Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

♣ Care Manager Service

♣ Service Specification

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DEFINITION:

Health Care Professional – General Practitioner, Medical Practitioner, Registered Nurse, Allied Health Professional

1 Philosophy

This Care Manager service is specified 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, strengths, values and goals.

This Care Manager Service aligns with the vision of an integrated continuum of care embodied by these Strategies, whereby people, their carers, families, and whanau receive co-ordinated 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

The purpose of the Care Manager Service is to provide early, proactive assessment across clinical, social and support needs to reduce onset and progression of chronic disease and disability assist individuals who have health and disability needs to achieve quality cost-effective outcomes, within available resources. It will approach this through facilitating a multidisciplinary collaborative process customised to meet an individual's acuity and complexity of need in order to enable them to live as independently as possible.

This is a process, which assesses a consumer's needs, plans, monitors and reviews the care and support a consumer is receiving, evaluates options and liaises on the consumer's behalf. The care manager is charged with ensuring that the dignity and safety needs of the client and their family/ whanau are met.

While the Care Manager service will initially be coordinated and delivered from within the Care Coordination Centre, the Care Manager will be closely linked with the GPs in the district. This will occur through assignment of Care Managers to designated PHO populations. In time, the Care Manager service may be coordinated and delivered from within PHOs. However, the process occurs across a spectrum of formal and informal settings including Primary, Community, Secondary, Tertiary care, disability support and wider community based care, support and involvement.

The service will provide:

- **Assessment**
- **Care planning**
- **Liaison**
- **Monitoring**
- **Review**
- **Education**

The care manager will facilitate communication, and liaise between those providing clinical services and health and disability care and support and the consumer and their caregiver/family/whanau, to ensure the assessed needs of the consumer and their main caregiver are being met, and in order to minimise fragmentation of the healthcare delivery system.

The service will also function as an accessible expert and will be a resource of advocacy, expertise and advice. It will be able to offer and provide input to:

- **Consumers/ caregivers/families/whanau**
- **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 and local body agencies.**

3 Objectives

The objectives of this service are as follows:

- **Improve the overall health and disability outcomes for the consumer groups**
- **Improve the ability of the consumer groups to maintain their independence**
- **Ensure that the health and social care and support within the scope are delivered in a way that maximises the control that consumers and their caregivers/family/whanau have over the service and their own lives.**
- **Improve the appropriateness and quality of care delivered to the consumer groups**
- **Reduce fragmentation of care and services provided to the consumer groups**
- **Improve the overall consumer satisfaction with, access to and provision of care and services**
- **Improve the overall CCDHB/PHO providers' satisfaction with access to and provision of care and support services**
- **Ensure consumers who have contact with the service have their care needs fully assessed**
- **Improve the access to community based services for the overall consumer groups**
- **Improve the access to community based services by Maori, Pacific and ethnic communities within the consumer groups**
- **To increase pro-active intervention with the consumer groups to prevent or delay deterioration which results in increasing levels of care.**
- **To increase pro-active intervention with the consumer groups to prevent unplanned and acute and residential care admissions**
- **Reduce the rate of growth of unplanned secondary/tertiary care services that are utilised by the consumer groups.**
- **Reduce the rate of increase of Ambulatory Sensitive Hospital admissions.**
- **Reduce the rate that aged residential care is utilised.**
- **Improve integration and efficiency of services eg. referral processes, discharge planning**
- **Support the development of best practice multidisciplinary care of the consumer groups across all settings.**
- **Assist in the implementation of the New Zealand Guidelines for Assessment Processes for Older People**

3.1 Maori Health

The service will 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 will 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 services 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)

3.2 Pacific Health

The service will 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 will 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

3.3 Health For Other Ethnic Groups

The service will 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 with chronic illness and/or high health needs, for instance chronic respiratory and congestive heart diseases
- Older people, including people aged 65+ and the 50-64 age group with early onset of conditions more commonly associated with older age, for instance Alzheimers dementia

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

The following will be excluded from this service:

- Children aged 16 years or under
- Non eligible people who reside outside the Capital & Coast DHB region
- People who have a life long impairment and who require non-age related life long disability support services.
- People who need non-age related mental health services for severe mental illness.
- People residing in the C&CDHB district with a short term, non complex need for home based nursing, therapy, support or other home based care.

5 Access To Service

5.1 Entry

Entry to the service will be by referral through the Care Coordination Centre.

