

Care Coordination Centre

Service Specification

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1 Philosophy

This Care Coordination Centre service is designed to align with the strategic objectives of the:

- 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 Maori Health Strategy - 2001
- The Pacific Health and Disability Action Plan - 2002

Taken together these Strategies emphasise the importance of developing services within the primary care and community sector. They embody the principle of consumer focused care where decision making is consumer directed and draws on the consumer's needs, values and goals.

This Care Coordination Service aligns with the vision of an integrated continuum of care embodied by these Strategies, whereby people, their carers, families, and whanau receive coordinated and responsive home and community care that pro-actively supports their ability to achieve their lifestyle goals.

Home and community services will be flexible, focus on best care for the consumer, and support personal, family and whanau wellbeing and positive ageing.

2 Definition

2.1 General

The purpose of the Care Coordination Centre is to assist individuals with health and disability needs to achieve quality, cost-effective outcomes in order to enable them to live as independently as possible. The Centre is charged with ensuring that the dignity and safety needs of the consumer and their family/ whanau are met.

To achieve the outcomes, the Centre is responsible for ensuring good coordination and communication among the providers of health and disability care and support. The process will occur across a spectrum of formal and informal settings including Primary, Community, Secondary, Tertiary care, disability support and wider community and family/whanau based support and involvement.

While the Care Coordination Centre will have clinical staff who will undertake triage, screening and assessment activities, clinical advice beyond these activities will not be available directly from the Centre. However, consumers will be able to access clinical advice from health care professionals normally involved in their care.

2.2 Functions

Single Point of Entry: The Centre will provide a ‘one-stop-shop’ single point of entry to all health and disability care and support, both long-term and short-term, delivered in a home and community setting within the Capital & Coast District Health Board district

Triage: The Centre will triage referrals to the appropriate provider/s.

Screening/assessment: If the referrer has not completed a screen of the consumer, the Centre will undertake this process if a screen/assessment is required.

Care Planning: Acceptance of the referral establishes the Care Plan. Relevant health care professionals and other providers of care and support will subsequently contribute to the care and support plan as required.

Coordination: The Centre will coordinate the care and support provided as part of the care plan to ensure the consumer receives the care in a timely and appropriate manner.

Providing and storing information: The Centre will:

- **store consumer assessment and care and support plan information**
- **provide an information and advisory service for all inquiries related to care and support options within the C&CDHB district**
- **establish comprehensive information systems that enable the understanding, monitoring and planning of care and support provided in the district.**

Managing resources effectively – The Centre will

- **manage flexible funding and direct payment**
- **manage an indicative budget**
- **monitor and report to C&CDHB Planning and Funding on expenditure and utilisation of long-term and short-term home & community care and support.**

2.3 Funding

This service will combine funding for home and community health and disability services at the point of referral, integrating the current funding streams for:

- **Personal Health**
- **Disability Support Services for older people and adults with chronic illness**
- **Mental Health Support Services for older people**

This will cover funding for services including:

- **Home support including personal care and household management**
- **Community therapy/allied health services including occupational therapy, physiotherapy, speech therapy, and social work**
- **Home and specialist community nursing services**
- **Mental Health support services for older people, for example supported accommodation for mental health ‘graduates’**
- **Disability support services for older people including**
- **Respite care and carer/family/whanau support**
- **Day programmes**
- **Aged residential care**
- **Packages of care provided through flexible funding or direct payment**

The Care Coordination Centre will also link with other home based Primary and community care services identified in the care plan, such as GP services, medication management, Maori services and Pacific services, palliative care services and services provided by NGOs, Government, community and voluntary agencies.

3 Objectives

3.1 General

The objectives of the Care Coordination Centre are:

- Improve overall integration and efficiency of services eg. referral processes, discharge planning
- To improve the efficiency and effectiveness of referrals by providing simplified service access.
- Reduce fragmentation of care and services provided to the consumer groups
- Improve the access to community based services by Maori, Pacific and ethnic communities within the consumer groups
- Improve service response to the cultural requirements of consumers, including ethnicity, age, gender, sexuality and disability.
- Improve the overall consumer satisfaction with and access to services
- Improve the overall provider satisfaction with access to and provision of services
- Ensure consumers who have contact with the service have their care needs appropriately assessed
- Improve the overall health and disability outcomes for the consumer groups
- Improve the ability of the consumer groups to maintain their independence
- Improve the appropriateness and quality of care delivered to the consumer groups
- Ensure that services within the scope are delivered in a way that maximises the control that consumers and their family/whanau have over the service and their own lives.
- To increase pro-active intervention with the consumer groups to prevent or delay deterioration which results in increasing levels of care, acute admissions and residential care admissions
- Assist in the implementation of the New Zealand Guidelines for Assessment Processes for Older People

3.2 Maori Health

The service must recognise the particular needs of Maori and the commitment to Maori under the Treaty of Waitangi. Maori have a bigger burden in terms of chronic illness/ co-morbidities at a

younger age than other cultures, but access proportionally less support/health services.

The service must identify and respond to the cultural values and beliefs that influence the effectiveness of care and support for Maori consumers and their whanau. The service will consider appropriateness of care and support and address inequalities in access to and provision of care and support to Maori. The service will work within the whanau-ora framework of He Korowai Oranga Maori Health Strategy, and seek to provide care and support that promote:

- Te taha tinana (physical well-being)
- Te taha wairua (spiritual well-being)
- Te taha whanau (family well-being)
- Te taha hinengaro (mental well-being)
- Te taha matauranga (learning)
- Whanaungatanga (extended family well-being)

3.3 Pacific Health

The service must recognise the particular needs of Pacific people who have a bigger burden in terms of chronic illness/co-morbidities at a younger age than other cultures, but access proportionally less support/health services.

The service must understand and respect the key principles and frameworks outlined in relevant Pacific health and disability strategy documents, including the Pacific Health and Disability Action Plan 2002, and demonstrate a commitment to these principles in the provision of services. The service will consider appropriateness of service and address inequalities in access to and provision of services to Pacific communities

3.4 Other Ethnic Health

The service must identify and respond to the needs of consumers from other ethnic populations eg Asian who also access services disproportionately relative to health need.

4 Service Users

4.1 Inclusions

The service will be provided to the following population resident within the DHB:

Adults over 16 years of age who are resident within the area covered by C&CDHB Wellington, Porirua and Kapiti.

Main Caregivers: A main caregiver is someone who has principal, active responsibility for the ongoing and frequent care of a person with a long term disability or chronic medical condition. Evidence supports the approach of including main caregivers within the definition of service user, as the ongoing status of the main caregiver directly impacts on that of the consumer and their need for care and support. Throughout this service specification, main caregivers of consumers are included as service users where appropriate.

4.2 Exclusions & Linkages

The following will be excluded from this service:

- Children aged 16 years or under in usual circumstances
- Non eligible people who reside outside the Capital & Coast DHB region

There will be instances where clients are eligible for CCC services and are also receiving services (including assessment, care planning and coordination services) funded via other sources. Eg:

- People with specific physical, sensory, intellectual or psychiatric disabilities who need non age related long term disability support services and/or rehabilitation
- Non-age related mental health services for severe mental illness.
- Specialist medical/surgical services
- People receiving services through ACC

In these instances, the CCC will work collaboratively with these services without duplicating the assessment, care planning and coordination which is the responsibility of other services.

