CHAPTER:	4	HOME HEALTH SERVICES	**NUMBER:**	4. A
SECTION:	A	GENERAL DESCRIPTION AND DEFINITIONS	**PAGE:**	1 OF 3
SUBSECTION:			**EFFECTIVE:**	OCTOBER 29, 2015

Intent
To describe health authorities' responsibilities in planning and delivering publicly subsidized home health services.

Policy
Health authorities must plan and deliver publicly subsidized home health services to eligible clients as part of their established care plans including:

- case management;
- home support, including self-directed care options;
- community nursing;
- community rehabilitation;
- adult day services; and
- other home health services specific to the unique needs of the client.

Health authorities must:

- establish local service delivery models that will provide clients with access to home health services within their community;
- authorize and manage access to home health services; and
- ensure clients identified as having the greatest need and urgency receive priority access to the relevant service(s).

Health authorities must pay for supplies during the first two weeks of time-limited home health services that are classified as Canadian Institute for Health Information Client Group Acute.

Health authorities must pay for supplies and equipment during the time a client is registered for British Columbia's Palliative Care Benefits by their medical/nurse practitioner based on the eligibility criteria, as set out in Policy4.G, Palliative Care Benefits: Medical Supplies and Equipment.

Definitions

adult day services are provided through an organized program of personal care, health care and therapeutic social and recreational activities in a group setting that meets client health care needs and/or caregiver needs for respite.

community nursing services are health care services provided by a licensed nursing professional to clients who require acute, chronic, palliative or rehabilitative support.

community rehabilitation services are health care services provided by a licensed physical therapist or occupational therapist to clients who require acute, chronic, palliative or rehabilitative support.

continuous home health services are services provided on a long-term basis (usually longer than three months) that typically fall into one of the following client groups as defined by the Canadian Institute for Health Information in the Home Care Reporting System*:*

- Long Term Supportive: The client who is at significant risk of institutionalization due to unstable, chronic health conditions, and/or living condition(s) and/or personal resources.
- Maintenance: The client with stable, chronic health conditions, stable living conditions and personal resources, who needs support in order to remain living at home.

home support services are direct care services provided by unregulated care providers to clients who require personal assistance with activities of daily living, such as mobilization, nutrition, lifts and transfers, bathing, cueing, grooming and toileting, and may include safety maintenance activities as a supplement to personal assistance when appropriate, as well as specific nursing and rehabilitation tasks delegated under Policy 1.C, Delegation of Tasks.

safety maintenance activities are identified through the care plan and focus on reducing, eliminating or monitoring risk or potential risk to a client. As part of the authorized services, these activities may include clean-up, laundry of soiled bedding or clothing, and meal preparation.

time-limited home health services are services provided on a short-term basis (usually less than three months) except for palliative care services that typically fall into one of the following client groups as defined by the Canadian Institute for Health Information in the Home Care Reporting System*:*

- Acute: The client who needs immediate or urgent time-limited (within three months) interventions to improve or stabilize a medical or postsurgical condition.
- End of Life: The client for whom death is anticipated within six months.
- Rehabilitation: The client with a stable health condition that is expected to improve with a time-limited focus on functional rehabilitation.

unregulated care provider is a paid care provider who is not licensed by a regulatory body and who has no regulated scope of practice and includes community health workers, rehabilitation assistants and life skills workers.

References

Home Care Reporting System Data Submission Specifications Manual, Canadian Institute for Health Information

Personal Assistance Guidelines, Ministry of Health Services, November 2008

CHAPTER:	4	HOME HEALTH SERVICES	**NUMBER:**	4.B.1
SECTION:	B	HOME SUPPORT SERVICES	**PAGE:**	1 OF 1
SUBSECTION:	1	SERVICE NEEDS DETERMINATION	**EFFECTIVE:**	OCTOBER 15, 2012

Intent

To describe health authorities' responsibilities in determining the appropriate home support services to meet the client's needs, including the option of Choice in Supports for Independent Living (see Policy 4.C.2, Service Needs Determination).

Policy

Health authorities are responsible for determining the appropriate home support services to meet the client's needs.

