



Australian Government
Department of Health

Short-Term Restorative Care Programme Manual



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STRC PROGRAMME MANUAL UPDATED December 2020

FOREWORD

The Short-Term Restorative Care (STRC) Programme is an innovative flexible care programme that provides early intervention care which aims to optimise the functioning and independence of older people and reverse and/or slow functional decline. STRC is delivered in the form of a tailored, multidisciplinary package of services which includes the provision of services and assistance such as physiotherapy, social work, nursing support, personal care and the provision of assistive technologies. It aims to enable older people to regain independence and autonomy rather than commencing long term aged care prematurely.

The STRC Programme Manual (the Manual) is a resource for approved providers of STRC to assist their understanding of the policy context and operational requirements for delivery of STRC to clients in a home or residential care setting. The Manual also outlines the responsibilities of approved providers under the *Aged Care Act 1997* (the Act), and its subordinate legislation which govern the operation of the programme.

1 CHAPTER 1: ABOUT THE MANUAL

This Manual provides information on how the STRC Programme is to be delivered. The Manual must be read in conjunction with the Act and the various principles under the Act.

1.1 What the Manual contains

The Manual explains the Australian Government's policy and legislative context and operational requirements for the provision of STRC within home or residential care settings. It outlines the responsibilities of approved providers delivering STRC.

1.2 Enforceability of the Manual

Compliance with the Manual is mandatory as it is a condition of allocation applying to all STRC places.

1.3 How the Manual will be updated

The Department of Health (the Department) will update the Manual, as required, to ensure its currency and accuracy. When significant amendments have been made, approved providers delivering STRC will be notified of the update.

Please refer to the online version of the Manual located on the [Department's website](https://www.health.gov.au/resources/publications/short-term-restorative-care-programme-manual) (<https://www.health.gov.au/resources/publications/short-term-restorative-care-programme-manual>).

1.4 Feedback

The Department welcomes any comments on the Manual. To provide feedback, please email strc@health.gov.au. Feedback received will be incorporated where appropriate, at the discretion of the Department.

1.5 Key definitions

For a full list of terms used in this document please see the [glossary](#).

1.5.1 Client

Where the term 'client' is used in this Manual, it is intended to refer to a consumer, My Aged Care client, veteran or other person applying for, or in receipt of, STRC. The aged care legislation (see [Attachment A](#)) uses the term 'care recipient' to refer to persons in receipt of a particular type of care. In certain circumstances, particularly where referring to legislation, the term 'client' is replaced with 'care recipient' in this Manual.

1.5.2 Carer¹

The [Carer Recognition Act 2010](#) (<https://www.legislation.gov.au/Latest/C2010A00123>) says a carer is someone who provides care and support for a relative or friend who:

- has a disability
- has a mental health problem
- has a medical problem (including an illness that's gone on for a long time, or an illness that's expected to end in death)
- is frail / aged.

Some state and territory laws are based on this Act, and others are not - all of them are similar.

¹ Source: [Carer Gateway](https://www.carergateway.gov.au/) (<https://www.carergateway.gov.au/>)

A person is not considered to be a carer if they are employed to look after someone, if they work as a volunteer for an organisation, or if they are doing work experience as part of a course.

1.5.3 Approved provider

An approved provider of STRC is a person or organisation, falling within the definition of approved provider in Schedule 1 of the Act, to whom an allocation of STRC places is in place. An STRC service is a service through which STRC is provided that is operated either by or on behalf of an approved provider as defined in this section.

1.5.4 Palliative and end of life care

For the purposes of STRC, end of life care is defined as care delivered following a final decision made by a doctor and care team to commence a person on an end of life (terminal) care pathway once they have shown symptoms or physical changes suggesting that they may be dying.²

A person cannot be approved to receive STRC when they are receiving end of life care, however, there may be instances where, after the assessment and approval, a person will have palliative care needs. In line with the [Quality of Care Principles 2014](#), once a person starts receiving STRC services, the provider is required to provide some palliative care services to any care recipient who needs it, where the STRC is provided in a residential care setting. Further information on palliative care is available on the Department of Health website - <https://www.health.gov.au/health-topics/palliative-care/about-palliative-care/what-is-palliative-care>.

1.6 Legislative framework

The Act and its subordinate legislation (listed in [Attachment A](#)), provide the legislative framework for the administration and delivery of the STRC Programme. This Manual must be considered in conjunction with the legislative framework. It is essential that approved providers become familiar with their responsibilities under the legislation when delivering the STRC Programme.

Throughout the Manual, specific references are made to relevant sections of the legislation. These references are hyperlinked to the appropriate section of the Act or this Manual, and should be referred to when requiring more detailed clarification.

The relevant legislation and related links are at [Attachment A](#).

1.6.1 Non-Compliance with legislation

Approved providers are required to meet all conditions specified in the legislation and note that failure to comply with the legislation may result in non-compliance action being taken.

Divisions 64 to 68 of the [Act](#) (<https://www.legislation.gov.au/Details/C2020C00164>) outline the consequences of non-compliance by approved providers.

² End of Life [Terminal] Care Pathways, Fact Sheet (10) dated March 2016
(https://www.caresearch.com.au/caresearch/Portals/0/PA-Toolkit/Resources_2016_Update/Fact_Sheet_10_End_of_Life_Terminal_Care_Pathways.pdf)

2 CHAPTER 2: THE STRC PROGRAMME

2.1 Policy background

In the 2015-16 Budget, the Australian Government announced the expansion of flexible aged care initiatives to include STRC.

The STRC Programme, in conjunction with the Commonwealth Home Support Programme (CHSP), Home Care Packages (HCP) Programme, residential aged care and other specialised aged care programmes, forms part of an end-to-end aged care system offering older people a continuum of care options as their care needs change over time.

While the various aged care programs have similarities, there are key differences in terms of overall objectives, how the programs are delivered and the types of services provided. In particular, there are strong linkages between the STRC programme, the Transition Care Program (TCP) and the CHSP.

The TCP and the STRC programme are both flexible care programmes and focussed on short-term, restorative care designed to improve a person's health with the aim of delaying their need for more intensive aged care supports such as a home care package or residential care. TCP, however, is designed for people immediately following discharge from hospital and as such, facilitates a continuum of care for older people who have completed their hospital episode (both acute and sub-acute care) and supports them as they make decisions on their long term aged care options. The intent is that, once a client has finished their TCP episode and has spent time readjusting after their hospital stay, they can access STRC if required. STRC is not available for people who have been recently discharged from hospital, or who have had an episode of TCP within the last six months.

There are also notable similarities between the STRC programme and CHSP. Whilst like services can be accessed through both programs, the significant difference is that STRC is time-limited and more intensive in nature. CHSP and STRC can be accessed at the same time, however, both providers must consult to ensure there is no duplication of care and services.

2.2 Objectives

The STRC Programme is an early intervention programme that aims 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. STRC services may be delivered in a home care setting, a residential care setting, or a combination of both.

STRC is ideal for people who:

- have a desire to return to earlier levels of independence; or
- wish to improve their levels of independence; and
- are **not** currently receiving residential care, home care or transition care.³

While 'functional decline' is defined as the 'reduced ability to perform tasks of everyday living due to a decrease in physical and/or cognitive functioning', the STRC Programme should also be inclusive of a client's medical, physical, social and psychological needs, however, it is not a disability or mental health program. A comprehensive description of how functional decline relates to the STRC Programme follows.

³ Note: Receipt of CHSP services or the DVA services listed at 4.3.2 does not affect a person's eligibility for STRC.

2.2.1 What is functional decline?

Functional decline is a term used throughout Ageing and Clinical Health literature and is interpreted in a variety of ways.⁴ Functional decline is most frequently synonymous with describing the loss of an individual's physical or mental ability, particularly in reference to individuals aged 65 years or older.⁵ The STRC programme broadly aligns with the following definition of functional decline as "the reduced ability to perform a task of everyday living due to a decrement on physical and/or cognitive functioning".⁶ Functional decline can therefore be interpreted as losing the ability to carry out activities of daily living such as bathing, dressing, feeding, shopping or driving, due to increasing age or frailty.⁷

Characteristics and indicators of functional decline

A broad interpretation of functional decline has led to a wide range of indicators being drawn upon in order to detect and prevent its prevalence amongst ageing populations.⁸ The Department identified three factors which are typically associated with functional decline.⁹ These being age, level of dependence when undertaking daily living activities and impaired memory.¹⁰ Research also discusses the use of frailty indicators as a measure to determine functional decline.¹¹ When three or more of the frailty indicators (slow walking speed, measured impaired grip strength, self-reported declined activity, exhaustion and unintended weight loss) are present then an individual is seen as experiencing functional decline.¹²

What is functional decline for the purpose of STRC eligibility?

For the purpose of STRC, functional decline should continue to reflect current literature and be defined as a progressive loss in an individual's mental and/or physical ability, which reduces their ability to perform everyday living tasks.¹³ From this definition a combination of indicators should be used to determine when an individual is experiencing, or about to experience functional decline. The indicators found to be most successful in detecting functional decline centre upon assessing an individual's age, ability to complete everyday living tasks, memory and level of physical activity.¹⁴ Individuals considered eligible for STRC are those whose functional decline (as determined through the clinical indicators) can be slowed or reversed, through a multidisciplinary intervention within the space of 56 days. Individuals should also only be deemed eligible for STRC on the understanding that without such intervention the individual would lose independence to an extent that they would likely require ongoing home care, residential care, or care through a multi-purpose service.

2.3 Definition of STRC

STRC is defined in section 106A of the [Subsidy Principles 2014](#) as follows:

Short-term restorative care is a form of flexible care that:

- (a) is aimed at reversing and/or slowing 'functional decline' in older people through provision of a package of care and services designed for, and approved by, the individual;*
- (b) depending on the needs of the care recipient, is provided in either or both of the following settings:*

⁴ (Drewes, et al., 2012, p. 42)

⁵ (Suijker, et al., 2014, p. 1121); (Beaton, McEvoy, & Grimmer, 2015, p. 133)

⁶ (Shearer & Guthrie, 2013, p. 319)

⁷ (Beaton, McEvoy, & Grimmer, 2015, p. 133)

⁸ Ibid

⁹ (Suijker, et al., 2014, p. 1121)

¹⁰ Ibid

¹¹ (Beaton, McEvoy, & Grimmer, 2015, p. 133)

¹² Ibid

¹³ Ibid

¹⁴ (Drewes, et al., 2012, p. 42)

- i. a residential care setting;
- ii. a home care setting; and

(c) can be characterised as:

- i. goal-oriented;
- ii. multidisciplinary; and
- iii. time-limited.

2.4 Key features of STRC

- A multidisciplinary package of care designed to meet the client's needs, help them stay at home and help delay their entry into higher levels of care.
- Access into STRC is due to functional decline (not linked to a recent hospital admission) resulting in a client needing assistance for a short period of time.
- It provides a high intensity short-term period of care (up to a maximum of 56 days).
- A client can have up to a maximum of 7 days leave, during which subsidy is not paid to the care provider. This is in addition to the 56 paid days / 8 paid weeks of care ([see 3.8](#))
- STRC can be accessed [twice within a 12 month period](#), however, each period of care will require an Aged Care Assessment Team (ACAT) assessment ([see 3.9.1](#))
- The STRC subsidy is paid to providers for days that are covered by a care plan and it is expected that subsidy and any client fees will be directed towards delivering the care and services the client needs. The current STRC daily [subsidy](#) rate can be found on the Department's website at: <https://www.health.gov.au/resources/publications/schedule-of-subsidies-and-supplements-for-aged-care>.
- A client may be asked to pay a [daily care fee](#), with the exception of when they are on leave.
- The care and services provided need to be multidisciplinary in nature, drawn from the relevant [specified care and services schedule](#) and be agreed in a care plan with the client as part of their [Flexible Care Agreement](#).

2.5 Overview of roles and responsibilities

There are six key entities that have roles and responsibilities in the delivery of the STRC Programme:

- The Australian Government
- Approved STRC providers
- My Aged Care
- Regional Assessment Services (RAS)
- ACAT¹⁵
- Aged Care Quality and Safety Commission (Commission).

The roles of each of the abovementioned entities are broadly outlined below.

2.5.1 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 this programme;
- administer the programme, including the development and maintenance of the Manual;

¹⁵ Note, in Victoria, an ACAT is referred to as an Aged Care Assessment Service (ACAS). Where ACAT is used throughout the Manual, it is intended that ACAS is interchangeable.

- allocate STRC places under the Act and pay a subsidy for each occupied STRC place for care and services delivered to clients in accordance with the programme; and
- collaborate with approved providers in the evaluation of the programme and reporting of STRC data.

The Australian Government's role in the programme is primarily undertaken by the Department and Services Australia (formerly known as the Department of Human Services).

2.5.2 Approved STRC providers

The responsibilities of approved providers are set out in detail in [Chapter 3](#) of this Manual. Approved providers are required to:

- manage the day-to-day delivery and coordination of care to STRC clients;
- ensure quality care is provided in accordance with the Aged Care Quality Standards;
- [manage complaints](#) and, where necessary, cooperate with the Commission to resolve complaints received;
- ensure that service level information on My Aged Care including contacts, service availability, and support plan information are kept up to date, through the provider portal;
- collaborate in programme evaluation activities by recording each client's [Modified Barthel Index \(MBI\)](#)¹⁶ score and provide feedback on STRC eligibility requirements to the Australian Government for inclusion in programme evaluations;
- meet the data reporting requirements set by the Australian Government;
- establish mechanisms to ensure that the requirements of this Manual are met; and
- comply with the necessary requirements to receive payment for claims submitted.

2.5.3 My Aged Care

My Aged Care plays a crucial role in the timely assessment of prospective STRC clients by:

- screening prospective STRC clients to determine their current needs and care arrangements; and
- quickly referring prospective STRC clients for an ACAT assessment.

It also provides details of STRC and other aged care provider services which facilitate access to STRC places by My Aged Care clients.

2.5.4 Regional Assessment Service (RAS)

Clients are referred to the RAS for assessment in those instances where a My Aged Care screening indicates that a client requires low level community care. Should a RAS Assessor consider a person may benefit from STRC, they must refer them for assessment by an ACAT.

2.5.5 Aged Care Assessment Teams (ACATs)

The role of ACATs is the comprehensive assessment of the care needs of frail older people using a multidisciplinary and multi-dimensional approach as outlined in the [My Aged Care Assessment Manual](#) (<https://www.health.gov.au/resources/publications/my-aged-care-assessment-manual>).

ACATs are required to:

- conduct comprehensive assessments of the physical, medical, psychological, cultural, social and restorative dimensions of clients' care needs, and provide a choice of appropriate services to meet their needs;

¹⁶ An overview of the Modified Barthel Index can be found under [section 3.13 – Evaluation and Reporting](#)

- provide information and refer clients to services – such as STRC – that are appropriate and available (including facilitating access to broader services such as CHSP, or mental health or disability services) to meet their needs and preferences; and
- provide care coordination to the point of effective referral.¹⁷

Please note that, as an STRC provider, you are not required to accept a referral from an ACAT if you do not believe you can provide the care and services needed to address the referred person's needs.

2.5.6 The Aged Care Quality and Safety Commission

The role of the Aged Care Quality and Safety Commission (the Commission) is to protect and enhance the safety, health, well-being and quality of life of people receiving aged care.

The Commission independently accredits, assesses and monitors aged care services subsidised by the Australian Government, resolves complaints about these services and provides information and education to providers.

The Commission assesses and monitors the quality of care and services against the Aged Care Quality Standards. Assessment and monitoring of STRC services is in accordance with the Aged Care Quality and Safety Commission Rules 2018. The Commission has developed Guidance and Resources to assist aged care services to implement and maintain compliance with the Aged Care Quality Standards. It describes the Commission's expectations and provides supporting information, suggested practices, examples and evidence required to ensure compliance. It also indicates any matters that the Commission's quality assessors will consider in evaluating compliance. The Guidance and Resources are available at this [link](#) or by searching "Quality Standards" at www.agedcarequality.gov.au.

2.6 Becoming an STRC provider

In order to be allocated an STRC place, prospective providers must be an approved provider of flexible care. There are two forms that organisations may use to apply for approved provider status:

Form A - for applicants that are not approved providers of aged care

- This form is for organisations that are not currently approved providers of aged care and would like to apply to become approved providers for residential care, home care and/or flexible care.
- If you are currently only providing services under the CHSP and would like to apply to become an STRC approved provider, you should complete [Form A](#) and indicate the care type(s) you would like to apply for, ensuring you complete all the relevant sections.

Form B - for existing approved providers seeking approval to provide another type of care

- [Form B](#) is for existing approved providers that have already demonstrated their suitability to provide aged care through a previous assessment process. It seeks more specific detail about providing an additional type of care.

Both forms, together with guidance material, are available on the [Commission's website](https://www.agedcarequality.gov.au/providers/becoming-approved-aged-care-provider) (<https://www.agedcarequality.gov.au/providers/becoming-approved-aged-care-provider>). If you have any queries about the approved provider application process, please send an email to the [Approved Provider team](mailto:approvedproviderapplications@agedcarequality.gov.au) (approvedproviderapplications@agedcarequality.gov.au) and include your name and contact details.

