Background

A key driver of Transform and Sustain, is improving our responsiveness to the inevitable frailty of our ageing population. To facilitate a better response, HBDHB has developed engAGE, a service to support our older people in partnership with primary care and community services.

EngAGE interprofessional teams work proactively with service users over a period of up to six weeks to achieve goals set by the user and engAGE team together. The overall aim is to maximise the user’s independence, choice and quality of life, and reducing their need for support in future. This is achieved by co-ordinated assessment by the interprofessional team and a personalized plan is developed which can involve short-term active reablement as well as ongoing support services.

EngAGE teams are organised to support primary care practices and service users within a defined geographic area. The teams meet weekly in a primary care setting to discuss clients and team members visit clients at home to assess and provide support.

EngAGE teams aim to support frail older people in the community and can assist to:

• Avoid unnecessary admission or readmission to hospital acute care
• Support the transition from hospital to home
• Reduce unnecessary extended stays in secondary care inpatient settings
• Avoid of preventable or premature admission to long-term residential care

Residential intermediate care is a key element of engAGE services to provide older people and clinicians with alternatives to acute hospital admission for those whose illness can be safely managed in the community but who cannot be managed in their own home. In some cases Intermediate Care is a step-down after discharge from hospital, where reablement can occur, allowing return home.

1 Service Definition

Intermediate Care stays will be provided when Service Users, HBDHB Geriatrician and/or Clinical Nurse Specialist Gerontology and their General Practitioner (GP) / Nurse Practitioner (NP) (or delegated GP/NP) have agreed the need of residential intermediate care service to allow engAGE interdisciplinary team assessment and reablement treatment for up to six weeks.

The Service is a 24 hour, seven day a week service within a contracted facility to the eligible Service Users where the objective of the stay is to avoid unnecessary acute hospital admission or ongoing acute hospitalization or preventable or premature admission to long-term residential care.

2 Exclusions

2.1 General

The Service is not for Service Users who are receiving residential care services under other public funding arrangements (unless formal written agreements have been made for joint funding for individuals with complex needs) such as:

• Respite & Day Care Service;
• Dementia Care Services;
• Palliative Care Services;

2.2 Exclusions from Service

The Service cost does not include visits outside of the engAGE in ARRC residential care service requirements.
3 Service Objectives

3.1 General

The Service will:

- facilitate the transition to ensure each Service User maintains their level of functioning and the ability to remain as independent as possible
- support the Service User to remain living in their own home, wherever possible including facilitating a smooth transition back home
- assist Service Users to adapt to ongoing health or support needs
- ensure staff understand the holistic needs of the Service User
- provide culturally and age appropriate services

3.2 Māori Health

An overarching aim of the health and disability sector is the improvement of health outcomes and reduction of health inequalities for Māori. Health providers are expected to provide health services that will contribute to realising this aim. This may be achieved through mechanisms that facilitate Māori access to services and provision of appropriate pathways of care, which might include, but are not limited to:

- processes such as referrals and discharge planning
- ensuring that the services are culturally competent
- ensuring that services are provided that meet the health needs of Māori. It is expected that, where appropriate, there will be Māori participation in the decision making around, and delivery of, the Service.

Providers must recognise Māori realities. The importance of Whānau, Hapu and Iwi structures, and the role the Service User, particularly Koroua and Kuia, plays within these structures.

Positive intervention for Māori Service Users can help to introduce healthier lifestyles, change habits and enhance positive social and functional activities.

4 Service Users

People who have been assessed by their GP/NP (or delegated GP/NP) and Geriatrician and/or CNS Gerontology as eligible due to an acute illness or functional decline from which they are expected to recover, and currently are not ill enough to be in hospital but not well enough to cope at home, such as people:

- aged 65 years of age or older, or
- aged 50 to 64 with age related needs, and
- reside within Hawke’s Bay DHB region

5 Access

5.1 General

The Service User, and where relevant their main carer and their support network, should be involved in the selection of the Aged Related Residential Care (ARRC) Facility.

