Transition Care Program

Client information and agreement

VICTORIA State Government | Department of Health

To receive this document in another format, phone the Department of Health Transition Care Program manager 03 9595 2307, using the National Relay Service 13 36 77 if required, or email <TCP@health.vic.gov.au>.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

Except where otherwise indicated, the images in this document show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services. This document may contain images of deceased Aboriginal and Torres Strait Islander peoples.

In this document, ‘Aboriginal’ refers to both Aboriginal and Torres Strait Islander people. ‘Indigenous’ or ‘Koori/Koorie’ is retained when part of the title of a report, program or quotation.

Available at https://www.health.vic.gov.au/publications/tcp-information-and-client-agreement-english

This booklet provides important information about the Transition Care Program and explains what you can expect when you are receiving care.

It explains your rights and responsibilities and the obligations of your Transition Care service.

This booklet is also a formal agreement between you and your Transition Care service provider as required by the Aged Care Act 1997.

Your case manager is: _____

and may be contacted on: _____

Contents

What is the Transition Care Program?

The Transition Care Program (TCP) provides short-term care and services for older people (and sometimes younger people) after they leave hospital. By offering maintenance (low level) therapy and support the TCP allows older people to continue their recovery out of hospital while appropriate long-term care is arranged.

To receive TCP you will need to be assessed and approved by the Aged Care Assessment Service while you are in hospital.

Where will I receive TCP?

TCP can either be provided in a bed-based care setting (such as in a residential aged care facility or in a hospital) or in your own home. Where you receive care will depend on the type of care you need.

How long can I stay on the program?

TCP will start when you leave hospital. Most people will stay on the program for four to six weeks. The maximum time you can stay on the program is 12 weeks, although in an exceptional circumstance you can be approved for an extension of up to another six weeks. Within this time your case manager will work with you to arrange suitable long-term support.

What is a case manager?

You will be allocated a member of the TCP team, known as a case manager, who will help you (and your carer or family) from the time you start on the program to when you finish. Your case manager will help you set goals for what you want to achieve.

Your case manager is part of the team of health professionals who are looking after you.

Your case manager will:

- conduct the initial and ongoing assessment of your care needs
- coordinate and monitor your care plan with you
- liaise with service providers to keep them informed of changes required in your care plan
- ensure you have the opportunity to participate in decisions affecting your care
- provide information and education
- act as an advocate or supporter on your behalf if needed
- provide emotional support to you and your carer
- develop a discharge plan with you to make sure the support and services you need are in place when you are discharged.

What are the care and services available under TCP?

The type of care you receive will depend on what you need and where you receive TCP. For example, the type of help you will need if you are at home may be different from what you will need if you are in a bed-based care setting. The TCP is not a form of rehabilitation. Services may include:

- case management
- nursing
- domestic home care, such as cleaning services
- meal assistance
- help with bathing and showering
- organisation of appointments (including transport)
- social activities
- maintenance therapy as provided by allied health staff such as a physiotherapist
- continence aids
- equipment, as recommended by the physiotherapist or occupational therapist, such as a shower chair
- in–home respite.

It is unlikely you will require all of these services. Hospital and TCP staff will discuss with you what they recommend in consideration of the care goals you (or your representative) have identified, and what can be provided with the available funding. You will be involved in developing a care plan that will outline the services to be provided. Your case manager will review this plan with you regularly.

The full range of specific care and services that can be provided are listed in the national TCP guidelines. Transition Care Programme Guidelines | Australian Government Department of Health If you require a paper copy of the guidelines please ask your case manager.

What types of services are not included?

If you require general medical services such as pathology or radiology services or an appointment with your GP, then TCP staff can help with your appointments. The cost for these services is not covered by the TCP, however costs for a General Practitioner will be fully covered by Medical Benefits Schedule rebates if you are receiving care in a bed-based setting.

When an ambulance is required for transfer from transition care to a permanent facility, home or back to hospital the ambulance cost is the responsibility of the client. For ambulance subscribers and pensioners this cost will be covered but non-pensioners and non-members will receive an invoice for the cost of transport.

Additionally, the cost of pharmacy (prescription) medicines is not included as part of TCP and you will be required to pay for these separately. If you are at your safety net level, please let your case manager know.

