SHORT-TERM RESTORATIVE CARE
FREQUENTLY ASKED QUESTIONS

1. What are the key differences between the STRC Programme and other programmes that offer ‘STRC like’ services?

While the STRC builds on the Transition Care Programme and has similarities to the Commonwealth Home Support Programme, the key differences between the programmes are that STRC services are:

- time-limited (up to eight weeks);
- accessible as a result of functional decline (not linked to a recent hospital admission) resulting in a client needing assistance for a short period of time;
- provided, in a home setting or residential care setting, or a combination of both, depending on the needs of the client; and
- aims to reverse or slow functional decline through a reablement and wellness focus.

In cases where the client has received Transition Care they cannot access STRC until 6 months has elapsed since discharge.

2. How will eligibility for STRC be determined for individual clients?

Any individual wishing to receive STRC will need to be referred for an Aged Care Assessment Team (ACAT) assessment through My Aged Care. The ACAT will conduct a comprehensive assessment of the individual’s physical, medical, psychological, cultural, social and restorative needs as well as their compliance with eligibility criteria, outlined in the Approval of Care Recipients Principles 2014. Each assessment will consider the client’s individual circumstances and needs.

3. Are clients currently receiving Commonwealth Home Support Programme (CHSP) able to receive STRC?

Yes. People receiving Commonwealth Home Support Programme (CHSP) services may be eligible for STRC services. The STRC service provider is expected to liaise with the STRC recipient’s current supports (including CHSP providers where applicable) to ensure care is coordinated with existing support/services.

However, as outlined in the CHSP Programme Manual1 ‘Commonwealth Home Support Programme services must not be provided to people who are already receiving other government-subsidised services that are similar to service types funded through the Commonwealth Home Support Programme’. Should both STRC and CHSP services be accessed, it is expected that they would not be similar but rather different and complementary.

4. Will STRC places be identified for special needs groups? Are veterans considered a special needs group?

STRC will not target specific special needs groups in the first round of competitive allocations. However, applicants can target particular special needs groups within their applications for STRC places. These will be considered by the Department as part of the comprehensive application assessment process. The Aged Care Act 1997 includes veterans in its definition of people with special needs. If the veteran is a former Prisoner of War (POW) or Victoria Cross (VC) recipient, DVA will pay the daily care fee component on their behalf.

5. Will STRC be offered to any individual experiencing functional decline or only those over the age of 65 years?

The Aged Care Act 1997 does not specify an age that a person becomes an aged person and eligible to receive aged care services. Any person who meets the eligibility criteria and is approved for STRC by an ACAT, irrespective of their age, may receive STRC.

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1 Commonwealth Home Support Programme, programme manual 2015, 3.1.1 General principles defining access to more than one programme.
6. What is the assessment of frailty and dementia - how would a person qualify if suffering these conditions?

While the programme is tailored to those clients who show evidence of functional decline access to STRC is made via an ACAT assessment. Part of the ACAT team’s role is to consider whether the client has cognitive difficulties, or behavioural problems related to such difficulties and/or the presence of depression or delirium, with specific regard to:

- evidence of verbal and physical aggressiveness and disruption, self-destructive behaviour, confusion and/or impaired judgement, reasoning or attention, and
- medical tests or investigations carried out by the client’s GP or medical specialist for a more detailed picture of their cognitive status.

Other psychosocial factors such as the person’s experience of loneliness, bereavement or loss of motivation, and their impact on cognitive functioning also need to be considered. It may be appropriate for the ACAT to refer the client for specialist psychogeriatric evaluation.

It is noted that ACATs should foster links with dementia specific services, including Dementia Behaviour Management Advisory Services (DBMAS), and where relevant, include this expertise in the assessment process. This will facilitate an understanding of the needs of ageing people with dementia and their carers and assist improved linkages, integrated care and access.

If a person is frail or suffers dementia and functional decline is evident, an Aged Care Assessment Team is best placed to determine which programme best meets the person’s needs.

7. Is MBI the most suitable form of assessment for determining functional decline?

An MBI assessment of itself doesn’t trigger payment but may trigger entry to the programme which, in turn, gives Providers access to payment.