5.1.1 Referral

While referrals will be made to the service through the Care Coordination Centre, they can originate from:

- **Consumers/caregivers/families/whanau**
- **Primary Healthcare 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.**

5.1.2 Guidelines For Referral

Referral to the Care Manager Service by the Care Coordination Centre will be timely, with a preventive focus. Referral should be initiated to provide early, proactive assessment across clinical, social and support needs to reduce onset and progression of chronic disease and disability. Referral will be considered in relation to, (but not limited to) the following scenario's, either individually or combined:

- **Consumer is referred from the Care Coordination Centre due to risk factors/unmet needs identified on attendance to a health care professional, identified by others who have referred the consumer to the Care Coordination Centre or identified through screening (where used)**
- **Consumer has been referred to the Care Coordination Centre due to multiple co-morbidities and increasing usage of primary care**
- **Consumer has not had a comprehensive assessment in the previous six months**
- **Consumer and/or their main caregiver safety is compromised by a deterioration in ability to undertake activities of daily living**
- **Consumer has been referred to the Care Coordination Centre due to avoidable or unplanned in-patient medical/surgical management**
- **Consumer has been referred to the Care Coordination Centre due to large unexplained increases in home and/or carer support**
- **Consumer has multiple problems and requires ongoing monitoring and review, and liaison over several services**

5.1.3 Specific Triggers

Referral to the service will always follow in these circumstances:

- **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**

Referral will include consultation with the consumer, their main caregiver/family/whanau, health care professionals and others providing care and support to the consumer as appropriate.

5.2 Exit From Service

A consumer will exit the service in the following situations:

- **Risk factors are eliminated/managed within resources**
- **All needs effectively met within resources**
- **Consumer able to self-manage without Care Manager input**
- **Consumer discharged from care manager service to ongoing monitoring within primary care**
- **Consumer declines further service input**

5.3 Time

The service will be provided between 9am and 5pm Monday to Friday excluding public holidays.

Outside these hours, the Care Manager service will have available a 24 hour urgent response service. This will be coordinated by the Care Coordination Centre, through which consumers and 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.

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**
- **Pri0vacy Act 1993**
- **Health Practitioner Competency Assurance Act 2003**
- **Health and Disability Services (Safety) Act 2001**
- **Health Information Privacy Code 1994**

The service is responsible for completing assessments, using the InterRAI suite of tools, and for developing the care and support plan based on the assessment.

SERVICE COMPONENT	DESCRIPTION
Consent Process	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 When assessing Maori, whänau should be involved in the consent process, according to the consumer's wishes. 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
Assessment process	Definition: The service will complete a comprehensive assessment using the InterRAI suite of tools. This is a process of systematic evaluation with the consumer and their caregiver/family/whanau which; ¬ identifies the consumer's medical, physical, cognitive, cultural, social and emotional needs, risk factors and where possible, causative factors (including the implications of any conditions which are chronic or will cause ongoing physiological or functional deterioration), ¬ links them to an overall plan for treatment, rehabilitation, education, long term management options and support needs appropriate to the needs and circumstances of the person and their caregiver/family/whanau. The assessment will be an objective process using the

	InterRAI suite of tools, and will not be driven by the availability of resources. The assessment process will cover those areas of life that consumers consider most important. This includes personal care, social participation, and control over daily life, food and safety. Consumers will be assessed for risk factors, physical health and function, mental health, social circumstances, social support, including family/whanau and the presence, role and potential needs of caregivers. The assessment will establish the goals of the consumer, their strengths, needs and risks, and those of their main caregiver/family//whanau as appropriate. During the assessment process the consumer's caregiver/family/whanau will be involved according to the consumer's wishes. The Care Manager will ensure that the consumer and their caregiver/family/whanau understand the assessment process. Assessments will be mainly community based, most likely to be the consumer's home, but the choice of environment will be determined taking account of the consumer's level of risk and their choice. The assessment process 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 process will take into account of ethnicity and language requirements of consumers and will endeavour to address these. The assessment process will take account of Maori cultural requirements, and will make use of Maori 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 Care Manager will identify the need for more detailed assessments as required, and will liaise with relevant health care professionals and/or specialist assessors to facilitate the assessment.** **For clients who require entry into aged residential care, Capital and Coast DHB delegates the authority to Care managers, through the CCC, to undertake clinical assessments required by Social Security Act 1964 and other statutes.** **The Care Manager will also identify and liaise with assessors funded by other government departments e.g. education.** **The consumer or their delegated advocate/ representative will sign off the completed assessment and receive a copy. Care and support coordination may need to commence prior to the completion of the assessment. Access to 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 assessment is delayed.** **The Care Manager will ensure s/he operates according to the Assessment Processes for Older People Guideline 2003. In line with this requirement, the Care Manager will be aware that evidence shows that assessment must be followed by effective interventions and regular follow-up to produce positive outcomes for consumers.** **Accordingly, the Care Manager will work with health care professionals and other providers of care and support to the consumer to ensure they fully understand and agree with the recommendations of the assessment.** **The Care Manager will also work with the consumer and their caregiver/family/whanau to promote concordance (as described in the Guideline) and implementation of recommendations that arise as a result of screening/assessment. The Care Manager will approach this by educating the consumer and their caregiver/family/whanau about their assessed needs and what care and support is available, its usefulness and effectiveness. The Care Manager will also educate the consumer and their caregiver/family/whanau regarding other health and social issues in order to prevent deterioration.**

