Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CORPORATE OFFICE

Level 1
32 Oxford Terrace
Christchurch Central
CHRISTCHURCH 8011

Telephone: 0064 3 364 4160
Fax: 0064 3 364 4165
Ralph.lasalle@cdhb.health.nz

24 December 2020

9(2)(a) [redacted]

[redacted]

RE Official information request CDHB 10494

I refer to your letter dated 25 November 2020, requesting the following information under the Official Information Act from Canterbury DHB. Specifically:

1. **Individualised funding personal care and respite policy/service specifications for children, under 65's and over 65's.**

Individualised funding (for Home and Community Support services (HCSS) and respite) is devolved via Manawanui Support (who acts as host for this funding, providing oversight and support for the use of this funding). Allocations are based on anticipated need (to align with what would be provided otherwise by HCSS providers, and to cover Carer Support needs). An Individualised funding package may be considered where other traditional options for support have been exhausted or has been found not to meet the needs of the individual. An allocation is calculated by the Clinical Assessor, to meet the HCSS and Carer Support needs of the client. Nursing needs are met via the District Nursing service.

Children and people under 65 with long-term chronic health conditions

Allocations are lodged with Manawanui by the Clinical Assessor, who will monitor the ongoing use of this funding and provide any support needed in terms of claiming. In some instances, these are larger packages which may be put in place to meet the needs of the individual and their family, particularly in the case where children have very high medical (as opposed to disability) needs. There are few options for residential care for children with such needs; for people who are not children but under 65, there are some residential options and for those in the higher end of this age bracket, Age-related Residential Care (ARRC) may be considered if appropriate.

People over 65 years of age

Individualised funding is rarely put in place for older people.

Approximately 8000 people per year are provided with HCSS via public funding. In addition, there are other supports available, such as Day Support services, Carer Support, and disease specific services.

Where a person can no longer be supported at home via HCSS, or the package of care required to support them is beyond what can be reasonably and safely supported at home, Aged Residential Care may be appropriate – this is also publicly funded (but is means tested).

All disability needs are covered by Disability Support Services funding (which is provided by the Ministry of Health).

2. **how families are informed about and offered individualised funding for children, under 65's and over 65's.**

Families are informed about Individualised Funding (IF) as an option where traditional supports have been found to be unsuitable.

Almost all HCSS is provided by three providers (Nurse Maude Association, Access Home Health, and HealthcareNZ).

Individualised packages can be made available where:

- Services are required that are unable to be provided by the three contracted providers, even if the package is split between them; AND
- Services cannot be provided by another provider subcontracted by one of the three contracted provider; AND/OR
- Services have been tried by the individual in question, but their needs have not been able to be met appropriately by the three contracted providers; AND/OR
- There is a cultural or linguistic barrier to the provision of care by the three contracted providers.

For people under 65 years of age with Long-term Chronic Health Conditions, an Individualised Funding package may be put in place by the Clinical Assessor. If this package is unusually large, this may be done in consultation with Planning and Funding, and approval sought at senior leadership level.

For older people, Individualised Funding may be put in place only with approval from Planning and Funding (and where traditional supports have been exhausted).

Where a Clinical Assessor finds that an Individually Funded package of care may be needed, they discuss this option with the client, and an application is made via Planning and Funding for an IF package to be put in place.

3. **CDHB support package allocation guide for children, under 65's and over 65's.**

No such guide exists: services are allocated according to need. They are provided to complement any existing natural supports (for example, those provided by parents for their children, or spouses for their husband/wife).

4. **the policy, procedures and guidelines for monitoring high and complex clients (children, under 65's and over 65's) in the community; including ensuring supports match the identified needs and equality of allocation.**

In terms of policy, please find attached as **Appendix 1** the OPHSS Community and Support Services Handbook. You will note this is currently an older document; this will be reviewed in the coming year to ensure alignment with the new HCSS National Guidelines and Service Specifications.

Once an interRAI assessment has been completed, a Clinical Assessor will determine what sort of supports will be needed, which may include a wide range of services including HCSS, District Nursing, Carer Support options (including Day Support or Community Activity programmes), referrals to disease-specific services as required (e.g. Dementia Canterbury), and residential respite.

HCSS providers, on receiving a referral for service, will determine the HCSS services that can be delivered in the home.

There is a yearly service review, and if there is a change in a person's needs over this time (or a change in circumstances around how families are able to support them) than service allocation can be reviewed. InterRAI assessments are redone every three years (if not triggered by substantive change in condition).

Clinical Gerontology Nurses and Geriatricians provide expert medical input for clients in the community who are highly complex with regards to acute episodes and determining whether further investigations in hospital or further rehab are appropriate.

Children are monitored regularly with an interdisciplinary approach; those involved may be Clinical Assessors, Paediatricians, Clinical Nurse Specialists and GPs to ensure that supports remain appropriate where needs may change constantly.

5. **what internal processes are in place to ensure Interai and casemix allocations are accurate.**

The interRAI tool can only be used by Registered Health Professionals who have received formal interRAI training. This includes a certification process whereby each professional must complete a number of monitored assessments. This is a national process overseen by TAS (Technical Advisory Services Ltd).

If a professional has not completed the required number of assessments in a year needed to keep their certification current, they must retrain. Refresher courses are available.

6. **what information is shared with families regarding case mixes to ensure they are accurate.**

Case Mixes are allocated via the interRAI assessment. This assessment may be undertaken in the presence of family/whānau if appropriate/desired.

A Case Mix does not generate a cap to the number of hours of support that may be provided - nor does it generate an entitlement to a number of hours of support that must be provided. The package of care that is delivered to an individual is determined by the provider based on the need of the individual, taking into account what natural supports (in the nature of inputs to be provided by family, friends, neighbours, etc) are available to the person.

If a person's needs (or circumstances) change, it is to be expected that their package of support may be adjusted (up or down). This is related to a clinical assessment of their needs, not to the designated Case Mix, although these may overlap.

7. **what the appeal process for a NASC review is and how families are informed of these policies.**

It is expected that in the first instance if a person, or their family/whānau, are unhappy with the outcome of an assessment, that they will be in touch with the clinical team. The usual practice when this occurs is for the clinician to discuss the issue with the Clinical Manager. Dependent on that discussion, the case may then be taken to the Inter-disciplinary team meeting for further consideration.

An information pack is given out at the first OPH Clinical Assessor visit, along with the assessor's business card. The assessor will go over this information with the client if necessary (for OPH and OPMH)

Additional information may be found on the MOH Website:

https://www.health.govt.nz/your-health/services-and-support/disability-services/disability-support-complaints-and-feedback

The HDS website: https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/

https://www.hdc.org.nz/making-a-complaint/how-to-raise-your-concerns-directly/

And the Canterbury DHB website: https://www.cdhb.health.nz/about-us/contact-us/contact-form/

8. **the auditing policy for home-based support services and CDHB results for the last 5 years.**

HCSS services are audited nationally via HealthCERT, a section of the Ministry of Health, against the Home and Community Support Sector Standards. HealthCERT's role is to:

- Maintain a central repository and collation point for audit reports, audit summaries and progress reports for corrective actions
- Manage and maintain the web page where audit summaries are published if they meet Ministry publication standards

HealthCERT audit providers on a three-year cycle. In addition to the contractual requirement for HCSS providers to be certified, funders may choose to undertake or commission additional audit and monitoring activities.

Canterbury DHB results for the last five years are therefore held by the Ministry of Health, who also monitor corrective actions. The Ministry alerts Canterbury DHB to any areas of pressing concern – over the last five years no such areas have arisen from the audit process.

Canterbury DHB undertakes its own quality monitoring via close and regular contact with providers and ongoing and regular consideration of data. Canterbury DHB staff meet on a monthly basis with contracted HCSS providers to discuss performance; there are meetings monthly between Planning and Funding, the Older Persons Health Specialist Services, and HCSS providers to discuss developing issues,

new challenges and service development; in addition there is a Clinical Review meeting held monthly to consider any cases where it is proving difficult to support the person at home (which may address clinical, family, equipment, funding capacity or safety concerns).

9. **what the requirement is regarding the periodic frequency for HBSS to review both non-complex and complex clients.**

Specifications governing HCSS (in terms of scheduled reviews for non-complex and complex clients) may be found in the National Framework for Home and Community Support Services: https://www.health.govt.nz/publication/national-framework-home-and-community-support-services-hcss

Please note that this is a new specification current as of late 2020.

10. **the policy, criteria, procedures and processes for HBSS arranging sleepovers.**

It is Canterbury DHB policy not to fund sleepovers. In some very exceptional situations a sleepover arrangement might be considered for a short-term duration where there is a high safety risk.

11. **the policies, procedures and guidelines for equipment to be serviced and maintained in the community, including who is responsible for this process?**

All long-term care equipment is issued by Enable NZ and funded by the Ministry of Health. All servicing and maintenance is therefore the responsibility of Enable NZ. Clinical assessors will work with Enable to ensure equipment is ordered appropriately. More information about the services provided by Enable can be found at:

https://www.enable.co.nz/

I trust this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Ralph La Salle
Acting Executive Director
Planning, Funding & Decision Support

APPENDIX 1

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Older Persons Health Specialist Service

Support Services Handbook

Ref No: 23-5474

Date of first issue: November 2010

Date of second issue: November 2015

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ACRONYMS USED IN THIS HANDBOOK

ACC	Accident Compensation Corporation
AT&R	Assessment Treatment & Rehabilitation service (OPHSS)
CA	Clinical Assessor (role undertaken by a registered health professional)
CAP	Client Assessment Protocol (used as part of interRAI)
CCC	Canterbury Care Coordination Centre (also known as the 4C's)
CDHB	Canterbury District Health Board
CGN	Community Gerontology Nurse
CREST	Community Rehabilitation, Enablement and Support Team
CST	Community Service Team OPHSS
DHB	District Health Board
ED	Emergency Department (Christchurch Hospital)
GP	General Practitioner
Health PAC	Business Unit within the Ministry of Health
HBSS	Home Based Support Services
IDF's	Intra-District Flows (movement of Clients and funding between DHB's)
IDT	Inter-Disciplinary Team
InterRAI	International Resident Assessment Instrument
KCA	Kaumatua Clinical Assessor
LTO	Licence to Occupy (relates to retirement villages)
MDS-HC	Minimum Data Set - Home Care (type of InterRAI tool)
MoH	Ministry of Health (NZ)

NASC	Needs Assessment and Service Coordination (function performed by clinicians)
NGO	Non-Government Organisation
OPHSS	Older Persons Health Specialist Service (part of CDHB)
ORA	Occupation Rights Agreement (relates to retirement village occupancy)
PI	Pacific Islanders
PSE	Psychiatric Service for the Elderly (OPHSS)
RCA	Residential Care Agreement
RCS	Residential Care Subsidy
SAP	Systems Applications Process (electronic patient management system used by OPHSS)
SAT	Supporting Allocations Tool
Serco	Service Coordination
SISSAL	South Island Shared Service Agency
SPoE	Single Point of Entry (admission/entry point to OPHSS CST's and PSE)
RHS	Restorative Home Support
RST	Referral Screening Tool (determines complexity of case)
TPMH	The Princess Margaret Hospital (current location of OPHSS)
WINZ	Work and Income New Zealand

The terminology "Client" has been used throughout this document in preference to "Service User", "Consumer" or "Patient"

REFERENCES & RESOURCES

ACC Website http://www.acc.co.nz/

Canterbury District Health Board and Canterbury Clinical Network, *Community Services Operations Manual, Community Nursing and Home Based Support* http://communityservices.healthpathways.org.nz/

Canterbury District Health Board OPHSS, Guidelines for Assessing "Close in Age and Need" (OPHSS-GEN 0086) (July 2012)

Ministry of Health, various articles and publications - Health of Older Persons Website http://www.moh.govt.nz/olderpeople
(This site is regularly updated and a handy resource for clinicians) including: "How to Claim Carer Support"

"Needs Assessment and Support Services for Older People"

"Long-term Residential Care for Older People"

Ministry of Health, *Health of Older People Strategy* (April 2002, Revised 2011) http://www.health.govt.nz/system/files/documents/publications/olderplebb.pdf

Ministry of Social Development and Employment, *A Guide for Carers* (2013) http://www.msd.govt.nz/documents/what-we-can-do/community/carers/carers-brochure-english.pdf

Ministry of Social Development and Employment, *Services for Seniors* (July 2014) https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/brochures/services-for-seniors.html

National Disability Authority, *Health and Personal Social Services for People with Disabilities in New Zealand- A Contemporary Developments in Disability Services Paper (pg 14-22; 25-29;34-35; 51-54)* (January 2011)

INTRODUCTION TO THE SUPPORT SERVICES HANDBOOK

Handbook designed to be used by all clinicians throughout OPHSS and as a reference for other CDHB Staff, e.g. those at Burwood and Christchurch Hospital as well as the staff of the CCCC, when accessing supports that are managed by OPHSS.

Name *Title*

HOW TO USE THIS HANDBOOK

This Support Services Handbook has been designed to be used electronically, to facilitate frequent updates and support the dynamic nature of the OPHSS environment, in which clinicians in work.

The handbook has been designed to complement existing CDHB policies and procedures with cross references included where appropriate.

Reference Manuals that are specifically relevant to the role of clinicians providing Support Services, are located separately to this Handbook; and include the OPHSS Line 3 Manuals:

Volume P - Psychiatric Service for the Elderly

CDHB Nursing Standards, Policies and Procedures

Clinicians should be familiar with these documents and not rely on this Handbook as a complete reference volume for their role.

The Canterbury District Health Board and Canterbury Clinical Network Operations Manual also contains relevant information for OPHSS clinicians as the complex/non-complex interface is further defined, and OPHSS clinicians are expected to be familiar with the guidelines contained in this manual.

Hyperlinks to websites containing relevant information for each section have been included, rather than duplicate the content of the website into this document. This will ensure that information referred to is current, and will facilitate clinician familiarity with key websites that include resources to support their role.

Each topic begins on a new page, so that if a hard copy of specific information needs to be printed, the relevant pages can be selected and printed accordingly. It is not recommended that clinicians' print out entire paper-based versions of this manual. It is suggested that the PDF file be copied onto the desktop of the clinicians' laptop, which will facilitate easy reference when not connected to the CDHB network. However, the Handbook is designed to use hyperlinks, and to be frequently updated as new published editions.

The pace of change of configuration for community-based services, and the complex funding environment, represents a significant challenge for OPHSS. To ensure that there are adequate guidelines to inform clinicians, it is imperative that this handbook is kept up to date and regularly reviewed. Therefore, to ensure clinicians are accessing the most recent edition, it is best used as an electronic (intranet-based) manual.

Part A

Overview

PART A OVERVIEW OF SUPPORT SERVICES

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1. OVERVIEW OF HOME BASED SUPPORT SERVICES

1.1 General Overview

Home Based Support Services (HBSS) in Canterbury are funded by the Canterbury District Health Board (CDHB). These services (including non-specialist community nursing services) are for clients who need support in their homes and community, whether on a short or long term basis. They are based on the Restorative Model, which utilises a goal based care plan with a strong client centred focus. The core concept of the Restorative Service Model is to maximise independence and minimise functional decline, whilst allowing older people to age in place[1].

These services align with the strategic objectives of:

- The New Zealand Health Strategy – 2000;
- New Zealand Health of Older People Strategy - 2002;
- The New Zealand Disability Strategy – 2001;
- Primary Health Care Strategy – 2001;
- He Korowai Oranga Māori Health Strategy – 2001; and
- The Pacific Health and Disability Action Plan – 2002.

Definition

Home based support services are flexible, integrated and responsive. They focus on clients' decision making and goal attainment, in order to facilitate the client living independently in their own homes and within the wider community.

Home based support services -

- are client driven
- provide an integrated approach to assessment and service delivery in support of the Restorative approach
- support an integrated continuum of care, by linking to both primary and secondary care
- are pro-active interventions to prevent or delay physical, psychological and/or social deterioration

[1] CDHB, Restorative Home Support, Draft Service Specification, 5 March 2009

- are inclusive of family/whānau and other natural supports

Purpose

- To promote and maintain the independence of people who require support, in order to enable them to continue to live in the community.
- To enable clients to live safely within their homes and communities, and for them to take part in activities that support and strengthen this objective.
- To promote recovery and return to independent living through outcome driven support services, based on the assessed need(s) of the client and their family/whānau.

Scope

All clients with age related disabilities who have been identified by SPoE as meeting the eligibility criteria.

Eligibility

Clients with health and/or disability support needs who are eligible for funding.

- Referrals received by SPOE are screened to check for eligibility for service using the following criteria:
- The Client-
    - lives within Canterbury's geographical boundaries
    - is a New Zealand resident, or has rights of reciprocity (Australia, UK, Cook Islands, Nuie, and Tokelau)
    - is aged 65 years or older; or 50 years and older when accepted as having needs *close in age and need* to a person over 65 years
    - (or their authorised representative) is aware of the referral and gives consent

In order for services to be allocated and implemented, clients must be assessed by a health professional and meet the eligibility criteria

Client Categories are described as follows:

- Over 65 years (or those 50+ identified as Close in Age and Need) with complex needs are managed by OPHSS or PSE.
- Over 65 years with non-complex needs are case managed by the community providers; Access, Healthcare NZ, and Nurse Maude.
- Under 65 years with a disability and not identified as Close in Age and Need may be managed by LifeLinks.
- Under 65 years with a long-term chronic health condition and **not** identified as Close in Age and Need may be managed by the Adult Community Therapy Service (ACTS)
- Under 65 years who have been identified as eligible for services under SupportCare (End of Life or Severe Medical Illness) are to be case managed by the Specialist Palliative Care service or the community providers, as appropriate. (See SupportCare Funding, Section 19 below)

Exclusions

Home Based Support Services are not appropriate;

- For Clients who are receiving a Residential Care Subsidy (RCS) and residing in a residential care facility.
- For clients who fail to meet the eligibility criteria listed above.

General Requirements

- Home support services and community nursing will be provided in an integrated manner that maximises opportunity for ongoing assessment and review of clients receiving simultaneous service
- Where possible, continuity of staff for the Client will be maintained as part of the integrated service
- Links with general practice are critical for all aspects of service delivery
- Personal goals are to be identified following assessment
- Home based Support Workers work *with* clients to achieve these goals, rather than 'doing tasks' for clients
- There is an expectation that the natural and available community supports will continue to be accessed, wherever appropriate, to respond to the needs of the Client
- It is expected that providers of HBSS services will ensure that services are delivered by a Support Worker who is competent to provide appropriate support for the clients to which they are assigned
- Support Workers are expected to be appropriately trained, and this should include the vocational qualification *National Certificate in Community Support Services (Level 2)*, as well as *Unit Standard 23925,* which focuses on Independence

- The provider is expected to facilitate the minimum number of Support Workers for each client as is logistically possible and safe
- Refer to the CDHB/Canterbury Clinical Network Community Services Operations Manual http://communityservices.healthpathways.org.nz/

1.2 Goal Ladders

Definition

A Goal Ladder is a documentation of goals agreed to by the client and the OPHSS clinician, from which the nature of the intervention by Home Based Support Services (HBSS) can be ascertained.