The Intermediate Care stay Service User will remain under the care of their GP/NP (or delegated GP/NP) admitting them into the engAGE in ARRC residential care services,
5.2 Entry Criteria
Assessment to enter engAGE in ARRC residential care services is a clinical one and made in conjunction with the Service User and their main caregiver and whānau where appropriate.

Intermediate Care stay entry must be approved by both the HBDHB Geriatrician and/or CNS Gerontology and their GP/NP (or delegated GP/NP) who will take the responsibility of the Service Users medical care during the stay.

All Service User are to be assessed as being medically stable and well enough to benefit from the EngAGE in ARRC residential care services, as per current engAGE Operational Guidelines. This will include (but not limited to):

- no anticipated significant acute changes in medical management with the expected period allocated
- the user does not require secondary inpatient services, treatment or investigations
- the user’s medical issue(s) (physical and/or cognitive) are expected to improve within the expected period allocated

5.3 Exit Criteria
Service Users will exit the Service by planned discharge, transfer to another service or death.

A Service User may choose to leave the residential facility before the agreed end date. In this situation the ARRC Facility will make every effort to inform their GP/NP (or delegated GP/NP) and where appropriate the main carer, family or whānau.

6 Service Components
6.1 Settings
The Service will be provided in the ARRC facility, general practice, or the Service Users home or other appropriate community setting.

6.2 Time
The Service will be available as required, i.e. 24 hours a day, seven days a week, including public holidays.

6.3 Costs
Service Providers will not charge Service Users any co-payments for admission to a contracted engAGE ARRC Facility and the required visits during the stay. There will be no claw-backs charged by GP’s for casual patients when a claim under this service is made.

6.4 Processes
6.4.1 Admission to ARRC Facility
Rest Home and Hospital Level of Care is available based on bed availability. Service Providers in conjunction with the HBDHB Geriatrician and/or CNS Gerontology can admit individual eligible Intermediate Care stays in a contracted engAGE in ARRC residential care service – Intermediate Care stay ARRC facility for up to 42 bed nights, provided they have a valid unique engAGE in ARRC residential care service reference number supplied by the Provider.

Stays for over 42 bed nights require engAGE team prior review and approval as per current engAGE Operational Guidelines.

Eligible Service Users are to be admitted into the ARRC facility within 2 working days of the face-to-face assessment with their GP / NP (or delegated GP/NP). Otherwise their GP / NP (or delegated GP/NP) need to visit the Service User within 2 working days of admission to the ARRC facility.

6.4.2 Visits to ARRC Facility
Service Providers are to have face-to-face visits with their Intermediate Care stay Service Users in the ARRC Facility, as clinically appropriate. These visits can be provided by either their GP / NP (or delegated GP / NP) or a Registered Nurse under the instruction of their GP / NP (or delegated GP / NP).

The engAGE Reablement Plan will identify the number and frequency of visits. No Intermediate Care Stay Service User should have more than 1 week between visits, on a case by case basis this may be extended for those clients medically stable and after agreement at the engAGE MDT meeting.

6.4.3 EngAGE Reablement Planning and Treatment

The engAGE team will undertake within two working days of admission of all Intermediate Care stay Service Users a comprehensive interdisciplinary assessment and develop a goal-directed support reablement plan. This assessment and plan will be shared with the ARRC Facility and is aimed at meeting the identified goals within the allocated timeframe and will identify the type of therapy and support required to meet these goals, including the specific support required from the ARRC Facility.

The ARRC Facility will ensure that each Intermediate Care stay Service User has a written and implemented engAGE assessment and reablement plan, and that each Service User has had the opportunity to participate in developing this plan. Where a Service User has a main carer they will also be involved in the development of the plan. The assessment and reablement plan is agreed with the Service User, and is written in a way that is understood by the Service User.

Where a Service User is unable to participate in developing the reablement plan, their main carer or nominated representative will identify who can provide information about the Service User’s preferences in relation to activities of daily living.

