1 SupportCare Funding Framework

1.1 Introduction

Policy

The Canterbury District Health Board (CDHB) will provide support services for eligible people with severe medical illness (SMI) or those in the 'end-of-life' (EOL) phase. Services will be provided in a fair, transparent and equitable manner according to the processes described in this policy.

Purpose

To document a process for the assessment and application for funding (SupportCare funding) for residential care services or home-based care services, for people with SMI or those in the EOL phase.

Scope

- Care Coordinators responsible for coordination of patients' ongoing health services
- Care Coordinators responsible for patients' InterRAI or needs assessment
- Senior Medical Officers
- CDHB nominated clinicians responsible for sign-off of SupportCare funding applications
- Service Development Manager(s), Planning and Funding Division
- Canterbury Care Coordination Centre
- Nurse Maude Community Palliative Care Services (Specialist and Generalist)
- Nurse Maude Allied Health Services
- Older Persons' Health Community Service Teams
- Social Workers
- General Practitioners
- Occupational Therapists
- Palliative Care Nurses

Definitions

- Care Coordinators are the social worker or clinical assessor responsible for coordination of patients' ongoing health services

Abbreviations

ACC	Accident Compensation Corporation
CCCC	Canterbury Care Coordination Centre
CNS	Clinical Nurse Specialist
DSD	Disability Services Directorate
EES	Environmental Equipment Support (Enable)
GP	General Practitioner
HOP	Health of Older Persons' (Funding)
HSS	Hospital & Specialist Service (includes all CDHB hospitals)
InterRAI	Resident Assessment Instrument
MDT	Multidisciplinary Team
MoH	Ministry of Health
NASC	Needs Assessment and Service Coordination Service
NM	Nurse Maude Association
NMCPC	Nurse Maude Community Palliative Care
NMSCPC	Nurse Maude Specialist Community Palliative Care
NMAH	Nurse Maude Allied Health
Occ Th	Occupational Therapy/Occupational Therapists
OPH	Older Persons Health (Service)
SC	SupportCare
SC-EOL	SupportCare – End-of-Life
SC-SMI	SupportCare – Severe Medical Illness
SW	Social Work
TLA	Territorial Local Authority
TPMH	The Princess Margaret Hospital

Associated Documents

Forms

All Forms detailed below are available on:

- CDHB Intranet under 'Forms'
- Nurse Maude IT system

Hardcopy forms may be ordered from CDHB Supply Department quoting Ref. No.

- SupportCare – 'End-of-Life' Funding Application Form (Ref. 1329)
- SupportCare – 'Severe Medical Illness' Funding Application Form (Ref. 1330)

- SupportCare Application Form: Conversion from End-of-Life to Severe Medical Illness Funding (Ref. 2072)
- Equipment Request: SupportCare and Palliative Care Patients (Ref. 2074)
- SupportCare – Summary of Service Coordination (Ref. 2281)
- SupportCare – Service Plan – Residential (Ref. 2075)
- SupportCare – Service Plan – Home Based Cares (Ref. 2076)
- SupportCare – Nominated Clinicians List (Ref. 1362)
- SupportCare – Patient Information Booklet (Ref. 2078)

Legislation

Social Security Act (1964) s.69F

SupportCare Group

The SupportCare Group was initiated in July 2004 was responsible for the development and implementation of a funding framework (SupportCare funding) in May 2005. SupportCare (SC) funding funds support services for people with severe chronic medical illness, and those in the 'end-of-life' phase. The SupportCare Group includes clinical, needs assessment and service coordination, service provider and funding representatives.

For eligible people with severe chronic medical illness and those in the end-of-life phase, SC funding enables transparent, flexible and equitable service provision to people, centralises the funding process, helps prevent funding wait lists and service gaps, and enables monitoring of volumes and spend. The objective of SC funding also focuses on achieving a seamless service delivery from both hospital-based and community-based perspectives. It gives patients, their families/whanau and health professionals' certainty and flexibility in terms of service provision, and ensures patient need is met in the best possible way.

The SupportCare Group is also responsible for reviewing and approving any changes to the SC funding framework and its associated processes.

1.2 SupportCare Funding – Purpose

SupportCare 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. In general there are two main care need levels identified within the SupportCare funding framework.

1.2.1 'End-of-Life' (EOL) Funding

Patients at this care need level are considered to be in the terminal phase of their illness, have a prognosis (life expectancy) of days to weeks, and need to meet specific criteria to qualify for this level of care.

They would have a high level of assessed need, equivalent to hospital level care.

SC-EOL funding is available for a maximum of one-three month (90 day) period only.

Patients, irrespective of age, who qualify for SC-EOL funding will receive fully funded care and will not be required to contribute towards the cost of their care for the three-month (90 day) period. If the patient survives the three-month (90 day) period, they may then be required to contribute towards the cost of their care. (Refer to 2.1.2 – 2.1.3).

1.2.2 'Severe Medical Illness' (SMI) Funding

Patients at this care need level are less than 65 years of age, are not considered to be in the terminal phase of their illness, and need to meet specific criteria to qualify for this level of care.

They would have a high level of assessed need, equivalent to hospital level care or high level rest home care.

Patients who qualify for SC-SMI funding may be required to contribute to the cost of their care if:

- they turn 65 years of age; OR
- if they are deemed as 'close in interest' to older persons; OR
- they are considered an 'eligible' person as per Social Security Act. Typically, if they are receiving a sickness or other benefit they will need to contribute a portion of this towards the cost of their residential care.

Note **-** SupportCare is not a clinical care or palliative care service; it is a funding mechanism only.

1.2.3 SupportCare Funding – What does it encompass?

SupportCare - 'End-of-Life' (EOL) Funding

For patients with this level of need, SC funding provides either:

- Residential (institutional) care (i.e. care in a hospital level facility);
  OR
- Home-based packages of care (i.e. services provided in the home environment)

SupportCare - 'Severe Medical Illness' (SMI) Funding

For patients with this level of need, SC funding provides either:

- Residential (institutional) care (i.e. care in a rest home or hospital level facility);
  OR
- Home-based packages of care (i.e. services provided in the home environment)

Note -

All patients who meet the eligibility criteria for SC-SMI funding are classified as ***requiring care services indefinitely***

Note –

Community Palliative Care Nursing Services

- Nurse Maude Specialist Community Palliative Care (NMSCPC) services are based on a multidisciplinary team (MDT) approach e.g. Physiotherapy, Occupational Therapy, Needs Assessment, Dietetic, Counselling, Specialist Medical services.
- In addition to SC funding, those patients who meet the eligibility criteria for SC-EOL funding also meet the entry criteria for community palliative care services, and may therefore receive community specialist and/or generalist palliative care services if clinically appropriate.
- NMSCPC services are responsible for providing services to the CDHB area (including rural areas).
- CDHB funds Nurse Maude (NM) to provide specialist community palliative care services to patients in a palliative phase of their life.
- CDHB funds community nursing service providers to provide generalist palliative care nursing services.

2 SupportCare Funding Eligibility Criteria & Exit Criteria

SupportCare Funding Eligibility Flowcharts (see section 3.3) assist clinicians with determining eligibility for SupportCare funding.

Eligibility criteria for SupportCare funding have been based on the World Health Organisation International Classification of Functioning (WHO ICF). (Refer to Appendix 1)

2.1 SupportCare – 'End-of-Life' Funding

2.1.1 SupportCare – 'End-of-Life' Eligibility Criteria

In order to qualify for SC-EOL funding, patients must be assessed by the CDHB clinicians or Nurse Maude (NM) Hospice clinicians and:

1. Have a prognosis (life expectancy) of less than three months; **AND**
2. Are being cared for as terminally ill; **AND**
3. Have a level of disability equivalent to hospital level care; **AND**
4. Have disability issues as a result of the terminal illness. The level of disability must be equivalent to hospital level care, which necessitates either:
   - Care in a hospital level care facility; OR
   - The equivalent level of care provided in the home environment.

Exclusions –

- Patients under 16 years of age
- Those patients who are already residing in a residential (institutional) care facility (rest home or hospital level)
- Retrospective applications (i.e. after the patient has died)
- Clients currently funded by MoH DSD services, Psych NASC, ACC.

If the answers to **all** of the above eligibility criteria are **'YES'**, the patient qualifies for SC–EOL funding.

If the answer to **any** of the above eligibility criteria is '**NO**', the patient does not qualify for SC–EOL funding.