	OSH Risk Assessment: If a current occupational safety and health risk assessment is not available, the Care Manager will undertake and document a risk assessment 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 requirements and will include an environmental risk assessment and a risk assessment for any manual handling tasks required. **The OSH risk assessment will be included in the consumer's care plan, will be referred to the CCC and will be updated as appropriate in compliance with the CM Standard of Practice (Appendix 1.)**

Care Planning and care management	Definition: This is the development and management of a care plan for health and disability services and other forms of care and support that results in a co-ordinated, integrated, multidisciplinary process which meets the assessed needs, and achieves the defined goals of the consumer and their caregiver/family/whanau. Purpose: The aim is, where possible, to address risk factors, improve reversible conditions and minimise symptoms for people, and/or identify appropriate management strategies for people whose conditions are not reversible. This will include referral on to other services for more detailed assessment as required. Approach: The development of the care plan and approach to care management will have a preventive focus. This process will take a multidisciplinary approach to prevent deterioration and/or facilitate the maintenance or restoration of the consumer's functional, communication and social skills to the optimal functional and participatory level for that person (appropriate to their age, their stage of life and their condition). This approach has the goal of maximising self-management. As part of their educative function, the Care Manager will promote this holistic, preventive, habilitation/rehabilitation model, promoting the model to consumers/families/whanau and formal and informal care and support providers, including health care professionals, hospital and residential facilities, support communities etc. Process: Following assessment, and in consultation with the consumer and their caregiver/family/whanau, the Care Manager will develop a care and support plan that identifies specific interventions, outcomes, goals, responsibilities and timeframes. This process will involve input from health care professionals and other appropriate sources (both formal and informal) of information and advice regarding the consumer's needs. In developing the care plan, the Care Manager will take account of the cultural requirements of the consumer, including ethnicity, age, gender, sexuality and disability, and will endeavour to address these. The Care Manager will consider a wide range of options to meet the assessed needs of the consumer and their main caregiver, 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. The assessment and care plan will govern access to home and community based services, with health care professionals and other providers across all health and disability services using the care plan as the shared communication, planning and monitoring/outcome tool.

	The care plan may include care and/or support to; • **address risk factors and prevent deterioration** • **restore the person to their maximum possible level of function** • **teach the person adaptive and compensatory skills** • **increase the level of safety for self and others** • **increase capacity for self care or assistance with self care** • **provide assistance for maintaining life roles** • **promote a greater understanding/clarification for the person and the family/whanau to assist them to adjust to the impact of their condition/disability** • **educate the person and their caregiver/family/whanau about the habilitation/rehabilitation pathway and how to integrate, into all activities of daily living, practices that restore and/or preserve the person's optimal functional level.** **The care plan will be defined within the indicative budgetary framework. However, the Care Manager, in consultation with the consumer and their caregiver/family/whanau, will consider a wide range of options to meet the assessed needs of the consumer and their main caregiver, including formal and informal, facility and community based care and support.** **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.** **An appropriate time frame for review will be identified as part of the care plan. This time interval will be indicated by the needs of the consumer and/or their main caregiver but should not be more than 6 months. This is provided always that the consumer, their caregiver/family/whanau, health care professionals or others involved in their care and support may at any time seek a review if the consumer's needs are not being met.** **As a result of this process, the Care Manager will work with the consumer, their caregiver/family/whanau, health care professionals and others who are providing care and support, to make adjustments to the care plan to maximise positive outcomes.** **The consumer or their delegated advocate/ representative will sign off the completed care plan and receive a copy.** **The Care Manager will refer the care plan to the Care Coordination Centre, which will coordinate and administer the**

