Home and Community Support Service (HCSS) Specification

Tier 2

Contents

1. Status

Approved to be used for mandatory nationwide description of services to be provided.

MANDATORY ☑

2. Review History

Review History	Date
First Published on NSFL	2020
Reviewed	April 2025

3. Introduction

This Tier Two Service specification for Restorative Home and Community Support Services (HCSS) is used for purchasing Services for people who have assessed support needs.

So that the total Service requirements are explicit, this Service specification is to be used in conjunction with the Tier One Community Health, Transitional and Support Services Service specification. If there are any discrepancies between the Tier Two Service specification and the Tier One Community Health, Transitional and Support Services specification, then the Tier One specification takes precedence.

This Service specification is also to be used in conjunction with provider specific Service Specification as described in section X. If there are any discrepancies between the Tier Two Service specification and Section X then this Tier Two Service specification takes precedence.

This Tier Two Service specification provides an overarching framework of provision of nationally consistent HCSS.

This Service specification supports the National Framework for Home and Community Services (HCSS) 1 vision for high-quality HCSS that flexibly meets the needs of individuals, are person, family and whānau-focused, are inclusive and accessible, and culturally appropriate. The inequities experienced by priority populations - Māori, Pacific and disabled people – will be addressed. The Service will be sustainable over time and delivered by a competent, skilled, well-trained workforce. This framework was developed in collaboration with key stakeholders in the HCSS sector, including older people and their whānau.

4. Service Definition

HCSS are part of ensuring a comprehensive range of services for people who need support to remain living independently in their own home. To ensure clarity in this document we refer to people receiving HCSS as clients. The Service is available for a wide range of clients but primarily will support older people. The Service will be delivered by a workforce who have the skills needed to meet individual client goals and needs. HCSS takes a proactive approach to regain and/or maintain client function and/or prevent deterioration. HCSS also aims to relieve Carer Stress. If clients enter a life stage where palliative care is necessary, the Service delivery will adjust to reflect palliative support needs.

5. Service Objectives

5.1.1 General

The purpose of HCSS is to provide clients with restorative, person-centered, culturally appropriate and responsive support that maintains or enhances functional ability, health and social connectivity, and to provide support at the end of life. HCSS objectives are to:

[1] National Framework for Home and Community Support Services (HCSS) | Ministry of Health NZ

- Maximize and maintain client's independence for as long as possible
- Enable clients to actively participate in setting personal goals and planning care
- Determine flexible Service delivery required to support client's goals and respond to their changing needs within a bulk funding model
- Identify where carer stress may impact on a person's independence and ensure appropriate Service responses are engaged
- Engage in continuous quality improvement within a 'best for person, best for system' framework.

The Service will be delivered in collaboration with the wider health system including:

- contracted providers
- allied health
- primary health care
- Need Assessment and Service Coordination (NASC)
- Ageing Well Health New Zealand teams

The Provider will participate in an integrated framework, working with Health New Zealand district and regional leadership to meet strategic and operational goals and objectives. The framework is responsible for ensuring integrated, coordinated and responsive HCSS delivery with a focus on continuous improvements within a 'best for person, best for system' framework.

5.1.2 Key Documents

The strategic links for HCSS are the:

- National Framework for Home and Community Support Services
- Pae Ora (Healthy Futures) Legislation[2],
- New Zealand Health Strategy[3],
- Healthy Ageing Strategy[4],
- He Korowai Oranga Māori Health Strategy[5],
- New Zealand Framework for Dementia Care[6],
- New Zealand Carers' Strategy[7]
- Te Ara Whakapiri[8] Principles and Guidance for the last days of life
- New Zealand Disability Strategy[9],
- Dementia Action Plan[10]

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[2] Pae Ora (Healthy Futures) Act 2022
[3] The New Zealand Health Strategy | Ministry of Health NZ
[4] Healthy Ageing Strategy | Ministry of Health NZ
[5] He Korowai Oranga: Māori Health Strategy | Ministry of Health NZ
[6] New Zealand Framework for Dementia Care | Ministry of Health NZ
[7] The New Zealand Carers' Strategy - Ministry of Social Development
[8] Te Ara Whakapiri: Principles and guidance for the last days of life – Health New Zealand | Te Whatu Ora
[9] New Zealand Disability Strategy 2016-2026 | Disability Support Services
[10] Dementia-Mateware-Action-Plan.pdf

- Te Mana Ola the Pacific Health Strategy[11]
- The Interim New Zealand Health Plan. Te Pae Tata [12]

HCSS are a key component of achieving the long-term vision of the Healthy Aging Strategy by supporting older people to live well, age well and have a respectful end of life in age-friendly communities. The Provider will adhere to the Code of Health and Disability Services Consumers' Rights 1996 and other relevant legislation as described in clause 11.1.1.

5.1.3 Māori Health

These requirements are in addition to the generic requirements for Māori Health in the Tier One Community Health, Transitional and Support Services service specification. The Provider will work within the Pae Ora framework of Pae Tū: Hauora Māori Health Strategy.

Pae ora reflects a holistic, indigenous worldview and includes three interconnected elements: mauri ora, whānau ora and wai ora. Improvements must be made across each of these elements for Māori to live with good health and wellbeing.