Service Needs Determination

Health authorities can approve home support services for a client who:

- has been assessed as requiring personal assistance and/or respite for their caregiver through a clinical assessment by a health authority health care professional (see Policy 2.D, Assessment); and
- has agreed to pay the assessed client rate (see Policy 7.B.2, Client Rates for Specific Services).

A client who requires support with instrumental activities of daily living, such as transportation, housekeeping or shopping will be directed to appropriate community resources.

CHAPTER:	4	HOME HEALTH SERVICES	**NUMBER:**	4.B.2
SECTION:	B	HOME SUPPORT SERVICES	**PAGE:**	1 OF 1
SUBSECTION:	2	ACCESS TO SERVICES	**EFFECTIVE:**	OCTOBER 15, 2012

Intent

To describe health authorities' responsibilities in managing the timely access to home support services.

Policy

Health authorities must deliver home support services to eligible clients consistent with all of the following requirements:

- allocation of home support services must be based on:
  - assessment of the client's health and functional status;
  - the ability of the client and caregivers to manage care needs with available community supports (see Policy 2.D, Assessment);
  - the client's established health care goals; and
  - assessment of risk to staff;
- priority must be given to clients who have been assessed as per Policy 2.D, Assessment as having the highest care needs or as living at the highest levels of risk;
- services must be provided in a manner that reflects the requirement to balance care needs and safety issues within available resources – no client will be denied home support services solely on the basis of the cost of the service required by that client;
- services will be available for a 24-hour period, on a short-term basis, where feasible and appropriate; and
- services may be authorized prior to assessment in urgent, exceptional situations, including outside of regular business hours.

CHAPTER:	4	HOME HEALTH SERVICES	**NUMBER:**	4.C.1
SECTION:	C	CHOICE IN SUPPORTS FOR INDEPENDENT LIVING (CSIL)	**PAGE:**	1 OF 2
SUBSECTION:	1	GENERAL DESCRIPTION AND DEFINITIONS	**EFFECTIVE:**	OCTOBER 15, 2012

Intent

To describe health authorities' responsibilities in funding Choice in Supports for Independent Living (CSIL) to meet the client's needs as an alternative to receiving home support services.

Policy

Health authorities are responsible to fund CSIL, a self-directed home support service, for eligible clients to meet the approved home support service needs, and other approved expenditures as detailed in the client's care plan.

Clients who cannot direct their own care or who cannot always direct their own care may still be able to participate in CSIL through a client support group or a CSIL representative. Health authorities must ensure that the client and their caregivers are aware of these options for managing CSIL.

Health authorities must establish procedures to address emergency requests for funding from a CSIL employer.

Health authorities may authorize home support services from an agency in exceptional circumstances, such as short-term acute illness, to augment CSIL funding.

Clients who were receiving CSIL funding as of March 31, 2011 will continue to be eligible for CSIL after April 1, 2011, regardless of eligibility criteria outlined in Policy 4.C.2, Service Needs Determination.

An individual cannot be a member of a client support group or a CSIL representative acting as a CSIL employer and a paid care provider for the client at the same time as per Policy 4.C.4, Payment to Family Members.

Definitions

approved expenditures are items approved by the health authority as part of the client's funded CSIL care plan.

care provider is the person or agency hired by the CSIL employer to provide home support services approved in the care plan.

client support group is incorporated as a non-profit society under the B.C. Registrar of Companies, comprised of family and/or friends of a CSIL client, to manage the provision of home support services to the client.

CSIL employer is the client, client support group or CSIL representative receiving CSIL funding who is a party to the CSIL agreement to manage the client's home support services and approved funds.

CSIL agreement is a legally binding contract between the health authority and the CSIL employer governing the terms and conditions of the funding.

CSIL funds are funds provided to the CSIL employer to pay for and administer the home support services authorized by the health authority.

CSIL representative is an individual designated as a representative for a CSIL client through a valid representation agreement and is acting as the CSIL employer.

CSIL services are the authorized services and approved expenditures identified in the client's individual care plan and funded by the health authority as an alternative to receiving home support services.