	care plan. **Care and support coordination may need to commence prior to the completion of the assessment. Access to care and support that is required to maintain the safety and/ or dignity needs of the client should not be delayed where the completion of needs assessment is subject to delays.** **The Care Manager will ensure consumers receive timely referral for the care and support identified in the care plan. As part of the care management process, the Care Manager will work with health care professionals and others involved in providing care and support to ensure everyone has a common understanding of the needs and goals of the consumer and their caregiver/family/whanau, and that those involved are working together to achieve these.** **The Care Manager will ensure that the consumer and their caregiver/family/whanau understand the manner in which the care and support plan will be delivered.** **The Care Manager will have ongoing oversight of the care plan, liasing with the Care Coordination Centre, health care professionals and others providing care and support, and the consumer, their caregivers and their family/whanau as required.** **Primary Care: The Care Manager will 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.** **Secondary care: The Care Manager will work effectively with Secondary Health Care practitioners to manage the care and support for consumers who experience planned or unplanned admissions to Secondary Care. This will cover the periods prior to admission and post discharge, and will include liaison around information relevant to the consumer.** **Key workers - In the case of some people with chronic medical conditions, it may be more appropriate that their care and support is managed by a health care professional in another service, such as the GP, hospital physician or palliative care nurse. In these cases the Care Manager will act as a central point of information and advice about the consumer and the care and support they have received.**

Episodic or Intensive Care Management	**On an episodic basis, the Care Manager is responsible for more intensive care management for consumers who experience an acute episode, or an episode that requires a period of more intensive service provision.** **The Care Manager is also responsible for providing intensive care management for people with ongoing high and complex needs, usually requiring a large amount of care and support resulting in the involvement of multiple providers and ongoing problem solving.** **Episodic intensive care management does not include the provision of direct clinical interventions by the Care Manager, but may include a period of more intense liaison, monitoring and review, including ensuring the provision of interim and crisis service provision pending further assessment. The tasks include:** **Negotiating the most appropriate means for achieving the outcomes and responsibilities with those providing care and support, including other sectors e.g. housing, WINZ.** **Working closely with acute care services, specialist services, etc. e.g. Specialist Health Service for Older People, in both admission and discharge planning, to ensure the needs of the consumer are identified and home and community based care and support needed for admission and discharge are identified in the care and support plan.** **Convening or participating in meetings as required with the consumer, their caregiver/family/whanau, health care professionals and others involved in the development and/or implementation of the care and support plan** **Regularly reviewing the consumer's needs and monitoring of the delivery of the care and support plan, with the view of revising it in response to the more rapidly changing needs of the consumer, their caregiver/family/whanau. Regularly reviewing the purpose of the intensive care management to ensure that it is appropriate.**

Monitoring and Review	**The Care Manager will reassess, evaluate and monitor the overall care plan, goals and outcomes on an ongoing basis, to assess the effectiveness, acceptability, and appropriateness, and will carry out systematic reassessment of the consumer's needs and status as required.** **As a result of this process, the Care Manager will work with the consumer, their caregiver/family/whanau, health care professionals and those who are providing care and support to make ongoing adjustments to the care plan to maximise positive outcomes.** **The Care Manager will conduct an overall review of the consumer's status within the time frame for review identified as part of the care plan. The review period should not be longer than 6 months.** **The Care Manager will change the care plan review time interval in response to changes in the consumer's needs and/or those of their main caregiver/family/whanau. 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 plan if they feel the needs of the consumer and/or their main caregiver are not being met.** **Changes in the status of the consumer or their caregiver/family/whanau may require re-assessment and the development of an updated care plan as a result.**