The provider will meet obligations under Te Tiriti o Waitangi that ensure Māori can live longer, healthier, and more independent lives

Pae Tū enhances and builds on the momentum of both He Korowai Oranga: Māori Health Strategy and Whakamaua: Māori Health Action Plan 2020–2025. It reaffirms the vision of 'pae ora – healthy futures for Māori', and the four outcomes set out in Whakamaua, which provide an important focus for collective action:

- Outcome 1: Whānau, hapū, iwi and Māori communities can exercise their authority to improve their health and wellbeing
- Outcome 2: The health system is fair and sustainable, and delivers more
- equitable outcomes for Māori
- Outcome 3: The health system addresses racism and discrimination in
- all its forms
- Outcome 4: The inclusion and protection of mātauranga throughout the Health System .

Pae Tū provides a platform for Māori to live with good health and well-being in an environment that supports good quality of life. It encourages everyone in the health and disability sector to work collaboratively, to think beyond narrow definitions of health, and to provide a high-quality and effective Service.

The Provider's policies and practices will demonstrate measurable benefit to Māori, including demonstration of:

- Services that will equitably and directly deliver on Māori health priorities,
- workforce training focused on the delivery of Services to Māori including the Service's, understanding of Māori principles/tikanga,
- client and whānau feedback on how they believe the Provider has delivered in relation to Māori values and beliefs,

[11] Te Mana Ola: The Pacific Health Strategy
[12] Te Pae Tata Interim New Zealand Health Plan 2022 – Health New Zealand | Te Whatu Ora

- linkages with the local Māori community and how these are enhanced; and,
- processes to include engagement and input from Māori into Service delivery management and ongoing improvement and development of the Service.

The Provider will recognise the fundamental concepts of Te Whare Tapa Wha Model and the importance of balancing the 4 cornerstones of Māori Health, Taha tinana (physical health), Taha wairua (spiritual health), Taha whānau (family health) and Taha hinengaro (mental health) [13]

5.1.4 Pacific Health

The Provider is expected to contribute to the reduction in health and disability inequalities for Pacific people and to be responsive to the 5 key priority areas of Te Mana Ola, the Pacific Health Strategy.[14]

Pacific perspectives of health are holistic, encompassing the physical, mental, spiritual, social and economic wellbeing of the collective.

The 5 key priority areas of Te Mana Ola focus on and embrace the interconnection between:

- population health, by working with communities to build, maintain and enable strong foundations for Pacific health and well-being
- prioritising disease prevention, health promotion and good health and wellbeing throughout the life course
- better understanding the needs of Pacific peoples and communities and enabling them to exercise authority over their health and wellbeing
- ensuring that timely, high-quality Services are reaching Pacific peoples, wherever they live
- growing and supporting strong Pacific health leadership and a resilient health workforce that reflects the population it serves

The Provider must consider the needs of culturally diverse communities. The Service should strive to minimise barriers to access, or communication and Services must be safe for all people. There must be no discrimination in any practice.

5.1.5 Disability Health

One in six New Zealanders are disabled people, with that number increasing to one in three for people who are over 65-year-olds and one in two for people who are over 80 years old.[15] Given the support needs of the people accessing HCSS, clients will have a disability. Consequently, it is essential that the delivery of HCSS is accessible, inclusive and equitable to disabled people.

Disabled People are a priority population for Health NZ. The Disability actions in Te Pae Tata Interim New Zealand Health Plan provide a commitment to, and progressive vision for, realising the obligations of Health NZ under the Pae Ora Act and the Health of Disabled People Strategy. To ensure HCSS are inclusive of, and accessible to, disabled people it is

[13] Te Whare Tapa Whā model of Māori health | Ministry of Health NZ
[14] Te Mana Ola: The Pacific Health Strategy
[15] Disability statistics: 2023 | Stats NZ

expected that Services are delivered in ways that are consistent with the principles and priorities in Te Pae Tata:

Principles:

- Human-rights based model of disability
- ‘Nothing about us, without us’
- Connected, holistic models of care Facilitating connected care

6. Service Users

Service Users are defined as clients for the purposes of this Service specification. Most clients will be over 65 or aged 50 to 64 years with age related needs but the Service may be delivered to clients of all ages in accordance with Regional Service inclusions which will be detailed in Section X (Provider and Regional Specific section).

Clients are people who are eligible for long term publicly funded healthcare and that have been assessed using an appropriate interRAI assessment tool and:

- have support needs because of an age-related condition aged over 65 years
- are aged 50 to 64 years, and like in age and interest
- are under the Non-Acute Rehabilitation pathway
- are determined as being eligible by Health New Zealand Region specific inclusion in Service model

7. Access

7.1.1 Entry and Exit criteria

Entry to the Service occurs through referral via the wider health system. Self-referral or referral from whānau may also occur.

The referral pathway to access initial screening may be through the Needs Assessment and Service Coordination Service (NASC), electronic screening protocols or referral directly to the Provider.

Entry to Service occurs once eligibility criteria is met and triage has been completed.

The eligible population is initially screened using a Service Allocation Tool (SAT), Appendix 1, to determine whether a client is complex or non-complex.

Clients are allocated to a Provider as determined in Section X, Provider Specific Specifications.

7.1.2 Assessment process

The client will receive an appropriate interRAI assessment from a registered health professional (RHP) during Service access.

Where a client is determined to have non-complex needs during the initial screening, the Provider will carry out the interRAI Contact Assessment to determine Service needs and Individual Support Plan (ISP) goals and inputs.