Note -

- All CDHB secondary service based (e.g. Christchurch, Christchurch Women's, Ashburton, Burwood, TPMH) applications for SC–EOL funding and the accompanying needs or InterRAI assessment should be completed by the appropriate Social Worker or clinical assessor.

- NM Hospice based applications for SC-EOL funding and the accompanying needs or InterRAI assessment will be completed by NMSCPC team.
- Community based applications for SC-EOL funding and the accompanying needs or InterRAI assessment will be completed by NMSCPC team, unless an assessment on an older person undertaken by an Older Persons' Health (OPH) clinical assessor identifies a need for SC-EOL funding. In this case the assessment and application for SC-EOL funding would be undertaken by an OPH clinical assessor.

2.1.2 SupportCare – 'End-of-Life' Exit Criteria

Patients who qualify for SC-EOL funding and:

- Die
  OR
- Survive longer than the maximum three-month (90 day) life expectancy (Refer to section 2.1.3)

will no longer qualify for SC-EOL funding.

2.1.3 SupportCare – 'End-of-Life' Funded Patients Surviving 3-Months

The SC funding framework ensures SC-EOL funded patients who meet the exit criterion of surviving the maximum three-month (90 day) period:

- have their care needs reviewed to ensure the support services in place are appropriate and will continue to meet their needs; and
- are administratively transferred to an alternative long-term funding source to provide support services on an ongoing basis:
  - Patients aged less than 65 years are transferred to SC-SMI funding (refer to sections 4.6)
  - Patients aged 65 years and over are transferred to Health of Older Peoples' (HOP) funding (refer to section 4.7).
  - Those patients who are aged between 50 and 64 years of age, AND have been assessed AND accepted as being 'close in interest' to older persons are transferred to HOP funding. (refer to section 4.7).

2.2 SupportCare – 'Severe Medical Illness' Funding

2.2.1 SupportCare – 'Severe Medical Illness' Eligibility Criteria

In order to qualify for SC-SMI funding, patients must be assessed by CDHB clinicians or NM Hospice clinicians and:

1. Have an advanced medical illness; **AND**
2. Are under 65 years of age; **AND**
3. Have an anticipated prognosis (life expectancy) of more than 3 months; **AND**
4. Have moderate to high level of disability ; **AND**
5. The disability issues above necessitate either:
   - hospital level care or high level rest home care in a residential care facility; OR
   - an equivalent package of care provided in the patient's home environment.

Exclusions –

- Patients under 16 years of age.
- Clients whose primary needs fall under the care of another agency e.g. OPH service, Psych NASC, Lifelinks, MoH DSD, or ACC.
- Those patients who are aged <65 years, being treated as terminally ill, and have a prognosis of three months or less. These patients should be directed under SC-EOL funding.
- Patients meeting the eligibility criteria for SC-EOL funding.
- Those patients who are aged between 50 and 64 years of age, have been assessed and have been accepted as being 'close in interest' to older persons. (These patients are funded through HOP funding).

Note –

- As SC-SMI patients have a prognosis (life expectancy) of greater than three months; they are classified as **requiring care services indefinitely.**
- All CDHB secondary service based (e.g. Christchurch, Christchurch Women's Ashburton, Burwood, TPMH) applications for SC-SMI funding and the accompanying needs assessment should be completed by Social Workers or clinical assessors.
- Community based applications for SC–SMI funding and the accompanying needs or InterRAI assessment should be completed by the NMSCPC team or CDHB / NM Social Workers / Needs Assessors.

- Patients aged <65 years that have been funded by SC-EOL funding and survived the maximum 3-month (90 day) funding period will continue to be funded through SC-SMI funding until they meet the funding exit criteria. (Refer to section 2.2.2).

2.2.2 SupportCare – 'Severe Medical Illness' Exit Criteria

Patients who qualify for SC-SMI funding and:

- Reach 65 years of age
  OR
- Reach 50-64 years of age, have been assessed and have been accepted as being 'close in interest' to an older person
  OR
- Their condition resolves
  OR
- Die

will no longer qualify for SC-SMI funding.

2.2.3 SupportCare – 'Severe Medical Illness' Funded Patients meeting the SC-SMI Funding Exit Criteria

The SC funding framework ensures SC-SMI funded patients who meet the first two exit criteria cited in section 2.2.2:

- have their care needs reviewed to ensure the support services in place are appropriate and will continue to meet their needs; and
- are administratively transferred to long-term HOP funding to provide support services on an ongoing basis (refer to section 4.7).

3 SupportCare Funding Rules

3.1 SupportCare – 'End-of-Life' Funding Rules

3.1.1 SupportCare-EOL Funding Rules for Community Residential Care or Home Based Care Services

1. The 3-month (90 day) SupportCare-EOL funding rule applies from the date a patient is admitted to the facility or from the date a patient's package of care services commence.
2. The period of time spent as inpatient stay in a DHB or Hospice Palliative Care service prior to assessment is excluded from the 3-month (90 day) SC-EOL funding period.
3. The patient must be admitted to a residential facility or package of care services must be implemented within two weeks of funding approval date. If placement or service implementation does not occur within two weeks, SC-EOL funding approval will be revoked.
4. Should a service (DHB or Hospice Palliative Care) discharge a patient to a residential care facility or should a patient receive package of care services prior to approval of SC funding, the cost of care for the period of time prior to funding approval will be charged to the service that has discharged the patient.

3.1.2 SupportCare-EOL Funding Rules for Community Residential Care Services

1. If the person is:
   - aged 65 years or over, OR, aged 50 – 64 years, have been assessed and have been accepted as 'close in interest' to an older person;
     AND
   - has previously had or currently has, a permanent placement in a residential (institutional) facility

   then that person will **not** qualify for SC funding and will continue to be funded through HOP funding. As such the person will be subject to financial means assessment (as per Section 69F, Social Security Act 1964).
2. Current residential care provision requirements for SC-EOL funded patients are detailed in the 'SupportCare Residential Care Agreement and Service Specification', and guided by the national 'Aged Related Residential Care Agreement'.
3. Any additional costs over and above those stated in the 'SupportCare Residential Care Agreement and Service Specification', and the national 'Aged Related Residential Care

Agreement', must be agreed to by the resident, and must be identified within the residential care facility's 'Admission Agreement'.

4. SC-EOL patients are not required to contribute a portion of their Superannuation or any other benefit to the residential care facility (as per Work and Income New Zealand (WINZ))
5. SupportCare funded residential care prices are currently those set by the national 'Aged Related Residential Care Agreement' Territorial Local Authority (TLA) price(s).
6. If a patient is receiving care in a residential care facility (funded through SC-EOL) and they wish to return to their home environment:
   - SC-EOL funding can be transferred from residential care services to home based care services (refer to section 4.4).
   - the funding period remains as per the original approval i.e. the patient receives a total period of 3-months (90 days) SC-EOL funding only.

3.1.3 SupportCare-EOL Funding Rules for Home-Based Cares

1. The needs or InterRAI assessment identifies the type and level of services required to effectively manage a patient's care in their home environment.
2. Home-based 'packages of care' are generally allocated to three main care need levels: low, medium and high. Patients funded through SC-EOL funding would generally require a medium or high level package of care.
3. Services identified in a patient's 'package of care' may include:
   - Personal care services (including toileting, bathing, feeding, dressing)
   - District Nursing (this may also include generalist palliative care services if clinically appropriate) (refer to note below)
   - Household management e.g. laundry, cleaning, meal preparation services. Refer note below re CSC.
   - Specialised equipment provision
   - Carer Support
   - Respite Care

- SC-EOL funded packages of care **exclude** specialist service requirements e.g. specialist palliative care, suction catheters, vac dressings, oxygen.
- Non-Community Service Card (CSC) cardholders will be required to meet the costs of household management.

Equipment Provision:

- Patients who have their packages of care funded through SC funding are required to purchase any equipment items that are valued at $50 or less.
- Equipment assessments for the post discharge period are performed by hospital/hospice Occupational Therapist. (Refer to section 4.3.5 for process).
- Within the 72 hour post discharge period an equipment assessment will be undertaken by a Community Occupational Therapist in the patient's home. This assessment will identify equipment required on an ongoing basis. (Refer to section 4.3.6 for process).
- For patients discharged from CDHB secondary services:
  - Equipment is provided to facilitate the discharge and should be sourced primarily from the CDHB equipment pool.
  - Only when equipment is not available through the pool, it should be sourced through Rehab Equipment Rentals.

  Note -

  The hire cost of any equipment considered an 'exception' that has been ordered without sign-off by the relevant service manager will be charged to the service that has requested the equipment.
- Equipment for SC-EOL patients required on an ongoing basis is funded by SC-EOL funding and provided through Rehab Equipment Rentals.