¹⁷ Examples of effective referral include:

- An STRC provider agreeing to provide an STRC episode to the client,
- a carer who is willing to assume responsibility for coordinating service provision being identified and taking on that role, or
- a home care provider agreeing to provide a HCP for the client.

If you are an existing approved provider of another care type and would like to enquire whether your flexible care status has lapsed, please contact your [state or territory office](#) (<http://health.gov.au/internet/main/publishing.nsf/Content/health-state.htm>) of the Department.

Prospective providers must be allocated STRC places by the Department before they will be able to claim STRC subsidy. The allocation of STRC places happens by way of the competitive process set out in Part 2.2 of the Act. In practice, this means that prospective providers will need to be successful in applying for an allocation of STRC places through an [Aged Care Approvals Round](#) (ACAR).

To be successful in this competitive process, prospective providers will need to meet a number of selection criteria, including demonstrated experience in delivering restorative care that would meet the objectives of the STRC Programme and ensure appropriate outcomes for clients.

STRC providers must register on My Aged Care in order to receive client referrals. Those providers who have been allocated STRC places but have not registered on My Aged Care can find details of the My Aged Care registration process on the Department's [website](#) (<https://agedcare.health.gov.au/our-responsibilities/ageing-and-aged-care/programs-services/my-aged-care/information-for-service-providers>).

3 CHAPTER 3: STRC DELIVERY REQUIREMENTS

To maximise the effectiveness of the STRC Programme and ensure that care delivery achieves the programme's policy objective, STRC must be delivered in accordance with the requirements detailed in this chapter. STRC service providers should note that compliance with these requirements is a condition of allocation attached to each allocation of STRC places.

3.1 Programme management

STRC providers are required to manage the day-to-day care coordination and delivery of care as part of the STRC Programme. This includes:

- Assisting in the admission of clients to STRC and subsequent case coordination of the services provided;
 - Offering to enter into a [Flexible Care Agreement](#) with eligible clients (see section 3.3 and 3.4);
 - Providing services in accordance with the [Flexible Care Agreement](#) and care plan, on a 7-day a week basis, including weekends and any public holidays falling within the STRC period;
 - Having appropriate processes in place to receive, record and [resolve complaints](#) and handle them fairly, promptly, confidentially and without retribution;
 - Reporting (activity, financial and quality) as per programme requirements including the provision to the Department, upon request, of de-identified client data (noting that the Department may request this data from time to time); and
 - Ensuring that service level information on My Aged Care including, contacts, service availability, and support plan information are kept up to date, through the provider portal.
- Providers will need to be set up in My Aged Care to access the provider portal, manage referrals and view the client record including assessment and approval information. The approved provider should ensure all service availability and waitlist information is up to date in the provider portal so the ACAT can make appropriate referrals on the My Aged Care system. **It is critically important that service information is maintained by providers to ensure appropriate referrals are sent to them.**

A key feature of the My Aged Care website is the Find a Provider tool. This empowers consumers to exercise choice by enabling them to search and identify providers in their preferred location. It also gives providers a platform to promote the services they offer.

To ensure that your services will display correctly in the [Find a Provider tool](#) (<https://www.myagedcare.gov.au/find-a-provider/short-term-care>) you will need to review your organisation's details in the My Aged Care provider portal and make any necessary updates.

- You can get further information, or technical support, for updating the provider portal from the My Aged Care service provider helpline on **1800 836 799**. Alternatively, there are a range of information materials to support provider use of the My Aged Care system which can be found at: <https://agedcare.health.gov.au/our-responsibilities/ageing-and-aged-care/programs-services/my-aged-care/information-for-service-providers>

3.2 Service delivery

In delivering STRC, service providers must:

- Provide care in accordance with a care plan that forms part of the [Flexible Care Agreement](#);
- Utilise a [multidisciplinary care approach](#) via multidisciplinary teams (MDT);
- Provide the care and services specified in the [Specified Care and Services for STRC](#), where required by the client, and in accordance with the Aged Care Quality Standards;
- Provide a coherent and integrated case coordination process that enables clients to meet their goals and takes into consideration the psycho-social situation of the client;

- Actively promote self-management and self-sufficiency by providing interventions that support the client to make the most of their own capacity and achieve their full potential;
 - Encourage clients to seek support from carers and families, community groups and others to foster their independence when required; and
 - Assist clients to achieve an optimum level of independence and wellbeing so that care needs are minimised over the longer term.
- STRC providers must ensure clients receive timely and appropriate access to therapy, care and equipment during the STRC episode. To meet this requirement, STRC providers must:
 - Provide a broad range of services tailored to meet the client's goals to improve or maintain function;
 - Provide the client with therapy from appropriately qualified staff to achieve their individual documented goals;
 - Ensure aids, appliances, equipment and services required for a client's therapy are provided in a timely manner;
 - Actively encourage clients, and/or their representatives, carers and family to participate in all aspects of STRC service provision;
 - Ensure that the client's progress against therapy goals is regularly [evaluated](#) throughout their STRC episode and on exit, with changes in physical and cognitive function measured and recorded to demonstrate achievement of the client's goals;
 - Ensure that clients' changing needs are reflected as they move between care settings; and
 - Ensure that client goals are delivered in accordance with the care plan, using an integrated case coordination approach.

Note: Technologies are moving very quickly and the Department is not prescriptive about the types of aids, appliances and equipment used other than that they must assist a client to improve their level of physical and cognitive functioning.

3.2.1 Service responses

Care will vary from person to person, ranging from services that improve a client's capacity for independent living to services that enable the client to improve their level of physical and cognitive functioning. An indication of the range and types of services that must be provided to clients where needed is at [Chapter 6: Specified care and services for STRC](#).

Some people entering STRC are likely to have dementia or be experiencing a level of cognitive impairment. Supporting clients with dementia to live well, and to their full potential as the disease progresses, could encompass the provision of a range of appropriate support programmes, developing new coping skills, and having technologies introduced to the home that can enable clients to retain their independence and live well at home for a longer period of time.

3.2.2 Service areas

The conditions of allocation attached to allotments of STRC places enable the delivery of care anywhere within the specified state / territory. Priority of access must, however, be given to persons in the region(s) targeted by the service in its application for places.

3.2.3 Service settings

Under section 49-3 of the Act, flexible care is defined as "care provided in a residential or community setting through an aged care service that addresses the needs of clients in alternative ways to the care provided through residential care services and home care services".

The service setting associated with a given allotment of STRC places is set by their conditions of allocation. The forms needed to vary the conditions of allocation attached to STRC places are available

on the Department's [website](https://www.health.gov.au/resources/collections/management-of-places-forms-and-guidance-material-for-approved-providers) (<https://www.health.gov.au/resources/collections/management-of-places-forms-and-guidance-material-for-approved-providers>). Applications to vary the conditions of allocation attached to STRC places are considered by the Secretary of the Department in accordance with Division 17 of the Act. Applications are subject to the Secretary's approval.

There are three possible service settings: residential, home, or a combination of both. The settings STRC may be delivered in are defined in section 4 of the [Subsidy Principles 2014](https://www.legislation.gov.au/Latest/F2016C00454) (<https://www.legislation.gov.au/Latest/F2016C00454>) as follows:

- **home care setting:** STRC is provided in a home care setting if it is not provided in a residential care setting
- **residential care setting:** STRC is provided in a residential care setting if it is provided in an aged care home

Where a provider is able to deliver in both settings, their STRC clients can move from one setting to another within the same care episode, e.g. from residential to home based care. To enable such a move, each service is able to change the mix of places delivered in a residential or home care setting on a daily basis, if required, within the limits of the number of places it has been allocated. **STRC services are not required to refer clients for an ACAT re-assessment to support a move between settings.** It should be noted that it is also possible that they may move between locations within the same setting in the same care episode.

Approved providers delivering in both settings are able to determine the mix of care delivery settings within the defined period of STRC support in line with individual client needs.

3.2.4 Provision of STRC in a residential care setting

The aged care homes from which an STRC service may deliver residential STRC are listed in the conditions of allocation associated with the service's allocation of places. The forms needed to vary the conditions of allocation attached to STRC places are available on the Department's [website](https://www.health.gov.au/resources/collections/management-of-places-forms-and-guidance-material-for-approved-providers) (<https://www.health.gov.au/resources/collections/management-of-places-forms-and-guidance-material-for-approved-providers>).

Clients who are **permanent** residents are not eligible for STRC services. This is intended to prevent a provider from claiming both residential care subsidy and STRC subsidy with respect to the same client at the same time. It does not, however, prevent an STRC client receiving services in an aged care home (e.g. someone who lives independently in the community, may temporarily relocate to an aged care home to receive STRC services as they may require daily support/monitoring whilst they restore their physical functioning).

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.

When providing STRC in a residential care setting, providers are expected to comply with the [Aged Care Quality Standards](#), and provide services that reflect the intent of the programme to optimise the client's health and independence.

If a client enters permanent care in an aged care home or starts receiving a home care package, they will no longer be eligible for STRC.

Service Delivery Setting

Providers of residential based STRC services are expected to provide services that reflect the intent of the STRC Programme and meet the following criteria for a more home-like environment.

Residential STRC 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 clients
- a dining area so clients are encouraged not to eat in bed
- clients being encouraged and supported to dress every day
- provision of morning tea, afternoon tea and supper for the client
- privacy particularly for personal care and bathing arrangements
- space for clients to be mobile especially outdoors
- physical arrangements which support the involvement of carers in the care activities
- a model of care and staff knowledge that supports the intent of the STRC Programme to promote the client's health and independence.

3.2.4 Provision of STRC in a home care setting

When providing STRC in a home care setting, providers are expected to comply with the [Aged Care Quality Standards](#), and provide services that reflect the intent of the programme to optimise the client's health and independence. The home care setting is deliberately widely defined to enable providers the flexibility to develop creative and effective models.

3.2.5 Infection control

All aged care workers entering clients' homes must practise good infection control. We encourage all aged care workers to complete the aged care and infection control training modules. These are available on the [Department's website](#). Make sure to register as an aged care worker to obtain access to all modules.

3.3 Flexible Care Agreement

STRC service providers, or their nominee, must offer and remain ready at all times, to enter into a Flexible Care Agreement with a client and/or with their representative. The Agreement should be developed in consultation with the client, carer or family member where applicable and include a care plan addressing the client's physical and cognitive needs identified in the ACAT assessment. To address these needs, consultation with a multidisciplinary care team is required, with coordination undertaken by the approved provider.

The Flexible Care Agreement must comply with the following requirements:

- include an interim [care plan](#) that meets the requirements set out in [section 3.4](#) below;
- include a clear statement of the [fees payable](#) by the client and how amounts of each fee are to be worked out;
- include the provision of financial information to the client, detailing the costs of services received by the client at a frequency agreed upon with the client. This must include the costs of administration (including care coordination);
- state the date for the commencement of STRC;
- state dates on which the care plan will be reviewed;
- specify the conditions under which either party may terminate the care service;

- provide an exit strategy for the client once STRC is completed, including the expected date of cessation of STRC, the service arrangements that are expected to be in place for the client following STRC, a carer briefing, and the client's consent for the exit strategy;
- provide that any variation to the Flexible Care Agreement must be by mutual consent, following adequate consultation, with the client and/or their representative and the STRC service provider, and only after the provider has given reasonable notice in writing about the proposed variation to the client;
- not be varied in a way that is inconsistent with the Act, the *Aged Care (Transitional Provisions) Act 1997*, their principles or the *A New Tax System (Goods and Services Tax) Act 1999*;
- state the range of services that the client has been assessed as requiring in their care plan, how these services will be provided, including how these services are provided in relation to any other services being provided, and any limits that will be placed on the services to be provided;
- state the [client's rights and responsibilities](#) in relation to decisions about the service that the client is to receive;
- include a guarantee that all reasonable steps will be taken to protect the [confidentiality of information](#) provided by the client, and details of the purpose for which the information may be used by the approved provider;
- state that the client is entitled to make, without fear of reprisal, any complaint about the provision of STRC, and state all of the [mechanisms available for making a complaint](#). This refers to both internal complaint mechanisms and external complaint mechanisms;
- be expressed in plain language; and
- not be provided on a template labelled for a different program such as Home Care or the Transition Care Programme.

STRC providers must comply with the terms of the Flexible Care Agreement.

In setting out the rights of a client of STRC, the Flexible Care Agreement must include the following rights:

- full and effective use of the client's personal, civil, legal and consumer rights;
- for STRC delivered in a residential care setting, to be in a safe, secure and comfortable environment;
- to have clear, easy to read written information about their rights, care, accommodation and any other information that relates to the client personally;
- to be involved in deciding and choosing the care most appropriate to meet their needs;
- to be given enough information 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 communal life as fully as possible;
- 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; and
- to choose a person to speak on their behalf for any purpose.

If a client has declined to sign a Flexible Care Agreement with the STRC service provider, the STRC service provider must:

- in all dealings with the client comply with the requirements in the Flexible Care Agreement as far as they are applicable, as if the client had signed the Flexible Care Agreement; and
- make and retain a written record of the nature and level of care that has been verbally or otherwise agreed with the client and the circumstances that led to the client declining to sign the Flexible Care Agreement.

The Flexible Care Agreement may be varied during the STRC episode. If needed or requested by a client or their representative during a period of provision of STRC, the STRC service provider must conduct a formal review of the agreement.

The STRC service provider must draw the current [Specified Care and Services for STRC](#) and the [Aged Care Quality Standards](#) to the attention of the client or their representative. Where the client has signed a Flexible Care Agreement, the provider should attach copies of the Specified Care and Services for STRC and the Flexible Care Standards to the Agreement.

A Flexible Care Agreement must not contain any provision that would have the effect of the client being treated less favourably in relation to any matter than the client would otherwise be treated, under this agreement or any law of the Commonwealth, in relation to that matter.

Unless the STRC client has chosen not to sign it, the Flexible Care Agreement must be signed by the STRC service provider, or their nominee, and the client or their representative and, in those instances where the carer undertakes to continue their caring role throughout the episode of care and thereafter, the carer.

Where required, the STRC service provider must provide guidance and access to interpreter or translator services, in order to assist clients in understanding the [Specified Care and Services for STRC](#), the [Aged Care Quality Standards](#), their Care Plan and the Flexible Care Agreement.

The Translating & Interpreting Service (TIS National) immediate phone interpreting service is available 24 hours a day, every day of the year for any person or organisation in Australia who needs an interpreter. STRC providers are eligible to access free interpreting services through TIS National, who can be contacted through the following channels:

Online: www.tisnational.gov.au

General enquiries: 1300 655 820

Immediate phone interpreting: 131 450

Providers can register for an account with TIS National through the following link:

<https://tisonline.tisnational.gov.au/RegisterAgency>

3.4 Care Plan design

STRC must be delivered in a way that empowers clients to influence the design and delivery of the services they will receive. Clients should also be provided with enough information to make an informed decision about their care.

Integral to this is the development of an agreed interim care plan, which forms part of the [Flexible Care Agreement](#).

The interim care plan must articulate the needs and goals of the client. Shortly after entering care, the client must be provided with a refined and further detailed care plan by the multidisciplinary team (MDT). The MDT will determine the full range of care and services that the client agrees will be provided, how those services will be delivered, who will deliver them and how the services will address the client's identified functional decline.¹⁸ The case conference undertaken by the MDT, in consultation with the client and their carer, will result in the following being developed and agreed:

1. a full schedule of the different care and services to be provided;
2. the transition arrangements, if required;
3. any equipment or minor home modifications required; and
4. other important service delivery details including if any leave is required by the client.

¹⁸ A definition of functional decline for the purpose of STRC can be found in Chapter 2 or in the glossary.

In developing the care plan, STRC service providers must:

- ensure that care planning is carried out by at least three members of a MDT with relevant clinical experience in reversing / stabilising functional decline;
- coordinate the assessment of the client's care needs through the MDT at the beginning of the STRC episode, including the measurement of a baseline level of functioning using a [MBI](#);
- assess and take into account the clients' physical and cognitive independence, as well as their psycho-social needs;
- ensure that STRC service provision will be coordinated with existing support services (e.g. CHSP services or DVA Services listed under [4.3.2](#));
- ensure care plan reviews / case conferencing include those members of the MDT involved in the client's treatment and occur as required and/or at predetermined intervals during the provision of STRC;
- allow clients or their representatives, assisted by carers and families as appropriate, to make informed choices between STRC service options in order to define and set their goals to stabilise and/or reverse their functional decline, optimise their independence and improve their wellbeing;
- be considerate of, and responsive to, the needs of special needs groups as defined in section 11-3 of the Act; and
- be considerate of, and responsive to, the needs of people who have a physical or cognitive impairment.

The care plan must:

- enable care delivery to respond to the identified needs of the client and target those goals which will reverse and/or stabilise the identified functional decline, optimise independence and improve wellbeing while taking into consideration the psycho-social needs of the client;
- identify how funding and client care fees will be spent, including how much each service response costs, and how much will be spent on administrative costs (including care coordination);
- provide the client with required therapies and treatments designed to support the client to achieve their goal(s);
- aim to improve the client's functioning by promoting independence; and
- provide for the ongoing monitoring of its success in achieving the client's goals in consultation with the client and/or their representative, carers and families, clinicians, and therapists.