Purpose

To provide a framework outlining:

- the participation of the client in their care and rehabilitation
- the role of the support worker in regard to supporting the client to achieve these goals
- the expected outcomes of the interventions to be put in place

Implicit in these goals are:

- The promotion and/or maintenance of the Client's independence in order to enable them to continue to live in the community
- Enabling clients to live safely within their homes and communities, and for them to take part in activities that support and strengthen this objective
- The promotion of recovery and a return to independent living (self-care)

1.2.1 Constructing a Goal Ladder

The Goal Ladder is based on needs identified in the interRai assessment and Case Mix.

- Goals need to be functional
- Goals are formulated with the clinician and the Client; and, where appropriate, their family/whānau/carers
- Goals are to be SMART (**S**pecific, **M**easureable, **A**chievable, **R**ealistic, **T**ime framed)
- HBSS providers work with the Client to assist them to achieve these goals.

- Rather than completing tasks on the Client's behalf, the provider works with the Client to accomplish tasks together, thus assisting the Client to improve function and regain independence
- Current goals can be stepping stones to achieving future goals

1.3 Close in Age and Need

1.3.1 Overview: Close in Age and Need

Purpose

The Close in Age and Need provisions are to ensure access to OPHSS funding for people whose needs are best met by health and disability services provided for older people.[2]

Some people 50-64 years of age have multiple medical conditions which impair their physiologic/mental/functional state and make them functionally more like an elderly individual, so that their chronological age does not reflect their true level of functioning

Scope

Those clients aged 50-64 who meet the eligibility criteria

Eligibility

Individuals who have complex disabilities, typically with multiple medical conditions which are more common in older people.

These problems may include, but are not limited to:

- Cognitive Impairment
- Increasing frailty
- Recurrent falls or instability
- Incontinence
- Not coping at home/difficulty managing personal cares

[2] Health Funding Agency Definitions of Disability April 1998

CDHB OPHSS will consider individuals 50-64 years of age for funding as "Close in Age and Need" if they fulfil **both condition A** and **at least one** of conditions **B, C or D**

A. They require access to multidisciplinary care to maintain their health and function

B. They have three or more advanced chronic conditions, each of which has associated disabilities which
- **i)** are similar to those commonly seen in advanced age
- **ii)** are persistent (not temporary) **AND**
- **iii)** require ongoing disability support services to maintain their function

C. They have Frailty syndromes (as defined by recognised international criteria). These clients are prone to rapid or profound decline in health and independence with minimal provocation

D. They have a formal diagnosis of dementia with disability needs consistent with the diagnosis

The final decision as to eligibility is a clinical judgement made by a Geriatrician or Psycho-Geriatrician.

Exclusion Criteria:

Clients who are considerably younger than 65 years may well be ineligible for funding under the Close in Age and Need provisions as:

- Their needs are less likely to be similar to those of an older person and
- There are other funding streams designed to serve them, such as Serious Medical Illness (see section 17.4 of this handbook), Mental Health and Disability Support Directorate (via Lifelinks).

General Requirements:

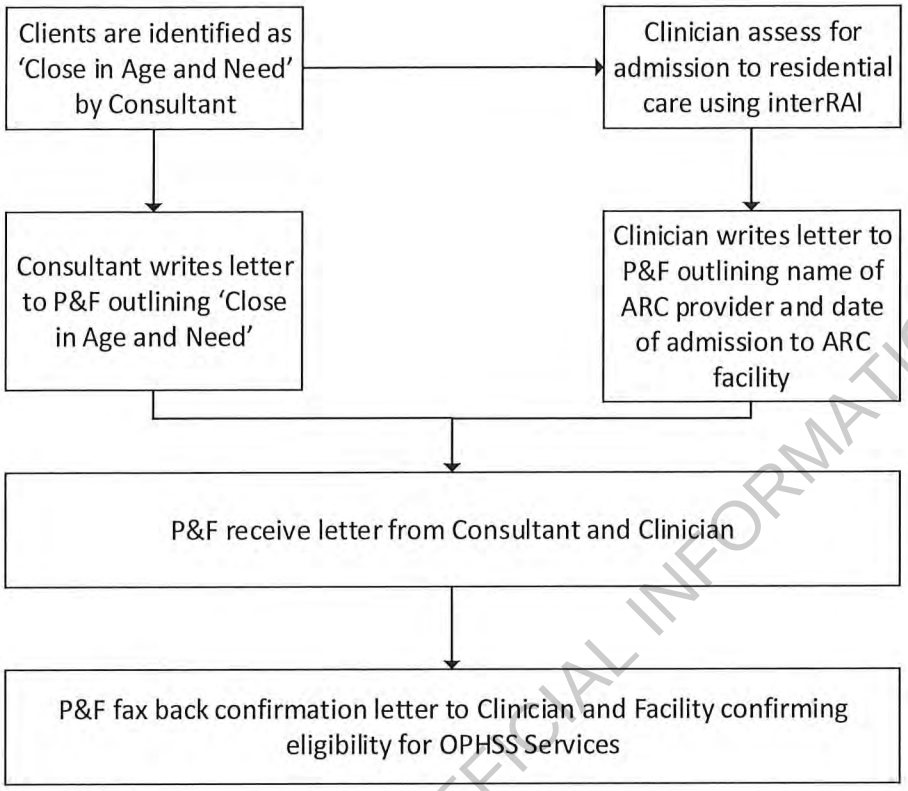
- A clear determination of eligibility to access OPHSS should be made for all people younger than 65 years of age.
- The decision should be documented in Health Connect South and Healthlinks

  - Health Connect South - an Administration letter, written by the treating Geriatrician or Psychiatrist, outlining the outcome (accept/decline of OPHSS services for the client) and clinical reasoning for this
  - Healthlinks- A note entitled OPHSS acceptance/decline letter is made. To avoid duplication of content, reference can be made to the note in Health Connect South
- Documentation of acceptance to OPHSS on Healthlinks and Health Connect South must occur prior to commencing support services
- Being admitted to, or treated by, any OPHSS services for specific clinical reasons does **not** automatically imply acceptance for long term funding. A clear determination of eligibility should be made and documented (as outlined above) by the treating Geriatrician or Psychiatrist during this clinical episode
- Patients with alternative funding sources (such as Lifelinks) regardless of age, should be identified on Healthlinks with a notation made as to the reason why that person is accepted or declined for OPHSS funding and/or clinical services
- Additional information can be found in "Guidelines for Assessing Close in Age and Need" Document

1.3.2 'Close in Age and Need' Residential Care Assessment Procedure

1. Clients must have undertaken the same assessment and approval to enter residential care procedure as OPHSS clients (See section 11).
2. A documented letter from the assessing Consultant is required to identify that the Client is *close in age and need*. This letter then acts as entry and entitlement to services provided by OPHSS.
3. The Clinician and Consultant are required to advise Planning and Funding in writing stating the Client's level of care, date of entry to OPHSS and placement details. When this notification has been received by Planning and Funding, they will confirm the Clients eligibility to the Clinicians and residential facility.
4. All correspondence letters and authorisations are forwarded to Healthpac Administrator and should state that the person is accepted as *close in age and need*.
5. If the Client is married, and/or has dependent children, they will not be income and asset tested. Clients that are not married will be asset tested.
6. Clients receiving a benefit will need to contribute part of their benefit towards the cost of their care. However, their weekly allowance is higher than that of those aged over 65 years.
7. Once the client reaches 65 years of age, they will be income and asset tested (regardless of marriage status and dependants) and will need to apply for the Residential Care Subsidy, if needed.

Figure 1: *Close in Age and Need* Admission to Residential Care Process Map



2. ASSESSMENT & SERVICE COORDINATION

2.1 Assessment Guidelines

Definitions

The ***interRAI*** suite of assessments are part of a comprehensive assessment and care planning system. This system is designed to support clinical decision making for the care, rehabilitation and support requirements of older persons in the community. The primary assessment used by OPHSS is the interRAI Home Care (interRAI HC) assessment. Other assessments, specific to the Client's presentation and needs, are used in addition to the interRAI, as required.

Purpose

To determine the Client's current status, identify client specific issues and develop a comprehensive, individualised, long term care plan to support that Client.

Scope

All clients who meet the eligibility criteria.

Eligibility

Clients are eligible for OPHSS Assessment;

- If they are over 65 years in age, deemed to be *close in age and need*, or Māori or Pacific Islanders aged over 50; and.
- If they have been referred by their GP or other recognised health professional
- If they hold NZ Citizen Status
- Prison inmates are eligible

Assessment services are not appropriate;

- For clients who normally reside in another DHB district to which they are planning to return
- For acute mental health issues that do not fall within the scope of Psychiatric Services for the Elderly

Review

Clients are required to have a regular re-assessment using the interRAI HC. The frequency of reassessment will be determined by the clients Casemix score (refer to section 2.2 Case Mix below) following their most recent assessment.

Reassessment may also be required if there is a change in the client's medical condition or social circumstances in regard to funding for Carer Support, and/or Respite Care, and/or Day Care.

General Requirements

Clients are referred to the service for assessment by;

- their GP
- Internal CDHB Staff
- Home Based Support Services (following a interRAI Contact Assessment with an assessment urgency score of 4 or more)
- Health professionals within other organisations

Referrals for assessment are triaged in the Community SPoE, to ensure that only appropriate referrals are actioned

OPHSS SPOE receives referrals for a number of specialist services as well as home-based support. If home-based support services are required, referrals are screened for complexity using the Supporting Allocations Tool (SAT) to determine if identified needs are complex or non-complex.

2.1.1 Supporting Allocations Tool (SAT)

Criteria considered on the SAT are:

- Cognitive impairment
- Progressive neurological condition
- Brittle social support
- Assistance with dressing
- Assistance with medication management
- Unmanaged pain
- Significant anxiety, low mood or other psychiatric illness, which impacts on everyday functioning

Referrals determined to be non-complex will be forwarded to the preferred provider or allocated to the next provider on a 1:1:1 basis. SPoE will document which provider the Client has been allocated on the NASC2 form.

- Referrals determined to be complex will be case-managed by clinicians from OPHSS/PSE.
- On receipt of a referral, the Clinical Assessor prioritises the referral within their current caseload.
- All assessments should be completed within 6-8 weeks of initial referral.
- All assessments are to be completed on the interRAI software Momentum within 3 days of the assessment being completed.
- It is preferable that interRAI assessments are completed electronically at the time of assessment.
- Following the completion of an assessment an assessor should:
    - Determine the Casemix (using the appropriate case mix flow chart)
    - Develop an appropriate care plan and goal ladder based on assessment findings.
    - Forward necessary information to Service Coordination for processing

2.1.2 Referral Processing and Implementation

Short Term Services and Community Nursing

Expected response time frames for implementation of home based support services is set out in the Community Services Specifications and is detailed below:

Risk Level	Initial Assessment	Service Initiation
Low Risk	Within 5 working days (Monday to Friday) of receipt of referral	Within 14 working days of receipt of referral
Medium Risk	Within 2 working days (Monday to Friday) of receipt of referral	Within 10 working days of receipt of referral
High or excessive level of risk	Within 24 hours of receipt of referral	Within 2 days of receipt of referral
Urgent Community Nursing	As required including same day response	As required including same day response

2.2 Case Mix

Definition

Case Mix is a system that classifies individuals into groups that are similar in their use of resources.

The Case Mix classification provides a framework for allocating resources following assessment.

It is designed to

- Provide guidance to allocate and monitor resources
- Enhance equity of allocation
- Ensure services are appropriately targeted

Appropriately allocate resources to service users who have potential to improve function

There are currently two case mix systems in use in Canterbury. These are based on the interRAI suite of assessments, which are being introduced around the country by the Ministry of Health. The two systems are:

- **Case Mix for Clients with Non-Complex Needs**
  - Based on interRAI **Contact** Assessment five groups; 1, 2a, 2b, 3a, 3b

- **Case Mix for Clients with Complex Needs**
  - Based on interRAI **Home Care** Assessment

- There are 33 groups with five main categories. These categories are based on clients' needs, considering combinations of Disability, Brittle Social Supports, Cognitive Impairment and Rehabilitation Potential.
- These five main categories are (numbered 4-8). Each of the categories 4-7 is then further categorized into 8 subgroups (alphabetically labelled A-H). Category 8 does not have subcategories.

Following either the interRAI Contact or Home Care assessment, the appropriate Casemix is determined manually, using algorithms based on how combinations of questions have been coded by assessors within the respective interRAI assessments.


Complex Casemix 07-04-2014.pdf


Non Complex Casemix 07-04-2014.


Understanding CaseMix.pdf


Simplified Review Table.docx

The uses of Casemix are as follows:

- A mechanism used by Planning and Funding to fairly fund Home Based Support Services based on the complexity of clients
- The ability to compare service provision to individuals with similar complexity
- A determinant in who and when the reassessment of clients is required (See Simplified Review Table above)

2.3 Service Coordination Guidelines

Definitions

Service Coordination is the process of establishing and coordinating services which meet the needs and goals of the Client.

Purpose

The Service Coordination process is designed to ensure that all clients who meet the eligibility criteria have support services which meet their needs.

Scope

All clients who meet the eligibility criteria.

Eligibility

Service Coordination is designed to be used for clients who;

- Live in the Canterbury geographical boundaries
- Hold NZ Citizen Status (or are covered by rights of reciprocity (Australia, UK, Cook Islands, Nuie, and Tokelau)
- Are aged 65 years or older, or 50+ and Māori or Pacific Island in descent and/or accepted as *close in age and need* to a person over 65 years.
- Cover Prison Inmates

Review

Service Coordination packages are reviewed in accordance with MoH guidelines.

Annual review is required in regard to service provision.

Reviews are done by either the service providers or OPHSS Clinicians, depending on the client's Case Mix.

General Requirements

- The Service Coordination involves:
  - investigation into / assessment of all options available to the Client,
  - assisting the Client to access support from other services,
  - allocation of funding, and
  - ensuring that services are implemented and goals agreed are being achieved.
- The interface between Clinicians and Service Coordinators is outlined in the Service Coordination Desk File
- For Clients requiring financial support, Disability Allowance Application forms can be downloaded from http://www.workandincome.govt.nz/individuals/a-z-benefits/disability-allowance.html or collected from a WINZ office.

2.4 Service Gaps

Definitions

***Service Gaps** are* shortcomings in the provision of services assessed as being required for Clients living in a particular geographical area.

General Requirements

- Service Gaps are required to be reported to Planning and Funding to ensure they are aware of shortcomings in service provision. This allows Planning and Funding to raise the issue with providers, on-report gaps to the Ministry of Health and identify trends and patterns, which can drive initiatives for new services.
- Clinical Assessors need to discuss any Service Gaps with the Clinical Manager, as the Clinical Managers are responsible for reporting Service Gaps to Planning and Funding.

3. INTER-NASC TRANSFERS

Definition

When a client is transferred from one District Health Board area to another an Inter-District transfer procedure and process need to be followed.

Purpose

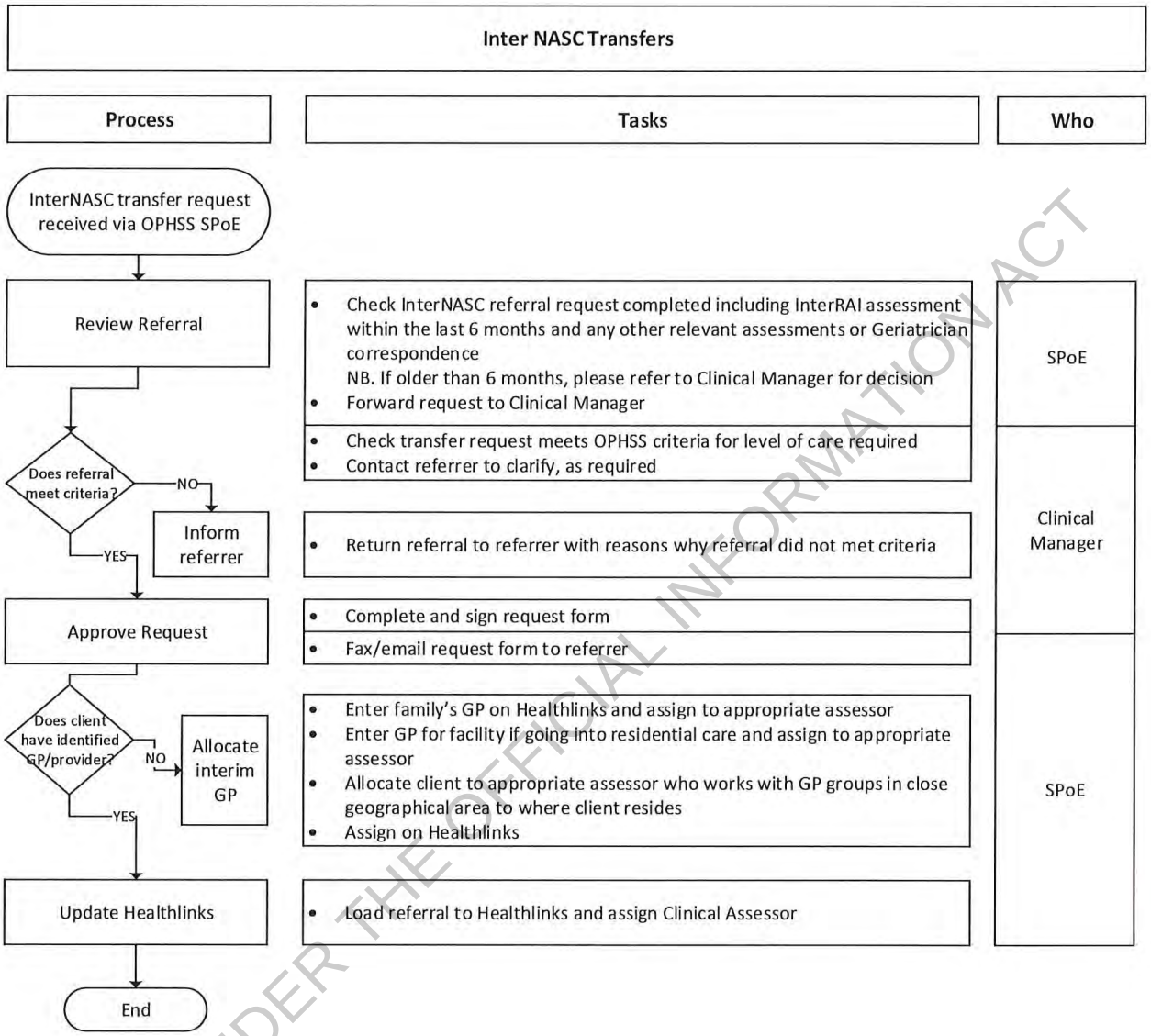
To ensure the continuation of appropriate care and services to the Client in all District Health Board jurisdictions

Scope

All clients transferring from one District Health Board to another.

