STANDARD GUIDELINE: **Assessment and Application Process for Personal Care Home, Supportive Housing and Chronic Care**

Program Area:	**Home Care**
Section:	**Case Coordination**
Reference Number:	**CLI.5413.SG.001**
Approved by:	**Regional Lead – Community & Continuing Care**
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PURPOSE:

The purpose of this guideline is to:

- Establish and maintain a consistent, comprehensive, client focused assessment and application process for individuals whose needs can no longer be met safely at home with available resources and;
- Identify the most suitable housing and care environment for individuals:
  - Personal Care Home (PCH)
  - Supportive Housing (SH)
  - Chronic Care

DEFINITIONS:

Primary Health Care Provider (PHCP): Physician, nurse practitioner, physician assistant.

Personal Care Home: Personal Care Home provides access to twenty-four (24) hour support and supervision as well as twenty-four (24) hour professional care within a facility setting for frail and/or cognitively impaired individuals who can no longer manage in the community within available resources and require greater professional support and supervision than what is provided in the SH environment.

Supportive Housing: Supportive Housing provides access to twenty-four (24) hour personal support and supervision within a group congregate setting for frail and/or cognitively impaired individuals who can no longer manage in the community with available resources but who do not yet require the type and level of care provided in a PCH. These individuals would not require twenty-four (24) hour professional care but may require episodic professional care (provided through the RHA). Individuals who require twenty-four (24) hour support and supervision as well as twenty-four (24) hour professional care would be more appropriate for other options i.e. PCH. As the program supports a social model, individuals living within this environment should be able to reside in a congregate setting.

Manitoba Health, Seniors and Active Living Application/Assessment for Long Term Care (MG-1682): A standardized multidisciplinary assessment tool that provides a consistent approach to the measurement of a client's medical status/history, degree of dependency, social history, emotional state and financial ability for payment. The Manitoba Health, Seniors and Active Living Application/Assessment for Long Term Care (MG-1682) (CLI.5413.SG.001.FORM.01) determines the client's level of care requirements and eligibility for Personal Care Home/Supportive Housing/Chronic Care placement.

Chronic Care: Chronic Care placement is available to support clients whose medical/functional care needs exceed what can be safely supported in a PCH. Generally, individuals with more than one chronic care indicator may be considered for residency in a chronic care environment.

IMPORTANT POINTS TO CONSIDER:

Supportive Housing Client Profile:

Frail and/or cognitively impaired older adults who can no longer manage in their own home with available resources (family and home care resources), but are not yet ready for Personal Care Home (PCH) placement. Individuals require services for meals, laundry and light housekeeping (provided by the sponsor through a service package). Individual care requirements justify the need for the availability of twenty-four (24) hour on-site support and supervision and assistance with personal support services i.e. bathing, dressing and grooming. These individuals would not require twenty-four (24) hour professional care but may require episodic professional care (provided through the RHA). Individuals who require twenty-four (24) hour support and supervision as well as twenty-four (24) hour professional care would be more appropriate for other options i.e. PCH. As the program supports a social model, individuals living within this environment should be able to reside in a congregate setting.

Personal Care Home Resident Profile:

- Client who meet **ALL** of the following criteria:
  - Client who requires twenty-four (24) hour care throughout the twenty-four (24) hour day.
  - Client who is medically stable and has had medical assessment and treatment to determine that the client has reached a maximum level of functioning and health.
  - Despite Home Care/community and support network (family/primary caregiver), the client can no longer be maintained safely at home.
  - Client whose care needs cannot be met in a setting such as seniors housing, supportive housing, or assisted living.
  - The client's support network (family and caregivers) indicate they are no longer able to support care in the community.
- There are five (5) levels of dependency; one (1) to four (4) and Chronic Care; one (1) being the lowest and Chronic Care being the greatest level of dependency. The client is assessed in six (6) functional categories to determine the client's overall degree of dependency;
  - Bathing and Dressing
  - Assistance with Meals
  - Ambulation/Mobility/Transfers
  - Elimination

- Professional Intervention
- Behavior Management

PROCEDURE:

- The Manitoba Health, Seniors and Active Living Application/Assessment for Long Term Care (MG-1682) (CLI.5413.SG.001.FORM.01) is used to identify the most suitable housing and care environment for clients. Responsibility for completion of the Manitoba Health, Seniors and Active Living Application/Assessment for Long Term Care (MG-1682) with client/substitute decision maker is:
  - Discharge Coordinator for patients who are in a regional hospital and not open to home care.
  - Home Care Case Coordinator for all other patients/clients in hospital and community.
- The most appropriate person (i.e. Primary Health Care Provider, Case Coordinator or substitute decision maker) initiates discussion with the client/substitute decision maker regarding the need to live in an environment that provides twenty-four (24) hour personal support and supervision or twenty-four (24) support and supervision as well as twenty-four (24) professional care.
- The Case Coordinator/Discharge Coordinator collaborates with other team members to identify the client's need to live in a housing and care environment (i.e. Personal Care Home, Supportive Housing or Chronic Care). Factors to consider are:
  - Client's risk level (CLI.5411.PL.003).
  - Community supports required and available to remain in the community, safely.
  - Client's medical stability (Has the client reached a maximum level of functioning and health. Have we exhausted all rehabilitative options?).
  - Client's decision-making ability relative to his/her ability to decide to remain/return to the community with a degree of risk.
  - Client's functional care need.
  - Client's housing and care needs could not be met in settings such as seniors housing/ assisted living.
  - Client's caregiver indicates they are no longer able to support care in the community.
  - Client residing in Supportive Housing has met the exit criteria for Supportive Housing.
- Where the need for Personal Care Home, Supportive Housing or Chronic Care has been assessed and the client/substitute decision maker wishes to pursue application the Case Coordinator/Discharge Coordinator:
  - Informs the client/substitute decision maker about different housing/care options and makes recommendations to the client/substitute decision maker based on clients assessed needs, level of risk, financial means, client preferences, available family support and community resources.
  - Reviews the application, assessment and placement process with client/substitute decision maker.
  - Provides printed information where such exists (i.e. Fact Sheets, Brochures, Personal Care Home Information Booklet, Southern Health Santé Sud public website etc.). Refers

