# Table of contents

## Contents

Table of contents ................................................................. 1  
FOREWORD ............................................................................. 4  
   What the guidelines contain ........................................ 5  
   How the guidelines will be updated ....................... 5  
   Feedback ........................................................................ 5  
CHAPTER 2: INTRODUCTION ................................................. 5  
   2.1 Transition care in brief ........................................ 5  
   2.2 Roles and responsibilities within the transition care programme ..... 6  
      2.2.1 Australian Government .................................. 6  
      2.2.2 State/territory governments (approved providers) .......... 6  
   2.3 Allocation of transition care places ................. 7  
      2.3.1 Service planning ...................................... 7  
      2.3.2 Flexible care setting .................................. 7  
      2.3.3 How to participate in transition care service delivery ...... 8  
   2.4 Funding and management of the transition care programme .... 8  
   2.5 Relevant Legislation ................................................. 8  
CHAPTER 3: THE TRANSITION CARE PROGRAMME ................. 10  
   3.1 What is transition care? .................................. 10  
      3.1.1 Services provided through transition care ............. 11  
   3.2 Eligible care recipients .................................... 12  
      3.2.1 Aboriginal and Torres Strait Islander people .......... 12  
      3.2.2 Older people with dementia .......................... 12  
      3.2.3 Existing recipients of residential or home care ....... 12  
      3.2.4 Older people who usually reside interstate .......... 12  
      3.2.5 Older people from overseas .......................... 12  
   3.3 The role of hospitals ....................................... 13  
      3.3.1 Referral process .................................... 13  
   3.4 Assessment and approval of care recipients for transition care .... 13  
      3.4.1 The Aged Care Assessment Team (ACAT) ............. 13
3.4.2 Who should participate in an ACAT assessment? ........................................ 14
3.4.3 Assessment process for transition care .................................................. 14
3.4.4 Approval for transition care ......................................................................... 15
3.4.5 Assessment and approval in a short stay unit of an emergency department ......................................................................................................................... 15
3.4.6 Hospital and assessment information for care plan development ............ 16
3.5 Entry to transition care .................................................................................. 16
3.5.1 Duration of care ...................................................................................... 16
3.5.2 The service provider ............................................................................... 16
3.5.3 Residential based transition care ............................................................ 17
3.5.4 Existing recipients of residential or home care in transition care .............. 18
3.5.5 Movement between care settings and services ........................................ 19
3.5.6 Re-admission to hospital from transition care .......................................... 19
3.5.7 Extensions .............................................................................................. 19
3.5.8 Accessing long-term care after transition care ......................................... 20

CHAPTER 4: CARE RECIPIENTS ........................................................................... 20
4.1 Care recipient rights ..................................................................................... 20
4.2 Recipient agreement .................................................................................... 21
4.3 Care recipient responsibilities ....................................................................... 22
4.4 Advocacy .................................................................................................... 22
4.5 Privacy/confidentiality ................................................................................ 23
4.6 Fees payable by care recipients .................................................................... 23
4.6.1 Care fees ................................................................................................ 23
4.6.2 Determining care fees ............................................................................. 23
4.6.3 Maximum fees ........................................................................................ 24
4.6.4 Payment of fees in advance ..................................................................... 24

CHAPTER 5: RESPONSIBILITIES OF APPROVED PROVIDERS OF TRANSITION CARE ................................................................................................................. 24
5.1 Compliance with the legislation ..................................................................... 24
5.1.1 Failure to comply .................................................................................... 25
5.1.2 Serious and immediate health and safety risk reporting ........................ 25
5.2 Specific legislative requirements ................................................................... 25
5.2.1 Accountability ......................................................................................... 25
5.2.2 Flexible care subsidy .............................................................................. 25
5.2.3 Record Keeping ....................................................................................... 26
5.2.4 Quality of care ....................................................................................... 26
FOREWORD

The Transition Care Programme Guidelines 2015 (the guidelines) are an updated version of the Transition Care Programme Guidelines 2011 which were developed by the Australian Government in consultation with all states and territories.

The guidelines are a resource for the state and territory governments, as the approved providers of transition care, as well as service providers, officers of the Department of Health and other interested parties.

The guidelines explain the Australian Government’s policy context and operational requirements for the transition care programme (the programme), including the clarification of responsibilities of the approved providers under the Aged Care Act 1997, the Aged Care (Transitional Provisions) Act 1997 and the Aged Care Principles (the principles) which govern the operation of the programme. Users of these guidelines should be aware that state and territory governments, as the approved providers, may develop jurisdiction specific operational guidelines that complement these national guidelines.

We trust you will find the guidelines a valuable tool that will assist in the provision and operation of transition care.

The Hon Sussan Ley MP
Minister for Aged Care

Australian Government Department of Health
CHAPTER 1: ABOUT THE GUIDELINES

These guidelines are intended to provide general information about the transition care programme (the programme). The guidelines are linked to the Aged Care Act 1997 and the Aged Care (Transitional Provisions) Act 1997 through a transition care payment agreement (payment agreement) between the Australian Government and each state or territory government. Compliance with the guidelines is a requirement under the payment agreement.

The guidelines should be read in conjunction with the Aged Care Act 1997, the Aged Care (Transitional Provisions) Act 1997, and the principles including the Aged Care (Transitional Provisions) Principles 2014. If there are any matters not fully clarified within the content of the guidelines, assistance should be sought from the Department of Health or the state or territory governments, as the approved providers of transition care (approved providers). Independent legal advice should be sought as relevant on any particular matter contained within the guidelines.

What the guidelines contain

The guidelines explain the Australian Government’s policy context and operational requirements for the provision of transition care.

How the guidelines will be updated

The Department of Health will update the guidelines, as required, in consultation with states and territories, to ensure their currency and accuracy.

Please refer to the online version of the guidelines located on the website to ensure that you have the most recent version. The footer of each page includes the issue date of the guidelines.

Feedback

The Department of Health and all state and territory governments welcome any comments on the guidelines. To provide comments, please forward your email to: myagedcare@dss.gov.au.

CHAPTER 2: INTRODUCTION

2.1 Transition care in brief

Transition care provides short-term care that seeks to optimise the functioning and independence of older people after a hospital stay. Transition care is goal-oriented, time-limited and therapy-focused. It provides older people with a package of services that includes low intensity therapy such as physiotherapy and occupational therapy, as well as social work, nursing support or personal care to maintain and improve physical and/or cognitive functioning. It seeks to enable older people to return home after a hospital stay rather than enter residential care prematurely.

Transition care facilitates a continuum of care for older people who have completed their hospital episode, including acute and subacute care (e.g. rehabilitation, geriatric evaluation and management), and who need more time and support to make a decision on their long term aged care options.

---

1 A detailed list of services to be provided is included in Schedule 1: Specified care and services for transition care services of the payment agreement and is provided at Attachment B.

2 Definitions for acute care and subacute care are included in the glossary at the end of these guidelines.
2.2 Roles and responsibilities within the transition care programme

There are six key entities that have roles and responsibilities within the programme:

- Australian Government;
- Approved providers;
- Service providers – regional and/or local managers;
- Aged Care Assessment Teams (ACATs)\(^3\);
- Hospitals; and
- Transition care recipients (recipients).

The roles of the Australian Government and state and territory governments are outlined below. For the other entities, see sections 3.3 The role of hospitals, 3.4.1 The Aged Care Assessment Team (ACAT), 3.5.2 The service provider, and 4.3 Care recipient responsibilities of these guidelines.

2.2.1 Australian Government

The Australian Government’s roles and responsibilities in relation to the programme are to:

- develop and implement national policies to meet the objectives of the programme in partnership with the state and territory governments as the approved providers;
- administer the programme in partnership with the state and territory governments, including the development of operating guidelines;
- allocate transition care places under the *Aged Care Act 1997*, and the *Aged Care (Transitional Provisions) Act 1997*;
- provide a subsidy under the Acts to each occupied transition care place for care and services;
- collaborate with state and territory governments in the evaluation of the programme and reporting of transition care data;
- manage complaints received by the Aged Care Complaints Scheme; and
- provide strategic direction.

The Australian Government’s role in the programme is undertaken by the Department of Health.

2.2.2 State/territory governments (approved providers)

State and territory government responsibilities in relation to the programme are broadly defined as follows:

- in partnership with the Australian Government, develop and implement policies;
- manage the day-to-day operations of the programme, including through service providers in their state/territory;
- ensure quality care is provided in accordance with Schedule 4: The Transition Care Programme Quality Improvement Framework of the payment agreement provided at Attachment A;
- manage complaints in their state/territory, and where necessary cooperate with the Aged Care Complaints Scheme to resolve complaints received by the scheme;
- collaborate with the Australian Government in the national evaluation of the programme;
- ensure that transition care data are collected and reported to the Australian Government;
- provide proportionate funding towards the operation of the programme;
- establish mechanisms to ensure that the guidelines and the Australian Government’s conditions for managing the programme are met, including monitoring the performance and the quality of service delivery of the service providers; and
- ensure that service providers comply with the provisions of the payment agreement and any recipient agreements in place.

\(^3\) Note, in Victoria, an ACAT is referred to as an Aged Care Assessment Service (ACAS). Where ACAT is used throughout the Guidelines, it is intended that ACAS is interchangeable.
2.3 Allocation of transition care places

The Australian Government and state and territory governments have clearly delineated roles relevant to the allocation of transition care places.

The Australian Government, represented by the Department of Health, makes allocations of new transition care places up to a defined limit, under section 14-1 of the Aged Care Act 1997 and the Aged Care (Transitional Provisions) Act 1997 to state and territory governments as the approved providers based on each state’s and territory’s number of non-Indigenous people aged 70 and over, and Aboriginal and Torres Strait Islander people aged 50 and over. The approved providers are responsible for planning the model of transition care based on local need.

Under Part 3.3 of the Acts, an approved provider is eligible for flexible care subsidy, provided:
- it holds an allocation of flexible care places;
- the allocated places have taken effect (i.e. have become operational); and
- the approved provider provides flexible care to a care recipient who has been approved as eligible under the Acts and Subsidy Principles 2014.

2.3.1 Service planning

Prior to each new allocation of transition care places, each state and territory government as the approved provider submits a bilateral implementation plan to the Department of Health that details how and where transition care will be delivered in their jurisdiction. Bilateral implementation plans include, but are not limited to:
- the number of places to be allocated in a particular period;
- the number of care recipients expected to receive these services, including Aboriginal and Torres Strait Islander people;
- the region in which these places are to be located; and
- how transition care will fit with the services provided through the hospital system, particularly subacute care.

In order to cater for care recipients who require care in either a residential setting or a home care setting, each jurisdiction’s bilateral implementation plan also includes the expected number of transition care places that will be delivered in a home care setting, in a residential setting, or flexibly in either setting (see also section 2.3.2 Flexible care setting).

Transition care places are allocated to the approved providers in respect of individual ‘transition care services’. Transition care services cannot exceed the number of transition care places that have been allocated to them. For example, if a service has been allocated ten transition care places, it may only claim flexible care subsidy for up to ten care recipients on any given day.

Where demand for transition care in a particular area of a state or territory is temporarily greater than the number of places available in that area, a service from another area in the same state or territory may provide care into that area, through a brokerage arrangement.

However, if there are ongoing discrepancies between supply of and demand for transition care places in various areas of a state or territory, an approved provider may apply to the Department of Health to move transition care places permanently from one service to another. This move requires a variation to the conditions of allocation (see also section 5.3.1 Conditions of allocation of flexible care places for transition care).

The services manage the delivery of transition care on behalf of the approved provider and may assign day-to-day management responsibility to a local service outlet, the service provider.

2.3.2 Flexible care setting

The flexible care places used for transition care are legislated by the Aged Care Act 1997, Aged Care (Transitional Provisions) Act 1997 and the Principles made under the Acts. Under section 49-3 of the Aged Care Act 1997, and the Aged Care (Transitional Provisions) Act 1997, flexible care is defined as “care provided in a residential or community setting through an aged care service that addresses the
needs of care recipients in alternative ways to the care provided through residential care services and home care services”.

Transition care places may be delivered flexibly in either a residential or a community setting. State and territory governments have the flexibility to determine the mix of care delivery settings in line with local service and individual care recipient needs.

Recipients can move from one setting to another within the same transition care episode, e.g., from residential based to home care based transition care. To enable such moves, a service may change the mix of places delivered in a residential or home care on a daily basis, if required, within the limits of the number of places it has been allocated. Such changes must adhere to any jurisdictional protocols set by the approved provider.

If a service has an allocation of ten places it can only service a maximum of ten care recipients on any one day (see also section 3.5.5 Movement between care settings and services).

2.3.3 How to participate in transition care service delivery

Organisations seeking to participate in the provision of transition care should contact the state or territory government as the approved provider in their jurisdiction.

2.4 Funding and management of the transition care programme

The Australian Government and states and territories jointly fund the programme.

Australian Government funding for transition care is provided in the form of flexible care subsidy under the Acts. From 1 August 2013, approved providers also receive the dementia and veterans’ supplement equivalent amount, in addition to the basic subsidy amount. This additional funding is paid in recognition that service providers may provide care to veterans with an accepted mental health condition and others with higher care needs associated with dementia or other mental health conditions.

The state and territory funding contribution is made in the form of direct funding and in-kind contributions.

Service providers may request fees from care recipients deemed able to contribute to the cost of their care (see also section 4.6 Fees payable by care recipients and section 5.2.5 User rights).

The arrangements for the payment of Australian Government subsidy are detailed in Chapter 4 of the Subsidy Principles 2014. To receive payment of flexible care subsidy for transition care, approved providers must enter into a payment agreement with the Australian Government as required under section 111 of the Subsidy Principles 2014.

Approved providers remain responsible for ensuring that service providers comply with the provisions of the payment agreement.

To meet their responsibilities, approved providers should enter into service agreements with service providers that mirror the relevant requirements of the payment agreement, including compliance with these guidelines.