Client story

Caterina was in hospital following a fall in which she broke her wrist. After three days in hospital she received two weeks of TCP in a bed-based setting. Caterina has Parkinson’s Disease, which probably contributed to her fall, and she lives alone. Her experience of TCP was positive, and she reported that she didn’t want for anything.

Caterina initially wanted to return to her own home but knew that she would need substantial help as her wrist was in a brace. Although she has three children that all live approximately half an hour away, she didn’t want to bother them as it would be difficult for them to provide the level of care she needed.

When TCP ended she stayed with a friend for a while with help from private services. Caterina is now at home and TCP staff arranged the equipment and support she needs so that she can live as independently and safely as possible.

What will I need to pay?

TCP receives funding from the Victorian and Australian governments, which covers most of the cost of the program; however, you are also asked to pay a fee to contribute to the cost of your care.

TCP is not covered by private health insurance.

Department of Veterans' Affairs recipients are not exempt from the fees unless you were a prisoner of war.

How much is the fee?

The maximum fee is determined by the Australian Government and is calculated as follows:

- home-based clients – daily rate of 17.5 per cent of current single aged pension
- bed-based clients – daily rate of 85 per cent of current single aged pension

If you are unable to pay the fee, please discuss this with your case manager. If applying for a fee reduction you may be asked to show proof of your income and financial situation.

You cannot be refused a service if you are unable to pay due to financial hardship. Fees can be reviewed and discussed with your case manager at any time.

How are fees collected?

You will be provided with information about how to pay your fees. Usually you will receive an invoice once you begin on the program.

If you are unable to pay your fees on time please discuss this with your case manager.

What if my care needs change?

It is expected that your care needs will change while you are receiving TCP. As your health needs change you may require less or different services. This will be reviewed regularly with your case manager (or care team).

If your care and service needs increase significantly, your case manager will discuss with you whether TCP can provide the care you need. Your case manager will also speak with the people involved in your care to work out how TCP can best assist you. This may include changing from TCP at home to TCP in a bed-based care setting.

If TCP is no longer able to meet your care needs, TCP will finish and your case manager will work with you to make alternative arrangements. These arrangements will be confirmed in writing.

What happens if I need to return to hospital during TCP?

From 1 July 2021 the government introduced a provision to allow people receiving services from transition care to take up to 7 days leave, in total, from their transition care episode. The leave can be used for hospital or social reasons and can be taken as single days or longer.

If there is an interruption to the TCP episode of care for more than 7 days, your transition care episode must end. To recommence TCP care, you will require a valid Aged Care Assessment Service approval and must commence a new transition care episode directly after another hospital stay.

What are my rights and responsibilities?

When you are receiving TCP you have the right to:

- be treated as an individual, with dignity and respect
- be supported in decision-making processes and have someone to speak on your behalf if you wish
- information to assist you to make decisions about your care
- take part in the planning and decision making about your care
- talk freely, and in confidence, with your case manager about any aspect of your care requirements
- an interpreter and culturally appropriate services.

You also have the responsibility to:

- actively participate in achieving your care plan goals
- accept personal responsibility for your own actions and choices, even though these may involve an element of risk.
- speak to your case manager about your care needs and any changes that may be needed to your care plan
- respect the rights of the people who are employed to provide your care and treat them with the same dignity with which you wish to be treated
- provide the people who are employed to work in your home with a safe and healthy place to do their work.

(An assessment of your home may be conducted to ensure it is safe and that recommended equipment is installed according to your care needs. If there are ongoing safety concerns, it may not be possible to provide TCP in your home.

What quality of service can I expect?

You are entitled to receive a high standard of care from TCP, as per State and Commonwealth government quality guidelines.

This will ensure that:

- care is provided by experienced and skilled staff
- the program is provided in a safe, more homely environment (where TCP is provided in a bed-based setting).
- care is provided in a timely, flexible and responsive manner
- the program is regularly reviewed to certify that it is responsive to the needs of its service recipients
- quality is an ongoing focus of TCP, including listening to feedback, reviewing any complaints and complying with the TCP guidelines.

Who will be provided with information about me?

Information regarding your health, care needs, and services is required to be shared with your GP, other health professionals, and relevant service providers so your care plan needs are met.

Information is also required by the Commonwealth Department of Health and the Victorian Department of Health and Human Services for funding and evaluation purposes.

When you or your guardian/administrator consent to the TCP agreement, you authorise your TCP service to provide your personal details and information about your health and the care you receive to these people and organisations.