Reference

Representation Agreement Act

CHAPTER:	4	HOME HEALTH SERVICES	**NUMBER:**	4.C.2
SECTION:	C	CHOICE IN SUPPORTS FOR INDEPENDENT LIVING (CSIL)	**PAGE:**	1 OF 1
SUBSECTION:	2	SERVICE NEEDS DETERMINATION	**EFFECTIVE:**	OCTOBER 15, 2012

Intent

To describe health authorities' responsibilities in determining the appropriate CSIL services to meet the client's needs.

Policy

Health authorities are responsible for determining eligibility for CSIL and the appropriate funding to meet the client's needs.

Service Needs Determination

Health authorities can approve CSIL for a client who has:

- been assessed as requiring home support services as part of their care plan;
- assessed needs that can be met within CSIL, within available resources;
- been assessed as having an interRAI HC ADL Long Form score of six or greater and a MAPLe score of three or greater, and requests CSIL service;
- agreed to pay the assessed client rate (see Policy 7.B.2, Client Rates for Specific Services); and
- can safely coordinate and manage CSIL services or has a client support group or a CSIL representative acting as a CSIL employer.

Exceptions

Health authorities can approve CSIL for a client who does not meet defined eligibility criteria in exceptional circumstances, as per CSIL Eligibility Exception Criteria Guidelines.

Reference

CSIL Eligibility Exception Guidelines, 2011

CHAPTER:	4	HOME HEALTH SERVICES	**NUMBER:**	4.C.3
SECTION:	C	CHOICE IN SUPPORTS FOR INDEPENDENT LIVING (CSIL)	**PAGE:**	1 OF 7
SUBSECTION:	3	CSIL ADMINISTRATION	**EFFECTIVE:**	JANUARY 1, 2016

Intent

To describe the responsibilities of health authorities and CSIL employers in administering CSIL.

Policy

Health authorities must provide funding for CSIL services to the CSIL employer, as outlined in a CSIL agreement between the health authority and the CSIL employer, to directly employ their own care providers.

Health authorities must provide CSIL funds directly to the CSIL employer, based on assessment of need and the CSIL Categories of Need Guidelines, at a minimum hourly rate as set out below:

- From April 1, 2011 – $27.63
- From April 1, 2012 – $28.63
- From April 1, 2013 – $29.50
- From April 1, 2014 – $29.50
- From April 1, 2015 – $29.80
- From April 1, 2016 – $29.94
- From April 1, 2017 – $30.39
- From April 1, 2018 – $30.85
- From February 1, 2019 – $31.16

The CSIL employer assumes full responsibility for the coordination and management of the funded services including:

- hiring, scheduling, and supervising the care provider;
- complying with relevant laws and regulations including those related to Canada Revenue Agency, the Workers' Compensation Board and Employment Standards; and
- paying family members of the client to provide home support services in accordance with Policy 4.C.4, Payment to Family Members.

Where the CSIL employer is a client support group, the CSIL employer must undertake tax responsibilities for corporations as required by the *Canada Income Tax Act*.

Quality and Purchase of Care Services

Health authorities must:

- ensure that services being provided through CSIL meet the needs of the client as set out in the care plan; and
- inform the CSIL employer if the health authority has concerns with the quality of care a client is receiving through CSIL.

CSIL employers are responsible for:

- all decisions regarding the quality of their care;
- acceptable standards of service; and
- training of their care providers.

The method of purchasing care provider services is at the discretion of the CSIL employer.

CSIL employers make their own determination of the qualifications, skills and experience they require in the care providers they hire with CSIL funds. CSIL employers are not covered by the *Criminal Records Review Act*; however the CSIL employer may choose to conduct their own criminal record check with the assistance of their local police or RCMP detachment.

CSIL Orientation

Health authorities must ensure that a CSIL employer:

- is provided with access to CSIL educational modules, either electronically or in hard copy, as requested by the client; and
- confirms in writing that they have completed an orientation package and understand the expectations under CSIL.