The payment agreement also requires that the service provider must offer, and remain ready at all times to enter into, a recipient agreement with a care recipient. If a care recipient declines to enter into a recipient agreement, the provider must observe the requirements it would otherwise have had under a recipient agreement. Section 4.2 Transition Care Recipient Agreement of these guidelines details the requirements for these agreements. The amount of care recipient fees charged forms part of the agreement between the care recipient and the service provider (see also section 4.6 Fees payable by care recipients).

2.5 Relevant Legislation

Transition care is legislated by the Aged Care Act 1997, the Aged Care (Transitional Provisions) Act 1997, and the Aged Care Principles made under these Acts. Approved providers and service
providers are required to meet all the conditions specified by the legislation, the payment agreement and the recipient agreement, including accountability and quality of care.

Figure 1 below outlines how the guidelines link into the legislative framework for transition care.

Under section 14-5 of the Acts, allocations of aged care places can be made subject to conditions. It is a condition of each allocation of transition care place and also a requirement under section 111 of the Subsidy Principles 2014 that each approved provider must enter into a payment agreement with the Australian Government.

**Figure 1: How the Guidelines link into legislation**
Programme guidelines should be considered in conjunction with:

- the Aged Care Act 1997, the Aged Care (Transitional Provisions) 1997 and the Principles;
- relevant state and territory legislation;
- the payment agreement;
- the service agreement; and
- the recipient agreement.

Throughout these guidelines, specific references are also made to other relevant sections of the Acts, the Principles and the payment agreement. These references are highlighted in text boxes and should be referred to when requiring more detailed clarification.

Copies of the Acts, the principles and any amendments to the legislation can be found on the Comlaw website.

The table below sets out the parts of the Acts that are of particular relevance to the programme.

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Part</th>
</tr>
</thead>
</table>
| Chapter 2 – Preliminary matters relating to subsidies | Part 2.1 – Approval of providers  
Part 2.2 – Allocation of places  
Part 2.3 – Approval of care recipients |
| Chapter 3 – Subsidies | Part 3.3 – Flexible care subsidy |
| Chapter 4 – Responsibilities of approved providers | Part 4.1 – Quality of care  
Part 4.2 – User rights  
Part 4.3 – Accountability etc.  
Part 4.4 – Consequence of non-compliance |
| Chapter 6 - Administration | Part 6.1 – Reconsideration and review of decisions  
Part 6.2 – Protection of information  
Part 6.3 – Record keeping  
Part 6.4 – Powers of officers  
Part 6.5 – Recovery of overpayments |

**CHAPTER 3: THE TRANSITION CARE PROGRAMME**

**3.1 What is transition care?**

On 23 April 2004 all Health State and Territory Government Ministers endorsed the definition of transition care (its role, functions and target group) developed by the Care of Older Australians Working Group. An extract of the definition is contained below.

“Aim/Objectives
Transition care provides short-term support and active management for older people at the interface of the acute/subacute and residential aged care sectors. It is goal-oriented, time-limited and targets older people at the conclusion of a hospital episode who require more time and support in a non-hospital environment to complete their restorative process, optimise their functional capacity and finalise and access their longer term care arrangements.

The potential for further recovery will vary according to the individual. Therefore, the services provided will vary from individual to individual, ranging from those that further improve physical, cognitive and psychosocial functioning thereby improving the person’s capacity for independent living, to those that actively maintain the individual’s functioning while assisting them and their family and carers to make appropriate long-term care arrangements.

4 While the definition is accurate in terms of specifying the interface between the acute/subacute and the residential aged care sectors, and while the programme applies to older people assessed as otherwise eligible for residential care, it also includes transition care provided in a community setting.
An outcome of transition care is that inappropriate extended hospital lengths of stay and premature admission to residential aged care are minimised. However, it should be stressed that transition care’s primary function is therapeutic, rather than administrative.

Mix of Services
Depending on their assessed level of need, transition care will offer eligible older people several or all of the following:
- nursing support or personal care;
- low intensity therapy (such as physiotherapy, occupational therapy) and support (such as social work) to maintain physical, cognitive and psychosocial functioning and to facilitate improved capacity in activities of daily living;
- medical support such as GP oversight; and,
- case management, including establishing community supports and services and where required, identification of residential care options."

To access transition care, a person must first be assessed and approved for transition care by an Aged Care Assessment Team (ACAT). A person must enter the programme directly upon discharge from hospital. Transition care can be delivered in either a facility based residential setting or in a community setting, e.g. the person’s own home. It is possible to receive transition care in a residential setting first and then in a home care setting, or vice versa.

All transition care clients can access the Pharmaceutical Benefits Scheme (PBS) and the Medicare Benefits Schedule (MBS).

Note: Some people from overseas do not have access to the PBS and MBS and therefore will need to meet their own medical costs while accessing the programme (see also section 3.2.5 Older people from overseas).

3.1.1 Services provided through transition care
Transition care provides older people with a package of services that includes low intensity therapy such as physiotherapy and occupational therapy, as well as social work and nursing support or personal care. Transition care must be provided in accordance with Schedule 1: Specified care and services for transition care services of the payment agreement, see Attachment B.

Schedule 1 is divided into three parts, i.e. care and services to be provided to:
1. all clients;
2. clients who receive care in a residential setting; and
3. clients who receive care in a community setting.

Schedule 1 indicates the basic level of care that a service provider must be able to provide, if required by a client.

The services provided as part of the programme are designed to meet a client’s daily care needs and provide additional therapeutic care to enable the client to maintain or improve their physical, cognitive and psychosocial functioning, thereby improving their capacity for independent living.

The therapeutic care will vary from person to person, ranging from services that improve a client’s capacity for independent living to services that enable a client to enter residential aged care at an optimum level of physical and cognitive functioning.

Some people entering transition care are likely have dementia or be experiencing a level of cognitive confusion. Therefore, where needed therapeutic care should include appropriate cognitive therapy to assist with restoration or stabilisation of cognitive skills.

In providing transition care specified care and services, the service provider must have systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, quality frameworks and guidelines relevant to transition care provision.

---

5 A detailed list of services to be provided is included in Schedule 1: Specified care and services for transition care services of the Payment Agreement and provided at Attachment B. 6 A care leaver is a person who was in institutional care or other form of out-of-home care, including foster care, as a child or youth (or both) at some time during the 20th century.
3.2 Eligible care recipients

Division 22 of the Aged Care Act 1997 and the Aged Care (Transitional Provisions) Act 1997 sets out how a person becomes approved as a care recipient. Section 8 of the Approval of Care Recipients Principles 2014 states the requirements a person must meet to be eligible for transition care.

To decide whether a person is eligible for transition care, the person must be an admitted patient of a public or private hospital and assessed in hospital by an Aged Care Assessment Team (ACAT).

The ACAT may need to assess the person in consultation with the hospital geriatric rehabilitation service or members of the multidisciplinary team treating the person (which may include the treating physician, a registered nurse, occupational therapist, physiotherapist, social worker or other allied health discipline), as well as carers, representative or family members as appropriate.

In assessing a person’s eligibility for transition care, the ACAT must use the eligibility criteria listed at section 3.4.3 Assessment process for transition care. The ACAT delegate will only approve a person for transition care if the person meets the eligibility criteria and is able to enter the service directly upon discharge from hospital.

3.2.1 Aboriginal and Torres Strait Islander people

The expansion of the programme from 2,000 to 4,000 places by 2011-12 included a commitment to improve access to the programme by Aboriginal and Torres Strait Islander people. The approved providers must manage the delivery of transition care to ensure that Aboriginal and Torres Strait Islander people are equitably represented in the target population of the programme.

An expected outcome of the programme in each state and territory is that the proportion of Aboriginal and Torres Strait Islander people assessed as eligible for transition care who subsequently receive transition care is no less than the proportion of non-Indigenous people assessed as eligible for transition care who subsequently receive transition care.

3.2.2 Older people with dementia

Each person’s experience with dementia is unique and some older people with dementia may benefit from tailored care when transitioning from a hospital stay to their usual place of residence. People with dementia who are assessed by the ACAT as able to benefit from the therapies and support provided by the programme are eligible to participate in the programme. For older people with dementia who are unable to express their care goals, the development of care goals should involve the person’s family, carer and/or representative. See also section 2.4 Funding and management of the transition care programme.

3.2.3 Existing recipients of residential or home care

Existing recipients of Australian Government funded residential or home care services are able to access transition care if they are assessed and approved as eligible by an ACAT. See also section 3.5.4 Existing recipients of residential or home care in transition care.

3.2.4 Older people who usually reside interstate

The eligibility provisions for transition care under the Aged Care Act 1997 and the Aged Care (Transitional Provisions) Act 1997 do not restrict provision of care based on where care recipients live, or where they are assessed. Older people who are not residents of a particular state, territory or region can therefore access transition care services in that state, territory or region in particular circumstances. For example, a care recipient transferred to a tertiary hospital away from their usual place of residence to access specialist care can be discharged to a transition care service in another location, based on their follow-up arrangements with their family, carer and/or representative. It is important that transition care commences immediately on discharge from hospital (see also section 3.5.5 Movement between care settings and services).

3.2.5 Older people from overseas

Older people from overseas can access the programme if they are ACAT assessed and approved as eligible using the same criteria as other patients. It is important to note that people who are not
permanent residents of Australia may not be eligible for Medicare and subsidised pharmaceuticals and would thus be responsible for meeting their own medical and pharmaceutical expenses while in transition care. However, there are several countries with which Australia has reciprocal health agreements, and people from these countries may be eligible for Medicare. Further information is available on the Department of Human Services website.

These guidelines, including section 4.6 Fees payable by care recipients, apply to people from overseas.

### 3.3 The role of hospitals

The role of hospitals in relation to the programme is to:

- provide acute and/or subacute care, including rehabilitation and geriatric evaluation (including dementia assessment) and management prior to referring a client to the programme;
- identify and refer potential care recipients to the ACAT for assessment;
- ensure that the care recipient is medically stable and ready for discharge before they are referred for ACAT assessment;
- ensure that the geriatric and rehabilitation service or members of the multidisciplinary team treating the care recipient work closely with the ACAT during the assessment process; and
- work with the service provider, the ACAT, the care recipient and their family or carer to develop a care plan as part of the care recipient’s hospital discharge planning process.

#### 3.3.1 Referral process

ACATs accept referrals from all sources. A care recipient in hospital may self-refer for assessment by the ACAT, or may be referred by any member of the multidisciplinary team caring for the care recipient in hospital, or by their carer or family member. However, the ACAT must not assess them until they are medically stable and ready for discharge, see 3.4.3 Assessment process for transition care. Hospital staff and the ACATs should be informed about the local availability of the programme and the potential benefits and services offered by the programme.

To avoid disappointment, all potential care recipients in hospital and carers or family members should be informed whether transition care is available in the area where the care recipient wishes to access care, i.e. in their own home or in the local area of a carer or family member. Potential care recipients should also be made aware that access to a transition care place depends on:

- their being assessed and approved as eligible for transition care;
- availability of a vacant transition care place; and
- whether a service provider can meet their care needs and accepts the person as a care recipient.

### 3.4 Assessment and approval of care recipients for transition care

Divisions 19-23 of the Aged Care Act 1997 and the Aged Care (Transitional Provisions) Act 1997 provide information on the approval of care recipients. Approval of care recipients is also outlined in the Approval of Care Recipients Principles 2014.

To access transition care, older people must first be assessed and approved by an ACAT as requiring the type and level of assistance transition care delivers, as set out in section 8 of the Approval of Care Recipients Principles 2014.

#### 3.4.1 The Aged Care Assessment Team (ACAT)

The role of an ACAT is to assess the medical, cognitive, physical, cultural, psychological, and social care needs of frail older people and to assist them to gain access to the most appropriate aged care services, including approval for Australian Government subsidised residential, home care or flexible care services, such as transition care.

Depending on the needs of the person, an ACAT assessment may need to be made in consultation with the hospital geriatric rehabilitation service and the multidisciplinary team treating the care recipient.
As with any other ACAT assessments, the ACAT should give consideration to people with special needs under section 11-3 of the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997*, including:

- people from Aboriginal and Torres Strait Islander communities;
- people from culturally and linguistically diverse backgrounds;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged;
- veterans;
- people who are homeless or at risk of becoming homeless;
- care-leavers ⁶;
- parents separated from their children by forced adoption or removal;
- lesbian, gay, bisexual, transgender and intersex people; and
- people of a kind (if any) specified in the *Allocation Principles 2014*.

Additionally, ACATs should give consideration to the needs of clients with dementia.

If the ACAT assessor establishes eligibility, a completed Aged Care Client Record (ACCR) for the person will be submitted to an independent ACAT delegate for approval. The ACAT assessor will provide the person with information about aged care services and make the necessary referrals to an appropriate service provider. The ACAT should also liaise with the service provider to ensure the types of services required can be provided and the service is available and appropriate for the care recipient (see also section 3.4.4 Approval for transition care).

During the transition care episode, the ACAT should assist the service provider, if necessary, in reviewing a care recipient’s needs, re-assessing appropriate care options or referring to a more appropriate service (see also section 3.5.2 The service provider). The ACAT also assesses a care recipient’s need for an extension on the request of the service provider (see also section 3.5.7 Extensions).

### 3.4.2 Who should participate in an ACAT assessment?

As with all ACAT assessments, where appropriate, and with the care recipient’s permission, the assessment should involve:

- the care recipient and their carer, family or representative;
- an interpreter or an Aboriginal or Torres Strait Islander health worker or liaison officer as required, in accordance with the individual’s preferences; and
- other health and rehabilitation professionals, as appropriate.

### 3.4.3 Assessment process for transition care

When considering a person’s suitability for transition care, the ACAT assessor must consider the eligibility criteria and several additional factors. The ACAT must ascertain that the person:

- is a public or private hospital in-patient, or is receiving acute or subacute care under a hospital-in-the-home or equivalent programme where the patient is classified as an in-patient;
- has completed his/her episode of acute and/or subacute care, is medically stable and ready for discharge at the time of assessment;
- wishes to enter transition care;
- would otherwise be eligible for residential care;
- would have the capacity to benefit from a package of services that includes, at least, low intensity therapy and nursing support or personal care; and
- would have the capacity to benefit from goal-oriented, time-limited and therapy-focussed care necessary to:
  - complete their restorative process;
  - optimise their physical and cognitive functional capacity; and
  - assist in making long-term arrangements for their care.

