Act 1991* states:

Disability, in respect of a person, means a disability—

- (a) that is attributable to an intellectual, psychiatric, sensory or physical impairment or a combination of those impairments;
- and
- (b) that is permanent or likely to be permanent; and
- (c) that results in—
 - (i) a substantially reduced capacity of the person for communication, learning or mobility; and
 - (ii) the need for continuing support services; and
- (d) that may or may not be of a chronic episodic nature

The World Health Organisation International Classification of Functioning, Disability and Health (ICF) defines disability as “the umbrella term for any or all of: an impairment of body structure or function, a limitation in activities, or a restriction in participation.”

The ICF defines functioning and disability as “multi-dimensional concepts, relating to:

- The body functions and structures of people
- The activities people do and the life areas in which they participate
- The factors in their environment which affect these experiences.

Each of these components is defined in the context of a health condition.”

SUPPORT SERVICES:

Provide individualised, practical assistance to the person with a disability and their carers, to maintain the best possible quality of life. Health services do not provide or fund these paid support services after the person has discharged from hospital. These services are generally the responsibility of formal community-based agencies with funding from a range of sources, including but not limited to Disability ACT. *n.b in the ACT context, people who have a primary diagnosis of a psychiatric impairment receive services from the ACT Mental Health program and are therefore not prioritised for services provided or funded by Disability ACT.*

Support services are delivered by staff with a range of qualifications and expertise. Examples of tasks undertaken by support services are:

- Showering, dressing and toileting
- Assistance with transfers and mobility
- Assistance with continence
- Oral feeding
- Meal preparation
- Household tasks
- Shopping and errands
- Carer respite; and
- Support to participate in social and avocational activities.

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MEDICALLY AND FUNCTIONALLY READY FOR DISCHARGE:

The following statements describe when a person's health status is such that they are considered ready for discharge from hospital.

- The person's progress in functional goal attainment has ceased or significantly slowed, and the person is considered unlikely to benefit further from the intensity and frequency of multidisciplinary care in an inpatient environment; AND/OR
- The person's goals relate to community integration and are more likely to be achieved in a community setting; AND
- The person, or their carer or guardian, demonstrates competency in managing their ongoing health needs, including knowledge and understanding of the relevant resources available; AND
- The person's medical condition is able to be managed in the community by his or her GP, with appropriate medical specialist support; AND
- The person's personal care can be safely managed by an appropriately trained carer (paid or unpaid); AND
- The person does not require clinical nursing intervention for activities of daily living, and any other clinical nursing needs, such as wound care, can be safely managed in the community, e.g. by the Community Nursing service

Whether a person can be safely discharged to and sustained in the community also depends upon the availability of suitable housing, equipment and support. This definition of "ready for discharge" relates only to the person's health status and does not include these other factors.

This Framework applies to people with high ongoing support needs who are considered at risk of, or who are experiencing, delayed transition to the community, as indicated by the presence of two or more of the following factors:

Social Issues

Such as no discharge destination, limited natural supports (e.g. no resident carer, carer health constraints, in-home carer in the paid workforce), the person is a carer of others, major financial issues, or major guardianship issues.

Equipment and Housing Issues

Such as the need for high cost equipment or home modifications.

Mobility, Self Care and Continence Issues

Such as the need for transfer by hoist or assistance of two carers, frequent assistance through the day, and assistance at night additional to that normally available in the home.

Cognition and Communication Issues

Such as the need for constant supervision to ensure safety and intensive support to manage challenging behaviours.

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Health Maintenance Issues

The need for intensive support to manage one or more significant health conditions, such as artificial feeding, artificial ventilation and airway management, pressure areas and mental illness.

As a result of these factors, the person's needs cannot readily be met or sustained by the existing service system.