# Module 5 - Support at Home - Care Management

## About

This Support at Home module gives providers a comprehensive understanding of how care management operates within the Support at Home program.

The department reserves the right to change or add supplementary information to this training.

## Duration

This course will take approximately **30 minutes** to complete. You can access the learning resources at any time.

## Start

Select **Start course** above or **select a specific lesson below** to begin.

- **Welcome**
- **Care management introduction**
- **Role of the Care Partner**
- **Provider Care Management Account**

 **Care Management Claiming**

 **Knowledge check**

 **Helpful resources**

 **Course wrap-up**

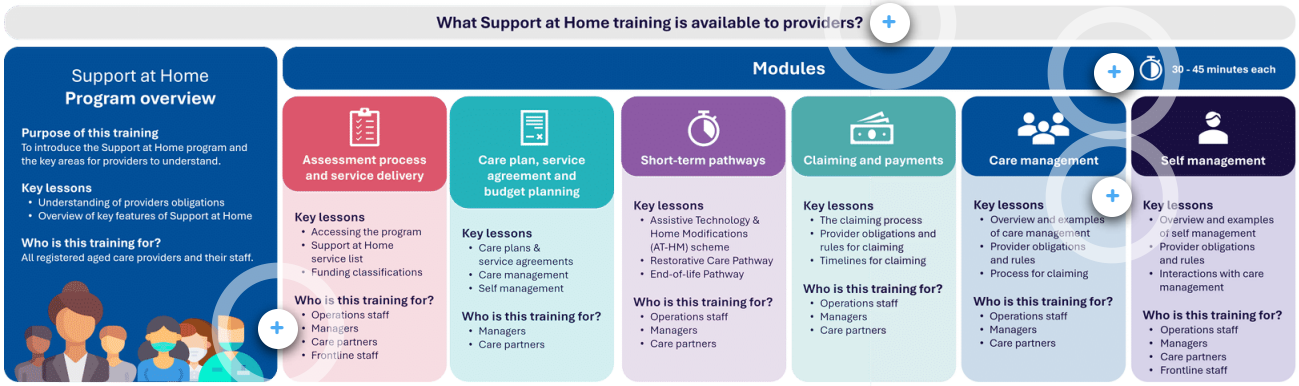
*Lesson 1 of 8*

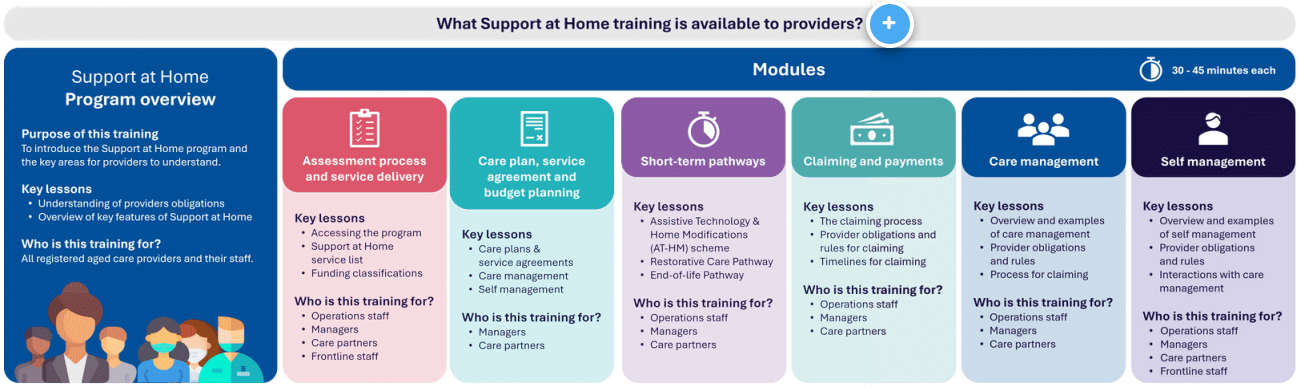
# Welcome

*The Department of Health, Disability and Ageing acknowledges and pays respect to the Traditional Owners and Custodians of the lands throughout Australia. We recognise the strength and resilience of Aboriginal and Torres Strait Islander people, and their continuing connections to land, sea and community. We pay our respects to Elders past, present and emerging. We also extend our respects to any Aboriginal and Torres Strait Islander people participating in this learning.*

*Aboriginal and Torres Strait Islander people should be aware that this training may contain images of deceased persons in photographs.*

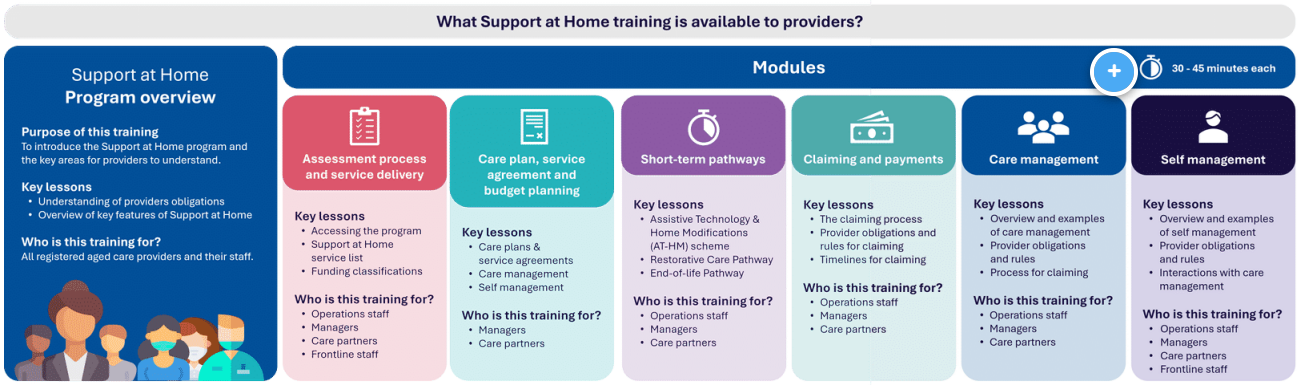
The diagram below provides an overview of the Support at Home training modules available.