The assessment and reablement plan will:

- identify how the Service User’s assessed health and support needs will be met
- be implemented to maximise the Service User’s level of physical and social functioning during the period of care
- be updated upon each admission according to the assessed needs of the Service User. The assessment will be documented by the ARRC Facility Registered Nurse accountable for the Service User’s plan with input from all relevant people
- reflect pre-existing and/or new directives by the Service User’s GP / NP (or delegated GP/NP) during any period of care
- be available to the Service User’s needs assessor for the purpose of reassessing the Service User’s care needs
- include strategies and actions to safeguard the Service User
- include length of stay and arrangements for return home
- include dietary needs, allergies (eg. medication, food etc)
- agree administration of provided prescribed medication (eg. antibiotics)
- where appropriate, include details from their care plan while at home
- where appropriate, include the Service User’s likes and dislikes
- where appropriate, include arrangements for other activities (eg. pool therapy sessions), including transport
- where appropriate, include communication and behavioural support.

The ARRC Facility will document:

- baseline information regarding the Service User’s health status, abilities and support needs, which is updated, collated and held upon each contact with the ARRC Facility
• relevant demographic information which is collected and retained and includes the names of the GP / NP, main carer, family and whānau, unique identification number (NHI), age, ethnicity and the number of short-term residential care days used during each stay.

6.4.4 Role within EngAGE Interdisciplinary Team

Intermediate Care Service users can only be admitted if the Service Provider has taken responsibility of their medical care during the stay in the engAGE in ARRC residential care service. This includes their GP / NP (or delegated GP/NP/RN) and the ARRC Facility involvement in the engAGE Interdisciplinary Team and attendance at weekly engAGE MDT meetings throughout the stay in the ARRC Facility.

The interdisciplinary reablement programme will be delivered for Intermediate Care stay Service Users in the most appropriate way for the client's functional status and stamina level. The interdisciplinary team may include (but not limited to) the following skill mix depending on the needs of the client:

• Geriatrician
• Clinical Nurse Specialist – Gerontology
• District Nurse
• General Practice
• Physiotherapy
• Occupational Therapy
• Social Worker
• Clinical Pharmacist Facilitator
• Needs Assessment and Service Coordination Service

The ARRC Facility will work directly with the engAGE team members to facilitate Service Users assessment and reablement plans, and will inform both the engAGE team and the service users GP/NP (or delegated GP/NP) immediately if there is concern about the client’s health status or condition.

Professional services will work directly with Service Users to facilitate their programme and will provide direction and education to the ARRC Facility in order that they can support the service users goal attainment. The ration and frequency of therapist and caregiver input is regularly adjusted to meet the client's assessed functional deficits, level of stamina, and their pace of goal attainment.

The engAGE team will educate the Service User and their main carer or family on how to integrate practices into all activities of daily living that restore and/or preserve the person’s optimal functional level in order to meet the identified goals.

6.4.5 Medicines

Service Providers will ensure:

• confirmation of Service User’s regular medicines with the Service user or main carer and then advise the ARRC Facility of these prior to admission
• notify the Service User or main carer to take all their medicines with them to the ARRC Facility

6.4.6 Discharge Planning

Service Providers, the engAGE team and the ARRC Facility will work together to plan discharge, the Service User, and where relevant, the Service User's main carer or family and whānau are to be involved in the discharge planning process.

## 7 Service Linkages

Where relevant and appropriate the Provider should be well integrated with other general and specialist services and there should be effective consultation, liaison and referral between services and sub-specialities to maintain continuity of care.