client/substitute decision maker to desired facility(s) for site specific moving in processes, printed brochures, on-site services, what to bring, facility tour, etc.

- Completes the Manitoba Health, Seniors and Active Living Application/Assessment for Long Term Care (MG-1682) in accordance with Completion of the Application/Assessment for Long Term Care (MG-1682) (CLI.5413.SG.002). Include supporting assessments (note these are not required but assist Panel to make a disposition decision and develop a complete client profile for the Personal Care Home):
  - Advance Care Planning Goals of Care Form (CLI.5910.PL.008.FORM.01) or the client' Health Care Directive – if completed;
  - Competency Assessment;
  - Swallowing assessments;
  - Cognitive testing/assessments (e.g. Mini–Mental State Examination, Montreal Cognitive Assessment);
  - Occupational/Physio Therapy assessments;
  - Respiratory assessments;
  - Seniors Consultation Team assessments;
  - Other assessments to support/provide additional information related to clients care needs/safety risks;
  - Calculates the client's dependency level.
- Completes the Application for Personal Care Home – Check List (CLI.5413.SG.001.FORM.02).

- Presence of Chronic Care indicators does not mean a client is not suitable for a Personal Care Home. The Case Coordinator contacts Personal Care Home to review chronic care indicators to determine if the Personal Care Home of client's choice is able to meet their chronic care needs. Chronic Care placement identified, if the client requires temporary or permanent placement in a chronic care facilities or requires chronic care in a hospital.
- Upon completion of the Manitoba Health, Seniors and Active Living Application/Assessment for Long Term Care (MG-1682) and required documentation the Case Coordinator/Discharge Coordinator:
  - Contacts Panel Administrative Assistant to schedule an appointment for application presentation;
  - Submits the original application to Panel Administrative Assistant;
  - Presents the application in accordance with the Panel Presentation Form (CLI.5413.SG.001.FORM.01).
  - Notifies the client or substitute decision maker of the panel's decision.
  - Discharge Coordinator informs the Case Coordinator in the corresponding geographical office of the acceptance of a hospital client's panel application for Personal Care Home/Supportive Housing/Chronic Care if the client will be awaiting placement in the community.
  - Case Coordinator opens client to Procura and documents in reference numbers:
    - Client panel status
    - Client panel date

- Clients whose application for Personal Care Home/Supportive Housing has been approved the Case Coordinator and client will await placement in the community:
  - Case manages and coordinates home care services.
  - Collaborates with the Personal Care Home/Supportive Housing and the client/substitute decision maker to facilitate a seamless transition for the client to Personal Care Home/Supportive Housing.
  - Completes the Manitoba Health, Seniors and Active Living Re-Assessment Form for Long Term Care Applicants (MG. 1946) (CLI.5413.SG.001.FORM.03) residing in the community, minimally every six (6) months or when there is a change in care and/or functional level and/or medical information.
  - The responsibility for completion of the six (6) month reassessment of clients residing in transitional or acute care facilities is with the facility.
- When reassessment indicates client's level of functioning has changed and client no longer meets eligibility requirements for Supportive Housing/Personal Care Home environment, Case Coordinator notifies the Panel Chair/designate.
- Clients are closed to home care when:
  - Application for Personal Care Home approved and client admitted to a Personal Care Home (first/second or third choice) or Transitional Care/Acute Care facility and no plans to return to the community.

SUPPORTING DOCUMENTS:

CLI.5413.SG.001.FORM.01	Application/Assessment for Long Term Care (MG-1682) (Panel Presentation)
CLI.5413.SG.001.FORM.02	Application for Personal Care Home – Check List
CLI.5413.SG.001.FORM.03	Re-Assessment Form for Long Term Care Applicants (MG-1946)

REFERENCES:

Manitoba Health, Seniors and Active Living *Application/Assessment for Long Term Care (MG-1682)*

Manitoba Health, Seniors and Active Living *Re-Assessment Form for Long Term Care Applicants (MG. 1946)*

Manitoba Health, Seniors and Active Living HCS 205.*5 Insured and Non-Insured Personal Care Services for Personal Care Home Residents*

Manitoba Health, Seniors and Active Living HCS 206.3 *Supportive Housing Program*

Manitoba Health, Seniors and Active Living HCS 207.18 *Access to Alternate Care Environments*

Manitoba Assessment and Placement Process (MAPP)

Advance Care Planning Goals of Care Form (CLI.5910.PL.008.FORM.01)

Client's Risk Level (CLI.5411.PL.003)

Completion of the Application/Assessment for Long Term Care (CLI.5413.SG.002)