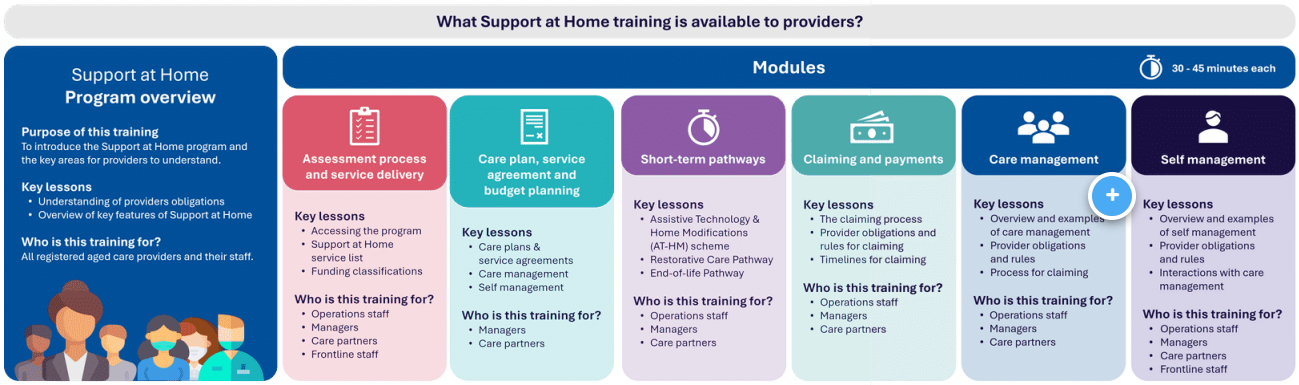

### Is this training mandatory?

No, but this training is strongly recommended. This training will help providers understand the Support at Home program prior to the changes taking effect when Support at Home commences.




## How long will it take to complete this training?

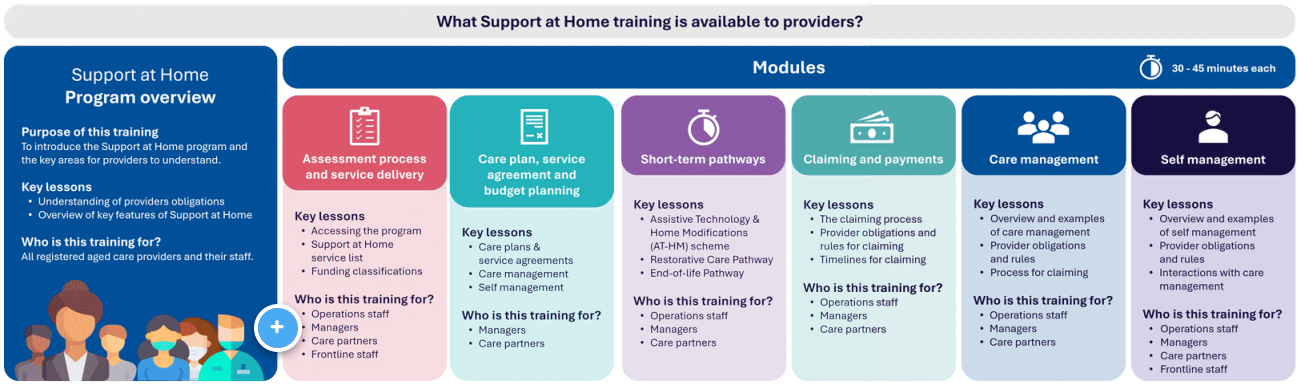
About 30 minutes.




## Purpose of this training

This training supports providers to deliver government-funded aged care services.

This training will cover the Support at Home short-term pathways and their relevant funding classifications.




## Who is this training for?

This training has been developed for all registered aged care providers and their staff.

This module may be more relevant to operations staff, managers and care partners within provider organisations. This includes staff members who need a comprehensive understanding of the services and funding under Support at Home.

This training may also be relevant to other groups such as independent aged care advocates and third-party providers.

### Accessibility

This training has been developed to meet accessibility standards. Learners who are using assistive technologies (such as Job Access with Speech) will also be able to complete the training.

The department is committed to inclusion, and we are aware that each of us experience inclusion differently. Please let us know what we can do to make this course accessible and inclusive for you. If you would like to request a different reasonable adjustment or to provide accessibility feedback please email learning.and.capability@health.gov.au.