The Royal Australian College of General Practitioners describe the Modified Barthel Index as "a simple to administer tool for assessing self-care and mobility activities of daily living. It is widely used in geriatric assessment settings. Reliability, validity and overall utility are rated as good to excellent. Information is gained from observation, self-report or informant report. It takes approximately 5/10 minutes to complete if the observational method is used.”

In using the MBI it is noted that:

1. When cognition impairment (e.g., memory, language, calculation) is becoming more severe, the functional performance of patients will be also affected. Thus, the assessment of function is an essential aspect of an assessment for dementia.
2. The index is useful in not only revealing the present disability of the patient but also estimating the capability of extension as well as determining when a patient will begin to need help.
3. Barthel Index should be applied periodically to monitor the disease progression and also revise the treatment plan. It aims to measure the degree of independence from any help, physical or verbal, however minor and for whatever reason.

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2 Source: Aged Care Assessment Programme Guidelines; Department of Social Services, May 2015; pages 22 and 23
3 Source: ibid page 30
Given its ease of use and relative accuracy, it would appear to be the most appropriate standard. It is also used in the Transition Care Programme.

8. **If you have received Transition Care in the last six months you are ineligible for STRC. Why does this exclusion exist?**

This exclusion exists to ensure that STRC and Transition Care remain two distinct, yet complementary programmes. Initially, there will be fewer STRC places than Transition Care places. It is therefore important that potential client are approved for the programme most appropriate to their needs; i.e. where a person can receive Transition Care, they should be approved for it and not STRC. In addition, unlike STRC, Transition Care episodes are able to be extended. Where a Transition Care client needs additional care after their Transition Care episode, this period of extension is more appropriate than an STRC approval.

A criterion requiring a timeframe of at least six months between programmes helps to differentiate access between them and ensures that members of the community are able to enter, or continue the programme that best suits their needs.

9. **As an older person currently occupying a place in a residential aged care facility cannot access STRC (as stated in the eligibility criteria), how can STRC be delivered in a residential aged care setting?**

There is a technical difference under the Act between the location of delivery and the allocation of a “place”.

The exclusion in the STRC eligibility criteria prevents an approved provider from claiming residential care subsidy and STRC subsidy with respect to the same client at the same time. It does not prevent an approved provider from delivering STRC in a residential care facility.

It is not intended that STRC will reduce access to the number of residential aged care places. Rather, STRC places are considered to be additional to other aged care places and an approved provider will need to demonstrate how they will source this additional capacity if they would like to be considered for STRC.

10. **What are the referral pathways for STRC?**

My Aged Care encourages a request for an ACAT from anyone who believes an assessment is necessary. In considering the client journey of STRC there are four main referral pathways:

1. a client is referred to My Aged Care by their geriatrician or usual GP who notices that they have progressive functional decline that could be stabilised by undertaking a short period of intense therapy;

2. the client’s carer (this can include family and friends who look after the client) may become aware of STRC through My Aged Care to support the person they care for, and may then contact My Aged Care for an ACAT assessment; or

3. the client is referred to a RAS for an assessment for another programme and the RAS identifies that a client requires a comprehensive assessment with an ACAT. The ACAT will determine the programme best suited to the client. That could include referral to STRC.

4. the client is referred to an ACAT for another type of care and the ACAT suggests the client would benefit from STRC.

11. **How does the My Aged Care waiting list differ from the Increasing Choices prioritisation queue?**

Through My Aged Care, service providers are able to manage their waitlists for particular services. When someone is approved for a certain care type, they are able to select their preferred service providers and choose their referral method (i.e. seeking services from one provider, or a number of providers in the region). My Aged Care contact centre, RAS and ACAT staff can issue referrals for services for the client. Once this has occurred, service providers can accept the referral, reject the referral, or place them on a waitlist. This allows each service to
maintain a waitlist in line with their own business processes relating to resident admissions. There can be significant variation in the waiting periods for packages across Australia with no systematic way of measuring or addressing the variation.

