

## Principles for sharing costs of bariatric equipment in ARC

<b>To:</b>	DHB Health of Older People Portfolio and Programme Managers
<b>From:</b>	DHB Health of Older People Steering Group
<b>Subject:</b>	Principles for the sharing of costs of bariatric equipment in aged residential care
<b>Date:</b>	21 September 2017

### 1.0 Background

The issue of increasing costs, and who pays for bariatric equipment in ARC has been raised by ARC sector representatives and DHBs in A21 Review discussions, starting in 2015.

It was agreed that the Joint ARC Steering Group would consider options to address cost sharing. Since September 2016, there have been discussions at both the HOP Steering Group and the Joint ARC Steering Group meetings, and a draft set of Principles has been on the table since May 2017.

Presented here are the final set of Principles, and the process flow chart by which providers and DHBs will determine whether or not the rental or purchase of required bariatric equipment is able to be shared.

### 2.0 Principles for the Sharing of Costs of Bariatric Equipment in ARRC

#### Rationale:

Provider representatives, through the Joint ARC Steering Group, have signaled the issue of costs related to residents requiring bariatric care is, and will remain, a priority for 2017/18.

Responsibility for provision of equipment to meet the needs of residents assessed as requiring aged residential care is set out under clauses D2.2 (Cost Obligations) and D15.3 (Facilities and Equipment), in the ARRC Agreement.

The ARRC agreement is not overly specific however about what equipment is included or excluded within the price paid for contracted care services but rather relies on the understanding that the responsibility to provide contracted care services that meet the assessed needs of residents is funded through the agreed bed day rates. It is important to note that currently bariatric equipment currently falls within the definition of standardised vs customised definition under clause D2.2

It is noted that each DHB will have a local process with regards to multidisciplinary team and specialist assessment advice which will determine the type of bariatric equipment required.

#### Assumptions:

- The resident has been needs assessed as an ARRC resident requiring age-related long-term care covered by the ARRC Agreement
- The resident has been assessed as requiring bariatric equipment by an allied health professional with equipment needs exceptional and above what could be provided currently by the facility.
- In complex discharges from acute care requiring bariatric equipment, the expert advice of the multidisciplinary team and discharging clinician influences the type of equipment needed The resident has not been assessed as needing long-term care simply to access hospital level of care requiring bariatric equipment outside of an acute hospital inpatient bed
- The facility/organisation has reviewed its own stock of bariatric equipment to determine what is available and suitable (if any).
- Assume that a provider has some bariatric equipment and is capable of caring safely for bariatric resident.
- The agreed process for providing exceptional circumstance bariatric equipment by DHBs to ARRC HOP clients is a contribution toward acknowledging the cost of bariatric equipment over and above standard equipment

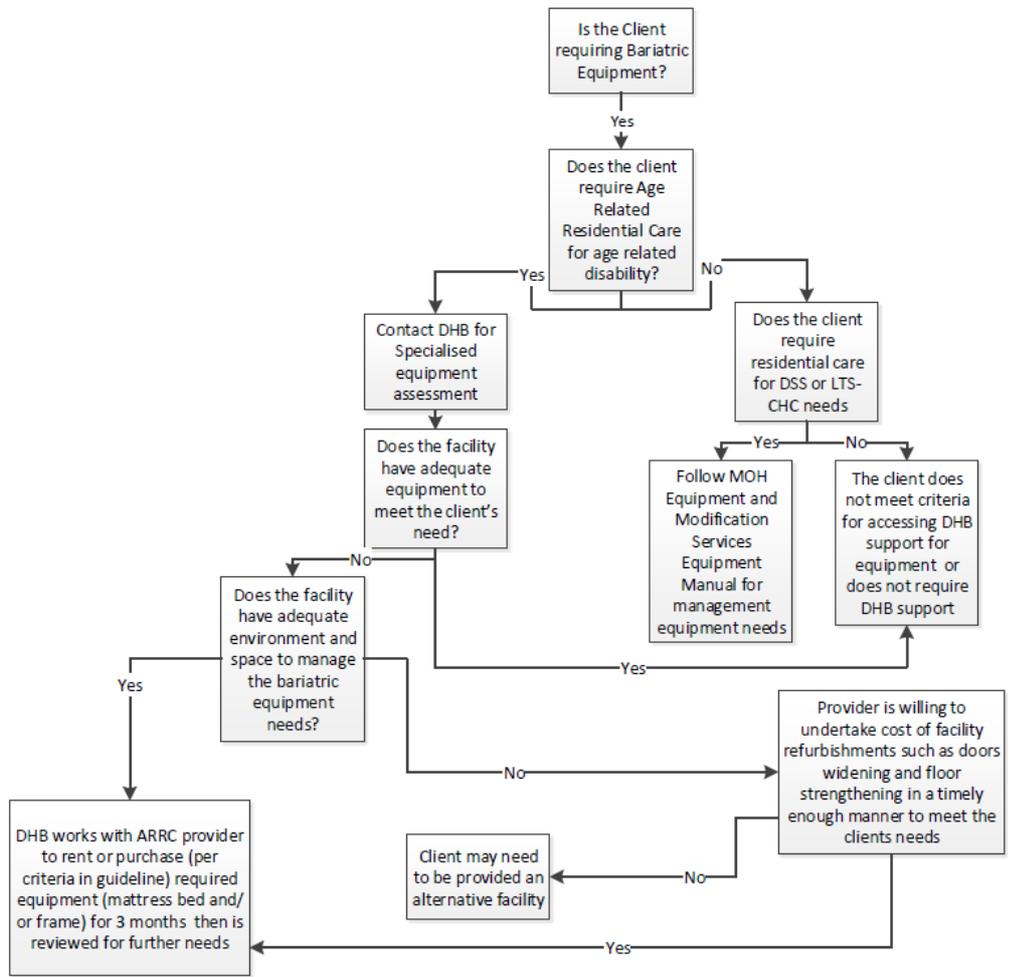
and is intended to cover individual needs such as beds, mattresses and walking frames but not intended to cover all needs or general communal needs such as slings hoists and commode/shower equipment.