Where a client is determined to have complex needs during the initial screening an interRAI assessment tool appropriate to the client needs will be carried out by NASC or other RHP as determined by Health New Zealand Regionally agreed process. This may include:

- Home Care Assessment
- Contact Assessment
- Palliative Assessment

7.1.3 Acute Care AssessmentTime

The Service will be available, seven days a week, as appropriate to meet client needs. In usual circumstances, Service hours are between 7.00 am and 10.00 pm or by negotiation, seven days a week. It is not expected that support Services will be delivered by support workers between 10.00 pm and 7.00 am.

Inside Service hours the client, referrers and support workers will be able to make direct contact with a Provider representative. Responses to queries will be available Monday to Sunday between the hours of 7.00 am and 10.00 pm. The Provider is expected to have a process to screen and allocate urgency to messages. This expectation includes all forms of message including but not exclusive to, phone, text and email.

8. Service Components

8.1.1 Settings and Facilities

This Service will be delivered in the client's home and other community settings as agreed in the ISP.

8.1.2 Processes

(a) Casemix allocation

The University of Auckland (AoU) casemix methodology is used to group clients with similar levels of assessed function together to support equitable resource allocation.

The interRAI assessment outcome scores are used to determine client casemix. The descriptions and goals of the casemix groups are provided in Appendix 2. The casemix enables Providers to identify high level client goals and describes Service response expectations.

(b) Referal management

The Provider will establish and maintain effective communication links with primary and secondary health services, Health New Zealand managers and the NASC, to achieve a responsive and informed referral management process. This includes involvement in hospital discharge planning.

(c) Service Implementation:

- Entry to Service occurs when the Provider receives the referral and has provided an electronic confirmation of receipt of referral to the referrer or NASC service. Receipt of referral will occur within one working day.
- The Service start date occurs after the following actions are completed:
    - referral has been reviewed by an appropriate staff member
    - client has been contacted, and the time of the first visit and initial assessment and development of individual support plan by Provider RHP has been agreed
- Service commencement is the initial contact visit and may consist of client assessment and Service goal setting or an immediate need enablement response delivered by a support worker.

The response time for each referral will be based on the client's level of contextual risk and needs (Appendix 3) assessed from the information given with the referral.

Early Supported Discharge response times will be determined by each Health New Zealand region and are detailed in Section X, Provider Specific Specification.

Service will commence within the time frames in the table below in relation to the contextual risk.

Table 1: Service implementation response times as determined by contextual risk:

contextual risk	**Response activities time frames- days from Receipt of referral**
Low	- Service start has been carried out within 5 working days - Services commence within 14 working days from receipt of referral
Moderate	- Service start has been carried out within 2 working days. - Services commence within 5 working days from receipt of referral
High Risk)	- Service Start has been carried out within 1 working day - Services commence within 2 working days from receipt of referral

8.1.3 Service delivery requirements

(a) Restorative approach

The Provider will use a restorative approach (Appendix 4) and work in partnership with the client to develop and agree goals and document these in the clients' ISP. Providers will deliver Services to facilitate achievement of the client's goals.

The Provider will actively collaborate with NASC, primary care, secondary care, and community providers to deliver Services to:

- Engage and work with both formal and natural supports to facilitate client goal attainment. Where appropriate, discharge clients who can manage independently with appropriate community and/or family supports in place.
- Work with a proactive restorative focus using flexible Service delivery to optimise client independence taking a 'doing with' as opposed to 'doing for' approach where appropriate.

- Deliver responsive and flexible Services, based on Provider RHP assessment of needs, that meet fluctuations in client health and support needs from Service entry to Service exit. This may require working closely with whānau, hospice, community health specialist nurses and primary care during times of unstable need or at end of life.
- Provide Services that facilitate 'falls prevention' through support activities that improve strength and balance consistent with current evidence or as advised by an allied health professional.

Share information and data with Primary Care to support Service development and individual client goal attainment.

(b) Individual support plan (ISP)

Client centred; goal-based Service planning informs the ISP. The Provider RHP will work with the client and their whānau to:

- understand the living situation including natural supports
- explore what is important to them
- understand what is meaningful to them
- provide information in a format that works best for the person, including New Zealand Sign Language (NSZL) and other alternative formats[16]
- understand the interRAI assessed support needs (Clinical Assessment Protocols and Outcome scores) of the client.

The ISP is developed with the client and family/whānau, and in reference to the NASC care plan, to agree goals that are focused on maintaining or increasing independence where possible and align with each client's potential to improve independence. Goals will also support clients to be involved in normal social activity.

Where clients have palliative care needs care, the goals of the ISP will reflect this and focus on support activities that promote clinical safety, dignity and comfort. End of life care will be delivered in line with Te Ara Whakapiri, Principles and Guidance for the last days of life.[17]

The Provider RHP will ensure the ISP documents how Service will be delivered flexibly and ensure clients access natural supports, whānau support, or technological aids to meet their agreed goals. ISPs provide sufficient detail for support workers to understand the restorative support interventions required for clients to achieve their goals. This may include:

- incontinence management, ensuring access to appropriate funded products and services. [18]
- medication support delivered as described in the "Medication Guidelines for the Home and Community Support Services Sector" [19] (MoH 2019)

A clear escalation pathway is documented within the ISP to manage situations where arrangements for support are uncertain or do not occur as planned. This may include processes for support to be provided by their carer or whānau and will ensure information on how to contact emergency services if required.