---

⁶ A care leaver is a person who was in institutional care or other form of out-of-home care, including foster care, as a child or youth (or both) at some time during the 20th century.
In addition, the ACAT must consider the following factors:

- The intent of transition care is to benefit older people through time-limited, low-intensity therapy and support immediately after a hospital episode.
- Transition care is designed to improve older people’s capacity for independent living and to maintain their functioning, while assisting them and their family and carers to make appropriate long-term care arrangements.
- The therapeutic care provided by the programme will vary from individual to individual, ranging from services that improve a care recipient’s capacity for independent living, to services that enable a person to enter residential aged care at an optimum level of physical and cognitive functioning.
- The ACAT, in consultation with the hospital geriatric rehabilitation services or equivalent, and other members of the multidisciplinary team caring for the patient, needs to ensure that the full range of clinical and/or rehabilitation support to be provided by the hospital has been completed before a person enters transition care.
- The cognitive abilities of a person with dementia may fluctuate from day to day, so the extent of a person’s dementia may not be immediately obvious at the initial assessment.
- Entry to transition care must immediately follow the person’s discharge from hospital.
- Close co-operation and liaison between the hospital discharge planner, the ACAT and the service provider is required to ensure a transition care place is available in a timely manner, to benefit the care recipient.
- As part of the comprehensive ACAT assessment, the care recipient and their carer and/or family as appropriate, should be fully informed of the range of other available aged care services that may be appropriate for them. The ACAT should assess the person’s eligibility for those options and approve them if clinically appropriate.
- If the person is only approved as eligible for transition care at the time of the initial ACAT assessment, it is likely that they will need a re-assessment before the completion of their transition care episode, to establish their long-term care requirements. Where this is necessary, the ACAT will take into account any changes to the person’s care needs and ensure that the long-term care recommendations reflect the revised level of need and the person’s preferences.

3.4.4 Approval for transition care


An ACAT approval to enter transition care is valid on the date the ACAT delegate signs the approval, and then for four weeks (28 calendar days) after the date of signing. The person must enter the programme within this four week ‘entry period’. If the person does not enter the programme within the four week period, their approval will lapse and they will need a re-assessment for transition care, if appropriate.

As transition care places may become vacant at short notice, ACATs should approve eligible clients for transition care even if there is not an immediate vacancy at the time of referral. As with all ACAT approvals, clients should be reminded that approval as a care recipient does not guarantee a place, particularly if a vacancy does not present itself during the person’s stay in hospital.

The result of an ACAT assessment, and the decision to approve or not approve a person to receive transition care, must be provided to the person who has applied for the care (or their representative) in writing and provide the reasons for the decision. A decision to reject a person’s application for transition care is a ‘reviewable decision’ under section 85-1 of the Aged Care Act 1997 and the Aged Care (Transitional Provisions) Act 1997. The relevant Aged Care Assessment Programme guidelines on reviewable decisions are available on the Department of Health website.

3.4.5 Assessment and approval in a short stay unit of an emergency department

Where appropriate, older people may access the programme from a short stay unit or equivalent in an emergency department, provided:
• they have been admitted to hospital (i.e. are classified as hospital in-patients);
• they are medically stable and have been ACAT assessed and approved as meeting all other eligibility criteria for transition care under section 8 of the Approval of Care Recipients Principles 2014; and
• it is not more appropriate for the patient to receive subacute care such as rehabilitation or geriatric evaluation and management.\(^7\)

The care provided while the care recipient is an in-patient of the short stay unit should involve discussion between the treating multidisciplinary team, geriatrician, and transition care service staff, as well as a comprehensive assessment by an ACAT to ensure that the person is medically stable and not identified prematurely for the programme.

### 3.4.6 Hospital and assessment information for care plan development

For those people approved as eligible for transition care, the hospital geriatric rehabilitation service and the ACAT assessment are key information sources for the development of a care plan to guide the physical and cognitive therapy services delivered through transition care. It is important that the ACAT attaches a copy of all relevant assessment documentation to the copy of the Aged Care Client Record given to the service provider.

### 3.5 Entry to transition care

A care recipient can only enter transition care directly upon discharge from hospital in order to derive maximum benefit from a time-limited episode of low intensity therapeutic interventions.

An ACAT approval to enter transition care is valid on the date the ACAT delegate signs the approval, and then for four weeks (28 calendar days) after the date of signing (see also section 3.4.4 Approval for transition care).

Older people who are receiving care under a hospital-in-the-home or equivalent programme cannot commence their transition care episode while they are still classified as an in-patient of the hospital.

Older people who are discharged from hospital and have returned to their usual place of residence before commencing the programme are no longer eligible to enter the programme.

#### 3.5.1 Duration of care

The average duration of a transition care is 7.5 weeks. Flexible care subsidy will be paid for all recipients up to a maximum of 12 weeks. Where an extension has been granted, up to a further six weeks flexible care subsidy will be paid (see also section 3.5.7 Extensions).

To ensure that the limited resources benefit as many older people as possible, there should not be an assumption that the programme is a ‘twelve-week programme’ for every care recipient. Care is provided based on each care recipient’s care needs.

While some care recipients may require the maximum 12 weeks of care and an extension of up to six weeks, the majority of care recipients do not require the maximum period of care.

Additionally, where residential and home care based services are both provided as forms of transitional care during one episode of care, there must not be a gap between these services.

#### 3.5.2 The service provider

Service providers manage the day-to-day operations of a transition care service\(^8\). This includes:

---

\(^7\) A definition for subacute care is included in the Glossary at the end of these Guidelines.

\(^8\) Definitions for transition care service and transition care service provider are included in the Glossary at the end of these Guidelines.\(^9\) Victorian Government Department of Human Services, 2005. *A Safety and Quality Improvement Framework for Victorian Health Services*, Victorian Government Department of Human Services, Melbourne.

---

16
• assisting in the admission of clients to transition care, their return to hospital if required and their transfer to their preferred long-term care option;
• liaising with their local ACAT and/or transition care coordinator and advising of the capacity of the service to accept new care recipients, and any transition care vacancies in the region;
• offering and remaining ready at all times to enter into a recipient agreement with eligible clients (see also section 4.2 Recipient agreement);
• having appropriate processes in place to receive, record and resolve complaints and handle them fairly, promptly, confidentially and without retribution (see also section 6.1.5 Complaints); and
• reporting (activity, financial and quality) as per programme and contract requirements to the approved provider.

Service providers are responsible for providing services appropriate to the needs of their care recipients for the period the care recipients are under their care. Transition care must be provided in accordance with Schedule 1: Specified care and services for transition care services of the payment agreement also provided at Attachment B, and Chapter 6: Quality Assurance in transition care.

The programme is organised on a calendar day basis. As it is a time-limited programme, services should be provided according to the care plan on a 7-day a week basis, including weekends and any public holidays falling within the transition care period.

Care planning
The service provider develops a care plan for a care recipient which should incorporate a therapeutic care plan for both their physical and cognitive needs developed through the care recipient’s hospital discharge planning, the ACAT assessment process and in consultation with the care recipient, carer or family, where appropriate. For older people with dementia who are unable to express their care goals, the development of a care plan may need to involve the person’s family and/or carer.

Case management
The service provider has a responsibility to assist in the admission of a client to the programme, in their return to hospital should this be required, and in their subsequent transfer to their preferred long-term care option at the end of their transition care episode. The service provider plays a significant role in the care recipient’s case management, including establishing community support and services and, where required, identification of residential care options.

Cooperation with ACATs
To facilitate the best outcome for each care recipient, both during and after the assessment process, service providers should have an effective working relationship with their local ACAT:
• Service providers should liaise with the ACAT and keep them informed about the capacity of their service to accept new care recipients, and any transition care vacancies in the region.
• Service providers may involve the ACAT in reviewing the care recipient’s needs, re-assessing appropriate care options and/or referring the care recipient to a more appropriate service.
• The service provider may also identify care recipients who potentially require an extension to their transition care episode and submit an transition care extension application form to an ACAT for review (see also section 3.5.7 Extensions).

ACATs can work with Dementia Behaviour Management Advisory Services to ease the transition of clients to home or residential aged care, and the Severe Behaviour Response Teams to ease the transition of clients with severe dementia behaviours to residential aged care.

3.5.3 Residential based transition care
Providers of residential based transition care are expected to provide services that reflect the intent of the programme to optimise the care recipient’s health and independence. Residential based
Transition care services should be provided in a more home-like, less institutional environment, including:

- communal living space/living room environment which is completely separate from sleeping areas and the location of acute/subacute care provision, i.e. a space that encourages family, carers and visitors to spend time with care recipients;
- a dining area and care recipients being encouraged not to eat in bed;
- care recipients being encouraged and supported to dress every day;
- facilities for care recipients to prepare snacks for themselves and their visitors;
- privacy, particularly for personal care and bathing arrangements;
- space for care recipients to mobilise, especially outdoors;
- physical arrangements which support the involvement of carers in the therapeutic activities; and
- a model of care and staff knowledge that supports the intent of the programme to promote the care recipient’s independence and health (including cognitive functioning).

Transition care services may also be provided in rural and remote hospitals when appropriate. The requirements for the more home-like environment may be relaxed on a case by case basis in these locations, if relevant (see also Schedule 2: Transition care programme quality standards of the payment agreement provided at Attachment C).

3.5.4 Existing recipients of residential or home care in transition care

Existing recipients of Australian Government funded residential or home care services are able to access transition care if they are assessed as eligible. The Australian Government has created a category of leave to enable this to occur. Australian Government subsidy continues to be paid to the original aged care provider during periods of leave for transition care.

For home care package recipients, home care subsidy is payable (at the full basic subsidy rate) for up to 28 consecutive days for each episode of transition care. After 28 consecutive days, the subsidy is payable at 25% of the basic subsidy rate.

For residential aged care residents, after 28 consecutive days of either hospital leave or leave for transition care (which must be preceded by hospital leave), the subsidy to the aged care home drops by 50% for residents who have a classification under the Aged Care Funding Instrument (ACFI) and are being paid the ACFI subsidy. The reduction in subsidy of 50% also applies to residents who have an ACFI classification but are still being paid a grand-parented subsidy rate under the old Resident Classification Scale (RCS).

It is the responsibility of the care recipient to notify the home care package service provider of their intention to take leave.

When an existing recipient of residential care is accepted into the programme, the care recipient must be provided with the full package of transition care services to be provided in a residential setting, in accordance with Schedule 1: Specified care and services for transition care services of the payment agreement, provided at Attachment B.

Similarly, when an existing recipient of a home care package is accepted into the programme, the care recipient must be provided with the full package of transition care services to be provided in the community setting, in accordance with Schedule 1: Specified care and services for transition care services of the payment agreement and provided at Attachment B and Chapter 6: Quality Assurance in transition care.

In both cases, the state or territory government as the approved provider must have a contract with the residential or home care provider engaged to provide transition care services.

In exceptional cases, a care recipient who is an existing recipient of residential aged care may be discharged home from hospital to receive interim home care based transition care with support from their family or carer before returning to residential aged care.

A home care based transition care package cannot be provided in a residential based setting.
3.5.5 Movement between care settings and services

To facilitate client-centred transition care delivery, it is possible for care recipients to move from one setting to another within the same transition care episode, i.e. from a residential setting to a home care setting or vice versa. Care recipients do not require an ACAT re-assessment to enable this move.

Where available and appropriate, the step-down from residential to home care based care within a transition care episode should be encouraged to maximise the care recipient’s opportunities to return to independent living in the community.

Care recipients are also able to transfer from one service provider to another (within their state or territory, or interstate), provided there is no break in care, i.e. there is no day during which the care recipient does not receive transition care services from the first or the second service provider.

Where a care recipient transfers between service providers within their own state or territory, there is no need to enter into a new recipient agreement if the approved provider is in the same state or territory. However, if a care recipient moves to a new service provider in a different state or territory, a new recipient agreement must be offered to the care recipient, reflecting the period remaining in the episode of care (see also section 4.2 Recipient agreement).

3.5.6 Re-admission to hospital from transition care

If the hospital re-admission is for a day procedure or for an overnight stay, the service provider must provide transition care up to the point of admission and then again from the point of discharge on the same day or the next day. This will ensure that there is no break in the service provider’s eligibility for flexible care subsidy under the Act.

If a transition care recipient requires re-admission to hospital for longer than an overnight stay, the transition care episode will cease, i.e. the care recipient must be discharged from the programme.

However, if a care recipient is re-admitted to hospital for longer than an overnight stay and the re-admission falls within the four week ‘entry period’ for which the ACAT approval to enter transition care is valid, the care recipient may be able to enter a new transition care episode without the need for an ACAT re-assessment, if clinically appropriate.

An ACAT re-assessment is only required if the care recipient wishes to re-enter the programme after the four week entry period has expired, and the re-admission to hospital may have changed the person’s eligibility status since the last approval for transition care services.

3.5.7 Extensions

In exceptional circumstances, a care recipient may require an extension to a transition care episode where their care will need to exceed the 12 week maximum. To apply for an extension, the service provider must complete a Transition Care Extension Form with the care recipient (or representative) within the initial 12 week episode of transition care. Once the service provider has completed the form, they must forward it to an Aged Care Assessment Team (ACAT) for review.

ACATs should only grant extensions if care recipients have further therapeutic care needs and wish to receive further transition care to achieve a better outcome. In such cases, an assessment for an extension to transition care, which specifies the duration of the extension, may be undertaken. A transition care episode can only be extended by up to 42 days (6 weeks). It is possible to have more than one extension as long as the total number of days does not exceed 42 days (6 weeks). For example, if an ACAT has only granted an extension of 20 days, it is possible to grant another extension of up to 22 days.

Based on the information provided by the service provider, and other sources such as the care recipient and relevant health professionals as appropriate, the ACAT will assess whether or not the transition care episode should be extended.