District Nursing:

- Following implementation of the patient's package of care it is acknowledged that the district nursing requirement can frequently vary. To enable flexibility in the package of care, the care coordinator can alter the original district nursing allocation by noting the new district nursing details (only) on the 'Summary of Service Coordination' form (Ref. 2077) and faxing the form to the CCCC for administrative processing.
- A full review and/or reassessment is **not** required for a **small** change in the DN component alone.
- Where the DN component requires a **substantial** change in nursing hours a formal **review** and/or **reassessment** of the patient should be undertaken.

Important -

For patients in the days to last weeks of life:

If the DN component needs to increase due to the level of care required to keep them in their home environment, and the increase in **DN costs**

results in the overall package of care cost **exceeding** the daily bed day rate for hospital level residential care services, the package of care will **require further sign-off** by the care coordinator's service manager.

4. If a patient is receiving home based care services (funded through SC-EOL) and they require residential care services:
   - SC-EOL funding can be transferred from home based care services to residential care services (refer to section 4.5).
   - the funding period remains as per the original approval i.e. the patient receives a total period of 3-months (90 days) SC-EOL funding only.

3.1.4 SupportCare–EOL Funding Rules for Patients Surviving 3-Months (90 Days)

1. If a patient is receiving residential or home-based services funded through SC-EOL funding and survives the 3-month (90 day) maximum funding period, the patient is classified as requiring care services indefinitely.
2. **Patients aged <65 years** require an administrative funding transfer to SC-SMI funding (refer to section 4.6)
   - Patients continue to receive funding through SC-SMI funding until such time as they meet the SC-SMI funding exit criteria.
   - Patients aged <65 years and require residential care services indefinitely are subject to the Social Security Act.
3. **Patients aged 65 years and over** require a funding transfer to HOP funding (refer to section 4.7).
   - Patients continue to receive funding through HOP funding until such time as they meet the HOP funding exit criteria.
   - Patients who are aged 65 years and over and require residential care services indefinitely are subject to the Social Security Act.
4. Patients aged 50 – 64 years and have been assessed and have been accepted as 'close in interest' to and older person require an administrative funding transfer to HOP funding (refer to section 4.7).
   - Patients continue to receive funding through HOP funding until such time as they meet the HOP funding exit criteria.
   - Patients aged 50 – 64 years and have been assessed and have been accepted as 'close in interest' to and older person are deemed an 'eligible person' under the Social Security Act and therefore will be required to contribute towards the cost of their care.

3.2 SupportCare – 'Severe Medical Illness' Funding Rules

3.2.1 SupportCare-SMI Funding Rules for Community Residential Care or Home Based Care Services

Patients eligible for SupportCare–SMI funding are:

- Patients who are aged <65 years and have met the SC-SMI funding eligibility criteria
  OR
- Patients who are aged <65 years, have been funded by SC-EOL funding, and survived the maximum 3-month (90 day) funding period.

For patients who are aged <65 years and have met the SC-SMI funding eligibility criteria:

1. The patient must be admitted to a residential facility or package of care services must be implemented within two weeks of funding approval date. If placement or service implementation does not occur within two weeks, SC–SMI funding approval will be revoked.
2. Should a service (DHB or Hospice Palliative Care) discharge a patient to a residential care facility or should a patient receive package of care services prior to approval of SC funding, the cost of care for the period of time prior to funding approval will be charged to the service that has discharged the patient.

3.2.2 SupportCare-SMI Funding Rules for Community Residential Care Services

1. If the person is aged between 50-64 years, has been assessed and has been accepted as 'close in interest' to older persons, then that person will not qualify for SC funding. The patient is funded through HOP funding. As such the person will be subject to financial means assessment (as per Section 69F, Social Security Act 1964).
2. Current residential care provision requirements for SC-SMI funded patients are detailed in the 'SupportCare Residential Care Agreement and Service Specification', and guided by the national 'Aged Related Residential Care Agreement'.
3. Any additional costs over and above those stated in the 'SupportCare Residential Care Agreement and Service Specification', and the national 'Aged Related Residential Care

Agreement', must be agreed to by the resident, and must be identified within the residential care facility's 'Admission Agreement'.

4. SupportCare-SMI patients may be determined an eligible person under the Social Security Act and therefore may be required to contribute to the cost of their care.
5. SupportCare funded residential care prices are currently those set by the national 'Aged Related Residential Care Agreement' Territorial Local Authority (TLA) price(s).
6. If a patient is receiving residential care services (funded through SC-SMI) and they require home based care services:
   - SC-SMI funding can be transferred from residential care services to home based care services (refer to section 4.4).
   - SC-SMI funding continues until such time as the patient meets an exit criterion.

3.2.3 SupportCare-SMI Funding Rules for Home-Based Cares

1 The needs or InterRAI assessment identifies the type and level of services required to effectively manage a patient's care in their home environment.

2 Home-based packages of care are generally allocated to three main care need levels: low, medium and high. Patients funded through SC-SMI funding would generally require a medium or high level package of care.

3 Services identified in a patient's 'package of care' may include:
   - Personal care services (including toileting, bathing, feeding, dressing)
   - District Nursing (this may also include generalist palliative care services if clinically appropriate)
   - Household management (previously referred to as domestic assistance) e.g. laundry, cleaning, meal preparation services
   - Specialised equipment provision (refer Note below)
   - Carer Support
   - Respite Care

- SC-SMI funded packages of care **exclude** specialist service requirements e.g. specialist palliative care, suction catheters, vac dressings, oxygen.
- Non-Community Service Card (CSC) cardholders will be required to meet the costs of household management.

Equipment Provision:

- Patients who have their packages of care funded through SC funding are required to purchase any equipment items that are valued at $50 or less.
- Equipment assessments for the post discharge period are performed by hospital/hospice Occupational
- Within 72 hours post discharge an equipment assessment will be undertaken by a Community Occupational Therapist in the patient's home. This assessment will identify equipment required on an ongoing basis. (Refer to section 4.3.6 for process).
- For patients discharged from CDHB secondary services:
  - Equipment is provided to facilitate to discharge and should be sourced primarily from the CDHB equipment pool.
  - Only when equipment is not available through the pool, it should be sourced through Rehab Equipment Rentals
    Note -
  - The hire cost of any equipment considered an 'exception' that has been ordered without sign-off by the relevant service manager will be charged to the service that has requested the equipment.

Equipment Provision for SC-SMI Patients Following the 72-Hour Post Discharge Period:

- A patient's ongoing equipment needs are assessed by a community Occupational Therapist in the patient's home.
- Patients who have a prognosis of **up to six months** have their equipment funded through SC-SMI funding and provided through Rehab Equipment Rentals.
- Patients, who have a prognosis of **more than six months** and **meet** the MoH DSD Environmental Equipment Services (EES) (Enable) criteria, have their equipment funded and provided through Enable.
- Patients, who have a prognosis of **more than six months** and **do not meet** the MoH DSD Enable criteria, have their equipment funded through SC-SMI funding and provided through Rehab Equipment Rentals.

District Nursing:

- Following implementation of the patient's package of care it is acknowledged that the district nursing requirement can frequently vary. To enable flexibility in the package of care, the care coordinator can alter the original district nursing allocation by noting the new district nursing details (only) on the 'Summary of Service Coordination' form (Ref. 2077) and faxing the form to the CCCC for administrative processing.

- A full review and/or reassessment is **not** required for a **small** change in the DN component alone.
- Where the DN component requires a **substantial** change in nursing hours a formal **review** and/or **reassessment** of the patient should be undertaken.