NEXT LESSON: CARE MANAGEMENT INTRODUCTION

# Care management introduction

**Care Management is the term used to describe the suite of activities delivered by providers to support the safety, wellbeing and quality of life of older people.**

**This includes planning, reviewing and monitoring care and service delivery with the participant.**

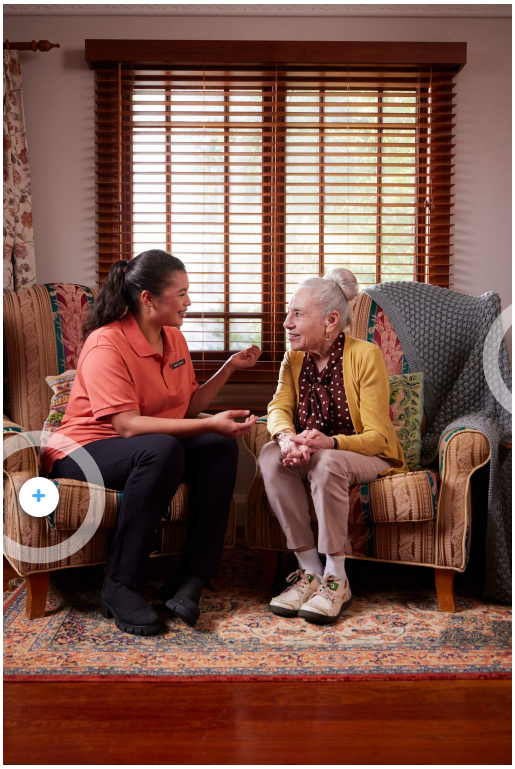
Care management is delivered by a **Care Partner** who works with the participant, their registered supporter and carers to engage and empower the older person to understand and connect fully with their available funded aged care services.

## The Support at Home program, including the three short-term pathways, aim to:

- support the participant to remain independent in their own home for longer
- maintain function
- reduce or prevent decline
- delay the entry into higher levels of care

**The delivery of effective and efficient care management is central to achieving this outcome.**

Providers are required to **deliver care management services to all older people in Support at Home**. This includes older people who self-manage their services. Click on the + signs below for more detail.

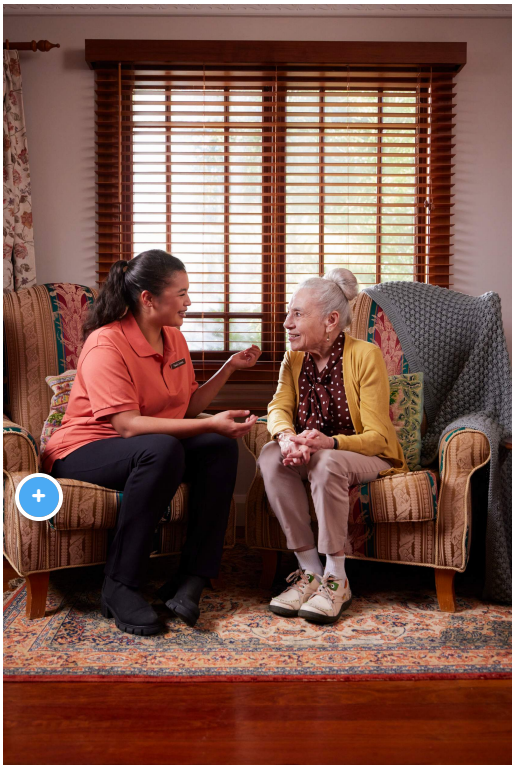


**Collaborative relationship**

Care management starts with the provider establishing a collaborative relationship with the older person.

**Understanding needs**

This collaboration will ensure that the provider understands the older persons needs and preferences when exploring the care and services to be implemented.



**Budget allocation**

Participants receiving ongoing services will have 10% of their quarterly budget allocated to the provider’s care management account.

Providers can use the care management account to claim for care management activities for ongoing services

## Care management activities

Click the below boxes to explore examples of care management activities that can be claimed by providers

Thumbnail

## Learn more about care management

Image of a magnifying glass

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- View Chapter 8 of the Support at Home Program Manual

NEXT LESSON: ROLE OF THE CARE PARTNER

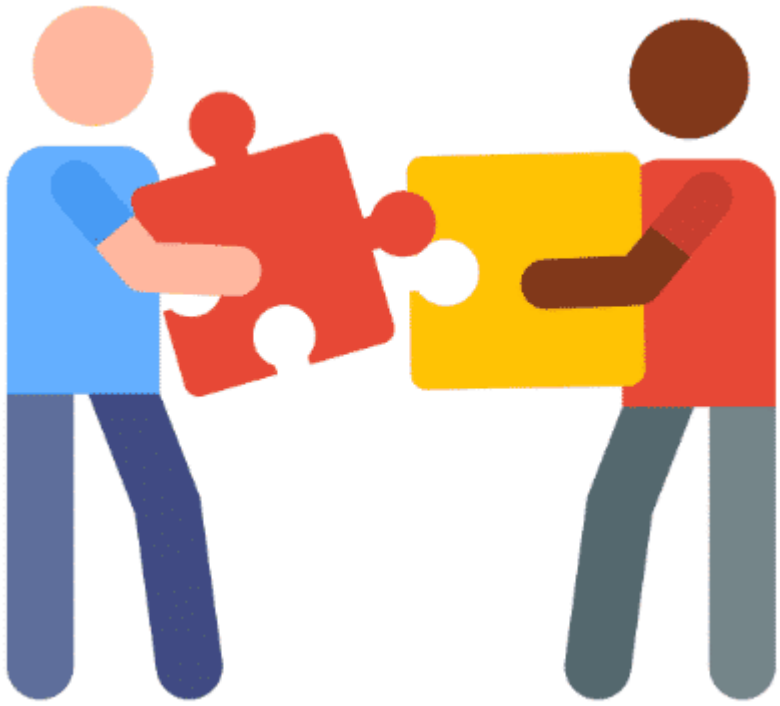
# Role of the Care Partner

**Care management is delivered by providers through a staff member known as a Care Partner.**

**Care partners** are an essential connection between the Support at Home program, the provider organisation, the older person, their registered supporters, family and carers.

They build an **enduring relationship** with the older person and work to empower them to achieve their goals.