It is not necessary for an ACAT to comprehensively re-assess a recipient if the service provider has identified that the person requires an extension and provides the following information:
reasons why goals were not achieved in 12 weeks;
physical, cognitive and psychosocial goals that the care recipient would be working on during the extension;
team action required to achieve care recipient goals and discharge;
action required by external services to achieve care recipient goals and discharge;
relevant information from other sources such as the care recipient (or representative) or health professionals; and
the proposed number of days of extension.

However, the ACAT may undertake a comprehensive re-assessment of the care recipient if they are not satisfied with the information provided by the service provider. The extension form can, but does not need to be signed by the same ACAT who undertook the initial assessment for eligibility for transition care.

The service provider should allow sufficient time for the ACAT to review the status of the care recipient if it is likely that a more comprehensive re-assessment is required.

Whilst a decision to extend or not extend a care recipient’s episode of transition care is not a ‘reviewable decision’ under the Act, the Department of Health offers a right of review to any person whose request for an extension is denied. In the first instance, the decision should be discussed with the ACAT, then a request for a review should be made to the state manager of the relevant state or territory office of the Department of Health.

The review conducted by the NSW/ACT Office of the Department would follow the same process as for reviewable decisions under the Act. The relevant Aged Care Assessment Programme guidelines on reviewable decisions are available on the Department of Health’s website.

3.5.8 Accessing long-term care after transition care

A person cannot commence both transition care and another form of Australian Government funded aged care, such as residential care, respite or a Home Care Package, on the same day.

Pre-entry leave for residential aged care
In accordance with section 42-3(3) of the Acts, a residential aged care service may claim up to seven days of residential care subsidy as ‘pre-entry leave’ for a care recipient who has accepted an offer of a place in that residential aged care service. This includes older people receiving transition care who are about to be discharged from transition care and enter residential aged care (see also section 4.6.2 Determining care fees).

Residential aged care services cannot claim pre-entry leave for an existing residential aged care recipient who is on leave from residential care and is receiving transition care.

Accessing home care
Transition care recipients can only commence Australian Government funded community care (such as Home Care Packages) after they have completed their transition care episode, i.e. no Australian Government subsidy is paid to Home Care Package providers until the care recipient has completed their transition care episode.

For care recipients who have not yet met their physical and cognitive therapeutic goals but wish to end their transition care episode early in order to accept a Home Care Package, their discharge plan should include strategies to help the care recipient and their carer or family to meet these goals after discharge from the programme.

CHAPTER 4: CARE RECIPIENTS

4.1 Care recipient rights
The rights of care recipients are reflected in the payment agreement.
All care recipients of the programme have specified rights, including the right to have a recipient agreement with the service provider.

In addition to a recipient agreement care recipients have the following rights:

- to full and effective use of their personal, civil, legal and consumer rights;
- for transition care delivered in a residential setting to be in a safe, secure and as home-like an environment as possible;
- to have written information about their rights, care, accommodation and any other information that relates to the care recipient personally;
- to be involved in deciding, and choosing, the care most appropriate to meet their needs;
- to be given sufficient information, and a translator or interpreter services where required, to make an informed choice about their care;
- to receive care that takes account of their lifestyle, cultural, linguistic and religious preferences;
- to be given a written plan of the services they will receive;
- to take part in social activities and community life as fully as practicable;
- to be treated with dignity, with their privacy respected;
- to complain about the care they are receiving, including the manner in which it is being provided, without fear of losing the care or being disadvantaged in any other way (see also section 6.1.5 Complaints); and
- to choose a representative to speak on their behalf for any purpose.

4.2 Recipient agreement

The payment agreement requires that a service provider must offer and remain ready at all times to enter into a formal agreement with the care recipient or their representative.

The recipient agreement must comply with the following requirements. The agreement must:

- be expressed in plain language that the care recipient or their representative can understand;
- state the range of services, particularly physical and/or cognitive therapies, that the care recipient has been assessed as requiring as per their care plan and how and when they will be provided;
- include a clear statement of the charges payable by the care recipient and how amounts of each charge are to be worked out;
- state a date for the start of the transition care services;
- provide conditions under which either party may terminate the care service;
- provide an exit strategy planned for the care recipient once transition care is completed, including expected date of discharge, where the care recipient is expected to be discharged to, support services to be arranged, carer briefing, and care recipient consent for the discharge strategy;
- provide that any variation to the recipient agreement must be made following adequate consultation and mutual consent of the care recipient and the service provider. The provider must give the care recipient reasonable notice in writing about the variation to the agreement. Any variations to the agreement must be clearly documented in the care recipient notes;
- not be varied in a way that is inconsistent with the New Tax System (Goods and Services Tax) Act 1999, the Aged Care Act 1997 or the Aged Care (Transitional Provisions) Act 1997;
- provide for the giving of financial information to the care recipient or their representative, including the costs of services and consideration of the care recipient’s financial circumstances;
- state the care recipient’s rights in relation to decisions about the service that he or she is to receive;
- include a guarantee that all reasonable steps will be taken to protect the confidentiality, so far as legally permissible, of information provided by the care recipient or their representative, and details of use to be made;
- state the limits of the transition care services to be provided; and
- state that the care recipient (or their representative) is entitled to make, without fear of reprisal, any complaint about the provision of transition care and state the mechanisms for
making a complaint. This refers to both internal and external complaints mechanisms (see section 6.1.5 Complaints).

If a care recipient does not want to formally acknowledge a recipient agreement, the service provider is still required to observe its responsibilities to negotiate and deliver the level and type of care each care recipient needs. It is important in these circumstances that the service provider documents in writing the reasons for not having a signed agreement with the care recipient and the basis on which agreed care is delivered.

The recipient agreement may be subject to modifications over the transition care episode. It is expected that a formal review of the information included in the recipient agreement would be conducted as needed and as requested by the care recipient (or their representative).

As indicated in 3.5.5 – movement between care settings and services, where a care recipient transfers between service providers within their own state or territory, there is no need to enter into a new recipient agreement. However, if a care recipient moves to a new service provider in a different state or territory a new recipient agreement must be offered.

4.3 Care recipient responsibilities

The payment agreement between the Australian Government and each state and territory government provides for the care recipient’s responsibilities to be included in the recipient agreement between the service provider and the care recipient.

As well as having rights that must be respected, recipients, or their representatives where appropriate, have responsibilities to the service provider, care staff, other care recipients and themselves.

While the Aged Care Act 1997, the Aged Care (Transitional Provisions) Act 1997 and the Aged Care Principles do not define the responsibilities of care recipients, the Department of Health expects that responsibilities will be agreed between both parties and would not be inconsistent with any requirements of the Acts and the Principles. These responsibilities should be clearly articulated in the recipient agreement.

In the spirit of the recipient and the service provider having reciprocal responsibilities, the care recipient’s responsibilities include the following:

- respecting the rights of staff and the provider to work in a safe and healthy environment free from harassment;
- respecting the rights and needs of other care recipients (for transition care delivered in a residential setting);
- caring for their own health and well-being, as far as he or she is capable;
- working to achieve the goals articulated in their agreed individual care plan;
- informing the provider about any required changes to the care plan or agreement;
- providing information to the provider about their wants and needs;
- notifying the provider of any special requirements;
- providing constructive feedback to the provider about the service’s performance; and
- contributing to the cost of care where appropriate.

4.4 Advocacy

Part 3 of Schedule 1: Specified Care and Service for transition care services attached at the payment agreement and provided at Attachment B provides for the care recipient to have access to an advocate.

Service providers should present information to care recipients on the role of advocates.

A care recipient has the right to call on an advocate of their choice to represent them as required in the management of their care, including establishing or reviewing their recipient agreement, negotiating the fees they may be asked to pay and in presenting any complaints they may have.
Service providers are also required, under Schedule 1, to accept the care recipient’s choice of an advocate.

4.5 Privacy/confidentiality

Part 6.2 and sections 62-1 to 62-2 of the Aged Care Act 1997 and the Aged Care (Transitional Provisions Act) 1997 describe the responsibilities relating to the protection of personal information. Section 62-1 imposes obligations on the approved provider relating to the use, disclosure of and keeping of personal information relating to care recipients.

The Australian Government, state and territory governments as the approved providers and service providers (engaged by the approved providers), can only use personal information concerning a care recipient:
- for a purpose connected with the provision of aged care to the care recipient; or
- for a purpose for which the personal information was given by the care recipient to the approved provider (section 62-1(a)), represented by the service provider.

It is the responsibility of each state or territory government as the approved provider to ensure that its service providers protect the privacy of the care recipient and comply with all applicable laws relating to the use of personal information.

Service providers must implement security safeguards to protect personal information relating to care recipients against loss or misuse (section 62-1(c)) of the Aged Care Act 1997.

Service providers should also determine how they meet the Australian Privacy Principles in the Privacy Act 1988 and/or similar obligations contained in state or territory privacy laws.

4.6 Fees payable by care recipients

The payment agreement sets out the maximum amount that can be charged for care recipient fees.

A service provider may charge a care recipient a daily care fee. The maximum amount that can be charged is outlined in section 4.6.3 Maximum fees and reflected in the payment agreement.

A care recipient’s access to transition care should not be affected by their ability to pay fees, but should be decided on the basis of need for care and the capacity of the service provider to meet that need.

4.6.1 Care fees

Service providers may ask care recipients to pay a care fee as a contribution to the cost of their care. Any fees should be fully explained to the care recipient and the amount charged should form part of the agreement between the care recipient and service provider. Any fees must be agreed with the care recipient prior to the service being delivered.

4.6.2 Determining care fees

The process of setting care fees should be as simple and unobtrusive as possible, respecting the care recipient’s right to privacy and confidentiality.

To ascertain a care recipient’s ability to make a contribution to the cost of their transition care, the service provider may only request information that is reasonable to request under the circumstances (i.e. the care recipient is an in-patient of the hospital before entering transition care).

In determining a care recipient’s capacity to pay fees, the service provider should take into account any exceptional and unavoidable expenses incurred by the care recipient, such as high pharmaceutical bills.

A care recipient receiving transition care, who is about to be discharged to residential aged care, can be charged applicable aged care fees for the period of pre-entry leave by the residential aged care.
service provider (see section 58-1(c) of the Aged Care Act 1997 and the Aged Care (Transitional Provisions Act) 1997). This is likely to mean that the care recipient's capacity to pay care fees in transition care is diminished.

Similarly, residents in residential aged care before entering hospital may continue to be charged fees by their original service whilst in receipt of transition care services, which may impact on their capacity to pay fees for transition care.

In the above situations, the payment of residential care fees by a care recipient may be required in order to hold their place.

Home care recipients who began their care before 1 July 2014 cannot be charged care fees by the home care provider while they take leave for transition care (section 130 (5) of the Aged Care (Transitional Provisions) Principles 2014).

Home care recipients who began their care on and after 1 July 2014 cannot be charged a basic daily fee while they take leave for transition care (section 68 of the Aged Care (Subsidy, Fees and Payments) Determination 2014).

Fees may be waived during the transition care episode should the care recipient's financial circumstances change, as negotiated with the service provider.

4.6.3 Maximum fees

The care fee for transition care is calculated on a daily basis for every day the care recipient receives transition care. The maximum value of the care fee is 85% of the basic daily rate of single pension for care delivered in a residential setting. A care recipient who is an existing recipient of residential care services, and is already paying 85% of the basic daily rate of single pension in care fees, cannot be asked to pay the same amount to their service provider.

The amount paid should be discussed and agreed upon between the care recipient and service provider, and before transition care is provided. Refer to 3.5.4 Existing recipients of residential or home care in transition care.

For home care based transition care, the maximum care fee is 17.5% of the basic daily rate of the single pension.

The above rules on maximum fees apply to both single and married care recipients.

Each March and September, when new pension rates are announced, the Department of Health notifies the approved providers of any variations in the rate of the maximum care fees for transition care. The approved providers should then notify all service providers of the new rate. Service providers may want to initiate negotiations with care recipients following these variations.

4.6.4 Payment of fees in advance

Service providers may ask for fees up to one week in advance. If a care recipient leaves the programme, any payment in advance beyond the date of cessation must be refunded to the care recipient as soon as possible.

CHAPTER 5: RESPONSIBILITIES OF APPROVED PROVIDERS OF TRANSITION CARE

Section 56-3 of the Aged Care Act 1997 and the Aged Care (Transitional Provisions) Act 1997 sets out the responsibilities of the state and territory governments as the approved provider and for service providers.

5.1 Compliance with the legislation
Approved providers are approved under the Aged Care Act 1997 and the Aged Care (Transitional Provisions) Act 1997 and therefore must comply with conditions set down in the Acts, the Aged Care Principles and the Aged Care (Transitional Provisions) Principles 2014. These conditions relate to all activities performed in the context of providing flexible care under these Acts. This chapter identifies the key responsibilities of service providers under the Act and Principles.

While these guidelines provide additional advice on responsibilities of the approved providers and a measure of policy interpretation, it is strongly recommended that approved providers and service providers become familiar with the Acts and the Principles so as to be fully aware of their responsibilities in all aspects of flexible care in the form of transition care.

5.1.1 Failure to comply

Divisions 64 to 68 of the Aged Care Act 1997 and the Aged Care (Transitional Provisions) Act 1997 outline the consequences of non-compliance of approved providers.

Failure to comply with the responsibilities under these Acts may result in a non-compliance action. Discussions with the state or territory government as the approved provider may remedy the non-compliance, particularly in cases of minor or unintentional non-compliance.

A sanction is the most serious form of disciplinary action an approved provider may face under the Acts.

Most instances of non-compliance can be resolved without the approved provider incurring any further sanctions. However, if the approved provider does not remedy the non-compliance, one or more sanctions may be imposed in accordance with section 66-1 of the Acts. A decision to impose sanctions is a ‘reviewable decision’ under section 85-1 of the Acts and is subject to appeal to the Administrative Appeals Tribunal.