5 Access to Services

5.1 Entry

Referral to the service can be by:

- 0800 number
- Fax
- Email – eg for inquiries
- Postal
- In person.

Once a person from the eligible population is registered with the Care Coordination Centre through the referral process, they are deemed to be enrolled with the service, for the purpose of data storage and access, until they become ineligible through moving out of the area or through death. The Health (Retention of Health Information) Regulations 1996 and the Privacy Act 1993 govern this data storage and access.

The Care Coordination Centre has an ongoing role in the consumer's service history, as the CCC will maintain an up to date service record for the consumer at all times while the consumer is eligible for the service. When assessment and service coordination is required, the CCC involvement with the consumer will be active, at other times the CCC will act as a storage depot for the consumers service data.

Therefore, the following sections on Referral and Exit mainly refer to the periods of active involvement of the CCC with the consumer around assessment and service coordination.

5.2 Referral

5.2.1 Referrals to the Care Coordination Centre

Referrals can be made to the Centre through self-referral or from any other source, including but not limited to:

- Consumers/ families/whanau and carers
- Primary health care providers
- General practitioners
- Home and community therapy & community care providers
- Specialist services for older people
- Acute hospital services

- Residential care
- Palliative services
- Rehabilitation services
- Maori services
- Pacific services
- Mental health support services
- Community, voluntary and non-government organisations
- Support groups/field workers
- Other Government departments or local body agencies

Referral to the Care Coordination Centre should be timely, with a preventive, habilitation/rehabilitation focus, and should be considered in relation to formal and informal care and support. It will include (but not be limited to) referrals for the following scenarios, either individually or combined:

- Specialist assessment
- Home support including personal care and household management
- Community therapy/allied health services including occupational therapy, physiotherapy, speech therapy, and social work
- Home and specialist community nursing services
- Mental Health support services for older people, for example supported accommodation for mental health 'graduates'
- Disability support services for older people including:
 - Respite care and carer/family/whanau support
 - Day programmes
 - Aged residential care
 - Packages of care provided through flexible funding or direct payment
- NGO/volunteer/community based formal and informal support

5.2.2 Care Coordination Centre Triage Processes

The Centre has a role in facilitating access to care and support, prioritising and allocating health and disability resources and is required to set and adhere to consistent and transparent processes for priority setting and associated resource allocation. The Centre, in keeping with NZ Health and Disability Strategies, will promote self-determination, quality of life and an environment that enables community participation and maximum independence for consumers. C&CDHB's relevant health and disability services policies and processes will guide these processes. The Centre should:

- meet the safety needs of consumers and the community
- promote equity for people to achieve similar outcomes for similar needs and circumstances

- be effective, including recognition and accessing of appropriate care and support for consumers
- support the continued needs based shift from institutional to community-based care and support
- work with consumers to identify care and support solutions from a wide variety of community based options
- be efficient and effective, including creative and innovative use of resources to meet needs
- work to demonstrate overall benefits to people and as a result, establish greater trust and credibility in the needs assessment and service coordination process
- work within the funding and policy boundaries of the funder when allocating public resources.

Referrals will be processed within one working day. Where there is uncertainty about aspects of the referral the Center will gather further information including assessment of the client where necessary. The Care Coordination Centre triage/screening process may include consultation with the referrer, consumer, their main caregiver/family/whanau, health care professionals and others providing care and support to the consumer as appropriate.

The timeframe for the CCC initial contact with the consumer for screening/assessment purposes will be determined by the urgency of the referral. Initial contact with the consumer may be by phone, letter or visit. The type of contact will be determined by the nature of the referral i.e. urgency.

5.2.3 Prioritisation

Prioritisation of onward referrals should be considered in relation to:

- Consumer's immediate clinical and/or support needs
- Consumer and/or their main caregiver safety is compromised
- Consumer and/or their main caregiver has risk factors for decline in physical health and function, safety, polypharmacy, mental health or social functioning and support
- Consumer has recently experienced a 'break down' in services/support network
- Consumer has a recent history of avoidable or unplanned admission(s) or A+E attendances
- Consumer has a recent history of falls or significant risk factors for falls.
- Consumer is a high service user who has not had a comprehensive assessment in the last six months e.g. has high use of primary care, has high care package at home, has several yearly in-patient admissions

5.2.4 Inter-Region Transfers

Within the specified C&CDHB geographic area, the Care Coordination Centre is expected to provide service to all consumers within the defined population groups, wherever they live.

To ensure continuity of service for consumers both moving into, and out of the C&CDHB region, the Centre will establish protocols and procedures with needs assessment and service coordination providers, and other health and disability service providers, in other areas of New Zealand. Such protocols will include:

- process for the development of a transfer plan
- the timely transfer or receipt of relevant information including assessment and care planning records to/from the new provider/s subject to the provisions of the Privacy Act
- immediate commencement of essential services according to the incoming consumer's transferred care and support plan until such time as a reassessment or review of the care and support plan are undertaken by the C&CDHB Care Coordination Centre
- timely needs assessment and review of the consumer's transferred care plan

In the event of the consumer leaving the C&CDHB area for a short period, e.g. for a holiday, work, study, etc, the Centre retains responsibility for ensuring that the consumer's needs continue to be met as outlined in the care plan.

5.3 Exit

A consumer will move from active to inactive service involvement with the Centre in the following situations:

- All goals, needs and risks effectively addressed within resources
- Risk factors are eliminated/managed within resources
- Consumer able to self-manage without Care Coordination Centre input or monitoring.
- Consumer discharged from active Care Coordination Centre service to ongoing oversight of their health status within primary care
- Consumer declines further service input

At all other times, while the consumer is resident within the C&CDHB district, the Centre has an ongoing role in the consumer's service history, acting as a storage and access depot for the consumer's service data. The consumer becomes ineligible and will be discharged from the service by moving out of the C&CDHB district.

5.4 Time

The Centre will be open from 8am to 6pm seven days a week.

Outside these hours, the Centre will provide an urgent response referral service and have available a 24 hour emergency call system through which consumers, their caregiver/family/whanau can access appropriate care and support when required. This service will align with emergency service cover provided in the C&CDHB district, eg: Healthline, A & M service, emergency department.

To fulfil this function the Centre will need to have agreements in place with providers of care and support to be able to source community based crisis response options.