They **work with** the older person to **coordinate** and **organise** their services and care.

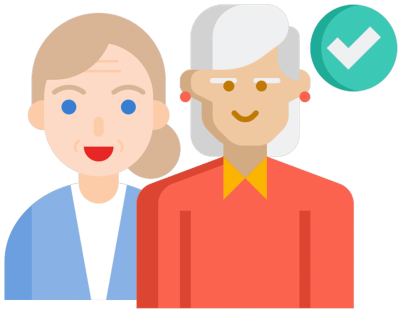


Care Partner

Effective **communication** between a participant and their care partner is essential.

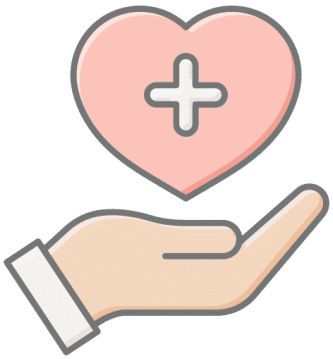
Care partners work with the older person and their support network to understand and interpret the information in the Notice of Decision and support plan.

### Focus of Care Partner Role



Empowering and encouraging the participant to be involved and engaged with their care.

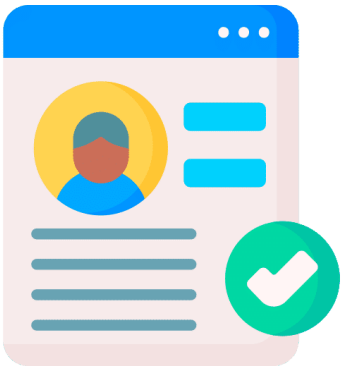
Ensure the participant understands the Support at Home Program, the 10% care management allocation, the quarterly budget breakdown and any participant contribution components that may be applicable.



Discuss the provider obligations and the care management activities that must be delivered both monthly and annually.

Agree with the participant the frequency and mode of contact.
This must be monthly, at minimum.
Explain the difference between activities that are direct or indirect care management.

Direct care management must be delivered at least once per month and this should be of at least 15 minutes.



Determine the process for reviewing the service delivery arrangements and care plan.
Discuss triggers for reviews such as when requested by the participant or if needs

## Who can be a care partner?

Care partners are appropriately trained and experienced aged care workers. While there are no mandatory qualifications or professional registrations, required, the following list of

qualifications may be useful for providers to consider when developing their care partner workforce.

| Non-clinical care partner | Clinically qualified care partner |
| --- | --- |
| Certificate III in Individual Support (Ageing) | To be known as a clinically qualified care partner, the individual must hold a university-level qualification in a relevant health-related discipline such as: |
| Certificate III Health Services Assistance | Bachelor of Social Work |
| Certificate IV in Aged Care | Bachelor of Physiotherapy |
| Certificate IV in Disability | Bachelor of Nursing |
| Certificate IV in Community Services | |

Diploma of Community Services (Case Management)

Diploma of Ageing Studies and Services

## Care partner teams

Providers may choose to employ care partners with a range of qualifications to implement a team-based approach to care management. A team-based approach can help providers respond and support a diverse range of participants needs.

Clinically qualified care partners may focus on supporting the more clinically complex needs of higher classification or End-of-Life Pathway participants. Non-clinical care partners are able to provide more generalist support to participants with less complex needs.

The role of a care partner and/or a clinically qualified care partner should be outlined in the provider's clinical governance framework in compliance with the Strengthened Quality Standards Guidance.

**Participants can choose to self-manage their own aged care services.**

- Self-management is where an older person, their registered supporter, family or carer chooses to manage their own care services. They can make decisions about

their services, budget and workers, based on their approved services in their notice of decision and support plan in collaboration with their provider.

- Providers must provide care management to all participants, regardless of the activities a self-managed participant is undertaking themselves. This ensures the provider can provide oversight of quality, safety, governance and compliance requirements.
- Self-managed participants receiving ongoing services will have 10% of their quarterly budget deducted for care management. This funding is allocated to the provider's care management account and is pooled together with the care management funding from other participants.