Discharge planning	**Planning for discharge from the Care Manager 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.** **Discharge planning will be an integral part of the care pathway and will commence during the initial assessment period, becoming an ongoing process to be performed throughout the consumer's contact with the Care Manager.** **Discharge will be appropriate when:** • **Consumer outcomes have been achieved** • **Goals of consumer have been achieved** • **Risk factors are eliminated/managed within resources** • **All needs effectively met within resources** • **No further benefit from service** • **Consumer self managing without Care Manager oversight** • **Consumer declines service** **Discharge will involve a hand over to the service provider, eg: PHO, which will have ongoing oversight of the consumer's health and disability status.** **On completion of discharge a summary of the service and outcomes achieved will be lodged with the Care Coordination Centre for distribution to the consumer, their PHO, relevant health care professionals and other services as appropriate.** **The care plan will be updated with all discharge details including which service provider will have ongoing oversight of the consumer's health status.** **The Care Manager will collaborate in the discharge planning from other services involved in the care of the consumer, as appropriate.**
Knowledge and learning	**Care managers will maintain competencies through adequate and appropriate training and supervision in:** ¬ **InterRAI suite of tools** ¬ **assessment** ¬ **client and carer goal setting and goal attainment** ¬ **care planning** ¬ **resource management** **The Care Manager service will function as an accessible expert and will be a resource of expertise in the support and**

	care of the consumer groups by: • Liaising with other services and people involved in the care and support of consumers • Training, supervising and assisting others in assessment, care planning and discharge planning within an integrated continuum of care • Educational activities promoting a holistic habilitation/rehabilitation model, eg: promoting this model to consumers/families/whanau, informal and formal care and support providers, support communities etc., • Educational activities that recognise the culturally sensitive issues relating to care and support and focus on the holistic taha Maori perspective of health, and the holistic community approach to health for Pacific Peoples'.

7 Service Settings

The service will be provided to the consumer at the most appropriate setting. This will primarily be in the home setting.

7.1 Key Inputs

The service will require input from Care Managers who:

- Are clinical staff from Nursing or Allied Health backgrounds who are able to be contracted for ACC Social Rehabilitation Assessment Services
- Have a current practising certificate relative to their professional background

The CCC service will have dedicated one Maori and one Pacific Care Manager FTE to address the needs of Maori and Pacific clients.

8 Service linkages

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

SERVICE PROVIDER	NATURE OF LINKAGE	ACCOUNTABILITIES
Care Coordination Centre	Manage referrals liaise and work with this service to coordinate the care plan and ensure a seamless continuum of care for the consumer.	The Care Coordination Centre (CCC) is responsible for forwarding/generating referrals to Care Managers in a timely manner with appropriate information. Care Managers are responsible for acknowledging and responding to referrals from the CCC. Care Managers are responsible for lodging summaries of relevant assessment and care plans with the CCC. The CCC is responsible for receiving and storing summaries of relevant assessment and care plans from Care Managers. The CCC is responsible for coordinating the care plan to ensure the consumer receives the care in a timely and appropriate manner. Care Managers are responsible for ensuring updates of assessment and care plans are communicated to the CCC 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. 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. The Care Manager is responsible for liaising with the consumer, their caregiver/family/whanau, health care professionals and other providers involved in their care, to ensure the consumer receives care and

		support that meets their needs in a timely and appropriate manner. **The CCC is responsible for liaising as necessary with the consumer, their caregiver/family/whanau,and health care professionals and other providers involved in their care, to ensure the coordination of care and support results in the assessed needs of the consumer being met in a timely and appropriate manner.** **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.** **The CCC is responsible for receiving discharge notification from Care Managers and storing discharge information on the consumer's file.** **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.** **The CCC is responsible for:** • **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** • **innitiating and managing the Care Manager's quality assurance programme**

SERVICE PROVIDER	NATURE OF LINKAGE	ACCOUNTABILITIES
PHOs GP services	Liaise and work with these services to facilitate the care plan and ensure a seamless continuum of care for the consumer.	Care Managers are responsible for responding to referrals from these services sent via the the CCC Care Managers are responsible for working closely with these services to maintain referral, assessment, joint care planning, ongoing care and review processes. to ensure the consumer receives care that meets their needs in a timely and appropriate manner.
HHS Services. Primary health services. Home & community support services. Community/specialist nursing services. Community therapy/allied health services. Rehab services. Specialist Health Service for Older People. Residential care providers. Maori/Pacific/Other ethnic Community care services. Volunteer/NGO services.	Liaise and work with these services to facilitate the care plan and ensure a seamless continuum of care for the consumer.	Care Managers are responsible for responding to referrals from these services sent via the the CCC Care Managers are responsible for working closely with these services regarding outcomes of assessment, care plans, ongoing care and review to ensure the consumer receives care that meets their needs in a timely and appropriate manner.