CSIL Agreement

Prior to issuing funding, health authorities must ensure that CSIL employers complete and sign a CSIL agreement that sets out the terms and conditions of the CSIL funding including:

- assessment of needs, assessed hours, approved expenditures and the total monthly funding amount;
- the requirement for regular reassessment of care needs, and changes to the contract agreement that may be required periodically;
- the start date for the agreement and a schedule for transfer of funds;

- the end date for the agreement, if applicable;
- the CSIL employer's responsibility to adhere to all employment laws and regulations;
- the CSIL employer's responsibility to report any changes in the client's situation or care requirements;
- provisions related to financial accountability and reporting;
- the requirement to inform the health authority and receive approval prior to hiring family members as per Policy 4.C.4, Payment to Family Members;
- information about the health authority appeal process;
- responsibility for expenses not covered by CSIL funds;
- requirement for a respite plan and backup service plan to ensure care needs are met on a continuous basis;
- the CSIL employer's responsibility to provide reasonable notice, whenever possible, to their existing health authority and the new health authority of any change in location and residence in the province;
- the CSIL employer's responsibility to provide reasonable notice, whenever possible, to their health authority for short-term absences outside the province for clinical or personal reasons;
- terms under which the agreement can be terminated; and
- information on eligibility for the government's master insurance program.

The use of a contracted home support agency as part of the backup service plan is permitted in exceptional circumstances and must be agreed upon as part of the care plan.

Health authorities must ensure that:

- a CSIL employer has a separate bank account to manage allocated funds prior to initiating direct funding;
- the health authority deducts the applicable client rate from the monthly CSIL funding amount;
- the CSIL employer contributes their assessed client rate by depositing it into their CSIL account; and
- the health authority establishes appropriate processes to manage circumstances where clients have difficulty meeting expectations, including those provisions set out in the CSIL agreement.

CSIL Funds

The hourly rate paid for CSIL is not intended solely to provide wages for care providers, but is a comprehensive rate expected to cover all of the following costs:

- wages and statutory benefits for care providers as employees of the client;
- payroll deductions and benefits;
- administrative costs of service (such as accounting services, bookkeeping, advertising, office supplies, training, scheduling);
- services identified in the client's care plan;
- allowable expenses related to hiring care providers and reporting on use of funds to the health authority (see CSIL Expense Guidelines); and,
- where approved by the health authority, services provided by an agency in the following circumstances:
  - emergencies;
  - regular back-up service; or
  - unique scheduling needs (such as a CSIL employer contracting with an agency for ongoing shifts that cannot be filled).

Health authorities must inform the CSIL employer of their responsibility to:

- pay all of the costs listed above from their CSIL funds;
- cover any costs associated with home support services that exceed the funding allocation (the CSIL employer can top up their CSIL account to purchase additional services not covered by their CSIL funds); and
- administer the CSIL services without claiming any personal compensation or payment for their time and effort.

The CSIL Expense Guidelines provide additional information about allowable and non-allowable expenses consistent with the expectations set out above.

Direct Funding From More than One Source

CSIL funds will be combined with direct funding from other sources or agencies to ensure the care needs of the client are met in the most appropriate manner.

Surplus Retention

Health authorities must permit a CSIL employer to retain up to one month's surplus funds at any given time and must provide 30 days' written notice to a CSIL employer prior to recovering surplus funds.

Financial Reporting Requirements

Health authorities must ensure that a CSIL employer submits monthly financial reports with receipts for expenses within 45 days of the end of the reporting month in a manner satisfactory to the health authority.

Health authorities must provide the CSIL employer with an optional standardized reporting template to allow them to report electronically. At any time, health authorities may conduct a financial audit of a CSIL account.

Funding During Temporary Service Interruptions

Health authorities may continue funding for a period of up to one month, and may extend this period, in the event that a client does not require care for an extended period of time, including:

- during an admission to hospital,
- short-term admission to a residential care facility,
- a significant change in health status, or
- any other significant change that alters service requirements.

Health authorities must advise the CSIL employer when funding will be temporarily suspended including the rationale.

The CSIL employer is responsible to notify their health authority within 24 hours of changes in the client's care needs.

Client Transfers between Health Authorities

The CSIL employer is required to provide reasonable notice, whenever possible, to the existing health authority and the new health authority of any pending move.

When a CSIL client permanently moves from one health authority to another, the new health authority must:

- honour the assessed hours from the original health authority for 60 days or a negotiated timeframe between the two health authorities; and
- reassess clients who move to ensure the client's needs are being met.