3.5 Multidisciplinary Care

The aim of the STRC Programme is to:

- support clients to regain their ability to carry out activities of daily life;
- help clients to manage new or changing health conditions; and
- provide assistance to clients so that they can live as independently as possible.

Both the care planning phase and the service delivery phase of an STRC episode must be delivered using a multidisciplinary care approach via multidisciplinary teams (MDTs). For the purpose of STRC, multidisciplinary care is defined as a practice of care in which three or more specialist care providers from different disciplines collaborate to provide a client with comprehensive, outcome-focused treatment.

As each client will have different needs, MDT members should be selected based on client need. The ACAT assessment should indicate the types of assistance the client needs (including but not limited to the treating GP and/or geriatrician, occupational therapists, physiotherapists, podiatrists, dietitians, registered nurses and optometrists).

One of the three (3) members of the MDT must always be a medical clinician (i.e. a GP or Geriatrician) so as to ensure that any underlying clinical issues are identified. The medical clinician along with the other two members will assist the assessment by working with clients to identify goals and plan therapies / services to meet those goals.

The number and type of specialists involved in a client's treatment during the service delivery phase should be determined by the level of care needed, type of outcome required, and client preferences. Having multidisciplinary care at the centre of STRC allows clients to receive comprehensive and unified treatment that supports undertaking the activities of daily living.

[Attachment C](#) provides examples of possible clinicians / qualified professionals who should be considered when developing the MDT.

What is Multidisciplinary Care?

Multidisciplinary care is a widely referenced health practice within Ageing and Clinical Health literature.¹⁹ Most commonly this practice of care involves health care providers working in collaboration to provide a positive patient outcome, through a holistic and high quality care plan.²⁰ The STRC programme broadly aligns with the following definition of multidisciplinary care as “a collaborative process among groups or individuals with different backgrounds”.²¹ Multidisciplinary care teams could therefore be made up of GPs, allied health professionals, social workers, community health workers or a range of other specialists.²² The number and types of disciplines drawn upon should reflect the client's needs and be able to contribute to the overarching treatment goal.²³ Research highlights the importance of multidisciplinary care to be driven by evidence based practice and an overarching goal.²⁴ Multidisciplinary care teams are expected to meet and discuss client outcomes and services regularly in order for the best level of care to be provided.²⁵

The benefits of Multidisciplinary Care

There are many noted benefits of multidisciplinary care within clinical health literature.²⁶ Most notably collaborative care has been linked with a higher level of client care and better patient outcomes.²⁷ This is because multidisciplinary care centres focus upon the welfare of the client and empowers them “through offering choices and better information”. Multidisciplinary care also reduces the risk of the client receiving fragmented, contradicting or poor quality care.²⁸ Health care workers and service providers may also benefit from multidisciplinary care, as collaborative work can broaden an individual's knowledge, skills and networks, all of which can have beneficial impact on clients' care.²⁹

Seamless multidisciplinary care is to be supported by an integrated system of care with other organisations through:

- the establishment of relationships and communication strategies that govern collaboration between aged and primary care services, promoting a clear understanding of each other's roles, responsibilities and admission criteria;
- the establishment of systems for the secure, timely and effective transfer of STRC client information between service providers;
- strengthening of partnerships with GPs and other STRC support services;
- facilitation of effective case conferences;

¹⁹ (Ndoro, 2014, p. 724)

²⁰ Ibid

²¹ Ibid

²² Ibid

²³ (Hartgerink, 2013)

²⁴ (Ndoro, 2014, p. 725)

²⁵ (Hartgerink, 2013, p. 792)

²⁶ (Ndoro, 2014, p. 724); (Hartgerink, 2013)

²⁷ (Ndoro, 2014, p. 726) (Stone, 2011)

²⁸ (Ndoro, 2014, p. 724); (Hartgerink, 2013, p. 792); (Stone, 2011, p. 5)

²⁹ (Ndoro, 2014, p. 726)

- facilitation of the client's entry to and exit from STRC so that the client has a seamless experience;
- effective coordination of the client's needs and goals between services;
- keeping the client and/or their representative well informed prior to moving between care settings (where applicable);
- the facilitation of education, training, networking and support across sectors and service boundaries in the broader health and aged care community where appropriate; and
- the facilitation of access to ongoing care and service provision through to the My Aged Care Gateway post-STRC should this be required.

STRC services must have documented procedures and protocols available to support the MDT in the care and review of clients. This is to include:

- the processes for communicating client information to relevant health professionals;
- all care plan reviews / case conferencing to include those members of the MDT involved in the client's treatment;
- all care plan reviews / case conferencing occur either as required or at predetermined intervals;
- ensuring MDTs have integrated client records;
- the MDT comprises an appropriate mix and level of staff, enabling the provision of effective client services; and
- a coordinator / case manager is in place to oversee and promote effective MDT and inter-agency working.

3.6 Care coordination

Effective coordinated service delivery is critical to the success of each STRC episode. Throughout each STRC episode, care plan reviews, case conferencing and processes for communicating client information must be facilitated. Prior to exit, access to ongoing care, service delivery or assessment should be facilitated where appropriate.

3.7 Duration of care

The duration of each STRC episode is limited to a maximum of eight weeks (56 days). No extensions will be granted beyond this eight week period. A client can enter a second episode of STRC within 12 months provided all eligibility requirements are met.

3.8 Leave provisions / breaks in care

STRC clients may take up to seven days unpaid leave from their episode. For example, a client may require leave to travel interstate for an event. This seven days leave is not counted towards the maximum 56 paid days of care that may be received. Clients could therefore receive STRC over a period of 63 days (56 days of care + 7 days of leave). STRC clients cannot be charged daily care fees during a period of leave. The [Flexible Care Agreement](#) must set out any other fees that may be applicable during a period of leave (e.g. specified care and services provided under Schedule 5 of the [Quality of Care Principles 2014](#) (<https://www.legislation.gov.au/Details/F2020C00096>)).

An STRC client can suspend their STRC episode (take leave) for up to seven days in total if, on that day or those days, the client will be absent overnight from the setting where the STRC is being provided. They can do so for any reason, except if the client enters residential respite care, without impacting their existing approval to receive STRC. For care to be suspended, the care recipient must ask for it to be suspended. STRC providers must grant requests for care to be suspended. If a client enters residential respite care for any duration, including less than 7 days, the STRC episode is considered to have ended on the day before the client enters residential respite, and the client will need to be reassessed before commencing a further episode of STRC (see [3.9.5](#)).

Note: If the provision of STRC is suspended for more than a total of seven days for any reason, the client's STRC episode (and approval to receive STRC) will end. You must cease the client's current episode if:

- their STRC episode is interrupted; and
- they are unable to recommence after the seven day leave period.

If this is the client's **first** episode of STRC, they can commence another episode when they are ready. This does **not** apply if the client's second episode is ceased.

A Support Plan Review request can be submitted to the ACAT where the client is able to commence another episode and would continue to benefit from STRC. You can contact the ACAT to discuss the situation in the first instance.

To initiate a Support Plan Review, submit the request through the My Aged Care provider portal, and provide as much detail as possible to explain the client's circumstances. You will need to note if the client's care needs have changed. The ACAT will then contact the client to undertake the review and determine next steps.

3.8.1 Admission to hospital

Whilst the seven day leave allowance still applies for hospital stays, in some circumstances, leave will not be required. For example, if a hospital admission for a day procedure or if 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.

Some examples of hospital leave are below:

1. If a STRC client were to be admitted to hospital for up to 7 days (not related to the condition that resulted in the referral to STRC) – can they continue to access to STRC post discharge?

Yes - they can continue to receive STRC.

2. If a STRC client were to be admitted to hospital for up to 7 days (related to the condition that resulted in the referral to STRC) – can they continue to access STRC post discharge?

Yes - they can still continue to receive STRC.

3. If a STRC client were to be admitted to hospital for more than 7 days (related OR not related to the condition that resulted in the referral to STRC) – can they continue to access STRC post discharge?

No - if their care is suspended for more than seven days, they can no longer receive STRC as a part of that episode. A new episode would require another assessment against the eligibility criteria and approval.

If a client has a current/valid ACAT, but is admitted to hospital prior to officially starting their STRC care episode, they can continue to remain eligible for STRC. After your client's discharge from hospital, however, careful consideration should be given to the STRC care and services to be provided. As the provider, you may wish to re-assess the client's care needs and either decline to commence STRC or commence the episode at a time that enables the best use of the restorative services.

3.8.2 Extension of leave

There is no provision for STRC leave beyond seven days, even in an emergency situation such as bushfires or COVID-19. Section 111C (5) of the [Subsidy Principles 2014](#) states that an episode of STRC cannot be suspended (i.e. leave taken) for a period of more than seven days. This timeframe is unable to be extended. Therefore, in the event a client has had their STRC episode interrupted and is still unable to recommence after the seven day leave period, the provider should cease the client's current episode, with the client then having the option to commence another episode when they are ready.

For those clients who wish to commence another episode and would continue to benefit from STRC, the provider can contact the ACAT directly to discuss the situation. The ACAT will contact the client to undertake a Support Plan Review and determine next steps. The ACAT will consider any changes in the care needs of the client and determine if a face-to-face assessment may be required.

3.8.3 Ceasing an episode of STRC

While some clients may require the maximum eight weeks of care, other clients may be able to complete the programme in less time. Where the client achieves the goals set out in their [Flexible Care Agreement](#) in less than eight weeks, their approval for the current instance of STRC will cease at the departure date agreed between the approved provider and client (and/or the client's representative).

3.9 Ongoing care / exit strategy

The approved provider, in accordance with its case coordination obligations under the [Specified Care and Services for STRC](#), must provide assistance to clients in finalising and obtaining access to their longer term care arrangements.

The STRC service provider must have systems in place to support the STRC client in the event the client requires ongoing care upon exit from their STRC episode. The service must therefore prepare an exit strategy that:

- provides the client with a copy of the care plan outcomes for inclusion in any future reassessment;
- provides appropriate STRC episode documentation to the client, specifying:
 - the length of stay in the STRC episode;
 - details of any assessment (RAS or ACAT) or referral arranged for the client;
 - the goals which the client agrees have been achieved or not achieved (with reasons for non-achievement);
 - the client's functional levels on entry and discharge from STRC, as assessed using the [MBI](#) assessment process;
 - client and/or representative, carer and family education and support to improve functioning following cessation;
 - where appropriate all services and equipment to be provided to the client on cessation of STRC episode, with key supplier contact details;
 - an up-to-date list of prescribed medications; and
 - a finalised financial statement, including the costs of services (including administrative costs) received by the client.
- includes working with the client to facilitate appropriate supports; and
- includes referring the client back to My Aged Care for an ACAT or RAS for assessment if they require further aged care supports.

The exit strategy must be prepared in advance of the episode ending. It must cover the service arrangements that are recommended to be in place for the client following the STRC episode.

Where the client will be returning to a carer, the carer must be briefed on the exit strategy. The client's consent must also be sought for the exit strategy.

When preparing an exit strategy, provider consideration must be given to the client's potential care needs post-STRC, and these must be discussed with the client. As part of this, it may be felt that a client may benefit from another episode of STRC.

3.9.1 Accessing a second episode of STRC

Eligible clients can access two episodes of STRC within a 12 month period, with no specified timeframe between the episodes. A client **must** be assessed by an ACAT for both episodes, regardless of whether or not the second episode falls within the 6 month validity period ([see 4.1.2](#)) of the first ACAT approval. To ensure the most accurate assessment of client capabilities, the second ACAT approval must not be sought until the client is nearing the end of, or has completed, their first episode.

The 12 month period commences on the **start date of the first episode** (not the date of the ACAT assessment), which ensures both STRC episodes are contained within the same 12 month period. If required, further episodes of STRC can commence on the day after the previous 12 month period expires.

Referrals for a second episode of STRC must be submitted as a Support Plan Review through the My Aged Care Provider Portal. The request will go to the most recent assessment organisation, who can start a new assessment from the Support Plan Request if an ACAT, or if a RAS they can transfer the referral to the ACAT. More information can be found in the Department's fact sheet [When to request a Support Plan Review from an assessor](#).

Examples of second episode of STRC:

John was assessed as eligible for STRC on 1 August 2020, so his ACAT approval period commenced on 2 August 2020 and expired on 2 February 2021. He started his first episode on 1 September 2020 (this is the start of the 12 month STRC period which expires on 1 September 2021) and finished on 27 October (56 days).

During John's exit strategy, he was advised by the provider that another episode of STRC would further improve his reablement. John was required to have another ACAT assessment before the commencement of the second episode, even though his first ACAT period was still valid.

John had another ACAT assessment on 25 November 2020 and his ACAT approval period commenced again on 26 November 2020. John's second episode of STRC commenced on 5 December 2020 and completed on 7 January 2021.

John would not be eligible for another STRC episode until after 2 September 2021.

3.9.2 Pre-entry leave for residential aged care

Pre-entry leave (section 42-3(3) of the Act) cannot be claimed with respect of persons currently receiving STRC. Pre-entry leave is 7 days of leave which can be taken after accepting a place but before moving into the aged care home. This allows the resident to secure their place and prepare for the move.

If a client enters or receives **permanent** care in an aged care home, they are not eligible for STRC. The exclusion of clients who are permanent residents prevents providers from claiming both the residential care subsidy and STRC subsidy with respect to the same client at the same time.

3.9.3 Accessing a Home Care Package (HCP)

In line with Section 8A(C) of the *Approval of Care Recipients Principles 2014*, a person cannot receive STRC if they are also receiving a Home Care Package (HCP) (home care under the Act). This also extends to people on leave from their HCP.

For clients who have not yet met their physical and cognitive goals but wish to end their STRC episode early in order to accept a HCP, or residential care place, their ongoing care plan should include strategies to help the client and their carer or family to meet their goals after exit from the programme.

3.9.4 Transition Care Programme (TCP)

Under Section 8A(C) of the [Approval of Care Recipients Principles 2014](#), a person cannot receive STRC if they are also currently receiving, or on leave from, flexible care in the form of transition care. A person is also not eligible for STRC if they would be assessed as eligible for the transition care if they applied for it, or have received transition care during the six months before the date of assessment.

A situation could arise where a person is approved for STRC and is then subsequently admitted to hospital prior to starting their STRC episode. If the person is approved by an ACAT as eligible for transition care, this does not technically impact on their STRC episode (unless they are starting their STRC episode outside of the ACAT validity period). This is because both the eligibility criteria around transition care and hospitalisation are centred on the date of assessment.

In this event, commencing an episode of STRC soon after transition care is not in line with the programme intent. As such, it is important to consider whether the care needs of the client have changed from what they were at the time of the ACAT assessment, as a result of their hospitalisation/transition care episode, and whether STRC is still the best care option for them. This same reasoning applies for someone who is admitted to hospital (for more than 7 days) after their ACAT assessment/approval, but has not yet started their STRC episode.

3.9.5 Residential Respite

If a client enters residential respite care (i.e. respite care provided in a residential aged care home through a residential aged care place) for any duration, including less than 7 days, the STRC episode is considered to have ended on the day before the client enters residential respite care. A client will need to be reassessed before commencing a further episode of STRC. Please note that the provision of respite care through other mechanisms such as respite in a home or cottage setting funded through the Commonwealth Home Support Programme, does not affect a client's eligibility to receive STRC.

3.10 Rights and responsibilities

3.10.1 Clients' and provider rights and responsibilities

Care recipient rights and responsibilities for STRC clients are specified in the Charter of Aged Care Rights in Schedule 1 of the [User Rights Principles 2014](#) (<https://www.legislation.gov.au/Details/F2019C00619>).

Approved providers must present information to clients on the role of advocates. To assist providers with this requirement a [Charter of Aged Care Rights Template for Signing](#) is available for use.

The rights and responsibilities of each party must be clearly articulated in each [Flexible Care Agreement](#). The agreement must be consistent with the Act and its principles.

3.10.2 Advocacy

The Specified Care and Services for STRC (reproduced in [Chapter 6](#)) provides for the client to have access to an advocate.

Service providers are required under the Act and its principles to accept the client's choice of advocate.

A client 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 [Flexible Care Agreement](#) and/or their care plan, negotiating the fees they may be asked to pay, and in presenting any complaints they may have.

A carer can advocate on behalf of a client directly with a provider. If they are dissatisfied with the provider's response they can speak to someone about this. The provider should direct them to the [National Aged Care Advocacy Program](#) (NACAP).

The NACAP is funded by the Australian Government under the Act. It provides free, independent and confidential advocacy support and information to older people (and their representatives) receiving, or seeking to receive, Australian Government funded aged care services. STRC clients are eligible for assistance through the NACAP. The [Older Persons Advocacy Network \(OPAN\)](#) provides NACAP services across Australia.

More information about NACAP can be found on:

- the [My Aged Care](#) website (<https://www.myagedcare.gov.au/advocacy>), and
- the [Department's](#) website (<https://www.health.gov.au/initiatives-and-programs/national-aged-care-advocacy-program-nacap>).

3.10.3 Privacy / confidentiality

The Australian Government, approved providers and members of the multidisciplinary team (engaged by the approved providers), can only use personal information concerning a client:

- for a purpose connected with the provision of STRC to the client; or
- for a purpose for which the personal information is given by the client.

It is the responsibility of each approved provider to ensure that members of the multidisciplinary team protect the privacy of the client and comply with all applicable laws relating to the use of personal information.

