

# **Community, Transitional and Support Services Service Specification Tier 1**

**September 2024**

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## 1. Status

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

**MANDATORY ☒ RECOMMENDED ☐**

## 2. Review History

Review History	Date
First Published on NSFL	June 2012
Amendments: included revised tier three Continence Education and Consumables service specification	November 2012
Amendments: included reference to tier two Services for People with Chronic Health Conditions service specifications and their purchase units.	June 2013
Amendments: included reference to tier two Orthotic Services service specifications and DOM110 purchase unit.	April 2014
Amendments: included reference to tier two Specialist Palliative Care service specifications and purchase unit.	November 2014
Amendments: included HOP1010 Home Based Support Personal Care purchase unit. Minor edits/formatting changes.	April 2015
Amendments: included HOP AT& R purchase units.	August 2015
Amendments: included HOP1009, HOP1010, COPL0004, COPL0005 and COPL0006 purchase unit codes. Edited, updated links to policy and strategy documents. References added.	April 2018
Amendments: updated Figure 1, section 4.2 standard Māori Health Clause, corrected descriptions of Purchase Unit codes, references, added new tier two Home Care and Support Service specification.	June 2020
Consideration for next Service Specification Review	Within five years
Moved to Health NZ template. Updated links for PUDD and NSFL only. Amended DHB to become District/Region where appropriate. No other changes to content made.	September 2024

**Note:** In September 2024 a small programme of work moved all Service Specifications to Health New Zealand branded templates. No amendments were made to the body text or content of the Service Specification, so references to DHB, Ministry of Health or other pre-2022 reforms vocabulary will still exist. A larger programme of work to review and revise all Service Specifications is planned for late 2024 to early 2025.

**Note:** Contact the NSF Team, Te Whatu Ora | Health New Zealand to discuss proposed amendments to the service specifications and guidance in developing new or updating and revising existing service specifications. [NSF@tewhatuora.govt.nz](mailto:NSF@tewhatuora.govt.nz)

Nationwide Service Framework Library web site [here](#)

### 3. Introduction

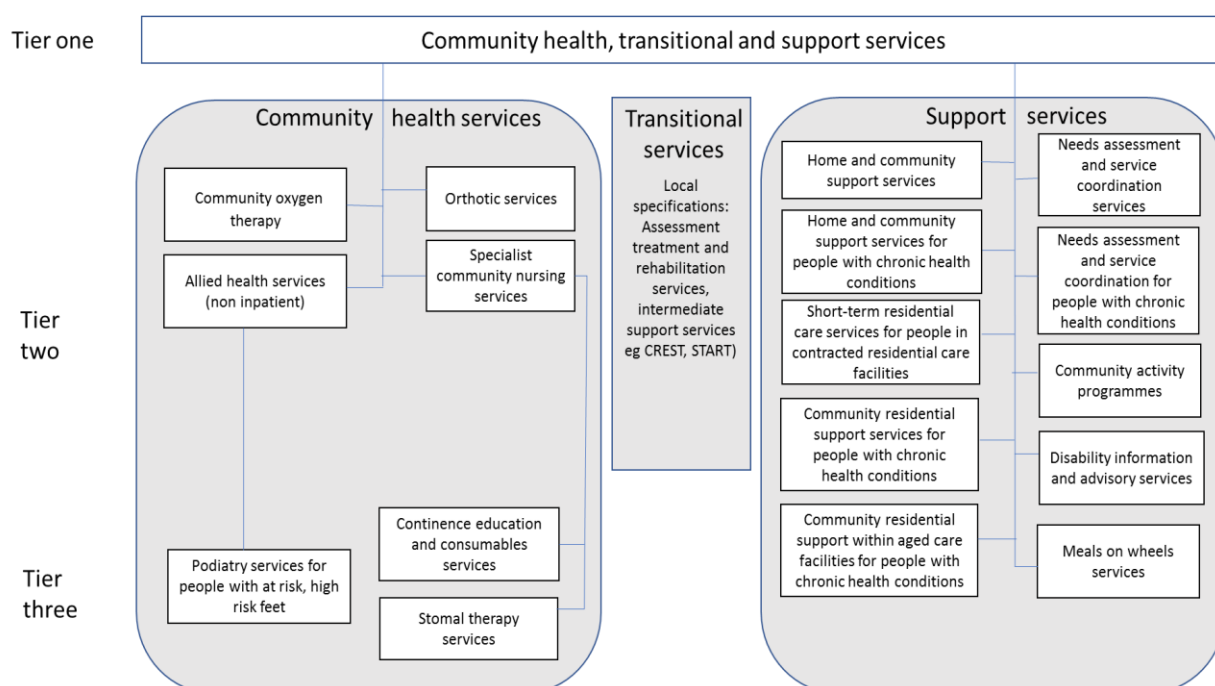
The Tier One Community Health, Transitional and Support Services service specification integrates a range of service specifications for people with chronic health conditions for all ages, older people (excluding aged residential care) and domiciliary/community services. It contains generic principles and content common to all the tiers of service specifications below.