**Learn more about care partners and self-management**

- For care partners view Chapter 8.5

- For self-management view Chapter 11

NEXT LESSON: PROVIDER CARE MANAGEMENT ACCOUNT

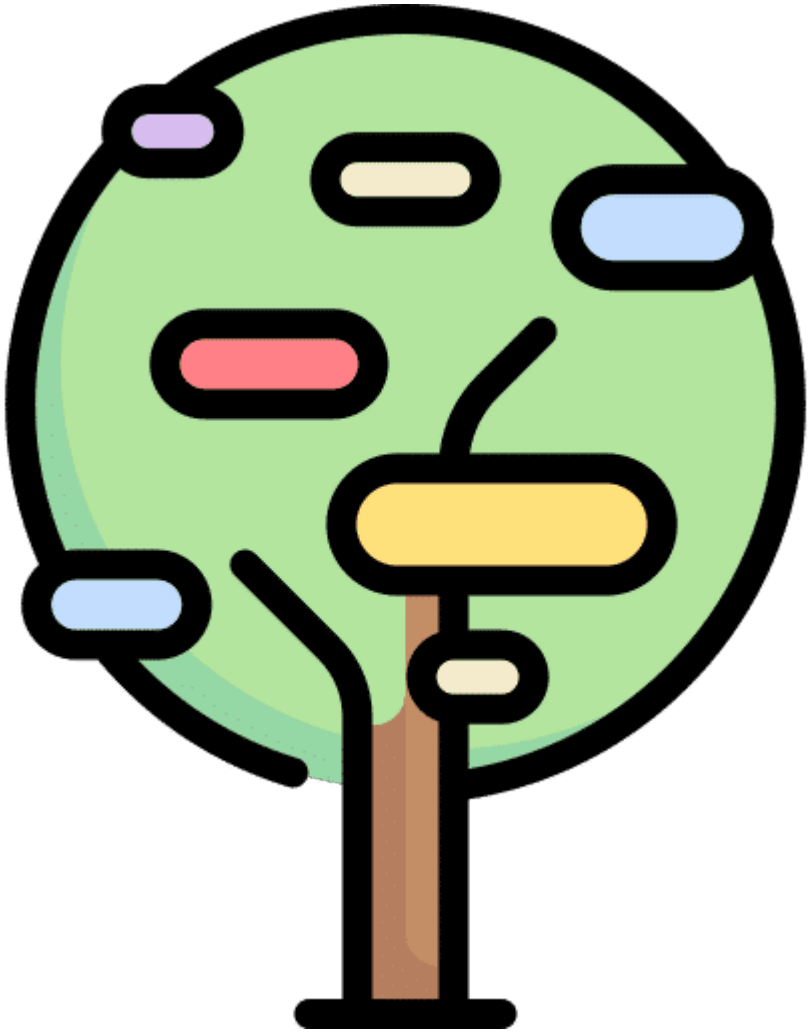
# Provider Care Management Account

Participants who receive ongoing services will have 10% of their quarterly budget deducted for care management.

This funding will be allocated to providers and pooled together with the care management funding from all other participants within a **service delivery branch.**

A **service delivery branch** is the place of business of the registered provider through which funded aged care services are delivered to an individual.

This care management account is held and managed by **Services Australia**.



Service Delivery Branch

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**All participants** must be connected to a service delivery branch.

The funding in the care management account can be used for any participant connected to the service delivery branch.

The amount of care management funding for each quarter **is variable.** It is based on the **number** of participants and the **classification** of each

**participant connected to a service delivery branch.**

Providers will be responsible for managing the available care management funding across the participants in the service delivery branch.

Detailed examples of the management of pooled care management funding can be found at Managing participants with pooled care management funding.

Funding

## Care Management in Short Term Pathways

Care management is delivered to all participants in Support at Home, including those accessing short term pathways.

Care management services delivered under the Restorative Care Pathway and End-of-Life Pathway are claimed directly from the respective budget, rather than from the care management account

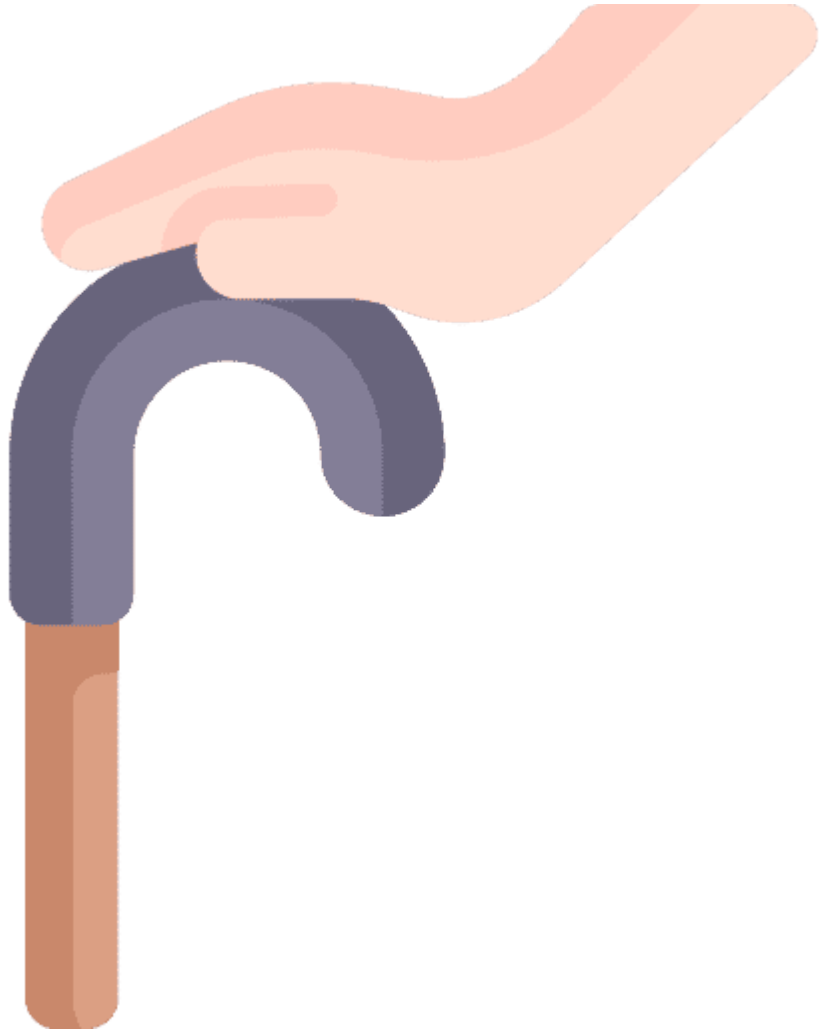
More detail on short term pathways can be found in Module 3 - Support at home - short-term pathways and in Part D of the Support at Home program manual.

**Assistive Technology - Home Modifications (AT-HM)**

Providers may use their **care management** funding to cover the broader care planning and service **planning discussions** with the older person on how AT-HM funding may be used.

This includes engaging with any relevant professionals about the participant's service needs.