5.1.2 Serious and immediate health and safety risk reporting

Approved providers must notify the Department of Health without delay if a serious and immediate health and safety risk to one or more transition care recipients is identified. This includes alleged, suspected or actual abuse of a recipient. In such cases, the approved provider must take appropriate and swift remedial action in consultation with the Department of Health to avoid non-compliance under Divisions 64 to 68 of the Acts.

5.2 Specific legislative requirements

In addition to the general responsibilities, approved providers under the Act have a number of specific areas of responsibility they and their service providers are required to meet.

5.2.1 Accountability

Division 63 of the Aged Care Act 1997 and the Aged Care (Transitional Provisions) Act 1997 deals with the accountability requirements for approved provider and service providers.

The requirements set out in Division 63 of the Acts include such responsibilities as maintaining and retaining records relating to the service and complying with any conditions of allocation to which the places included in the service are subject. The requirements set out in Division 63 also include other responsibilities that are specified in the Accountability Principles 2014, such as the requirement for all staff and volunteers to have a current police certificate (section 48 Accountability Principles 2014).

5.2.2 Flexible care subsidy

Divisions 49 to 52 of the Aged Care Act 1997 and the Aged Care (Transitional Provisions) Act 1997 state the requirements to be satisfied to claim subsidy, the basis on which it will be paid and how the rates will be set.

The conditions under which subsidy may be claimed are established under section 50-1 of the Acts. The Subsidy Principles 2014 set out the arrangements for payment of flexible care subsidy to approved providers.
5.2.3 Record Keeping

Divisions 88 to 89 of the Aged Care Act 1997 and the Aged Care (Transitional Provisions) Act 1997 cover the types of records approved providers and service providers are required to keep in relation to the administration of the service and with regard to care recipients. It also covers the issues of false and misleading records and the penalties that may apply.

The Records Principles 2014 focus on records relating to care recipients. Approved providers should also ensure that service providers maintain the health records of individual care recipients in accordance with the local state or territory legislation and policy guidelines, as appropriate.

5.2.4 Quality of care

Section 54-1(b) of the Aged Care Act 1997 and the Aged Care (Transitional Provisions) Act 1997 outlines the responsibilities of the approved providers (and their service providers) in relation to the quality of the care provided.

Approved providers are required to ensure that service providers maintain an adequate number of appropriately skilled staff to meet the care needs of care recipients. The payment agreement requires the approved providers to adhere to Schedule 4 of the payment agreement, the Transition Care Programme Quality Improvement Framework (Attachment A).

5.2.5 User rights

Section 56-3 of the Aged Care Act 1997 and the Aged Care (Transitional Provisions) Act 1997 describes the responsibilities of the approved providers in relation to flexible care recipients. The payment agreement sets out the requirements and specifications of the recipient agreement.

‘User rights’ refers to the approved providers’ and their service providers’ general responsibilities to care recipients, and potential care recipients. These responsibilities include fees, the resolution of complaints, the requirement for recipient agreements and the protection of personal information.

5.3 Transition care payment agreement

Section 3(a) of the Subsidy Principles 2014 sets out the requirements of the payment agreements for flexible care subsidy to the approved providers.

In order for payment of flexible care subsidy to be made, approved providers are required to enter into a payment agreement with the Australian Government. Adherence to the payment agreement forms one of the conditions of allocation of flexible care places for transition care.

5.3.1 Conditions of allocation of flexible care places for transition care

An allocation of flexible care places for transition care may be subject to conditions in respect to the allocation of places generally or allocations of places of a specific kind. Sections 14-5 and 14-6 of the Aged Care Act 1997 and the Aged Care (Transitional Provisions) Act 1997 set out examples of conditions of allocations.

The Australian Government allocates transition care places to approved providers of transition care under the Acts. These conditions can be specific in terms of determining the area in which the places are to apply or the target group for particular places. They also cover general conditions such as meeting the requirements of the Acts, such as entering into a payment agreement with the Australian Government, reporting and provision of information to the Department of Health and specific matters including those outlined below.

5.3.2 Provision of information to the Department of Health

Approved providers must participate in any monitoring and evaluation programmes undertaken by the Department of Health. As such, approved providers must provide the Department with any relevant information when requested, including items specified in the payment agreement.
5.3.3 Insurance
As set out in the payment agreement, approved providers must ensure that their service providers maintain appropriate insurance while providing transition care. Service providers should be aware of any relevant state or territory legislation regarding insurance requirements and standards that may affect the delivery of transition care services.

5.3.4 Compliance with the laws of the Australian Government, states and territories
Approved providers and their service providers must comply with the provisions of any relevant statutes, regulations, by-laws and requirements of any Australian Government, state, territory or local authority.

CHAPTER 6: QUALITY ASSURANCE IN TRANSITION CARE

6.1 Complaints
The payment agreement requires service providers to state the mechanisms available for making a complaint. This includes informing care recipients (or their representatives) in the recipient agreement of internal and external mechanisms for addressing complaints made by, or on behalf of, the care recipient.

6.1.2 Internal complaints processes
If care recipients have concerns, they should be encouraged to approach the service provider in the first instance. In most cases the service provider is best placed to resolve complaints and alleviate concerns of care recipients. Service providers must handle any complaints fairly, promptly, confidentially and without retribution.

Complaints should be used positively to monitor and improve the quality of services provided by the service provider. Actively encouraging care recipients to provide feedback, both positive and negative, and duly considering this feedback will improve services and provide continuous improvement.

Service providers must also provide information in the recipient agreement about external complaint mechanisms and relevant contact information, such as telephone numbers of state and territory health complaints bodies.

6.1.3 External complaints processes
If care recipients (or their representatives) cannot resolve their dispute with the service provider, the state and territory health complaints bodies should be the first point of call. Relevant bodies in each state and territory are:

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Health Complaints Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>Health Care Complaints Commission</td>
</tr>
<tr>
<td>Victoria</td>
<td>Health Services Commissioner</td>
</tr>
<tr>
<td>Queensland</td>
<td>The Office of the Health Ombudsman</td>
</tr>
<tr>
<td>South Australia</td>
<td>Health and Community Services Complaints Commissioner</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Health and Disability Services Complaints Office</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Health Complaints Commissioner</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Health and Community Services Complaints Commissioner</td>
</tr>
</tbody>
</table>
If the care recipient (or their representatives) cannot resolve their dispute with the state and territory complaints bodies they may wish to contact the Aged Care Complaints Scheme (the Scheme).

The Scheme, which operates nationally, responds to complaints and information regarding care and services provided by Australian Government subsidised aged care services. Transition Care is an aged care programme that falls within the jurisdiction of the Scheme.

The Scheme’s resolution approaches range from supporting the complainant to resolve their concerns with the service provider, through to officers investigating the complaint. Where necessary, the Scheme has the power to direct a service provider to demonstrate that it is meeting its responsibilities under the *Aged Care Act 1997*. The Scheme will refer matters for compliance action where there are serious concerns regarding the safety, health and wellbeing of care recipients.

The Aged Care Complaints Scheme can be contacted as follows:

**Free Call:** 1800 550 552  
9am – 5pm Monday – Friday  
12noon – 5pm Weekends & Public Holidays

**Mail:**  
Aged Care Complaints Scheme  
Department of Social Services  
GPO Box 9820  
In the capital city & state/territory care is being provided

**Email:** cis.[enter state name]@dss.gov.au
The Transition Care Programme Quality Improvement Framework was developed in 2010-11 by the cross-jurisdictional Transition Care Working Group (TCWG) as a strategic approach to achieving the goals of the Programme and improving the quality of care and service delivery for transition care recipients nationally. The TCWG oversaw the expansion of the transition care programme from 2,000 to 4,000 places from 2008 to 2012 and reported to the Australian Health Ministers’ Advisory Council until 30 June 2013.

The Quality Improvement process provides the opportunity to change for the better. The underlying ethos of any quality improvement framework is one that fosters improvement and performance. The results are improved client outcomes, as well as efficiency and ease of compliance with Commonwealth and state/territory legislation and requirements. The Framework is applicable to transition care services of any size and to stakeholders at each level of the transition care programme, namely:

1. Governments – Australian and state/territory (approved providers);
2. Transition care service providers – regional and/or local managers;
3. Hospitals; and
4. Transition care recipients.

**Framework Dimensions**

The Framework describes the dimensions of quality and the cross dimensional organisational elements that underpin effective safety and quality improvement.

---

Essential Transition Care Quality Components

1. Organisational elements
The Framework is based on four organisational elements\textsuperscript{10} critical to quality improvement:

I. Governance and leadership
II. Consumer involvement
III. Competence and education
IV. Information management

In the context of transition care, the four organisational elements critical to quality improvement refer to:

I. Governance and leadership
   • Corporate governance exercised by Australian and state/territory governments and their respective structures and processes which ensure fulfilment of strategic, statutory and financial obligations.
   • Clinical governance refers to the accountability of approved providers and authorised service providers for monitoring, supporting, evaluating and continuously improving the safety and quality of care and service delivery.

II. Consumer involvement
   • Consumers need to be involved at two levels, either:
     i. as people who either directly or indirectly make use of transition care services, predominantly older people and their families and carers; or
     ii. as representatives of the community or population served by the particular service they are attending.

III. Competence and education
   • Competence needs to be assured at all levels of the Programme and requires the provision of education and training to ensure understanding of the quality framework to foster compliance. Regular review and follow-up action is also required to ensure maintenance of skills and knowledge appropriate to all levels of service provision.

IV. Information management
   • There needs to be accurate, relevant and timely collection, analysis and reporting of data, supported by appropriate software and hardware and the capacity to convert the data into information which can be used to support and to enable continuous improvement in practice.

2. Dimensions of quality
Each of these organisational elements intersects with six commonly recognised dimensions\textsuperscript{11} of quality:

I. Safety
II. Effectiveness
III. Appropriateness
IV. Stakeholder satisfaction
V. Access to services
VI. Efficiency

These dimensions form the basis for monitoring, managing and reporting on the quality of transition care services provided nationally. There is significant overlap and interdependence between them, therefore making it important for all dimensions to be included in a system designed to improve the quality of care and services being provided.

Components of the six dimensions of quality as they pertain specifically to the provision of transition care include, but are not limited to, the following activities:

\textsuperscript{10} Ibid.

\textsuperscript{11} Ibid.
I. Safety

- **Management and reduction of risks**
  1. Transition care service providers must have up-to-date policies and procedures to manage and reduce risks, including falls, incidents of abuse of older people and other adverse events (see also clause 6.3 of this Payment Agreement).

- **Police checks**
  1. All transition care staff and contractors who have or are reasonably likely to have access to care recipients of a transition care service must undergo a national criminal history record check every three years.
  2. This includes volunteers who have unsupervised access to care recipients (see also part 6 of the Accountability Principles 2014 and section 63-1 of the Aged Care Act 1997).

- **Buildings used for the provision of residential based transition care must comply with the relevant state/territory building regulations**

- **Credentialing / professional registration / accreditation of service providers**
  1. Allied health, medical and nursing staff who provide transition care services must have current national registration or be a member of the appropriate professional association, a Department of Veterans’ Affairs (DVA) approved provider or a Registered Medicare Provider.

- **Environmental safety checks**
  1. Transition care services must meet appropriate environmental standards, including food handling and hotel services in residential based transition care services.

II. Effectiveness

Transition care service provision should include:

- quality improvement reviews and studies, both quantitative and qualitative, including robust monitoring, reporting and response systems;
- consumer satisfaction surveys and other feedback mechanisms; and
- monitoring of functional improvement using an endorsed or validated tool*.

*Note: The use of the Modified Barthel Index for assessments by the transition care service at entry to and exit from the transition care programme is mandatory for Australian Government subsidy payments.

III. Appropriateness

- Transition care service provision should include outcome monitoring in accordance with principles of transition care, including returning home to live in community and admission to residential care rates, and re-admission to hospital during a transition care episode.
- Service settings should be suitable for meeting transition care outcomes, including provision of a more home-like, less institutional environment in residential services and space available for therapy, see Standard 1, Outcome 1.3 in Schedule 2- Transition Care Programme Quality Standards at Attachment C.

IV. Stakeholder Satisfaction

- Transition care service provision must have internal and external processes for monitoring and managing complaints.
- Complaints processes should be informed by stakeholder consultation and feedback, including satisfaction surveys, focus groups and interviews with internal and external stakeholders at all levels.¹²

V. Access to services

- Transition care service provision must comply with admission/eligibility criteria governing access to services, including utilisation of services by target groups, including Aboriginal and Torres Strait Islander people, and special needs populations.
- This should include reviews of the utilisation of services encompassing target groups and special needs populations to optimise access.

VI. Efficiency

- Transition care service provision should be guided by systemic reviews and updating of policies and procedures to ensure consistency at national, state and local levels. This should include:
  - transparent data analysis and reporting on performance, including occupancy rates, lengths of stay and re-admission rates; and
  - regular benchmarking and comparing of organisational performance.

3. Operating Environment

There are a number of key external and internal safety and quality drivers impacting on the environment in which the Transition Care Programme Quality Improvement Framework operates.

I. Compliance with legislative and regulatory requirements – Commonwealth and state/territory

II. External health or aged care accreditation standards and review processes

III. An internal self-assessment and reporting system

IV. Local quality improvement plans which address operational priorities and implications for safety and quality are reviewed and updated annually or in line with requirements of the approved provider and the accreditation agency

I. Compliance with legislative and regulatory requirements – Commonwealth and state/territory.

II. Transition care service provision must comply with external health or aged care accreditation standards and review processes. This is expected to:
- provide mechanisms for assessment of and reporting on the quality and safety of the transition care service;
- are conducted by external health or aged care quality assessment agencies;
- involve a site visit by an independent assessor contracted by the external health or aged care quality assessment agency endorsed by the organisation within which the transition care service operates. Participants in the site visit are to be negotiated by the local service provider and the approved provider; and
- require a copy of the external health or aged care quality assessment agency’s report on the transition care service to be provided to the approved provider.