Temporary Absences outside the Province

A CSIL client may be temporarily out of the province while receiving CSIL funds if the period of absence is reasonable and is in the best clinical or personal interests of the client. Client absences for clinical or personal reasons are limited to periods not exceeding 30 consecutive days. The health authority may authorize an exception to avoid undue hardship where there are reasonable circumstances to justify this. Examples of clinical or personal circumstances include:

- obtaining medical therapy prescribed by a medical practitioner;
- participating in sporting and cultural events; or
- taking a vacation.

Longer term out of province absences for such activities as education or employment will be granted based upon individual need and circumstances.

Authorization of continued access to CSIL funding for clients who request to leave the province for more than 30 consecutive days must be obtained prior to the client leaving the province.

Modification of CSIL Agreement

Health authorities or a CSIL employer can initiate changes to the CSIL agreement related to the changing service needs of the client. All amendments must be in writing and signed by the health authority and CSIL employer.

Termination of CSIL Agreement

A CSIL agreement may be terminated in any of the following circumstances:

- where the client is admitted to another health service that replaces or eliminates the need for services provided under CSIL;
- at the CSIL employer's request, with 30 days' written notice;
- at the health authority's request, with 30 days' written notice;
- immediately by notice in writing for cause if:
  - the health authority determines that the client's health or safety would be at risk if the client were to continue on CSIL, or
  - the CSIL employer fails to comply with any terms or conditions of the CSIL agreement including, but not limited to:
    a. deliberate mismanagement of the funds provided; or
    b. failure to follow WorkSafeBC or Employment Standards Regulations; or
- upon death of the client.

Where a CSIL agreement is terminated, the health authority must ensure that the client is provided with appropriate health services to meet their needs.

Unexpended funds in the CSIL bank account must be returned to the health authority upon termination of the CSIL agreement.

References

Canada Income Tax Act
Canada Revenue Agency Corporate Income Tax (T2) Return
Criminal Records Review Act
CSIL Categories of Need Guidelines, 2011
CSIL Education Modules, 2011
CSIL Expense Guidelines, April 2011

CHAPTER:	4	HOME HEALTH SERVICES	**NUMBER:**	4.C.4
SECTION:	C	CHOICE IN SUPPORTS FOR INDEPENDENT LIVING (CSIL)	**PAGE:**	1 OF 2
SUBSECTION:	4	PAYMENT TO FAMILY MEMBERS	**EFFECTIVE:**	OCTOBER 15, 2012

Intent

To clarify how family members can be paid as caregivers, in exceptional circumstances, for providing home and community care services to eligible home support clients.

Policy

Family members may be paid as caregivers while providing care to clients who have been approved to receive home support services through the Choice in Supports for Independent Living (CSIL) option or for admission to a family care home (see Policy 5.D, Family Care Home Services).

Definitions

child is a child of any age, of the client, including stepchildren, adoptive children, daughters-in-law and sons-in-law.

family member is anyone who is related to the client by blood, marriage, adoption or custom adoption (e.g., children, grandparents, etc.).

immediate family member is a parent, child or spouse.

parent is a parent of the client, including parents-in-law, step-parents and adoptive parents.

spouse is a person who is married to or is living in a marriage-like relationship with, a client and, for the purposes of this definition, the marriage or marriage-like relationship may be between persons of the same gender.

General

A family member, except an immediate family member, may be paid to provide care for a CSIL or family care home client.

A family member who is paid to provide care for a client must comply with all policies, procedures and standards that apply to these services, and cannot be the client's CSIL representative or a member of the client support group.

Health authorities must discuss with the client, client support group or CSIL representative the following risks associated with paying a family member:

- the potential risk for conflicts of interest;
- the potential risk to negatively impact the health and quality of life of the client and caregiver; and
- if the client has complex care needs and is considering having only one family member providing care, whether that situation is realistic and appropriate.

Exception to Allow Payment to an Immediate Family Member

An immediate family member cannot be paid to provide care for a client unless an exception is approved by the health authority. In order to be considered for an exception, the client, client support group or CSIL representative must submit an application for an exception in the required form.