Approved providers must implement security safeguards to protect personal information relating to clients against loss or misuse (section 62-1(c) of the Act).

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.

Part 6.2 and sections 62-1 to 62-2 of the [Act](https://www.legislation.gov.au/Details/C2020C00164) (<https://www.legislation.gov.au/Details/C2020C00164>) 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 clients.

3.10.4 Use of protected information

Approved providers must familiarise themselves and their staff with Part 6.2 of the Act, which relates to the protection of information, including the use and disclosure of protected information. Protected information is defined under section 86-1 of the Act as information that was acquired under or for the purposes of the Act; and:

- is personal information (as defined in the Privacy Act 1988);
- relates to the affairs of an approved provider;
- relates to the affairs of an applicant for approval under Part 2.1 of the Act; or
- relates to the affairs of an applicant for a grant under Chapter 5 of the Act.

Any unauthorised release or misuse of protected information can result in a breach of the Act with personal penalties of up to two years imprisonment.

Part 6.2 of the [Act](https://www.legislation.gov.au/Details/C2020C00164) (<https://www.legislation.gov.au/Details/C2020C00164>) controls the use and disclosure of protected information.

3.11 Care fees

Subject to certain conditions, the approved provider may charge client fees for STRC.

3.11.1 Determining care fees

The care fees that a client must pay are to be agreed upon in the Flexible Care Agreement, at [3.3](#) above. The process of agreeing to care fees should be as simple and unobtrusive as possible, respecting the client's right to privacy and confidentiality.

3.11.2 Maximum amount that may be charged for care and services

The care fee that clients may be charged for STRC is calculated on a daily basis for every day the client receives care.

- For STRC delivered in a residential care setting, the maximum value of the care fee is 85% of the basic daily rate of the single basic age pension.
- For STRC delivered in the home, the maximum care fee is 17.5% of the basic daily rate of the single basic age pension.

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

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

When new pension rates are announced (which is generally in March and September), the Department will notify the approved providers of any variations in the rate of the maximum care fees for STRC. Approved providers may want to initiate negotiations (bearing in mind that fees cannot go above their respective caps) with clients following these variations. Approved providers should familiarise themselves with the pension rates, which are available at the Services Australia [website](https://www.servicesaustralia.gov.au/individuals/services/centrelink/age-pension) (<https://www.servicesaustralia.gov.au/individuals/services/centrelink/age-pension>).

3.11.3 Affordability of care

Approved providers must not refuse to provide STRC to a person because of the person's inability to pay fees. Where a client states that they cannot afford fees and provides reasonable evidence of this, the approved provider must waive the client fee.

To ascertain a client's ability to make a contribution to the cost of their STRC, the service provider may only make a request for information that is reasonable under the circumstances. In determining a client's capacity to pay fees, the service provider should take into account any exceptional and unavoidable expenses incurred by the client, such as high pharmaceutical bills.

Clients must not be asked to pay fees that cover a period of leave. A detailed classification of leave can be found under [section 3.7](#).

Fees may be waived during the STRC episode should the client's financial circumstances change.

The intent of STRC is for the approved provider to assist a client to improve their level of physical and cognitive functioning, however, neither the STRC program nor the provider is responsible for refunds, replacement or ongoing costs associated with items purchased during the STRC episode.

3.11.4 Refundable Accommodation Deposits (RADs) and Daily Accommodation Payments (DAPs)

The approved provider, or the approved provider's nominee, must not seek or accept from a client, or a prospective client, any lump sum refundable accommodation deposit (be that as a refundable accommodation deposit (RAD) or refundable accommodation contribution (RAC)) or rental style daily accommodation payment (be that as a daily accommodation payment (DAP) or daily accommodation contribution (DAC)) or any other form of financial benefit other than that described in this section, in relation to STRC.

Note: The approved provider's nominee may be an organisation.

3.11.5 Payment of fees in advance

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

As the STRC Programme is focused on delivering care and services, care fees received in advance must only be used to benefit the paying client. Unused fees must be refunded to the client or their estate.

Approved providers must not require a client to pay fees for any period prior to the time when the approved provider commenced provision of STRC.

Where a client's fees will be paid for by the Department of Veterans Affairs (DVA) (see 3.11.6 below), the approved provider may not ask for payment of fees in advance.

For STRC claiming enquiries, please contact Services Australia on **1800 195 206** or via email to: aged.care.liaison@servicesaustralia.gov.au

3.11.6 Care fees for DVA Clients and Veterans

Former prisoners of war (POW) and Victoria Cross (VC) recipients receiving STRC may be asked to pay a fee. However, DVA will pay the daily care fee component on their behalf.

All other members of the veteran community may be asked to pay a fee towards the cost of their care.

Where an approved provider is delivering STRC to a veteran, the approved provider must inform the client that any former POW and VC recipients will have any fees associated with the care delivery paid by DVA.

Where a client identifies as a POW or VC recipient, the approved provider must contact DVA on 133 254 or at health.approval@dva.gov.au to arrange for the payment of care fees to be made.

3.12 Complaints

Service providers must ensure clients are fully informed of the mechanisms available for making a complaint. This includes informing clients (or their representatives) via the [Flexible Care Agreement](#), of internal and external mechanisms for addressing complaints made by, or on behalf of, the client.

It is a condition of allocation that providers of the STRC Programme must allow the [Aged Care Quality and Safety Commission](#) (the Commission) to manage complaints about their services (which may include access in order to assess and report to the Department) where the Commission deems it necessary to discharge their functions.

3.12.1 Internal complaints processes

If clients have concerns with regard to the provision of their STRC episode, 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 clients. 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 clients to provide feedback, both positive and negative, and duly considering this feedback will improve services and provide continuous improvement.

3.12.2 External complaints

To cater for situations where the client, their carer or family representative is uncomfortable making a complaint direct to the approved provider, the approved provider must inform them – **before care**

delivery commences – that complaints can be lodged with the Commission. This is a free service for anyone to raise a concern or make a complaint about the quality of care or services provided to people receiving Australian Government funded aged care.

Complaints can be submitted to the Commission:

- **Online** – visit the Commission’s website (www.agedcarequality.gov.au)
- **By telephone** – call [1800 951 822](tel:1800951822)
- **In writing** – address written complaints to:
Aged Care Quality and Safety Commission GPO Box 9819
(The capital city of your state / territory)

Information about making a complaint is available on the Commission’s [website](#).

3.13 Quality of care

STRC providers are required to comply with the relevant sections of the [Aged Care Quality Standards](#) (<https://www.agedcarequality.gov.au/providers/standards>), as outlined in the [Application of Aged Care Quality Standards by Service Type](#).

The Aged Care Quality Standards focus on quality outcomes for consumers rather than provider processes. This will make it easier for consumers, their families, carers and representatives to understand what they can expect from a service. It will also make regulation simpler for providers working across multiple aged care services, and encourage innovation, excellence and continuous improvement.

Resources for providers and consumers are available from the Commission. This includes Guidance and Resources on the Aged Care Quality Standards for Providers to assist aged care services to implement, and maintain compliance with the Aged Care Quality Standards.

Importantly, there are no additional accreditations or quality review requirements in those instances where the provider is an approved provider of STRC and also an approved provider for residential care or home care.

Consistent with compliance activity for other types of aged care under the Act, compliance action may be taken against approved providers who do not meet their responsibilities.

3.13.1 People with special needs

Approved providers must manage the delivery of STRC to ensure that they can cater for people with special needs as defined in section 11-3 of the Act. Section 11-3 defines people with special needs as:

- people from Aboriginal and Torres Strait Islander communities;
- people from culturally and linguistically diverse backgrounds (*refer to the [National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse Backgrounds](#) (<https://fecca.org.au/wp-content/uploads/2015/06/national-cald-aged-care-strategy.pdf>)*);
- 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;
- 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*.

3.13.2 Older people with dementia

Each person's experience with dementia is unique and some older people with dementia may benefit from tailored care following a setback or functional decline. Older 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 it. For older people with dementia who have difficulty expressing their care goals, the development of care goals should involve the person's family, carer and/or representative.

3.14 Functional review at entry to and exit from STRC

STRC services must use the Modified Barthel Index³⁰ (MBI) 0-100 point system to assess clients at entry to, and exit from, an STRC episode. A better practice approach is to have the same person conduct an MBI on a client's entry to, and exit from, the programme. While it is acknowledged that this may not be possible in every case, staff availability and staff competency are matters for providers to manage as part of the care coordination component of STRC.

An MBI template is available at [Attachment D](#).

As a part of the process for claiming the STRC subsidy, STRC providers must provide the entry and exit functional capacity scores of each client. This scoring will be on the Claim for Subsidy form and must be completed in order for the subsidy to be claimed and payment to be made. An increase in functional capability would point to goals being met. While it would be preferable for the MBI assessment to be delivered by a health professional, there is no requirement for it to be delivered by someone with a specific qualification.

In using the MBI for clients with dementia, it is noted that

- i. *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.*³¹
- ii. *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.*³²
- iii. *The Modified Barthel Index should be applied periodically to monitor client progress 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.*³³

³⁰ **Source:** Older people leaving hospital: A statistical overview of the Transition Care Programme in 2008–09 (Australian Institute of Health and Welfare)

³¹ **Source:** Rockwood, K. & MacKnight, C. (2001). Understanding Dementia: A Primer of Diagnosis and Management. Retrieved from Dementia Guide

³² **Source:** Collin, C., Wade, D.T., Davies, S., Horne, V. (1988). The Barthel ADL Index: a reliability study. International Disability Studies, 10(2), 61-6

³³ **Source:** Juva, K., Makela, M., Erkinjuntti, T., Sulkava, R., Yukoski, R., Valvanne, J. & Tilvis, R. (1996) Functional assessment scales in detecting dementia. Oxford Journals: Age and Ageing. 26(5), 393-400.

The Modified Barthel Index (MBI)

The MBI is a tool used to measure personal functioning, or the ability to perform certain self-care tasks. Specifically, the MBI measures how much help a person needs with personal hygiene, bathing, feeding, using the toilet, stair climbing, bowel control, bladder control, ambulation or the ability to move about (for those not in a wheelchair), wheelchair use for those trained in using one, and chair / bed transfers. The MBI score is measured at the start and end of the STRC Programme care.

Scoring

For each of the elements mentioned above, there are five associated questions, which are ranked on a numerical scale. This scale ranges from 0 to 5, 10 or 15, depending on the element, with 0 being 'unable to perform the task', through to 5, 10 or 15 being 'fully independent'. The scores for these elements are then added to obtain a total score. The total MBI scores are out of 100 and for STRC this overall score is related to level of dependency and hours of help required per week. Lower scores relate to greater levels of dependency and hours of help and higher scores relate to lower dependency levels and hours of help.

When a STRC recipient dies or is admitted to hospital, the MBI score at the end of the episode is recorded as zero.

3.14.1 Alternate assessment tools

In addition to the MBI, providers may supplement the assessment of client functionality with other relevant tools. It is important to note that these assessment systems cannot replace the use of the MBI, but must be used as ancillary tools.

3.15 Care delivery when client changes location

The conditions of allocation attached to STRC services enable the delivery of care anywhere **within the specified state / territory**. Priority must, however, be given to people in the region targeted by the service in its application for places.

If the client relocates during the care period and:

1. The client moves to a location where the same approved provider is also able to operate effectively (noting that providers will not always have appropriate linkages in all areas of the state / territory) the provider may continue to deliver care to the client.
2. The client moves to a location where their approved provider cannot deliver effectively, but a different approved provider does operate an STRC service, then the original approved provider, where reasonable, should negotiate a sub-contracting arrangement with the receiving approved provider in order to complete the client's episode of care.
3. The client moves to a location where there is no approved provider capable of delivering STRC, the exit strategy outlined in [section 3.9 \(ongoing care\)](#) should be implemented. This exit strategy should have covered the service arrangements that are expected to be in place for the client following STRC, a carer briefing, and the client's consent for the exit strategy.

3.16 Accountability

STRC approved providers must adhere to the accountability requirements of the legislation. For example, providers are to maintain and retain records relating to the service and comply with any conditions of allocation to which the places included in the service are subject. The legislation requires that all staff and volunteers have a current police certificate.³⁴

³⁴ Accountability Principles 2014, Part 6.

Division 63 of the [Act](https://www.legislation.gov.au/Details/C2020C00164) (https://www.legislation.gov.au/Details/C2020C00164), the [Approved Provider Principles 2014](https://www.legislation.gov.au/Latest/F2014L00698) (https://www.legislation.gov.au/Latest/F2014L00698) and [Accountability Principles 2014](https://www.legislation.gov.au/Details/F2020C00068) (https://www.legislation.gov.au/Details/F2020C00068)

3.17 Record keeping

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

Divisions 88 to 89 of the [Act](https://www.legislation.gov.au/Details/C2020C00164) (https://www.legislation.gov.au/Details/C2020C00164) 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 clients. It also covers the issue of false and misleading records and the penalties that may apply.

3.18 Participation in programme reviews

Approved providers must participate in any monitoring and evaluation programmes undertaken by the Department including the provision of de-identified client data upon request by the Department or its representative/s.

STRC providers must participate in any programme reviews, assessments, or evaluation, including participation in surveys, census taking and in any on-going provision of care recipient and service data.

The Department will work collaboratively with approved providers, as part of a national approach to developing mutually agreed strategies for any review, assessment or evaluation of the STRC Programme. Further information is available on the Aged Care Quality and Safety Commission's website: <https://www.agedcarequality.gov.au/providers/standards>

3.19 Insurance

Approved providers must ensure that they and their service providers maintain appropriate insurance while providing STRC. Service providers should be aware of any relevant state or territory legislation regarding insurance requirements and standards that may affect the delivery of STRC services.

4 CHAPTER 4 – CLIENT ENTRY INTO STRC

4.1 Approval and referral process

As required under the [Approval of Care Recipients Principles 2014](#), to be eligible for STRC a person must first be approved by an ACAT delegate as requiring STRC. People can access an ACAT assessment by contacting the My Aged Care contact centre on **1800 200 422** or by submitting a web form referral through the [My Aged Care website](http://www.myagedcare.gov.au/) (<http://www.myagedcare.gov.au/>).

My Aged Care Regional Assessment Service (RAS) home support assessors are able to refer suitable clients who are identified as requiring a comprehensive assessment to the ACAT, through the My Aged Care system. Additionally, the My Aged Care website has a specially designed referral web form that health professionals can use to refer their clients to My Aged Care for an ACAT assessment.

STRC providers will need to be set up in My Aged Care to access the provider portal, manage referrals and view the client record including assessment and approval information. The approved provider should ensure all service availability and waitlist information is up to date in the provider portal so the ACAT can make appropriate referrals on the My Aged Care system. Further information and resources are available on the Department's [website](https://www.health.gov.au/initiatives-and-programs/my-aged-care/using-my-aged-care/my-aged-care-for-service-providers) (<https://www.health.gov.au/initiatives-and-programs/my-aged-care/using-my-aged-care/my-aged-care-for-service-providers>). You can also get system support from the My Aged Care assessor and provider helpline on **1800 836 799**.

As with all ACAT assessments, where appropriate, and with the client's permission, the assessment should involve:

- the client 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 (e.g. existing DVA service providers if identified as a DVA client).

As with all ACAT approvals, clients should be reminded that approval as a client does not guarantee a place, particularly if a vacancy does not present itself within the entry period.

4.1.1 Lapsing of approval to access STRC

Under Part 5, section 15(2) of the [Approval of Care Recipient Principles 2014](#), ACAT approval to enter STRC is valid for six months, **beginning on the day after the approval is given**. To receive STRC, the person must enter STRC within this six month 'entry period'. If the person does not enter the programme within the entry period, their approval will lapse and they will need a re-assessment and another approval for STRC, if appropriate. The client's entry period start and end dates are clearly displayed under the STRC approval on the Approvals tab of the client record.

4.1.2 Accepting and rejecting care

A person who is approved to receive STRC by an ACAT delegate is not obliged to receive STRC.

An STRC service is not obliged to provide STRC to a potential client. The decision to accept or reject a referral is a decision for the STRC provider.

When accepting a client, however, STRC providers must give priority of access to people in the region(s) specified in the conditions of allocation linked to their STRC places.

Example of timings of ACAT and entering an STRC episode

1. Joan was approved for STRC by the ACAT delegate on 12 September 2019. As such, her approval takes effect from 13 September 2019 and is valid for 6 months. Joan has until midnight on 13 March 2020 to commence her STRC episode, after which time her approval becomes invalid.
2. Raj was approved to receive STRC by the ACAT delegate on 30 October 2019. As such, his approval takes effect from 31 October 2019 and is valid for 6 months. Raj has until midnight on 30 April 2020 to commence his STRC episode, after which time his approval becomes invalid. This end date reflects the last day of the calendar month that is 6 months after the approval month.

4.1.3 Termination of care

The [Flexible Care Agreement](#) must set out conditions under which either party may terminate the provision of STRC.