The **cost** that the provider incurs to **source** the **equipment, products** and **home modifications** that their participant needs is **drawn from their AT-HM funding**. These cannot be claimed from the care management pooled funding.



**Restorative Care Pathway**

- Older people receiving services through the Restorative Care Pathway must receive restorative care management services, delivered by a restorative care partner.
- Funding for **restorative care management** services can only be claimed from the Restorative Care Pathway Payments account. This cannot be claimed from the care management account.
- Restorative care management activities may be intensive and involve assessing progress on a weekly or more regular basis.

- Restorative care has no specific limit or amount deducted from the budget for care management.
- The care management budget will be determined by the provider and participant.
- Providers will ensure that the care management costs are proportionate and in the best interests of the participant.

**End-of-Life Pathway**

- Participants receiving end of life services on the End-of-Life Pathway will receive care management delivered by the care partner.
- Funding for End-of-Life care management will be claimed directly from the participant's End-of-Life Pathway budget. This cannot be claimed from the care management account.
- End-of-Life Pathway claims cannot be made to the care management account.
- There is no limit to the amount of care management that can be claimed.
- Providers need to ensure claims are reasonable and in the best interests of the older person

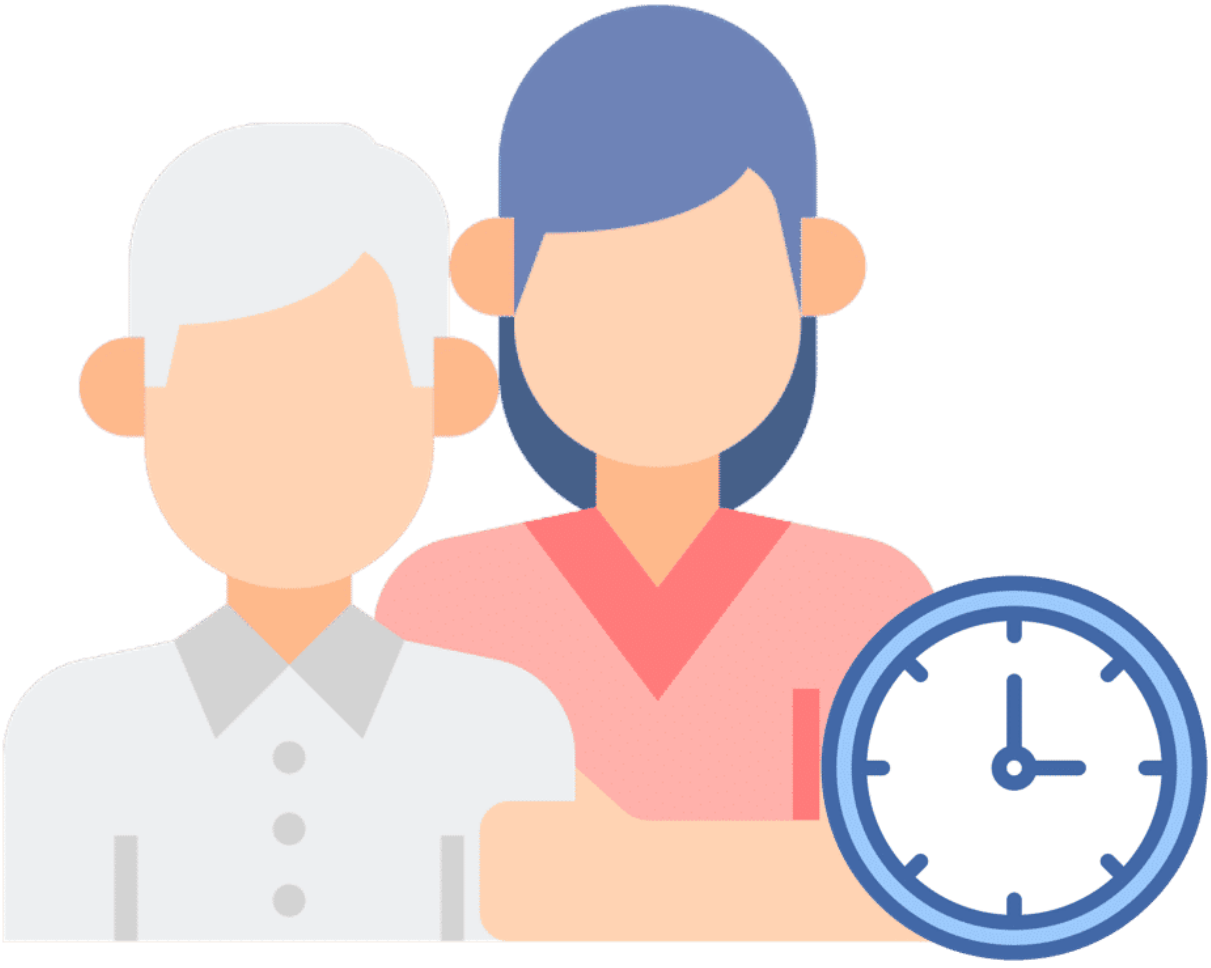
## Learn more on Care Management

View Chapter 8 - Care Management

NEXT LESSON: CARE MANAGEMENT CLAIMING

*Lesson 5 of 8*

# Care Management Claiming



Care Management

For existing providers, care management funding for ongoing services is credited to the **provider's care management account on the first**

**day of each quarter.**

Providers use this account to **claim** for the care management services that have been **delivered.**

Providers will identify the individual participant for whom the care management activity was delivered and the **day on which the activity took place.**

Claims **must be itemised** in the same way as other Support at Home claims.