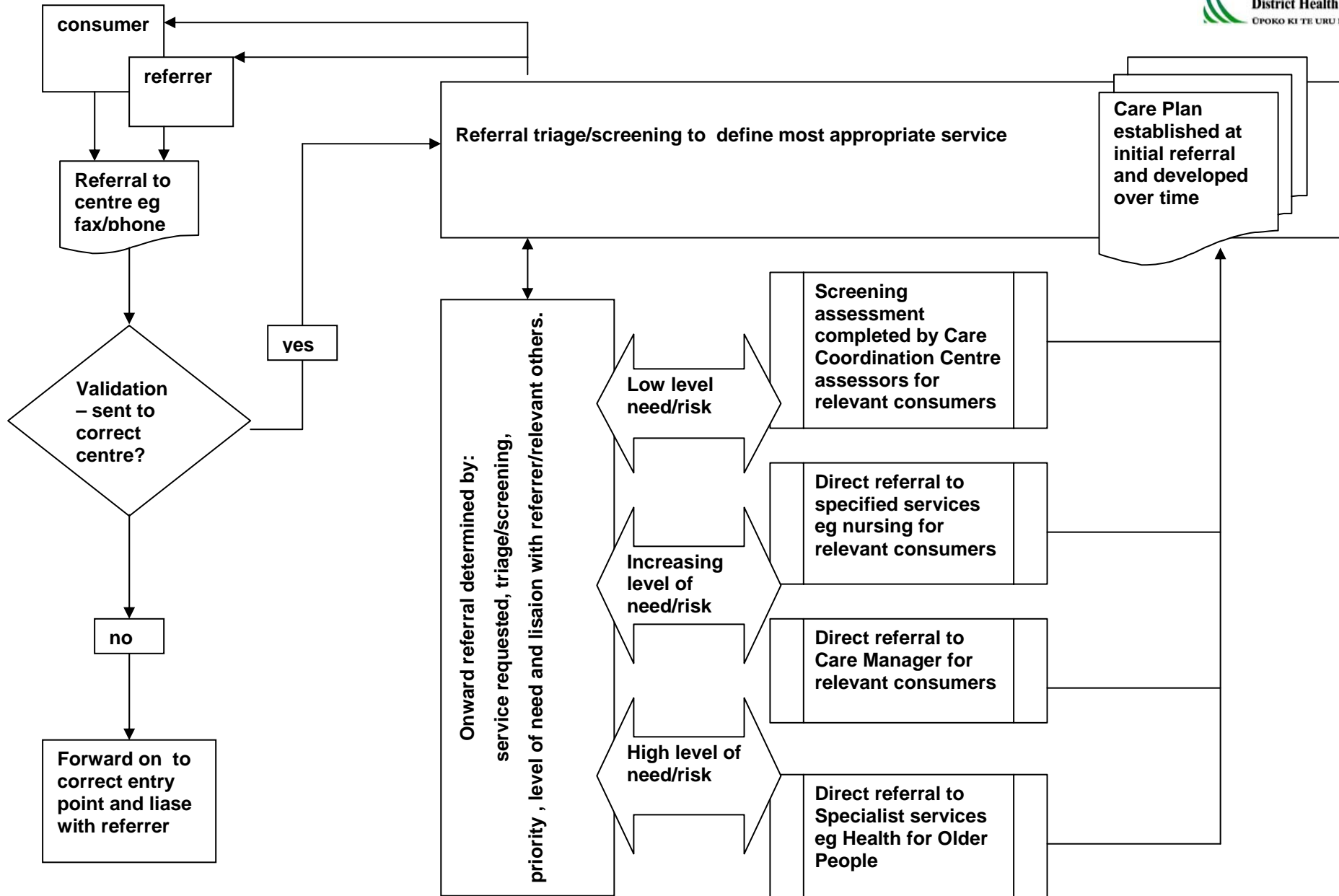
6 Service Components

The service is governed by a number of NZ Regulations and Legislation, specifically:

- Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996
- Health (Infectious and Notifiable Diseases) Regulations 1966
- Health (Retention of Health Information) Regulations 1996
- Health and Safety in Employment Regulations 1995
- Human Rights Regulations 1993
- Privacy Act 1993
- Health Practitioner Competency Assurance Act 2003
- Health and Disability Services (Safety) Act 2001
- Health Information Privacy Code 1994

The service will use the InterRAI suite of tools as the agreed standard assessment tool/s when undertaking all screening and assessment.

The following diagram broadly shows the overall information & process flows to and from the Care Coordination Centre. The processes, information flows and linkages are expanded upon in the subsequent sections.



| Service Component | Description |
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| Referral Management | <p>Definition: This is a process whereby referrals to the Centre will be validated, logged and triaged.</p> <p>The Centre will operate an effective and efficient system to receive, document, prioritise & allocate all referrals into the service. The Centre will have written documentation detailing the process for managing referrals.</p> <p>This system will be operated by staff who are knowledgeable about the scope and nature of the Care Coordination Centre service.</p> <p>The Centre will have a process in place to notify relevant providers eg PHO/GP when a referral is made through another source, eg: self or family referral</p> <p>The service will provide standard documentation for referrers to use.</p> |
| Referral validation | <p>Each referral will be validated against criteria (eg; not ACC, consumer over 16 years, etc.) to ensure that the Centre is the appropriate response to the referral.</p> <p>Where there is uncertainty about aspects of the referral the Center will gather further information, including assessment of the client where necessary.</p> <p>Referrals for service that cannot be coordinated by the Care Coordination Centre will be forwarded on to the appropriate service and the referrer informed, eg: housing issues.</p> <p>Once a referral has been accepted by the Care Coordination Centre, this signifies the establishment of a Care and Support plan for the consumer that will be developed over time with input from other providers as required.</p> |

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| <p>Triage Screening</p> | <p>+ The Centre's clinical screeners will utilise a clearly structured decision tree to determine the most appropriate response and prioritisation for the referral. This process may involve consultation with:</p> <ul style="list-style-type: none"> • the referrer • consumer • caregiver/family/whanau • other health care professionals already involved with the consumer • other appropriate sources (both formal and informal) <p>to establish relevant information and advice regarding the consumer's goals, needs, risks, on-going care and previous history.</p> <p>The Center will undertake screening using an agreed standard tool based on the InterRAI suite of tools. In the future in many cases the referrer (eg GP, hospital ward staff) may include an initial screening assessment as part of the referral (using the InterRAI agreed standard screening tool supplied by the Centre).</p> <p>Once screening/triage has been completed, the Centre will:</p> <ul style="list-style-type: none"> • record referral data • forward the referral to the appropriate provider(s) • record referrals against relevant events • generate review date(s) <p>The timeframe for onward referral will be determined by the nature of the referral, Eg: urgency.</p> <p>A clear procedure will exist to assign unclear/uncertain referrals. This may include gathering more information, and, if necessary, assessing the client and/or their caregiver/family/whanau so that an informed decision can be made based on the client's needs, goals and risks and those of their caregiver/family/whanau.</p> <p>The Centre will notify the referrer, the consumer and any other relevant person eg: GP, of the outcome of the referral and the review date.</p> <p>In the case of a self or family referral, the Centre will notify the consumer's normal lead Primary carer, eg: GP, that a self referral has been made. Once assigned to appropriate service(s) the referral will be tracked until closed by provider(s).</p> |
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The following sections will consider processes following triage/screening. The Centre is responsible for completing assessments, using the InterRAI suite of tools, and for developing and coordinating the care and support plan based on the screening and assessment. This is described in section 6.2.1. and 6.2.2.