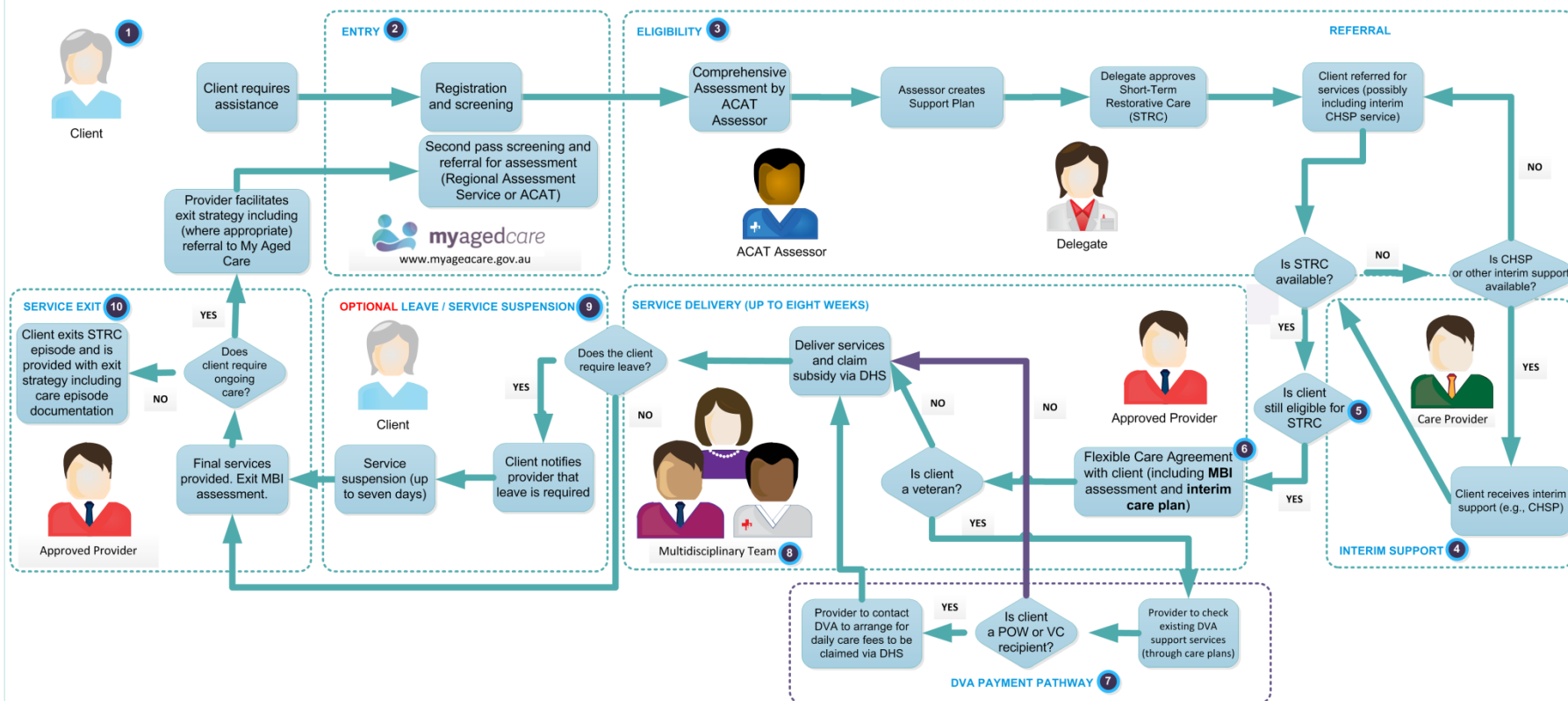
An episode of STRC can only be terminated unilaterally in accordance with the conditions in the [Flexible Care Agreement](#).

4.2 Client journey

The following diagram details how a potential STRC client would move through the process of assessment to access STRC, and how they may be referred to different aged care programmes.

Short-Term Restorative Care

Client Journey



NOTES

1 Carers and informal supports

Clients may be supported by carers or informal supports.

2 Entry

Clients may contact My Aged Care themselves, or be registered by someone else (e.g., their carer, or general practitioner).

3 Eligibility

ACATs will comprehensively assess a client's eligibility for aged care. The proposed Support Plan may include any care type a person is eligible (e.g., STRC together with a level 2 Home Care Package).

4 Referral

The ACAT's role continues to the point of effective referral. Where STRC is not immediately available, referrals to suitable interim supports (e.g., CHSP or residential respite) must be made.

5 Ongoing eligibility

- A client's approval to receive STRC lasts six months.
- A client cannot receive STRC if they are receiving or on leave from a Home Care Package, Residential Care (including respite), or another form of Flexible Care.
- STRC can be received together with CHSP services (e.g., if the service is different but complementary).

6 Flexible Care Agreement

Includes interim care plan and agreement as to client contribution to care cost (daily care fee). Preparation includes carrying out an MBI assessment.

7 DVA payments

Where a client identifies as a veteran, the approved provider must contact DVA before negotiating client contributions, as DVA will pay the daily care fees for former POWs or VC recipients.

8 Multidisciplinary Team

Care planning and service delivery must be carried out using a multidisciplinary team, with three members at least one of which must be a medical practitioner.

9 Leave / service suspension

If leave is to be taken, the approved provider must be notified. Leave days do not need to be consecutive, but only a total of seven may be taken.

10 Exit Strategy

The approved provider must prepare an exit strategy for the client. Where ongoing care is required, appropriate facilitation of care / services must be undertaken.

4.3 Client eligibility for STRC

Any individual wishing to receive STRC will need to be referred for an 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. The ACAT delegate will only approve a person if the person meets the eligibility criteria for STRC.

4.3.1 Eligibility under the Act

Section 21-4(c) of the Act and section 8A of the [Approval of Care Recipients Principles 2014](#) (<https://www.legislation.gov.au/Latest/F2016C00452>) set out the eligibility criteria a person needs to be eligible to receive flexible care in the form of STRC. To receive STRC an individual must be:

- experiencing functional decline (see [section 2.2.1](#)) that is likely to be reversed or slowed through short term restorative care;
- at risk of losing independence to such a degree that, without STRC, it is likely that the person will require home care, residential care or flexible care provided through a multi-purpose service.

And:

- not currently be receiving residential care, home care through a Commonwealth HCP or transition care;
- would not be assessed as eligible to receive transition care if the person applied for it;
- not, at any time during the six months before the date of assessment, received flexible care in the form of transition care;
- not, at any time during the three months before the date of assessment, been hospitalised for a condition related to the functional decline which would be the focus of that episode of STRC;
- not receiving end of life care; and
- not have accessed more than two episodes of STRC in the previous 12 month period ([see 3.9.1](#)).

4.3.2 Access by DVA clients

People in receipt of the following DVA services are able (where otherwise eligible and approved) to access STRC:

- Veterans' Home Care (VHC)
- Community Nursing (CN)
- Rehabilitation Appliances Programme (RAP)
- Attendant care
- Household services
- Home modifications
- Counselling Services including the Veterans and Veterans Families Counselling Service (VVCS) (now known as Open Arms - Veterans and Families Counselling)
- Coordinated Veterans' Care (CVC)
- Medical and Allied Health services

Note: For identified DVA clients, providers should check with the client and their nominated representative or carer for the services the client may be accessing from DVA to ensure care is coordinated with existing support/services and there is no duplication.

4.3.3 Access by older people who usually reside interstate

The eligibility provisions for STRC under the Act and the Transitional Provisions do not restrict provision of care based on where clients live, or where they are assessed. Older people who are not permanent residents of a particular state, territory or region where they are currently residing can therefore access STRC services in that state, territory or region in particular circumstances. For example, a client temporarily staying with family or friends away from their usual place of residence can be provided STRC services in this location, if suitable and agreed by their hosts, carer and/or representative. It is important that STRC commences as soon as practical.

If the client relocates during the care period and the client moves to a location where the same approved provider is also able to operate effectively (noting that providers will not always have appropriate linkages in all areas of the state / territory) the provider may continue to deliver care to the client. The provider cannot use places to deliver services outside the state or territory where they were allocated.

4.3.4 Access by 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 clients. 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 receiving STRC. There are several countries, however, with which Australia has reciprocal health agreements, and people from these countries may be eligible for Medicare. Further information is available on the Services Australia [website](https://www.servicesaustralia.gov.au/individuals/services/medicare/reciprocal-health-care-agreements) (<https://www.servicesaustralia.gov.au/individuals/services/medicare/reciprocal-health-care-agreements>).

The requirements of this Manual apply to people from overseas.

4.3.5 Access by National Disability Insurance Scheme (NDIS) participants

As STRC is a time-limited flexible care programme, an episode of STRC will not make the client ineligible to receive NDIS services.³⁵ Conversely, receipt of NDIS services will not prevent an otherwise eligible person from receiving STRC services. There is an expectation in both the NDIS scheme and the STRC Programme that care be coordinated with other services.

If a person has an approved NDIS plan they may be able to access services through the programme where other disability or aged care services are not appropriate or available. In this situation, the National Disability Insurance Agency (NDIA) should facilitate contact with My Aged Care so that a referral to an ACAT can be arranged. The NDIA should be able to provide evidence that clearly demonstrates an NDIS plan is in place, that all other options have been tested, and that short-term restorative care is the only practical service response. Where people are receiving services under both programs at the same time, it is expected that providers will coordinate care to ensure that there is no duplication of services.

³⁵ In accordance with section 29 of the National Disability Insurance Scheme Act 2013, an NDIS participant will cease to be an NDIS participant if they commence receiving permanent residential or permanent community aged care (i.e. home care packages).

5 CHAPTER 5: FINANCIAL MANAGEMENT OF STRC PLACES

5.1 Client entry and payment of subsidy

In accordance with the Act, an approved provider is eligible for flexible care subsidy for STRC in respect of a day if the Secretary³⁶ is satisfied that, during that day, the STRC service provider:

- holds an allocation of places for flexible care subsidy that is in force (under Part 2.2 of the Act (other than a provisional allocation));
- is providing care according to a care plan;
- has offered a [Flexible Care Agreement](#) to the client prior to service delivery;
- delivered flexible care in the form of STRC, as defined under Chapter 4 of the *Subsidy Principles 2014*, to an approved client; and
- is an approved provider of STRC.

An STRC service provider is not eligible for flexible care subsidy for STRC provided to a client, if:

- the client is excluded (under section 50-3 of the Act) because the STRC service provider exceeds their allocation of places for flexible care subsidy for a STRC Service (see subsection 50-1(2) of the Act).
- if the client is not approved as a recipient of flexible care (see Divisions 7 and 20 of the Act).

5.1.1 Submitting claims through Services Australia

The STRC provider should, no later than on the twentieth day of the calendar month following the end of each payment period (a payment period being one calendar month), give to Services Australia:

- a digital or paper-based claim for flexible care subsidy for STRC that is, or may become, payable in respect of the service for that payment period; and
- any information relating to the claim that is stated on the form to be required.

The claim requires STRC providers to:

- provide the functional capacity score of each client on entry to and on exit from the STRC service using the MBI 0-100 point system; and
- provide the number of days spent in a community care setting or residential care setting for each client for that claim month.

The claim also replaces the need to submit Aged Care Entry Record (ACER) forms for STRC care recipients.

Claims and events are to be lodged either:

- Digitally via the Aged Care Provider Portal; or
- By emailing a completed claim form to aged.care.liaison@servicesaustralia.gov.au

To request a claim for payment form, STRC providers can contact Services Australia on **1800 195 206** Monday to Friday, between 9.00 am and 5.00 pm (call charges may apply). Please ensure you have your NAPS Service ID number ready.

If using paper claim forms, providers must ensure that the correct Registered Post address is registered in the system, as statements will only be sent by Services Australia to a postal address, not the physical address of the service.

³⁶ **Note:** the Secretary includes the Secretary's delegate.

Providers who choose to register claim events via the Aged Care Provider Portal can view and download statements digitally at any time.

5.1.2 Subsidy payments

The Flexible Care Subsidy for STRC is payable monthly in advance and any adjustment is made to a subsequent monthly advance, for any overpayment or underpayment.

An advance of flexible care subsidy for STRC is not payable in respect of a payment period (other than the first payment) if the STRC service provider has not made a claim, relating to the last preceding payment period for the service. For example, an advance for flexible care subsidy for STRC is not payable for March if Services Australia has not been given a claim for January of the same year.

The amount of flexible care subsidy for STRC that will be paid for the first STRC payment period will be based on the expected occupancy level for that period.

The maximum period for payment of flexible care subsidy for a specific episode of STRC (in respect of a particular approved client), is 56 days.

The total amount of STRC subsidy that can currently be claimed is the combined total of the basic subsidy amount and the dementia and veterans' supplement equivalent amount for the current financial year. The subsidy amounts are indexed annually and set out in the Chapter 4, Part 4 of the [Aged Care \(Subsidy, Fees and Payments\) Determination 2014](#)³⁷. It is important to note that the reference to the 'dementia and veterans' supplement' is for an **equivalent** amount. As such, it is not a supplement in itself, and hence there is no specific application process for that component. The combined amount is automatically paid to providers. In order to be paid a subsidy for STRC services, you will need to ensure your organisation's bank details are registered appropriately with Services Australia.

- Providers should complete the [Application to add or change approved care service's bank details form](#)
- Submit the form to the Services Australia Aged Care Payments team at: aged.care.liaison@servicesaustralia.gov.au

5.1.3 New providers applying for a subsidy

For new STRC providers, the first claim will be blank and will have to be populated with the organisation's details. All subsequent claims will be prepopulated with the same information. Each month providers need to check this information is correct and update if necessary.

All providers, in particular new providers, need to ensure they have their **NAPS Service ID number & Aged Care User ID** (if claiming online) available when contacting Services Australia.

5.2 Use of subsidy

Any expenditure of STRC funds must be in line with recommendations of the multidisciplinary team and must be primarily spent on care delivery. This includes services provided by the multidisciplinary care team, as well as other health professionals. To assist with transparency, providers are required to discuss with the client and/or their representative how the subsidy is being used, including any items being purchased and their cost. This needs to be clearly outlined in the [Flexible Care Agreement](#). A financial statement must also be provided to the care recipient at a frequency agreed upon in that agreement.

³⁷ Aged Care (Subsidy, Fees and Payments) Determination 2014 (<https://www.legislation.gov.au/Details/F2020C00634>)

When preparing financial statements, the provider should clearly show both direct and indirect costs to the client.

As part of the service delivery model, STRC funding must primarily be spent on care delivery. In some circumstances, STRC service providers are able to have sub-contracting/brokerage arrangements with other organisations for the delivery of services, but the provider is ultimately responsible for compliance with the programme objectives and legislation. As care delivery is the primary focus of STRC, payment of health professionals and members of the multidisciplinary team will usually account for a significant portion of the subsidy payment.

Any part of a STRC subsidy payment that is an overpayment is a debt to the Commonwealth to be recovered in accordance with Part 6.5 of the Act. Any overpayment of subsidy should be identified on the following months claim for subsidy form.

It is important to note that the STRC program is not a package of funding and clients do not have discretion to spend funds in the same way they might under a Home Care Package. Rather, STRC provides a range of services that form a multidisciplinary package of care designed to optimise the functioning and independence of older people.

STRC funding must not be used to pay for activities that do not meet the objectives of the programme (e.g., hairdressing or entertainment services). If a client wishes to receive such services, the cost must be met by the client.

There are clear limits on what can be included in a client's care plan, which must be developed in conjunction with a multidisciplinary team of health professionals. Providers should ensure potential clients understand how funds are allocated for each episode, such as what is spent on administration fees (including care coordination).

5.3 Unspent Funds

As the STRC 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.

While some clients may require the maximum eight weeks of care, other clients may be able to complete the programme in less time. Client fee contributions and subsidy are only paid for days that are covered by the care plan included in the Flexible Care Agreement and it is expected that fees and subsidy will be directed towards delivering the care the client needs (including the administration and care coordination costs associated with delivering this care).

This should be detailed in the budget agreed to with the client at the commencement of the program. For transparency, all costs relating to the delivery of the STRC episode, including administration, care coordination, and any unspent funds need to be documented and financial statements provided to the client.

In instances where services such as home modifications cannot be delivered and completed within the 8 week timeframe, it is appropriate to arrange the equipment during the episode, and put the money aside to pay the invoices once it has been completed.

Any unspent funds should be clearly documented in the provider's financial statements and reported to the Department (email strc@health.gov.au), who will then make a determination on whether funds will be recovered. For further information regarding the acquittal of unspent funds, please email - aged.care.liason@servicesaustralia.gov.au.

5.4 Payment of medical clinicians

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](#) (MBS)

(<http://www.mbsonline.gov.au>), or the [Pharmaceutical Benefits Scheme](http://www.pbs.gov.au) (<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 via the MBS.

Where appropriate, Medicare would cover the relevant portion of the service fee and the remaining amount (gap payment/out-of-pocket cost) would be paid for by the client directly, or by the STRC provider using the client contribution.

As of 13 March 2020, there are additional COVID-19 Telehealth [MBS](#) items that can be claimed through Medicare. These items include: GPs and other Medical Practitioners, Nurse Practitioners, Occupational Therapists and Social Workers. Further information is available at: www.health.gov.au/sites/default/files/documents/2020/03/covid-19-national-health-plan-primary-care-bulk-billed-mbs-telehealth-services_2.pdf

5.5 Private Health Insurance

STRC funds may be used to pay the remainder or gap for your client's private health insurance for appointments such as physiotherapy, as long as no Medicare benefit is payable for that part of the treatment.