Important -

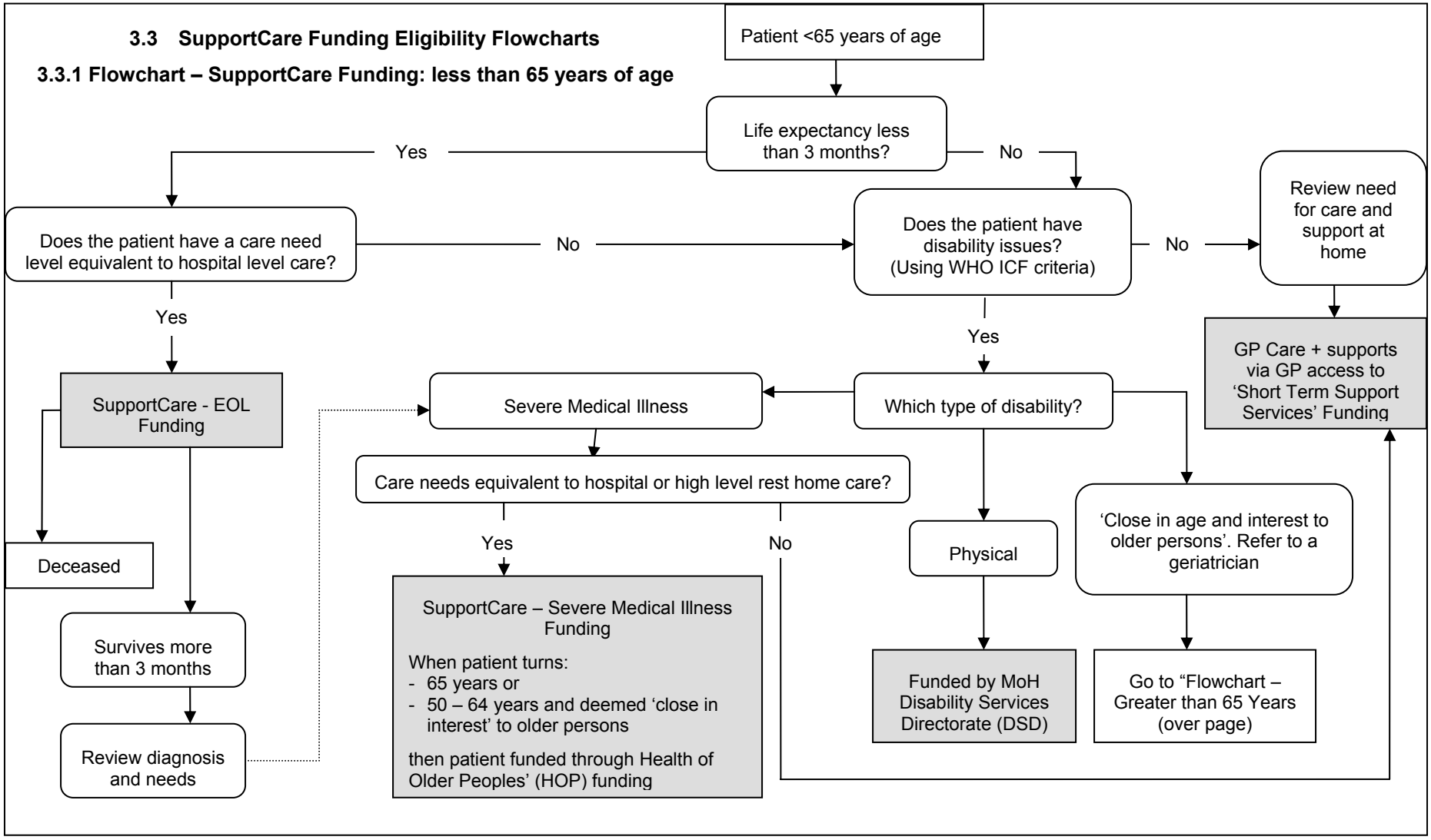
For patients in the days to last weeks of life:

If the DN component needs to increase due to the level of care required to keep them in their home environment, and the increase in **DN costs** results in the overall package of care cost **exceeding** the daily bed day rate for hospital level residential care services, the package of care will **require further sign-off** by the care coordinator's service manager.

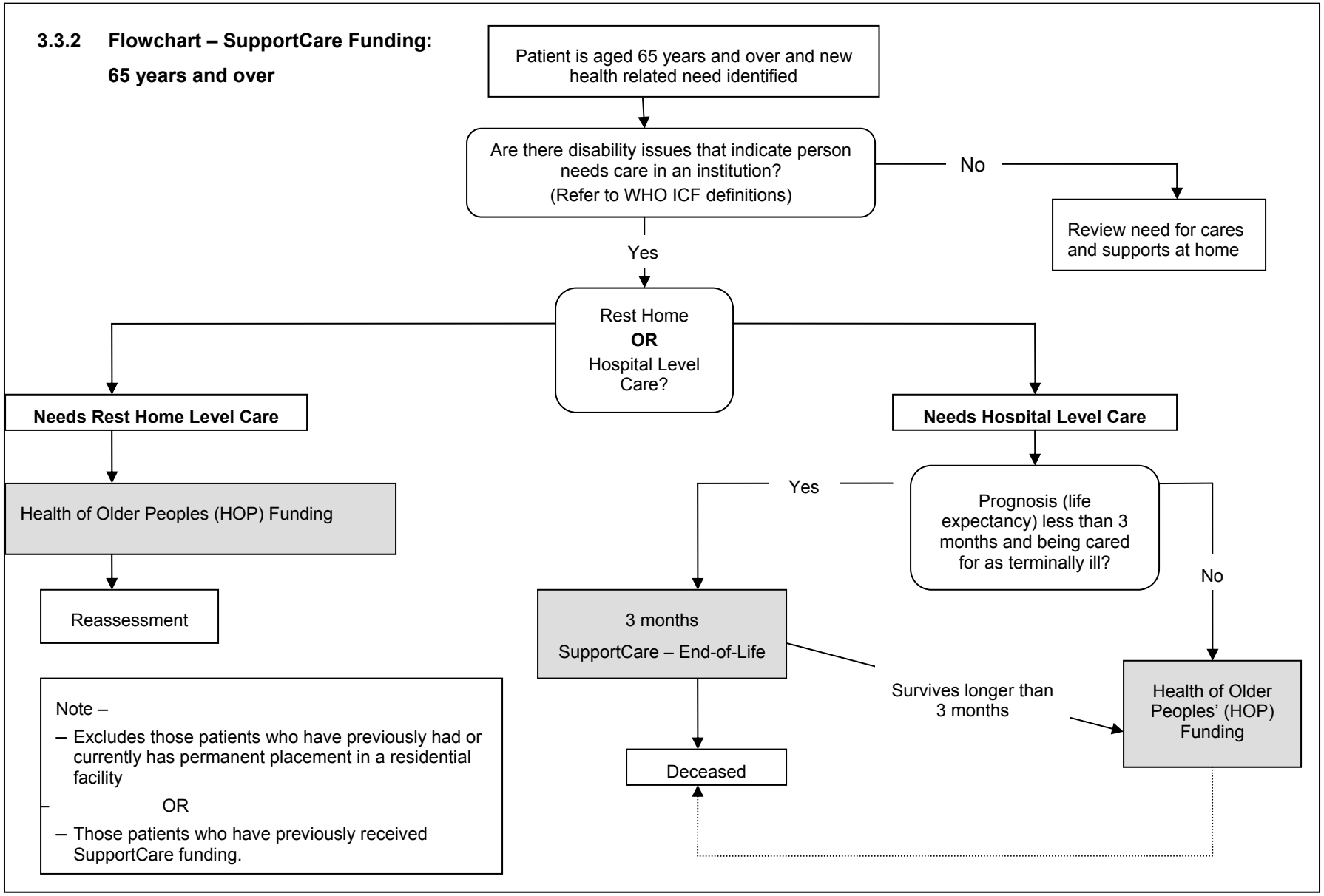
4 If a patient is receiving home based care services (funded through SC-SMI) and they require residential care services:
   - SC-SMI funding can be transferred from home based care services to residential care services (refer to section 4.5).
   - SC-SMI funding continues until such time as the patient meets an exit criterion.

3.3 SupportCare Funding Eligibility Flowcharts

3.3.1 Flowchart – SupportCare Funding: less than 65 years of age



3.3.2 Flowchart – SupportCare Funding: 65 years and over



4 SupportCare Processes

4.1 Service Coordination – Roles and Responsibilities

4.1.1 Care Coordinator

The Care Coordinator has the role and responsibility of **overseeing the entire coordination** of a SupportCare funded patient's care services. This includes:

- Oversight and completion of the needs or InterRAI assessment
- Oversight of any other service assessments required by the patient e.g. referral to an Occupational Therapist for an equipment assessment.
- Assisting in referral for specialist services where required e.g. specialist palliative care, suction catheters, oxygen.
- Oversight and completion of the SC Funding Application (SC-EOL or SC-SMI Funding)
- Submitting the completed SC Funding Application to the CCCC for administrative processing.
- Follow-up on any requirement(s) identified by the CCCC prior to SC Funding Confirmation.
- Ensuring SupportCare funding confirmation has been received from the CCCC.
- Overseeing the coordination of services to enable a patient's discharge:
  - Residential Care Services e.g. confirming the facility, entry date, level of care.
  - Home Based Cares e.g. confirming service provider details, level of services, equipment provision commencement date. Liaising with the CCCC and service providers where necessary.
  - If for some reason, the patient's discharge date is delayed, the care coordinator is responsible for advising care service providers of the change in discharge date e.g. home based care service providers, hospital/hospice Occupational Therapist, and residential care facility.
  - Ensuring/assisting the ward staff referring the patient to community based services.
- Oversight and completion of administrative requirements when a patient is discharged.