Health authorities may approve an exception to pay an immediate family member if the following four criteria are met as per the Payment to Family Members Guidelines (2011):

1. the client, CSIL representative or client support group wishes to pay an immediate family member to provide assessed services (as per Policy 2.D, Assessment) that the health authority would otherwise provide either through CSIL or a family care home.
2. the health authority has determined there is no appropriate and available caregiver to provide for any extraordinary or unique needs of the client for one or more of the following reasons:
   - nature and degree of care required;
   - rural or remote location;
   - cultural barriers; and
   - communication barriers.
3. the family circumstances of the client have been considered and the risks are considered manageable.
4. the client's care plan includes appropriate respite for the immediate family member.

Health authorities must review the exception at least annually. Approval may be withdrawn if the health authority determines:

- the criteria no longer apply; or
- the client's needs are not being met.

Reference

Payment to Family Members Guidelines, Ministry of Health, Home and Community Care, 2011

CHAPTER:	4	HOME HEALTH SERVICES	**NUMBER:**	4.D
SECTION:	D	COMMUNITY NURSING SERVICES	**PAGE:**	1 OF 2
SUBSECTION:			**EFFECTIVE:**	OCTOBER 15, 2012

Intent
To describe health authorities' responsibilities in determining the appropriate community nursing services and manage access to services in a timely manner to meet the client's needs.

Policy
Health authorities are responsible for determining the appropriate community nursing services to meet the client's need and prioritizing access to services.

Community nursing services may be provided in a variety of settings such as the client's home, assisted living residences, family care homes, group homes, clinics or other community settings as determined by the health authority in the following circumstances:

- following discharge from an acute care hospital;
- at home or in a clinic setting to prevent or reduce the need for hospital or emergency department services or admission to a residential care facility;
- because of a life-limiting illness; or
- to meet time-limited acute nursing needs;

Service Needs Determination
Health authorities can approve community nursing services for a client who has been assessed as per Policy 2.D, Assessment as requiring nursing care, and where established care outcomes can be achieved through community nursing intervention; and the client meets all of the following criteria:

- care of the client can be provided with reasonable safety to the client within established standards, policies, and guidelines for nursing practice;
- staff are adequately prepared to manage any specialized nursing functions and/or technological needs of the client;
- the client's behaviour and/or home environment does not jeopardize the safety of the community nursing staff. Potential risks have been assessed and any necessary risk mitigation strategies can be successfully implemented;
- client/family agrees to participate in self care activities as appropriate, considering such factors as:
    - current health and functional status of both the client and caregiver;
    - interest and ability to manage the client's condition;
    - willingness to participate in activities identified in the care plan;
    - participation in planning for discharge from the services;
    - mobility;

- specialized technology needs; and
- client/family has agreed to provide or arrange for ongoing care and support between visits of the nursing staff.

Health authorities must give priority to clients who have been assessed as per Policy 2.D, Assessment as having the highest care needs.

There is no client rate assessed for this service but the client will be responsible for the cost of supplies such as wound dressing supplies or intravenous medications *except* for the first two weeks of time-limited acute nursing services and/or during the time a client is receiving end-of-life care, as set out in Policy 4.G, Palliative Care Benefits Program: Medical Supplies and Equipment.

Discharge from Community Nursing Services

Health authorities will discharge a client from community nursing services if:

- the client no longer requires nursing intervention;
- care of the client can no longer be provided safely;
- the client's behaviour and/or home environment jeopardizes the safety of the nursing staff; or
- the client/family is capable, but unwilling to participate in self care activities.

When the client is discharged from community nursing services due to safety concerns, health authorities must ensure that an alternative plan is developed and offered to appropriately support the client, and must provide this information to the client's primary care provider.

References

Adult Guardianship Act

Personal Assistance Guidelines, Ministry of Health Services, November 2008

CHAPTER:	4	HOME HEALTH SERVICES	**NUMBER:**	4.E
SECTION:	E	COMMUNITY REHABILITATION SERVICES	**PAGE:**	1 OF 2
SUBSECTION:			**EFFECTIVE:**	OCTOBER 15, 2012

Intent

To describe health authorities' responsibilities in determining the appropriate community rehabilitation services and manage access to services in a timely manner to meet the client's needs.