Your client's private health insurance policy may have restrictions on benefits where another party is liable for all or part of the charges for a covered service. Your client may wish to discuss this with their insurer or the Private Health Insurance Ombudsman (PHIO) which can provide free, independent advice on health insurance.

Contact the PHIO on 1300 362 072, by email to phio.info@ombudsman.gov.au or through: www.ombudsman.gov.au.

5.6 Subcontracting STRC for the delivery of services

In some circumstances, STRC service providers are able to have sub-contracting/brokerage arrangements with other organisations for the delivery of services, but the provider is ultimately responsible for compliance with the programme objectives and legislation, in accordance with the Act and its principles.

5.7 Places Management

5.7.1 Revocation of STRC places

Approved providers must note that the Secretary of the Department of Health may revoke the allocation of a place if the approved provider to whom the place is allocated has not, for a continuous period of six months, provided care in respect of the place.

5.7.2 Transfers of STRC places

Aged care places can only be transferred to another organisation through the submission of a Notice to Transfer Aged Care Places to Another Provider form (Transfer Notice) to the Department. The Transfer Notice must be complete and signed by both the transferee (the receiving organisation) and the transferor (the transferring organisation).

The Department reserves the right to veto the transfer or issue a Notice to Resolve, as occurs with transfer of other aged care places.

The approved Transfer Notice form can be downloaded from the Department's [website](https://www.health.gov.au/resources/publications/notice-to-transfer-aged-care-places-to-another-provider) (<https://www.health.gov.au/resources/publications/notice-to-transfer-aged-care-places-to-another-provider>)

5.7.3 Surrender of STRC places

If an approved provider elects to close its STRC services, under section 15-6 of the Act the approved provider may surrender (relinquish) the allocation of STRC places by providing notice in writing to the relevant state or territory office of the Department at least 60 days before the proposed date of surrender. The approved provider must ensure that the care needs of clients are appropriately met before surrendering places.

Further information on management of STRC places:

For further information, either phone **1800 020 103** and ask to speak to the Places Management section in the state or territory office where the service is located, or email the relevant state or territory office at:

NSWplaces@health.gov.au (NSW and ACT)

NTplaces@health.gov.au

Qldplaces@health.gov.au

SAplaces@health.gov.au

Tasplaces@health.gov.au

Vicplaces@health.gov.au

WApplaces@health.gov.au

6 CHAPTER 6: SPECIFIED CARE AND SERVICES FOR STRC

The types of care and services that can currently be included in a STRC care plan include those referred to below for delivery in both the residential and home based settings. Advice on those services / items that cannot be provided under STRC is also provided.

The required care and services are as stated in Schedule 5 of the [Quality of Care Principles 2014](#). Where care is delivered in a residential care setting, Part 1 Divisions 1 to 3 apply. Where care is delivered in a home care setting, Part 2 Divisions 1 and 2 apply.

6.1 Care and services for STRC delivered in a residential care setting

STRC that is provided in a residential care setting must include the specified care and services listed in Schedule 5 of the [Quality of Care Principles 2014](#) (<https://www.legislation.gov.au/Details/F2020C00096>). Part 1 has been reproduced below for reference.

Note: The [Guidance on the Care and Services in Aged Care Homes](#) has been developed to assist aged care providers to understand the care and services that must be delivered to residents of an aged care home, and where there may be additional costs for the resident. This document should be used when seeking further clarification on the services listed.

Division 1—Hotel services—to be provided for all care recipients who need them

1 Hotel services—for all care recipients who need them

The following table specifies the hotel services that an approved provider of STRC must provide for all care recipients who need them, if the STRC is provided in a residential care setting.

Hotel services—to be provided for all care recipients who need them		
Item	Service	Content
1.1	Administration	General operation of the flexible care service, including documentation relating to care recipients.
1.2	Maintenance of buildings and grounds	Adequately maintained buildings and grounds.
1.3	Accommodation	Utilities such as electricity and water.
1.4	Furnishings	Bedside lockers, chairs with arms, containers for personal laundry, dining, lounge and recreational furnishings, draw-screens (for shared rooms), wardrobe space and towel rails. Excludes furnishings a care recipient chooses to provide.
1.5	Bedding	Beds and mattresses, bed linen, blankets, and absorbent or waterproof sheeting.
1.6	Cleaning services, goods and facilities	Cleanliness and tidiness of the entire flexible care service. Excludes a care recipient's personal area if the care recipient chooses and is able to maintain this himself or herself.
1.7	Waste disposal	Safe disposal of organic and inorganic waste material.

Hotel services—to be provided for all care recipients who need them		
Item	Service	Content
1.8	General laundry	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.
1.9	Toiletry goods	Bath towels, face washers, soap, toilet paper, tissues, toothpaste, toothbrushes, denture cleaning preparations, mouthwashes, moisturiser, shampoo, conditioner, shaving cream, disposable razors and deodorant.
1.10	Meals and refreshments	(a) Meals 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; (b) Special dietary requirements, having regard to either medical need or religious or cultural observance; (c) Food, including fruit of adequate variety, quality and quantity, and non-alcoholic beverages, including fruit juice.
1.11	Care recipient social activities	Programs to encourage care recipients to take part in social activities that promote and protect their dignity, and to take part in community life outside the flexible care service.
1.12	Emergency assistance	At least one responsible person is continuously on call and in reasonable proximity to render emergency assistance.

Division 2—Care and services—to be provided for all care recipients who need them

2 Care and services—for all care recipients who need them

The following table specifies the care and services that an approved provider of STRC must provide for all care recipients who need them, if the STRC is provided in a residential care setting.

Care and services—to be provided for all care recipients who need them		
Item	Care or service	Content
2.1	Daily living activities assistance	<p>Personal assistance, including individual attention, individual supervision, and physical assistance, with the following:</p> <p>(a) bathing, showering, personal hygiene and grooming;</p> <p>(b) maintaining continence or managing incontinence, and using aids and appliances designed to assist continence management;</p> <p>(c) eating and eating aids, and using eating utensils and eating aids (including actual feeding if necessary);</p> <p>(d) dressing, undressing, and using dressing aids;</p> <p>(e) moving, walking, wheelchair use, and using devices and appliances designed to aid mobility, including the fitting of artificial limbs and other personal mobility aids;</p> <p>(f) communication, including to address difficulties arising from impaired hearing, sight or speech, or lack of common language (including fitting sensory communication aids), and checking hearing aid batteries and cleaning spectacles.</p> <p>Excludes hairdressing.</p>
2.2	Meals and refreshments	Special diet not normally provided.
2.3	Emotional support	Emotional support to, and supervision of, care recipients.
2.4	Treatments and procedures	<p>Treatments and procedures that are carried out according to the instructions of a health professional or a person responsible for assessing a care recipient's personal care needs, including supervision and physical assistance with taking medications, and ordering and reordering medications, subject to requirements of State or Territory law.</p> <p>Includes bandages, dressings, swabs and saline.</p>
2.5	Recreational therapy	Recreational activities suited to care recipients, participation in the activities, and communal recreational equipment.
2.6	Rehabilitation support	Individual therapy programs designed by health professionals that are aimed at maintaining or restoring a care recipient's ability to perform daily tasks for himself or herself, or assisting care recipients to obtain access to such programs.
2.7	Assistance in obtaining health practitioner services	Arrangements for aural, community health, dental, medical, psychiatric and other health practitioners 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 a health practitioner.
2.8	Assistance in obtaining access to specialised therapy services	Making arrangements for speech therapists, podiatrists, occupational or physiotherapy practitioners to visit care recipients, whether the arrangements are made by care recipients, relatives or other persons representing the interests of care recipients.
2.9	Support for care recipients with cognitive impairment	Individual attention and support to care recipients with cognitive impairment (for example, dementia and behavioural disorders), including individual therapy activities and specific programs designed and carried out to prevent or manage a particular condition or behaviour and to enhance the quality of life and care for such care recipients and ongoing support (including specific encouragement) to motivate or enable such care recipients to take part in general activities of the residential care service.

Division 3—Care and services—to be provided for all care recipients who need them—fees may apply

3 Care and services—for all care recipients who need them—fees may apply

Please note that maximum fees are those outlined in 23AB of the [User Rights Principles 2014](https://www.legislation.gov.au/Details/F2019C00619) (<https://www.legislation.gov.au/Details/F2019C00619>)

The following table specifies the care and services that an approved provider of STRC must provide for all care recipients who need them, if the STRC is provided in a residential care setting.

Note: A care recipient to whom subsection 7(6) of the Quality of Care Principles 2014 applies must not be charged an additional fee for the provision of care or services specified in the following table (see subsection 7(5)).

Care and services—to be provided for all care recipients who need them		
Item	Care or service	Content
3.1	Furnishings	Over-bed tables.
3.2	Bedding materials	Bed rails, incontinence sheets, ripple mattresses, sheepskins, tri-pillows, and water and air mattresses appropriate to each care recipient's condition.
3.3	Goods to assist care recipients to move themselves	Crutches, quadruped walkers, walking frames, walking sticks, and wheelchairs. Excludes motorised wheelchairs and custom made aids.
3.4	Goods to assist staff to move care recipients	Mechanical devices for lifting care recipients, stretchers, and trolleys.
3.5	Goods to assist with toileting and incontinence management	Absorbent aids, commode chairs, disposable bed pans and urinal covers, disposable pads, over-toilet chairs, shower chairs and urodomes, catheter and urinary drainage appliances, and disposable enemas.

Care and services—to be provided for all care recipients who need them		
Item	Care or service	Content
3.6	Nursing services	<p>Initial assessment and care planning carried out by a nurse practitioner or registered nurse, and ongoing management and evaluation carried out by a nurse practitioner, registered nurse or enrolled nurse acting within their scope of practice.</p> <p>Nursing services carried out by a nurse practitioner, registered nurse or enrolled nurse, or other professional appropriate to the service (for example, medical practitioner, stoma therapist, speech pathologist, physiotherapist or qualified practitioner from a palliative care team), acting within their scope of practice.</p> <p>Services may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> (a) establishment and supervision of a complex pain management or palliative care program, including monitoring and managing any side effects; (b) insertion, care and maintenance of tubes, including intravenous and naso-gastric tubes; (c) establishing and reviewing a catheter care program, including the insertion, removal and replacement of catheters; (d) establishing and reviewing a stoma care program; (e) complex wound management; (f) insertion of suppositories; (g) risk management procedures relating to acute or chronic infectious conditions; (h) special feeding for care recipients with dysphagia (difficulty with swallowing); (i) suctioning of airways; (j) tracheostomy care; (k) enema administration; (l) oxygen therapy requiring ongoing supervision because of a care recipient's variable need; (m) dialysis treatment.
3.7	Therapy services, such as, recreational, speech therapy, podiatry, occupational, and physiotherapy services	<ul style="list-style-type: none"> (a) Maintenance therapy delivered by health professionals, or care staff as directed by health professionals, designed to maintain care recipients' levels of independence in activities of daily living; (b) More intensive therapy delivered by health professionals, or care staff as directed by health professionals, on a temporary basis that is designed to allow care recipients to reach a level of independence at which maintenance therapy will meet their needs. <p>Excludes intensive, long-term rehabilitation services required following, for example, serious illness or injury, surgery or trauma.</p>

6.2 Care and services for STRC delivered in a home care setting

STRC that is provided in a home care setting may include the specified care and services listed in Part 2 of Schedule 5 of the [Quality of Care Principles 2014](https://www.legislation.gov.au/Latest/F2016C00451) (<https://www.legislation.gov.au/Latest/F2016C00451>).

Part 2 has been reproduced below for reference.

Division 1—Care and services that may be provided

4 - Care services

The following table specifies the care services that an approved provider of STRC may provide if the care is provided in a home care setting.

Care services		
Item	Service	Content
4.1	Personal services	Personal assistance, including individual attention, individual supervision and physical assistance, with: (a) bathing, showering including providing shower chairs if necessary, personal hygiene and grooming, dressing and undressing, and using dressing aids; and (b) toileting; and (c) dressing and undressing; and (d) mobility; and (e) transfer (including in and out of bed).
4.2	Activities of daily living	Personal assistance, including individual attention, individual supervision and physical assistance, with communication including assistance to address difficulties arising from impaired hearing, sight or speech, or lack of common language, assistance with the fitting of sensory communication aids, checking hearing aid batteries, cleaning spectacles and assistance in using the telephone.
4.3	Nutrition, hydration, meal preparation and diet	Includes: (a) assistance with preparing meals; and (b) assistance with special diet for health, religious, cultural or other reasons; and (c) assistance with using eating utensils and eating aids and assistance with actual feeding, if necessary; and (d) providing enteral feeding formula and equipment.
4.4	Management of skin integrity	Includes providing bandages, dressings, and skin emollients.
4.5	Continence management	Includes: (a) assessment for and, if required, providing disposable pads and absorbent aids, commode chairs, bedpans and urinals, catheter and urinary drainage appliances and enemas; and (b) assistance in using continence aids and appliances and managing continence.

Care services		
Item	Service	Content
4.6	Mobility and dexterity	<p>Includes:</p> <p>(a) providing crutches, quadruped walkers, walking frames, walking sticks and wheelchairs; and</p> <p>(b) providing mechanical devices for lifting, bed rails, slide sheets, sheepskins, tri-pillows, and pressure relieving mattresses; and</p> <p>(c) assistance in using the above aids.</p>

5 – Support services

The following table specifies the support services that an approved provider of STRC may provide if the care is provided in a home care setting.

Support services		
Item	Service	Content
5.1	Support services	<p>Includes:</p> <p>(a) cleaning; and</p> <p>(b) personal laundry services, including laundering of care recipient's clothing and bedding that can be machine-washed, and ironing; and</p> <p>(c) arranging for dry-cleaning of care recipient's clothing and bedding that cannot be machine-washed; and</p> <p>(d) gardening; and</p> <p>(e) medication management; and</p> <p>(f) rehabilitative support, or helping to access rehabilitative support, to meet a professionally determined therapeutic need; and</p> <p>(g) emotional support including ongoing support in adjusting to a lifestyle involving increased dependency and assistance for the care recipient and carer, if appropriate; and</p> <p>(h) support for care recipients with cognitive impairment, including individual therapy, activities and access to specific programs designed to prevent or manage a particular condition or behaviour, enhance quality of life and provide ongoing support; and</p> <p>(i) providing 24-hour on-call access to emergency assistance including access to an emergency call system if the care recipient is assessed as requiring it; and</p> <p>(j) transport and personal assistance to help the care recipient shop, visit health practitioners or attend social activities; and</p> <p>(k) respite care; and</p> <p>(l) home maintenance, reasonably required to maintain the home and garden in a condition of functional safety and provide an adequate level of security; and</p> <p>(m) modifications to the home, such as easy access taps, shower hose or bath rails; and</p> <p>(n) assisting the care recipient, and the homeowner if the home owner is not the care recipient, to access technical advice on major home modifications; and</p> <p>(o) advising the care recipient on areas of concern in their home that pose safety risks and ways to mitigate the risks; and</p> <p>(p) arranging social activities and providing or coordinating transport to social functions, entertainment activities and other out-of-home services; and</p>

Support services		
Item	Service	Content
		(q) assistance to access support services to maintain personal affairs
5.2	Leisure, interests and activities	Includes encouragement to take part in social and community activities that promote and protect the care recipient's lifestyle, interests and wellbeing.

6 – Clinical services

The following table specifies the clinical services that an approved provider of STRC may provide if the care is provided in a home care setting.

Clinical services		
Item	Service	Content
6.1	Clinical care	Includes: (a) nursing, allied health and therapy services such as speech therapy, podiatry, occupational or physiotherapy services; and (b) other clinical services such as hearing and vision services.
6.2	Access to other health and related services	Includes referral to health practitioners or other related service providers.

Division 2—Excluded care and services

7 – Items that must not be included in package of care and services

The following table specifies the items that must not be included in the package of care and services provided under section 15C.

Excluded items		
Item	Service	Content
7.1	Excluded items	<p>The following items must not be included in the package of care and services provided under section 15C:</p> <ul style="list-style-type: none"> (a) use of the package funds as a source of general income for the care recipient; (b) purchase of food, except as part of enteral feeding requirements; (c) payment for permanent accommodation, including assistance with home purchase, mortgage payments or rent; (d) payment of flexible care fees; (e) payment of fees or charges for other types of care funded or jointly funded by the Australian Government; (f) home modifications or capital items that are not related to the care recipient's care needs; (g) travel and accommodation for holidays; (h) cost of entertainment activities, such as club memberships and tickets to sporting events; (i) gambling activities; (j) payment for services and items covered by the Medicare Benefits Schedule or the Pharmaceutical Benefits Scheme.

