Nova Scotia Department of Health and Wellness

Continuing Care Branch

Self-managed Support-Care Services

“hereinafter and commonly referred to as Self-Managed Care”

POLICY

February 4, 2013

Section: 1.0 INTRODUCTION
Policy: 1.1 Overview

Effective date: March 1, 2013	**Version:** 2
Approved by: Kevin McNamara**,** Deputy Minister, Department of Health and Wellness	
Signature: Original signed by Kevin McNamara, Deputy Minister	

1.1. OVERVIEW

Self-managed Care funding is provided in order that clients may directly employ care providers for the purpose of meeting their assessed needs, as outlined in an approved care plan. Self-managed Care services provide an opportunity for clients to gain increased control over their lives and may enhance their participation in the community.

Eligible applicants are medically stable and have a long-term requirement for support services. They have the ability to participate actively in the development of their care planning and to directly arrange and administer their own support services. They must have the mental capacity to participate fully in decisions regarding their own care. The client assumes full responsibility for the coordination and management of the funded services. However, the client may delegate a third party to assume the role of care manager to arrange the client's care and fulfill administrative requirements.

District Health Authorities administer and deliver Self-managed Care services with funding from the Nova Scotia Department of Health and Wellness. This policy is provided in accordance with the *Self-managed Support-care Act,* for the delivery of Self-managed Care services.

Section: 1.0 INTRODUCTION
Policy: 1.2 Definitions

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1.2. DEFINITIONS

Administration: Any task associated with administering a payroll, employee deductions, remittances to government (federal, provincial or municipal), and keeping of the records required by the *Self-managed Care Agreement*.

Applicant: A person who applies to the District Health Authority for Self-managed Care services.

Approved Care Plan: A Care Plan that has been approved for funding by the District Health Authority.

Approved Setting: Settings approved by the District Health Authority where support services are delivered; may include the client's home and/or residence or a location where the client attends for volunteer, social, educational or employment purposes.

Assessed Needs: The applicant's requirements for support services, as determined by a Continuing Care assessment and outlined in a care plan.

Care Manager: An unpaid individual who is appointed by the client to manage, on behalf of the client, the client's care and/or manage the administrative aspects of the client's participation in Self-managed Care services. A care manager must be at least 19 years of age.

Care Plan: A document completed by the client, in conjunction with the Continuing Care Coordinator, identifying the client's assessed needs, support services being requested, and the anticipated health outcomes of the provision of those services.

Care Provider: A person hired as an employee, by the client or the care manager, to provide the funded support services.

Case Management: The process of providing assessment, coordination, monitoring, follow-up and evaluation of services provided by and through the District Health Authority. This process involves the client and their support network, care coordinator and care manager.

Care Coordinator: A person employed by the District Health Authority who is responsible for assessments, referrals, service planning, resource allocation and case management of clients.

Client: An applicant who has been approved to receive Self-managed Care services funding, is the direct recipient of the funded support services, and employs their care provider(s).

Employee: Qualified care provider paid (including statutory benefits) by the client to provide the support services as articulated in the approved care plan.

Family Members: Relations through blood, marriage or adoption and other relatives living in the same household as the client. Family members include: spouses or partners living together in a spousal relationship; parents, step-parents and adoptive parents; grandparents, step-grandparents and adoptive grandparents; children, step-children and adopted children; grandchildren, step-grandchildren and adopted grandchildren; siblings, step-siblings and adopted siblings; aunts and uncles (including step-aunts and step-uncles); parents-in-law, sons/daughters-in-law and brothers/sisters-in-law; nephews and nieces.

Fiscal Year: The period covering April 1st of one year to March 31st of the next year.

Health Professional: A licensed health services provider which includes, but is not limited to: physicians, registered nurses, nurse practitioners, licensed practical nurses, occupational therapists or physiotherapists.

Home Support Services: Services that assist clients with homemaking in their own homes and includes light housekeeping, meal preparation and laundry.

Medically Stable: A person with a medical illness/disease in which the expected course over the next 12 months can be defined as long standing, steady and relatively predictable. Conditions in which the expected course over the next 12 months is unpredictable, fluctuating, irregular or intermittent would not be considered stable. In addition, individuals who have required frequent inpatient hospitalizations or visits to an emergency department in the previous 6 to 12 months would not be considered to have a stable medical condition.

Mental Capacity: The cognitive ability to understand a decision and appreciate the consequences (to oneself and others) of making or not making that decision.

Personal Care Services: Those services that assist the client with hygiene, toileting, dressing, undressing, feeding and mobility.