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[16] Alternate formats - Ministry of Social Development
[17] Te Ara Whakapiri: Principles and guidance for the last days of life – Health New Zealand | Te Whatu Ora
[18] Continence NZ - Empowering people affected by incontinence to thrive
[19] Medication Guidelines for the Home and Community Support Services Sector

(c) Review and reassessment

The Provider will review the ISP and/or respond to client self-report or whānau report when:

- clients experience a change or deterioration in health status or functional abilities noted by the support team
- there is a change to the carer status or personal circumstance
- there is a scheduled review or reassessment as per the client complexity level and casemix

An evidence-based review tool should be used at scheduled or unscheduled reviews undertaken by the support team, see Appendix 5 for example.

If the review is going to be undertaken by a support worker, the support worker must meet the micro credentialling requirements outlined in section 8.1.4. NZQA, Home and Community Support Services Kaiāwhina Client Service Review (micro-credential) Level 3 qualifications or any subsequent replacement of that qualification.[20]

The outcome of a review may require the ISP and risk assessment to be redeveloped, or the client may be ready for discharge.

For complex clients the Provider RHP may request the NASC to reassess the client if any significant change is noted. This may result in a new casemix allocation.

A full assessment and review schedule to support this process is attached in Appendix 2 and is mandatory.

Reassessment must always be carried out using the appropriate interRAI tool

(d) Health promotion and education

The Provider will promote and improve health literacy and knowledge for older people, their informal carers, whānau, and for the HCSS workforce, including sharing information resources such as:

- Advanced care plans (ACP) www.myacp.org.nz/your-plan,
- ACC Live Stronger for Longer About, www.livestronger.org.nz
- Alzheimers New Zealand Booklets and Factsheets - Alzheimers New Zealand
- Dementia NZ fact sheets Information Sheets | Dementia New Zealand
- Office for Seniors Creating an Enduring Power of Attorney | Te Tari Kaumātua
- Ministry for Social Development Supported decision-making - Ministry of Social Development

(e) Health and Safety management

In adherence with legislative requirements the Provider will ensure an occupational safety and health risk assessment is undertaken in the location the Service is delivered and documented at the earliest opportunity in relation to the specific Services to be delivered.

[20] Qualification Overview

(f) Discharge planning or onward referral

Clients will be discharged from the Service when they:

- no longer wish to receive the Service
- cease to meet the Service access criteria
- choose to transfer to another Service Provider
- transfer to aged residential care
- have met Service goals and restored /returned to independence
- are deceased
- where the provider has identified significant risk to the client remaining at home. This would be reviewed in conjunction with Health NZ clinical teams and the funder where required.

(g) Liaison and consultation

The Provider will liaise with the NASC when respite care, carer support, day activity, palliative care or residential care is required.

(h) Case management

Complete case management to ensure clients access the support they need from natural supports, other providers and the wider community, as required.

Deliver Services to facilitate integration across the health system, including, but not limited to integration with primary and secondary health services.

8.1.4 Key Inputs

The Provider will:

- Develop and maintain a capable, diverse, experienced, disability-responsive, culturally aware and well-trained workforce to deliver this Service to clients with diverse levels of assessed clinical complexity and support needs.
- Match client complexity with staff knowledge and competency
- Ensure allocation of clients to staff is appropriate and meets requirements of the Health and Safety at Work Act 2015

(a) Support workers

All support workers will have attained NZQA New Zealand Certificate in Health and Wellbeing – Level 2, within 12 months of commencement.

Support workers will have access to and be supported to complete further professional development, including training to attain the New Zealand Certificate in Health and Wellbeing level 3.

Support workers will have access to and be supported to attain Home and Community Support Services Kaiāwhina Client Service Review (micro-credential) Level 3 qualifications. The purpose of this micro-credential is to provide training to undertake a comprehensive non-complex ISP review.

Support workers will have access to available micro-credentials related to home and community support as determined by the New Zealand Qualifications Authority.21

(b) Registered health professionals (RHP)

RHPs'will have a current practicing certificate as required under the Health Practitioners' Competence Assurance Act 2003 or the Health Social Workers Registration Act (2003) or relevant professional authorities for self-regulated professions. RHPs' will work within their scope of practice and may provide an outline of delegated duties for the support workers.

RHPs' will receive training to understand the HCSS model, with a particular focus on understanding casemix and goal setting. E-Leaning modules to support understanding of Ngā Paerewa Health and Disability Services Standard are available through the Ministry of Health, Training and support | Ministry of Health NZ

The client's assessment must be completed by an interRAI trained RHP.

8.1.5 Service Levels

Service levels are determined by the Model of Care provided in Appendix 2

8.1.6 Work force diversity

The Provider will ensure Services are provided by a workforce that is reflective of the communities in which they provide Services and has active strategies to attract more Māori and Pacific staff, and staff from other minority groups (e.g. disabled and Deaf people, people from the Rainbow community, migrant and refugee communities) to health roles as reflected by the community service area. Where possible the client will be matched with support staff of the same culture who can speak in the same language as the client. Clients are enabled to access interpreter services as required, including New Zealand Sign Language for the Deaf.