3.1 Transfer of Older Persons (>65 years) into CDHB OPHSS

Procedure/Process



General Requirements for transfer of Clients >65 years into the CDHB.

- All requests for age-related transfers into the CDHB district are managed by OPHSS.
- The cost of the transfer is to be met by the transferring DHB.
- The transferring client should not require a full re-assessment. However, the Clinical Assessor will need to make contact with the client and/or family/whānau and complete any outstanding documentation (e.g. a Case Mix, Care Plan, Permanent Placement Plan) to ensure appropriate services are in place.

3.2 Transfer of Persons Under 65 (Close in Age and Need) into CDHB OPHSS

- The same guidelines for transfer of older persons into CDHB OPHSS, (as outlined above), apply to the transfer of persons deemed *close in age and need* (as they are under 65 years of age).
- However, as the Client is *close in age and need* and does not meet the regular eligibility criteria (i.e. >65 years), approval by a Consultant is required to ensure eligibility to OPHSS services (refer to Residential Care (Section 11) and Close in Age and Need (Section 1.3) of this handbook).

3.3 Transfer out of CDHB District

- The Clinical Assessor is required to identify the NASC agency the client will be involved with once transferred.
- A directory of NASC Services (including contact details) throughout NZ is located at http://www.moh.govt.nz/moh.nsf/indexmh/hop-supportservicesaccess
- The Inter-NASC Transfer Request (OPHSS 0379) is to be used to communicate transfer of a Client out of the CDHB district. http://cdhbintranet/olderpersonshealthandrehab/allophr/Forms/OPHSS_CST_0379.pdf
- The Clinical Assessor is responsible for collating and checking that the necessary paperwork is completed. The transfer form and the most recent interRAI assessment are faxed to the new NASC agency.
- The Clinical Assessor awaits the response from the receiving NASC agency to ensure that appropriate services will be in place as required before discharging the client.
- Admin/Serco ensure that any existing home support services are cancelled, and that a *Summary of Service Co-ordination* sheet is completed.

Part B

Home Based Support Services
HBSS

PART B HOME BASED SUPPORT SERVICES (HBSS)

4. Carer Support ..... Error! Bookmark not defined.
4.1 Carer Support Guidelines ..... **Error! Bookmark not defined.**
4.2 Claiming for Carer Support ..... **Error! Bookmark not defined.**
4.3 Resources for Carers ..... **Error! Bookmark not defined.**
4.4 Carer Support Brochure ..... **Error! Bookmark not defined.**
5. Day Support ..... Error! Bookmark not defined.
5.1 Day Support Guidelines ..... **Error! Bookmark not defined.**
5.2 Day Support Allocation Procedure ..... **Error! Bookmark not defined.**
5.3 Non Contracted Day Support ..... **Error! Bookmark not defined.**
6. District Nursing ..... Error! Bookmark not defined.
6.1 District Nursing Allocation Guidelines ..... **Error! Bookmark not defined.**

7. Domestic Assistance (Long-Term) ..... Error! Bookmark not defined.

7.1 Funding of Long-Term Domestic Assistance: Guidelines **Error! Bookmark not defined.**

7.2 Domestic Assistance Providers ..... **Error! Bookmark not defined.**

8. Meal Provision ..... Error! Bookmark not defined.

8.1 Meals on Wheels Guidelines ..... **Error! Bookmark not defined.**

8.2 Alternative Meal Providers ..... **Error! Bookmark not defined.**

9. Personal Care ..... Error! Bookmark not defined.

9.1 Personal Care Allocation Guidelines for Long Term Clients . **Error! Bookmark not defined.**

9.2 Personal Care Providers ..... **Error! Bookmark not defined.**

4. CARER SUPPORT

4.1 Carer Support Guidelines

Definitions

A ***Full-time Carer*** is someone who has the principal, active responsibility for the ongoing and frequent care of a person with a disability[3]. This care needs to be provided for a minimum of four hours per day.

The full time Carer is usually unpaid; however some Caregivers are eligible for a Carer's benefit from WINZ.

A person with a ***Disability*** is someone who has been assessed as having a physical, psychiatric, neurological, intellectual, sensory, or age related disability which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required[4].

A ***half-day*** of Carer support is between four to eight hours, and a ***full-day*** is from eight to 24 hours.

Purpose

To provide essential relief for the full-time unpaid carer of a disabled person.

Carer Support offers the Carer a break by contributing to the cost of an alternative Carer to support the disabled person for a specified number of days based on assessed need. This break enables the full-time carer to continue providing the required support that allows the disabled person to continue living in the community. Carer Support can be used to fund Day Care/Activity programmes, or in-home relief care.

Scope

All clients who meet the eligibility criteria.

[3] Ministry of Health, Support Needs Assessment and Service Coordination, Policy Procedure and Information Reporting Guidelines (15 February 2002)

[4] Ministry of Health, Support Needs Assessment and Service Coordination, Policy Procedure and Information Reporting Guidelines (15 February 2002)

Eligibility

Carer Support eligibility is determined through a needs assessment process conducted by an appropriate clinician.

Carer Support is designed to be used;

- For the relief of Carer responsibilities for ***full-time***, unpaid Carers of disabled people, whom a Clinician has assessed as eligible for the service.

Carer Support is not appropriate;

- For individuals who are assessed as not eligible for MoH or CDHB funding, e.g. Non-residents or those covered by ACC (accident related) compensation.
- For individuals living in full-time MoH or CDHB funded residential care services or clients under the care of mental health services.
- For clients who do not have the support of a full-time Carer.
- When a needs assessment, i.e. InterRAI does not indicate Carer Support is required.
- To fund spouses, partners or adult children of a client to provide relief care for their relative, even if they do not reside at the same address as the client[5].
- As a crisis response or for long-term care. Carer Support is expected to be part of the overall care management plan.
- To be used whilst the full-time Carer is at work (paid employment).
- Please note: When there is a change of Carer and the assigned person is no longer in the full-time Carer role, the Carer Support allowance does **not** automatically transfer to a new/replacement Carer.

Review

Carer Support allocation is to be reviewed annually, with review as required during the year if the Client or Carer's circumstances change.

General Requirements

[5] MoH, How to Claim for Carer Support brochure, 2009 http://www.moh.govt.nz/moh.nsf/pagesmh/8489/$File/how-to-claim-carer-support-09.pdf

- Carer support payments are intended to be a reimbursement towards the cost of providing relief support, and are not a salary or wage
- The full time unpaid Carer is able to choose how they use their support days, subject to Ministry of Health guidelines as outlined in the How to Claim for Carer Support brochure.
- It is the individual's right to choose, and coordinate their relief support
- Carer Support can be used in half days, daily, weekly and/or in a bulk block, as long as the total days used does not exceed the annual allocation. For information on how to calculate hours to be claimed refer to the MoH How to Claim for Carer Support brochure http://www.health.govt.nz/new-zealand-health-system/claims-provider-payments-and-entitlements/carer-support-claims
- Carer Support is designed to provide relief to the Carer. If the Carer chooses to stay in their home when Carer Support is being provided, it is expected that the Carer would not remain in the presence of, or provide care-giving, for the disabled person but engage in another activity in their home.
- There is no entitlement to a specific number of days of Carer Support that can be allocated to full-time unpaid Carers. However, an annual allowance in excess of 28 days can only be allocated with the written approval of the assessing clinician's Clinical Manager.
- Annual allocations of Carer Support are based on assessed need. The annual allocation is documented on the summary sheet and as part of the service plan letter.

Unusual /Rarer Circumstances for Carer Support Allocation:

- Where more than one person in a family has a disability, the need for Carer Support would be assessed on the basis of a maximum of 28 days per annum per disabled person with Carer Support allocations being approved by the assessing clinician's Clinical Manager, taking into account the type of relief support that is available.
- Where two disabled people live together, support/care for each other, and both meet the above criteria in their own right, they may both be eligible for Carer Support from a relief carer.
- Where the full-time unpaid Carer does not live with the disabled person, Carer Support is normally only available if the level of support being provided by the Carer is at least four hours per day, and/or someone without whose support the person would not be able to remain in community. However, there are exceptions to this guideline, which need to be approved by the Clinical Manager; e.g. if the Clinician identifies that less than four hours per day is required, but the support is vital to keep the person living in the community, then Carer Support may be available.
- Individuals are not able to carry over entitlement for Carer Support days from one year to the next. Days are allocated for use during the 12-month period for which they were allocated.

4.2 Claiming for Carer Support

- The brochure 'How to Claim for Carer Support' can be downloaded from the MoH website using the following link http://www.health.govt.nz/new-zealand-health-system/claims-provider-payments-and-entitlements/carer-support-claims
- A sample of the Carer Support Claim form is available on the MoH website http://www.health.govt.nz/new-zealand-health-system/claims-provider-payments-and-entitlements/carer-support-claims
- Both formal and informal providers of Carer Support need to lodge an application for payment on the Carer Support Claim Form, within 90 days of the relief support ending. Reimbursements are made within 10 working days of the MoH receiving a correctly completed form.
- Any queries regarding claiming for Carer Support can be made to the MoH Contact Centre on 0800 281 222.
- After referral from their Assessor, clients will need to be reviewed annually for Carer Support by their original referrer in order to be eligible to claim ongoing Carer Support (allocation) for that year.
- Private agencies providing formal carer support can charge at a rate decided by them.
- Suspicions of inappropriate Carer Support claiming can be brought to the attention of the Carer Support Fraud Programme by calling the Fraud Hotline 0800 377 277.

4.3 Resources for Carers

The booklet titled *A Guide for Carers* (available in English, Māori, Samoan, Tongan, Cook Island Māori and Niuean) contains practical help for people caring for family or friends who are older or have ill health, a disability, or a mental health, alcohol or other drug issue.

The guide includes information on the government funded services and supports available for carers, such as: financial help, needs assessments, help at home, help if Carers need a break, help related to children with special education needs, health and disability rights and equipment and modifications. This booklet can be downloaded from

http://www.msd.govt.nz/what-we-can-do/community/carers/index.html

If required, hard copies can be ordered by phoning Work and Income 0800 559 009.

5. DAY SUPPORT

5.1 Day Support Guidelines

Definition

Day Support is the provision of day-time care which forms part of a comprehensive package of care for people who have been needs assessed, and whose support needs are able to be met in the community.

Purpose

Day Support services enable the client and/or carer to have a break from their usual routine. It also allows for increased social contact and daily activities.

Scope

All clients that meet the eligibility criteria

Eligibility

Day Support is designed to be used;

- For people who would benefit from increased socialisation and/or for people whose full time carer would benefit from having a regular break from their caring activities.
- For any person accepted by OPHSS as over the age of 65 (or deemed close in age and need), or Māori or Pacific Islanders accepted as close in age and need aged 50 and over, who has been needs assessed as requiring Day Support services.
- As part of a comprehensive package of care.

Day Support is generally not appropriate;

- For clients assessed as requiring either general or dementia Hospital Level of Care. (See under Day Support Allocation Procedure below)

Review

Annual review as part of the package of care

General Requirements

- Day support allows the client to attend either a specific day care centre or rest home which invites non-residents to join in daily activities. Close links should be maintained between the Day Support Provider and OPHSS.
- Contracted Day Support providers are expected to provide transportation to and from the client's home/facility, as long as the client lives within the general area of the facility. Where providing transportation for the client is problematic the Clinical Assessors needs to work with Planning and Funding to address the transportation issues.
- Meals, snacks and drinks are to be provided by the facility for the duration of the Day Support programme.

5.2 Day Support Allocation Procedure

- Clients usually attend a Day Support programme on the same day every week. Day Support is allocated on an annual basis i.e. if a client is to attend one day per week then 52 days would be allocated for a 12 month period.
- Clients may attend a Day Support programme for one day per week, Additional days can be negotiated and funded privately directly with the service provider. A case can be made for *(funding of)* additional days where this is clinically indicated. This is done by the clinician to the Planning and Funding Service Development Manager.
- The CDHB has a contract with a number of funded Day Support providers, both residential and standalone day care centres. Day Support funding can only be allocated to these providers.
- The CDHB has contracts with providers to provide general day support and Dementia Day Care. To access dementia level Day Care, the client must be assessed by PSE as requiring this level of care in order to provide the appropriate sign off.
- Once a client has been assessed as requiring contracted Day Support Services, then a referral, comprising of the InterRAI care plan and the Request to Day Support providers form (OPH CST 0485) is sent to the appropriate Day Support provider http://cdhbintranet/olderpersonshealthandrehab/allophr/Forms/OPHSS_CST_0485.pdf
- The Request to Day Support providers form (OPH CST 0485) must be completed annually, at the time that the Care Plan is reviewed, and forwarded to the providers.

- As there are no funded Day Support Services at Hospital Level of Care or Dementia Hospital Level of Care, approval *for clients with high needs is required* from Planning and Funding, on a case by case basis.

5.3 Non Contracted Day Support

Clients and/or their carer(s) can make private arrangements with the provider of their choosing. This will not be directly funded by the OPHSS.

Clients can choose any facility that provides Day Support services.

Payment options for Non Contracted Day Care providers are:

1. Carer Support allocation
   A carer may choose to use their carer support allocation to fund Day Support. The details of payment would need to be worked out with the provider. It may involve the provider claiming the carer support payment directly from the Ministry of Health, or the carer may be required to pay for the service in the first instance then seek reimbursement via Carer Support from the MoH. To use this option, clients need to have been assessed, and allocated Carer Support funding.

2. Disability Allowance
   The client would need to pay privately and may be eligible to claim under a Disability Allowance from WINZ for Day Support funding. Their GP would need to verify their medical eligibility, and they would be income tested.

3. Private payment
   In this instance the families make their own arrangements and fund the services themselves.

4. Home Share

This service is run by Presbyterian Support Services Enliven Positive Ageing Services. Home Share enables isolated older people who cannot access existing day care facilities to meet in small groups in private homes in their community.

Those with special needs related to memory loss may also benefit from a small group setting.

- Hosts with suitable premises are contracted to open their homes to a small group of elderly people.
- The hosts are trained and receive ongoing support from the service co-ordinator.
- Each session is for six hours during which time a hot meal is provided.
- There is no charge, but donations are welcome.
- Home Share is not recorded on the NASC2 and is funded separately to HBSS.
- Referrals are made using the Enliven Referral Form at https://uppersouthisland.enliven.org.nz/services/homeshare

6. DISTRICT NURSING

6.1 District Nursing Allocation Guidelines

Definition

***District Nursing** is* in home nursing care provided by a Registered Nurse (RN)

In Canterbury, District Nursing is provided through community-based providers.

Purpose

To provide skilled nursing care to meet the needs and goals clients in the community.

District Nursing tasks may include, but are not limited to:

- Medication management
- Catheter cares
- Monitoring of blood sugar levels
- Wound care

Scope

All clients who meet the eligibility criteria.

Eligibility

This is determined by the provider.

District Nursing is designed to be used:

- For clients who are unable to learn and/or perform necessary self-cares, and
- Where there is no carer, or the carer is unable to learn and/or administer the required care or treatment.
- For residents of community homes (run by NGO's and other similar agencies) for clients with intellectual, physical or mental disabilities. These clients are eligible for

nursing services, supplies and equipment under the same criteria as people living in their own homes.

Review

As determined by the referrer and the district nursing assessment.

If district nursing is discontinued the provider should notify the referrer.

General Requirements

- Referrals for District Nursing can be made by any health professional through the CCC. However, in most circumstances, the client's GP is responsible for the referral to, and oversight of, District Nursing services.
- Referrers may request a preferred provider as part of the referral process to the CCC. This is often at the client's request, and may stem from the desire to have the same provider as other services which are already in place. This can be beneficial in terms of improved communication between the client, the service provider, the GP practice, the referrer, and internally within the team providing the support services
- District Nursing is not recorded on the NASC2 and is funded separately to HBSS
- For detailed information on District Nursing refer to Health Pathways
- http://www.cdhb.health.nz/Search/Pages/results.aspx?k=District%20Nursing

7. DOMESTIC ASSISTANCE (LONG-TERM)

7.1 Funding of Long-Term Domestic Assistance: Guidelines

Definitions

Domestic Assistance is a DHB funded service using contracted providers to undertake essential domestic tasks in the clients' home.

Purpose

To meet clients' essential domestic needs, which if not met, will affect their health and safety.

Domestic Assistance Services may include (but are not limited to):

- Routine housework
- Laundry (not ironing)
- Meal preparation
- Grocery shopping

Domestic Assistance services do not include spring cleaning and tasks undertaken by trade's people.

Scope

All clients who have a Community Services Card and meet the eligibility criteria.

Eligibility

Domestic Assistance is designed to be used:

- For persons with a chronic, long term, age related disability

- To assist persons living alone with diminished independence
- To assist Clients and their Carers where the Client has high care needs

Domestic Assistance is not appropriate;

- For clients who do not have a Community Service Card
- For clients who do not have a chronic disability
- For clients who have an able bodied person living with them, who is able to perform domestic tasks (aside from where an exception is made for carers of clients with very high care needs)

Review

Required to be done annually, if there is a significant change in the client's condition or circumstances, or as per the service review date.

General Requirements

- Domestic Assistance is intended to compliment the domestic activities that the client and family members are able to undertake.
- Domestic Assistance is allocated to meet essential domestic needs as indicated by the outcome of a Needs Assessment.
- In rare cases, where a client receiving Domestic Assistance lives with capable family members, Domestic Assistance is allocated to assist with the client's immediate personal area only.
- Variables to be considered when allocating Domestic Assistance:
- Informal supports available to the client (e.g. family, friends, community groups)
- The clients' holistic abilities and disabilities (e.g. visual impairment, mobility, medical needs and carer stress levels)
- The clients' preferences and needs (need to be prioritised)
- Eligibility and availability of services, e.g. meals on wheels, meal preparation from friends or family supports.

7.2 Domestic Assistance Providers

A list of providers is to be included in the Operations Manual (currently under development)

8. MEAL PROVISION

8.1 Meals on Wheels Guidelines

Definitions

Meals on Wheels is a subsidised service provided by the CDHB which delivers a hot meal to clients on weekdays.

Purpose

To support clients' essential nutritional needs which, if not met, will affect their health and safety.

Scope

All eligible clients that live within the greater Christchurch city area.

Eligibility

Meals on Wheels is designed to be used to assist persons with diminished independence, who are not able to prepare their own main meal.

Referrals

Referrals can be made directly by the GP or as part of the NASC process, using the standard Meals on Wheels referral form
CDHB Intranet/FoodServices/Meals on Wheels

Review

Review process and frequency is the responsibility of the Meals on Wheels service.