For consumers who have high levels of acuity or complexity of need that require specialist intervention, the Care Coordination Centre will forward referrals on to the appropriate health care professionals and/or other providers of care and support. The role of the Care Coordination Centre will be to hold assessment summaries from those providers and to hold and possibly coordinate the overarching care and support plan developed across those providers. This is described in section 6.3.

| Assessment & care planning processes completed by care coordination centre assessors | |
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| Consent | <p>Written informed consent will be sought from the consumer at the outset of the intervention in compliance with the requirements of the Code of Health and Disability Services Consumers' Rights 1996 and other relevant legislation.</p> <p>When assessing Maori, whānau will be involved in the consent process, according to the consumer's wishes.</p> <p>For Pacific peoples, consent is seen as a dynamic relationship, rather than a one-off event, and should be revisited at times while the consumer is in contact with the service</p> |
| Assessment & care planning | <p>The assessment will be an objective process using the InterRAI suite of tools, and will not be driven by the availability of resources. It will clearly identify the consumer's goals, needs and risks and those of their caregiver/family whanau. Goal assessment will be a key element of the assessment.</p> <p>Assessments will be conducted in the environment most appropriate to the individual consumer. The choice of environment will be determined taking account of the consumer's level of risk and the consumer's choice.</p> <p>The Centre will ensure that the consumer and their caregiver/family/whanau understand the assessment process. The assessment processes will take account of the cultural requirements of consumers, including ethnicity, age, gender, sexuality and disability, and will include advocacy and support services as required. The Centre will take into account ethnicity and language requirements of consumers and will endeavour to address these.</p> <p>The assessment process will take account of Maori cultural requirements, and will make use of Maori</p> |

assessors/assistance/advocates who understand health and disability services and conditions, as required by Maori. Where a Maori assessor with the necessary skills is not available, assessors will be supported by someone who is fluent in te reo Maori me ona tikanga and who is well known and respected in the community.

The assessment process will take account of Pacific cultural requirements, and if required during assessment, will make use of Pacific assessors/assistance/advocates who understand health and disability services and conditions.

Where a Pacific assessor with the necessary skills is not available, assessors will be supported by someone who is fluent in the language and culture of the consumer, and who is well-known and respected in the community. The consumer or their delegated advocate/ representative will sign off the completed screen/assessment and receive a copy.

Care and support coordination may need to commence prior to the completion of the assessment. Access to care and support services that are required to maintain the safety and/ or dignity needs of the consumer will not be delayed where the completion of the needs assessment is subject to delays.

The Centre will identify and facilitate access to assessors funded by other government departments e.g. education, vocational as appropriate.

The Centre will ensure it operates within the Assessment Processes for Older people Guideline 2003. In line with this requirement, the Centre will be aware that evidence shows that screening/assessment must be followed by timely and effective interventions and regular follow-up to produce positive outcomes for consumers.

Accordingly, the Centre will have strategies in place to work with the consumer and their caregiver/family/whanau, health care professionals and other providers of care and support to ensure they fully understand and agree with the recommendations of the assessment and to promote concordance (as described in the Guideline) and implementation of recommendations for care and support planning that arise as a result of screening/assessment.

When the assessment is carried out by Care Coordination Centre staff or by a Care Manager, the Centre will ensure an occupational safety and health risk assessment is undertaken and documented at the earliest opportunity to minimise the risk of harm occurring to the consumer or providers during the provision of care and support. The risk assessment will meet OSH regulation requirements and will include an environmental risk assessment and a risk assessment for any manual handling tasks required.

Care Plan

The Centre will work with the consumer and their caregiver/family/whanau to find solutions, and will consider a wide

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| | <p>range of options to address their goals, needs and risks, including formal and informal, facility and community based care and support. This will include referral on to other services for more detailed assessment as required.</p> <p>In consultation with the consumer and their caregiver/family/whanau, the Centre will develop a goal orientated care and support plan that will address consumer’s risk factors, optimise functional level, prevent deterioration and maximise self-management in a way that achieves the defined goals and meets the assessed needs of the consumer and their caregiver/ family/whanau. The care and support plan will identify specific interventions, outcomes, goals, responsibilities and timeframes and will govern access to community based services, acting as a shared communication, planning and monitoring/outcome tool. The development of the care plan will involve consultation with health care professionals and other appropriate sources (both formal and informal) of information and advice regarding the consumer’s needs.</p> <p>In developing the care plan, the Centre will take account of the cultural requirements of consumers, including ethnicity, age, gender, sexuality and disability, and will endeavour to address these.</p> <p>The care plan will also detail the processes to be followed in response to episodes that occur outside normal working hours. This will cover the processes the consumer, their caregiver/family/whanau, health care professionals and other providers of care and support will follow in this situation, and will include appropriate contact details.</p> <p>Occupational safety and health risk assessments (including any OSH risk assessments undertaken by a contributing service) will be included in the consumer’s care plan. The Centre will have a procedure in place for documenting new risks as they arise and reporting them to staff and contributing services. Risk assessments will be updated as appropriate and will be reviewed immediately where an accident or incident occurs. The Centre will ensure that risk assessments will be accessible to all those providing care and support to the consumer, including formal and informal providers.</p> <p>The consumer or their delegated advocate/ representative will sign off the completed care plan and receive a copy.</p> <p>The Centre will also promote a holistic, preventive, habilitation/rehabilitation model of care and support, eg: promoting this model to consumers/families/whanau, formal and informal care and support providers, residential facilities and community support services etc.</p> |
| <p>Coordination, monitoring, review and evaluation of the Care and</p> | <p>The coordination, monitoring, review and evaluation of care and support plans, developed for consumers across a range of services, are key functions of the Care Coordination Centre.</p> <p>As noted in section 6.1.1 acceptance of a referral by the Care Coordination Centre initiates a care and support plan. The care and support plan will govern access to community based services, and will become a shared communication,</p> |

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| <p>support plan</p> | <p>planning and monitoring/outcome tool. Once a referral has been accepted by the Centre it will be allocated to a specific case owner within the Care Coordination Centre, eg: service coordinator. The case owner will remain the principle contact within the Care Coordination Centre for the consumer, their caregiver/family/whanau, care managers, health care professionals and others providing care and support throughout the Centre’s active involvement with the consumer.</p> <p>Following onward referral from the Centre, health care professionals and other providers of health and disability care and support will contribute further to the development of the care plan as appropriate. Each provider will supply the Centre with assessment summaries and details of the care plan defined by that provider.</p> <p>The Centre is responsible for receiving and storing the care plan that health care professionals and other providers of care and support supply, and coordinating the care plan in collaboration with them. The Centre is responsible for updating the copy of the care plan that is held by consumers as appropriate.</p> <p>For all referrals, the Centre will coordinate care and support that will result in a timely and integrated process to address the assessed needs of the consumer and their caregiver/ family/whanau. The realistic achievement of the consumer’s defined goals will drive the approach and determine prioritisation of resources.</p> <p>This includes ensuring the information and recommendations that arise from the ongoing review and evaluation of the care plan are stored, and alterations to the care and support plan are coordinated, resulting in the consumer receiving ongoing care and support that meets their assessed needs in a timely and appropriate manner.</p> <p>The Centre will facilitate a process to ensure that the care and support is provided in the most appropriate setting for the consumer, and will ensure that the consumer and their caregiver/family/whanau understand the manner in which the care and support plan will be delivered.</p> <p>Primary Care: The Centre will have policies and procedures in place to work effectively with the Primary Health Care practitioners who have ongoing responsibility for the oversight of the consumer’s health status, to ensure they are appropriately informed and involved in the consumer’s care and support.</p> <p>Secondary Care: The Centre will have policies and procedures in place to cover the coordination of community based care and support for consumers who experience planned or unplanned admissions to Secondary Care. This will cover admission and discharge, and will include the coordination of information relevant to the consumer. Eg: the Centre accesses the HHS Clinical Information System and the Patient Admission System on a regular basis in order to respond to admission and discharge coordination requirements.</p> <p>Standard Packages of Care: the Centre will develop standard packages of care for common conditions and routine</p> |
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situations, working in conjunction with the appropriate services.