- Forwarding a copy of the needs or InterRAI assessment to community based services as required e.g. specialist palliative care service, generalist palliative care provider, residential care provider.

4.1.2 Hospital / Hospice Occupational Therapist

The hospital/hospice Occupational Therapist has the role and responsibility of assessing a patient's equipment requirements **during the post discharge period only** i.e. up to **72 hours post discharge**. This includes:

- Performing the equipment assessment.
- Liaise with CCCC to ensure the entire package of care does not exceed dollar limit.
- Obtaining sign-off for any equipment exceptions.
- Administrative processing of equipment requests.
- Liaising with the patient's hospital/hospice care coordinator to confirm a patient's date of discharge and equipment delivery date.
- Liaising with the Community Occupational Therapist and/or community care coordinator regarding the return of equipment where required.
- **Refer to section 4.3.3 for Hospital/Hospice Occupational Therapist Process.**

4.1.3 Community Occupational Therapist

The community Occupational Therapist has the role and responsibility of assessing a patient's **longer term equipment requirements within their home environment**. This includes:

- Assessing a patient's ongoing equipment needs.
- Obtaining sign-off for any equipment exceptions
- Review and/or reassessing a patient's ongoing equipment needs
- Where appropriate, referring SC-SMI patients to MoH Disability Services Directorate (DSD).
- Liaising with a patient's hospital/hospice care coordinator and/or hospital/hospice Occupational Therapist where necessary.
- Liaising with a patient's community care coordinator where/when appropriate.
- **Refer to section 4.3.4 for Community Occupational Therapist Process.**

4.2 SupportCare Funding – Application Components

A SupportCare Funding Application for:

- **Residential Care services**
  OR
- **Home Based Care services**

consists of the following:

- SupportCare Funding Application Form - this will be either:
  - SupportCare – EOL Funding Application Form (Ref. 1329)
    OR
  - SupportCare – SMI Funding Application Form (Ref.1330)
    AND
  - A needs or InterRAI assessment
    AND
- Summary of Service Coordination (Ref. 2281)
- Service Plan (Ref: 2075 and 2076)

4.3 Support Care Funding - Application Process

4.3.1 Completion of the SupportCare Funding Application

The **Care Coordinator** is responsible for completing and submitting the 'SupportCare Application' (refer to section 4.2).

1. A needs or an InterRAI assessment for the patient must be performed.
   - The Care Coordinator is responsible for ensuring the assessment has input by the relevant health professionals.
2. The SupportCare Funding Application Form's details are completed.
   (Ref. 1329 or 1330).
   i. The Care Coordinator:
      - is responsible for completing the SC funding application form.
      - determines whether the patient meets the **eligibility criteria** for SC-EOL or SC-SMI funding.

Important – The completed assessment and other relevant information must be used in determining whether a patient meets the eligibility criteria for SC funding.

   ii. The SMO:
      - Provides agreement that the patient meets the SC funding eligibility criteria and is being referred for SupportCare funding.
      - Completes the required SMO details on the application form, including signature.
      - For SC-SMI funding the SC nominated clinician must sign off on the application form. The completed assessment **must** be provided to assist sign-off for SC-SMI funding.
      - For SC-EOL discussion with the SC nominated clinician is only required if there is a query regarding funding eligibility.

Note – 'CDHB Nominated Clinicians List' (Ref. 1362) is available on the CDHB intranet under 'forms' or NM Hospice Palliative Care 'shared drive'.

   iii. The care coordinator ensures:
      - the SC funding rules and (where necessary) Social Security Act requirements have been explained to the patient/representative(s).

- the patient/representative(s) have accepted the needs assessment and conditions of funding.

iv. The Care Coordinator:

- confirms they have explained the conditions of SC funding to the patient/representative(s) by signing the SC application form.
- completes the care coordinator details.
- enters the fax number for the 'SC funding approval confirmation' fax to be sent to.

3. The Care Coordinator works with the patient/patient representative(s)/carer to identify the most appropriate care service option(s) for the patient:
   i. Residential care services –
      - Identifies suitable residential care facility options. Works with the residential care facility (and patient) to determine a suitable entry date.
   ii. Home based care services –
      - Identifies service type(s) and level(s) required. Refer to section 5 for package of care details and requirements.
      - if a need for equipment has been identified the patient is referred for an equipment assessment.
4. The Care Coordinator, where required, assists with referral of a patient to specialist services e.g. specialist palliative care services, suction catheters, vac dressings, oxygen. (Refer to Appendix 2 for Specialist Service contact details).
5. The Care Coordinator completes the Summary of Service Coordination (Ref. 2281):
6. The Care Coordinator **faxes** a copy of the completed:
   - SupportCare Application Form (Ref. 1329 or Ref. 1330)
   - Needs or InterRAI assessment
   - Summary of Service Coordination (Ref. 2281 and Service Plan)

   to the CCCC for administrative processing and service coordination.

CCCC contact details:

Manager

Canterbury Care Coordination Centre

PO Box 36126

Merivale

Christchurch

Phone: 355 5066

Fax: 355 5225

4.3.2 SupportCare Funding Application – CCCC Process

Following receipt of the SupportCare Funding Application, the CCCC is responsible for:

1. Checking the application is correct and complete.
2. Logging the date of SupportCare funding approval (the date the application is accepted by CCCC).
3. Advising the care coordinator by fax that the SC application has been accepted and the date of approval).
4. Advising the care coordinator of any forms that are either incomplete or illegible or do not have the appropriate sign off. The care coordinator is responsible for completing or rewriting and resubmitting any illegible sections.
5. Logging the residential care facility details, date of entry to the facility, and level of care required e.g. rest home or hospital; where a patient is receiving residential care services.
6. Logging the home based care details and coordinating home based care services; where a patient is receiving home based cares. This includes equipment hire.
7. Advising the care coordinator when home based care service providers have been engaged. This includes the type of service(s), level of service(s), and service provider(s) engaged for the patient.

Note –

- In some instances services and the level of services cited on the Summary of Service Coordination are unable to be secured (e.g. carer shortages). Should this situation arise, the Care Coordinator is responsible for determining whether the level of available services is adequate to meet a patient's needs. This may require further discussion with the patient/representative(s) and/or carer(s).

Alternative options may need to be considered e.g. residential care services.

8. Providing faxed confirmation to the Occupational Therapist following receipt of the 'Equipment Request: SupportCare and Palliative Care Equipment' (Ref. 2074) (from the Occupational Therapist):
   - the CCCC fax confirms the patient's equipment request has been received and forwarded to equipment provider Rehab Equipment Rentals.

Note –

- Any equipment requests with equipment items considered an 'exception' that have not had the justifications section of the Equipment Request: SupportCare and Palliative Care Patients (Ref. 2074) completed, and/or have not been signed off by the relevant service manager, will be returned to the hospital /hospice Occupational Therapist for completion.
- Rehab Equipment Rentals provides the requesting Occupational Therapist with faxed confirmation of:
  - receipt of the equipment request from the CCCC; and
  - delivery of equipment to the patient.

4.3.3 SupportCare Funded Patients – Hospital/Hospice Occupational Therapist Process

The hospital/hospice Occupational Therapist assesses a patient's equipment requirements for the **post discharge period only**. The hospital/hospice Occupational Therapist:

1. Following a request from the patient's Care Coordinator, the Occupational Therapist performs the equipment assessment.
2. Completes the Equipment Request Form: SupportCare and Palliative Care Patients (Ref. 2074). The SupportCare and Palliative Care Equipment List (Ref. 2073) should be used as a guide.
3. For CDHB secondary services: determines what equipment can be ordered through the CDHB equipment pool. If an item of equipment cannot be sourced from the CDHB equipment pool it should be sourced through Rehab Equipment Rentals.
4. Forwards the equipment request (for equipment items sourced through Rehab Equipment Rentals) to the CCCC for administrative processing.
   - Confirmation of receipt of the equipment request is sent by the CCCC to the Occupational Therapist.

- The CCCC forwards the equipment request to Rehab Equipment Rentals.
- Confirmation of receipt of the equipment request is sent by Rehab Equipment Rentals to the Occupational Therapist.