From 27 February 2017, as part of the Increasing Choice in Home Care initiative, there will be a national system to manage eligible consumers’ access to packages within My Aged Care called the prioritization queue. In the new system, clients will be placed on a national queue when they have been approved for home care. A client’s position on the queue will be dependent on:

- Their relative needs and circumstances as determined through the comprehensive assessment undertaken by an Aged Care Assessment Team (ACAT); and
- The time that a person has been waiting for care

Once a consumer reaches the front of the national queue, they will be assigned a home care package which they can use to receive care from a provider of their choice.

12. Will there be a waitlist for STRC services?

Unlike the Increasing Choice in Home Care initiative, there will not be a national waitlist for STRC services. My Aged Care will refer potential clients to a STRC service provider in their area. It is possible that some STRC service providers will maintain their own waitlist for STRC services, but they are not required to do so.

There are situations where the use of a provider waitlist may be helpful to providers and clients, such as where a client has been referred for STRC and a preferred provider expects a place to become available shortly.

This however is a business decision for the approved provider in determining how they manage through-put of clients receiving STRC.

13. What procedures are in place to avoid further functional decline to recipients waiting for placement?

Under the Aged Care Assessment Programme Guidelines, ‘Placement of a person on a waiting list is not considered an effective referral to a programme, as the client will not receive care or services in this time period’. If approved care is not available (STRC in this instance) the ACAT may arrange alternative options such as the provision of Commonwealth Home Support Programme services (HACC services in WA) in the interim to ensure further functional decline does not occur whilst waiting for placement.

Alternatively, if the recipient’s ACAT approval allows for it, the recipient may choose to commence a home care package or residential care, noting that this will make them ineligible to receive STRC.

14. Will STRC increase ACAT responsibility, workload and assessment time?

The Department does not anticipate a noticeable increase in ACAT workloads due to STRC because:

1. the initial rollout will only include a small number of places (475) in the first two years of operation, with this number reaching 2000 by 2021;

2. one of the eligibility criteria for STRC is that without STRC the person will need ongoing care through a home care package or residential care. This means that people that would be referred to an ACAT for STRC would already be being referred to an ACAT for a home care package or residential care.

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8 Aged Care Assessment Programme Guidelines for assessors; 5.1.3 ‘Care Coordination to the Point of Effective Referral’
15. What is the exact role of the ACAT in care coordination?

As outlined in the ACAP Guidelines, there are three core activities that are critical to an ACAT comprehensive assessment:

1. initial client assessment and needs identification;
2. development of a support plan, which details the types of services recommended to support the client; and
3. care coordination to the point of effective referral.

STRC does not change the role or focus of ACAT comprehensive assessments.

16. What will happen during an episode of care if the STRC recipient’s care needs change?

STRC is an intensive package of services that supports clients in their home, in a residential care facility or a combination of both, depending upon their needs for up to eight weeks. It is the responsibility of service providers to transition recipients between these settings, as the recipient’s needs change. The client may exit the programme at any time.

If clients feel that they need different services while they are receiving STRC, they should:

1. think about other types of services that could meet their needs so that they can be included in their care plan; and
2. talk with their STRC service provider about changing their care plan to meet their needs.

If a hospital admission for a day procedure or for an overnight stay is required, the service provider must provide STRC up to the point of admission and then again from the point of discharge on the same day or the next day. There is therefore no break in the service episode and the approved provider’s subsidy for the episode of care continues.

17. What services can form the multidisciplinary team?

Care services to be offered as part of the multidisciplinary team can include anything in the specified care and services tables in the Quality of Care Principles 2014. This can include nursing support, particularly in a residential setting. Other allied health services that may be provided include, but are not limited to: physiotherapy, speech therapy, podiatry, dietetics, chiropractic services, occupational therapy, exercise physiology, psychology or counselling support, and therapy.

Unlike residential care, where individuals on a lower level of care only have access to a restricted list of services without extra payment, all recipients of STRC have access to all services in their care plan. The provider and recipient should agree on what services will be delivered with the subsidy and in line with the care plan.

18. Is a multidisciplinary team too intrusive?

The aim of the Short Term Restorative Care Programme is to:

- Support clients to regain their ability to carry out activities of daily life after an assessment.
- Help clients to manage new or changing health conditions.
- Provide assistance to clients so that they can live as independently as possible.