These packages will be rehabilitation-focussed and based on clinical pathways and best practice. As far as possible these packages will enable resources to be tailored flexibly to meet individual need within a set maximum expenditure. Appropriate review periods will be built into specific packages of care.

Entry to Aged Residential Care: For clients who require entry into aged residential care, Capital and Coast DHB delegates the authority to the CCC to undertake clinical assessments required by Social Security Act 1964 and other statutes. Entry to aged residential care is only appropriate when there are no other home and community based options which are adequate. At a minimum a Care Manager assessment and CCC team leader approval is required before a client is referred to aged residential care, or their level of residential care increased (eg., rest home to hospital level).

Flexible Funding and Direct Payment: The Centre is able to use up to 1% of the annual indicative aged residential care budget to purchase services from providers which are not contracted through the DHB (flexible funding) and/or provide clients with individualised funding so that they can arrange and pay for the agreed services themselves (direct payment). Such services must only be used on a one-off / ad hoc basis where usual formally contracted services are not the best option for helping clients to meet their goals. Flexible funding and direct payment may be particularly useful options for supporting Maori and Pacific people where culturally appropriate service solutions are not available.

Consultation should occur with C&C DHB before coordinating flexible or direct funding arrangements which may raise financial, perception, precedent or other sensitive issues. In each instance, the Centre will forward all relevant details to: Contract Manager, Aged Care/Disability, Planning and Funding, Capital and Coast DHB, Private Bag 7902, Wellington. C&C DHB will then enter into agreement with the provider/individual for the proposed services. The Centre will verify all invoices for services provided through flexible funding before submitting the invoice to C&C DHB for payment. This arrangement can be reviewed at any time within the first 12 months of the contract, and will be formally reviewed at 12 months.

Monitoring and Review: The Centre will, in conjunction with health care professionals and other providers, monitor the care and support being provided, to assess the effectiveness, acceptability, and appropriateness, and will ensure that the systematic reassessment of the consumer's needs and status is carried out as required. The monitoring and review will be based on appropriate timeframes. The review timeframe will be 6 weeks for short term care. Timeframes for review for consumers with longer term needs will be indicated by the consumer's needs, but should not be more than 6 months, unless this function is superseded by contracts with other service providers. This is provided always that the consumer, their caregiver/family/whanau, health care professionals and others providing care and support may at any time seek a review of the care and support plan if they feel the needs of the consumer and/or their main caregiver are not being met.

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| | <p>The Centre will coordinate appropriate referrals based on the outcomes of monitoring and reviews or as indicated by a change in the status of the consumer or their care giver/family/whanau.</p> <p>Key workers: In the case of some people with chronic medical conditions, it may be more appropriate that their services are coordinated by a health care professional/key worker in another service, such as the GP, hospital physician or palliative care nurse. In these cases the Centre will act as a central point of information about the consumer, their key worker and the care and support they are receiving.</p> |
| <p>Provider monitoring</p> | <p>The Care Coordination Centre will implement a process of monitoring:</p> <ul style="list-style-type: none"> • negotiated and actual delivery timeframes • actual delivery to the care and support plan as negotiated between the Centre, health care professionals and other care and support providers. • whether service providers are able to meet the needs of the consumers during service delivery. The Centre might, for example, comment on the willingness of the provider to understand the needs of the consumer, their caregiver/family/whanau and be flexible, within reason, in how these are met • gaps in services available from providers • any unresolved issues, problems or complaints and significant risks with service delivery by providers. <p>The Centre will report to C&CDHB Planning & Funding any major risk or complaint within 24 hours of it occurring.</p> |
| <p>Discharge planning</p> | <p>Planning for discharge from the Care Coordination Centre service will take place as a collaborative process involving the consumer, their caregiver/family/whanau, health care professionals and others involved in the care and support as appropriate.</p> <p>Discharge planning will be appropriate when:</p> <ul style="list-style-type: none"> • the consumer becomes ineligible by moving out of the C&CDHB region • when the consumer no longer needs the service • the consumer declines service <p>The care and support plan will be updated with all discharge details. When the consumer is moving out of the C&CDHB district, this will include which region the consumer has moved to and which service provider will have ongoing oversight of the consumer's health status.</p> <p>Discharge will involve a hand-over to the service provider who will have ongoing oversight of the consumer's health and disability status.</p> |

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| | <p>On completion of discharge the consumer's data and a discharge summary of the service and outcomes achieved will be sent to the service provider who will have ongoing oversight of the consumer's health and disability status. Eg: PHO. The consumer will receive a copy of this information. When all interventions by all providers are concluded, all relevant events will be closed.</p> |
| Appeals | <p>The Centre will make available to all consumers, and their caregiver/family/whanau, information detailing the procedure by which they may request a review of a part or the whole of the assessment and service co-ordination process. Such procedures are to include the following elements:</p> <ul style="list-style-type: none"> • Ability to screen out or resolve through discussion complaints arising through misunderstandings • Undertake a further assessment or a new support plan using assessors not involved in the previous assessment • If the consumer and/or their caregiver/family/whanau remain dissatisfied then they will have access to a second level of review within the Centre – to be defined in the Centre's Complaints Procedure. <p>The above steps to be at the Centre's expense.</p> <p>If a complaint still exists the consumer may appeal to the funder. The Standard Appeals Procedure provided by the funder will be followed.</p> |
| Budget Management | <p>The Care Coordination Centre is responsible for managing a defined indicative budget on behalf of C&CDHB, based upon an annual allocation, for home and community health and disability services. This will include individualised funding for some clients and direct payment.</p> <p>The Centre will operate a system of budget monitoring, data gathering and analysis, and reporting back to referrers and providers to ensure that commitments made to purchase care and support packages for consumers are such that they will not exceed the indicative budget for the current and out years.</p> <p>The Centre will provide documentation to C&C DHB that tracks expenditure against budget streams.</p> <p>Where they exist, the Centre will observe Memorandums of Understanding between C&CDHB and other Government funders and agencies e.g. ACC, SES, CYFS and WINZ. The Centre will also have in place protocols with providers defining areas of responsibility for providing integrated access to care and support.</p> <p>The consumer service record will also contribute to the administrative process for validation of provider invoices. The Centre will have the capacity to make provider payments.</p> |
| Information advisory and | <p>Specific Consumer Information: The Centre will store consumer assessment and care and support plan information & manage for risk factors for multiple interventions. Coordination information will be stored and transferable to integrated</p> |