Policy

Health authorities are responsible for determining the appropriate community rehabilitation services to meet the client's needs and prioritizing access to services.

Community rehabilitation services may be provided in a variety of settings such as the client's home, assisted living residences, family care homes, group homes, clinics or other community settings as determined by the health authority in the following circumstances:

- following discharge from an acute care hospital;
- at home or in a clinic setting to prevent or reduce the need for hospital or emergency department services or admission to a residential care facility;
- because of a life-limiting illness; or
- to meet time-limited acute rehabilitation needs.

Service Needs Determination

Health authorities can approve community rehabilitation services for a client who has been assessed as per Policy 2.D, Assessment as requiring community rehabilitation care and where established care outcomes can be achieved through rehabilitation intervention and the client meets all of the following criteria:

- care of the client can be provided with reasonable safety to the client within established standards, policies, and guidelines for rehabilitation practice;
- staff are adequately prepared to manage any specialized rehabilitation functions and/or technological needs of the client;
- the client's behaviour and/or home environment does not jeopardize the safety of the rehabilitation staff. Potential risks have been assessed and any necessary risk mitigation strategies can be successfully implemented;
- client/family agrees to participate in self care activities as appropriate, considering such factors as:
    - current health and functional status of both the client and caregiver;
    - interest and ability to manage the client's condition;
    - willingness to participate in activities identified in the care plan;
    - participation in planning for discharge from the services;
    - mobility;

- specialized technology needs; and
- client/family has agreed to provide or arrange for ongoing care and support between visits of the rehabilitation staff.

Health authorities must give priority to clients who have been assessed as having the highest care needs as per Policy 2.D, Assessment.

There is no client rate assessed for this service but the client will be responsible for the cost of items such as equipment except for the first two weeks of time-limited acute rehabilitation services and/or during the time a client is receiving end-of-life care as set out in Policy 4.G, Palliative Care Benefits Program: Medical Supplies and Equipment.

Discharge from Community Rehabilitation Services

Health authorities must discharge a client from community rehabilitation services if:

- the client no longer requires rehabilitation intervention;
- care of the client can no longer be provided safely;
- the client's behaviour and/or home environment jeopardizes the safety of the rehabilitation staff; or
- the client/family is capable but unwilling to participate in self care activities.

When the client is discharged from rehabilitation services due to safety concerns, health authorities must ensure that an alternative plan is developed and offered to appropriately support the client, and must provide this information to the client's primary care provider.

References

Adult Guardianship Act

Personal Assistance Guidelines, Ministry of Health Services, November 2008

CHAPTER:	4	HOME HEALTH SERVICES	**NUMBER:**	4.F
SECTION:	F	ADULT DAY SERVICES	**PAGE:**	1 OF 1
SUBSECTION:			**EFFECTIVE:**	OCTOBER 15, 2012

Intent
To describe health authorities' responsibilities in determining the appropriate adult day services and manage access to services in a timely manner to meet the client's needs.

Policy
Health authorities are responsible for determining the appropriate adult day services to meet the client's needs and for prioritizing access to services.

Adult day services may include:
- personal assistance;
- health care services including nursing and/or rehabilitation services;
- an organized program of therapeutic social and recreational activities in a protective group setting;
- health education and promotion, nutrition and bathing programs, blood pressure and podiatry clinics, telephone checking, and counselling; and
- caregiver support, including respite, activities such as caregiver support groups, information and education programs.

Service Needs Determination
Health authorities can approve adult day services for a client who:
- has been assessed as requiring adult day services (see Policy 2.D, Assessment); and
- has agreed to pay the applicable daily rate (see Policy 7.C.2, Adult Day Services Rates).

CHAPTER:	4	HOME HEALTH SERVICES	**NUMBER:**	4.G
SECTION:	G	PALLIATIVE CARE BENEFITS: MEDICAL SUPPLIES AND EQUIPMENT	**PAGE:**	1 OF 3
SUBSECTION:			**EFFECTIVE:**	OCTOBER 29, 2015

Intent
To describe health authorities' responsibilities in determining and providing approved medical supplies and equipment to individuals as part of British Columbia's Palliative Care Benefits.