Providers can make **part-hour claims of 15, 30, 45 and 60 minutes.**

## Care Management - claiming in practice

Care management is delivered in multiple environments and scenarios. Highlighted below are some common examples of how care management works in practice.

## Support at Home - ongoing services - Team based care management in action

Bill is a Support at Home participant who has been allocated a Support at Home Classification.

Bill's provider organisation uses a team-based approach to deliver care management.

This means Bill is in regular contact with his care partner James to discuss his services.

James works closely with Eve, a clinically qualified care partner to ensure the clinical services Bill receives are most suitable for his needs.

Step 2

## Check in

During their most recent check-in, Bill mentions to James that he is not very confident in his balance after a recent fall.

James suggests an additional session with his physiotherapist each week may be useful to address this.

Bill agrees, and James confirms he will review his care plan and individualised budget and follow up with him the next day.

Step 3

## Clinical oversight

Following the check-in with Bill, James meets with Eve to discuss Bill's care plan.

Eve agrees the additional physiotherapist sessions would be useful.

They suggest they should review this arrangement with Bill again in one month.

Step 4

## Care plan adjusted

James adjusts the care plan and budget and provides Bill with an updated copy of each.

With Bill's consent, James then organises for a physiotherapist to visit Bill and commence treatment.

Step 5

## Care management calculation example

| Care management activity | Description | Time | Funding source |
|---|---|---|---|
| Service planning and management | Check-in with Bill | 30 minutes | Care Management Account |
| Monitoring, review and evaluation | Discussion about Bill's care plan with Eve | 15 minutes | |
| Care planning | Review of Bill's care plan | 30 minutes | |
| Monitoring, review and evaluation | Discussion about Bill's care plan with James | 15 minutes | |
| | Total | 90 minutes of care management activities delivered | |

When submitting a claim for the care management delivered to Bill, the provider claims for each occasion of care management.

The total claimed for the month will be 90 minutes against the provider's care management account for the relevant service delivery branch.

Each occasion of care management will be identified by date of service and other required data to support the claim.

## Summary

Bill receives his physiotherapy support and reports increased confidence in getting around his home.

## Support at Home - ongoing support - routine care check in

David has been diagnosed with moderate cognitive impairment. He lives at home with his husband Jason, who works full time. David attends a community day centre 3 days a week and has a carer coming in to see him 2 half days per week. He also has some domestic assistance.

Step 2

## Care review and monitoring

David's care partner Jane meets with David and Jason once a month to check on how they are managing and confirm if the supports in place are meeting David's needs. Every three months Jane undertakes a longer review of the arrangements and makes any necessary adjustments in collaboration with David and Jason. Jane also speaks to Jason on the phone once a week to confirm any arrangements and ensure that the services are being delivered as expected.

Step 3

## Care Management - Routine quarterly in-depth check in claims

Jane reviews her records of engagement with David and Jason. She claims 15 minutes care management for the weekly check ins, and 30 minutes for the monthly care review meeting. The quarterly in-depth review takes 1 hour.

Each occasion of care management will be identified by date of service and other required data to support the claim.

This brings the total monthly care total to 75 minutes for the routine months, and 105 minutes for the in-depth review month.

# Summary

| Care management activity | Activity description | Time | Funding source |
|---|---|---|---|
| Monitoring, review and evaluation | Weekly discussion with David and Jason | 15 minutes | Care Management Account |
| Monitoring, review and evaluation | Weekly discussion with David and Jason | 15 minutes | |
| Care planning | Review of David's care plan | 30 minutes | |
| Monitoring, review and evaluation | Weekly discussion with David and Jason | 15 minutes | |
| | **Total** | 75 minutes of care management activities delivered per month | |

David and Jason are happy with the care that they receive from Jane and trust that, as Davids's illness progresses, they will be supported with the right services for them.

## Support at Home - Restorative Care Pathway - multidisciplinary team (MDT) care management

Lesley has been recovering from a recent chest infection.

Lesley is keen to regain her independence and get back to her hobbies and friends but is worried about how she is going to manage. She has lost a lot of weight and isn't sure she is strong enough to stand in the kitchen for long periods to cook and prepare nutritious meals. She is also worried about getting back to her aquarobics class and being able to get into and out of the pool.

She has also just started using a walker and isn't sure how she is going to manage in her home.

Step 2

## Setting goals

Lesley's GP referred her for an aged care assessment.

Following the assessment and approval, Lesley is referred for the Restorative Care Pathway. Lesley's restorative care partner meets with her to discuss her options and identify Lesley's goals for recovery.

Lesley's goals include getting back to preparing and cooking her own meals as well as rejoining her aquarobics class. She is also keen to become more confident in getting around with her walker which she is finding very clumsy at the moment.

Step 3

## Bringing the MDT together

Lesley's goal plan includes occupational therapist and nutritionist visits to support her to adapt her cooking skills and help her prepare more nutritious meals.

It also includes physiotherapy sessions to build Lesley's skills in navigating with her walker.

After two weeks of appointments, Lesley's restorative care partner coordinates a case conference with Lesley's multidisciplinary team (MDT) to review progress and explore future service delivery.

Dr Grace, Lesley's GP is supportive of her restorative care plan and is keen to be part of the MDT.

Step 4

## Lesley's input

Lesley's restorative care partner meets with Lesley the day before the case conference to discuss her progress and review her goals, so she can represent Lesley's views in the meeting.

Lesley is happy with how she is progressing and is enjoying the clever ideas to make cooking easier. She is feeling a bit more comfortable with the walker and expressed a hope to get back to her aquarobics class soon as she misses her friends and their regular coffee mornings afterwards.