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| <p>resource function</p> | <p>providers to facilitate continuity of service. The Centre must ensure confidential and secure storage of all client information.</p> <p>The Centre will provide sufficient information to enable care and support providers to do their job and will establish an information transfer protocol with referral agencies to facilitate ease of transfer, efficacy of service coordination and aid administration. This includes the transfer of consumer information and service information that may be used by health care professionals and care and support providers as they plan their services e.g. information on trends, un-met needs, service gaps etc, for the purpose of fostering creative, innovative, flexible services.</p> <p>General Information and Advice: The Centre will distribute information about the Care Coordination Centre service, ensuring that it is widely known and is in a style and format that is accessible and appropriate to people of all cultures represented in the C&CDHB district.</p> <p>The Centre will provide an information and advisory service for all inquiries related to care and support options within the C&CDHB district. The information will be easily accessible and will be provided in formats that meet the needs of the C&CDHB population eg: translated, large print, audio tape, Braille, etc.</p> <p>To facilitate this process, the Centre will compile and store up-to-date information on services and care and support options within the C&CDHB district and act as an information broker, referring and advising people where further information can be obtained.</p> <p>It is expected that general information will be readily available to the client and their caregiver/family/whanau on:</p> <ul style="list-style-type: none"> • Medical conditions which result in long term support needs Disabling conditions • Eligibility and entitlement to financial assistance, and benefit information • Comprehensive details of nature, type and quality of care and support available – both care and support accessed through the Centre and available from other sources. • How to access those that care and support • Expected outcomes and approximate costs <p>The Centre is not expected to compile and duplicate specific detailed information already available from other information agencies. However the Centre will need to maintain effective networks and linkages with a wide range of appropriate organisations in order to keep up to date and reliable information from which to advise and make referrals.</p> <p>The service will log all general inquiries made. If the inquiry is related to a current referral, this and any action will be noted against the referral event. At a minimum this will include:</p> |
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| | <ul style="list-style-type: none"> • Name of inquirer • Reason for inquiry • Contact details • Information given/action taken |
| Service development | <p>The Centre will establish and maintain a process to ensure the ongoing participation of the local community. This will include the involvement of consumers, caregivers, families, whanau, hapu, iwi and advocacy groups in the effective development and delivery of the service.</p> <p>The Centre will actively involve Maori advice and perspectives at all levels of the organisation when developing services and models of delivery.</p> <p>The Centre will actively involve Pacific advice and perspectives when developing services and models of delivery.</p> <p>The Centre will actively involve the advice and perspectives of other cultural groups significantly represented in the C&CDHB region when developing services and models of delivery.</p> |
| Information systems | <p>The Centre will develop a comprehensive information system that records and stores consumer information from assessment & referral to review & exit. This will include at a minimum the InterRAI suite of tools. The Care Coordination Centre will provide access to its information systems to facilitate sharing of assessment, care plan and discharge information to appropriate providers.</p> |
| Employment, Training and Monitoring of Care Managers | <p>While the Care Managers are located within the Care Coordination Centre, the Centre will:</p> <ul style="list-style-type: none"> • manage the ongoing recruitment and employment of Care Managers • provide adequate and appropriate training and supervision for Care Managers. This will involve competency in relation to: <ul style="list-style-type: none"> – InterRAI suite of tools – assessment – client and carer goal setting and goal attainment – care planning – resource management • provide the necessary ongoing guidance and mentoring of Care Managers • oversee the workload of Care Managers • provide the necessary clinical supervision for Care Managers • monitor Care Managers' performance and resource management • initiate and manage the Care Manager's quality assurance programme |

7 Key Inputs

The Centre will:

- have competent clinical screening & coordination staff to enable accurate identification and triage of referrals and screening. Staff undertaking clinical triage and screening/assessment will have an appropriate clinical qualification and clinical experience.
- have adequate staff to meet all the processing and timeframe requirements and to process all referrals within 1 working day of receipt of the referral.
- have at least one Maori and one Pacific Care Manager FTE and appropriate screening and coordination staff to address the needs of Maori and Pacific clients
- have an integrated information system that captures client-level information on all significant aspects of care and support provided within the C&CDHB district.
- Have adequate systems and processes for providing regular reports from this system and for accessing information from related systems. Eg: HHS Clinical Information System, Patient Admission System.
- have an exceptional circumstances process to enable crisis / urgent referrals to be sent from the referrer direct to the provider, or implemented directly by the provider then accepted and processed by the Centre in retrospect
- have policies and procedures in place to deliver adequate supervision and training for staff, and continuous quality improvement
- have appropriate systems in place to collate and submit client eligibility information to HealthPAC in a timely manner to ensure providers receive payments for services.

8 Service Linkages

The Care Coordination Centre will establish and sustain effective relationships with other organisations providing services to the eligible population. These relationships will reflect the profile of the population and their communities and will include Primary, Secondary, and Tertiary health services, community organisations, voluntary groups, support service providers, and other public sector agencies.

The Centre will assist people to access care and support not only from providers contracted by the funder, but also from other providers and services available within their community. This should include those contracted with other funding bodies. Particular attention should be given to establishing effective working relationships that will ensure people are aware of and understand the processes for referral and services available through the Care Coordination Centre.

C&CDHB will require the Centre to provide evidence of the effectiveness of relationships. For key agencies or providers, the Centre should have in place Memorandums of Understanding, Protocols and other liaison mechanisms that agree how the relationship will be conducted. These will be an area for audit.

The Centre will also need to provide evidence of effective linkages with the community, involving Maori, Pacific Peoples, disability groups, support networks and advocacy groups. Relationships will be managed in a way that has regard for the interrelationships that exist between consumers and their social support systems.

The Centre is required to demonstrate particular links with the following services, for which separate service specifications may apply:

| Service Provider | Nature of Linkage | Accountabilities |
|------------------------------------|---|--|
| <p>Care Manager Service</p> | <p>Manage referrals liaise and work with this service to coordinate the care and support plan and ensure a seamless continuum of care for the consumer.</p> | <p>The Care Coordination Centre (CCC) is responsible for forwarding/generating referrals to Care Managers in a timely manner with appropriate information.</p> <p>Care managers are responsible for acknowledging and responding to referrals from the CCC.</p> <p>Care Managers are responsible for lodging summaries of relevant assessment and care plans with the CCC.</p> <p>The CCC is responsible for receiving and storing summaries of relevant assessment and care plans from Care Managers.</p> <p>The Care Manager is responsible for educating the consumer and their caregiver/family/whanau with regard to their assessed needs and the usefulness and effectiveness of the appropriate care and support available.</p> <p>The CCC is responsible for coordinating the care and support plan to ensure the consumer receives the care in a timely and appropriate manner.</p> <p>Care Managers are responsible for ensuring updates of assessment and care plans are communicated to the CCC</p> <p>The CCC is responsible for ensuring that updates of assessment and care plans are stored and coordinated following any monitoring and review of care plans.</p> <p>The Care Manager is responsible for liaising with the consumer, their caregiver/family/whanau, health care professionals and other providers involved in their care and support, to ensure the consumer receives care that meets their needs in a timely and appropriate manner.</p> <p>The CCC is responsible for liaising as necessary with the consumer, their caregiver/family/whanau, health care professionals and other providers involved in their care and support, to ensure the coordination of care and support results in the</p> |

