



## Background

The Issue of transition to community living for long-term patients in hospital with complex and ongoing needs is a consistent and significant challenge for staff and service providers. There are examples of patients remaining in hospital for over 12 months after they have been declared medically ready for discharge. These are younger people who have experienced traumatic brain or spinal injuries or who have degenerative and disabling health conditions (such as Multiple Sclerosis, Huntington's Disease, Motor Neurone Disease) and it is inappropriate for them to enter residential aged care services.

Whilst the financial costs of remaining in hospital are significant for the health system, the ACT Government also acknowledges the large social cost to the individual and their families and carers.

The barriers impeding transition are complex and multi-faceted, and include, but are not limited to, accessing funding for needed equipment, obtaining accommodation that contains the necessary modifications, and reduced ability to secure public funding for community support.

Currently, there are no obvious policy supports in place to facilitate this process. The lack of a framework often results in an inconsistent approach to the planning and outcomes for the individuals.

Progress in this area requires a joint response from both ACT Health and Disability, Housing and Community Services (DHCS) and the respective Chief Executives, Mr Mark Cormack and Ms Sandra Lambert, have acknowledged this priority for their agencies, and have endorsed the establishment of a joint project team to develop and implement a solution. Key staff from the Aged Care and Rehabilitation Service (ACRS), Community Health and The Canberra Hospital (TCH) along with colleagues in DHCS have been invited to form the project team. Ms Linda Kohlhagen (Allied Health Manager, ACRS) is Project Manager and Ms Sarah King (Senior Manager, Disability ACT) is the Deputy Project Manager.

The two departments have contributed toward the employment of a part-time Project Officer, from within existing budgets, to assist with this important piece of work. The Project Officer is Ms Raelene McNaughton, phone 6244 4205.

This work will be informed by various previous projects undertaken by ACT Health, DHCS and other government departments & NGOs to improve service coordination and outcomes for younger people in the ACT with complex care needs.

**For the purpose of this project which is auspiced by ACRS and DCHS, people within the target population must:**

- Be an ACT resident
- Be inpatients of an ACRS' TCH based unit [wards 11A, 12B or RILU] and be aged between 18 - 65 years [18 - 50 for Aboriginal and Torres Strait Islander people ]

- Have a newly acquired disability and/or deterioration in chronic condition.
- Be a long term patient with ongoing, high care needs requiring a multifaceted discharge planning/transition process.
  - Their accommodation, personal support, caring and quality of life needs can not be met or sustained by existing community services.
  - There is no current service system response, and/or the patient requires a tailored funding package

Planning began in late 2008. Representatives from a range of ACT Government Departments, key community groups and consumer groups have been identified as key stakeholders.

Coordinated and timely service planning as well as consistent decision making (based on a policy framework) will enable better understanding and justification of any subsequent unmet needs.

It is anticipated that this project will result in an improved process for transitioning long term patients with complex and ongoing care needs, improving patient and carer outcomes and improving the efficiency of, and access to, relevant services. The project team anticipates a framework will be endorsed and implemented by 2010. In the interim, ACT Government agencies will continue to work collaboratively with our colleagues in community agencies to facilitate safe and sustainable transition from hospital, for patients with high needs.

**For further information contact:**

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