9. Service Linkages

9.1.1 Service linkages

See Tier One Community Health, Transitional and Support Services service specification Section 8, Service Linkages.
The Provider will establish key linkages with other Service providers. These linkages are critical to the effective delivery of seamless and integrated HCSS and to maintain social connections for clients. Key linkages will be established with:

Other Service provider	The provider will engage with the other provider to:
The Clients Primary care provider	- receive communication regarding client Service risk or deterioration in the client's well-being
NASC	- develop Service time frames and ensure continuing two-way communication regarding Service requests/referrals and client support needs

21 https://www2.nzqa.govt.nz/

	- Work collaboratively to case manage clinically or socially complex clients - Provide Care Plans for complex client based on interRAI assessment outcome scores that contribute to provider Service plans
Secondary health care	- develop and promote integrated client pathways including Early Supported Discharge
Community agencies/voluntary sector • local Māori networks, kaumātua groups, marae, whānau groups and Māori health providers • support groups and consumer advocacy groups • cultural and disability networks • accredited community providers of strength and balance classes • interpreter services including New Zealand Sign Language • community based Non-Government Organisations (NGOs) including those providing mental health services.	- facilitate delivery of Services to Clients as per their organisational funding and responsibilities
Work force training groups	- facilitate and support delivery of training

10. Exclusions

The following people will be excluded from this Service where there are duplicate services that are already funded by Health New Zealand under other service specifications and by other government agencies who:

- are funded for Home Support Services by Accident Compensation Corporation (ACC). Unless under a Non-Acute Rehabilitation Pathway (NARP)
- are eligible for Disability Support Services

11. Quality Requirements

Refer to Tier One Community Health, Transitional and Support Services service specification for Quality Requirements for General, Access and Acceptability quality requirements.

11.1.1 Legislative requirements

The Provider's Services are governed by NZ Regulations and Legislation, including but not limited to:

- Pae Ora (Healthy Futures) Act 2022

- Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996
- Privacy Act 2020
- Health Practitioners Competence Assurance Act 2003
- Home and Community Support (Payment for Travel between Clients) Settlement Act 2016
- Crimes Act 1961 (duty of care Section 151).
- Health and Disability Services (Safety) Act 200 Te Mauri o Rongo – NZ Health Charter
- Te Pae Waenga – NZ Health Plan
- Health (Retention of Health Information) Regulations 1996
- Health and Safety at Work Act 2015.

11.1.2 Audit, Quality improvement and risk management

The Provider must hold and maintain current certification against Ngā Paerewa Health and Disability services standard NZS 8134:2021 [20]. The Provider must also be compliant with NZS 4121:2001 for accessibility. Certification audits will be completed by a designated audit agency. All certification audit reports, and associated progress reports will be provided to Health New Zealand as soon as finalised.

Complaints management will align with the Complaints Categorisation (2015) [22] and the Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996and will seek resolution through proactive management. Complaints data will be available on funder request.

Clinical Services will meet Professional Body standards of practice.

The Providers continuous quality improvement strategy will involve a best practice approach to organisational management including consumer rights, entry to Service, human resource management, exception reporting and complaints management, and Service planning and delivery.

11.1.3 Service Outcome Measures

The Provider will work collaboratively with Health NZ and other Providers at a regional and national level to monitor and benchmark Service outcomes.

Service outcomes will be measured using quality indicators derived from interRAI Home Care (HC) data and interRAI Contact Assessment (CA) wellbeing measures. Using this suite of quality indicators and wellness measures the Provider and Health NZ will work collaboratively to identify when measures perform less positively and target interventions to improve Service performance. They will be used at the provider and health system level to support quality initiatives, program evaluation and benchmarking [23] This information will be used for operational, statistical and research purposes.

The interRAI HC quality indicators and CA Wellness measures are provided in Appendix 6.

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[22] Complaints Categorisation Guidance now available - Home and Community Health | Sustainable, equitable, high-quality provision of home and community health services across Aotearoa

[23] interRAI home care quality indicators | BMC Geriatrics | Full Text

In addition to the interRAI quality and wellness measures, Health NZ will measure national system outcome measures derived from population and health system data to determine Service performance, this will include but is not limited to:

- ARC and hospital admission rates
- Acute bed day stay and hospital readmission rates
- Days spent at home per year (365)
- Percentage of people over 75 living in their own home
- Percentage of first interRAI completed in the community
- The number of complex clients compared to the number of non-complex clients

These system level measure and interRAI measures will:

- Compare outcomes by provider and regions to identify improvement opportunities
- Monitor results over time and track progress towards quality outcomes
- Support accountability
- Be available for public reporting requirements

12. Purchase Units

Purchase Units[24] are defined in the Nationwide Service Framework Purchase Unit Data Dictionary. The following Purchase Units apply to this Service:

PU Code	PU Name	PU Description	PU Measure	PU Measure Definition	National Collections or Payment Systems
HOP1055	National Restorative Home and Community Support	Provides home and community based restorative, person-centered, culturally appropriate and responsive support that maintains or enhances functional ability, health and social connectivity, and to provide support at the end of life. Bulk funded model based on interRAI assessment and casemix allocation	Service	Service purchased in a block arrangement uniquely agreed between the parties to the agreement	CMS

[24] Purchase Unit Codes are published in the Purchase Unit Data Dictionary on www.nsfl.health.govt.nz. They are reviewed, agreed and updated annually

13. Reporting Requirements

13.1.1 Health Data Platform collection

The Provider must comply with the requirements of health data collections as detailed in the table below. Data requirements may be changed from time-to-time following consultation and agreement. Collection of this data will inform funding arrangements.