The purpose of this Tier One service specification is to:

- provide a set of guiding principles to allow for flexibility and support continuum of care that is responsive to emerging health needs and changing models of care
- acknowledge the range of primary, community, and hospital services that have a focus on people eligible for District funded assessment, service coordination, care management, treatment, rehabilitation or support services
- recognise the importance of an integrated continuum of care as well as an efficient use of professional resources, and
- provide for an integrated care focus.

The Tier Two and Three service specifications listed below describe requirements that are particular to those services. They must be used in conjunction with this Tier One service specification so that the total service requirements are explicit. Refer to Figure 1

*Figure 1* Tier relationships between the service specifications<sup>1</sup> under this Tier One specification.



<sup>1</sup> Abbreviations used in Figure 1. CREST: Community Rehabilitation Enablement and Support Team, (Canterbury DHB), START: Supported Transfer and Accelerated Rehabilitation Teams for older persons, (Waikato DHB.)

The Tier One Community Health, Transitional and Support Services Service Specification is the overarching service specification for the following nationwide service specifications<sup>2</sup>:

**Tier Two:**

- *Community Health Services service specifications:*
  - Specialist Community Nursing Services
  - Allied Health Services (Non Inpatient)
  - Community Oxygen Therapy
  - Orthotic Services

**Tier Three:**

- *Community Health Services service specifications:*
  - Continence Education and Consumables Services
  - Stomal Therapy Services
  - Podiatry for People with at Risk/High Feet Risk

**Tier Two:**

- *Transitional Services service specifications:*
  - Needs Assessment and Service Coordination Services, and
  - Other Specialist Assessment, Treatment and Rehabilitation Services
- *Support Services service specifications:*
  - Short Term Residential Care Services for People in Contracted Residential Facilities
  - Community Activity Programmes
  - Home Care and Support Services
  - Meals on Wheels Services
  - Home Support Services (Personal Care and Home Support) for People with Chronic Health Conditions
  - Community Residential Services for People with Chronic Health Conditions
  - Needs Assessment and Service Coordination Services for People with Chronic Health Conditions

Other relevant local District service specifications may be used with this Tier One specification.

When planning community services this Tier One service specification should also be considered (where relevant) with other national agreements and service specifications for example: the Community Pharmacy Services Agreement, Services for Children and Young People, Specialist Medical and Surgical Services, Mental Health and Addiction Services, Equipment and Modification Services (EMS), Disability Support Services and Public Health Services.

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<sup>2</sup> The nationwide service specifications for Community Health, Transitional and Support Services are available on the NSF library <https://www.tewhatauora.govt.nz/health-services-and-programmes/nationwide-service-framework-library/about-nationwide-service-specifications>



### 3.1 Background

The New Zealand Health Strategy's approach to reduce the health loss from acute and chronic disease is for services to reach priority populations/groups<sup>3</sup>, to contribute to equity of health outcomes<sup>4</sup> and for people with long term conditions:

- being supported to manage their condition<sup>5, 6</sup>
- being enabled to thrive in their own homes and communities<sup>7</sup>, and
- to maintain their independence and a good quality of life.<sup>8, 9</sup>

The Healthy Aging Strategy<sup>10</sup> (2016) and Priority actions<sup>11</sup> for 2019-2022 presents the overarching direction and action plan for the next 10 years, taking a life course approach that seeks to maximise health and wellbeing for older people.

It is recognised that up to half of people with long term conditions will also have a common mental health condition such as anxiety and depression. Key to achieving good outcomes are integrated community physical and mental health teams.

Terms used in this service specification are in the glossary of terms *Appendix One* and are consistent with the New Zealand Palliative Care Glossary.<sup>12</sup>

## 4. Service Definition

This Tier One service specification provides a common set of guiding principles, philosophies and reporting requirements for District funded community health, transitional and support services. It is designed to support an integrated continuum of care across health services for people of all ages living in the community. It includes specialist community nursing, community allied health for non-inpatients, transitional and community support services for older people (excluding aged residential care) and people with chronic health conditions.