While noting that the client always has the right to refuse access, for them to achieve their goals a partnership between the multidisciplinary team, the client and their support (family and/or friend) is required. The support of the multidisciplinary team can be provided in a physical setting or a virtual one (using tele Health for example) at times that are mutually acceptable to all parties.

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9 ibid
10 Quality of Care Principles 2014, Schedule 1 and 3, ‘Care and Services for residential care services’ and ‘Care and services for home care services’
19. How will the services and health professionals as part of the multidisciplinary team be paid/ funded?

STRC service providers are responsible for providing a broad range of services tailored to meet the client's therapeutic goals to improve or maintain function. This includes payment of the care providers who form the multidisciplinary team.

The amount paid for the care services will be a business decision determined by the service provider using the flexible care subsidy and any client fees collected. In some circumstances, this may include a sub contract or other engagement with outside services. As care delivery is the primary focus of STRC, payment of service providers and members of the multidisciplinary team will need to account for a significant portion of the subsidy payment.

However, whilst the services of medical clinicians are integral to the delivery of STRC, STRC funding must not be used to pay for services that may be claimed through the Medicare Benefits Schedule (http://www.mbsonline.gov.au), or pharmaceutical goods covered by the Pharmaceutical Benefits Scheme (http://www.pbs.gov.au).

These aspects of the client’s care plan must be paid for by the client, with client care fees, or (where appropriate) claimed through Medicare under the Medicare Benefits Schedule.

20. How will service providers manage costs?

The focus of STRC is on ensuring the programme is to reverse and/or slow ‘functional decline’ in older people and improve wellbeing through the delivery of a time-limited (up to 56 paid days), goal-oriented, multidisciplinary and coordinated range of services designed for, and approved by, the client. The cost of providing services – including managing the co-ordination of them – is a matter for providers. The care agreement made with the client is required to be transparent on the issue of fees and the costs of the care/services provided.

The programme allows providers to charge a fee above the subsidised amount to meet any additional costs.

Note: the restriction on the amounts that can be charged above the subsidised amount are:

- For STRC delivered in a residential setting, the maximum value of the care fee is 85% of the basic daily rate of the single pension.
- For STRC delivered in the home, 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 clients.

If a client transitions between residential and home settings the maximum care fee charged is determined by where they will stay overnight (sleep that evening). For example if they will sleep in a residential facility, the maximum is 85% that day. If they will sleep in a home setting, it is 17.5%.

If a client leaves the programme, providers will be funded up to the client’s point of exit.

To assist with transparency, providers are required to show clearly the cost of services and the cost of administration in the care agreement with the client.

21. Are Medicare benefits payable for services delivered in accordance with a client’s STRC care plan? Would the health professional be able to ‘bulk bill’? What about services not directly relating to the care plan (that is, they relate more to their general ongoing care)?

See Question 19 above.
22. Can a person who chooses to stay on the National Disability Insurance Scheme (NDIS) be eligible for STRC?

As STRC is a time-limited flexible care programme, an episode of STRC will not make the person ineligible to receive NDIS services. Conversely, receipt of NDIS services will not prevent an otherwise eligible person from receiving STRC services. There is an expectation in both the scheme and the STRC Programme that care be coordinated with other services.

23. Can I use telehealth or remote monitoring services?

As part of the multidisciplinary approach to care, providers can use telehealth or remote monitoring services where it is clinically appropriate and relevant to address the needs identified in the care plan.

If telehealth or remote monitoring services are used, approved providers will need to ensure that appropriate support is available for these services, including technical supports and staffing/nursing support on the patient-end of a videoconferencing service.

24. Given that no extensions are available, what happens to clients at the end of an episode of STRC if they need ongoing support? Who is responsible for this?

The STRC service provider must have systems in place to support the STRC recipient in the event that the recipient has not been able to meet the objectives of the programme and requires ongoing care. The approved provider must provide assistance to clients in finalising and obtaining access to their longer-term arrangements.