Self-managed Care Agreement: The contract between the Department of Health and Wellness, the District Health Authority, the client and the care manager (if applicable) which governs the terms and conditions of the funding.

Self-managed Care: A service option through which funds are provided to a client in the community to directly employ a care provider(s) to deliver support services as articulated in an approved care plan. Self-managed Care services are authorized by the District Health Authority and funded by the Department of Health and Wellness.

Stable Care Requirements: For the purposes of establishing a care plan and a *Self-managed Care Agreement*, the applicant's assessed support service needs are steady and predictable and may be determined for a one year period of time. Clients whose

support service requirements are intermittent or are likely to change significantly during that time would not be considered to have stable care requirements.

Support Services: Assistance with the routine activities of living, as determined by the Continuing Care assessment and provided by a person hired by the client or care manager. This may include assistance with personal care activities and home support activities necessary to maintain hygiene and safety in the home.

Section: 2.0 PROGRAM ELIGIBILITY
Policy: 2.1 Program Eligibility Criteria

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2.1 PROGRAM ELIGIBILITY CRITERIA

To be eligible for Self-managed Care services, applicants must:

- meet the eligibility requirement for Nova Scotia's Health Insurance Plan (i.e. the person has been issued a valid Nova Scotia Health Card or
  be in the process of establishing permanent residence in Nova Scotia and have applied for coverage under Nova Scotia's Health Insurance Plan);

- be 19 years of age or older;

- have a chronic and medically stable condition with stable care requirements that will extend beyond 90 days, i.e. have been assessed as a potential long term user of Self-managed Care services;

- require physical assistance with the routine activities of daily living as a result of a functional disability and be willing and able to participate in the development of a care plan for self-management;

- be willing and able to participate with the Care Coordinator in the development of a self-managed care plan;

- be assessed by a Care Coordinator as being mentally capable to fully participate in decisions regarding his or her own care requirements;

- be assessed by the District Health Authority as having the ability to adequately coordinate and manage the delivery of the support services;

- be assessed by the District Health Authority as having the ability to provide adequate direction to a care manager, if the applicant intends to delegate a care manager;

- have an assessed need for support services that can be safely met by Self-managed Care services and does not exceed the current allowable Self-managed Care monthly service cost limit established by the Nova Scotia Department of Health and Wellness;

- have no alternate funding sources for the assessed support services; for example, the applicant must not be living in a place where the same support services are already funded by a government sponsored program or where the services are purchased by the applicant as part of his or her living arrangements;

- agree to be assessed for the applicability of Self-managed Care service fees;

- be able and willing to enter into a contractual arrangement, with the Department of Health and Wellness, the District Health Authority and the care manager (if applicable), governing the terms and conditions of Self-managed Care funding.

Section: 3.0 ROLES AND RESPONSIBILIITIES
Policy: 3.1 Role and Responsibilities of the Department of Health and Wellness

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3.1 ROLE AND RESPONSIBILITIES OF THE NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

The Department of Health and Wellness is responsible to:

- develop, monitor and revise (as required) provincial policy, congruent with the *Self-managed Support-Care Act*, for the delivery of Self-managed Care services;
- establish and revise (as required) the funding rate and monthly maximum amount of funding which is available to a client;
- set Self-managed Care service fees and to establish policy and procedures related to the determination and collection of these fees;
- provide funding directly to the client/care manager for support services identified in the approved care plan;
- develop and monitor accountability and performance measures and set reporting requirements for the District Health Authorities;
- collect, use and disclose the personal health and financial information collected for the purposes of the Self-managed Care service according to Department of Health and Wellness policy and all relevant federal and provincial legislation related to privacy and confidentiality; and

- audit Self-managed Care services for compliance with provincial program requirements.

Section: 3.0 ROLES AND RESPONSIBILITIES
Policy: 3.2 Role and Responsibilities of the District Health Authority

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3.2 ROLE AND RESPONSIBILITIES OF THE DISTRICT HEALTH AUTHORITY

Each District Health Authority is responsible to:

- provide access to Self-managed Care services for eligible residents of Nova Scotia;
- ensure that the Self-managed Care services provided are in compliance with the *Self-managed Support-care Act,* the *Self-managed Care Policy* and the *Self-managed Care Agreement* established by the Nova Scotia Department of Health and Wellness;
- assess the eligibility of applicants for Self-managed Care services using standard assessment tools, as indicated in section 5.2 of the *Home Care Policy Manual,* and in accordance with the eligibility criteria outlined in section 2.1 of this *Self-managed Care Policy*;
- determine the Self-managed Care client's obligation to pay fees, in accordance with the policy and procedures established by the Nova Scotia Department of Health and Wellness, and to notify the Department of Health and Wellness when the client's Self-managed Care funding is to be adjusted;
- ensure that all clients approved for Self-managed Care services are oriented to the program by identifying financial reporting requirements, the client's obligations as an employer, relevant contact information and any other program

requirements;

- provide case management services for Self-managed Care clients;

- ensure that a legally binding *Self-managed Care Agreement*, governing the terms and conditions of funding, is completed, understood and signed by all clients. The terms of the *Self-managed Care Agreement* must include, but are not limited to:
    i. the amount of approved funding and a schedule for transfer of funds;
    ii. the client's responsibilities;
    iii. provisions related to financial accountability and reporting;
    iv. a liability agreement; and,
    v. terms under which the Agreement can be terminated;

- establish any district level policies and procedures necessary to support the delivery of Self-managed Care services;

- notify the Department of Health and Wellness when the *Self-managed Care Agreement*/client funding are to be terminated and also when client funding is to be temporarily placed on hold, as indicated in the *Self-managed Care Agreement*;

- reconcile, collect and request clients' financial documentation as required and forward clients' financial statements to Department of Health and Wellness on a quarterly basis;

- comply with all performance measurement and reporting requirements for Self-managed Care services, as established by the Department of Health and Wellness; and

- comply with Department of Health and Wellness' auditing processes intended to measure compliance with the Self-managed Care Policy, as established by the Department of Health and Wellness.

Section: 3.0 ROLES AND RESPONSIBILITIES
Policy: 3.3 Role and Responsibility of the Client

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3.3 ROLE AND RESPONSIBILITIES OF THE CLIENT

The Self-managed Care client is responsible to:

- sign an agreement with the Department of Health and Wellness, the District Health Authority and the care manager (if applicable) governing the terms and conditions of Self-managed Care funding;
- use the Self-managed Care funding only for the support services identified in the client's approved care plan and cover any costs associated with support services, which are in excess of the Self-managed Care funding amount;
- establish and retain proof of the qualifications for the care providers hired and monitor and report on (as required) the quality of the care provided (in relation to meeting the health outcomes as articulated in the approved care plan);
- hire care providers as employees, who receive statutory benefits;
- recruit, screen, interview, hire and terminate care providers;
- provide initial and ongoing training, supervision and direction of care providers;
- develop a backup service plan for contingencies and emergencies;

- maintain a separate bank account for the purpose of managing allocated funds;

- maintain and keep all records related to the Self-managed Care funds received including, but not limited to: bank statements establishing all deposits and payments; canceled cheques; original receipts; time sheets and invoices; records of the dates and number of hours of service provided; proof of payment to the care providers; and employment records;

- register and enroll for coverage with the Workers' Compensation Board;

- register with the appropriate agencies such as the Canada Revenue Agency, as required by their status as an employer, and to calculate and submit all required remittances from employee wages;

- submit any required financial reports quarterly to the District Health Authority on the schedule established by the District Health Authority and to cooperate with financial and/or quality audits related to the Self-managed Care funding;

- comply with all applicable legislation and regulations, including but not limited to, the *Income Tax Act*, the *Workers' Compensation Act*, the *Employment Insurance Act*, the *Labour Standards Code* and the *Occupational Health and Safety Act* and all other relevant requirements and standards as defined by federal and provincial legislation;

- agree to accept case management services from the District Health Authority;

- notify the District Health Authority in the event that there is a change in the requirement for services, including but not limited to:
    - client admission to an acute care facility,
    - client admission to a long term care facility,
    - significant change in client's health status, impacting on service,
    - interruption in the need for support services for a period exceeding 14 consecutive days;

- appoint a care manager, if desired, to manage the care of the client and/or the financial/administrative requirements of Self-managed Care services;

- notify the District Health Authority of the appointment of a care manager or any change in care manager so a new agreement may be signed; and

- accept the risks inherent in and associated with the self-management of support services and liability issues for Self-managed Care services.