ATTACHMENT A – Legislative framework

Document:	Website:
<i><u>Aged Care Act 1997</u></i>	https://www.legislation.gov.au/Latest/C2016C00138
<i><u>Aged Care Quality and Safety Commission Rules 2018</u></i>	https://www.legislation.gov.au/Details/F2020C00079
<i><u>Administrative Appeals Tribunal Act 1975</u></i>	https://www.legislation.gov.au/Latest/C2015C00546
<i><u>Accountability Principles 2014</u></i>	https://www.legislation.gov.au/Latest/F2016C00048
<i><u>Allocation Principles 2014</u></i>	https://www.legislation.gov.au/Latest/F2015C00622
<i><u>Approval of Care Recipients Principles 2014</u></i>	https://www.legislation.gov.au/Latest/F2014L00804
<i><u>Approved Provider Principles 2014</u></i>	https://www.legislation.gov.au/Latest/F2014L00698
<i><u>Carer Recognition Act 2010</u></i>	https://www.legislation.gov.au/Latest/C2010A00123
<i><u>Certification Principles 1997</u></i>	https://www.legislation.gov.au/Latest/F2012C00749
<i><u>Classification Principles 2014</u></i>	https://www.legislation.gov.au/Latest/F2014L00805
<i><u>Committee Principles 2014</u></i>	https://www.legislation.gov.au/Latest/F2014L00799
<i><u>Complaints Principles 2014</u></i>	https://www.legislation.gov.au/Latest/F2015L02125
<i><u>Extra Service Principles 2014</u></i>	https://www.legislation.gov.au/Latest/F2016C00050
<i><u>Fees and payments Principles 2014 (No.2)</u></i>	https://www.legislation.gov.au/Latest/F2015C00623
<i><u>Grant Principles 2014</u></i>	https://www.legislation.gov.au/Latest/F2014L00697
<i><u>Information Principles 2014</u></i>	https://www.legislation.gov.au/Latest/F2016C00051
<i><u>Quality of Care Principles 2014</u></i>	https://www.legislation.gov.au/Latest/F2015C00075
<i><u>Records Principles 2014</u></i>	https://www.legislation.gov.au/Latest/F2014L00810
<i><u>Sanctions Principles 2014</u></i>	https://www.legislation.gov.au/Latest/F2014L00803
<i><u>Subsidy Principles 2014</u></i>	https://www.legislation.gov.au/Latest/F2015C00949
<i><u>User Rights Principles 2014</u></i>	https://www.legislation.gov.au/Latest/F2016C00049

Copies of the legislation and any amendments to it can be found on the [Federal Register of Legislation](https://www.legislation.gov.au/) (<https://www.legislation.gov.au/>).

ATTACHMENT B – STRC client scenarios

The following STRC client scenarios provide:

- an overview of each hypothetical individual's functional decline that could be reversed or slowed through STRC;
- their personal situation;
- potential questions that could be asked by ACATs during the assessment process to determine the individual's suitability;
- potential services to be delivered under STRC; and
- the expected outcome once the individual receives STRC.
-

CLIENT A – PHUONG

Phuong lives alone and has no carer. Her GP referred her for an assessment via My Aged Care and Phuong successfully completed STRC earlier than planned.

Client Situation:

Phuong is 85 years old, lives alone and has a history of falls. She has house cleaning funded through the CHSP. Phuong is desperate to stay home and look after her garden. She has not been able to garden recently due to progressive weakness, poor balance, low energy levels, and unintended weight gain.

Phuong:

- *Has Type 2 diabetes;*
- *Had a heart attack eight years ago; and*
- *Has begun to stay indoors watching television.*

Phuong's Goals:

Phuong wishes to stay at home, continue to work in her garden and go to her local shops.

Referral / ACAT Assessment / Outcomes:

- Phuong's GP assessed her thoroughly to determine the cause of her physical deterioration;
- The GP determined that Phuong had frailty syndrome, and was putting on weight because she was not exercising or cooking, nor eating nutritious food;
- Phuong's GP contacted My Aged Care on Phuong's behalf. Phuong was referred to and attended a comprehensive assessment;
- The ACAT approved Phuong as eligible for a level 2 HCP and STRC;
- A STRC place was available, so Phuong was referred to the provider, who subsequently accepted the referral;
- The STRC provider assessed Phuong at home in consultation with her GP.

Assessment Outcome/s:

Phuong was committed to achieving her goals and agreed to proceed with STRC at home.

Possible Multidisciplinary Care Team response to the care recipient's needs identified in the care plan / Short-Term Restorative Care outcomes:

- Treating GP ruled out other serious causes of Phuong's deterioration and adjusted medication to improve her diabetes control;

- Physiotherapist assessed Phuong as being deconditioned and with poor balance – one-on-one sessions were provided;
- Exercise physiologist – provided one-on-one and group exercise sessions to improve her strength and balance;
- Occupational therapist – assisted Phuong in developing strategies to regain independence in daily living tasks, and arranged for hand rails to be installed for the steps to her garden and in other risky areas of her house, such as her bathroom. The occupational therapist also arranged for a personal alarm system in case Phuong fell and could not get up;
- CHSP – continued with home cleaning and started to provide meals at home; and
- A dietitian – helped Phuong improve her diet and food intake in line with diabetic requirements.

Short-Term Restorative Care Episode Outcome/s:

Phuong completed STRC after 6 weeks with the following outcomes:

- Felt more confident;
- Healthier diet;
- Function at home had improved – was able to move around the house and garden;
- Continued with the exercise regime at home;
- Continued with CHSP services;
- Returned to visiting her local shops regularly; and
- No need for a HCP, but was confident that she could and knew how to access one, should she need to in the future.

CLIENT B – ZORAN

Zoran lives alone in a rural area. His CHSP provider referred him to My Aged Care. He received assistance from STRC whilst waiting to see an ophthalmologist about his deteriorating eyesight.

Client Situation:

Zoran is 85 and lives alone in the Riverina, NSW. Zoran's wife died five years ago - they immigrated to Australia in 1955 from Croatia.

Zoran receives frozen meals at home via a CHSP provider. The meal deliverer recently noticed that Zoran had:

- Lost weight;
- Was less talkative and was less willing to converse in English (as he had previously taken every opportunity to do so); and
- Started to stumble.

Zoran's Goal/s:

Zoran wishes to not be so lonely and be able to easily walk around his home and environs.

Referral / Aged Care Assessment Team / Outcomes:

- The CHSP provider asked Zoran (with the aid of a translator) whether he would like to see a GP, and possibly access some additional services – Zoran agreed;
- The CHSP provider contacted My Aged Care. Zoran was referred to and attended a comprehensive assessment;

- The ACAT assessed Zoran as eligible for STRC. He was approved for STRC by the delegate, and referred to an STRC provider who accepted this referral;
- The STRC provider contacted Zoran to arrange a visit, at which time he was asked if he wished for an interpreter be present. Zoran agreed;
- During the visit the STRC provider ascertained that Zoran did not have a regular GP, and he agreed to the provider sourcing a GP;
- The STRC provider arranged for transport for Zoran to visit a GP for a long consultation, at which time the following health issues were identified:
 - Lost weight – Zoran did not like the meals that were delivered to him and was therefore eating a sparse amount of food. He felt too ‘down’ to eat;
 - he did not feel like talking or socialising, due to depression; and
 - he was stumbling because he could not see well.
- The GP recommended an urgent optometrist assessment which the STRC provider arranged.

Assessment Outcome/s:

Zoran agreed to access STRC at home.

Possible Multidisciplinary Care Team response to the care recipient’s needs identified in the care plan / Short-Term Restorative Care outcomes:

- Optometrist review suggested visual loss due to cataracts and possible macular degeneration. The optometrist referred Zoran to an ophthalmologist;
- Provision of visual aids such as tactile instalments in house to improve confidence and large print and audio-books were supplied;
- GP prescribed anti-depressants and arranged regular review of Zoran;
- Occupational Therapist assessment - Provision of ramps and other equipment around the home;
- Dietitian – developed a diet acceptable to Zoran;
- Meal preparation advice – Zoran learnt to acquire the ingredients for, and to prepare some of his own meals to ensure that he was able to eat nutritionally complete meals.
- Social support service to attend culturally-specific men’s group or multicultural group where a specific cultural group is not available. (A member of the culturally-specific men’s group has offered to pick up and return Zoran to his home after men’s group activities.);
- Physiotherapy to identify movement issues related to his low vision;
- Exercise physiology to provide an exercise routine to maintain functionality; and
- The care planning conference was facilitated by an interpreter.

Short-Term Restorative Care Episode Outcome/s:

- After a few months Zoran had put on weight and had more energy;
- Zoran once again converses in English with CHSP staff;
- Zoran is now able to modify the meals the CHSP provider delivers to suit his palate, and is receiving housework and home maintenance; and
- Zoran has established a new network of male friends in the community.

CLIENT C – FRED AND ELLEN:

Fred, who is a veteran and a former Prisoner of War, looks after his wife, Ellen who has multiple sclerosis. Fred is struggling with his own health issues. Fred's GP refers him to My Aged Care.

Client Situation:

Fred is an 95-year-old veteran, former prisoner of war and Department of Veterans Affairs Gold Card holder, who cares for his wife, Ellen who has multiple sclerosis. Fred is becoming increasingly frail and finding it hard to look after Ellen.

The highlight of Fred's week has been attending his local Returned Services League club with his wife, and playing bowls. In the last few months, worsening shoulder pain has stopped him sleeping, he has become less mobile and he no longer participates in these social activities.

Fred was starting to struggle with things he'd previously found simple, such as bending to put socks on, and moving around the house, when he decided that it was time to seek help – he arranged for a GP appointment, his first in a long time.

Fred and Ellen currently access the DVA Veterans' Home Care (VHC) Program and receive:

- Domestic assistance; and
- Home and garden maintenance.

Fred and Ellen's Goals:

That Fred regain sufficient strength to enable him to continue to care for Ellen, at home, for as long as possible. Ideally, Fred wants to be able to recommence his social activities.

My Aged Care / ACAT / Outcomes:

- Fred's GP acknowledged his decline and his concern that he may not be able to continue to care for his wife if it continued;
- The GP conducted a thorough clinical assessment of Fred;
- The GP advised Fred that he may benefit from receiving STRC;
- Fred agreed to the GP referring him to My Aged Care for an assessment with a view to accessing STRC;
- A comprehensive assessment was arranged, and an ACAT assessor visited Fred and Ellen. Fred was approved as eligible for STRC. Fred was referred to an STRC provider, a place was available, and the provider accepted Fred's referral;
- The STRC provider visited Fred and Ellen in their home at which time they expressed a wish to not be separated;
- The STRC provider confirmed that Fred was a veteran, and enquired as to whether or not:
 - He was a former Prisoner of War or Victoria Cross recipient. Fred informed the provider that he was a former Prisoner of War; and
 - He was in receipt of any Veteran-specific services.
- The STRC provider contacted DVA to confirm that Fred was a STRC recipient, who identified himself as a prisoner of war, to organise for a basic daily care fee payment arrangement; and
- The STRC provider also contacted Fred's VHC provider to ensure that in receiving STRC Fred would not be receiving any duplicative services and to ensure that the care plan is coordinated and agreed between the STRC provider, Fred, and his VHC provider.

Assessment Outcome/s:

- Fred and Ellen were both glad that they will be assisted in attaining their goal of staying home together for as long as possible and that the STRC services / support would be provided in their home.

Possible Multidisciplinary Care Team response to the care recipient's needs identified in the care plan / Short-Term Restorative Care outcomes:

- The treating GP diagnosed generalised deconditioning, poor balance plus suspected shoulder bursitis;
- The STRC provider arranged transport for Fred to have an ultra sound guided injection of his painful shoulder;
- The physiotherapist supervised shoulder, general and balance exercises;
- The occupational therapist developed strategies to improve independence in daily living tasks, and arrange for things like hand rails and a raised toilet seat in the bathroom;
- The GP recommended Fred take pain-killers at night which improved his sleep;
- The exercise physiologist provided and sourced group exercise sessions to improve Fred's strength and balance;
- The dietitian reviewed the couple's current diet and provided information on appropriate dietary habits for both Fred and Ellen;
- A CHSP meal service was organised to increase their intake of fresh fruit and vegetables;
- Fred was advised of and linked with carer support services; and
- The GP agreed to review Fred regularly to monitor his progress and see if further assistance, such as a psychogeriatric assessment, was needed.

Short-Term Restorative Care Episode Outcome/s:

Fred was empowered to continue his caring role.

The STRC provider:

- Contacted DVA and advised that the couple are likely to require sporadic episodes of in-home respite (following agreement by Fred and Ellen) and wished to continue with the VHC domestic assistance and home and garden maintenance services;
- Advised Fred that he should contact DVA about the ongoing availability of services similar to those he received through his STRC episode;
- Arranged for a CHSP service provider to continue the meal service; and
- Reminded Fred that he was eligible to continue to access in home respite under the DVA VHC Programme.

CLIENT D – LOUISE

Louise and Phillip benefit from residential and home based services provided through the STRC Programme.

Client Situation:

Louise is 81, and her husband Phillip is 79. They have been married for 48 years.

Louise has dementia and requires Phillip's constant attention. She is mobile and can care for herself, if Phillip prompts her. Phillip is happy with his caring role, as it means they can stay together at home.

Phillip has Type 2 Diabetes and worsening Parkinson's disease, which is beginning to limit his physical capacity.

Louise was recently unwell with the flu and fell in the bathroom breaking her coccyx. Her GP discussed with Phillip whether Louise should be admitted to hospital. Phillip didn't believe hospital could assist her other than administer pain killers which her GP would be able to prescribe.

Louise received some support via the CHSP, but became weaker, confined to bed, and was starting to struggle to walk. Support with housework, showering assistance, and provision of meals reduced the impact on Phillip, but Louise's functional capacity was dropping before his eyes.

Phillip called My Aged Care as he could no longer care for Louise at home.

Louise and Phillip's Goals:

Louise to live at home and Phillip to continue to care for her.

Referral / ACAT Assessment / Outcomes

- Louise referred to My Aged Care by Phillip;
- My Aged Care referred Louise for a comprehensive assessment;
- The ACAT deemed Louise eligible for STRC. A place was available in her region, and she was referred to an STRC provider;
- The STRC provider accepted the referral, reviewed Louise's assessment and support plan, and arranged to meet with Louise;
- At the meeting, the provider and Louise discussed her needs and the care / services that could be offered through STRC. As a part of this process, the provider conducted and recorded an MBI assessment. Phillip attended this meeting with Louise;
- Louise, Phillip and the provider all agreed that her needs would best be met by a short stay in a residential care facility. Together, they drafted an interim care plan (on the understanding that this would be revised / finalised with the multidisciplinary team), and Louise was offered a Flexible Care Agreement attaching this interim care plan;
- Following this, the provider established a multidisciplinary team based upon Louise's needs and preferred care / service options, including Louise's GP;
- The multidisciplinary team, together with the provider and Phillip and Louise, refined the care plan and agreed on the detailed arrangements for the care episode;
- Phillip stressed that he wished to resume his caring role following Louise's care episode.

Assessment Outcome/s:

- Louise was assessed as eligible for STRC and residential respite;
- Louise was referred to a STRC provider; and
- Phillip stayed at home and received CHSP house cleaning and meal services.

Possible Multidisciplinary Care Team response to the care recipient's needs identified in the care plan / Short-Term Restorative Care outcomes:

- Treating GP – role included pain management and assessment of possible osteoporosis;
- Physiotherapist;
- Occupational therapist – Assessment of the home;
- Dietitian – dietary advice;
- Exercise Physiologist - one-on-one and group exercise sessions to improve Louise's strength and balance;
- Louise was admitted to a residential care facility at which time she:
 - participated in a daily programme to improve her strength and endurance; and

-
- ate healthy food.
 - Equipment (wheeled walking frame) was provided for Louise's use in residential care and at home she was provided with rails in the bathroom in line with occupational therapist's assessment;
 - After four weeks Louise returned home with the walking frame where her care plan services continued for a further four weeks;
 - Phillip also benefited from aspects of Louise's care plan i.e.:
 - education and referral to advisory, carer and support services for dementia;
 - assistance with setting up the home in a way that would support them both;
 - participation in the group exercise sessions with Louise; and
 - participation in consultation with Louise's dietitian to support healthier eating habits at home.
 - At the six week point of the programme, Louise had progressed and was able to walk around without her frame;
 - Phillip continued to receive the previously provided CHSP house cleaning service while Louise was in residential care.

Short-Term Restorative Care Episode Outcome/s:

- Louise ceased STRC at 8 weeks and was back 'to her old self';
- Louise and Phillip continued with the exercises they learnt in the group sessions;
- Phillip was stronger and more confident in caring for his wife and was thankful for the rails installed in the bathroom; and
- Phillip and Louise were advised of local respite care services, noting that Louise had been assessed as eligible for this service.

ATTACHMENT C – Examples of possible Multidisciplinary Team Members

Either a GP or a Geriatrician must be on the Multidisciplinary Team so as to identify any underlying medical condition. Whilst understanding that, especially in rural and regional areas, it can be difficult to access a GP or Geriatrician, it is expected that providers take all reasonable actions to include health professionals in the Multidisciplinary Team. This may include conducting appointments via tele or video conferencing.