5. Orders equipment from the CDHB equipment pool (CDHB patients only)
6. Ensures they receive faxed confirmation of an equipment request from the CCCC and (where relevant) Rehab Equipment Rentals.
7. Liaises with the patient's hospital/hospice care coordinator to confirm a patient's discharge date. The Occupational Therapist confirms the equipment delivery date with:
   - CDHB equipment pool (CDHB patients only)
   - Rehab Equipment Rentals (where necessary).
8. On confirmation of a patients expected discharge date, forwards an Occupational Therapist referral to the community Occupational Therapist.

   Note –

   The equipment referral should identify items of equipment provided through the CDHB equipment pool.
9. Liaises with the patient's Care Coordinator to advise them that the equipment has been delivered and that the referral to the community Occupational Therapist has occurred.
10. For equipment hired from the CDHB equipment pool; following notification by the community Occupational Therapist that the home based equipment assessment has occurred, confirms a suitable date for pick up and return of the CDHB equipment.
    The hospital Occupational Therapist organises the pick up and return of CDHB equipment to the CDHB equipment pool.

4.3.4 SupportCare Funded Patients – Community Occupational Therapist Process

The community Occupational Therapist assesses a patient's longer-term (i.e. ongoing) equipment requirements following receipt of a SC funded patients referral from the hospital/hospice Occupational Therapist. The community Occupational Therapist:

1. Completes an equipment assessment in the patient's home.
2. Where appropriate, refers a patient's details to MoH DSD services to determine whether or not they are eligible for long-term funding through MoH DSD services and equipment provision through Environment Equipment Support (EES) (Enable).
3. Requests any required equipment items by :

- Completing an Equipment Request: SupportCare and Palliative Care Patients (Ref. 2074). The SupportCare and Palliative Care Equipment List (Ref. 2073) should be used as a guide.

4. Forwards the equipment request (for equipment items sourced through Rehab Equipment Rentals) to the CCCC for administrative processing.
   - Confirmation of receipt of the equipment request is sent by the CCCC to the Occupational Therapist.
   - The CCCC forwards the equipment request to Rehab Equipment Rentals.
   - Confirmation of receipt of the equipment request is sent by Rehab Equipment Rentals to the Occupational Therapist.
5. Liaises with Rehab Equipment Rentals to determine the date of delivery of ordered equipment items.

   Note –

   - If items of equipment have been hired through Rehab Equipment Rentals for the post discharge period and are no longer required the community Occupational Therapist organises the pick up and return of these equipment items by Rehab Equipment Rentals.
   - If items of equipment have been sourced through the CDHB equipment pool for the post discharge period, the community Occupational Therapist liaises with the CDHB hospital Occupational Therapist regarding the pick up return of these equipment items (refer to section 4.3.4).
6. Advises the patient of any items of equipment that will need to be picked up by CDHB and/or Rehab Equipment Rentals.
7. Where the patient is accepted for funding by MoH DSD, liaises with Enable regarding the delivery of equipment for the patient, and organises the pick up of any (SC funded) equipment by Rehab Equipment Rentals. The Occupational Therapist will also inform the patient of any change over of equipment that is required.
8. Determines a suitable review and/or reassessment date.
9. Liaises (where necessary) with the care coordinator regarding the patient's equipment provision.

4.4 SupportCare Funding – Transfer of Care Service Type: Residential Care to Home Based Care Services

The SC funding framework enables SC-EOL or SC-SMI funded patients to transfer their care service type from residential care services to home based care services. This is performed by the care coordinator.

The care coordinator is responsible for:

1. Reviewing the patient's needs or InterRAI assessment to determine whether home based care services will adequately meet the patient's assessed need.
2. Performing a needs reassessment or InterRAI if necessary.
3. Assisting with referral of a patient to specialist services if required e.g. specialist palliative care services, suction catheters, vac dressings, oxygen. (Refer to Appendix 2 for Specialist Service contact details).
4. Explaining the SC funding rules to ensure the patient/ representative(s) continue to be fully informed of SC funding implications i.e. the exit criteria for SC-EOL funding or SC-SMI funding (whichever is applicable). The SupportCare Patient Information Booklet (Ref. 2078) should be used as a reference.
5. Working with the patient/patient's representative(s)/carer to identify the most appropriate home based care service option(s) for the patient.

   Note –

   - Any exceptions must be signed-off by an appropriate manager as required
   - If a need for equipment has been identified the patient is referred for an equipment assessment. Equipment assessments are performed by a HSS, or OPH Community Service Team, or NMCPC team Occupational Therapist.
   - Refer to section 5 for Packages of Care Guide.
6. Determining a suitable review and/or reassessment date.
7. Completing the Summary of Service Coordination (Ref. 2281).
   - Faxing a copy of the Summary of Service Coordination and needs assessment (if applicable) to the CCCC for administrative processing and service coordination
8. Following confirmation of home based care service coordination by the CCCC, the care coordinator sends a copy of the SupportCare Service Plan – Home Based (Ref. 2076) to the:
   - Patient
   - Patient's GP.

4.5 SupportCare Funding - Transfer of Care Service Type: Home Based Care to Residential Care Services

The SC funding framework enables SC-EOL or SC-SMI funded patients to transfer their care service type from home based care services to residential care services. This is performed by the care coordinator.

The care coordinator is responsible for:

1. Reviewing the patient's needs or InterRAI assessment to determine whether residential care services will best meet the patient's assessed need.
2. Performing a needs or InterRAI reassessment if necessary.
3. Assists with referral of a patient to specialist services if required e.g. specialist palliative care services, suction catheters, vac dressings, oxygen. (Refer to Appendix 2 for Specialist Service contact details).
4. Explaining the SC funding rules to ensure the patient/representative(s) continue to be fully informed of SC funding implications i.e. the exit criteria for SC-EOL funding or SC-SMI funding (whichever is applicable).
   The SupportCare Patient Information Booklet (Ref. 2078) should be used as a reference.
5. Working with the patient/patient's representative(s)/carer to identify the most appropriate residential care facility for the patient.
6. Determining a suitable review and/or reassessment date.
7. Completing the Summary of Service Coordination (Ref. 2077).
8. Faxing a copy of the Summary of Service Coordination and SNL Reassessment (if applicable) to the CCCC for administrative processing. Refer to section 4.2, step 6 for:
   - CCCC contact details
   - CCCC administrative process for residential care services.
9. Following confirmation of residential care services and the date of entry to residential care by the CCCC, the care coordinator sends a copy of the:
   i. SupportCare Service Plan – Residential Based (Ref. 2075) to the:
      - Patient
      - Patient's GP
      - Residential care facility.
   ii. InterRAI reassessment to the residential care facility.

4.6 SupportCare Funding Transfer – SC-EOL Funding to SC-SMI Funding

- Should patients aged <65 years survive the maximum 3-month (90 day) funding period; the patient is classified as ***requiring care services indefinitely***. The SC funding framework enables patients to have care services funded on an ongoing basis through an administrative transfer to long-term SC-SMI funding.
- Should a patient aged 50 – 64 years survive the maximum 3-month (90 day) funding period; the patient is classified as requiring care services indefinitely. If, at that stage, the patient has been assessed and has been accepted as 'close in interest' to and older person, the patient requires an administrative funding transfer to HOP funding (refer to section 4.6).

Patients transferring from SC-EOL funding to SC-SMI Funding:

- Patients transferring from SC-EOL to SC-SMI funding will continue to receive SC-SMI funding until such time as they meet the SC-SMI funding exit criteria. (Refer to section 2.2.2 – 2.2.3)
- An application for SC funding transfer from SC-EOL to SC-SMI requires the 'SupportCare Funding Application Form: Conversion from End-of-Life to Severe Medical Illness Funding' (Ref. 2072). A care coordinator is responsible for completing and submitting this administrative funding transfer form to the CCCC. (Refer to 4.5.1).

  For this purpose a care coordinator would be:
  - Palliative Care Clinical Nurse Specialist (CNS) (Community)
  - Palliative Care CNS (Hospital)
  - CDHB Social Worker.
- An administrative transfer of funding occurs following submission of the SC-EOL to SC-SMI transfer form (Ref. 2072) to the CCCC. The CCCC is responsible for forwarding the funding transfer form to CDHB's payment agent; HealthPAC. (Refer to 4.5.2)

4.6.1 SC-EOL to SC-SMI Funding Transfer Application Process

1. The care coordinator completes the SC-EOL to SC-SMI funding transfer application form (Ref. 2072).
2. Completion of the application form requires the following:
   i. The care coordinator inserts the patient's details and relevant information.

ii. The care coordinator assesses whether the focus of the patient's care has changed from supportive/palliative care to active care.