Section: 3.0 ROLES AND RESPONSIBILIITIES
Policy: 3.4 Role and Responsibilities of the Care Manager

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3.4 ROLE AND RESPONSIBILITIES OF THE CARE MANAGER

The Care Manager, appointed by the client, is responsible to:

- manage the care of the client and fulfill the financial/administrative requirements of *Self-managed Care* services as they relate to the client;

- act on behalf of the Self-managed Care client;

- fulfill the duties outlined under section 3.3 of the *Self-managed Care Policy* and the terms of the *Self-managed Care Agreement*;

- comply with the *Self-managed Care Policy* and the *Self-managed Care Agreement* and to ensure the terms and conditions therein are followed;

- sign as a party to the *Self-managed Care Agreement*, with the Department of Health and Wellness, the District Health Authority and the client, prior to assuming the role of care manager.

Section: 4.0 CONSENTS, CONFIDENTIALITY AND PRIVACY
Policy: 4.1 Consents, Confidentiality and Privacy

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4.1 CONSENTS, CONFIDENTIALITY AND PRIVACY

1. The District Health Authority is required to treat as confidential, all information concerning an individual client. District Health Authority staff are responsible to protect the privacy of individual clients with respect to any personal information about them.

2. The District Health Authority must have written policies regarding client consent and the collection, use, disclosure, and retention of personal information which are consistent with all applicable legislation.

3. District Health Authority staff shall have authorized access to confidential information for program purposes only (i.e. on a “need to know” basis).

Section: 5.0 SELF-MANAGED CARE FUNDING
Policy: 5.1 Conditions on the Use of Self-managed Care Funding

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5.1. CONDITIONS ON THE USE OF SELF-MANAGED CARE FUNDING

1. Self-managed Care funds may only be used:
   - to hire care providers as employees (who receive statutory benefits);
   - to provide support services identified in the client's approved care plan; and
   - for the delivery of personal care services in approved settings.

2. Self-managed Care funding is comprehensive and is to be used by the client for the following costs:
   - wages for care providers;
   - payroll deductions and benefits;
   - Workers Compensation premiums;
   - administrative costs of service (payroll, scheduling, etc.); and
   - bookkeeping fees up to maximum of $100 per month.

3. Self-managed Care funds may not be used:
   - to hire workers, on a contractual basis, who would be considered self-
   - employed;
   - to purchase support services from an agency, except as a back-up plan for contingencies;
   - to purchase services from a person or organization when that person or organization owns, rents, or otherwise manages the residence in which the client lives;

- to purchase services which require the provider to be a health professional; or

- for personal compensation or payment to the client or care manager for the time and effort expended in administering Self-managed Care services.

4. Self-managed Care funding is provided in lieu of the direct delivery of personal care and home support services that may be available through the District Health Authority, Home Care Program. Clients who receive Self-managed Care funding are not eligible to receive personal care or home support services through the Continuing Care Home Care Program.

5. A client who wishes to use Self-managed Care funds to pay for personal care services in an approved setting outside of Nova Scotia, must obtain written approval from the District Health Authority at least two weeks in advance.

Section: 5.0 SELF-MANAGED CARE FUNDING
Policy: 5.2 Use of Self-managed Care Funding for Home Support Services

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5.2. USE OF SELF-MANAGED CARE FUNDING FOR HOME SUPPORT SERVICES

1. The client must require home support services in conjunction with personal care services.

2. Funding for light housekeeping services, essential to the client's activities of daily living, should be authorized to a maximum number of hours per month.

3. Funding for laundry services may be authorized for the client's laundry only and is generally authorized to a maximum number of hours per month.

4. Funding for meal preparation is provided to ensure maintenance of the client's nutritional health and generally should only be authorized if all other options have been explored first (e.g. Meals on Wheels/other community meal programs, family, volunteers).

5. Funding for additional hours of home support services may be considered in exceptional circumstances. Authorization for additional home support hours must be approved by designated District Health Authority personnel and documented on the client's file.

Section: 5.0 SELF-MANAGED CARE FUNDING
Policy: 5.3 Restrictions on Hiring Family Members

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5.3 RESTRICTIONS ON HIRING FAMILY MEMBERS

1. Family members of a Self-managed Care client may not be hired as care providers, except as may be allowed under the provisions and conditions contained in this section.

2. For the purposes of these requirements, family members include:
    - spouses or partners living together in a spousal relationship;
    - parents, including parents-in-law, step-parents, and adoptive parents;
    - children, including step-children, adoptive children, daughters-in-law, and sons-in-law;
    - grandparents and grandchildren, including step-grandparents and step-grandchildren;
    - siblings, including step-siblings, sisters-in-law and brothers-in-law;
    - aunts and uncles, including step-aunts and step-uncles; and
    - nephews, nieces; and
    - other relations, through blood, marriage, or adoption, who are living in the same household as the client.