Other professionals can include (but are not limited to)

1. Registered Nurse
2. Orthotist
3. Audiologist
4. Pharmacist
5. Community health worker
6. Physiotherapist
7. Dental hygienist
8. Podiatrist
9. Certified Accredited Dietitian (or if a dietitian cannot be available physically or via a telehealth conference link, a nutritionist).
10. Optometrist
11. Exercise physiologist
12. Psychologist
13. Occupational therapist
14. Social worker
15. Osteopath
16. Speech pathologist

ATTACHMENT D – Modified Barthel Index (MBI)

MODIFIED BARTHEL INDEX (SHAH VERSION)		
INDEX ITEM	SCORE	DESCRIPTION
CHAIR/BED TRANSFERS	0	Unable to participate in a transfer. Two attendants are required to transfer the care recipient with or without a mechanical device.
	3	Able to participate but maximum assistance of one other person is required in all aspects of the transfer.
	8	The transfer requires the assistance of one other person. Assistance may be required in any aspect of the transfer.
	12	The presence of another person is required either as a confidence measure, or to provide supervision for safety.
	15	The care recipient can safely approach the bed walking or in a wheelchair, lock brakes, lift footrests, or position walking aid, move safely to bed, lie down, come to a sitting position on the side of the bed, change the position of the wheelchair, transfer back into it safely and/or grasp aid and stand. The care recipient must be independent in all phases of this activity.
	0	Unable to participate in a transfer. Two attendants are required to transfer the care recipient with or without a mechanical device.
AMBULATION	0	Dependent in ambulation.
	3	Constant presence of one or more assistant is required during ambulation.
	8	Assistance is required with reaching aids and/or their manipulation. One person is required to offer assistance.
	12	The care recipient is independent in ambulation but unable to walk 50 metres without help, or supervision is needed for confidence or safety in hazardous situations.
	15	The care recipient must be able to wear braces if required, lock and unlock these braces, assume standing position, sit down, and place the necessary aids into position for use. The care recipient must be able to use crutches, canes, or a walkalette, and walk 50 metres without help or supervision.
* Use the next item only if the care recipient is unable to walk (is rated “0” for ambulation) and has been trained in wheelchair management.		
AMBULATION/ WHEELCHAIR	0	Dependent in wheelchair ambulation.
	1	Care recipient can propel self short distances on flat surface, but assistance is required for all other steps of wheelchair management.

MODIFIED BARTHEL INDEX (SHAH VERSION)

INDEX ITEM	SCORE	DESCRIPTION
	3	Presence of one person is necessary and constant assistance is required to manipulate chair to table, bed, etc.
	4	The care recipient can propel self for a reasonable duration over regularly encountered terrain. Minimal assistance may still be required in "tight corners" or to negotiate a kerb 100mm high.
	5	To propel wheelchair independently, the care recipient must be able to go around corners, turn around, manoeuvre the chair to a table, bed, toilet, etc. The care must be recipient able to push a chair at least 50 metres and negotiate a kerb.

INDEX ITEM	SCORE	DESCRIPTION
STAIR CLIMBING	0	The care recipient is unable to climb stairs.
	2	Assistance is required in all aspects of stair climbing, including assistance with walking aids.
	5	The care recipient is able to ascend/descend but is unable to carry walking aids and needs supervision and assistance.
	8	Generally no assistance is required. At times supervision is required for safety due to morning stiffness, shortness of breath, etc
	10	The care recipient is able to go up and down a flight of stairs safely without help or supervision. The care recipient is able to use hand rails, cane or crutches when needed and is able to carry these devices as he/she ascends or descends.
TOILET TRANSFERS	0	Fully dependent in toileting.
	2	Assistance required in all aspects of toileting.
	5	Assistance may be required with management of clothing, transferring, or washing hands.
	8	Supervision may be required for safety with normal toilet. A commode may be used at night but assistance is required for emptying and cleaning.
	10	The care recipient is able to get on/off the toilet, fasten clothing and use toilet paper without help. If necessary, the care recipient may use a bed pan or commode or urinal at night, but must be able to empty it and clean it.
BOWEL CONTROL	0	The care recipient is bowel incontinent.
	2	The care recipient needs help to assume appropriate position, and with bowel movement facilitatory techniques.

INDEX ITEM	SCORE	DESCRIPTION
	5	The care recipient can assume appropriate position, but cannot use facilitatory techniques or clean self without assistance and has frequent accidents. Assistance is required with incontinence aids such as pads, etc.
	8	The care recipient may require supervision with the use of suppository or enema and has occasional accidents.
	10	The care recipient can control bowels and has no accidents, can use suppository, or take an enema when necessary.
BLADDER CONTROL	0	The care recipient is dependent in bladder management, is incontinent, or has indwelling catheter.
	5	The care recipient is generally dry by day, but not at night and needs some assistance with the devices.
	8	The care recipient is generally dry by day and night, but may have an occasional accident or need minimal assistance with internal or external devices.
	10	The care recipient is able to control bladder day and night, and/or is independent with internal or external devices.
	10	The care recipient is dependent in bladder management, is incontinent, or has indwelling catheter.
BATHING	0	Total dependence in bathing self.
	1	Assistance is required in all aspects of bathing, but care recipient is able to make some contribution.
	3	Assistance is required with either transfer to shower/bath or with washing or drying; including inability to complete a task because of condition or disease, etc.
	4	Supervision is required for safety in adjusting the water temperature, or in the transfer.
	5	The care recipient may use a bathtub, a shower, or take a complete sponge bath. The care recipient must be able to do all steps of whichever method is employed without another person being present.
DRESSING	0	The care recipient is dependent in all aspects of dressing and is unable to participate in the activity.
	2	The care recipient is able to participate to some degree, but is dependent in all aspects of dressing.
	5	Assistance is needed in putting on, and/or removing any clothing.
	8	Only minimal assistance is required with fastening clothing such as buttons, zips, bra, shoes, etc.
	10	The care recipient is able to put on, remove, corset, braces, as prescribed.
PERSONAL HYGIENE (Grooming)	0	The care recipient is unable to attend to personal hygiene and is dependent in all aspects.

INDEX ITEM	SCORE	DESCRIPTION
	1	Assistance is required in all steps of personal hygiene, but care recipient able to make some contribution.
	3	Some assistance is required in one or more steps of personal hygiene.
	4	Care recipient is able to conduct his/her own personal hygiene but requires minimal assistance before and/or after the task.
	5	The care recipient can wash his/her hands and face, comb hair, clean teeth and shave. A male care recipient may use any kind of razor but must insert the blade, or plug in the razor without help, as well as retrieve it from the drawer or cabinet. A female care recipient must apply her own make-up, if used, but need not braid or style her hair.
FEEDING	0	Dependent in all aspects and needs to be fed, nasogastric needs to be administered.
	2	Can manipulate an eating device, usually a spoon, but someone must provide active assistance during the meal.
	5	Able to feed self with supervision. Assistance is required with associated tasks such as putting milk / sugar into tea, salt, pepper, spreading butter, turning a plate or other "set up" activities.
	8	Independence in feeding with prepared tray, except may need meat cut, milk carton opened or jar lid removed, etc. The presence of another person is not required.
	10	The care recipient can feed self from a tray or table when someone puts the food within reach. The care recipient must put on an assistive device if needed, cut food, and if desired use salt and pepper, spread butter, etc.
SCORE	INTERPRETATION	
00 - 20	Total Dependence	
21 - 60	Severe Dependence	
61 - 90	Moderate Dependence	
91 - 99	Slight Dependence	
- 100	Independence	

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GLOSSARY

Term	Meaning
ACUTE CARE	<p>Acute Care in the context of Short-Term Restorative Care is care in which the clinical intent or treatment goal is to:</p> <ul style="list-style-type: none"> • cure illness or provide definitive treatment of injury; • 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.
ADVOCATE	A person who acts on behalf of another party. In the absence of a carer or other support person, an independent advocate could be a general practitioner, legal representative, person appointed by the guardianship board, specialised advocate through the National Aged Care Advocacy Program or another person who can represent the interests of the client adequately.
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 <i>Aged Care Act 1997</i> is the Australian Government legislation that relates to Australian Government funded residential, home care and flexible aged care services.
AGED CARE (TRANSITIONAL PROVISIONS) ACT 1997	The <i>Aged Care (Transitional Provisions) Act 1997</i> apply to continuing care recipients, that is people who entered care before 1 July 2014 and have not chosen to opt into the new post 1 July 2014 arrangements.
AGED CARE SERVICE	<p>An undertaking through which aged care is provided in the form of residential, home care or flexible care.</p> <p>Schedule 1, <i>Aged Care Act 1997</i> and Schedule 1, <i>Aged Care (Transitional Provisions) Act 2014</i></p>
AGED CARE QUALITY AND SAFETY COMMISSION	The role of the Commission is to protect and enhance the safety, health, well-being and quality of life of people receiving aged care. The Commission independently accredits, assesses and monitors aged care services subsidised by the Australian Government, resolves complaints about these services and provides information and education to providers.
AGED CARE PRINCIPLES	The Aged Care Principles are the subordinate legislation of the <i>Aged Care Act 1997</i> .
APPROVED PROVIDER	Approved provider means a person or body in respect of which an approval under Part 2.1 of the <i>Aged Care Act 1997</i> (the Act) is in force, and, to the extent provided

Term	Meaning
	<p>for in section 8-6 of the Act, includes any state or territory, authority of a state or territory or local government authority.</p> <p>Schedule 1 of the <i>Aged Care Act 1997</i></p>
AUSTRALIAN PRIVACY PRINCIPLES	<p>The <i>Australian Privacy Principles</i> took effect from 12 March 2014 as a result of changes to the <i>Privacy Act 1988 (Cth)</i>.</p> <p>These 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:</p> <ul style="list-style-type: none"> ▪ 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 individuals' own personal information.
CARE PLAN	<p>A plan developed by the Short-Term Restorative Care approved provider in consultation with the client. The care plan describes the goals of Short-Term Restorative Care agreed with the client, 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 client. The care plan for Short-Term Restorative Care should be informed by the client's GP or other relevant medical or clinical professional and the ACAT.</p>
CLIENT	<p>A person applying for or receiving Short-Term Restorative Care services.</p>
CARER	<p>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 client. Carers frequently live with the person for whom they are caring. A carer may also be the client's advocate.</p> <p>2014, <i>STRC Training Handbook for Aged Care Assessment Teams</i></p>
COMMONWEALTH HOME SUPPORT PROGRAMME	<p>The Commonwealth Home Support Programme (CHSP) is a consolidated programme that provides entry-level home support for older people who need assistance to keep living independently at home and in their community. Carers of these clients will also benefit from services provided through the CHSP.</p>
DEMENTIA	<p>Dementia is an umbrella term describing a syndrome associated with around 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 and progressive in nature.</p>
FLEXIBLE CARE	<p>Flexible care means care provided in a residential or community setting through an aged care service that addresses the needs of clients in alternative ways to the care provided through residential care services and home care services.</p> <p>Section 49-3 of the <i>Aged Care Act 1997</i> and Part 3.3 of the <i>Aged Care (Transitional Provisions) Act 1997</i></p>

Term	Meaning
FLEXIBLE CARE AGREEMENT	An agreement between a Short-Term Restorative Client and a Short-Term Restorative Care approved provider which details services to be delivered by the approved provider, charges payable by the client to the approved provider, external complaint mechanisms and how to access these and other arrangements.
FLEXIBLE CARE SUBSIDY	Flexible care subsidy is a payment by the Australian Government to approved providers for providing flexible care to clients. Further information on flexible care subsidy is included in Part 3.3 of the <i>Aged Care Act 1997</i> and the <i>Subsidy Principles 2014</i> of the Aged Care Principles.
FUNCTIONAL DECLINE	<p>Functional decline is a progressive loss in an individual's mental and/or physical ability, which reduces their ability to perform everyday living tasks. It typically includes losing the ability to carry out activities of daily living such as bathing, dressing, feeding, shopping or driving, due to increasing age, frailty, or illness.</p> <p>For more details on the definition of functional decline in relation to STRC, please see the highlighted box in Chapter 2.</p>
GP	General Practitioner
HOME CARE PACKAGE	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.
IN-PATIENT HOSPITAL EPISODE	<p>In relation to a client, means a continuous period during which the client is:</p> <ul style="list-style-type: none"> (a) an in-patient of a hospital (b) provided with acute care or subacute care or both. <p>Section 4 Definitions of the <i>Subsidy Principles 2014</i></p>
LOW INTENSITY THERAPY	<p>In relation to a client, means therapy that:</p> <ul style="list-style-type: none"> (a) maintains the client's physical and cognitive functioning; and (b) facilitates an improvement in the client's capacity in respect of activities of daily living. <p>Examples include Occupational therapy, Physiotherapy and Social work.</p> <p>Section 4 Definitions of the <i>Subsidy Principles 2014</i></p> <p>The therapy services that Short-Term Restorative Care service providers must be able to provide, if required by a client, are detailed under item 3.4 - Therapy services of <i>Chapter 6: Specified care and services for Short-Term Restorative Care services</i>.</p>
MULTIDISCIPLINARY CARE	<p>Multidisciplinary care is a practice of care, which involves health care providers working in collaboration to provide a positive patient outcome, through a holistic and high quality care plan.</p> <p>Please refer to the highlighted box in section 3.5 for a more detailed definition of multidisciplinary care.</p>

Term	Meaning
MULTIDISCIPLINARY TEAM	For STRC a multidisciplinary team is a care team made up of three or more health care disciplines. Please refer to the highlighted box in section 3.5 for a more detailed definition of multidisciplinary team.
NSAF – NATIONAL SCREENING AND ASSESSMENT FORM	<p>The NSAF has been designed to support the collection of information for the screening and assessment processes conducted under My Aged Care.</p> <p>The NSAF ensures that questions are appropriate to each level of assessment (screening, home support assessment or comprehensive assessment); that there is no duplication which would result in the client having to repeat their story; and that the appropriate client pathway can be facilitated through the completion of an action plan or support plan.</p> <p>The NSAF also includes a set of decision support rules that assists the screening and assessment workforce to make recommendations for the type of support a client requires.</p>
REHABILITATION	<p>Rehabilitation, in the context of Short-Term Restorative Care, is a form of subacute care as outlined in section 4 of the <i>Subsidy Principles 2014</i> - see 'Subacute Care' below.</p> <p>Short-Term Restorative Care is not a substitute for rehabilitation and should only commence after completion of the client's rehabilitation care episode.</p>
REPRESENTATIVE	<p>Representative of a client means:</p> <ul style="list-style-type: none"> (a) a person nominated by the client as a person the care recipient wishes to participate in decisions relating to his or her care; or (b) a *partner, carer, or *close relation of the client; or (c) a person who holds an enduring power of attorney given by the client to decide the health care and other kinds of personal services the client is to receive; or (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 client is to receive. <p>Section 44-26B <i>Aged Care Act 1997</i></p> <p>*partner, in relation to a person, means the other member of a couple of which the person is also a member.</p> <p>*carer is a person who provides domestic services and support to a client otherwise than for remuneration (whether from the client or any other person) on a regular basis, but who may be in receipt of a carer allowance or carer payment from the Australian Government.</p> <p>*close relation, in relation to a person, means a:</p> <ul style="list-style-type: none"> (a) parent of the person; or (b) sister, brother, child or grandchild of the person; or (c) person included in a class of persons specified in the <i>Subsidy Principles</i>. <p>Section 44-11 of the <i>Aged Care Act 1997</i></p>
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

Term	Meaning
	<p>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.</p> <p>Section 41-3 of the <i>Aged Care Act 1997</i> and Section 41-3 of the <i>Aged Care (Transitional Provisions) Act 1997</i></p>
SANCTIONS	Penalties may be imposed by the Aged Care Quality and Safety Commission under Part 7B of the <i>Aged Care Quality and Safety Commission Act</i> (Quality Commission Act) on an approved provider for not complying with one or more of the responsibilities under section 63R of the Quality Commission Act. Certain procedures must be followed for sanctions to be imposed.
SECRETARY	The person filling, or temporarily filling, the position of Secretary of the Department of Health with portfolio responsibility for Ageing and Aged Care.
SHORT-TERM RESTORATIVE CARE	<p><i>Short-term restorative care</i> is a form of flexible care that:</p> <ul style="list-style-type: none"> (a) is aimed at reversing or slowing functional decline in older people through the provision of a package of care and services designed for, and approved by, the care recipient who is to receive the care and services; and (b) depending on the needs of the care recipient, is provided in either or both of the following settings: <ul style="list-style-type: none"> i. a residential care setting; ii. a home care setting; and (c) can be characterised as: <ul style="list-style-type: none"> i. goal-oriented; and ii. multidisciplinary; and iii. time-limited.
SHORT-TERM RESTORATIVE CARE SERVICE	An aged care service to which an allocation of short-term restorative care places is in effect.
SHORT-TERM RESTORATIVE CARE SERVICE PROVIDER	An organisation to which an allocation of short-term restorative care places is in effect.
SPECIFIED CARE AND SERVICES FOR SHORT-TERM RESTORATIVE CARE SERVICES	Services to be provided for all Short-Term Restorative Clients who need them. They are listed at Chapter 6.
SUBACUTE CARE	<p>Subacute care means medical or related care or services provided to a client who is not in the acute phase of an illness. Examples include:</p> <ul style="list-style-type: none"> 1. Rehabilitation; 2. Palliative care; 3. Psychogeriatric care; and

Term	Meaning
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4. Geriatric evaluation and management.

Section 15.3 of the *Flexible Care Subsidy Principles 1997*

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VERSION HISTORY

Version	Changes
September 2016	Original publication
November 2017	Updated publication
December 2020	Updated publication