Policy
Health authorities must determine and provide approved medical supplies and equipment to individuals who reside outside residential care facilities and who have been registered for British Columbia's Palliative Care Benefits by their medical/nurse practitioner using the following criteria:
Any BC resident who:

- is diagnosed with a life-threatening illness or condition,
- has a life expectancy of up to 6 months,
- wishes to receive palliative care at home**; and,
- consents to the focus of care being primarily palliative rather than treatment aimed at a cure.

*** For the purposes of this program, "home" means wherever the person is living, whether in their own home, with family or friends, in a supportive/assisted living residence, or in a hospice unit of a residential care facility (e.g., a community hospice bed that is not covered under PharmaCare Plan B). Your care facility can advise you whether you are covered by PharmaCare Plan B.*

To request an assessment for British Columbia's Palliative Care Benefits services through the health authority, the medical/nurse practitioner must complete and submit the British Columbia's Palliative Care Benefits registration form to the local community care office of the health authority. The HA is authorized to provide any required medical equipment and supplies from the approved list below, upon receipt of this form. Verification of registration for Palliative Care Benefits is only required for the drug component of the British Columbia's Palliative Care Benefits.

Service Needs Determination
For individuals registered by their medical/nurse practitioner for British Columbia's Palliative Care Benefits, health authorities must:

- assess an individual's need for medical supplies and equipment;

- provide approved medical supplies and equipment free of charge;
- reassess the client's need for approved medical supplies and equipment on an ongoing basis;
- discontinue the provision of approved medical supplies and equipment to stable clients who are no longer eligible for approved medical supplies and equipment;
- discontinue the fee waiver for home support service to clients who are no longer eligible for approved medical supplies and equipment;
- approve exceptions when clients do not meet assessment criteria, but supplies and equipment are clinically indicated; and
- notify the client's medical/nurse practitioner when a client is assessed as no longer needing supplies and equipment through British Columbia's Palliative Care Benefits.

Approved Medical Supplies

The following medical supplies will be provided to eligible clients based on assessed need:

- Routine dressing supplies
  - Sterile dressing supplies
  - Bandages, including elastic and adhesive, and tape
  - Trays (disposable or re-usable)
- Solutions and ointments (not covered by the Palliative Care Drug Plan of the B.C. Palliative Care Benefits)
- Medication administration supplies
  - Needles, syringes, swabs
- Intravenous therapy and subcutaneous supplies
  - Hydration solutions: normal saline, 2/3 & 1/3, D5W
  - Mini-bags, tubing, cathlons, syringes, needles, heparin locks and caps
  - Hypodermoclysis equipment
- Urinary catheter care supplies
  - Urinary catheter equipment, including drainage tubing, drainage bags,
  - connectors, leg bag drainage set
  - Catheterization tray
  - Disposable gloves (non-sterile)
- Incontinence supplies
  - Incontinence briefs and pads
  - Condom drainage sets
  - Disposable gloves (non-sterile)

The following medical supplies are not approved under British Columbia's Palliative Care Benefits:

- ongoing diabetic supplies (covered by PharmaCare plan);
- ostomy supplies (covered by PharmaCare plan);
- wound care supplies requiring a prescription (see Palliative Care Drug program);
- home oxygen (may be provided by other sources including the Home Oxygen Program, Veteran's Affairs, WorkSafeBC).

Approved Equipment

The following equipment is available to eligible clients based on assessed need:

- computerized ambulatory drug delivery infusion pump equipment, including cassettes, and other approved pain control delivery technologies;
- pressure redistribution mattresses;
- mechanical lifts with slings – may include ceiling lifts with installation;
- commodes, transfer boards, bath seats, floor-to-ceiling poles, wheelchair shower chair;
- walkers;
- non-motorized wheelchairs; and
- hospital beds for symptom management and safety

References

Plan P – British Columbia's Palliative Care Benefits:
http://www2.gov.bc.ca/gov/topic.page?id=7BBE4B270DBA40B8A949D92910E087A2

The Supportive and Palliative Care Indicators (SPICT) Tool:
http://www.spict.org.uk