

Interim care options for aged people on discharge from an admitted acute care episode in a public hospital in WA (Updated March 2008)

Aged person is medically ready for discharge following admitted acute care episode

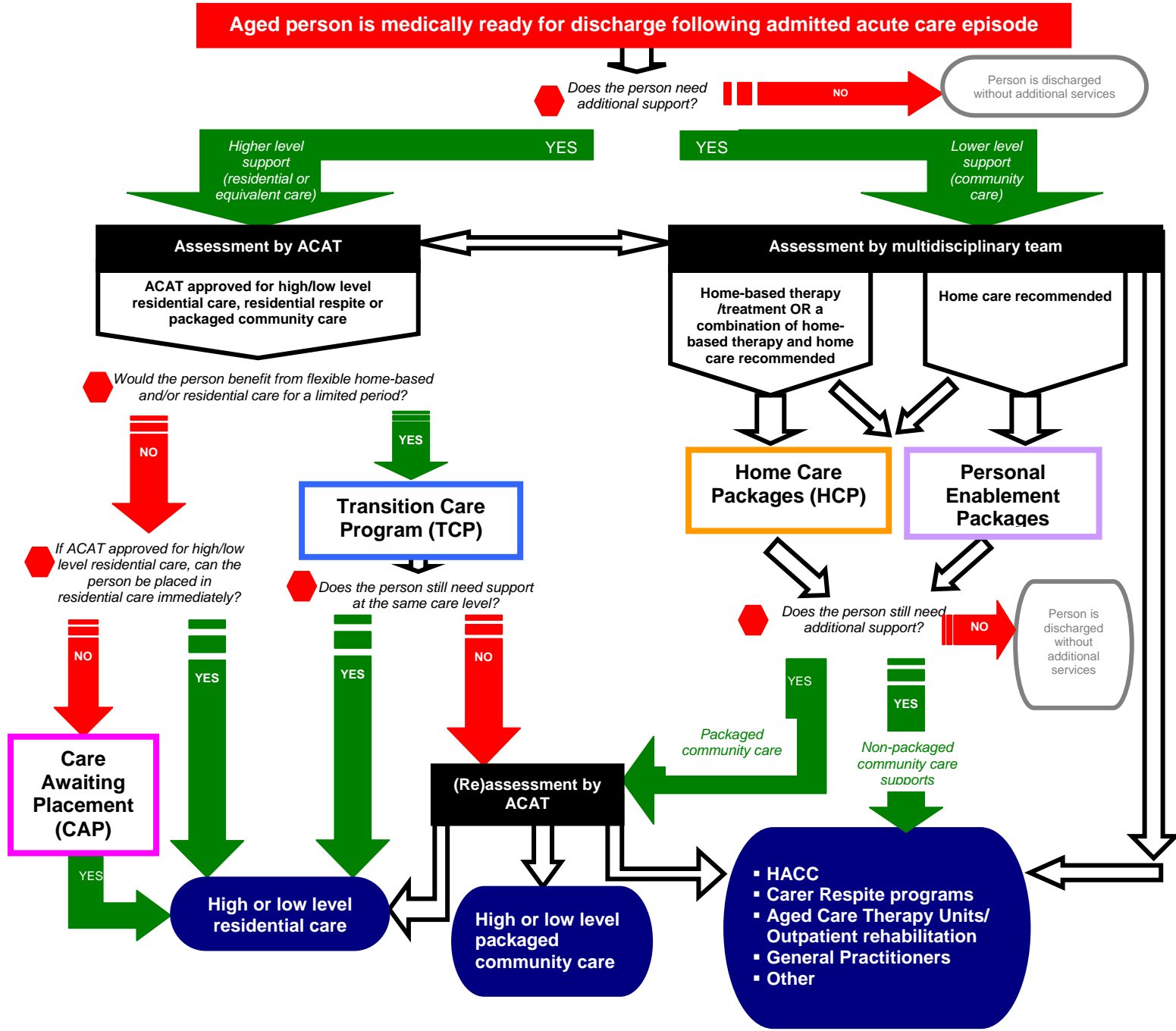
Does the person need additional support? **NO** → Person is discharged without additional services

- Care Awaiting Placement (CAP)**
- Residential
 - Person must be ACAT-assessed
 - Priority to patients in teaching hospitals
 - Not therapy or treatment based
 - Person must be waitlisted for at least 1 residential care homes
 - Timeframe: Up to 12 weeks

- Transition Care Program (TCP)**
- Residential and/or home based
 - Person must be ACAT-assessed
 - Person must be motivated to improve
 - Person must be assessed as having potential to benefit from service
 - Person suitable for GP management
 - Therapy/treatment based program
 - Timeframe: Up to 12 weeks

- Home Care Packages (HCP)**
- Home based
 - Person needs support to return to their own home
 - Person is assessed as having potential to improve level of functional independence
 - All other care options have been explored
 - May include treatment or therapy based service if required
 - May provide short term alternative for patients waiting for other services
 - Timeframe: Up to 8 weeks

- Enablement Packages**
- Home based
 - Person must be assessed as having potential to improve level of functional independence
 - Person must be HACC eligible (have long term functional disability)
 - Timeframe: Up to 8 weeks



Program	Care Awaiting Placement (CAP) Residential	Transition Care Program (TCP)	CAP Home Care Packages (HCP)	HACC Personal Enablement Packages (PEP)
Purpose	Temporarily accommodate and care for frail aged people who are waiting for permanent residential care. First priority is given to patients in teaching hospitals.	To maintain or return older people to their optimum level of independence following an acute episode through providing services in a residential setting or the client's home. Client must be approved and admitted directly following hospital discharge.	Facilitating earlier hospital discharge by providing short-term packages of care to support frail aged people to return to their own home. The packages can be used as an alternative for patients whilst waiting for other services.	Assist HACC eligible* clients to improve their health status and independence following discharge from an acute episode of care and thereby reducing dependence on community services.
Medically ready for discharge	Yes	Yes	Yes	Yes
ACAT assessment required	Yes	Yes	No	No
Type of care recommended &/or approved	Permanent Low or High residential care (ACCR required)	Approval for transition care needing at least permanent low level residential care (ACCR required)	Home based therapy and care services	Must be *HACC eligible and recommended for home care services
Treatment or therapy based	No	Yes	Yes (if required)	Yes (if required)
Residential or home based	Residential	Residential and/or home based	Home based	Home based
Additional requirements	Actively seeking a place in a residential aged care facility (refer CAP Operational Circular OD 0043/07)	Suitable for GP management; potential and motivation to improve or maintain their level of functioning, need more time to make long term care decision	Person assessed as having the potential to improve functional independence or at risk of premature readmission.	Person assessed as having potential to improve in functional independence
Target Time Frame	Up to 12 weeks	Up to 12 weeks (with possible extension to of 6 weeks with further ACAT approval)	Up to 8 weeks	Up to 8 weeks
Funded by	State only	State and Australian Govts	State only	State and Australian Govts

For more information about specific programs see Operational Circular OD 0043/07 or contact the Aged Care Policy Directorate.

*HACC eligibility: client must have an **ongoing** functional disability and live in the community.

ACCR: Aged Care Client Record

ACAT: Aged Care Assessment Team