General Requirements

- Meals on Wheels are available to all OPHSS Clients.
- It is advisable for the Clinical Assessor to check availability of Meals on Wheels. At times there may be a waiting list for specific geographical areas. This applies especially to the city surrounds and rural areas.
- There is a direct per meal cost to clients for Meals on Wheels. There are several payment method options. Meals on Wheels will discuss these and make payment arrangements directly with the client.
- Any special dietary requirements such as diabetic diet, pureed diet, food allergies, etc., must be noted by the referring clinician.
- Meals on Wheels can be provided up to 5 days per week (on week days only).

8.2 Alternative Meal Providers

There are alternative meal providers available if clients prefer these.

Age Concern Canterbury Information Centre provide information on alternative meal providers. http://ageconcerncan.org.nz/resources/

Their contact telephone numbers are 0800 803 344 or 366 0903

9. PERSONAL CARE

9.1 Personal Care Allocation Guidelines for Long Term Clients

Definitions

Personal Care is a CDHB funded service, using contracted providers, to assist with personal activities of daily living, in the clients' home.

Purpose

To meet clients' essential personal hygiene needs in order to support them to live independently in the community

Scope

All clients who meet the eligibility criteria and require long-term Personal Care services.

Eligibility

Personal Care is designed to be used:

- For persons with a chronic, long term, age related disability
- To assist persons living alone with diminished independence
- To assist clients and their carers where the client has high care needs

Review

Required to be done annually; if there is a significant change in the client's condition or circumstances; or as per the service review date.

General Requirements

- The need for Personal Care must be identified through an InterRAI Assessment, undertaken by a clinician.
- Personal Care is allocated according to the recommendations of the Clinical Assessor, as outlined in the Case Mix and Care Plan
- Clinical issues and needs will determine the frequency and daily timing of visits by the provider.
- Operational issues, such as availability of provider staff will also influence the frequency and timing of visits. Liaison with the provider is required in order to ensure the client' needs are met.
- Where there are concerns that the providers are unable to meet the needs of the client, the Clinical Manager needs to be advised in order to allow gaps in services to be identified and addressed by Planning and Funding.
- Services may include, but are not limited to, assistance with:
    - Dressing, undressing & personal grooming
    - Bathing/showering
    - Transfers between chair/bed etc.
    - Monitoring of skin and scalp, application of prescribed treatments
    - Toileting and use of continence products
    - Eating and preparation of special dietary needs

- Supporting of safe mobility around the home
- Application of splints and exercises as taught by Physiotherapist
- Monitoring of health and safety and reporting of concerns to Case Manager
- Other tasks that relate to personal care, such as bed making, breakfast preparation and medication prompts

9.2 Personal Care Providers

The following providers are able to undertake Personal Care services:

- Nurse Maude Association,
- Healthcare NZ,
- Access NZ

To refer to a provider, a copy of the InterRAI care plan is sent to the provider with a request that they notify the referrer of acceptance of the referral.

Part C
Aged Residential Care

PART C AGED RESIDENTIAL CARE

10. Eldernet ..... Error! Bookmark not defined.

10.1 Eldernet Website ..... **Error! Bookmark not defined.**

10.2 Eldernet Booking System ..... **Error! Bookmark not defined.**

11. Residential Care ..... Error! Bookmark not defined.

11.1 Residential Care Placement Guidelines ..... **Error! Bookmark not defined.**

11.2 Residential Care Subsidy ..... **Error! Bookmark not defined.**

11.3 Residential Care for 'Close in Age and Need' Clients ..... **Error! Bookmark not defined.**

11.4 Additional Charges for Residential Care ..... **Error! Bookmark not defined.**

11.5 Licence to Occupy (also known as Occupation Rights Agreement) ..... **Error! Bookmark not defined.**

11.6 Temporary Alteration to Level of Care ..... **Error! Bookmark not defined.**

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11.8 Temporary Leave/Absence from Residential Care ..... **Error! Bookmark not defined.**

11.9 Twenty-One Day Extension ..... **Error! Bookmark not defined.**

11.10 Aged Care Facilities in Canterbury ..... **Error! Bookmark not defined.**

11.11 Useful Resources & Information for Clients . **Error! Bookmark not defined.**

12. Respite Care ..... Error! Bookmark not defined.

12.1 Planned respite ..... **Error! Bookmark not defined.**

12.2 Acute Respite ..... **Error! Bookmark not defined.**

12.3 Respite Care for Clients not Known to OPHSS **Error! Bookmark not defined.**

12.4 Respite Care Outside of SPoE Operating Hours ..... **Error! Bookmark not defined.**

12.5 Respite Care Allocation Process ..... **Error! Bookmark not defined.**

12.6 Respite Care Following Discharge from Hospital (Public, Private & Charity Hospital) ..... **Error! Bookmark not defined.**

12.7 ACC Interface ..... **Error! Bookmark not defined.**

12.8 Respite Care for palliative patients ..... **Error! Bookmark not defined.**

12.9 Client Not Returning to the Community ..... **Error! Bookmark not defined.**

12.10 Temporary/Permanent Change in Level of Care.....**Error! Bookmark not defined.**

12.11 Changing Providers within an Episode of Respite Care**Error! Bookmark not defined.**

12.12 Enquiry Procedure for Providers..... **Error! Bookmark not defined.**

12.13 Respite Care Outside of the CDHB Area..... **Error! Bookmark not defined.**

12.14 Providing Respite Care within the CDHB Area for Clients from other DHB's ..... **Error! Bookmark not defined.**

12.15 Process Tables..... **Error! Bookmark not defined.**

12.16 Respite Care Notification Form..... **Error! Bookmark not defined.**

10. ELDERNET

10.1 Eldernet Website

The Eldernet website contains information and links to useful resources for older people in NZ.

It includes a nationwide database, directory and comprehensive information about:

- community groups and organisations
- home help services
- retirement villages
- residential care
- rest homes
- hospital level care
- dementia care
- dementia hospital level care
- private hospitals
- public hospitals
- other third age services for seniors.

The website can be accessed using the following link: http://www.eldernet.co.nz/Home

10.2 Eldernet Booking System

- The Eldernet website is a useful tool for identifying current residential care vacancies in the Canterbury region.

- Searches can be generated for each level of care, i.e. Rest Home, Hospital, Dementia Rest Home and Dementia Hospital.
- Each residential facility is responsible for keeping their facility's information up to date.
- As the website is dynamic, availability can change at any time. Therefore, it is important to confirm any vacancies by phone as well as on the website.
- The website holds information from throughout the country. This is useful to assist clients who are transferring to a residential facility in another geographic region. If required, a list can be generated of vacancies in the region they are moving to.

11. RESIDENTIAL CARE

11.1 Residential Care Placement Guidelines

Purpose

To ensure safe and appropriate care for all clients whilst upholding the philosophy of 'Ageing in Place'.

Scope

All clients who meet the eligibility criteria.

Eligibility

Residential Care is appropriate when:

- One of the following conditions is met:
  - The client has been assessed using the MDS-HC interRAI Assessment and placement is approved by the Interdisciplinary Team (IDT); OR
  - A PSE client has been assessed using the psychiatric assessment plus the interRAI assessment; OR
  - The client is an inpatient and they have been assessed as part of the IDT assessment method; OR
  - Other circumstances identified during an assessment (other than those identified as part of the MDS-HC interRAI Assessment) indicate that residential care is the only option for the client, and this has been approved by the IDT and Consultant.

And / Or

- The care packages that have been considered or tried, in order to maintain community living, are no longer sufficient.

General Requirements

- Principles and Processes for Permanent Residential Care Placement (http://cdhbintranet/olderpersonshealthandrehab/allophr/Forms/OPHSS_GEN_0117.pdf) outlines guiding principles and indications for Residential Care
- Entry to Residential Care should be appropriate and timely, and should occur when all attempts to maintain the client in their own home have been considered and deemed inappropriate.
- The interRAI assessment provides information to the clinician to support the clinician's clinical judgement. It is used to guide the clinician's decision on whether Residential Care is appropriate, whilst the overriding focus is to support the client to stay in their own home wherever possible.
- When Clients living in the community are assessed as requiring Residential Care, the case will need to be presented at the IDT meeting(s) outlining the reasons why the client cannot stay at home. All requests for permanent Residential Care require authorisation by a Consultant (Geriatrician/Psychiatrist) and the relevant Clinical Manager.
- For clients in the TPMH inpatient setting, the ward interdisciplinary team make the decision regarding the need for residential care in conjunction with the ward Clinical Assessor. The ward Clinical Assessor has the responsibility to ensure the IDT are made fully aware of all of the options for the client to remain at home and that these avenues are exhausted before the decision is made for residential care. Once this process has been completed Consultant sign off is required as above.
- Once the client has been signed off/approved to go into residential care, SERCO Admin process the application through Healthlinks and Health Connect South

11.2 Residential Care Subsidy

- Residential Care Subsidy (RCS) is financial assistance provided by the MoH and funded through the District Health Boards.
- The subsidy assists with the cost of long-term residential care in a hospital or rest home when this is expected to occur indefinitely.
- Work and Income are responsible for income and asset testing people who apply for a Residential Care Subsidy. The Residential Subsidy unit of Work and Income assess a client's financial eligibility for Residential Care Subsidy and the income contribution they are required to make from their own resources.
- Ministry of Health http://www.health.govt.nz/our-work/life-stages/health-older-people/long-term-residential-care/residential-care-subsidy
- The MoH is responsible for the payment of Residential Care Subsidy to the hospital or rest home where the Client resides. Generally, the amount of subsidy is the difference between the cost of contracted care and the amount a client is required to contribute for that care.
- People who require long-term supported accommodation due to an illness or a disability may be entitled to access one of three subsidies: the Residential Care Subsidy, the Residential Support Subsidy, or the Top-Up Subsidy.

http://www.health.govt.nz/new-zealand-health-system/claims-provider-payments-and-entitlements/residential-care-subsidies

- Information provided by the Ministry of Health on Residential Care Subsidies entitled Long Term Residential Care for Older People, What You Need to Know (2012), is available in booklet form from the Ministry of Health and can be downloaded from http://www.health.govt.nz/publication/long-term-residential-care-older-people-what-you-need-know-2012
- Clients who have been assessed as requiring residential care must reside in a facility with a DHB contract in order to access any subsidies

11.2.1 Residential Care Subsidy Application Procedure

1. Client must be assessed as requiring residential care at the appropriate level, and have the corresponding sign off authority, to be eligible for a Residential Care Subsidy (RCS).
2. If the Client believes they may meet WINZ's financial requirements for an RCS, as outlined in the following link.(http://www.workandincome.govt.nz/manuals-and-procedures/income_support/extra_help/residential_care_subsidy/residential_care_subsidy-01.htm), then page five of the subsidy application form should be completed by the Client's Clinician and given to the Client or family/whānau to complete and forward to the Residential Care Subsidy unit of WINZ.
3. Clients have 90 days from the date of entry into care to apply for a RCS. If they are successful their subsidy will be backdated up to 90 days.
4. Clients who entered residential care without a corresponding needs assessment and have been privately paying, but now wish to apply for a subsidy will have their subsidy backdated to the date of their new needs assessment or 90 days (whichever is shorter).

11.3 Residential Care for 'Close in Age and Need' Clients

Clients who are between 50-64 years of age may be deemed *close in age and need, due to their medical and physical conditions* to older persons (>65 years). To be deemed *close in age and need* the client is required to be assessed by an OPHSS Consultant and accepted into the service. This process is outlined in section 1.3 of this handbook.

Once accepted, they are managed as per normal OPHSS procedures.

11.4 Additional Charges for Residential Care

- Residential providers may charge whatever the Client agrees to pay for any extra services that are not contracted care services. However, residents must be informed

as to the nature and cost of any additional services and have a choice whether they receive the additional services.

- Full details of the Subsidised Resident's rights to receive or not receive additional services; and of each additional service and the charge for each additional service, are required to be set out in writing in the Admission Agreement. Any additional charges must be agreed to by the resident.
- Admission to or residence in a facility is not to be contingent on the resident agreeing to receive and pay for any such additional services
- The Subsidised Resident is able, at any time to decide to receive or cease to receive any additional service(s)
- For further information refer to Licence to Occupy section below as well as http://www.workandincome.govt.nz/individuals/a-z-benefits/residential-care-subsidy.html.
- Clinicians have a role to inform clients and their families about this process so that they can make an informed choice about the agreements they make with the facility of their choice.

11.5 Licence to Occupy (also known as Occupation Rights Agreement)

Considerations for complex funding and contractual issues in Licence to Occupy (LTO) facilities are explained below:

- When Clients residing in LTO, studio or apartment rooms, are assessed as requiring rest home level of care, and both the facilities management and the Client wish for them to remain located in their current accommodation situation (and this is possible as the studio/apartment is Certified), the Licence to Occupy agreement is required to be terminated. This is due to the fact that Work and Income will not approve a subsidy for a room that has a License-to-Occupy agreement in place. Due to the changes in the Social Security Act this applies to whether the person receives a subsidy or whether they are paying the maximum contribution as a private payer. There must also be no weekly charge for accommodation and care.
- Clients residing in studio/apartment facilities that are receiving subsidised services as part of an Admission Agreement are funded so that certain services *will be* provided. Therefore it is important to ensure that residents are located in an appropriate setting, which can be effectively serviced by staff, and safety/risk management issues addressed. Planning and Funding staff or auditors may undertake a visit to the facility to ensure that the conditions of the contract can be met.
- Where residents assessed as requiring residential care occupying a studio/apartment in a residential care complex, the Occupation Rights Agreement should involve only one payment for the use of the studio/apartment. This one-off payment situation should be the same even if a couple is occupying a single studio/apartment.

- Where a spouse is the main carer for a resident in a LTO facility, it may be more appropriate to assess the Carer for Carer Support or other support services, rather than subsidise the facility as part of a RCA.
- Where residents are eligible for Residential Care Subsidy and are being provided services as part of an RCA, the provider must not gain additional benefit from this situation, nor be seen to be 'double dipping' as per clause A14.1 of the RCA.
- Providers are able to charge additional charges to residents as long as the Provider meets the Admission Agreement clauses in the RCA. Clauses A13 - Charges to Subsidised Residents and D13 - Admission Agreement in the RCA (http://www.health.govt.nz/our-work/life-stages/health-older-people/long-term-residential-care/age-related-residential-care-services-agreement), as well as the following Clause explain the Providers responsibilities.

  A14 NO OTHER BENEFIT FOR SERVICES: A14.1To avoid doubt, if you are party to any other arrangement (for example, a Licence-to-Occupy or similar arrangement) that results in you effectively receiving payment, benefit, or value whether from a Subsidised Resident or any other Person, for the supply of Services, or any component of them, to a Subsidised Resident, whether or not the arrangement was entered into before you commenced receiving payment under this Agreement in respect of that Subsidised Resident, you must either alter the arrangement so that you do not receive any such payment, benefit or value, or terminate the arrangement.

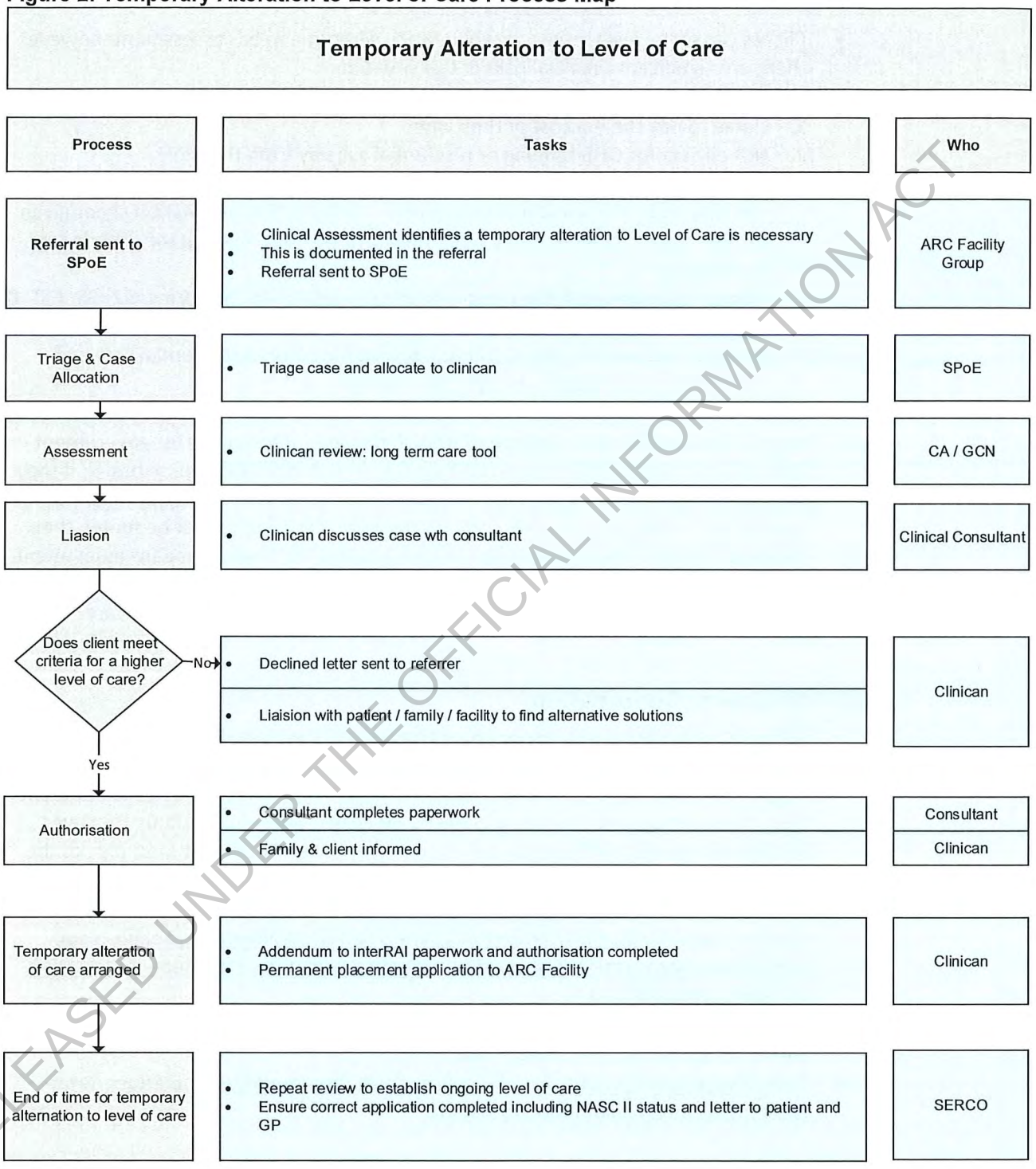
- As outlined in the Residential Care Subsidy section above, all clients who wish to apply for a RCS must be assessed as requiring that level of care and have Consultant approval.
- Further information on LTO facilities is outlined in the Code of Practice for NZ Retirement Villages. It can be accessed using the following link: http://www.dbh.govt.nz/code-of-practice-2008
  Clinicians have a role to inform clients and their families about this process so that they can make an informed choice about the agreements they make with the facility of their choice.