Field name	Description	Type	Format	Requirement
NHI	NHI of patient	Char 7	AAANNNN	Mandatory
DISTRICT_OF_SERVICE	HPI_Organisation_ID of the District where Service was provided to patient	Varchar (8)	GNNNNN-A	Mandatory
REFERRAL_RECEIVED_DATE	Date of person's referral to the Service (Confirmation of receipt of referral)	Date	YYYYMMDD	Mandatory
SERVICE_START_DATE	Referral has been reviewed by an appropriate staff member. Client has been contacted, and the time of the first visit and initial assessment has been agreed	Date	YYYYMMDD	Mandatory
DISCHARGE_DATE	Date of discharge from the Service	Date	YYYYMMDD	Mandatory; nulls are acceptable
SW_CONTACT_HOURS	Total SW (Support Worker) hours - as a decimal	Decimal	N.NN	Mandatory; nulls are acceptable

13.1.2 Information technology systems

The Provider's Information Technology Systems will comply with the system requirements described in national and HISO Ethnicity Data Protocols (2017)24, including the Health Records NZS 8153:2002, Ngā Paerewa Health and Disability services standard 25, the Health Act 1956, the Health (Retention of Health Information) Regulations 1996 and the Health Information Privacy Code 2020. The Service Provider's IT Systems will support electronic information processing, interfaces and workflows, specifically interRAI software.

13.1.3 Data sharing

To support the Service objectives of Health NZ, Providers will work together with Primary Health Organisations, General Practices and other community-based providers towards identification and exploration of data sharing opportunities that will benefit the care and outcome of their clients. In undertaking any such data sharing arrangements, they must be cognisant of the confidential nature of client data and obligations to appropriately protect clients' rights to confidentiality.

13.1.4 Non National Collections

The Funder may require other data collection from the Provider. These are described in Provider Specific section X if required.

Current reporting email address for Sector Operations is:

Email: performance_reporting@health.govt.nz

14. Glossary – to be developed

Term	Meaning

15. Appendices

Appendix 1: SAT Tool

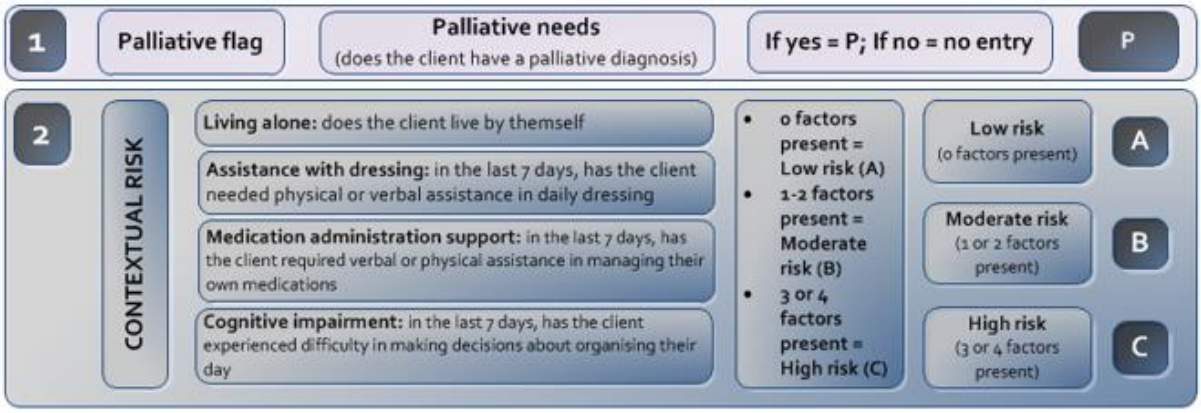
Lead Issue	Screening Question
1. Cognitive impairment	Does the client have a cognitive impairment that affects their everyday life through a decreased ability to think, concentrate, remember ideas and make safe decisions?
2. Progressive neurological condition	Does the client have a progressive neurological condition such as Parkinson's Disease, Multiple Sclerosis or Huntington's Disease that requires daily support?
3. Carer stress	Is the client's carer unable to continue caring for the client or feeling overwhelmed or distressed and/or there is abuse and neglect concerns?
4. Dressing	Does the client require ongoing/long-term physical assistance with daily dressing of their lower body? (does not include application or removal of compression hosiery).
5. Medication Management	Does the client require ongoing/long-term verbal or physical assistance in managing their own medications?
6. Mood	Does the client have fluctuating anxiety, low mood, other mental illness or experience chronic pain that significantly impacts on daily living?

Key: If yes to any = complex, if no to all questions, then the client is non-complex.