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Nature of Linkage</th>
<th>Accountabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy services (including Elder Abuse and Neglect Prevention advocacy services, Health and Disability Commission advocacy)</td>
<td>Referral and consultation</td>
<td>Service Users have timely and appropriate access to advocacy services</td>
</tr>
<tr>
<td>Community health services, including professional community services, social workers, district nursing</td>
<td>Referral and consultation</td>
<td>Clinical consultation and referral services that support continuity of care</td>
</tr>
<tr>
<td>DHB approved needs assessment and service coordination services</td>
<td>Referral and consultation</td>
<td>Service Users needing reassessment of their support needs have timely access to individual needs assessment and service coordination services</td>
</tr>
<tr>
<td>Equipment and Modification Services (eg. Long-term equipment, including specialist assessment services, home modifications) to assist with daily activities</td>
<td>Referral and consultation</td>
<td>Eligible Service Users needing environmental support services receive appropriate equipment and environmental modifications</td>
</tr>
<tr>
<td>Information and advisory services (eg. on available services and how to access these eg. Disability and Information Advisory Service, Age Concern, Alzheimers New Zealand)</td>
<td>Referral and consultation</td>
<td>Service Users have timely access to appropriately presented information and relevant advice</td>
</tr>
<tr>
<td>Major incident management including Civil Defence</td>
<td>Liaison and coordination of services</td>
<td>Ensure appropriate and timely response in the event of an emergency</td>
</tr>
<tr>
<td>Occupational therapy, Physiotherapy, Speech Language therapists, Social workers, Podiatry services</td>
<td>Referral and consultation</td>
<td>Clinical consultation and referral services that support continuity of care</td>
</tr>
<tr>
<td>Other specialist services</td>
<td>Referral and consultation</td>
<td>Expert clinical consultation and referral services that support continuity of care</td>
</tr>
<tr>
<td>Public health service, communicable disease programmes, and the Medical Officer of Health</td>
<td>Referral and consultation</td>
<td>Clinical consultation and referral services that support continuity of care</td>
</tr>
<tr>
<td>Service Provider</td>
<td>Nature of Linkage</td>
<td>Accountabilities</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Social support services (eg. benefits, disability allowances, services for senior citizens, children etc)</td>
<td>Referral and consultation</td>
<td>Service Users have access to appropriate social support services for which they are eligible</td>
</tr>
<tr>
<td>Social services, counselling, home based support, meals on wheels, community services, new migrant Community Health Workers, accredited visiting services</td>
<td>Referral and consultation</td>
<td>Ongoing support, service coordination that supports continuity of care</td>
</tr>
<tr>
<td>Voluntary organisations, eg. Age Concern, Alzheimers New Zealand, Cancer Society, National Heart Foundation</td>
<td>Liaison, consultation and coordination of services</td>
<td>Ensure relevant and accurate information is available to support service delivery</td>
</tr>
<tr>
<td>If Applicable:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist behavioral support teams</td>
<td>Referral and consultation</td>
<td>Clinical consultation and referral services that support continuity of care</td>
</tr>
<tr>
<td>Day and / or recreational activities</td>
<td>Referral and consultation</td>
<td>Maintain Service User's access, support seamless service delivery and continuity of care</td>
</tr>
<tr>
<td>Disability Support Services (Ministry of Health funded)</td>
<td>Liaison, consultation and coordination of services</td>
<td>Maintain Service Users access, support seamless service delivery and continuity of care</td>
</tr>
<tr>
<td>Ethnic and cultural services</td>
<td>Liaison, consultation and coordination of services</td>
<td>Ensure culturally appropriate support is provided</td>
</tr>
<tr>
<td>Mental health services</td>
<td>Referral and consultation</td>
<td>Clinical consultation and referral services that support continuity of care</td>
</tr>
<tr>
<td>Palliative care - Hospice</td>
<td>Liaison, consultation and coordination of services</td>
<td>Support seamless service delivery and maintain continuity of care</td>
</tr>
<tr>
<td>Transport services, including Total Mobility, to recreational and / or day activities etc. National Travel Assistance to specialist services</td>
<td>Liaison, consultation and coordination of services</td>
<td>Maintain the Service Users’ access</td>
</tr>
</tbody>
</table>

### Quality Requirements

#### 8.1 General

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

#### 8.2 Acceptability

The Service will be acceptable to Service Users and, as appropriate, their main carers, families, and whānau. This will be supported by Service User participation in on-going evaluation of the Service
and by feedback contained in Service User satisfaction surveys which, where appropriate, include input from main carers, family, and whānau.