- There should be a 'reasonableness test' as a principle for decisions about sharing costs for bariatric equipment between DHBs and ARRC facilities. If a particular ARRC facility does not meet a person's needs (wide doors, reinforced floors, equipment etc.) then the person should be directed to an appropriate facility/facilities that has/have those essentials for bariatric care. However, precise wording must be agreed because technically a NASC may not direct a prospective resident to a particular facility, and client choice is required. Furthermore it needs to be noted that directing clients to particular facilities would be a hardship for people who live rurally, difficult for family to drive long distance to a residential care facility far from home town.
- Client choice is important, and providers also have the right to refuse any prospective resident (other than as provided for under clause A13).
- DHBs and ARRC providers prefer a principles approach to this process.

- Principle 1** DHBs will discharge patients with bariatric equipment requirements needing long-term residential care into Age Related Residential Care contracted facilities only when:
- The DHB has assessed the resident as meeting the definition of a 'bariatric resident' and has been assessed as requiring bariatric equipment by an equipment assessor allied health professional with equipment needs above what could be provided currently by the facility
  - The facility agrees to accept the resident. An agreement will be reached between DHB and the provider regarding the provision of the required equipment and care (including taking responsibility for the safe moving and manual handling of the equipment and patient by their staff)
  - The resident is able to access facility equipment that meets equipment specifications and staff have received training according to relevant moving and handling guidelines
  - The facility and the DHB have in place a clinical care agreement and timeline for outcomes
  - Providing the equipment is necessary to enable the resident to participate and access to the facility environment and activities
  - Complex discharges have involved the multidisciplinary team in determining bariatric equipment needs
- Principle 2** When the facility does not agree to accept the resident because of additional requirements related to the cost and availability of bariatric equipment, and the discharge team is unable to reach agreement on a timely discharge plan, the discharge team and/or the receiving facility may approach the DHB for assistance to achieve an effective outcome for the resident.
- Principle 3** Where the facility already has appropriate bariatric equipment available – the DHBs expects that this equipment would be used in the first instance to meet the resident's needs. However, an assessment may be needed when the facility equipment is in regular use for other bariatric clients and/or the resident has additional requirements.
- Principle 4** If an ARRC facility seeks DHB funding assistance with the purchase and/or rental of bariatric equipment, the DHB will assess the resident as requiring bariatric intervention and/or equipment or otherwise.
- Principle 5** Where it is agreed that a DHB will provide additional assistance to achieve the best clinical outcome for the patient/resident, this does not relinquish providers from their contractual obligation to provide and meet the cost of standard equipment.
- Principle 6** There should be no differentiation between small and large facilities in terms of a DHB response to a request for assistance. Providers have the total revenue available for all residents and are expected to manage the operational costs of equipment and/or consumables for all residents within this revenue:
- Assistance to be advised using a consistent approach and then reviewed and agreed by the DHB
  - The focus should be on an effective outcome for the resident
- Principle 7** Labour inputs remain the responsibility of providers and is out of scope of this document with the exception of specialist advice and input from DHBs as required for specific residents. Health and Safety obligations for employees remain the responsibility of the provider. This issue should be addressed more comprehensively in the ARRC funding review process.

### 3.0 Flowchart for determining cost sharing

Flowchart for the Sharing of costs of Bariatric Equipment in Age Related Residential Care (To be read in conjunction with Principles)



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