3. The hiring of a client's family member as a care provider may be approved as a temporary measure and is only permitted by approved exception.

4. The client/care manager must satisfactorily demonstrate to the District Health Authority that there is no other realistic temporary alternative to meet service needs,

including direct service delivery through the Home Care Program.

5. The hiring of a client's family member as a temporary care provider shall not be approved if the family member has provided care without compensation in the past; unless there is the potential for unique hardship to the client, resulting from the lack of an available care provider.

6. The hiring of a family member as a care provider shall not be approved to compensate for loss of income or any other loss incurred as the result of providing care.

7. All exceptions allowing the hiring of a family member as a care provider, must be approved in writing by the designated District Health Authority personnel and documented on the client's file.

8. Whenever a family member has been hired as a care provider on a temporary basis, it must be reviewed on a quarterly basis to determine whether another care provider or an alternative service arrangement is available to the client. After each review, the approval to employ a family member as a care provider shall be renewed only if the grounds for the exception are still valid.

Section: 5.0 SELF-MANAGED CARE FUNDING
Policy: 5.4 Self-managed Care Funding Limit and Funding Rate

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5.4 SELF-MANAGED CARE FUNDING LIMIT AND FUNDING RATE

1. The monthly service maximum is $3780.29 per month or 205 hours per month.

2. The hourly funding rate for Self-managed Care services is $18.36. This funding rate does not represent an hourly wage or rate of pay for care providers, but is a comprehensive rate provided for the coverage of all applicable Self-managed Care costs.

Section: 6.0 SELF-MANAGED CARE FEE
Policy: 6.1 Self-managed Care Fee

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6.1 SELF-MANAGED CARE FEE

1. District Health Authorities are required to charge a fee for Self-managed Care services except to clients whose income falls within the fee exempt category.

2. Clients who are required to pay a Self-managed Care fee and who are also receiving Home Oxygen Services shall have any applicable fee waived.

3. An applicant's requirement to pay Self-managed Care fees, and the amount of fees to be charged, shall be identified during the assessment process. This determination shall be made using the Self-managed Care Fee Determination Process and the current Self-managed Care Fee Determination Tables in the appendices of this policy manual.

4. Applicants for Self-managed Care services must be informed, as part of the assessment process, about any fees they will be required to pay and their right to appeal the application of fees, as per section 6.3 of this *Self-managed Care Policy*.

5. Applicants who do not wish to provide income information, but who otherwise meet program eligibility criteria, may still be able to receive Self-managed Care services. For the purposes of service fee determination, eligible applicants choosing not to disclose income information shall be deemed to be in the highest Client Income Category.

6. A client’s fee status shall be reassessed annually, or on an as needed basis.

7. The Self-managed Care fee shall be deducted, at source, from the monthly Self-managed Care funding allotment.

Section: 6.0 SELF-MANAGED CARE FEE
Policy: 6.2 Self-managed Care Fee Determination

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6.2 SELF-MANAGED CARE FEE DETERMINATION

1. District Health Authorities are required to follow provincially established criteria in determining any applicable fees for Self-managed Care services.

   For the purposes of client fee determination, net family income and family size are calculated in accordance with the following criteria:
   - for partnered relationships, the incomes of both partners are included and family size includes all children under the age of 19, who are living at home;
   - for partnered relationships where one partner is a resident in long term care and there is a spousal income split, the income retained by the spouse in the community is used to determine service fees. Family size includes all children under the age of 19, who are living at home; and
   - siblings or friends living together are not considered a core family unit and each individual is treated separately for the purposes of fee determination.

2. For the purposes of income verification, the net income of all applicable individuals, as identified on line 236 of the Federal Income Tax Return or in the Notice of Assessment provided by the Canada Revenue Agency, shall be used.

3. Where more than one fee eligible applicant/client resides in the same household, each individual is treated separately for the purposes of fee determination.

Section: 6.0 SELF-MANAGED CARE FEE
Policy: 6.3 Appeal of Fee Assessment Decisions

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6.3 APPEAL OF FEE ASSESSMENT DECISIONS

1. Clients have the right to appeal decisions related to the application of a Self-managed Care fee if the fee will cause personal financial hardship. The client is required to provide sufficient information to support the appeal. The appeal is to be directed to the District Health Authority.

2. For clients appealing the application of the Self-managed Care fee, the District Health Authority shall follow the same, or a similar, appeal process for clients as is described in Section 5.6 of the *Nova Scotia Department of Health and Wellness, Home Care Policy Manual*.