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| | | <p>assessed needs of the consumer being met in a timely and appropriate manner.</p> <p>Care Managers are responsible for informing the CCC when discharge from the service is appropriate and ensuring that all relevant details for on going care are specified for the CCC to action.</p> <p>The CCC is responsible for receiving discharge notification from Care Managers and storing discharge information on the consumer's file.</p> <p>The CCC is responsible for establishing services for discharge and ensuring that the ongoing oversight of the consumer's health status is transferred to their PHO/lead Primary carer.</p> <p>The CCC is responsible for:</p> <ul style="list-style-type: none"> • managing the ongoing recruitment and employment of Care Managers • providing the necessary training for Care Managers • providing the necessary ongoing guidance and mentoring of Care Managers • overseeing the workload of Care Managers • providing the necessary clinical supervision for Care Managers • monitoring Care Managers' performance • initiating and managing the Care Manager's quality assurance programme |
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| <p>Information technology support services for service providers eg HHS, PHOs</p> | <p>Provision of access to relevant patient admission information and clinical information to assist with coordination of care and clinical screening</p> | <p>Linkages should be developed between the CCC and other service providers to cover:</p> <ul style="list-style-type: none"> • Access to information systems to facilitate sharing of assessment and care plan information, discharge information and planned/unplanned admission information. <p>Access to information will be managed in accordance with the C&CDHB Information security policy C&CDHB Version 1.0 June 2001 and Health Information Privacy Code 1994</p> |
| <p>ACC</p> | <p>Liaise and work with ACC as appropriate eg: Case Manager or contact centre, to ensure a seamless continuum of care for individual consumers.</p> | <p>The Centre is responsible for establishing appropriate links with ACC and liaising with ACC representatives regarding the coordination of care and support to ensure the consumer receives care that meets their needs in a timely and appropriate manner.</p> |
| <p>Equipment management services. Eg ENABLE NZ & hospital short term equipment management services</p> | <p>Liaise and work with to share relevant information</p> | <p>The CCC is responsible for establishing appropriate links with agencies as required to ensure relevant information is held on the consumer care plan</p> <p>The CCC is not responsible for equipment ordering/delivery/management</p> <p>Equipment agencies are responsible for equipment ordering/delivery/ management</p> |
| <p>Other government departments and local body agencies, eg: WINZ, Family Court, Council housing services,</p> | <p>Liaise and work with these services as appropriate to ensure a seamless continuum of care for individual consumers.</p> | <p>The Centre is responsible for establishing appropriate links with agencies involved in the formal and informal care and support of the consumer. The Centre will liaise with the consumer, their caregiver/family/whanau and the services to ensure the consumer receives care that meets their needs in a timely and appropriate manner.</p> |

Significant interfaces will exist with, but will not be limited to:

- **Consumer support/advocacy services, including Maori and Pacific support/advocacy services**
- **HealthPAC**
- **Chaplaincy**
- **Citizens Advice Bureau**
- **Disability Information Centres**
- **Interpreting services**
- **Maori community care services**
- **Other appropriate Maori organizations**
- **Pacific community care services**
- **Other appropriate Pacific organisations**
- **Other ethnic/cultural advocacy/support groups**

9 Information Requirements

The Care Coordination Centre will, at a minimum, record the following information per consumer:

| Demographic Details | Referral Details | Assessment and Care and Support Plan Details | Financial Details |
|---|---|--|--|
| <ul style="list-style-type: none"> * Patient NHI * Patient ACC number if applicable * Patient Name * Patient Date of Birth * Patient Gender * Patient Ethnicity * Contact Details * Emergency contact details * Next of kin/carer details including contact details * Residence type * Known access/safety issues * Preferred language * GP details * PHO details | <ul style="list-style-type: none"> * Referral source * Referring Practitioner Name or name of referrer * Referring Practitioner Registration Number (where possible) * Date of referral to service * Reason for Referral (problem/issue/diagnosis) * Known Previous medical history/ diagnosis * Services referred for * Date referral accepted/rejected (case made active) * Outcome of referral eg accepted/declined (with reason) | <ul style="list-style-type: none"> * Date of assessment(s)/review(s) * Assessor name(s) + contact details where possible * Main problems/issues * Main goals * Other services involved + contact details * All assessment/review information generated from InterRAI tools for those consumers completing an InterRAI assessment * Summary of identified risks other than clinical eg environmental, manual handling * Service(s)/inputs required to achieve objectives * Date of service(s) starting * Amount of service(s) required + contacts provided * Processes to be followed in response to episodes that occur outside normal working hours * Provider of service – name if possible * Contact details of service provider * Significant changes to service(s) providers – reason/date/new provider + service details * Date service(s) stopped + reason * Review dates + reviewer * Date of discharge (case made inactive) * Discharge summaries | <ul style="list-style-type: none"> * Provider Contract details * Cost per service per consumer * Provider invoice details * Provider payment details |

The Care Coordination Centre will keep an audit of all users who access or modify data held by the Care Coordination Centre. Data collected must meet the following minimum standards:

- National Health Data Index version 5.2 (2003)
- Standard diagnostic codes eg ICD-10-AM

10 Quality

10.1 Standards

The service is required to comply with the General Terms and Conditions and the Provider Quality Specifications as defined in the C&C DHB contract. The service is also required to follow the Support Needs Assessment and Service Coordination Policy, Procedure and Information Reporting Guidelines, Feb 2002.

The service will require accreditation under NZS 8134:2001 New Zealand Health & Disability Standards (specifically criteria identified by the letters A and B).

The Centre is also required to be compliant with the quality requirements outlined in:

- Needs Assessment Standards (HFA 1999)
- Service Co-ordination Standards (HFA 1999)
- Standards for NASC Agencies (HFA 1999)

In some instances, these Standards are superseded by the quality requirements detailed in this service specification.

The following specific quality requirements also apply.

10.2 General

The Centre will have a documented quality improvement and risk management system in place that reflects continuous quality improvement principles. This will involve a best practice approach to organisational management including consumer rights, entry to services, human resource management, exception reporting and complaints management, and service planning and delivery.

This must include a strategy for planning, implementing and reviewing service delivery to consumers, from a consumer perspective. All consumers should be involved in the development of their service plan and personal outcome objectives. In addition, outcome measures should be developed for each consumer and their family/whanau. The Centre must ensure that all processes consider and meet the needs of Maori and are reviewed in conjunction with the C&CDHB requirements to consult with Maori

For every client:

- the expected outcome of the service will be documented
- progress toward achievement of outcome will be documented
- dates are set to review long term plans will be documented
- there will be a documented discharge plan.

The Centre will report quarterly on the development and implementation of the quality improvement plan and compliance with standards.

10.3 Information Security

The Care Coordination will be expected to satisfy requirements of the information security policy C&C DHB Version 1.0 June 2001. Specifically aspects relevant to:

- Access to electronic information resources
- Computer access and management
- Network access control
- Physical security
- Encryption and key management
- System development and maintenance

10.4 Access

10.4.1 Access Development Plan

The service will develop a plan to improve access to the service by Maori, Pacific, consumers from other ethnic groups and those in low socio-economic groups who access services disproportionately relative to health need.

Service Timeframes:

10.4.2 Referrals

Referrals will be processed within one working day.

10.4.3 Screening/Assessment

Initial screening will commence within 5 working days.