Your personal information will be used and disclosed in accordance with relevant privacy legislation.

Your rights are protected under the:

- *Commonwealth Aged Care Act 1997, Aged Care (Transitional Provisions) Act 1997* and the Principles made under the Acts
- *Victorian Charter of Human Rights and Responsibilities 2006*
- *Victorian Privacy and Data Protection Act 2014*
- *Victorian Health Records Act 2001*
- *Commonwealth Privacy Act 1988*

What is My Aged Care and how does it affect me?

While in TCP your case manager may discuss with you services that can support you in the medium to long term. With your consent, referrals will be made to these services, some of which will need to be made to My Aged Care.

My Aged Care is the central entry point into the aged care service system in Australia, particularly for services that are funded in part or full by the Australian government. My Aged Care is part of a number of changes the Australian Government is making to the aged care service system to ensure people have access to information and find it easier to locate and access services.

My Aged Care is made up of a contact centre (1800 200 422) and website. The contact centre operates from 8.00 am to 8.00 pm Monday to Friday and 10.00 am to 2.00 pm on Saturdays; the staff in the contact centre can assist you with any questions you may have. The website address is http://www.myagedcare.gov.au. Your case manager will be involved in discussions with you to ensure that a good care plan is possible in preparation for your discharge from TCP.

What is advance care planning?

Advance care planning is the process of planning for your future health and personal care whereby your values, beliefs and preferences are made known so they can guide clinical decision making at a future time if you cannot make or communicate your decisions.

Advance care planning involves making a plan for future health and personal care should you lose your decision making ability so that the care you receive is consistent with what you would want.

Your case manager can:

- Have a conversation with you about advance care planning
- Provide you with information about advance care planning
- Help you explore what in life, is important to you
- Support you to have a conversation with your GP, family and friends about what in life is important to you
- Assist you to understand the steps in preparing and formalising an advance care directive.

By articulating your wishes in an advance care plan, you are enabling the treating team, your family and friends to make informed decisions on your behalf, that are the decisions you would have made, at a time when you cannot do so yourself.

Medical Treatment Planning and Decisions Act 2016

From the 12 March 2018 the *Medical Treatment Planning and Decisions Act 2016* provides a framework for making decisions about medical treatment. This includes allowing people to make decisions in advance, through an advance care directive, about medical treatment they do or do not want in future in case they no longer have capacity to make those decisions.

You will be able to:

- Create a values directive outlining your preferences and values
- Create an instructional directive consenting to or refusing medical treatment
- Appoint a medical treatment decision maker to make decisions on your behalf when you are not able to.
- Appoint a support person to support your decision-making and represent your interests.

*Advance care planning documents made prior to 12 March 2018 (Enduring Power of Attorney - Medical and Refusal of Treatment Certificate) will continue to be recognised in the new framework.

For further information, visit The Office of the Public Advocate webpage <http://www.publicadvocate.vic.gov.au/power-of-attorney>.

What if I have a concern or complaint?

You have the right to make a complaint and take steps to address any concerns.

If you have a complaint or concern you have the right to:

- raise it without fear of retribution
- have the matter resolved in the shortest possible time
- have an advocate of your choice appeal to senior levels of management.

TCP works to ensure that complaints and concerns are dealt with promptly and confidentially. You are encouraged to discuss these matters with your case manager.

If you have a complaint

You will be provided with information about how to address your concerns.

Where possible it is always best to talk to your case manager about your complaint first. However, you may decide that your complaint should be raised with the TCP manager. In both cases your complaint will be dealt with promptly.

The TCP manager at your health service is:

Name:	Rod Petrie
Phone:	Via the Eastern Health TCP Administration team: (03) 9955 7585

If you are unable to raise your concern with your TCP service or you are dissatisfied with the outcome of your complaint, you may wish to raise the matter with the patient advocate or liaison officer of your health service. If you are still unhappy with the outcome, an external organisation may be contacted to address your concern.

In Victoria, the Health Services Commissioner is responsible for receiving and resolving complaints about health service providers. The Commissioner is also responsible for receiving and resolving complaints about TCP.

Office of the Health Complaints Commissioner

Phone: 1300 582 113

As TCP is a partly Commonwealth funded aged care service, you also have the right to contact the Aged Care Quality and Safety Commission with any concerns.