Note –

- It is important that the care coordinator ensures there is palliative care service input into this assessment.
- Patients whose care has changed from supportive/palliative to active care:
  - The patient may benefit from a medical review e.g. by the GP and/or Specialist to re-focus and plan ongoing care.
  - The care coordinator must discuss the case with a CDHB nominated SMI Clinician. (Refer 'CDHB Nominated Clinician List' (Ref. 1362). The patient may meet an exit criterion for SC-SMI funded services and receive more appropriately focused services which are funded through alternative funding sources.
- Patients whose care continues to be supportive/palliative:
  - the patient can be transferred to SC-SMI funding until such time as they meet a SC-SMI funding exit criterion.

iii. The care coordinator ensures the SC funding rules and where necessary Social Security Act requirements have been explained to the patient/representative(s).

The SupportCare Patient Information Booklet (Ref. 2078) should be used as a reference.

iv. The care coordinator confirms they have explained the conditions of SC funding to the patient/representative(s) by completing the care coordinator details and signing the SC-EOL to SC-SMI funding transfer application form (Ref. 2072).

v. The care coordinator faxes a copy of the SC-EOL to SC-SMI funding transfer application form (Ref. 2072) to the CCCC for administrative processing. Refer to section 4.2, step 6 for CCCC contact details.

vi. The care coordinator forwards a copy of the SC-EOL to SC-SMI funding transfer application form (Ref. 2072) to the:

- Patients GP
- Residential care facility (if the patient is receiving residential care services)

4.6.2 SC-EOL to SC-SMI Funding Transfer - Administrative Process

The CCCC logs the date of receipt of the SC-EOL to SC-SMI funding transfer form (Ref. 2072).

1. The CCCC forwards the completed SC-EOL to SC-SMI funding transfer form (Ref. 2072) to CDHB's payment agent; HealthPAC (Payments Section).
2. The CCCC logs the date the SC-EOL to SC-SMI funding transfer form (Ref. 2072) was forwarded to HealthPAC.
3. HealthPAC update their records to show patient has now changed to SC-SMI funding.
4. The copy of the SC-EOL to SC-SMI funding transfer form (Ref. 2072) is retained on HealthPAC records to verify ongoing payment on invoice from the residential care providers until such time as the patient meets a SC-SMI funding exit criterion.

4.7 SupportCare Funding Transfer - SC-EOL Funding to Health of Older Peoples' Funding

Should a patient aged:

- 65 years and over; OR
- 50 – 64 years, and has been assessed and has been accepted as 'close in interest' to an older person

survive the maximum 3-month (90 day) SC-EOL funding period; the patient is classified as ***requiring care services indefinitely***. The SC funding framework enables patients to have care services funded on an ongoing basis through an administrative transfer to long-term Health of Older Peoples' (HOP) Funding.

1. Patients transferring from SC-EOL funding to SC-SMI Funding:
   - Patients continue to receive funding through HOP funding until such time as they meet HOP funding exit criteria.
   - Patients who are:
     - aged 65 years and over; OR
     - 50 – 64 years, and have been assessed and have been accepted as 'close in interest' to an older person

     and require residential care services indefinitely are subject to the Social Security Act Section 69F.
   - An Older Persons Health (OPH) community service team worker is the care coordinator and is responsible for completing the administrative transfer of funding from SC-EOL to HOP funding.

2. SC-EOL to HOP Funding Transfer Process
   i. For patients residing in residential care:
      - 3 weeks (21 days) prior to the SC-EOL funding expiration date, the CCCC logging system alerts the CCCC that a patient's SC-EOL funding is due to expire.
      - The CCCC advises the residential care facility that the patient's SC-EOL funding is due to expire (and date of expiry) and remind the facility they are required to book a review for the patient with the OPH Community Service Team. This is required to action an administrative funding transfer to HOP funding.

Note –

The minimum notice period required by the OPH Community Service Team for a patient review is 10 working days.

Booking a patient review with OPH Community Service Team is the responsibility of the residential care facility where the patient is residing.

- The residential care facility advises the OPH Community Service Team a patient review is required for a transfer of funding.

ii. For patients residing in their home environment (home based cares):

- 3 weeks (21 days) prior to the SC-EOL funding expiration date, the CCCC logging system alerts the CCCC that a patient's SC-EOL funding is due to expire.
- The CCCC advises OPH Community Service Team that a review of the patient is required for a transfer of funding.

3. The OPH Community Service Team worker:

- Reviews the patient's situation to determine whether the patient's current care services best meet the patient's assessed need.
- Performs a needs or InterRAI reassessment if necessary.
- Assists with referral of a patient to specialist services if required e.g. specialist palliative care services, suction catheters, vac dressings, oxygen. (Refer to Appendix 2 for Specialist Service contact details).
- Explains the HOP funding rules and Social Security Act requirements to the patients/representative(s) to ensure the patient/representative(s) are fully informed of HOP funding implications.
- Determines a suitable review and/or reassessment date.
- Completes the required OPH Service documentation for HOP funding.
- Administrative funding transfer:
- Forwards the HOP funding documentation to HealthPAC.
- Forwards confirmation of HOP funding to:
  - CCCC for logging
    AND
  - Residential Care Provider (where the patient is receiving residential care services)

5 SupportCare Packages of Care Guide

5.1 'Package of Care' Guide for Care Coordinators

5.1.1 Package of Care – General Information

- This guide is for hospital/hospice and community care co-ordinators responsible for assessing whether or not home-based care services are appropriate for a patient, and the level of services that are required.
- The patient's level of need is identified through the needs or InterRAI assessment.
- Packages of care are intended to be flexible for each patient's circumstances.
- Patients qualifying for SupportCare funding will by definition, require at least a medium level package of care.
- The packages of care outlined in this guide are examples of services that would support medium and high needs patients within their home environment. The services described and the number of hours allocated are a guide only.
- Any exceptions require service manager sign-off (e.g. a package of care that exceeds the maximum value allocation).
- Those patients who are eligible for SC-EOL funding also meet the entry criteria for community palliative care services, and may therefore receive community specialist and/or generalist palliative care services.
- Those patients who are eligible for SC-SMI funding may meet the entry criteria for community palliative care services. Those patients meeting the entry criteria may therefore receive generalist and/or specialist palliative care services.
- For patients discharged from CDHB secondary services, the purpose of the package of care for SC funded patients is to meet the patient's needs within the post discharge period.
- All patients, following discharge from hospital/hospice services, will be contacted by their allocated community care coordinator. Where necessary, their package of care may be altered to meet ongoing care need(s). For some patients, this will include input from the community Occupational Therapist.

5.1.2 Package of Care – Equipment

- Equipment requirements for hospital/hospice patients are identified through an equipment assessment performed by a HSS, or OPH Community Service Team, or NMCPC team Occupational Therapist (i.e. hospital/hospice Occupational Therapist). (Refer to section 4.3.5).
- Equipment requirements for community based patients (e.g. post discharge) are identified through an equipment assessment performed by a community Occupational Therapist. (Refer to section 4.3.6).
- Expected equipment items required by SC funded patients are identified on the 'SupportCare and Palliative Care Equipment List' (Ref. 2073) and cited in section 5.4 of this policy.
- Equipment items required for a package of care are identified on the 'Equipment Request: SupportCare and Palliative Care Patients' (Ref. 2074)
- Any equipment items required as part of a patients package of care that are valued at $50 or less are required to be purchased by the patient / patients family/whanau.
- Standard items listed are those that may normally be included in the patient's package of care.
- Equipment items considered an 'exception' requires the 'Exceptions and Justification' section of the equipment request form to be completed and requires sign-off by a service manager.
- **Refer to sections 3.1.3 and 3.2.3 for home based cares funding rules.**

5.1.3 Package of Care – Specialist Services

- The care co-ordinator developing the package of care is responsible for ensuring that a referral for the patient is made if they require:
  - Specialist NMCPC services
  - Specific service requirements e.g. suction catheters, vac dressings, oxygen. (Refer to Appendix 2 for Specialist Service contact details).
- Specialist services are provided in addition to the home-based packages of care described in this guide.