11.6 Temporary Alteration to Level of Care

- Clients requiring a temporarily altered level of care (normally a higher level of care) will require *Consultant/Geriatrician* sign off.
- SPoE receives referral for a Temporary Alteration to Level of Care and checks the client's record.
- Within the referral, the ARC facility provides a clinical assessment, which outlines their clinical reasoning for the request for a higher level of care. An assessment is then completed by the Clinical Assessor, or the Community Gerontology Nurse or the Gerontology Nurse Specialist, and the case is then brought to the geriatrician or psycho-geriatrician for sign off.

- If there are issues, which require interdisciplinary team input the case should be brought to the IDT.
- Once it is established that a temporary alteration to the level of care is appropriate, the authorisation along with normal Respite Care paperwork is passed on to the Service Coordinator/ Healthpac Administrator for processing
- At the end of the period of Altered Level of Care the Client requires reassessment.
    - High-level care authorisation can be cancelled if the client returns to their previous level of functioning, or
    - The client can be permanently allocated respite at the appropriate level of care or
    - The client, can enter permanent care at the higher level of care.
- Progress notes should outline the reasons for *any* changes to level of care.

Figure 2: Temporary Alteration to Level of Care Process Map



11.7 Assessment of Private Paying Residents

- Clients can enter residential care voluntarily, without a needs assessment; however there are significant financial risks in this situation.
- Residents without needs assessments are:
  1. Liable to pay the full cost of their care,
  2. Not eligible for DHB funding or residential subsidy from the MoH,
  3. Not protected by the Maximum Contribution, i.e. the amount that they pay is not capped by the maximum contribution. Refer to the information sheet given to clients who chose to enter residential care without meeting the criteria for placement (http://cdhbintranet/olderpersonshealthandrehab/allophr/Forms/OPHSS_CST_0456.pdf) and Maximum Contribution section, below.
  4. At risk of not meeting the OPHSS guidelines for entry to residential care and therefore not be eligible to apply for a subsidy.
- Clients currently living in residential facilities for which they pay all the costs of their care (i.e. as certified as a designated Rest Home bed), may qualify for government funding towards most of the cost of their care (the Residential Care Subsidy), if they have assets less than or equal to the applicable asset threshold. If they have not already had a needs assessment, or their needs assessment cannot be found, then they must have a needs assessment before applying for financial means assessment. Until they have had a financial means assessment (that determines they are eligible for Government funding), they continue to be liable for the cost of their care.

11.7.1 Maximum Contribution

- If Clients have been needs assessed and have service provided to them under a DHB contract, the most they are liable to pay for services covered by the contract is the 'maximum contribution'. A means assessment will determine the assessed amount the person will actually have to pay (up to the maximum contribution). However, the person remains liable to pay for any other services that do not form part of the contracted care services.
- Further information on maximum contribution amounts and details is available on the MoH website http://www.health.govt.nz/our-work/life-stages/health-older-people/long-term-residential-care/maximum-contribution/maximum-contribution-questions-and-answers
- Maximum contribution values (in dollar terms) for each Territorial Local Authority can be accessed using the following link
- http://www.health.govt.nz/our-work/life-stages/health-older-people/long-term-residential-care/maximum-contribution

11.8 Temporary Leave/Absence from Residential Care

- Subsidised residents may leave a residential care facility temporarily. As long as the bed is not used for another subsidised resident, the CDHB will continue to fund the resident's place during hospitalisation or temporary absence. Payments will continue to be made for residents who choose to be away from their residential facility for up to 28 days in one financial year. However, they resident may only be away for up to 14 days at any one time.
- Funding for subsidised residents who are hospitalised (in a tertiary or secondary hospital) is normally only maintained for up to 21 days (in a financial year). However, this may be extended if recommended by a Clinician. The reason for the extension will need to be outlined in a letter to the Healthpac Administrator. If the funding is not extended, the resident will need to be re-admitted to that facility or give up their bed in the facility. It is not necessary to re-apply to WINZ for subsidy.

11.9 Twenty-One Day Extension

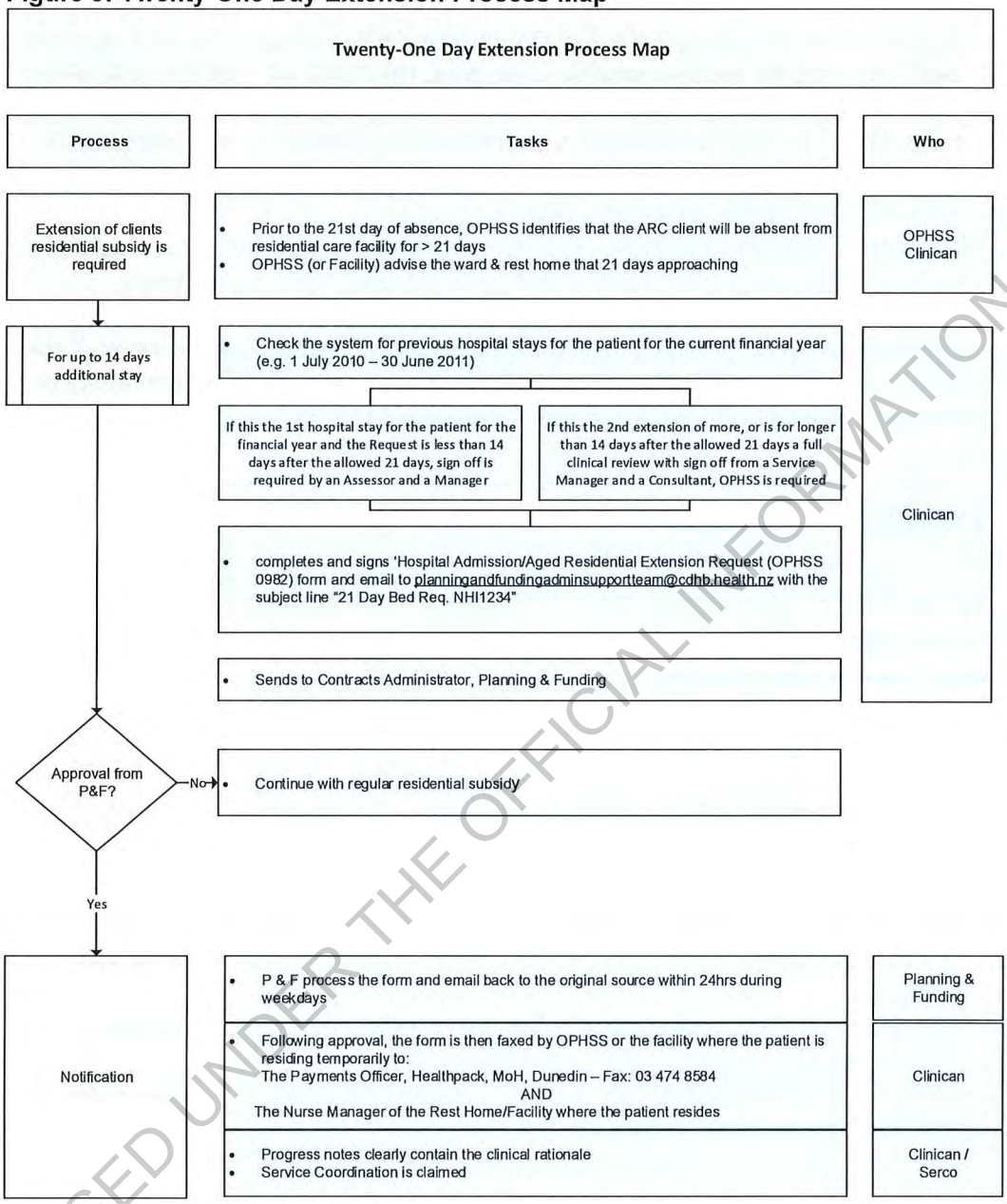
The aim of the 21-day extension is to allow the Client to improve sufficiently to be able to return to the level of care required prior to their absence from Residential Care. If this is no longer viable, then the Client's existing residential placement should be cancelled and a new placement organised when needed.

11.9.1 Twenty-One Day Extension Procedure

Once it is apparent that the client will be absent from the residential care facility for greater than 21 days:

1. An application needs to be made to the Contracts Administrator, Planning and Funding.
2. Written approval from Planning and Funding is sent to the relevant clinician.
3. The clinician then forwards this to the Ministry of Health.
4. A *Service Co-ordination* is to be claimed for this intervention and progress notes to clearly outline the clinical rationale.
5. If a further extension is required, the same process is repeated.

Figure 3: Twenty-One Day Extension Process Map



11.10 Aged Care Facilities in Canterbury

Providers of Long-Term Rest Home, Hospital, Dementia and Psychogeriatric Care in Canterbury can be found on the Eldernet website http://www.eldernet.co.nz/Home

11.11 Useful Resources & Information for Clients

The booklet titled A Question of Care contains valuable information for clients on entitlements, village living, staying at home, moving into care, how the health system works and other information. This booklet is available at http://www.carepublications.co.nz/; or 286 Keyes Road, Christchurch, 8083. OPHSS maintains a stock of these booklets and they are provided free of charge to clients as required.

12. RESPITE CARE

Definition

Respite Care is the term given to a short-term stay in a residential care facility.

Purpose

To ensure appropriate temporary care for the client when this care is unable to be maintained in the community.

Scope

All clients who meet the eligibility criteria.

Eligibility

Respite care is available to clients with health and/or disability support needs who are eligible for OPHSS funded supports, as assessed by a Clinical Assessor, Community Gerontology Nurse, Gerontology Nurse Specialist, Social Worker, Geriatrician, PSE Clinician, or Psychiatrist of Old Age.

Guiding Principles:

- **Respite Care is for carer relief.**
- Respite Care is a high level of support and can be detrimental to the client's level of independence if allocated inappropriately
- Respite is intended for those people whose physical and psychiatric needs cannot be managed without the support of the primary carer,
- AND
- whose needs are greater than can be met by home based supports

- **Respite care should:**
  - effectively promote and maintain the client's independence
  - be allocated in a fair and equitable manner

Respite Care is designed to be used in the following specific circumstances;

- Carer stress
- To support a client when the primary caregiver
  - has become unwell, or been discharged from hospital, and cannot undertake their role as the client's carer
  - requires a break from the carer role or
  - has passed away
- Individuals who live alone, and whose long term plan is to remain at home, may be eligible for Respite Care on a **case by case** basis. Respite may be an appropriate option to provide relief from the demands of living at home with disabilities (or reduced function)
- Exacerbation of the client's medical condition, meaning that the client is temporarily unable to be supported at home;
- Temporary disruption to the home environment.

- A combination of the following requirements suggest eligibility for respite:
  - 24 hour supervision
  - Input or care at night
  - Encouragement, supervision or cueing for mobilization
  - Significant assistance with toileting
  - Prompting for all ADL's
  - Frequent support from carers throughout the day and/or night to manage changes in psychiatric condition

When required, the client may be placed in Respite Care until the primary caregiver can undertake this role again.

It is important to consider whether or not the Caregiver can manage the Client at home with additional support, or if family members are able to care for the Client for a period of time.

If extra support is not appropriate to keep the Client at home, or the Carer needs time to recover without the Client being present with them in their home, then Respite Care may be the best option.

Exclusion criteria

Respite Care is not appropriate;

- When the client is eligible for respite care funded by the Ministry of Health for people with lifelong physical, sensory or intellectual disabilities (e.g. clients under Lifelinks)
- When the client is eligible for respite care available for people with long term mental health conditions (e.g. clients with PSE or Lifelinks funding)
- In cases of acute medical illness where clients will require comprehensive medical assessment and likely admission to hospital
- If respite care with subsequent GP follow-up will not resolve the client's recently altered health status.
- For clients who can be maintained safely in the community with an increased package of support for a short time
- As a trial for permanent residential placement
- Generally Respite Care is not appropriate post-hospital discharge. However there are exceptions to this Refer to Respite Care following Discharge from Hospital (section 12.6 below).
- Where the main carer is well and requires a break, the well carer is not eligible for Respite Care themselves, while the Client they need the break from is left at home with family and/or other supports.

Alternative Options

As Respite Care is a high level of support, access to this level of care needs to be considered and appropriately justified. Therefore, it is worthwhile considering alternative options including, but not limited to, the following:

- Referral to the Community Rehabilitation, Empowerment and Support Team (CREST)
- Remaining at home with supports funded by ACC, short term services or OPHSS long-term services
- Admission to an Acute Medical ward or AT&R for assessment, treatment of presenting issues and rehabilitation. Appropriate additional services need to be arranged on discharge.
- An acute assessment by appropriate clinical members e.g. Clinical Assessor, Social Worker, Physician, Community Gerontology Nurse (CGN) or PSE Clinician

General Requirements

- All clients are assessed for eligibility for respite care by authorised personnel and this eligibility is documented in the InterRAI client care plan.

- Assessment is done in consultation with the client, their family/whānau, G.P. practice, the relevant Geriatrician and/or Clinical Assessor/Community Gerontology Nurse/Gerontology Nurse Specialist/PSE Clinician who have had involvement with the client and eligibility should be communicated to the family and client
- Acute Respite can be arranged through SPoE. However, the client needs to be assessed for this Respite Care while still in Respite (within 5 days) (See section 12.4 and process map page 81)
- If the need for respite care is identified by other health professionals within the CDHB, Community Service Team (CST) or Psychiatric Services for the Elderly (PSE), the client should be referred for a full InterRAI assessment
- PSE clients requiring Respite Care (either in specialised dementia facilities or aged residential care) will be assessed by the PSE service
- The client can choose to access respite in any facility which has an appropriate contract for the level of care for which the client has been assessed, subject to availability

Carer Unable to Manage:

- Where the main carer has become unwell or has been discharged from hospital and cannot undertake their role as the client's carer, the client (often a spouse of the carer) may be placed in Respite Care until the main carer can undertake this role again. It is important to consider whether or not the carer can manage the client at home with additional support, or if family members are able to care for the client for a period of time. It is also important to consider the likely duration for need of respite, and whether the carer is likely to be able to resume the caring role. If the carer is unlikely to resume the caring role, then alternative options, including permanent residential care should be explored as soon as possible.
- If extra support is not appropriate to keep the client at home, or the carer needs time to recover without the client being present with them in their home, then Respite Care is the best option.
- Where the main carer is admitted to hospital and the client requires support, the Clinical Assessor should review the client to determine what additional supports are needed for the client to remain at home. SPoE should facilitate Clinical Assessor or PSE follow-up at the earliest opportunity.

Elder abuse:

- In cases of suspected or known elder abuse, respite may be utilized to ensure the safety of the older person.

Review

Planned Respite Care is allocated on a needs basis. It is only able to be allocated for up to one year.

Therefore, clients identified as needing this level of support require an annual review or reassessment.

12.1 Planned respite

- Annual (Planned) Respite is arranged when the Client's medical and social issues indicate, through assessment, that they require regular Respite Care to remain living in the community, (i.e. Pre-arranged Respite Care allocation enables families to plan regular breaks).
- The funding of planned respite is intended to allow the usual caregivers and clients to use respite at times that will make a real difference for them
- Clients who meet the acceptance criteria for Respite Care are allocated up to a maximum of 28 days per year.
- For clients requiring more than 28 days per annum, an extension to the allocation is required. Any extension needs to be approved by the CST or PSE Clinical Manager, and requires a clearly defined reason to justify the extended respite care
- Staff are expected to allocate the predicted number of days per annum that the Client will require under these circumstances. This allows the Client and their Carer(s) to make arrangements directly with the appropriate residential facility, when it suits them, and not have to contact OPHSS unless they require further assistance.

12.1.1 Client's Choosing Beds and Bookable Beds

- Clients can choose to access respite in any facility that has an appropriate contract for the level of care for which the Client has been assessed
- Accessing respite in any given facility is subject to bed availability
- If the client requires respite because they are unwell or having medications reviewed, a facility that their regular GP can visit them in would be considered the most appropriate.

12.2 Acute Respite

Acute respite is arranged as per the Respite Care Outside of SPoE Operating Hours procedure detailed below (12.4)

12.3 Respite Care for Clients not Known to OPHSS

- It is essential to obtain a clear picture of the client's needs from the General Practitioner to ensure that Respite Care is the most appropriate option and admission to a tertiary facility is not required. If clinical concerns exist, discuss with Geriatrician/Psychiatrist of old age or Community Service Clinical Manager.
- The Geriatrician/Psychiatrist of old age should inform SPoE if he/she agrees to a respite request by a GP, to ensure SPoE staff act promptly on the request and arrange appropriate follow up.
- PSE triage clinician to decide whether an acute assessment for level of care is required if secure care is indicated.
- These clients will require urgent assessment by a Clinical Assessor or CGN/PSE Clinician as soon as possible following their admission to respite care.

The "Urgent Respite Care Process" should be followed for clients not known to the OPHSS:

- Clients who are not known to the service may have respite approved following the Acute Respite/Respite Care Outside of SPoE Operating Hours (12.4) process.
- These clients require urgent assessment as soon as possible following their admission to respite care. Assessment is required to be completed within five working days.
- It is essential to ascertain from the client's family and General Practitioner a clear picture of the client's needs. This is to ensure that respite care is the most appropriate option and admission to a tertiary facility is not required. If there are clinical concerns, discuss with Geriatrician/Psychiatrist of old age or Community Service Clinical Manager.
- Geriatrician approval must be obtained if Hospital Level Respite Care is required.

12.4 Respite Care Outside of SPoE Operating Hours

- Approval for Respite Care can be obtained from the Duty Consultant for OPHSS.
- The Respite Allocation Form (available on the intranet OPHSS-CST -399) is required to be completed by the Duty Consultant and faxed to
  - the receiving facility: to ensure acceptance
  - SPoE to: facilitate CGN or Clinical Assessor follow-up on the next working day
    and
    ensure the GP is notified of the Respite placement

- CGN or Clinical Assessor follow-up on the next working day

- ED Social Workers can facilitate Respite Care direct from ED:

- For Clients who have a current allocation in place,
  but only if the client is medically stable
  AND
  - respite is required for carer relief or
  - respite is required to ensure the safety of the older person, or
  - the main carer is unable to care for the client, or
  - it is considered in their best interests to use the planned allocation for this acute presenting need.

It is important to consider whether or not the client can manage at home with additional support, CREST, or if family members are able to care for the client.