Aged Care Quality and Safety Commission

Phone: 1800 951 822

If you require information, assistance or someone to speak on your behalf, you can contact the National Aged Care Advocacy Line. This is a free and confidential service for people receiving aged care services.

National Aged Care Advocacy Line

Phone: 1800 700 600 (freecall) or if calling from a mobile contact

Elder Rights Advocacy 03 6902 3066.

If you have feedback

You will be sent or provided with a client satisfaction form at the end of your program. This form gives you an opportunity to tell us about your experience of TCP. We welcome your suggestions on how we could improve the service for you and future clients.

Charter of Aged Care Rights

Australian Government
Department of Health

I have the right to:

1. safe and high quality care and services;
2. be treated with dignity and respect;
3. have my identity, culture and diversity valued and supported;
4. live without abuse and neglect;
5. be informed about my care and services in a way I understand;
6. access all information about myself, including information about my rights, care and services;
7. have control over and make choices about my care, and personal and social life, including where the choices involve personal risk;
8. have control over, and make decisions about, the personal aspects of my daily life, financial affairs and possessions;
9. my independence;
10. be listened to and understood;
11. have a person of my choice, including an aged care advocate, support me or speak on my behalf;
12. complain free from reprisal, and to have my complaints dealt with fairly and promptly;
13. personal privacy and to have my personal information protected;
14. exercise my rights without it adversely affecting the way I am treated.

Consumers

Consumers have the option of signing the Charter of Aged Care Rights (the Charter). Consumers can receive care and services even if they choose not to sign.

If a consumer decides to sign the Charter, they are acknowledging that their provider has given them a copy of the Charter, and assisted them to understand:

- information about consumer rights in relation to the aged care service; and
- information about consumer rights under the Charter.

Consumer (or authorised person)'s signature (if choosing to sign)	
Full name of consumer	
Full name of authorised person (if applicable)	

Providers

Under the aged care law, providers are required to assist consumers to understand their rights and give each consumer a reasonable opportunity to sign the Charter. Providers must give consumers a copy of the Charter that sets out:

- signature of provider's staff member;
- the date on which the provider gave the consumer a copy of the Charter; and
- the date on which the provider gave the consumer (or their authorised person) the opportunity to sign the Charter;
- the consumer (or authorised person)'s signature (if they choose to sign); and
- the full name of the consumer (and authorised person, if applicable).

The provider will need to retain a copy of the signed Charter for their records.

Signature and full name of provider's staff member	
Name of provider	
Date on which the consumer was given a copy of the Charter	
Date on which the consumer (or authorised person) was given the opportunity to sign the Charter	

Eastern Health

Bradma

Consent to be waitlisted for TCP

(a) I authorise the TCP Service to provide my personal details and information about my health and the care I receive under TCP to the Australian Government Department of Health and the Victorian Department of Health and Human Services for funding and evaluation purposes.

(b) I authorise TCP staff to discuss my health, care and service needs with my GP, other health professionals, service providers and the following additional persons:

List additional persons:

(c) I understand that all reasonable steps will be taken to protect my privacy and confidentiality in accordance with applicable privacy laws when discussing with or receiving information from my carer or representative in relation to my care and service needs.

(d) I understand that the TCP admission from hospital will be as soon as a vacancy is available and within 28 days of my approval by the Aged Care Assessment Service. I will be informed as soon as the admission can be confirmed and recognise this may be at short notice. If a vacancy does not arise within 28 days, I understand that the Aged Care Assessment Service may need to reassess me.

(e) I understand that I will receive a written care plan and discharge plan that details the services to be provided to me under TCP.

(f) I understand I will be charged fees and these are outlined in “My TCP agreement”.

(g) I understand that TCP is a time-limited program and the duration is determined by the goals to be achieved. My case manager will actively assist me to access available long-term care arrangements or services which best suit my needs.

(h) I understand that I am entitled to make a complaint, without fear or reprisal, about the provision of transition care and can do so by discussing these matters with my case manager or the TCP manager in the first instance or can contact the office of the Aged Care Complaints Commissioner or the office of the Health Complaints Commissioner.