Appendix 2: Service model

Goal	Older people live well, age well and have a respectful end of life in their communities					
Aim	**Older people establish and maintain meaningful social and cultural connections that support holistic wellbeing to enable a purposeful life.**					
	Non-Complex		**Complex**			
Case Mix	**Group 2 - Low Needs**	**Group 3 - Low Needs**	**Group 4 - Disability Only**	**Group 5 - Carer Stress**	**Group 6 - Cognitive Impairment**	**Group 7 - Carer Stress &Cognitive Impairment**
Case Mix Goal	Older people are socially connected to their local community and utilise this to ensure their social and nutritional needs are appropriately met.	Older people are supported to maximise functional capacity, build confidence and regain independence to enable active engagement in their local community.	Older people receive appropriate support services which enable them to live as independently as possible.	Older people and their carers live purposeful lives within their communities.	Older people are safe and secure in their own home within a supportive community.	Older people and their carers wellbeing is maximised through flexible and responsive appropriate support plans that enable them to remain living in their own homes in a supportive community.
HCSS Service Response Expectations	• Link and integrate with existing community networks i.e. activities promoted by NGOs, churches, councils and cultural groups. • Return to independence with shopping or an alternative method for shopping. • Ongoing case management–annual review.	• Return to independence with shopping or an alternative method for shopping.		• Goals that encompasses meaningful community participation for the older person and their carer. • Goals to best support the carer if appropriate i.e. use of respite. • **Engagement with Older Persons specialty services.**	• Engagement with Older Persons specialty services. • Consider technology to support client. • Flexible and responsive support plan.	• Engagement with Older Persons specialty services. • Flexible and responsive support plan. • Goals to best support the carer if appropriate i.e. use o respite.
Consider Referral						
Reassessment Timeframe	**Annual review SW**	**6m review SW 12m CA reassessment RHP**	**6m review SW 12m CA/HC reassessment RHP**	**3m review SW 12m HC reassessment RHP**	**3m review SW 12m HC reassessment RHP**	**3m review RHP 12m HC reassessment RHP**
Outcomes	ARC and hospital admission rates | Acute bed day stay and hospital readmission rates | Days spent at home per year (365) Percentage of people over 75 living in their own home | Percentage of first interRAI completed in the community | Complex v Non-complex split					
Key	Support plan that reflects each CAP triggered on the interRAI	Annual environmental assessment	Whānau plan	Medication review	Falls Prevention	EPOA and ACP

Appendix 3: Contextual Risk Rating for Response Time



Appendix 4:

Definition of the Restorative Model

Restorative is a person-centered, holistic approach that aims to enhance an individual's physical and/or other functioning, to increase or maintain their independence in meaningful activities of daily living at their place of residence and to reduce their need for long-term services. Restorative consists of multiple visits and is delivered by a trained and coordinated interdisciplinary team. The approach includes an initial comprehensive assessment followed by regular reassessments and the development of goal-oriented support plans. Restorative supports an individual to achieve their goals, if applicable, through participation in daily activities, home modifications and assistive devices as well as involvement of their social network. Restorative HCSS is an inclusive approach irrespective of age, capacity, diagnosis or setting.

Supporting literature and links:

Parsons JG, Parsons MJ. The effect of a designated tool on person-centred goal identification and service planning among older people receiving homecare in New Zealand. Health Soc Care Community. 2012 Nov;20(6):653-62. doi: 10.1111/j.1365-2524.2012.01081.x. Epub 2012 Jul 19. PMID: 22812380.

The effect of a designated tool on person-centred goal identification and service planning among older people receiving homecare in New Zealand - Parsons - 2012 - Health & Social Care in the Community - Wiley Online Library

King AI, Parsons M, Robinson E, Jörgensen D. Assessing the impact of a restorative home care service in New Zealand: a cluster randomised controlled trial. Health Soc Care Community. 2012 Jul;20(4):365-74. doi: 10.1111/j.1365-2524.2011.01039.x. Epub 2011 Nov 22. PMID: 22106952.

Assessing the impact of a restorative home care service in New Zealand: a cluster randomised controlled trial - King - 2012 - Health & Social Care in the Community - Wiley Online Library

King AI, Parsons M, Robinson E. A restorative home care intervention in New Zealand: perceptions of paid caregivers. Health Soc Care Community. 2012 Jan;20(1):70-9. doi: 10.1111/j.1365-2524.2011.01020.x. Epub 2011 Aug 5. PMID: 21819474.

A restorative home care intervention in New Zealand: perceptions of paid caregivers - King - 2012 - Health & Social Care in the Community - Wiley Online Library

Senior HE, Parsons M, Kerse N, Chen MH, Jacobs S, Hoorn SV, Anderson CS. Promoting independence in frail older people: a randomised controlled trial of a restorative care service in New Zealand. Age Ageing. 2014 May;43(3):418-24. doi: 10.1093/ageing/afu025. Epub 2014 Mar 4. PMID: 24598085.

Promoting independence in frail older people: a randomised controlled trial of a restorative care service in New Zealand - PubMed

Appendix 5 - Review tool: Question	Activity	Question	Intention of question from interRAI	Advanced Support Worker question	Additional prompts
SAT 1	Cognition	Does the client have cognitive impairment	To determine whether they have cognitive impairment. Do they have a memory problem which effects how they can do for themselves If yes – complex	Does the client have any difficulty with their ability to make decisions relating to tasks of daily life? (preparing meals, dressing and bathing, remaining safe, taking medication)? Has the client had any deterioration in their ability to make decisions relating to their daily life over the past three months?	Have they developed this problem since the last review? Has their cognitive impairment got worse since the last review? Try to get a list of problems that their cognitive impairment causes so that a decision can be made about the urgency of the case. these include wandering, aggression, safety (meal preparation, heating, feeding themselves, fluid intake)
SAT 2	Neurological condition	Does the client have a progressive neurological condition?	Do they have a neurological condition that may worsen over time. Do they have a condition that affects the brain and nervous system and worsens over time (eg Parkinsons Disease, Motor neurone disease, multiple sclerosis) If yes - complex	Does the client have a neurological condition that has been diagnosed and will get worse over time? These conditions include: Parkinsons Disease, Motor Neurone Disease and Multiple Sclerosis). Is this a new diagnosis since the last review?	
SAT 3	Carer stress or unstable social support systems	Does the client have a brittle social support system	To identify families who can be expected to have difficulty in responding to the developing needs of impaired clients. Identified families provide limited/minor care at baseline and can be expected to change little over the ensuing months. These family systems are considered to be brittle. In the	Does the client have informal support that has changed since the last review? Are the providers of informal support indicating that they are unable to cope or are more stressed?	Informal support is provided by families, friends and neighbours. It provides help to the client in many different ways and often means that paid support can be less than it would be without the informal support.