III. Transition care service provision must have an internal reporting and self-assessment system.

IV. Transition care service provision must have a culture that promotes continuous quality improvement. This should include, but not limited to, local quality improvement plans which address operational priorities and implications for safety and quality and are reviewed and updated annually or in line with requirements of the approved provider and the external health or aged care quality assessment agency. The local plans must:
- reflect an organisational or service level culture which fosters safety and quality improvement;
- enable individual transition care services to draw on appropriate organisational structures, processes and resources (including technical support and information) to monitor, manage and improve service delivery; and
- utilise a simple quality improvement methodology, comprising:
  i. a feedback loop which ensures that data and information are collected, analysed and acted on, with the results of action review for effectiveness and all parties concerned kept informed of progress;
  ii. improvements that could be adopted by individual organisations or services;
  iii. improvement tools and techniques that could be utilised and chosen locally and which are consistent with the environment in which the transition care service operates; and

32
iv. the involvement of people who are directly impacted by change as a result of improvement activities. These people could be staff, consumers, the community, and other stakeholders.

Figure 2 below illustrates the Transition Care Programme Quality Improvement Framework Operating Environment.

**Figure 2: Quality Improvement Framework Operating Environment**

4. **Review of Framework**

This Framework should be reviewed from time to time to ensure it remains current and consistent with new developments in health and aged care, and to facilitate changes identified through growing experience with the Programme.

The review should be undertaken by a group which includes representatives from the Department with portfolio responsibility for the transition care programme and state/territory approved providers to ensure the perspectives of all jurisdictions are taken into account.
**SCHEDULE 1 – SPECIFIED CARE AND SERVICES FOR TRANSITION CARE SERVICES**

The Transition Care Payment Agreement provides that the care and services listed in Schedule 1 are to be provided in a way that meets the standards set out in *Schedule 2 - Transition Care Programme Quality Standards* of the Agreement.

The following lists of care and services are not intended to be exhaustive or to limit the range of care and services provided. They indicate the basic level of care that transition care service providers must be able to provide, if required by a recipient of transition care, for receipt of flexible care subsidy for that recipient. The use of telehealth and telecare devices should be considered where medically indicated and appropriate to the care recipient’s goals. The availability and adoption of this equipment may be subject to adequate infrastructure to support the transmission of data and images.

**Part 1  Care and services that must be provided, when required, to transition care recipients in a residential setting**

<table>
<thead>
<tr>
<th>Col.1</th>
<th>Column 2 Service</th>
<th>Column 3 Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Maintenance of all buildings and grounds</td>
<td>Adequately maintained buildings and grounds.</td>
</tr>
<tr>
<td>1.2</td>
<td>Accommodation</td>
<td>Utilities such as electricity and water.</td>
</tr>
<tr>
<td>1.3</td>
<td>Furnishings</td>
<td>Bed-side lockers, chairs with arms, containers for personal laundry, dining, lounge and recreational furnishings, draw screens (for shared rooms), care recipient wardrobe space, towel rails, over-bed tables.</td>
</tr>
<tr>
<td>1.4</td>
<td>Bedding materials</td>
<td>Beds and mattresses, bed rails, bed linen, blankets and absorbent or waterproof sheeting, incontinence sheets, ripple mattresses, sheepskins, tri-pillows, and water and air mattresses appropriate to each care recipient's condition.</td>
</tr>
<tr>
<td>1.5</td>
<td>Cleaning services, goods and facilities</td>
<td>Cleanliness and tidiness of the entire service. Excludes: a care recipient's personal area if the care recipient chooses and is able to maintain it himself or herself.</td>
</tr>
<tr>
<td>1.6</td>
<td>General laundry</td>
<td>Heavy laundry facilities and services, and personal laundry services, including laundering of clothing that can be machine washed. Excludes: cleaning of clothing requiring dry cleaning or another special cleaning process, and personal laundry if a care recipient chooses and is able to do this himself or herself.</td>
</tr>
<tr>
<td>1.7</td>
<td>Toiletry goods</td>
<td>Bath towels, face washers, soap, toilet paper, sanitary pads, tissues, toothpaste, toothbrushes, denture cleaning preparations, mouthwashes, moisturiser, shampoo and conditioner, shaving cream, disposable razors and deodorant.</td>
</tr>
<tr>
<td>1.8</td>
<td>Meals and refreshments</td>
<td>Preparing nutritious meals that are culturally appropriate and of adequate variety, quality and quantity for each care recipient, served each day at times generally acceptable to both care recipients and management, and generally consisting of 3 meals per day plus morning tea, afternoon tea and supper. Special dietary requirements, having regard to either medical need or religious or cultural observance. Food should include fruit of adequate variety, quality and...</td>
</tr>
<tr>
<td>Service</td>
<td>Content</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>quantity, and non-alcoholic beverages, including fruit juice. Assisting care recipients in eating meals. For care recipients requiring enteral feeding in residential based transition care, the transition care service provider is responsible for providing the enteral feeding formula at no extra cost to the care recipient. See also 3.3 of this Schedule regarding the provision, care and maintenance of tubes for enteral feeding.</td>
<td></td>
</tr>
<tr>
<td>Emergency assistance</td>
<td>Assisting care recipients in eating meals. For care recipients requiring enteral feeding in residential based transition care, the transition care service provider is responsible for providing the enteral feeding formula at no extra cost to the care recipient. See also 3.3 of this Schedule regarding the provision, care and maintenance of tubes for enteral feeding.</td>
<td></td>
</tr>
<tr>
<td>Treatments and procedures with respect to ongoing medical management</td>
<td>Treatments and procedures that are carried out according to the instructions of a health professional, such as a GP or a representative for assessing a care recipient’s personal care needs, or undertaken according to the care recipient’s wishes, including supervision and physical assistance with taking medications, and ordering and reordering medications, subject to requirements of state and territory law. It is expected that the provision of primary medical care to a transition care recipient would be undertaken by a GP and that the services provided by the GP in the residential setting would be covered by Medical Benefits Schedule (MBS) rebates, as is currently the case in residential aged care services. Where GPs are asked to provide different medical services or a higher volume of services than specified in the MBS requirements, then funding of these additional services should occur through the Transition Care Programme. For the purpose of monitoring the care recipient’s health status, telehealth and telecare devices may be used where medically indicated and appropriate to the care recipient’s goals.</td>
<td></td>
</tr>
<tr>
<td>Assistance in obtaining health practitioner services</td>
<td>Arrangements for aural, community health, dental and oral health, medical, psychiatric, optometry and other health professionals to visit care recipients whether the arrangements are made by care recipients, relatives or other persons representing the interests of care recipients, or are made direct with the practitioner.</td>
<td></td>
</tr>
<tr>
<td>Goods to assist care recipients to move themselves</td>
<td>Crutches, quadraped walkers, walking frames, walking sticks, wheelchairs and off-the-shelf aids to assist with upper limb function, should be available as required for the duration of a care recipient’s stay. Excludes: motorised wheelchairs and custom-made aids.</td>
<td></td>
</tr>
<tr>
<td>Goods to assist staff to move care recipients</td>
<td>Medical devices for lifting care recipients, stretchers, trolleys should be provided as required for the duration of a care recipient’s stay.</td>
<td></td>
</tr>
<tr>
<td>Goods to assist with toileting and incontinence management</td>
<td>Includes the provision as required of absorbent aids, commode chairs, disposable bed pans and urinary covers, disposable pads, over toilet chairs, shower chairs, urodomes, catheter and urinary drainage appliances, and disposable enemas.</td>
<td></td>
</tr>
<tr>
<td>Basic medical and pharmaceutical supplies and equipment</td>
<td>Includes analgesia, anti-nausea agents, bandages, creams, dressings, laxatives and aperients, ointments, saline, swabs, urinary alkalisng agents, and anti-diarrheals. Non-prescription pharmaceutical goods should always be administered to a care recipient only as the result of a clinical decision and be recorded on the care recipient’s medical chart. Excludes: any goods prescribed by a health practitioner for a</td>
<td></td>
</tr>
<tr>
<td>Col.1</td>
<td>Column 2</td>
<td>Column 3</td>
</tr>
<tr>
<td>-------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td>Service</td>
<td>Content</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>particular care recipient and used only by the care recipient. In this case, the medication would be covered, as is normal, under the Pharmaceutical Benefits Scheme (PBS).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.16</td>
<td>Medications</td>
<td>Medications subject to requirements of state or territory law.</td>
</tr>
</tbody>
</table>

Part 2 Care and services that must be provided, when required, to transition care recipients in a community setting

<table>
<thead>
<tr>
<th>Col.1</th>
<th>Column 2</th>
<th>Column 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Service</td>
<td>Content</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Bedding materials</td>
<td>Provision of absorbent or waterproof sheeting, incontinence sheets.</td>
</tr>
<tr>
<td>2.2</td>
<td>General laundry</td>
<td>Assistance with laundry.</td>
</tr>
<tr>
<td>2.3</td>
<td>Meals and refreshments</td>
<td>Arrange, where required, transport to help a person shop. Assistance with nutrition, hydration and preparing and eating meals. The definition of preparing and eating meals assumes that the care recipient is responsible for providing and paying for the food, including enteral feeding formula, if required. See also 3.3 of this Schedule regarding the provision, care and maintenance of tubes for enteral feeding. However, where Meals on Wheels is required, it is important that the payment arrangements for Meals on Wheels services are clearly described in the care recipient agreement between the service provider and the care recipient. Assistance with special dietary requirements, having regard to either medical need or religious or cultural observance.</td>
</tr>
<tr>
<td>2.4</td>
<td>Emergency assistance</td>
<td>Having at least one responsible person or agency, approved by the organisation providing the community care, in close proximity and continuously on call to give emergency assistance when needed. For example, this could be through a personal alert system or a phone number to a mobile or land line which is staffed 24 hours per day. In a medical emergency, which requires immediate action, appropriate medical assistance must be sought, e.g. by dialling 000. Each transition care service provider must develop a protocol for emergency situations and this protocol must be reflected in the service provider’s policies and procedures.</td>
</tr>
<tr>
<td>2.5</td>
<td>After hours assistance</td>
<td>As part of each care recipient’s care plan, the service provider must manage the risk of the care recipient requiring after hours assistance. The possible risk factors for each care recipient should be identified and management strategies implemented for these risk factors. Where the need for after hours assistance has been identified, there should be 24 hour on call access to at least one responsible person or agency in reasonable proximity who is familiar with the care plan and who has given consent to be included in the care plan as contact. The responsible person may be a relative, friend</td>
</tr>
</tbody>
</table>
or neighbour who is located close to the care recipient and who will organise after hours assistance or emergency assistance when required. The service provider may also have their own staff on call (i.e. from a nearby aged care service) to go to the care recipient's home after hours. Should the care recipient not nominate a person as a contact, the transition care service provider must provide the after hours assistance.

If the care recipient requires 24 hour on call assistance and access to an emergency call system, this must be provided. If a care recipient requires access to an emergency call system on a long-term basis, the care recipient should be given the option of having an emergency call system of their choice installed at their own cost.

2.6 Home help

Assistance with home help including domestic assistance. This includes assistance with cleaning or the provision of cleaning services, goods and facilities, if required.

2.7 Home maintenance and functional safety

Home maintenance reasonably required to maintain the home and garden in a condition of functional safety and provide an adequate level of security.

Efforts to ensure functional safety must also include identifying and addressing any Occupational Health and Safety issues that might have an adverse effect on care staff working in the home.

If a care recipient requires home modifications, such as the installation of grab rails, hand rails and ramps to enable the care recipient to continue living at home, service providers, in their role as case manager, should confirm eligibility of the care recipient for home modification services provided under the Home and Community Care (HACC) or Veterans’ Home Care Programmes and availability of the required home modifications through these Programmes. For care recipients who are not eligible for services under these Programmes, the care recipient or their representative is responsible for arranging the home modifications and meeting the cost involved.

As a follow-up, unless otherwise advised in the discharge plan (i.e., referral to have external follow up), the prescribing therapist should liaise with the care recipient after the transition care episode to ensure that the care recipient's functional needs have been met once the home modifications are complete or the necessary equipment has been supplied. The follow-up by the relevant therapist could be a home visit or a phone assessment as appropriate, depending on what type of home modification has been undertaken and the needs of the care recipient.

2.8 Treatments and procedures with respect to ongoing medical management

Control and administration of medication prescribed by a medical practitioner, subject to legal restrictions on providing the medication. Administration of treatment such as eye drops, pressure care, dressings and urine tests, subject to legal restrictions on providing treatment.

Telehealth and telecare devices may be used where medically indicated and available for monitoring the care recipient’s health status, especially for those who live in rural, remote and outer metropolitan areas.

2.9 Assistance in obtaining health practitioner services

Transport to help a care recipient visit a medical practitioner or assistance in arranging a home visit by a medical practitioner.