10.4.4 Coordination

Service coordination will be managed on the basis of the following risk management framework:

| Risk Level | Service Coordination Initiated |
|--|--|
| High or excessive level of risk | within 24 hours of receipt of referral |
| Medium risk | within 2 working days (Monday to Friday) of receipt of referral |
| Low Risk | within 5 working days (Monday to Friday) of receipt of referral |

Note: It is anticipated that in the majority of situations a screen and service co-ordination will progress to the point where immediate support needs are clearly identified and services put in place within 10 working days of the referral. Service co-ordination in this context refers to the development of a support plan and arranging access to services - it is recognised that the full service co-ordination role may extend over a longer period as services are reviewed and adjusted to meet the needs of the consumer. The intent of the time lines for completion of service co-ordination is to ensure that access to available services occurs in a timely manner once needs and goals have been identified.

Information will be transferred to another DHB within 5 working days of the transfer request being received.

10.5 Acceptability

Consumer/care giver/family/whanau Involvement: Consumers, care givers, family and whanau members should be central to the consumer's care and support. This requires:

- the consumer be given an opportunity to identify who to include or exclude from their needs assessment and service coordination processes
- the consumer, their care giver, family and whanau members, and other involved in the consumer's care and support be provided information on how they can be involved in the needs assessment and service coordination processes
- the consumer, their care giver, family and whanau members be notified of complaint procedures

In addition, the Centre must deliver services so that consumers:

- receive services in accordance with consumer rights legislation
- receive services in a manner that recognises their values and beliefs
- have their confidentiality, privacy and dignity respected and met during service delivery

- are able to exercise choice and control over their lives during service delivery and maintain their independence and their links with their family and community
- are not subject to abuse and neglect as a result of service delivery
- receive comprehensive and accessible information
- have access to a complaints procedure

The Centre will monitor the acceptability of services provided on an ongoing basis. This monitoring will use a range of methods to gather this information. All surveys must follow the MOH Guidelines for Consumer Surveys. The methods used will identify the acceptability of the following areas of the service as indicated by consumers, their care giver/family/whanau, and others providing care and support.

- Information distribution
- Staff professionalism
- Staff cultural sensitivity
- Staff communication skills
- Appropriateness of decisions
- Respect for privacy
- Rights of the consumer
- Level of choice
- Informed consent
- Participation in community-based activities
- Ease of use of the Centre's services
- Reduction of barriers that enable easier access to the Centre's services
- Complaint and feedback systems\

10.6 Safety & Efficiency

The Care Coordination Centre must ensure that the safety of consumers and their care giver/family/whanau is not compromised as a result of service delivery.

Risk Management & Complaints: The Centre will have documented operational programmes /policies/protocols and guidelines that identify and minimise risk areas for organisational management and service planning and delivery. The use of these systems will be included as part of the Centre's Quality Improvement System. These areas must include but are not limited to:

- Abuse reporting
- Poor service delivery identification and how this will be reported to C&CDHB
- Service gap identification and how this is reported to C&CDHB

- **Provider withdrawal of care and support to consumers and reporting this to C&CDHB**

As part of this system, the Centre will record all adverse, unplanned or untoward events and ensure the exception reporting system is a planned and coordinated process that links to the quality and risk management system. The Centre will also have a complaint management system that is accessible and complies with legislation.

Human Resources: Human resource management processes will be conducted in accordance with good employment practice and comply with relevant legislation and regulations. Eg: ERA and OSH. The Centre will ensure that all staff employed are competent, appropriately trained and qualified and, where relevant, currently registered with or licensed by the appropriate statutory and/or professional body. Employment safety measures will include reference checking and police record checking. The Centre will have a clearly documented rationale for assessor and coordinator availability and skill mixes that will meet the needs of the eligible C&CDHB population, and will provide staff with adequate training and supervision.

10.7 Facilities

The Centre must be compliant with NZS 4121 for accessibility.

11 Purchase Units

| Purchase unit Code | Purchase unit Description | Purchase Unit of Measure |
|---------------------------|---------------------------------------|--|
| HOP1008 | Care Coordination Centre (CCC) | Block - agreed service fee paid 1/12 |
| HOP1007 | Care Manager FTE | Fee per FTE Number of full time equivalent care mangers (to max of 12 FTEs) |

12 Reporting Requirements

12.1 Purchase Units

To be invoiced monthly.

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|---------------------------------------|---|
| Purchase unit Code | reporting |
| Care Coordination Centre (CCC) | Monthly service charge |
| Care Manager FTE | Number of FTEs Ethnicity of FTEs |

12.2 Quality Measures

These are to be reported on an annual basis and can form the basis of a narrative report based on aggregate information. Much of the information will be available from information collected as part of the InterRAI suite of tools. At a minimum the information should cover the following and should be linked to providers wherever possible

| Measure | Reports |
|--|---|
| Consumer satisfaction | Summary of satisfaction surveys Goal attainment |
| Quality management | Progress against service quality plans as per NZS 8134:2001 standards |
| Home Care Quality Indicators | Profile of indicators |
| Profile of CAPS triggered | Profile by age bandings and ethnicity where appropriate |
| Changes in outcomes embedded within InterRAI | Reports should cover ethnicity, age bandings and domiciles where appropriate |
| Rug III scores and changes in RUG III groupings over time | Reports should cover ethnicity, age bandings and domiciles where appropriate |
| Changes in risk/prioritisation indicators embedded within InterRAI eg Maple/MI Choice | Reports should cover ethnicity, age bandings and domiciles where appropriate |

12.3 Service planning information

The service will submit reports using the following framework. Additional reports can be raised at any time if there are issues that the service wishes to raise.

| Measure | Reports BY | Frequency |
|--|---|---------------------------|
| Referrals | <ul style="list-style-type: none"> Numbers received by source Service referred for eg nursing/home care | Quarterly |
| Referral, screening and coordination times as per section 10.4 | <ul style="list-style-type: none"> % achievement | Quarterly |
| Average waiting time to first assessment from date of decision to assess | <ul style="list-style-type: none"> Average waiting times | Quarterly |
| Care Manager assessments and care plans | <ul style="list-style-type: none"> Total number of assessments Numbers of new assessments Numbers of follow up assessments/reviews Numbers of care plans actioned | Quarterly |
| Service provision by providers | <ul style="list-style-type: none"> Volumes and types of service provided Variation of service costs across providers Average length of service Profile of packages of care utilized (narrative) linked to InterRAI data where possible (see section 12.2) and goal attainment | Quarterly Annually |
| New admission to residential care | <ul style="list-style-type: none"> Domicile | Quarterly |
| Service gaps | <ul style="list-style-type: none"> Narrative of service gaps identified | Annually |
| Access to services | <ul style="list-style-type: none"> Progress against service access improvement plans and changes in access to services by Maori, Pacific, consumers from other ethnicities and those from low socio-economic groups | Annually |

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|---------------------------------|---|-----------------|
| Care Manager development | <ul style="list-style-type: none"> • Narrative report on Care Manager workforce development noting training in relation to assessment, goal setting/attainment and care planning and provision of supervision. | Annually |
|---------------------------------|---|-----------------|

The information reports will be submitted directly to C&C DHB quarterly, in an electronic format that is agreed to by both of us.

The information report for each quarter is due by the 20th of the month following the end of the quarter. Delays beyond this date will be notified to us.

The quarters for reporting throughout the term of the agreement are:

- | | | |
|--------------------------|---|-------------------|
| 1 July to 30 September | - | due by 20 October |
| 1 October to 31 December | - | due by 20 January |
| 1 January to 31 March | - | due by 20 April |
| 1 April to 30 June | - | due by 20 July |