An MDT case conference is held and all of Lesley's care team are present - her occupational therapist, nutritionist, physiotherapist and her GP.

Step 5

## MDT Meeting

The restorative care partner reviews progress and discusses Lesley's goals. The MDT team all agree that these goals are achievable and that the treatment plan at the moment will assist in achieving them.

Dr Grace, Lesley's GP is concerned that Lesley hasn't rejoined some of her social events and is worried that this might lead to Lesley losing some important community connections.

It is agreed by the team to help focus on supporting Lesley to rejoin her aquarobics class. It is agreed to discuss adding exercise physiology support with Lesley and also propose extending the occupational therapist time. It is noted that these suggested approaches will help support Lesley achieve her stated goals.

Lesley's restorative care partner agreed to discuss these proposals with Lesley. Another MDT case conference is scheduled for 1 month to review progress.

Step 6

## Calculating the care management amount for MDT case conferences

| Care management activity | Activity description | Time | Funding source |
|---|---|---|---|
| Preparing for MDT | **Care management** - meet with Lesley to discuss goals and progress | **45 minutes** | Restorative Care Pathway Payment Account |
| Restorative Care Partner | **Care management** - conduct MDT | **30 minutes** | |
| Physiotherapist | Episode of service - attend MDT | 30 minutes | |
| Exercise physiologist | Episode of service - attend MDT | 30 minutes | |
| Nutritionist | Episode of service - attend MDT | 30 minutes | |
| GP | Episode of service - attend MDT | | *Time charged to relevant MBS Item* |
| | Total | 75 minutes of care management | |

When submitting claims for Lesley's restorative care episode all claims are submitted against the Restorative Care Pathway Payments account, including restorative care management services.

The restorative care partner time is calculated as care management time. All other professionals claim their attendance at the MDT as an occasion of service.

Each occasion of care management will be identified by date of service and other required data to support the claim.

GP's claim MDT case conferencing through relevant MBS item numbers.

## Summary

Lesley continues with her Restorative Care Pathway, building her confidence and knowledge in managing mealtimes. She is more comfortable and confident in using her walker.

Her next set of goals are to have some supported trips to the pool and practice safely getting in and out of the pool using the ramp.


## Activities relating to service delivery, not included in care management.

There are a number of activities that are included in the delivery of Support at Home services that are not directly claimable as care management activities. These can include activities such as managing rosters, recruitment, scheduling appointments as well as travel to and from appointments. These types of activities should be included in the providers service price.

It is important that providers consider the totality of their costs in delivering services when establishing their pricing model and preparing their organisations for claiming under Support at Home.

Support at Home requires that the price for each service represents the entirety of the revenue that Support at Home providers will receive for delivering that service.

## Learn more on Care Management

View chapter 8 - Care Management

NEXT: KNOWLEDGE CHECK

# Knowledge check

Test your knowledge by answering the questions below.

*Question*

**01/06**

What percentage of a participant's quarterly budget is deducted for care management when they are receiving ongoing services?
(Select 1 option)

- ○ 20%
- ○ 15%
- ○ 10%
- ○ 7%

*Question*

**02/06**

To be known as a clinically qualified care partner, one must hold:
(Select 1 option)

- ○ A High School Certificate
- ○ A Certificate III in Health Services Assistance
- ○ A university-level qualification in a health-related discipline
- ○ A Certificate IV in Community Services

*Question*

**03/06**

True or False
Care management is delivered to all participants in Support at Home, including those accessing the Restorative Care Pathway and End-of-Life Pathway
(Select 1 option)

- ○ True
- ○ False

*Question*

**04/06**

Which of the following cannot be claimed as care management activities?

- recruitment
- managing rosters
- scheduling appointments
- all of the above

*Question*

**05/06**

When is care management funding for ongoing services credited to existing provider's care management account?

- [ ] first day of each quarter
- [ ] at the beginning of the financial year
- [ ] first day of each month
- [ ] at the beginning of the calendar year

*Question*

**06/06**

True or False
Care partners are an essential link between the Support at Home program, the provider organisation, their registered supporters, family and carers.

- ◯ True
- ◯ False

# Helpful resources

**The links below will open in a new window. Links are regularly reviewed, however if a link is not working, please search for the information directly within the department's website.**

## Webpages

1. Support at Home program webpage
2. My Aged Care webpage
3. New Aged Care Act webpage

## Guidelines and procedures

1. Support at Home program manual – A guide for registered providers
2. Support at Home Program Provider Transition Guide
3. Support at Home: Claims and Payments Business Rules Guidance
4. Support at Home service list
5. Assistive Technology and Home Modifications List (AT-HM List)

## Fact Sheets

1. Guidance for setting Support at Home prices – fact sheet for providers
2. Summary of indicative Support at Home prices

## Existing Home Care Package care recipients

Existing Home Care Package (HCP) and Short-Term Restorative Care (STRC) care recipients will transition to the Support at Home program.

Providers will continue to support and deliver services to these transitioned care recipients.

Refer to the Support at Home provider transition guide for detailed information on supporting transitioning existing HCP and STRC care recipients.

## NEXT LESSON: COURSE WRAP-UP

*Lesson 8 of 8*

# Course wrap-up

**Thank you for completing the Support at Home claiming and payments module.**

*We appreciate the time and effort you dedicated to completing this training, engaging with the information, and applying your knowledge.*

*You should now understand your responsibilities and obligations as a Support at Home provider.*

## We'd love your feedback!

To help us continue improving this training, please take a moment to complete a short survey about your experience in completing the Support at Home claiming and payments module. This survey will take no more than 1-2 minutes to complete.