- For Clients who **do not** have a respite allocation, the ED Social Worker(s) must contact the duty Consultant for OPHSS for approval.
  The duty Consultant completes the Respite Allocation form, and faxes it to the ED social worker, who should fax it to
  - the receiving facility - to ensure acceptance
  - SPoE to: facilitate CGN, Clinical Assessor, or PSE Clinician; to follow-up on the next working day **and** ensure the GP is notified of the Respite placement

12.4.1 Respite Care Outside of SPoE operating hours for PSE clients:

- The rostered weekend/public holiday nurse will complete a clinical assessment to confirm the need for urgent respite and specify the type of facility required (specialised dementia care, general rest home, hospital level care or dementia hospital level care).
- The client is then placed in appropriate care
- The case is discussed with the IDT on the next working day and, if specialised dementia care is required, the Application for Residential Care (OPHSS 0324) is completed and signed by the Psychiatrist of Old Age.
- The GP is notified of the respite placement.
- The application form must be faxed to the receiving facility to ensure acceptance

12.5 Respite Care Allocation Process

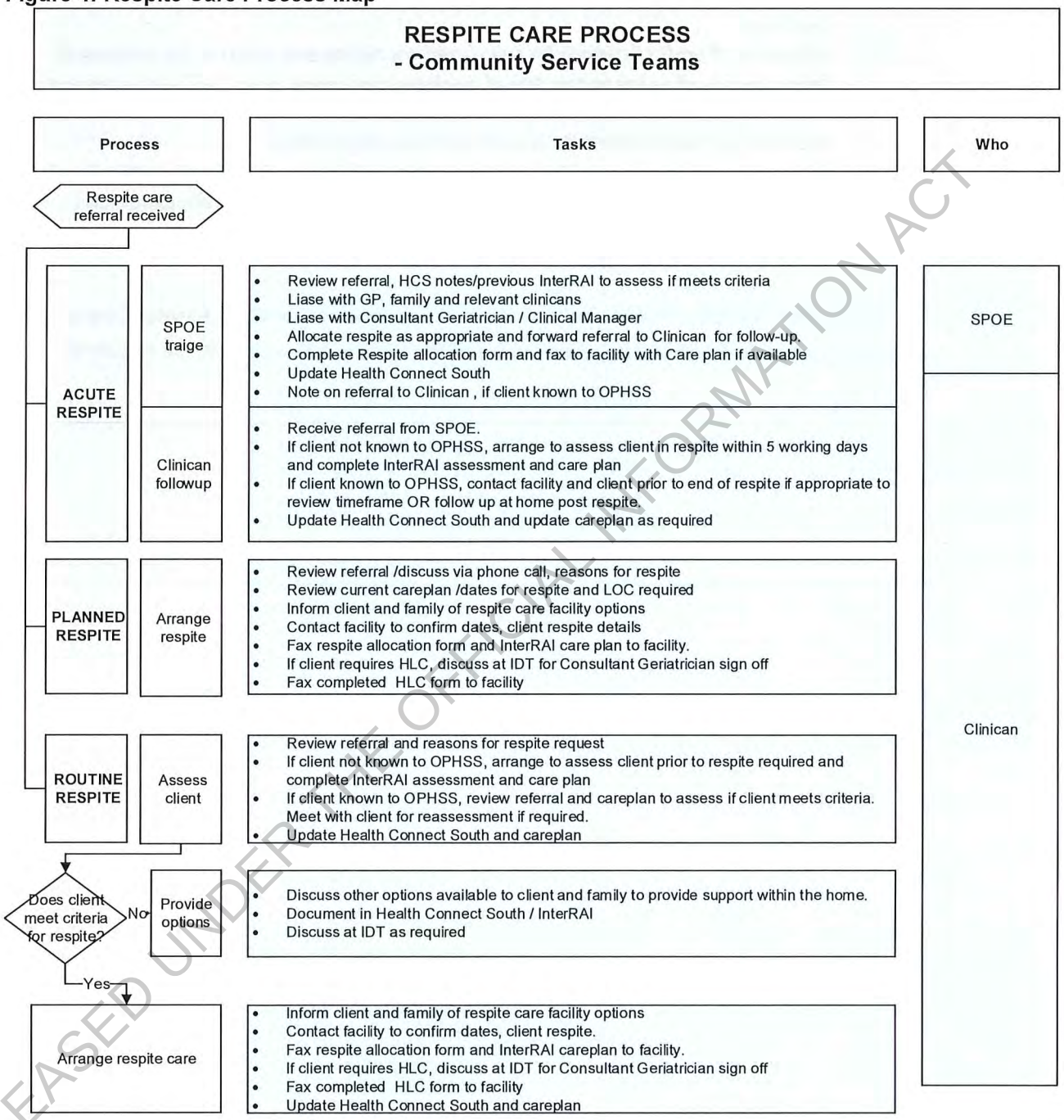
Calculation of Days for Respite Care payment

- A day starts at midnight and ends at midnight the following day.

- Providers are paid for each whole day the client stays, and part days for admission or discharge.
  Allocation therefore **cannot be calculated on nights** and needs to be **calculated from the day of entry to the day of discharge inclusive**. (e.g. If a Client is resident in a care facility from Sunday to Tuesday, then the payment should reflect three days, even though two of these days were part-day stays only.)
- If the assessor is unsure of the total time that will be required for the episode of Respite Care, they should allocate up to seven days, review the allocation and increase/adjust the allocation as required.

It is important for the providers to be paid in a timely manner, and that Respite Care is allocated as quickly as it can be, even if it is not the full allocation that will be required.

Figure 4: Respite Care Process Map



12.6 Respite Care Following Discharge from Hospital (Public, Private & Charity Hospital)

Generally Respite Care is not appropriate post-hospital discharge. However, there are circumstances where the Clinical Manager, Geriatrician, or Psychiatrist of Old Age may approve this. These exceptions should be discussed in person or by telephone.

Once the need for respite care has been identified, a referral is forwarded to SPOE so that urgent follow-up with a CGN, CA or PSE Clinician can be arranged.

- When Respite Care following hospital discharge is approved, it is the responsibility of the discharging organisation to ensure an appropriate discharge plan has been developed to assist the Client with transition to independence or to their former level of functioning, and allow them to return to independent living in their own home. If the discharging social worker identifies a need for a complete assessment to ascertain the long term support needs of the client once at home, then an MR51 referral is required to be completed by them, and forwarded to OPHSS. http://cdhbintranet/olderpersonshealthandrehab/allophr/Forms/OPHSS_GEN_0246.pdf
- It is important families are made aware of bed availability and, if unavailable, an alternative bed may be sourced outside of the region.

12.6.1 Christchurch Hospital Emergency Department

If a client presents at the Christchurch Hospital Emergency Department because the client and/or their family/whānau are not coping with care needs. When

- **no** acute medical issues are identified following assessment,
  AND
- alternatives to respite such as additional home based supports or CREST have been explored and deemed not appropriate,

it may be appropriate for the client to be admitted to a Rest Home/ Hospital for a short period of Respite Care.

The Community (CST or PSE) Clinical Manager, or Service Manager, must be contacted to approve this.

Currently ED Social Workers at CPH can only access this if it is already allocated. Otherwise the Respite Care Outside of SPoE Operating Hours procedure is to be followed.

12.7 ACC Interface

- ACC **do not** fund Respite Care. This is to ensure that OPHSS retains control of Respite Care allocation and approval
- If an ACC client is **unable** to remain at home following an injury, CREST involvement should be considered in the first instance.
- If CREST has been considered and excluded as an option, and the **ACC** client continues to be **unable** to remain at home, ACC may be able to assist with funding Convalescent Care at a facility.
- The Clinical Assessor needs to ensure that the GP will contact ACC to assess the client, in order to ensure that appropriate supports can be in place for the client after the period of Convalescent care
- The client may also require assessment by OPHSS clinician(s) to identify which needs are injury related and which are due to existing co-morbidities. Any such assessment is provided to both ACC and the OPHSS case managers, in order to establish funding proportionality. The Clinical Manager will discuss this with Planning and Funding as required.

12.8 Respite Care for palliative patients

Palliative patients will usually receive respite care in aged residential care facilities as opposed to The Nurse Maude Hospice, because of limited bed numbers in the hospice.

- **If the patient is under End of life funding* AND is NOT KNOWN to OPHSS NASC**
  - Palliative care NASC at Nurse Maude does the assessment and arranges respite under SupportCare/EOL funding.
  - An interRAI assessment is NOT required to allocate respite

- **If the patient is under End of Life funding[6] AND IS KNOWN to OPHSS NASC**
  - Referral is sent to SPoE and allocated to a CGN, or a CA (if well known to the Assessor) or a PSE Clinician.

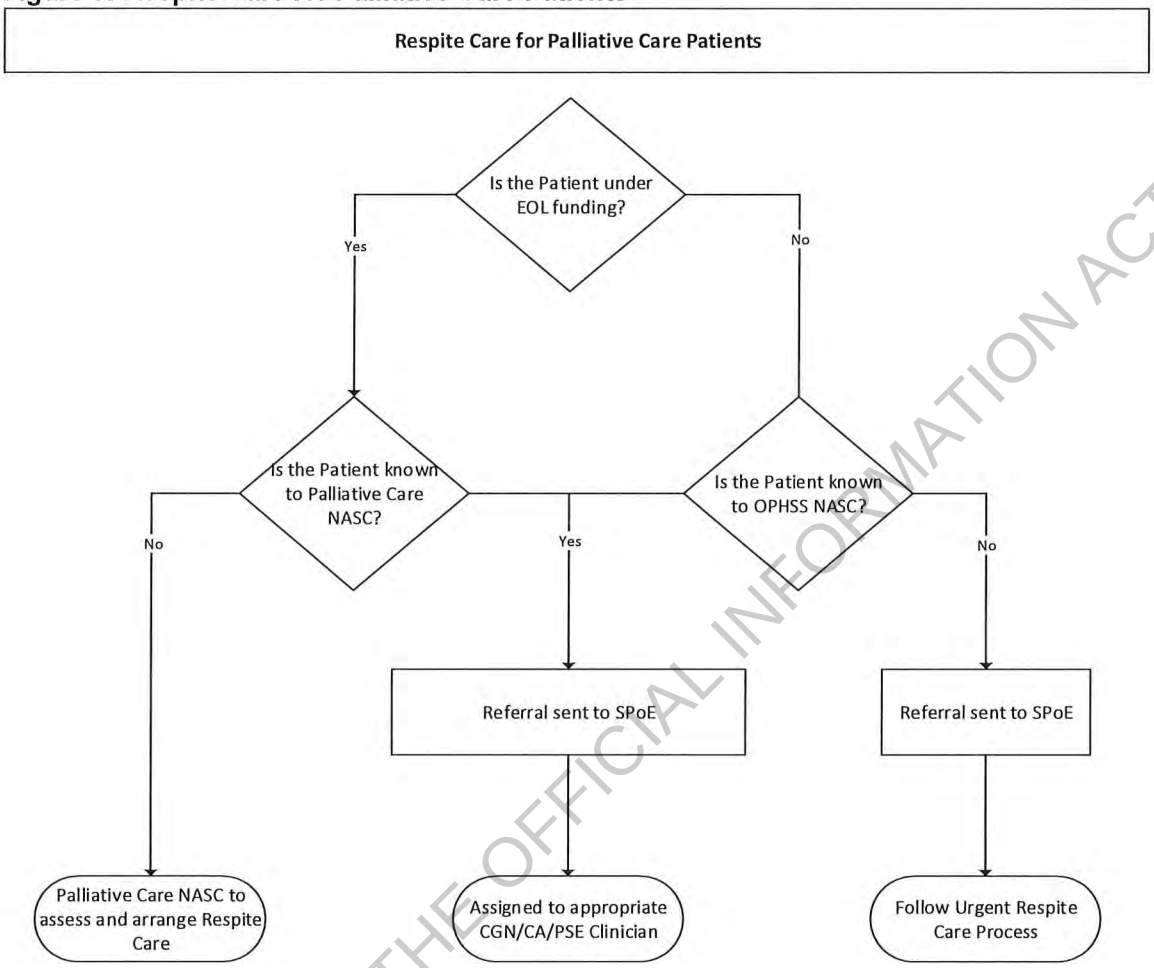
[6] EOL funding is a DHB funding stream for support services. It is not related to the GP "End of Life Care" benefit which is special funding for the General Practice to provide end of life care

- An interRAI assessment is NOT required to allocate respite

- **If the patient is receiving palliative care (but not under EOL funding) and is NOT KNOWN to OPHSS NASC**
  - Referral is sent to SPoE and the URGENT RESPITE CARE PROCESS is followed, with CA/CGN/PSE Clinician follow up arranged

- **If the patient is receiving palliative care (but not under EOL funding) and IS KNOWN to OPHSS NASC**
  - Referral is sent to SPoE and assigned to a CA/CGN/PSE Clinician for follow up.
  - An interRAI is completed if not previously done

Figure 5: Respite Care for Palliative Care Patients



12.9 Client Not Returning to the Community

If a client is in Respite Care, and a decision is made for the client to enter permanent Rest Home or Hospital Level care, an interRAI assessment by an OPHSS clinician must be completed and signed off by the Geriatrician or Psychiatrist of Old Age, to ensure all options for supporting the individual have been explored.

The funding requirements then need to be altered to reflect the permanent care funding level, from the date the decision is made. Any outstanding Respite Care allocation is forfeited.

- The funding requirements then need to be altered to reflect permanent care funding level, from the date the decision is made. Any outstanding Respite Care allocation is forfeited

12.10 Temporary/Permanent Change in Level of Care

If a change in the level of care is required, whether it be temporary or permanent,

- The Aged Residential Care facility provides a Long Term Care Facility (interRAI) assessment which articulates their clinical reasoning for the request for a higher level of care.
- A review of the assessment is then completed by an OPHSS clinician, and the case is presented to the Geriatrician or Psychiatrist of Old Age for sign off.
- If there are issues which require interdisciplinary team input, the case should be brought to the IDT

12.11 Changing Providers within an Episode of Respite Care

Where possible, clients should be encouraged to complete each single episode of respite care with one provider. When finding a bed they should be encouraged to ensure the provider can accommodate them for the entire period they wish to stay for. From time to time, clients change providers during the episode if the current provider is not providing the required level of care.

- When clients request a move during an episode of care, the following procedure should be followed:
  - If the client uses two different facilities **at the same level of care**, the Service Coordinator completes the form as one allocation and the approval form is sent to each provider for the appropriate days in each facility. Careful calculation is required as each facility will claim the first and last day.
  - If the client's **level of care has changed**, this needs to be allocated separately for rest home or hospital as appropriate, and the usual process for hospital sign off needs to be followed

12.12 Enquiry Procedure for Providers

- Providers should contact the call centre or Payments Office at Sector Services for any payment queries they may have. The phone number is 03 474 8274. Providers can also email southernpayments@moh.govt.nz link, attention Payments Officer.

- Information outlining the current allocation the client has in place, and utilisation to date, can be given to providers. The Payments Officer cannot provide information on utilisation patterns, only a current total in the system.
- Clients no longer receive forms with their updated allocation or balance, as was the case in the past.

12.13 Respite Care Outside of the CDHB Area

A client may choose to use their Respite Care allocation at a facility in a different DHB (i.e. outside the jurisdiction of Canterbury DHB).

This is possible provided:

- the assessing clinician deems this clinically safe; **and**
- appropriate, contracted respite services are available in the alternative DHB.

The current interim process outlined below should be followed while options for other processes are explored.

- The assessing clinician should discuss the case with the Clinical Manager and, if he/she is in agreement, the assessor will indicate this on the NASC 2 form
- The needs assessment and service coordination transfer process should be completed prior to the commencement of the client's stay in Respite Care.
- The Respite Care in the alternative DHB must be provided in a facility that has a contract with that alternative DHB for respite services for older persons.
- Payment for the respite in the alternative DHB is made by the DHB in which the client normally resides.

12.14 Providing Respite Care within the CDHB Area for Clients from other DHB's

If a person from a DHB outside of Canterbury has a respite allocation from their DHB and wishes to have their respite in a contracted Canterbury DHB facility, the needs assessment and service coordination agency from the client's DHB of residence should complete and send the interRAI care plan to the Canterbury facility where they wish to have respite and submit the information to Healthpac as per their DHB policy.

12.15 Process Tables

Urgent Respite Care Process

• Referral received from GP Practice or other health professional stating why respite care is required (request a written referral) CA's working in SPoE need to arrange respite care requests within 72 hours of notification of referral. If respite is deemed the most appropriate option • Respite care is appropriate only if subsequent GP or OPHSS follow up will resolve the clients recently altered health status • GP needs to outline a plan for ongoing review of the patient and their need for respite
• All clients placed in urgent respite should be referred to a CGN or CA for follow up
• Print off NHI labels and complete assessment
• CA must ascertain whether respite care is appropriate and consider if clinical review / additional or new community supports in the client's home could prevent admission to a residential care facility. • Consider if input from allied health or other health professionals are required (including CGN assessment or CREST) prior to respite care decisions • The accepting respite facility should ensure the client has a medical practitioner assessment within 24 hours of admission
• Consider appropriate level of care. If hospital level of care required discuss with a geriatrician for a temporary sign off at hospital level care. If querying dementia care, negotiate with PSE Duty Person and handover as appropriate.
• Consider which disciplines are required for following up care and complete referral.
• CA to negotiate respite care bed in consultation with family.
• Send confirmation of allocation along with any relevant information to facility i.e. InterRAI care plan.
• Pass all paperwork to SPoE Administrator to load both the referral and the Serco completed by the SPoE CA. Client will be placed on the waitlist to be followed up by the appropriate discipline (usually, but not always, a CA) • The SPoE Administrator then passes the completed triage documents to the Health Pac Administrator (using the 'Respite' labelled box in the Administrators office). The Health Pac Administrator will then forward the referral to the appropriate clinician for follow-up. Aim to have the paperwork to the clinician on the same, or next, working day. The SPoE staff is to advise the clinician by phone if respite period is less than 5 days.