Eastern Health

Bradma

Signature of care recipient or nominated representative:	
Witnessed by (if signed by a nominated representative):	
Date:	

This agreement is to be signed by the care recipient. In some circumstances a nominated representative may sign on the care recipient's behalf. If written consent is not practicable to obtain, the nominated representative may sign at the direction of the care recipient and this direction must be witnessed. Should this be the case, please complete the following:

Why was the care recipient unable to sign?	
Name of person who did sign:	
Relationship to the TCP care recipient (such as spouse, person responsible):	
Name of witness:	

Copy for: [Mark with an 'X' as appropriate]

TCP client: Health service client file:

Eastern Health

Bradma

My TCP agreement

Copy for: [Mark with an 'X' as appropriate]

TCP client: Health service client file: Health service finance department:

1. Transition Care Program (TCP) Care agreement between:

TCP service provider:	Eastern Health Transition Care Program
Care recipient:	

(a) I acknowledge that I have read or had explained to me the contents of this TCP Client information and agreement booklet and agree to receive [Mark with an 'X' as appropriate]:

Bed-based: **Home-based:**

and or

TCP at:

Location: **MARTIN LUTHER HOMES / REGIS INALA / VERMONT AGED CARE**

(b) I understand that the written care plan and discharge plan form part of this agreement and may be amended over time as mutually agreed.

(c) I understand that my consent to be waitlisted forms part of this agreement.

(d) I understand that this agreement can be reviewed at any time and changed with mutual consent. I will be notified in writing of any change.

(e) I understand either party can terminate this agreement at any time. If the TCP service terminates this agreement, you will be notified in writing.

Eastern Health

Bradma

2. Nomination of the person responsible for payment of the TCP fees

For care recipient:

I, (person responsible):

I understand and agree that:

(a) I am the person responsible to pay the Transition Care Program fees for the abovementioned care recipient.

(b) the TCP fees are set by the Australian Government at (delete the one that does not apply):
17.5 per cent of the basic, single aged care pension for the home based service
85 per cent of the basic, single aged care pension for the bed based service

(c) I will pay a daily care fee of: $ For home based care equivalent per week to: $

Insert amount per week

(d) I will pay a daily care fee of: $ For bed based care equivalent per week to: $

Insert amount per week

for the time that the Transition Care Program is provided.

(e) I will pay for pharmacy costs incurred during bed based TCP.

(f) This is a daily fee that includes weekends and days that services may not be provided.

(g) I will **receive invoices from**:

Eastern Health Ph: (03) 9955 1339

(h) Fees can be reviewed at any time if requested.

(i) Please note fees are not covered by Medicare, Private Health Insurance or DVA.

(j) Issuing of invoices will be via regular post unless email or SMS is requested.

(k) Direct Debit or Centrepay is available as a payment option, the accounts department will contact you to discuss this option.

Eastern Health

Bradma

Personal particulars of person responsible for TCP fees:

Full name:	
Postal address:	
Phone number:	
Email address:	
Relationship to care recipient:	

Issuing of invoice by: [Mark with an 'X' as appropriate]

Regular post: **Email:**

Signature of care recipient or nominated representative:	
Witnessed by (if signed by a nominated representative):	
Date:	

This agreement is to be signed by the care recipient. In some circumstances a nominated representative may sign on the care recipient's behalf. If written consent is not practicable to obtain, the nominated representative may sign at the direction of the care recipient and this direction must be witnessed. Should this be the case, please complete the following:

Why was the care recipient unable to sign?	
Name of person who did sign:	
Relationship to the TCP care recipient (such as spouse, person responsible):	
Name of witness:	

Eastern Health

Bradma

3. Pharmacy costs (only applicable to care recipient of bed based TCP)

All prescription medication and over the counter pharmacy supplies must be paid for by the care recipient or person nominated as responsible for paying these costs. Please note that no exemptions can be made as the supplier is a community pharmacy.

Person responsible for payment:	
Signature of care recipient and/or nominated representative:	

I (named above) am the person responsible for payment of the pharmacy account for (care recipient) and understand and agree that:

(a) an invoice will be received for the cost of medication issued to the care recipient while in the bed based Transition Care Program.

(b) the medication will be charged at the retail/ PBS/ or Safety net price (as applicable) and will be dispensed from:

One of the Transition Care Program pharmacies, as determined by the TCP site.

the invoice is sent from the pharmacy with payment details:

Personal particulars of person responsible for the pharmacy account:

Full name:	
Postal address:	
Phone number:	
Email address:	
Relationship to care recipient:	

Issuing of invoice by: [Mark with an 'X' as appropriate]

Regular post: **Email:**

Copy for: [Mark with an 'X' as appropriate]

TCP client: Health service client file: Health service finance department: