What can I expect from being part of the Community Transition Care Program?

You will be discharged home from hospital and receive a visit at your home from one of our nursing staff and your appointed case manager the next day. These staff members will assess your health and care needs and establish a written care plan with you stating agreed goals and services to be provided. You may wish to have a family member or friend present during this visit.

Each clients' care plan is different and may include assistance to shower, assistance with cooking, cleaning and laundry, therapy services such as Physiotherapy, Occupational Therapy and/or Speech Pathology, nutrition management, social support and planning.

Your Case Manager will be responsible for coordinating the scheduling of these services. Your Case Manager will make contact with you weekly to discuss how you are progressing with your goals and make changes to your care plan as required such as decreasing services or adding additional services.

As you progress on the program and your long-term care needs can be identified your Case Manager will assist with establishing these supports and transition you from the program to new service providers.

What is expected of you?

Setting goals and participating

Before you commence with the program, you will be asked to set goals that you wish to achieve. These goals are important in planning and focusing your care and therapy and will be reviewed during your time on the program. We ask you to actively participate in the program and openly raise any concerns you may have with visiting staff or your Case Manager.

Staying Safe at Home

To ensure the safety of our staff in your home, we ask that pets are restrained, and your home is smoke free whilst staff are visiting. A home safety assessment will be conducted by staff during the first visit and advice provided by staff to improve your safety at home.

Program Operating Days/ Hours

Nursing services 7 days per week

8:00am - 4:30pm including public holidays.

Allied Health and Administrative Support (Monday-Friday) 8:00am - 4:30pm excluding public holidays.

Medical Services – clients' own General Practitioner upon appointment.

V3, Effective: 05/2023.

Review: 05/2025

Metro North Hospital and Health Service

Putting people first

Community Transition Care Program

A program of short-term care for the older person who after a hospital stay requires more time and support to improve their functioning and independence.

Community Transition Care Program

Phone: (07) 3631 7300

Queensland Government

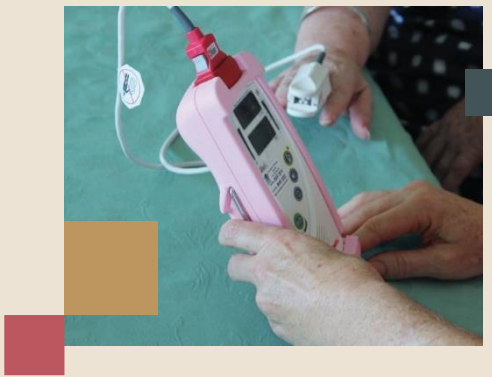
Program Overview

The Community Transition Care Program provides short-term care that seeks to optimise the functioning and independence of older people after a hospital stay. The program provides the necessary support and care in a clients' own home to restore their health and function and prevent the need for early admission to residential aged care.

The Program provides:

- Case Management – a designated health professional to coordinate care, establish support and services as well as coordinate a clients' discharge from the program
- Nursing care including showering assistance, wound care and medication management
- Therapy services delivered by Allied Health staff including Physiotherapy, Occupational Therapy, Speech Pathology, Dietetics, Social work and Pharmacy
- Medical management in collaboration with clients' General Practitioner
- Light domestic support if required
- Transport to essential medical appointments when no alternative arrangements can be made

There is a daily co-payment payable for participants of the program.



Frequently Asked Questions

How do I access this program?

A referral to the Aged Care Assessment Team for an eligibility assessment will be made by your hospital treating team.

Clients must commence the program directly upon discharge from hospital or a sub-acute (rehabilitation or geriatric) facility.

Why do I have to pay a co-payment to participate in the Program?

The program is not part of your hospital stay and is not funded as a Queensland Health public service. The Commonwealth Government subsidises this program.

All clients are required to pay a co-payment which has been set at 17.5% of the current single aged pension rate. (subject to commonwealth change bi-annually).

Those clients who face financial hardship may request a co-payment reduction. The request for a co-payment reduction must be supported by income and expenses information which is used to assess the request.

Is there anything else I have to pay for?

All clients are required to pay for their normal everyday living expenses.

Will someone come to visit every day?

How often staff visit, and which staff members visit, will depend on your care plan and the services and supports you require. For most clients this involves nursing and/or Allied Health staff visiting you at home every couple of days.

How long do most people stay on the Community Transition Care Program?

An estimated discharge date will be given to you when you start the program and reviewed with you and your Case Manager. Most clients remain on the program for about 5 to 7 weeks, while some may require the maximum 12 weeks based on their care needs and discharge plans.

Are there doctors in the Community Transition Care Program?

Medical Management is provided in collaboration with your General Practitioner. If there is a change in your medical condition, the client or nursing staff will contact the doctor and discuss the concerns. Those clients who are experiencing a significant health event will be transported to hospital.

What happens after I finish the program?

If you require ongoing supports such as domestic assistance, personal care assistance or further therapy, your Case Manager will organise referrals to other care providers for these services.