**Community Health Services** include non-inpatient allied health services, orthotic services, specialist community nursing; palliative care delivered in the community, community oxygen therapy, stomal therapy, and specialist older people's services delivered in the community.

**Transitional Support Services** provide support to avoid unnecessary admission or support discharge from hospital for people with a stable health condition, who are assessed as

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<sup>3</sup> Ministry of Health. 2016. *New Zealand Health Strategy: Future Direction* Wellington: Ministry of Health. [www.health.govt.nz/publication/new-zealand-health-strategy-2016](http://www.health.govt.nz/publication/new-zealand-health-strategy-2016) at Action 5 (pg 8).

<sup>4</sup> Op. cit., Theme 2 *Closer to Home* Action 9 (pg 12) Theme 3. Value and high performance Action 14, 15 & 17 (pg 15-16).

<sup>5</sup> Op. cit., *The Part I. Future Direction: Theme 1. People-powered*. Pg 16. *Part 22. Roadmap of Actions*. Actions 1, (pg 7) 2 (pg 8) & 5. (pg 11).

<sup>6</sup> Ministry of Health. 2016. *Self-management Support for People with Long-term Conditions* (2nd ed). Wellington: Ministry of Health. Pg 11. [www.health.govt.nz/publication/self-management-support-people-long-term-conditions](http://www.health.govt.nz/publication/self-management-support-people-long-term-conditions)

<sup>7</sup> Theme 2. *Closer to Home*, (pg 19-24). *2 Roadmap of Actions*, Action 6 & 8 (pg 10-11).

<sup>8</sup> Op. cit., *New Zealand Health Strategy Theme 2 Closer to Home* (pg 22).

<sup>9</sup> Op. cit., *2 Roadmap of Actions*, Action 2 (pg 8) Action 8 (pg 11)

<sup>10</sup> Ministry of Health. 2016. *Healthy Aging Strategy* Wellington: Ministry of Health. [www.health.govt.nz/publication/healthy-ageing-strategy](http://www.health.govt.nz/publication/healthy-ageing-strategy)

<sup>11</sup> [www.health.govt.nz/our-work/life-stages/health-older-people/healthy-ageing-strategy-update/priority-actions-2019-2022](http://www.health.govt.nz/our-work/life-stages/health-older-people/healthy-ageing-strategy-update/priority-actions-2019-2022)

<sup>12</sup> [www.health.govt.nz/publication/new-zealand-palliative-care-glossary](http://www.health.govt.nz/publication/new-zealand-palliative-care-glossary)



needing District funded support to recuperate and increase their level of independence. Some services are provided by inter-disciplinary teams with advanced competence in physical and/or mental health and addiction conditions and interventions to treat, rehabilitate or maintain functional capacity.

These Transitional Support Services consist of:

- assessment, treatment and rehabilitation for people with multiple or complex health support needs; and
- consultation and liaison with other services - providing information, advice, knowledge transfer and, where appropriate, shared planning and management of ongoing treatment and rehabilitation.

**Support Services** include: information, education and advocacy services; needs assessment and service coordination; home based support services (including personal care and household management); community activity programmes; short-term residential care; meals on wheels; post hospital discharge support and provision of short-term equipment for eligible people.

The Service Provider (the Provider) will develop an integrated approach to service delivery and will work collaboratively with a range of service providers as needed.

## 5. Service objectives

### 5.1 General

The Provider will:

- contribute to improving health outcomes and reduce health inequities (see 5.3 below) by working collaboratively with other service providers
- ensure each stage of service provision (assessment, planning, provision, evaluation, review, and discharge) is undertaken by suitably qualified and/or experienced staff who are competent to meet each Service User's level of need
- ensure that Service Users have their health and disability related support needs fully assessed and appropriate services are provided to:
  - prevent or delay the onset or development of increasing levels of dependence and disease
  - prevent avoidable admission to hospital
  - enable facilitated timely discharge from hospital
  - reduce the need for long term residential care where appropriate
  - optimise their independence by minimising the impact of their health problem or disability and promote self-management
  - support multidisciplinary clinical pathways,<sup>13</sup> where appropriate
  - minimise duplication and fragmentation of services
  - improve Service User access to, and provision of, integrated services
  - support the use of best-practice guidelines in developing services for Service Users across all delivery settings
  - promote self-care and optimise their independence by enabling Service Users to effectively adapt to their long-term conditions to
  - assist the Service User in proactive planning.