5.1.4 Package of Care – Changes to District Nursing Service Hours

- Following implementation of the patient's package of care it is acknowledged that the district nursing requirement can frequently vary. To enable flexibility in the package of care, the care coordinator can alter the original district nursing allocation by:
  - Noting the new district nursing details (only) on the 'Summary of Service Coordination' form (Ref. 2077) and faxing the form to the CCCC.
  - The CCCC adjusts the district nursing requirement with the district nursing service provider.
  - The CCCC logs the new district nursing hours and other details where necessary (e.g. if the district nursing service provider has changed).
  - The CCCC provides confirmation to the care coordinator that the patients new district nursing hours can be provided and service provider details.
- Following initial approval of the patient's package of care:
  - A full review and/or reassessment is not required for a change in the DN component alone.
  - Where the DN component requires a substantial change in nursing hours a formal review and/or reassessment of the patient should be undertaken.

Important -

For patients in the last days to weeks of life:

If the DN component needs to increase due to the level of care required to keep them in their home environment, and the increase in DN costs results in the overall package of care cost exceeding the daily bed day rate for hospital level residential care services, the package of care will require further sign-off by a care coordinators service manager

5.2 Moderate Package of Care

Example of service requirements in a Medium Package of Care

Service	Hours Required / Days Required
Household Management	4 hours per week
Personal Cares	3 hours per week
District Nurse	2 hours per week
Carer Support / Respite Care	28 days per year

Important –

Refer to 5.1 'Package of Care' Guide for Care Coordinators

5.2.1 Sign-Off for Moderate Packages of Care

The care coordinator has sign-off authority for packages of care below the cost equivalent to hospital level care.

The total package of care cost **includes**:

- Support services e.g. personal cares, district nursing, household management, respite care, carer support and equipment hire.
- Equipment

The total package of care cost **excludes**:

- Specialist services -
  - Specialist Palliative Care services
  - Other specialist services e.g. suction catheters, vac dressings, oxygen

Specialist services are considered additional services. They are funded separately and independently to SupportCare funding.

(Refer to Appendix 2 for Specialist Service contact details).

5.3 High Package

Example of service requirements in a High Package of Care

Service	Hours Required / Days Required
Household Management	4 hours per week
Personal Cares	14 hours per week
District Nurse	7 hours per week
Carer Support	28 days per year
Respite Care	28 days per year

Refer to 5.1 'Package of Care' Guide for Care Coordinators

5.3.1 Sign-Off for High Packages of Care

The care coordinator has sign-off authority for packages of care below the cost equivalent to hospital level care. Higher cost packages require service manager signoff.

The total package of care cost **includes**:

- Support services e.g. personal cares, district nursing, household management, respite care, carer support
- Equipment hire

The total package of care cost **excludes**:

- Specialist services –
  - Specialist Palliative Care services
  - Other specialist services e.g. suction catheters, vac dressings, oxygen

Specialist services are considered additional services. They are funded separately and independently to SupportCare funding.

(Refer to Appendix 2 for Specialist Service contact details).

5.4 SupportCare and Palliative Care Equipment List (As at 2008)

Standard Equipment:

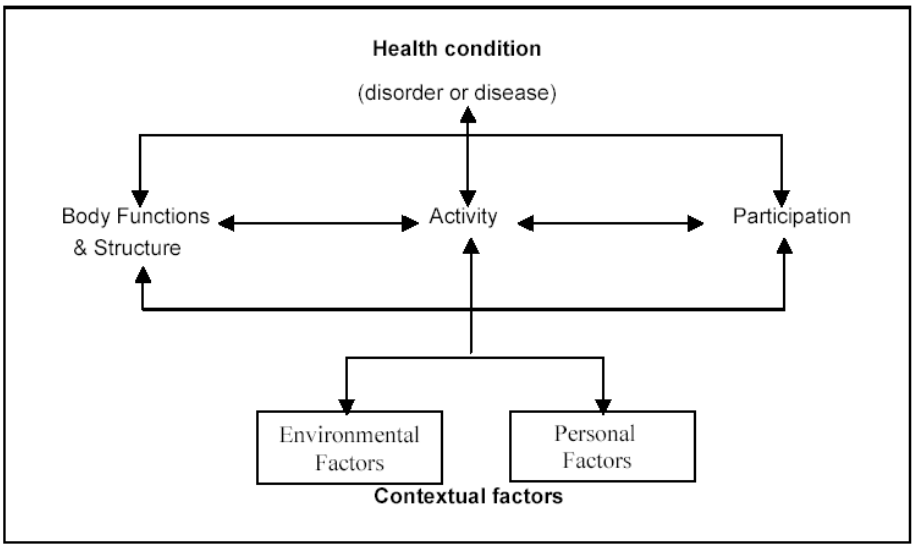
Equipment Item	Code / Catalogue
Electrically controlled armchair	W20R
Back Rest	P25BK
Electric 4 section bed	P2EB
Over bed table	P49NC
Bed rails (pair)	P10BR
Bed cradle	P60BC
Bed loop / lever	P45BC
Silicore mattress overlay	V14M/Q11
Air mattress overlay (E-mattress)	
Basic foam mattress	P15HM
Alova Visco High risk cushion	V64H
Bath board	K10W
Shower stool	K41PA
*Tub transfer bench	K61SH
*Shower chair	K52A
*Wheeled shower chair / commode	G8Z
Chair raisers	O28
Wheelchair (with option of 16/20” width)	NB46T
Jem / Elf hoist	S25FS
Pivot Slings	S131M/S132M–D4
Walking frame	
3-in-1 Commode / toilet frame	H18E
Portable ramp	A15F
Swivel bather	K72SB
Over head pole	P11OP
Slide Board	T74W
Bed pan and carrier	J10B

5.5 Appendix 1

World Health Organisation International Classification of Functioning, Disability and Health (WHO ICF)

See http://www3.who.int/icf/beginners/bg.pdf

The following diagram is one representation of the model of disability that is the basis for ICF



Concepts of functioning and disability

As the diagram indicates, in ICF disability and functioning are viewed as outcomes of interactions between ***health conditions*** (diseases, disorders and injuries) and ***contextual factors.*** Among contextual factors are external ***environmental factors*** (for example, social attitudes, architectural characteristics, legal and social structures, as well as climate, terrain and so forth); and internal ***personal factors***, which include gender, age, coping styles, social background, education, profession, past and current experience, overall behaviour pattern, character and other factors that influence how disability is experienced by the individual.

The diagram identifies the three levels of human functioning classified by ICF: functioning at the level of body or body part, the whole person, and the whole person in a social context. Disability therefore involves dysfunctioning at one or more of these same levels: impairments, activity limitations and participation restrictions. The formal definitions of these components of ICF are provided in the box overleaf.

Body functions are physiological functions of body systems (including psychological functions).

Body Structures are anatomical parts of the body such as organs, limbs and their components.

Impairments are problems in body function or structure such as a significant deviation or loss.

Activity is the execution of a task or action by an individual.

Participation is involvement in a life situation.

Activity Limitations are difficulties an individual may have in executing activities.

Participation Restrictions are problems an individual may experience in involvement in life situations.

Environmental Factors make up the physical, social and attitudinal environment in which people live and conduct their lives.

5.6 Appendix 2 Specialist Service Contact Details

Nurse Maude Specialist Community Palliative Care Services

35 Mansfield Ave
PO Box 36126
Merivale
Christchurch
Phone: 03 375 4274 Fax: 03 375 4267

Canterbury DHB Palliative Care Service

Christchurch Hospital Palliative Care Service
C/- Oncology Services
Riccarton Ave, Christchurch
Private Bag 4710
Christchurch
New Zealand
Phone: 03 3641473 Fax: 03 3640759

Suction Catheters for Respiratory Patients

- Requires a clinician to complete a Respiratory Outreach service request form. Respiratory Outreach obtain sign-off from a Respiratory Physician
- Respiratory Outreach is responsible for logging the receipt of the service request form.

Domiciliary Oxygen

This is provided by Respiratory Outreach on completion of a Respiratory Outreach Service requisition form. This process secures sign-off by:

- A Respiratory Physician; or
- Christchurch Hospital Palliative Care Physician (for palliative care patients);

Phone: 03 364 0167 (internal 88303) Fax: 03 364 0849 (internal 80849)

Canterbury DHB Respiratory Services

Respiratory Outpatients Phone: 03 364 0463
Respiratory Outreach Phone: 03 364 0167

Vac Dressings

Requires discussion and sign-off by:
A Specialist Physician or equivalent;
AND
A relevant service manager (see contact details below):
Clinical Manager, OPH Service
Clinical Manager, Social Work Services
Clinical Manager, Nurse Maude Hospice Palliative and Aged Care Manager