Consumer/Carer Support. **Consumer support groups.**		
ACC	**Liaise and work with ACC to ensure a seamless continuum of care for the consumer**	**ACC is responsible for referring suitable consumers to the Care Manager for ACC 'Social Rehabilitation Assessments' as per ACC guidelines** **The CM is responsible for completing ACC 'Social Rehabilitation Assessments' as per ACC guidelines.** **The CM is responsible for liaison with specific ACC representatives eg Case Manager, contact center.**

Significant interfaces will exist with:

- **Other appropriate Maori organisations**
- **Other appropriate Pacific organisations**
- **Other ethnic/cultural advocacy/support groups**
- **Consumer advocacy services, including Maori and Pacific advocacy services**
- **Interpreting services.**
- **WINZ**
- **Disability Information Centres**
- **Family Court**
- **Chaplaincy**

9 Quality Requirements

The service will be required to comply with the General Terms and Conditions and the Provider Quality Specifications as defined in the C&C DHB contract. The service will be required to meet:

- **NZS 8134:2001 Health and Disability Sector Standards**
- **Care Manager Standard of Practice that is attached to this service specification as Appendix 1.**
- **Requirements defined in the ACC Social Rehabilitation Assessment contract**
- **Support Needs Assessment and Service Coordination Policy, Procedure and Information Reporting Guidelines, Feb 2002**

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.

9.1 General

The provider is responsible for implementing 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 care and support plan and personal outcome objectives. In addition, outcome measures should be developed for each consumer and their caregiver/family/whanau.

9.2 Acceptability

The service should be provided in a way that is sensitive to the needs of the community within which the provider operates and should have effective working relationships based on co-operation with a range of relevant community and support link groups.

Consumer satisfaction surveys should explicitly measure satisfaction with the service.

In addition, acceptability to Maori should be included in the review conducted by the provider in conjunction with Maori. Support services to Maori requiring care and support should be proactively offered and available.

9.3 Safety and Efficiency

The provider will ensure that all persons who supply or provide or assist in the provision of this service are competent, appropriately qualified and currently registered with or licensed by the appropriate statutory and/or professional body.

10 Information Requirements

At a minimum the service will collect the following information for all consumers seen by the service:

- **Patient NHI**
- **Patient ACC number if applicable**
- **Patient Name**
- **Patient Date of Birth**
- Patient Gender
- **Patient Ethnicity**
- **Contact Details**
- **Next of kin/carer details including contact details**
- **Referral source**
- **Referring Practitioner Name or name of referrer**
- **Referring Practitioner Registration Number (where possible)**
- **Date of referral to service**
- **Reason for Referral**
- **Diagnoses**
- **Date of first assessment with service**
- **Outcome of referral eg accepted/declined (with reason)**
- **Date of service starting**
- **Residence on admission**
- **Residence on discharge**
- **Date of discharge**
- **Number and types of contacts**

The service will be expected to collect data in line with NATIONAL HEALTH INDEX DATA DICTIONARY Version 5.2 and diagnostic codes as per ICD-10-AM.

11 Purchase Unit

The following purchase unit(s) apply for this service.

PURCHASE UNIT CODE	PURCHASE UNIT DESCRIPTION
HOP1007	Full time equivalent of Care Managers

12 Service Reporting

12.1 Purchase Unit

Information but will be reported quarterly.

PURCHASE UNIT CODE	REPORTING
Care Manager FTE	• Number of FTEs • Ethnicity of FTEs

12.2 Quality Measures

These are to be reported on an six monthly basis. (See also Care Coordination Centre service specification for reporting related to the InterRAI suite of tools).

- **Consumer satisfaction with service**
- **Overall achievement of Care Manager Standard of Practice (see appendix 1)**

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	FREQUENCY
Average waiting time to first assessment from Care Manager from date of decision to assess made	• % achievement	Quarterly
Care Manager assessments and care plans	• Total number of assessments • Numbers of new assessments • Numbers of follow up assessments/reviews • Numbers of care plans actioned	Quarterly
Access to service	• Progress against service access improvement plans and changes in access to service by Maori, Pacific, consumers from other ethnicities and those from low socio-economic groups	Quarterly