2.10 Goods to assist care recipients to move

Service providers may need equipment to assist in the provision of transition care services and meet care recipients' needs (e.g. a
<table>
<thead>
<tr>
<th>Col.1</th>
<th>Column 2 Service</th>
<th>Column 3 Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>themselves</td>
<td>wheelchair for assistance with mobility or a personal alert system to provide on-call emergency assistance). Transition care service providers using Australian Government subsidies may purchase such equipment and, where appropriate, this equipment may be loaned temporarily to individual care recipients. When purchasing equipment for the service, ownership of the equipment vests with the service provider. Any equipment loaned to individual care recipients should be returned to the provider at the conclusion of the transition care episode, for use by other care recipients. It is important to note that the provider is purchasing the equipment for use in service provision. If a care recipient requires aids and equipment on an ongoing basis, service providers should, in their role as case manager, seek equipment from such places as state/territory government equipment schemes or equipment loan services. For care recipients who are not eligible for services under these equipment schemes or equipment loan services and the required services are not available, the care recipient or their representative is responsible for the cost of the equipment.</td>
<td></td>
</tr>
</tbody>
</table>

| 2.12 | Other | Other services required to maintain the person at home as agreed with the care recipient. |

---

**Part 3**

**Common care and services that must be provided, when required, to all transition care recipients**

<table>
<thead>
<tr>
<th>Col.1</th>
<th>Column 2 Service</th>
<th>Column 3 Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Administration and care planning</td>
<td>General operation of the transition care service, including care recipient documentation and care planning and management. When an older person is in a transition care service, initial and ongoing assessment, planning and management of care will be undertaken by appropriately qualified and trained staff members or others (including external practitioners) with expertise in geriatric and/or therapeutic management, with the involvement of the care recipient (or the representative), and his or her carer, where appropriate.</td>
</tr>
</tbody>
</table>

| 3.2   | Case management | The transition care service provider should ensure that appropriate case management is available to recipients of transition care, to coordinate and monitor all aspects of their care and their movement from hospital, through transition care and back into the community or to their normal care arrangements, and act as a central point of contact for everyone involved in the care of the recipient. This will include:  
- ensuring that a comprehensive care plan is available at the time of discharge from hospital;  
- ensuring that all aspects of the care plan are carried out, monitoring progress against the care plan goals and adjusting the plan where necessary;  
- identifying any changes to a recipient’s care needs that occur during transition care and arranging for appropriate adjustments to the services provided;  
- liaising with and organising all care requirements provided by external service providers (including GPs |
<table>
<thead>
<tr>
<th>Service</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>and specialists); and</td>
</tr>
<tr>
<td></td>
<td>• arranging for appropriate care, if required, following transition care or managing the return of the recipient to the community or their normal care arrangements.</td>
</tr>
<tr>
<td></td>
<td>Throughout the time spent in transition care and with respect to any subsequent arrangements, the case management role includes ensuring that the individual lifestyle choices of the care recipient are taken into account and that everything possible is done to enable social contact between the care recipient and their family and friends.</td>
</tr>
</tbody>
</table>

3.3 Specialised clinical services
Clinical care provided as part of the transition care Programme, where required, is to be carried out by a registered nurse, or under the direct or indirect supervision of a registered nurse or other professional appropriate to the service delivery and in accordance with professional standards and guidelines. These services may include, but are not limited to, the following:

• assessment for pain and a plan implemented to keep the care recipient as free from pain as possible;
• provision and care and maintenance of tubes, including enteral feeding, naso-gastric and tracheostomy tubes etc;
• establishment, review and maintenance of urinary catheter care and/or stoma care programme;
• complex wound management;
• enema administration or insertion of suppositories;
• suctioning of airways and tracheostomy care;
• oxygen therapy requiring ongoing supervision because of a care recipient’s variable need, including the provision of oxygen and oxygen equipment at no additional cost to the care recipient;
• appropriate medication management;
• appropriate nursing services;
• appropriate dementia support;
• taking appropriate action to prevent falls among care recipients;
• on-call access to specialist nursing services, if required; and
• specialised swallowing management.

3.4 Therapy services
The therapeutic care to be delivered through the transition care programme includes low intensity therapy such as physiotherapy, occupational therapy, podiatry, dietetics, speech pathology, counselling and social work to maintain and improve physical and cognitive functioning and to facilitate improved capacity in activities of daily living. This care is to be provided by appropriately qualified and trained staff or consultants and in accordance with any levels of care specified under the recipient’s care plan.

---

13 Day to day diabetes education and management forms part of ‘dietetics’ and is to be undertaken by a qualified diabetes educator who oversees and manages diabetes therapy where clinically appropriate, according to the client’s care needs and care plan.
A key component of the transition care programme is the therapeutic services that care recipients can receive. These services are not a substitute for the subacute care delivered through the hospital sector. Hence eligibility for transition care includes an ACAT assessment that concludes that, where appropriate, a care recipient has already received hospital based subacute rehabilitation care and/or geriatric evaluation and management where necessary (or will have received it prior to discharge).

The therapy services do not include acupuncture and as such, the cost of the provision of acupuncture is not covered by the transition care programme.

### 3.5 Daily living activities assistance

Personal assistance, including individual attention, individual supervision and physical assistance with:

- bathing, showering, personal hygiene and grooming;
- maintaining continence or managing incontinence, and using aids and appliances designed to assist continence management;
- eating and eating aids, and using eating utensils and eating aids (including actual feeding if necessary);
- dressing, undressing and using dressing aids;
- moving, walking, wheelchair use and using devices and appliances designed to aid mobility, including the fitting of artificial limbs and other personal mobility aids; and
- communication, including to address difficulties arising from dementia, impaired hearing, sight or speech, or lack of common language (including the fitting of sensory communication aids).

### 3.6 Social activities

Arranging social programs and activities or providing / coordinating transport to socialisation activities/functions at a reasonable frequency. Encouraging transition care recipients to take part in social activities. Providing other services that help to prevent social isolation and promote and protect the dignity and well-being of recipients.

### 3.7 Religious and cultural activities

Provide support to the care recipient in accessing religious and cultural activities.

### 3.8 Advocacy

Advocacy services to help protect the care recipient's interests.
<table>
<thead>
<tr>
<th>Col.1</th>
<th>Column 2</th>
<th>Column 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.9</td>
<td>Support</td>
<td>Support services to maintain personal affairs.</td>
</tr>
<tr>
<td>3.10</td>
<td>Waste disposal</td>
<td>Safe disposal of organic and inorganic waste material.</td>
</tr>
</tbody>
</table>
SCHEDULE 2 – TRANSITION CARE PROGRAMME QUALITY STANDARDS

Standard 1 – OPTIMISING INDEPENDENCE AND WELLBEING

The transition care service optimises the independence and wellbeing of its care recipient.

Outcome

1.1 Assessment processes:
- allow care recipient or their representative, assisted by carers and families as appropriate to make informed choices between transition care service options in order to define and set their goals to optimise their independence and wellbeing;
- include an assessment of care recipients’ physical and cognitive independence, as well as their psycho-social needs; and
- consider special needs groups, including people from Aboriginal and Torres Strait Islander communities, people from culturally and linguistically diverse backgrounds, and people who have a physical or cognitive impairment.

1.1.1 Care planning is focussed on optimising independence and wellbeing and includes a goal-oriented care plan for the care recipient that:
- responds to the identified needs of the care recipient and targets those goals which optimise independence while taking into consideration the cognitive and psycho-social needs of the care recipient;
- provides the care recipient with required physical and cognitive therapies and treatments designed to teach the care recipient to achieve their own goals; and
- improves the care recipient’s functioning by promoting independence and monitors that improvement in consultation with the care recipient and/or their representative, carers and families, clinicians, and therapists.

Note: For further detail on care planning, see outcome 2.2.

1.2 The transition care service demonstrates that its service:
- provides a coherent and integrated case management process that enables care recipients to meet their goals and takes into consideration the psycho-social situation of the care recipient;
- actively promotes self-management and self-sufficiency by providing interventions that support the care recipient to make the most of their own capacity and achieve their full potential;
- encourages care recipients to seek support from carers and families, community groups and others to foster their independence when required;
- assists care recipients to achieve an optimum level of independence and wellbeing so that care needs are minimised over the longer term;
- where applicable, provides facility-based residential Transition Care services in a more home-like, less institutional environment. This may include:
  - communal living space/living room environment which is completely separate from sleeping areas and the location of acute/subacute care provision, i.e. a space that encourages carers, families and visitors to spend time with care recipients;
  - a dining area and care recipients encouraged not to eat in bed;
  - care recipients being encouraged and supported to dress every day;
  - facilities for care recipients to prepare snacks for themselves and their visitors;
  - privacy, particularly for personal care and bathing arrangements;
  - space for care recipients to mobilise, especially outdoors;
physical arrangements which support the involvement of carers and family in
the therapeutic activities; and
a model of care and staff knowledge that supports the intent of the transition
care programme to promote the care recipient's health and independence.

Note: Transition care services may also be provided in rural and remote hospitals where
appropriate. The requirements for a more home-like environment may be relaxed on a case by
case basis in these locations, if relevant.

Standard 2 – MULTIDISCIPLINARY APPROACH AND THERAPY FOCUSED
CARE

The transition care service provides its care recipients with high quality, evidence-based
therapeutic services focussed on maintaining or improving function in line with established
goals.

Outcome

2.1 Assessment processes include:

- assessment of the care recipient’s transition care needs by the multidisciplinary team
  (MDT) at the beginning of the transition care episode;
- the use of validated assessment tools deemed appropriate by clinicians/therapists*;
- a dementia assessment;
- measurement of a baseline level of functioning using validated assessment tools, and
  re-assessment of functional performance at pre-determined intervals; and
- evidence of discharge planning throughout the transition care episode.

*Note: The use of the Modified Barthel Index for assessments by the transition care service at
entry to and exit from the transition care programme is mandatory for Australian Government
subsidy payments.

1.1 Care planning processes demonstrate that:

- a goal-oriented physical and cognitive therapy programme is developed by the provider
  in consultation with the care recipient or representative, carer and family prior to the
  commencement of therapy or treatment, with input from the MDT of the transferring
  hospital and the ACAT;
- the therapy programme duration is estimated and informs planning for the care
  recipient’s discharge;
- hospital discharge information is incorporated into the initial care planning process;
- care provision is responsive to the identified needs and goals of the care recipient;
- physical and cognitive therapy goals agreed with the care recipient or their
  representative/carer are documented and prioritised;
- the care recipient receives timely and appropriate access to therapy, care and
  equipment during the transition care episode. This is demonstrated by:
  - ensuring aids, appliances, equipment and services required for a care
    recipient's therapy are provided in a timely manner;
  - providing a broad range of services tailored to meet the care recipient's
    therapeutic goals to improve or maintain function;
  - providing the care recipient with low intensity therapy from appropriately
    qualified staff to achieve their individual documented goals; and
  - actively encouraging care recipient, and/or their representative, carer and
    family participation in all aspects of transition care service provision.
- the care recipient’s progress against therapy goals is regularly evaluated throughout
  their transition care episode and on exit, with changes in physical and cognitive
  function measured and recorded to demonstrate achievement of the care recipient’s
  goals;
- the care recipient’s changing needs are reflected as they move between care settings; and
• care recipient goals are delivered in accordance with the care plan, using an integrated case management approach.

2.1 The MDT approach to the planning and review of care recipient care demonstrates that:
• documented procedures and protocols are available to support the multidisciplinary team in the care and review of care recipients. This includes processes for communicating care recipient information to relevant health professionals;
• care planning is carried out by members of the MDT with relevant clinical experience in goal-oriented, low intensity therapy;
• care plan reviews/case conferencing include those members of the MDT involved in the care recipient’s treatment and occur at predetermined intervals;
• care is informed by discussions with and between the relevant Geriatrician and the care recipient's GP, where possible, and/or other appropriate medical input;
• MDTs have integrated care recipient records;
• the MDT comprises an appropriate mix and level of staff, enabling the provision of effective care recipient services; and
• a coordinator/case manager is in place to oversight and promote effective MDT and inter-agency working.

Standard 3 – SEAMLESS CARE

The transition care service uses a collaborative service delivery model that delivers seamless care.

Outcome

3.1 Assessment processes:
• follow agreed protocols for the effective transfer of care recipient information between primary, community, acute and aged care services;
• recognise and incorporate hospital assessment, care planning and discharge arrangements, including ACAT assessment and approval recommendations;
• enable staff of the receiving transition care service to meet and assess the care recipient’s care needs and the transition care service’s ability to meet these care needs prior to the care recipient’s admission into the service, where possible; and
• provide for a verbal as well as a written handover of care recipient information and status whenever the care recipient moves between or within services, where practical.

3.2 The transition care service works within an integrated system of care with other organisations by:
• establishing relationships and communication strategies that govern collaboration between acute/sub-acute, aged and primary care services, promoting a clear understanding of each other’s roles, responsibilities and admission criteria;
• establishing systems for the secure, timely and effective transfer of transition care, care recipient information between service providers;
• strengthening partnerships with GPs and other transition care support services;
• facilitating effective interagency case conferences;
• facilitating the care recipient’s entry to and exit from transition care so that the care recipient experiences a seamless move;
• effectively coordinating the care recipient’s needs and goals between services;
• keeping the care recipient and/or their representative well informed prior to moving to a new service;
• facilitating education, training, networking and support across sectors and service boundaries in the broader health and aged care community where appropriate; and
• facilitating access to ongoing care and service provision post discharge from the Programme, as required.