			extreme case, there are also a very small number of actively involved families for whom new demands for care giving help can strain their response capacity and they may not be able to address the care giving needs of the client appropriately. If yes - complex		Ask the main providers of the informal support to complete the caregiver reaction assessment.
SAT 4	Dressing	Does the client require assistance with dressing	To identify whether clients need help with dressing. If yes - complex	Since the last review, does the client need help with dressing? This can include choosing clothes, getting clothes from their place of storage, removing clothes and putting clothes on in an appropriate and safe manner.	
SAT 5	Medications	Does the client require assistance with medication management	If the client did not have support of another person, they would be unable to take the right medications at the right time If yes - complex	Does the client need help to manage their medications safely? Are they able to keep their stock of medications up to date? Are they able to follow instructions in terms of when and how to take the medication? Are they able to physically manage their medications (in terms of memory, vision, hand / finger dexterity)?	If the client did not have support of another person, they would be unable to take the right medications at the right time. This includes all prescribed medications, and all tasks involved in taking medications safely (maintaining an up to date prescription, using medication that is the appropriate dosage and not expired, able to take the right dose at the right time in the prescribed manner)
SAT 6	Pain/Mood/Anxiety	Does the client have uncontrolled pain	Does their pain effect what they do during the day and they are in considerable pain throughout or at times in the day If yes - complex	Does the client have pain that is not controlled and stops them doing activities that they could do if the pain was not there?	

		Does the client experience low mood or anxiety that impacts on their everyday activities	Does the client experience low mood or anxiety that impacts on their everyday activities If yes - complex	Does the client have low mood or anxiety that stops them doing activities? Does the client express any wish / or show any desire to harm themselves?	
Additional	Shopping	Does the client require assistance with shopping	This question is being used to determine a level of disability to access home support services. Shopping requires independence in making the list, using transport to get to and from the shops, buying the groceries and carrying them, and storing the groceries safely Not part of SAT tool	Does the client need help with shopping? This includes any help with a task related to shopping and can include informal support to complete these tasks.	This includes any help with compiling list, accessing transport, completion of purchasing groceries, transport of groceries and safe storage

Appendix 6: interRAI quality indicators and wellness measures

From: interRAI home care quality indicators

Home care quality indicator	Improvement	Decline	Follow-up prevalence
Functional HC-QIs			
Instrumental activity of daily living	X	X	
Activity of daly living	X	X	
Cognition	X	X	
Communication	X	X	
Clinical HC-QIs			
Bladder continence	X	X	
Falls			X
Weight loss			X
Injuries			X
Mood	X	X	
Pain	X		
Daily pain, severe +			X
Pain not adequately controlled			X
Social HC-QIs			
Caregiver distress			X
Alone and distressed			X
Does not go out but used to			X
Utilization HC-QIs			
No flu vaccination			X
Hospital, emergency department, emergent care			X

(J.N Morris, 2013)

Contact Assessment wellness measures

Scale	Purpose	Output Information
Assessment Urgency Algorithm (AUA)	To determine if a person has complex needs and how urgently they require a comprehensive assessment (interRAI Home Care or Palliative Care assessment). Scores of 4 or more require a Home Care assessment. The person required an HC assessment.	Scale 1 – 6. Indicator 4 or more.
Rehabilitation Urgency Algorithm (RUA)	To determine a person's potential for rehabilitation. Scores of 3 or more may require Allied Health input. If coupled with a high AUA apply clinical decision whether to proceed to a HC assessment, if short term improvement is likely. The person required Allied Health input.	Scale 1 – 5. Indicator 3 or more.
Service Urgency Algorithm (SUA)	To prioritise which types of nursing or support service a person needs to be referred to. A score of 2 or more may require nursing intervention. The person required nursing services.	Scale 1 – 4. Indicator 2 or more.
Disease, Signs and Symptoms (CHESS)	Identifies people who are at serious risk of hospitalisation or mortality due to instability of conditions. A score of 3 indicates moderate health	Scale 0 – 5. Indicator 3 or more

	instability. A score of 4 or more indicates high risk. The person had moderate or higher health instability.	
Personal Support Algorithm (PSA)	To prioritise community-based support and allocation of resources. Includes measurement of carer stress. Higher scores indicate the need for home based services in the absence of an informal helper (family/whānau/friend) The person had moderate to high need of assistance with ADL and IADLs.	Scale 1 – 6. Indicator 4 or more.
Self-Rated Mood (SRM)	To measure mood disturbance based on person's own reported experience. Higher scores indicate potential clinical depression and should be further investigated. The person was at risk of clinical depression.	Scale 0 - 9. Indicator 6 or more.