Where the client requires ongoing care, the service provider is obliged to refer them back to My Aged Care for re-assessment or referral to the supports they need. The STRC service provider must provide documentation to the client specifying:
- the length of stay in the STRC episode,
- details or a reassessment arranged for the recipient,
- goals which the client agrees have or have not been achieved,
- the recipients functional level on discharge, using the Modified Barthel Index score,
- client and/or representative, carer and family education and support to improve function,
- services and equipment, as well as key contacts to be provided to the recipient after STRC,
- an up to date list of prescribed medications, and
- other follow up arrangements/referrals, which are the responsibility of the client or their representative.

It should be noted that to be eligible to receive STRC, a person must be on the verge of needing other subsidised forms of aged care. Consequently, when a person is approved for STRC, it is likely that they will also be approved by the ACAT delegate to receive other types of care/services as an alternative. In such instances, the STRC recipient could be referred directly to the other services during or after their STRC episode without the need for another ACAT assessment.

25. What happens to unspent funds? Is there a policy similar to that of the Increasing Choice in Home Care Initiative?

Unlike home care packages under the Increasing Choice in Home Care Initiative, funds will not follow the consumer. Given that the programme provides time-limited services, there is no option for any unspent funds to be rolled over to be used at a later date or into another episode of care. Client care fee contributions and subsidy are only paid for days that are covered by a care plan and it is expected that fees and subsidy will be directed towards delivering the care the client needs (including the administration costs associated with delivering this care).

26. When will providers be paid?

STRC builds on the success of the Transition Care programme in that STRC approved providers will be paid in a monthly advance cycle. Like the Transition Care Programme, there are provisions for overpayments (which differ from unspent funds). More information is available at https://agedcare.health.gov.au/for-providers/guidance-for-providers/the-claim-and-advance-payment-cycle-information-for-transition-care-providers
27. Can STRC providers spend subsidy received for care delivery on one day, on delivering care for the same client on a different day?

Yes. Each client’s care plan is tailored to the client’s needs. These needs may be best met by higher value services that cannot be covered by a single day’s subsidy/care fee. In such instances, the STRC provider can spend subsidy claimed against multiple days for care delivery on one day.

28. Can STRC providers claim subsidy for a day on which a service has not been provided to a client?

STRC providers can claim subsidy for a client for days that are covered by a care plan. This care plan does not need to have services delivered on every day covered by it. All subsidy and client fees however must go towards covering the cost of care and services being delivered.

29. Can only residential care providers access STRC funding?

No. A single care delivery setting is not specified. STRC places can be delivered in the home, the community, or in a residential care facility. However, STRC providers are expected to be able to deliver care that meets the needs of clients, and access to residential care (or similar care) may be important for meeting the needs of some clients.

Where STRC is delivered in a residential care setting, it is not intended that STRC will reduce access to the number of residential aged care places. STRC places are considered additional to other aged care places, and service providers must identify how they will provide these places upon application.

30. Will consortia be considered as eligible to apply for STRC places in the competitive process?

Consortia may apply for STRC places. All proposed business models will be assessed on their merits in the competitive application process. However, places will need to be allocated to the one approved provider who will be accountable for the services. The application will need to identify how the consortia model will work. It is not intended that STRC will reduce access to the number of residential aged care places.

31. Are STRC service providers able to take unused residential care places “offline” to meet the residential care needs of STRC recipients?

Applicants seeking STRC places will be expected to make business decisions on the service delivery model they propose to implement, including how they will source the additional capacity required for STRC delivery.

Providers should be mindful of the Department’s current policy on operationalising existing places and the moves that it has been making to ensure that places that remain non-operational for unreasonable periods of time are revoked and reallocated to areas of need.

32. Given that the Department is moving towards allocating care places to recipients rather than providers (Increasing Choice) why is STRC allocating places through an ACAR?

The model of allocating places to clients as opposed to providers is being implemented for home care packages in February 2017 through the Increasing Choice in Home Care initiative. This will involve a significant period of change management for the sector.

STRC is a flexible care programme, and governed by the flexible care provisions of the Act. The Act sets out requirements for allocating flexible care places, and STRC places will be allocated in line with those requirements. As there will initially be a small number of places available, targeting service provision is considered the most effective approach. As well as this small number of places, there will also be a high turnover of clients based on the short timeframe of the programme (56 days). Assigning places to the recipient would limit a provider’s capacity to build the skills and staffing requirements that will be needed to provide the services.