3.3 The transition care service develops systems for the safe discharge of care recipients that help prevent re-admission, including:
• providing transition care service discharge plan information to any subsequent care organisation; and
• providing appropriate discharge documentation to the care recipient, specifying:
  o length of stay in transition care;
  o destination post transition care;
  o goals which care recipient agrees have been achieved or not achieved (with reasons for non-achievement);
  o care recipient physical and cognitive functional levels on discharge from transition care, assessed using the same validated instrument used on admission;
  o care recipient and/or representative, carer and family education and support to improve functioning following discharge;
  o where appropriate all services and equipment to be provided to the care recipient on discharge from transition care, with key supplier contact details;
  o an up-to-date list of prescribed discharge medications; and
  o other follow-up arrangements/referrals such as information for the care recipient’s GP, which are the responsibility of the care recipient and/or their representative.
<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACAT</td>
<td>Aged Care Assessment Teams (ACATs) are multidisciplinary teams of health professionals who provide assessment, information, advice and assistance to frail older people to gain access to the types of services most appropriate to meet their care needs. This includes responsibility for determining eligibility for entry to Australian Government subsidised residential aged care, home care and flexible care (including transition care) as and when appropriate. ACATs conduct a comprehensive assessment of the restorative, physical, medical, psychological, cultural and social dimensions of a person’s needs, and/or promote their independence as and when appropriate. ACATs refer care recipients to services that are appropriate and available to meet their needs. <em>Aged Care Assessment Program Guidelines, January 2014</em></td>
</tr>
</tbody>
</table>
| ACUTE CARE | Acute Care in the context of transition care is care in which the clinical intent or treatment goal is to:  
- cure illness or provide definitive treatment of injury;  
- perform surgery;  
- relieve symptoms of illness or injury (excluding palliative care);  
- reduce severity of an illness or injury;  
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function; or  
- perform diagnostic or therapeutic procedures. *Australian Institute of Health and Welfare (AIHW), 2012, National Health Data Dictionary. Note: ‘manage labour (obstetric)’ has been removed due to the target population of transition care recipients.* |
<p>| ADVOCATE | A person who acts on behalf of another party. In the absence of a carer, an independent advocate could be a general practitioner, legal representative, person appointed by the guardianship board or another person who can represent the interests of the care recipient adequately. <em>Department of Health and Ageing, 2006, Aged Care Assessment and Approval Guidelines, Canberra</em> |
| ADVOCACY SERVICE | An advocacy service is an independent, confidential service provided free of charge in each state and territory. If you receive Australian Government-subsidised aged care services, advocacy services can help you to exercise your rights by representing you, and providing information, advice and support to you, your carer, your family or your friends. |
| AGED CARE ACT 1997 | The <em>Aged Care Act 1997</em> is the Australian Government legislation that relates to Australian Government funded residential, home care and flexible aged care services for care recipients after 1 July 2014. |
| AGED CARE (TRANSITIONAL PROVISIONS) ACT 1997 | The <em>Aged Care (Transitional Provisions) Act 1997</em> apply to continuing care recipients, that is people who entered care after 1 July 2014 and have not chosen to opt into the new arrangements. |
| AGED CARE FUNDING INSTRUMENT (ACFI) | ACFI is the classification instrument underpinning the funding model to pay care subsidies to Australian Government funded residential aged care services. The ACFI is used to assess core care needs as a basis for allocating funding. |
| AGED CARE SERVICE | An undertaking through which aged care is provided in the form of |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
</table>
| AGED CARE CLIENT RECORD                                              | Aged Care Client Record (ACCR) is an approved form for a person to apply to be approved as a recipient of aged care under section 22-3(3) of the Aged Care Act 1997. This care includes residential care, home care and flexible care services.  
Aged Care Assessment Program Guidelines, January 2014 |
| AGED CARE COMPLAINTS SCHEME                                           | The Aged Care Complaints Scheme (the Scheme) is a free service which can consider concerns raised by care recipients, their representatives and others regarding the quality of care or services provided through Australian Government subsidised aged care services, relating to an approved provider’s responsibilities under the Aged Care Act 1997. The Scheme is administered by the Department of Health and manages complaints relating to home care and residential aged care, including complaints about transition care delivered in a residential aged care facility. |
| AGED CARE PRINCIPLES                                                 | The Aged Care Principles are the subordinate legislation of the Aged Care Act 1997.                                                                 |
| APPROVED PROVIDER                                                    | Approved provider means a person or body in respect of which an approval under Part 2.1 of the Aged Care Act 1997 (the Act) is in force, and, to the extent provided for in section 8-6 of the Act, includes any state or territory, authority of a state or territory or local government authority.  
Schedule 1 of the Aged Care Act 1997 |
| AUSTRALIAN PRIVACY PRINCIPLES                                        | The Australian Privacy Principles took effect from 12 March 2014 as a result of changes to the Privacy Act 1988 (Cth). These new principles relate to the National Privacy Principles (NPPs) and the Information Privacy Principles (IPPs) (except for ACT agencies who continue to be covered by the IPPs). The APPs:  
• deal with all stages of the processing of personal information, setting out standards for the collection, use disclosure, quality and security of personal information; and  
• provide obligations on agencies and organisations subject to the Privacy Act (1988) concerning access to, and correction of, an individual’s own personal information. |
| CARE PLAN                                                            | A plan developed by the transition care service provider in consultation with the care recipient. The care plan describes the goals of transition care agreed with the care recipient, the type of services to be provided, the frequency and hours of actual service provision, the location at which the service will be provided and the respective responsibilities of the service agency, its staff and the care recipient. The care plan for transition care should be informed by the hospital geriatric rehabilitation service and the ACAT. |
| CARE RECIPIENT                                                       | A person receiving transition care services.                                                                                          |
| CARER                                                               | Carers can include family members, next of kin, friends or neighbours who have been identified as providing regular and sustained care and assistance to the care recipient. Carers frequently live with the person for whom they are caring. A carer may also be the care recipient’s advocate.  
2014, Transition Care Training Handbook for Aged Care Assessment Teams |
<p>| COMMONWEALTH HOME AND COMMUNITY CARE (HACC) PROGRAMME               | The Commonwealth Home and Community Care (HACC) Programme provides services that support older people to stay at home and be more independent in the community. This programme differs from Home Care Packages in that it provides basic |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>maintenance, support and care services, while Home Care Packages provide for people with more complex care needs that require an ongoing level of case management.</td>
<td>DEMENTIA  Dementia is an umbrella term describing a syndrome associated with more than 100 different diseases that are characterised by the impairment of brain functions, including language, memory, perception, personality and cognitive skills. Although the type and severity of symptoms and their pattern of development varies with the type of dementia, it is usually of gradual onset, progressive in nature and irreversible.</td>
</tr>
<tr>
<td>DEPARTMENT</td>
<td>The Australian Government Department of Health</td>
</tr>
<tr>
<td>FLEXIBLE CARE</td>
<td>Flexible care means care provided in a residential or community setting through an aged care service that addresses the needs of care recipients in alternative ways to the care provided through residential care services and home care services.</td>
</tr>
<tr>
<td>Section 49-3 of the Aged Care Act 1997 and Part 3.3 of the Aged Care (Transitional Provisions) Act 1997</td>
<td>FLEXIBLE CARE SUBSIDY  Flexible care subsidy is a payment by the Australian Government to approved providers for providing flexible care to care recipients. Further information on flexible care subsidy is included in Part 3.3 of the Aged Care Act 1997 and the Subsidy Principles 2014 of the Aged Care Principles.</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HOME CARE PACKAGE</td>
<td>A Home Care Package is a coordinated package of services tailored to meet a person’s specific care needs. The package is coordinated by an approved home care provider, with funding provided by the Australian Government. A range of services can be provided under a Home Care Package, including care services, support services, clinical services and other services to support a person living at home.</td>
</tr>
<tr>
<td>HOME-LIKE ENVIRONMENT</td>
<td>Providers of residential based transition care services are expected to provide services that reflect the intent of the transition care programme and meet the following criteria for a more home-like environment (see Transition Care Programme Quality Standards at Attachment C). Residential transition care services are provided in a more home-like, less institutional setting, with the setting including:  • communal living space / living room environment completely separate from sleeping areas and location of acute/subacute care provision, i.e. a space that encourages family/carers and visitors to spend time with care recipients;  • a dining area so care recipients are encouraged not to eat in bed;  • care recipients being encouraged and supported to dress every day;  • facilities to prepare snacks etc by the care recipient themselves or visitors;  • privacy particularly for personal care and bathing arrangements;  • space for care recipients to mobilise especially outdoors;  (cont.)  • a model of care and staff knowledge that supports the intent of the transition care programme to promote the care recipient’s health and independence. Transition care services may also be provided in rural and remote hospitals where appropriate. The requirements for the more home-</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>IN-PATIENT HOSPITAL EPISODE</strong></td>
<td>In relation to a care recipient, means a continuous period during which the care recipient:</td>
</tr>
<tr>
<td></td>
<td>(a) is an in-patient of a hospital; and</td>
</tr>
<tr>
<td></td>
<td>(b) is provided with acute care or subacute care or both.</td>
</tr>
<tr>
<td>Section 4 Definitions of the <em>Subsidy Principles 2014</em></td>
<td></td>
</tr>
<tr>
<td><strong>LOW INTENSITY THERAPY</strong></td>
<td>In relation to a care recipient, means therapy that:</td>
</tr>
<tr>
<td></td>
<td>(a) maintains the care recipient’s physical and cognitive functioning; and</td>
</tr>
<tr>
<td></td>
<td>(b) facilitates an improvement in the care recipient’s capacity in respect of activities of daily living.</td>
</tr>
<tr>
<td>Examples</td>
<td>1. Occupational therapy.</td>
</tr>
<tr>
<td></td>
<td>2. Physiotherapy.</td>
</tr>
<tr>
<td></td>
<td>3. Social work.</td>
</tr>
<tr>
<td>Section 4 Definitions of the <em>Subsidy Principles 2014</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The therapy services that transition care service providers must be able to provide, if required by a care recipient, are detailed under item 3.4 Therapy services of <em>Schedule 1: Specified care and services for transition care services</em> at <em>Attachment B</em>.</td>
</tr>
<tr>
<td><strong>MINISTER</strong></td>
<td>The Federal Government Minister with portfolio responsibility for Ageing.</td>
</tr>
<tr>
<td><strong>OLDER PEOPLE</strong></td>
<td>For the purposes of aged care planning, older people are regarded as those aged 70 years and over or 50 years and over if Aboriginal and Torres Strait Islander people. The <em>Aged Care Act 1997</em> does not specify an age when a person becomes an aged person.</td>
</tr>
<tr>
<td><strong>REHABILITATION</strong></td>
<td>Rehabilitation, in the context of transition care, is a form of subacute care as outlined in section 4 of the <em>Subsidy Principles 2014</em> - see ‘Subacute Care’ below.</td>
</tr>
<tr>
<td></td>
<td>Transition care is not a substitute for rehabilitation and should only commence after completion of the care recipient’s rehabilitation care episode.</td>
</tr>
<tr>
<td><strong>REPRESENTATIVE</strong></td>
<td>Representative of a care recipient means:</td>
</tr>
<tr>
<td></td>
<td>(a) a person nominated by the care recipient as a person the care recipient wishes to participate in decisions relating to his or her care; or</td>
</tr>
<tr>
<td></td>
<td>(b) a *partner, carer, or *close relation of the care recipient; or **</td>
</tr>
<tr>
<td></td>
<td>(c) a person who holds an enduring power of attorney given by the care recipient to decide the health care and other kinds of personal services the care recipient is to receive; or</td>
</tr>
<tr>
<td></td>
<td>(d) a person appointed by a state or territory guardianship board (however described) to decide the health care and other kinds of personal services the care recipient is to receive.</td>
</tr>
<tr>
<td>Section 44-26B <em>Aged Care Act 1997</em></td>
<td></td>
</tr>
<tr>
<td><em>partner</em>, in relation to a person, means the other member of a couple of which the person is also a member.</td>
<td></td>
</tr>
<tr>
<td><em>carer</em> is a person who provides domestic services and support to a care recipient otherwise than for remuneration (whether from the care recipient or any other person) on a regular basis, but who may</td>
<td></td>
</tr>
</tbody>
</table>
**Term** | **Meaning**
---|---
be in receipt of a carer allowance or carer payment from the Australian Government.  
*close relation*, in relation to a person, means:  
(a) a parent of the person; or  
(b) a sister, brother, child or grandchild of the person; or  
(c) a person included in a class of persons specified in the *Subsidy Principles*.  
Section 44-11 of the *Aged Care Act 1997*

**RESIDENTIAL AGED CARE**  
Residential care is personal and/or nursing care that is provided to a person in a residential facility in which the person is also provided with accommodation that includes appropriate staffing, meals, cleaning services, as well as furnishings, furniture and equipment for the provision of that care and accommodation. However, residential care does not include care provided to a person in the person’s private home; care provided in a hospital or in a psychiatric facility; or care provided in a facility that primarily provides care to people who are not frail and aged.  
Section 41-3 of the *Aged Care Act 1997* and Section 41-3 of the *Aged Care (Transitional Provisions) Act 1997*

**SANCTIONS**  
Penalties may be imposed by the Secretary of the Department of Health under Part 4.4 of the *Aged Care Act 1997* on an approved provider for not complying with one or more of the responsibilities under Part 4.1, 4.2 or 4.3 and under Section 3-4 of the *Aged Care (Transitional Provisions) Act 1997*. Certain procedures must be followed for sanctions to be imposed.

**SECRETARY**  
The person filling, or temporarily filling, the position of Secretary of the Department with portfolio responsibility for Ageing.

**SPECIFIED CARE AND SERVICES FOR TRANSITION CARE SERVICES**  
Services to be provided for all transition care recipients who need them. They are listed at Attachment B.

**SUBACUTE CARE**  
Subacute care means medical or related care or services provided to a care recipient who is not in the acute phase of an illness. Examples include:  
1. Rehabilitation;  
2. Palliative care;  
3. Psychogeriatric care; and  
4. Geriatric evaluation and management.  
Section 15.3 of the *Flexible Care Subsidy Principles 1997*  
Note: To be eligible for transition care, a care recipient must have completed their acute and/or subacute episode of care.

**TRANSITION CARE**  
Transition care is a form of flexible care that:  
(a) is provided to a care recipient:  
   (i) at the conclusion of an in-patient hospital episode; and  
   (ii) in the form of a package of services that includes at least low intensity therapy and nursing support or personal care; and  
(b) can be characterised as:  
   (i) goal-oriented; and  
   (ii) time-limited; and  
   (iii) therapy-focused; and  
   (iv) targeted towards older people; and  
   (v) necessary to complete the care recipient’s
<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Term</td>
<td>Meaning</td>
</tr>
<tr>
<td>restorative process, optimise the care recipient’s functional capacity and assist the care recipient, and his or her family or carer (if any), to make long-term arrangements for his or her care.</td>
<td>Section 106 of the <em>Subsidy Principles 2014</em></td>
</tr>
<tr>
<td>TRANSITION CARE SERVICE</td>
<td>An aged care service operated by a state or territory government as the approved provider to deliver transition care. Some transition care services engage ‘transition care service providers’ (see below) for the delivery of transition care.</td>
</tr>
<tr>
<td>TRANSITION CARE SERVICE PROVIDER</td>
<td>An organisation engaged by the approved provider (state and territory governments) to deliver transition care.</td>
</tr>
<tr>
<td>TRANSITION CARE PAYMENT AGREEMENT</td>
<td>An agreement between the Australian Government and each state and territory government as the approved provider of transition care which details the arrangements for the payment of flexible care subsidy by the Australian Government to the approved provider.</td>
</tr>
<tr>
<td>TRANSITION CARE RECIPIENT AGREEMENT</td>
<td>An agreement between a transition care recipient and a transition care service provider which details services to be delivered by the service provider, charges payable by the care recipient to the service provider, external complaint mechanisms and how to access these and other arrangements.</td>
</tr>
</tbody>
</table>