Urgent Respite Care process for PSE clients

• Referral received from GP practice or other health professional stating why respite care is required (request a written referral) • Respite care is appropriate only if subsequent GP or OPHSS follow up will resolve the clients recently altered health status • GP needs to outline a plan for ongoing review of the patient and their need for respite
• PSE triage clinician must ascertain whether respite care is appropriate and consider if clinical review / additional or new community supports in the client's home could prevent admission to a residential care facility. • PSE triage clinician to decide whether acute assessment for level of care is required if secure care is indicated. If indicated, to allocate to PSE duty staff. • If an assessment is not warranted, then PSE triage clinician to forward urgent respite care request to PSE service coordination for action. • PSE triage clinician to ensure authorisation for dementia/hospital level of care is current
• PSE triage clinician to ascertain whether client is eligible for respite care from an allocation perspective, e.g. they may have used more than 28 days this calendar year or support plan may have reached maximum level. Discuss issues with Clinical Manager if this is the case.
• The appropriate PSE service coordinator to negotiate respite care bed in consultation with family
• The accepting respite facility should ensure the client has a medical practitioner assessment within 24 hours of admission
• Send confirmation of allocation along with any relevant information to facility i.e. InterRAI care plan.
• Service coordinator to complete SERCO documentation

12.16 Respite Care Notification Form

Respite Allocation Form

http://cdhbintranet/olderpersonshealthandrehab/allophr/Forms/OPHSS_CST_0399.pdf

Part D

Other Information & Services

PART D OTHER INFORMATION & SERVICES

13. ACC/OPHSS Interface..... Error! Bookmark not defined.

14. Specialist Services within the Community Services Teams ..... Error! Bookmark not defined.

14.1 CGN Assessment & Service Coordination Interface..... **Error! Bookmark not defined.**

14.2 Cultural Care..... **Error! Bookmark not defined.**

14.3 Social Work Assessment & Service Coordination Interface.. **Error! Bookmark not defined.**

15. Electronic Patient Management Systems Error! Bookmark not defined.

15.1 Overview ..... **Error! Bookmark not defined.**

15.2 Healthlinks ..... **Error! Bookmark not defined.**

15.3 Health Connect South ..... **Error! Bookmark not defined.**

15.4 Momentum (interRAI) ..... **Error! Bookmark not defined.**

15.5 Collaborative Care Management System (CCMS) ..... **Error! Bookmark not defined.**

16. Financial Support and Other Relevant Agencies Error! Bookmark not defined.

16.1 Financial Support ..... **Error! Bookmark not defined.**

16.2 Other Relevant Agencies/Services ..... **Error! Bookmark not defined.**

17. SupportCare Funding ..... Error! Bookmark not defined.

17.1 End of Life Guidelines ..... **Error! Bookmark not defined.**

17.2 End of Life Procedure ..... **Error! Bookmark not defined.**

17.3 SupportCare – "End of Life" Exit Criteria ..... **Error! Bookmark not defined.**

17.4 Severe Medical Illness Guidelines: ..... **Error! Bookmark not defined.**

13. ACC/OPHSS INTERFACE

Definitions

The Accident Compensation Corporation (ACC) provides comprehensive, no fault personal injury cover for all New Zealand residents and visitors to New Zealand[7].

ACC defines ***Personal Injury***[8],

Personal injury means—

a) the death of a person; or
b) physical injuries suffered by a person, including, for example, a strain or a sprain; or
c) mental injury suffered by a person because of physical injuries suffered by the person; or
d) mental injury suffered by a person in the circumstances described in section 21; or
da) work-related mental injury that is suffered by a person in the circumstances described in section 21B; or
e) damage (other than wear and tear) to dentures or prostheses that replace a part of the human body

Purpose

To ensure the interface between ACC and OPHSS delivers a seamless client journey with the best outcome for the patient.

Scope

All clients that have sustained a *Personal Injury* for which they have an accepted ACC claim.

[7] As cited from the ACC website http://www.acc.co.nz/index.htm
[8] As cited from Section 26 Accident Compensation Act 2001

Procedure

ACC contracts CDHB to provide specific OPHSS rehabilitation for their clients. These services include both inpatient and outpatient rehabilitation.

A CDHB health professional (e.g. Charge Nurse Manager, OT, Physio) liaise with the ACC Case Co-ordinator regarding the client's post discharge needs. An ACC 705 form is sent to ACC. ACC then arrange the necessary services.

Eligibility

ACC funding is for;

- The provision of services for clients with an accepted ACC claim.
- ACC is responsible for coordinating service provision to support the client to return to their previous level of functioning following a *Personal Injury*.

ACC do not fund:

- Respite or Convalescent Care when this care is primarily needed in relation to the client's general medical condition/co-morbidities rather than due to the personal injury sustained.
- Clients with an injury and other co-morbidities require assessment to determine funding source(s) for appropriate services to meet their needs.

Review

ACC Services are regularly reviewed by ACC to ensure that the on-going needs are accident related.

General Requirements

- Services for ACC-funded Inpatients on discharge are assessed by the ward interdisciplinary team and a referral form (ACC705) sent to ACC.

- If clients are likely to need services beyond the rehabilitation phase of the personal injury, then the relevant community-based clinician (e.g. Clinical Assessor, CGN or OT) coordinates services and access to OPHSS controlled funding streams.
- ACC funded clients residing in the community who require services provided by OPHSS should be referred by their GP or other relevant health professional. This may be to continue services funded by ACC or for age-related medical issues that have become apparent during rehabilitation from personal injury, e.g. exacerbation of osteoarthritis which is impacting on independence with personal care.
- GP and other relevant health professional referrals should contain details of the injury and/or age-related issues that require assessment by OPHSS clinicians, and documented on the ACC45.
- The client is assessed by OPHSS clinician(s) to identify injury related needs and needs due to existing co-morbidities. This assessment is provided to both ACC and the OPHSS team manager in order to establish funding proportionality. The team manager will discuss this with Planning and Funding as required.
- For a client to have access to ACC non-acute rehabilitation funding for their injury, they must have been either an inpatient at Christchurch Hospital, been treated at the Emergency Department or referred by their GP or other relevant health professional.
- Burwood, The Princess Margaret and Ashburton Hospitals provide rehabilitation services funded by ACC.
- Refer to ACC Contracts Manager (based at TPMH) for further information.

14. SPECIALIST SERVICES WITHIN THE COMMUNITY SERVICES TEAMS

14.1 CGN Assessment & Service Coordination Interface

14.1.1 CGN Assessment & Service Coordination Procedure

Definitions

The Community Gerontology Nurse (CGN) is a nurse with in-depth gerontology nursing knowledge and skills. CGNs' provide clinical assessment, nursing care and education to older people with significantly complex needs within the OPH&R Community Service.

Purpose

CGNs are responsible for the clinical assessment and monitoring of clients with acute complex care needs, in order to ensure continuity and coordination of care.

General Requirements

- CGNs receive internal (within OPHSS) and external referrals for clinical assessments of clients. Medical/Consultant input may or may not be required.
- Assessments (e.g. clinical, residential care, HBSS, interRAI), can be undertaken individually by the CGN, or in conjunction with an SMO, and can be completed and coordinated within the team by the CGN.
- CGN's have an Administrator/Service Coordinator assigned to them who completes the service coordination documentation for HBSS as assessed by the CGN.
- When required, the CGN liaises with the Clinical Assessor assigned to the client's GP practice in order to coordinate support services and ensure that the needs of the client are met.
- Packages of care consisting of Domestic Assistance and/or Personal Care can be managed by the CGN, with Service Coordination Administrator support. However, if long term supports and reviews are required, a referral to the appropriate clinical assessor should be made.

- If the package of care allocation involves Day Care, Carer Support and/or Respite Care, the CGN will liaise with the Clinical Assessor assigned to the client's GP practice to ensure service allocations are correct.

14.1.2 CGN Role in HBSS

- If the client is new to the OPHSS, the CGN completes an interRAI assessment, the Care Plan and the Admin/Serco HBSS form and forwards these to Admin/Serco staff to process and implement.
- If the client is known to the OPHSS/already has a package of care, but there has been a change in the client's condition and/or circumstances which indicate(s) that the package of care needs to be altered, clinical judgement is required to determine the most appropriate course of action. (The interRAI should not be completed if Client's condition is acute and they are expected to improve).
- If the client has had an InterRAI assessment within the last 24 months the CGN is only required to update the Care Plan, document the rationale for doing so, and forward to Admin/Serco staff to process and implement.
- If the client has not had an interRAI assessment within the last 24 months the CGN needs to complete an interRAI and Admin /Serco HBSS form and forward to Admin/Serco staff to process and implement.

14.1.3 CGN Role in Residential Care Placement

- When a CGN assesses a client in the community for Residential Care it is the CGN's responsibility to present that client to the IDT or the Consultant in order to complete the required documentation, including an interRAI.

Once the residential placement is approved, the CGN needs to coordinate the client's placement, including advising the Service Coordinator as to the client's need for Residential Subsidy Applications. (Refer to Residential Care chapter of this Handbook for further details).

- Once decisions on placement details are finalised, the CGN needs to complete the Residential Placement Information form Admin/Serco form and forward this to the Service Coordination Administrators for processing.

14.2 Cultural Care

14.2.1 Tangata Whenua (Māori Indigenous Peoples)

Role of the Kaumatua Clinical Assessor (KCA) in OPHSS

Definition

The Kaumatua Clinical Assessor (KCA) is a Clinical Assessor with a strong understanding of the Māori holistic concept of health (taha wairua, taha tinana, taha hinengaro and taha whānau). The KCA is able to articulate and apply this understanding in regards to service implementation.

Purpose

The KCA is available to specifically assess and support clients and their family/whānau who identify as Māori.

The KCA acts as a consultant for the CSTs:

- To uphold the mana of whānau, hapu and iwi
- To ensure cultural care for Kaumatua (the elderly) is upheld in the delivery of services within the OPHSS

Scope

Kaumatua who meet the eligibility criteria for OPHSS, identify as Māori and request involvement of the KCA.

Clients who identify as Māori are accepted into the OPHSS at 50+ years of age. This is due to the lower life expectancy and higher health related risks in the Māori population.

General Requirements

- As is the case for all staff within the OPHSS, the KCA will endeavour to uphold the principles of Te Tiriti o Waitangi (principles of participation, protection and partnership[9]). All staff endeavour to work together with cultural understanding and sensitivity to ensure that care meets the objectives in the CDHB 2013 Strategic Plan, i.e. services in the right place, right time for the right person.
- The KCA will work in partnership with staff regarding Māori clients within the OPHSS to:
    - support staff when engaging with whānau
    - discuss/debrief with staff regarding cultural awareness and dynamics in regard to processes and service provision
    - provide community links to organisations and activities which may be of benefit to the Kaumatua/Client.
    - case manage clients where appropriate.
- The KCA will have strong relationships with home support and community health providers/organisations to ensure there is an awareness and understanding of Kaumatua needs
- The KCA, and all those involved with caring for Kaumatua, need to ensure that the Kaumatua and their whānau have an awareness and understanding of:
    - The services provided by OPHSS within the wider community
    - Access to these and all other available services
    - GP's and their role
    - Referrals to specialist(s)
- If there is no KCA available to the service for a period of time, the Clinical Manager will be able to advise as to what interim measures are in place to provide additional support to meet Māori cultural needs. Other resources are Te Huarahi Oranga (The Māori Health Service) including an inpatient Māori health worker.
- Information pamphlets on Te Huarahi Oranga can be accessed CDHB Intranet, Older Persons Health & Rehabilitation Forms

CDHB Cultural Guidelines

The Cultural and Spiritual section of the CDHB Volume 2 Legal and Quality Manual contains the CDHB Māori Health Policy and Tikanga Policy, (including a Glossary of Māori terms). The Māori Health Policy can be accessed using the following link http://cdhbintranet/corporate/cdhbpoliciesanddocumentation/SitePages/Volume%202%20Legal%20and%20Quality.aspx

[9] Principles of the Treaty of Waitangi

14.2.2 Tauiwi (Different Cultural/Population Groups)

New Zealand has had many waves of immigration with people from all continents making their home here. As a result of this, the nation has become culturally diverse.

Each of these cultural groups have their own language, traditions, religions and cultural mores. These are taken into account in order to deliver culturally appropriate assessment and service delivery.

14.2.3 CDHB Interpreter Services

Where English is not the first language for clients, an interpreter can be arranged using the CDHB Intranet Interpreter services interpreterbookings@dchb.health.nz .

14.2.4 Other Organisations

There are many cultural groups which provide support, assistance and camaraderie to those who share their cultural roots. Tapping into these organisations can be of great value in assisting with the coordination and delivery of health care and services to clients with specific cultural needs.

14.3 Social Work Assessment & Service Coordination Interface

Definitions

Social Workers in the OPHSS Community Service have specific training and skills to undertake bio psychosocial assessments with older people who experience significantly complex health/social issues. This holistic approach to healthcare recognises that illness, disability and health interventions have an impact on the individual in the context of their family/whānau/community and society.

Purpose

To ensure continuity and co-ordination of services for clients with complex social needs. Social Work intervention aims to:

- support and promote self determination
- enable the restoration of individual, family/whānau and community wellbeing
- promote principles of social justice.
- recognise people's strengths, and encourage them to utilise these strengths in order to benefit from them

General Requirements

- Social Workers receive internal and external referrals for the clinical assessment(s) of OPHSS (e.g. Social Work specific assessment or interRAI for HBSS, residential care)
- interRAI assessments are undertaken where appropriate and summarised in the Care Plan, which is co-ordinated by the Service Co-ordinators.
- Social Worker's have a Service Co-ordinator assigned to them who completes the documentation for HBSS/ residential care placement as assessed by the Social worker.
- Packages of care consisting of Domestic Assistance/Personal Care/Daycare/Carer Support/Respite Care/Residential Care can be managed by the Social Worker, with Service Co-ordination support. However, if the Social Work assessment and intervention has ceased, then reviews can be referred back to the appropriate Clinical Assessor.
- Where appropriate, the Social Worker liaises with the Clinical Assessor assigned to the client's GP Practice to ensure that the needs of the client are met.

14.3.1 Social Work Role in HBSS

- If the client is new to OPHSS, the Social Worker completes an interRAI Assessment/ Care Plan and the Admin/Serco HBSS form and forwards these to the Service Coordinator assigned to them to process and implement.
- If the client has previously undertaken an interRAI assessment/has HBSS, but a change has occurred in the Client's health or social situation indicating the package of care needs to be altered, clinical judgement is required to determine the appropriate course of action. Eg whether to undertake a new interRAI assessment to reflect the client's current level of need. This can be determined after discussion with the IDT.
- If the client has recently had an interRAI assessment (which continues to reflect the client's current level of need and/or was done within the last 24 months) the Social Worker up-dates the care plan and forwards it to the Admin/Serco staff to process and implement.

14.3.2 Social Work Role in Residential Care Placement

- Following an interRAI assessment indicating residential care placement is appropriate, the Social Worker presents the clinical information to the IDT. The IDT is responsible in determining if residential care is the appropriate option to support the client's needs.
- If the residential placement is approved, the Social Worker co-ordinates the client's move into permanent care and, where appropriate, liaises with the Service Co-ordinator to provide information and the application form for a Residential Care Subsidy.
- The Social Worker completes the Admin/Serco form and forwards this to the Service Co-ordinator for processing.

15. ELECTRONIC PATIENT MANAGEMENT SYSTEMS

15.1 Overview

Definitions

The electronic patient management systems used by OPHSS include:

1. ***Healthlinks*** *(formally known as SAP)* is used to record the clinical intervention a client receives, by whom, during episodes of care.
2. ***Health Connect South*** - *HCS* is used to record the clients' clinical record.
3. ***Momentum*** is the platform used for the InterRAI assessment tool.
4. ***Collaborative Care Management System*** *(CCMS)* a system which allows input and access by CDHB staff, GP practices and Service Provision Organisations

Self learning packages and bookings for training can be accessed through the CDHB Intranet http://cdhbintranet/corporate/Supportandtraining/SitePages/Home.aspx

Ongoing support can be accessed by phoning the help desk: ext 80999 or fax: ext 80539.

15.2 Healthlinks

15.2.1 Healthlinks Documentation Procedures

There are three sections of Healthlinks that OPHSS clinicians will use frequently; the Patient Master Data, Case Overview and Document List.

- Patient Master Data – a record of clients' demographic details and Disclosure form
- Case Overview – a record of all the episodes of care a client has had with the TPMH site and/or sector bases
- Document List – a record of documents (i.e.: letters, support plans, services, applications for residential care and permanent placement etc.) created about a client.

Note: Inpatient clinical records are not recorded on Healthlinks, and client discharge summaries can be found on Health Connect South. However, there are some historical case notes (from 2007-2012) for some community clients recorded in Healthlinks.

General Requirements

- It is worth noting that Healthlinks is not used by Christchurch, Burwood and Kaikoura hospitals. However, staff at these hospitals can access Healthlinks in read-only mode. Staff at Ashburton Hospital have full access to Healthlinks
- To view Client information stored at another CDHB site, Clinician's will need to access Health Connect South.
- Clinicians should refer to their Manager for information on how to access Healthlinks at their site.
- All new staff are expected to complete Healthlinks computer training during their orientation period, after commencing employment.
- A range of resource documents to assist clinicians in using Healthlinks are available on the intranet.
- Serco Admin input all data into Healthlinks (e.g. SAP codes for Treatment Categories, Patient Master Data for client's new to the service, updating of all patient data).
- Clinical Assessors should consider Healthlinks as a "read only" platform. Healthlinks should be used to access information on: who is involved with the client; the frequency and type of interventions the client is currently receiving; and what interventions the client has received in the past and from whom, (as relevant to the current episode of care).

15.2.2 Case Overview

Clinicians are responsible for recording their interventions with clients on the Appointments Form. Administrators for the Community Services Team and PSE use this information to input details of clinical interventions relating to each client during the episode of care.

Specific Treatment Category codes are entered into Healthlinks to facilitate analysis of the type of work undertaken by OPHSS Clinical staff.

A list of the codes in use is available in the CTS folder, G drive

15.3 Health Connect South

Health Connect South is used to record the clients' clinical record.

General Requirements

- All clinical records documenting health professional interventions with clients are documented by the clinician in Health Connect South.
- This running record should be documented chronologically.
- It is expected that these documents will be created in as close to a real time record as possible.
- Some letter templates are available.
- Discharge Summaries and Discharge Letter templates are available
- Serco Admin currently complete and send Residential Placement letters and SupportCare Funding (EOL) letters.
- To view Client information stored at another CDHB site, Clinician's will need to access Health Connect South.
- Clinicians should refer to their Manager for information on how to access Health Connect South
- All new staff are expected to complete computer training on Health Connect South during their orientation period, after commencing employment.
- A range of resource documents to assist clinicians in using Health Connect South are available on the intranet

15.4 Momentum (interRAI)

Momentum Healthware is the national software platform used for completing the interRAI suite of assessments. The software is funded by the Ministry of Health and is used by all DHBs allowing the electronic transfer of individual records wherever they move around NZ. As the interRAI assessments become mandatory in Aged Residential Care (ARC) many ARC facilities will also be using the software. The interRAI Home Care and Contact assessments are used nationally by all DHBs. The MOH is currently rolling out the interRAI Long-Term Care Facility Assessment to all aged residential care facilities in New Zealand to be mandatory by 1 July 2015.

All assessments are completed by assessors trained to certification standards set by the New Zealand National interRAI Training Service.

General Requirements:

- The use of the interRAI Assessment suite in the CDHB is guided by the current Ministry of Health interRAI Implementation Service agreement.
- All interRAI assessments are to be entered onto the Momentum Software, preferably directly.
- All Clients new to OPHSS who require long term home support services or residential care are required to have an interRAI assessment completed.
- Existing clients who require reassessment will need to have an interRAI assessment completed at this time.
- Privacy: As per standard CDHB policy staff should only access the records of individuals with whom they are currently involved with providing care/treatment. The Momentum system is audited and you actions on the system can be traced. Standard Privacy rules should be followed when using the system.