Service Providers will ensure that the Services are culturally appropriate. That is, staff should be able to demonstrate an appropriate level of cultural competence.

8.3 Professional Standards

Service Providers will ensure all General Practitioners (GP), Nurse Practitioners (NP) and Registered Nurses (RN) delivering this service hold current annual practicing certificate and are experienced in delivering personal, primary and continuing care to individuals, families and practice populations.

Service Providers training should include identification and management of abuse to Service Users. Where elder abuse or neglect is observed or suspected the Family Violence Intervention Guidelines Elder Abuse and Neglect should be followed.

8.4 Claiming

Service Providers are to claim within 30 days of admission(s) and/or visit(s).

9 Purchase Units and Reporting Requirements

9.1 Purchase Units

The following information is to be reported as per the Information and Reporting Requirements. Purchase Units are defined in the joint DHB and Ministry’s Nationwide Service Framework Purchase Unit Data Dictionary. The following Purchase Units apply to this Service.

The Service must comply with the requirements of national data collections where available.

<table>
<thead>
<tr>
<th>PU Code</th>
<th>PU Description</th>
<th>PU Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOP1021C</td>
<td>Ageing in Place – Community Support</td>
<td>As part of the health goals of the Positive Ageing Strategy, a wide range of service(s) are being trailed to enable older people to have the ability to make choices about where they live, and to receive the support needed to do so. In particular, they aim to prevent premature or unnecessary residential care entry.</td>
</tr>
</tbody>
</table>

9.2 Reporting Requirements

Quarterly reports will be completed via Ministry of Health Performance Monitoring Returns

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Report Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st July to 30th September</td>
<td>20th October</td>
</tr>
<tr>
<td>1st October to 31st December</td>
<td>20th January</td>
</tr>
<tr>
<td>1st January to 30th March</td>
<td>20th April</td>
</tr>
<tr>
<td>1st April to 30th June</td>
<td>20th July</td>
</tr>
</tbody>
</table>

Quarterly Data

- Number of practices contracted to this service
- Number of practices delivering this service
- Number of admissions to Intermediate Care stay (preferably by Rest Home and Hospital Level of Care)
- Number of claimed GP/NP visits for Intermediate Care stay (preferably by Rest Home and Hospital Level of Care)
Number of claimed RN visits for Intermediate Care stay (preferably by Rest Home and Hospital Level of Care)

**Quarterly Narrative**

List new practices contracted to this service

Progress and issues of the service outside of business as usual

### 9.3 Clinical Indicators Data

The following is the minimum data set to be collected per Service User for each Intermediate Care stay. Upon request and within 20 days HBDHB is to be given data summary or extract.

<table>
<thead>
<tr>
<th><strong>Mandatory</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Users NHI</td>
<td>Service Users Date of Birth</td>
</tr>
<tr>
<td>PHO Unique reference number</td>
<td>Service Users Gender</td>
</tr>
<tr>
<td>Practice Admitting</td>
<td>Service Users Ethnicity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Preferably</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for Admission by:</td>
<td>Admitting GP/NP</td>
</tr>
<tr>
<td>• ACC Non-weight bearing / Reablement</td>
<td>ARRC facility admitted to</td>
</tr>
<tr>
<td>• Medical Reablement</td>
<td>Level of Care admitted to</td>
</tr>
<tr>
<td>• Pain Management</td>
<td>Date of Admission</td>
</tr>
<tr>
<td>• Post Procedure</td>
<td>Number of nights admitted for</td>
</tr>
<tr>
<td>• Pre Procedure</td>
<td>Number of GP/NP visits</td>
</tr>
<tr>
<td>• Other (if the above are not applicable) – please specify care required</td>
<td>Number of RN visits</td>
</tr>
</tbody>
</table>