To access the software:

a) New Users - Complete a User Request form (link to form on intranet page) and then scan and send it to interRAI@cdhb.health.nz. The interRAI team will set up an account for you on Momentum using the user's current CDHB network login details and will email back once complete.

b) Once an account has been set up the user can access Momentum from the CDHB home page via the Clinical Applications menu. Alternatively the user can enter either of the following addresses directly into Internet Explorer - https://southern.interrai.health.nz/Production/MappLogin.aspx

Use of the software:

a) Trained assessors will find a detailed software guide for how to use Momentum in the current National interRAI Training Service Manual

b) All others will be able to find basic instructions for navigating the software on the interRAI intranet page.

Troubleshooting

- Any issues with the Momentum Software should in the first instance be reported to the CDHB interRAI team to investigate using the email address interRAI@cdhb.health.nz
- If the interRAI team is unavailable issues can be reported directly to the Service Desk. It is helpful to be as descriptive as possible when reporting issues.

Momentum Mobile

a) Momentum Mobile is a lite version of the software installed on mobile computing devices i.e. laptops. This version of the software is used for completing assessments directly onto the computer while disconnected from the CDHB network. Instructions for using the Mobile software are on the interRAI intranet page

Further information on the interRAI assessments, CAPs and other terms can be found from the following sources:

- CDHB interRAI Manager or Facilitator
- Official interRAI website - http://www.interRAI.org/
- Current version of the National interRAI Training Service workbook
- CDHB InterRAI intranet site (under construction)

15.5 Collaborative Care Management System (CCMS)

This system is available for CDHB staff, some GP practices and private support service providers, to record each intervention during the client journey.

This is currently the primary system used by CREST.

Community Teams have read only access at this point in time.

If there is a CCMS record for a client there will be a link on the client's Health Connect South Overview page.

16. FINANCIAL SUPPORT AND OTHER RELEVANT AGENCIES

16.1 Financial Support

Scope

CDHB staff are not directly involved in the financial affairs of our clients.

However, the client's situation is heavily influenced by the interrelationship between clinical decisions and the client's own financial circumstances.

Therefore it is important that clinical staff are aware of:

- possible financial implications to the client of clinical decisions
- possible sources of funding for clients

Eligibility

Each organisation will have its own eligibility criteria.

General Requirements

- In most circumstances a person needs to be a New Zealand citizen (or at minimum have New Zealand residency status) in order to receive funding from WINZ and the other organisations outlined below
- OPHSS clinicians need to ensure they have an understanding of the client's social and occupational history as a basis for awareness of possible eligibility to funding.
- The OPHSS clinician can then provide initial contact information for the appropriate organisation to facilitate the client making further enquiries of the funding agencies themselves as to their eligibility.
- Where there is a need to consider financial assistance for clients, liaison with, and possible referral to, a Social Worker is indicated.

16.1.1 Work and Income NZ (WINZ)

The primary source of funding for OPHSS clients is Work and Income NZ (WINZ).

Details of the assistance they provide can be found in their publication "Services for Seniors" or on line at http://www.msd.govt.nz/what-we-can-do/seniorcitizens/index.html

WINZ Senior Services case managers can be contacted by phone on 0800 552 002.

The client may also have access to private superannuation, pension funds or overseas pensions. The client is required to notify WINZ of any such entitlements as these affect any payment the client receives.

WINZ funds:

- NZ Superannuation (with or without the Living Alone payment)
  Or
- NZ Veterans Pension
- Living Alone payments

And provides the

- SuperGold Card (Discount card)

Additional funding from WINZ includes, but is not limited to:

- Accommodation Supplement to assist with housing costs
- Community Services Card to assist with Health Costs
- Disability Allowance to assist with the extra costs due to a disability or medical condition
- Advanced Payment
- Special Needs Grant
- Temporary Additional Support
- Funeral Grant
- Residential Care Subsidy Or Residential Care Loan

16.1.2 Other Sources of Financial Assistance

Other sources of financial assistance to consider include, but are not limited to:

- The Salvation Army
- St Vincent de Paul
- Christchurch City Council (for assistance from funds such as the Mayor's Welfare Fund)
- Local Members of Parliament (on specific application)
- Non-Government Organisations (NGOs)
- Veterans Affairs

If these options for financial assistance are being considered for clients, liaison with, and possible referral to, a Social Worker is indicated.

16.2 Other Relevant Agencies/Services

OPHSS clients may also have needs, other than financial, which the CDHB and associated support services are unable to meet.

There are a range of organisations which provide services to the elderly such as transport, companionship, assistance with cleaning and maintenance not provided for under Domestic Assistance. Some of these organisations and their contact details are listed in the table below.

Name of Organisation/Service	Phone No.	E-mail/Web site address
Age Concern	366 0903 0800 803 344	www.ageconcern.org.nz
Alzheimer's (Canterbury)	379 2590	www.alzcanty.co.nz/ mailto:admin@alzcanty.co.nz
Arthritis New Zealand	366 8383	www.arthritis.org.nz/
Canbreathe	366 5235	www.canbreathe.org.nz
Canterbury Men's Centre	940 9487	www.canmen.org.nz
Christchurch Budget Service	366 3422	www.christchurchbudgetservice.co.nz/
Christchurch City Council	941 8999	www.ccc.govt.nz
Citizens Advice Bureau	0800 367 222 0800 FOR CAB	www.cab.org.nz/acabnearyou/christchurchcity
Community Energy Action Charitable Trust	374 7222 0800 438 9276	www.cea.co.nz
Deaf Aotearoa NZ	379 5074	www.deaf.org.nz
Enliven–Positive Ageing Services	0800 365 4836 0800 ENLIVEN	www.enliven.org.nz www.ps.org.nz
Housing New Zealand Corporation	0800 801 601	www.hnzc.co.nz
Mobility Parking Scheme	0800 227 2255	www.ccsdisabilityaction.org.nz

Name of Organisation/Service	Phone No.	E-mail/Web site address
Multiple Sclerosis and Parkinson's Society	3662857	www.ms-pd.org.nz/
Partnership Community Worker Team	379 1739	www.partnershiphealth.org.nz
Rates Rebate Scheme	0800 257 887	www.ratesrebates.govt.nz
Royal Foundation for the Blind	0800 243 333	www.rffb.org.nz
Royal New Zealand Returned and Services' Association	379 9724 3529770 349 4701 326 6242 04 384 7994	christchurch.rsa@xtra.co.nz papanui.rsa@xtra.co.nz www.rsa.org.nz enquiries@rnzrsa.org.nz
Salvation Army	377 0799	www.salvationarmy.org.nz
Stroke Foundation of New Zealand	381 8500	www.stroke.org.nz/node/26 southern@stroke.org.nz
Timeout Carers Bureau	358 2331	www.timeoutcarers.co.nz
Total Mobility Scheme	365 3828	www.transport.govt.nz/ourwork/land/the - total-mobility-scheme ecan.govt.nz/publications/General/general-

Name of Organisation/Service	Phone No.	E-mail/Web site address
		information-total-mobility.pdf
Veterans Affairs	0800 483 8372 0800 4VETERAN	www.veteransaffairs.mil.nz

17. SUPPORTCARE FUNDING

SupportCare (SC) Funding is CDHB funding targeted to provide services to patients who have either a severe chronic medical illness or terminal illness and require services to meet their health care needs.

17.1 End of Life Guidelines

Definitions

End-of Life (EOL) refers to the stage at which a client

- of any age, who
- has a (life expectancy) of less than ninety days,
- is being cared for as *terminally ill;* and
- requires the equivalent of hospital level care

Purpose

End of Life SupportCare is designed:

- to allow expedient access to both equipment and services, into a client's own home,

OR

- to provide non-means tested Hospital Level Residential Care for a ninety day period for those over 65 or "*close in age and need" or* Māori and Pacific Island clients over 50.

Should the client live longer than ninety days, they may be transferred to general OPHSS funding, as per the Residential Care guidelines. It is possible for them to continue to access End of Life SupportCare if this is deemed appropriate by a Consultant.

Clients under the age of 65 will remain on the Severe Medical Illness funding stream

Scope

All clients who meet the eligibility criteria.

Eligibility

SupportCare guidelines cover End of Life Care.

These guidelines include the eligibility criteria and funding requirements and are located in Vol. 11 Clinical Manual: SupportCare Funding Policy and Guide.

End of Life Care is designed to be used for persons who:

- have been assessed by a Consultant as having a life expectancy of less than ninety days. (Discussion with the SupportCare nominated clinician is only required if there is a query regarding funding eligibility). Contact details for SupportCare Clinicians can be found in Vol. 11 Clinical Manual: SupportCare nominated Clinicians
- are either living in the community, or about to enter permanent residential care for the first time
- have been assessed as meeting the requirements for Hospital Level of Care (even if they chose to stay in their own home)

Exclusions

End of Life Care is not appropriate for clients who:

- are already permanently placed in residential care or have been in permanent placement in the past
- have a life expectancy of more than ninety days
- have died. End of Life funding cannot be applied for retrospectively
- are funded by MoH DSD services, Psych NASC, or ACC

17.2 End of Life Procedure

Clients may be identified as requiring End of Life care:

- from a GP referral
- through CGN assessment
- while on respite care
- by a member of the Community Service Team
- as part of an inpatient IDT process

Please refer to Flow Chart Page 19 in the Clinical Policy: SupportCare funding & guide

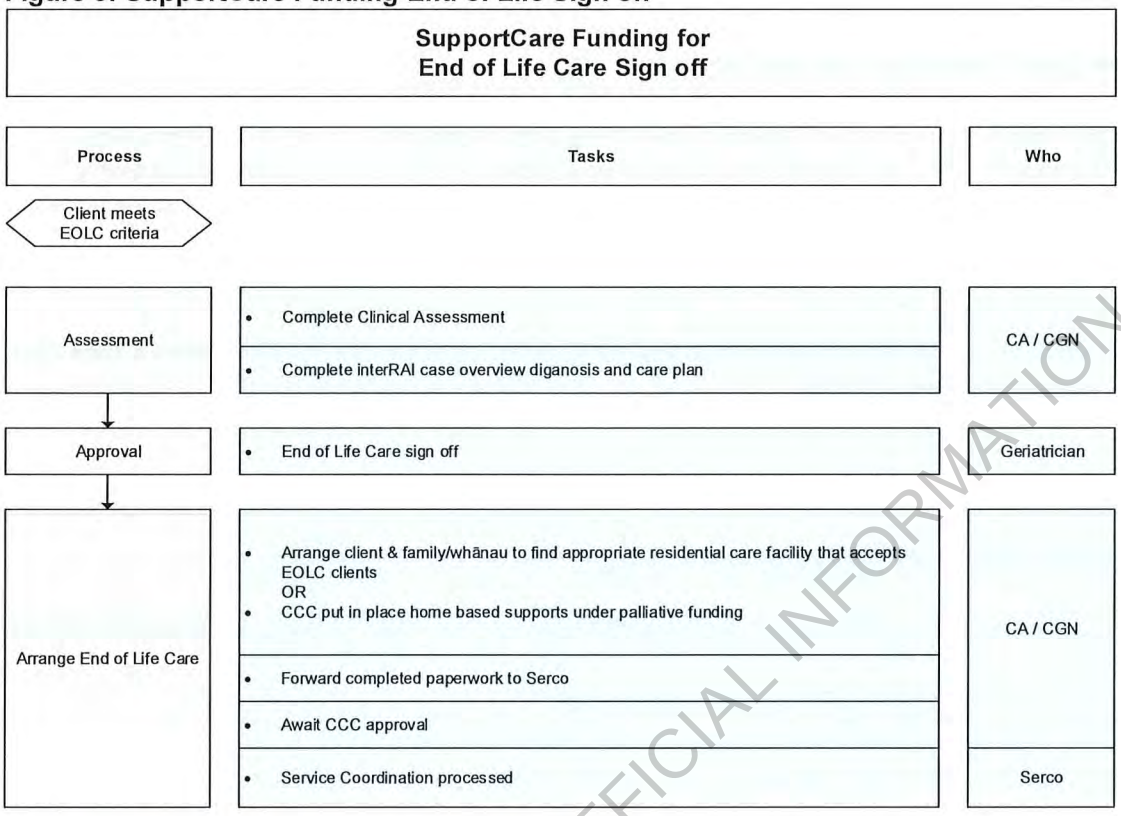
The procedure for setting this up is as follows:

CGN or Clinical Assessor:

- Completes a clinical assessment
- Obtains EOL sign off from Geriatrician
- Completes the InterRAI case overview diagnosis and care plan
- Completes a permanent placement form, as required
- CGN or Clinical Assessor may also complete other documents which need to be forwarded to CCCC i.e. discharge summaries or continuation notes

- All paperwork is given to Admin Serco to process

Figure 6: SupportCare Funding-End of Life Sign off



17.3 SupportCare – "End of Life" Exit Criteria

Clients who qualified for SC-EOL funding and survive longer than the ninety day life expectancy may no longer qualify for SC-EOL funding.

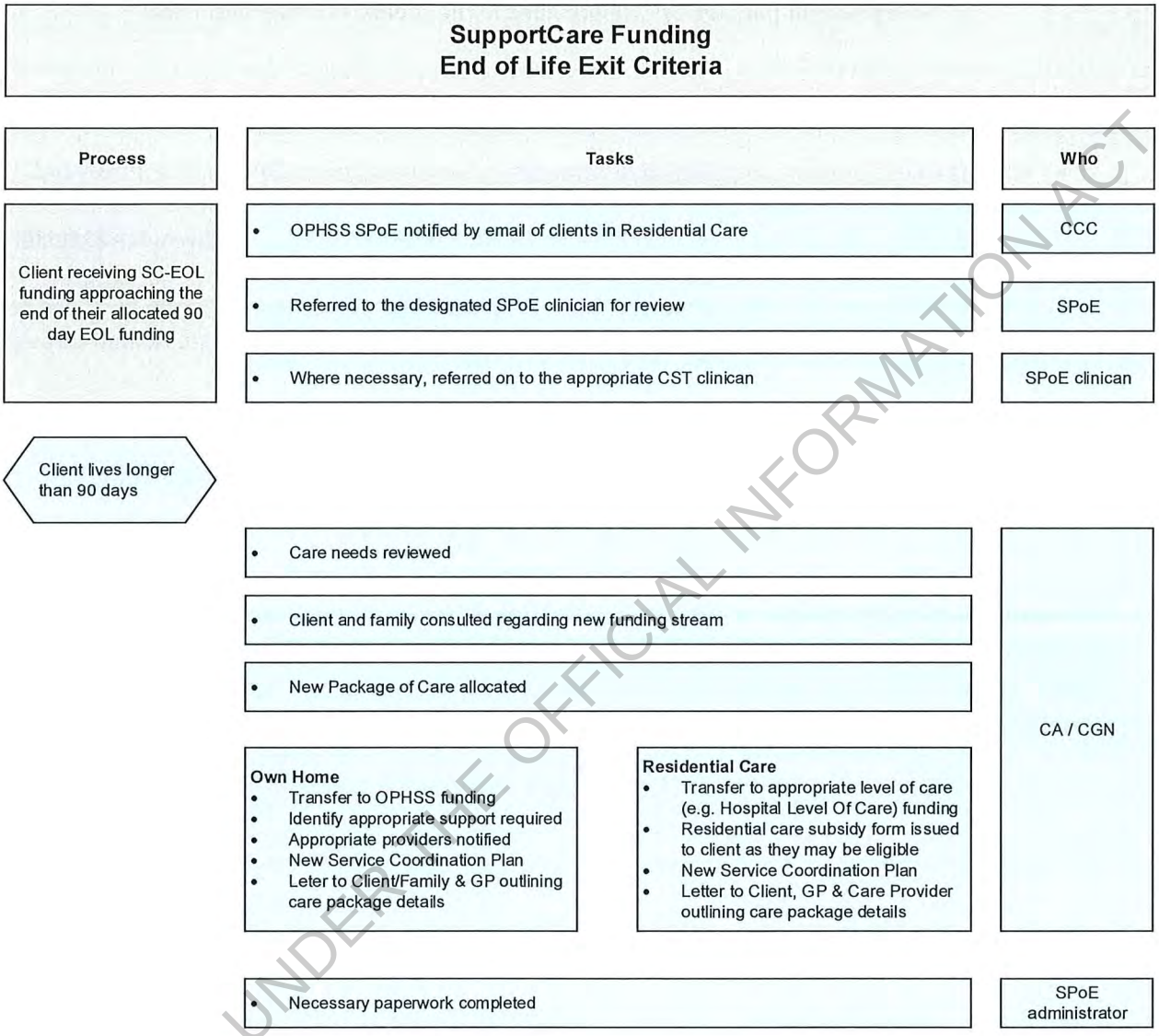
Should this occur, the client:

- has their care needs reviewed to ensure the support services in place are appropriate and will continue to meet their needs; and
- is administratively transferred to an alternative long-term funding source to provide support services on an ongoing basis;

- Clients aged less than 65 years are transferred to SC-SMI funding
- Clients aged 65 years and over are transferred to OPHSS funding
- Clients aged between 50 and 64 years of age AND assessed as being *"close in age and need"* to older persons are transferred to OPHSS

In some circumstances it is possible for End of Life SupportCare funding to be extended if this is deemed appropriate.

SPoE receives a list of clients on EoL funding on a monthly basis. When the end of the 90 days (three month) period is approaching, SPoE contacts (phones) the facility concerned and updates the client's prognosis. Depending on the prognosis, a referral to SPoE may be required for an assessment to transfer the client to an alternative funding stream.



17.4 Severe Medical Illness Guidelines:

Definitions

Severe Medical Illness applies where a client is not considered to be in the terminal phase of their illness, but has met specific criteria to qualify for this level of care.

Severe Medical Illness care is designed to be used:

- for persons who have been assessed by a Consultant Geriatrician *and*
- have an advanced medical illness *and*
- are under 65 years of age *and*

- have an anticipated life expectancy of more than ninety days
  and
- have a moderate to high level of disability necessitating either:
  - hospital level care or high level rest home care in a residential facility
    OR
  - an equivalent package of care provided in the clients' home environment

Severe Medical Illness care excludes, among other exclusions,

- Clients whose primary needs fall under the care of another agency. OPH service, Psych NASC, Lifelinks, MoH DSD, or ACC.
- Those clients who are aged <65 years, being treated as terminally ill, and have a life expectancy of ninety days or less.
- Those clients who are aged between 50 and 64 years of age, have been assessed and have been accepted as being *"close in age and need"* to older persons. (These clients are funded through HOP funding).

17.4.1 SupportCare – 'Severe Medical Illness' clients meeting the SC-SMI Exit criteria.

Clients who qualified for SC-SMI funding and reach 65 years of age, or reach 50 – 64 years of age and have been accepted as *"close in age and need"* to an older person, have their care needs reviewed to ensure support services are appropriate to meet their needs and are administratively transferred to OPH funding to provide ongoing support services.