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<sup>13</sup> Clinically managed episodes of care/pathways throughout the health continuum with pathway algorithms specific to common reasons for referral thus enabling staff to plan time framed care and transfer back to General Practitioner

## 5.2 Māori Health

Achieving Pae Ora (healthy futures for Māori), including Mauri Ora (health individuals), Whānau Ora (healthy families) and Wai Ora (healthy environments), is an overarching aim of the health and disability system. Meeting our obligations under Te Tiriti o Waitangi (the Treaty of Waitangi) is a necessary part of achieving these goals. The principles of the Treaty provide guidance on how we can approach these obligations and achieve these aims. For the purpose of commissioning and delivering of the services the following principles will apply:

**Options:** One of the key principles which flows from Te Tiriti o Waitangi is the principle of options, which requires us to recognise the need to provide, resource and grow:

- kaupapa Māori health and disability services as an option for Māori which are uniquely Māori
- whānau centred services that directly drive towards Māori health equity
- mainstream health and disability services that are culturally safe and support the expression of hauora Māori models of care.

**Equity:** The principle of equity requires us to commit to achieving equitable health and disability outcomes for Māori through the allocation of time, effort, resource and funding to where the greatest need exists. We will focus on addressing unfair and unjust differences by:

- building the capacity and capability of the Māori health workforce
- working to eliminate racism and discrimination in all its forms.

**Active protection:** The principle of active protection requires us to act to the fullest extent possible in providing options and achieving equity. This includes ensuring that all services are designed in ways that make them accessible, timely and effective for Māori whānau and communities.

Ensuring that the robust information, that can be disaggregated, and is collected is necessary to ensure that Māori are well informed on the extent of Māori health and disability outcomes and efforts to achieve equity for Māori.

We will work in accordance with the principle of partnership in the governance, design, delivery, and monitoring of health and disability services, with a strong focus on upholding the Treaty at all levels of decision-making. Through this we will enable Tino rangatiratanga, providing for Māori self-determination and mana motuhake in the design, delivery and monitoring of the services.

## 5.3 Achieving equity in health outcomes

The Ministry's definition of equity is:

*In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.*

The Ministry's definition of equity is designed to:

- fit the New Zealand context
- align with Te Tiriti obligations
- be principle based

- be inclusive enough to incorporate all possible dimensions of equity (indigenous, socio-economic, geographically, disability, etc.)
- reflect the international literature on equity
- reflect the definition put forward by the World Health Organisation.

Inequitable health outcomes are evident amongst populations with different levels of underlying social advantage/ disadvantage. This may be on the basis of socioeconomic status, ethnicity, gender, stage of the life course, locality, or due to racism and discrimination. These disparities result in cumulative effects throughout life and across generations. The causes of disparities in health outcomes largely arise from the inequitable distribution of and access to the wider determinants of health such as income, education, employment, housing and quality health care amongst populations.

Both the Ministry and providers have an important role in supporting intersectoral approaches to address the social determinants of health and in ensuring health services themselves achieve equity and eliminate disparities in health outcomes between population groups. To be effective, services must ensure they are culturally safe, accessible and relevant.

## 5.4 Other Ethnic Groups

As New Zealand is made up of culturally diverse communities, the Provider will take into account the particular cultural and linguistic needs of the groups within the community it serves. The Provider will strive to minimise barriers to access and communication and will ensure the Service is safe for, and respectful of all people.

### 5.4.1 Pacific Health

Compared to the total New Zealand population, Pacific peoples have poorer health status across a wide variety of measures, including child and youth health, and risk factors leading to poor health and long-term conditions such as obesity, diabetes, cardiovascular and respiratory disease.

Pacific peoples are more exposed to risk factors leading to poor health, and experience more barriers to accessing health and disability support services than other groups. In addition, Pacific people with English as a second language may have difficulty understanding health information and engaging effectively with health professionals. Beliefs about individual health and family and community needs and realities can also influence health choices and behaviours.

The Service must be responsive to Pacific health needs and identified concerns, and should be aligned with Ora Manuia 2020-2025 and the Pacific Health Action Plan that set out priority outcomes and actions that will contribute to the Government's overarching goal that all New Zealanders, including Pacific peoples, to achieve better health outcomes. Service delivery should aim to improve Pacific health outcomes and reduce inequalities.

The Service will respond to the needs of Pacific people by recognising differences, especially as they relate to linguistic, cultural, social and religious practises. The Provider must develop and maintain linkages with key local cultural groups in order to facilitate consultation and involvement of these groups in planning, implementing, monitoring and reviewing the Service. The Provider will consider the appropriateness and quality of the Service and address inequalities in access to and provision of the Services to Pacific people communities.

The Provider will be culturally competent and have the ability to respond to the needs and expectations of Pacific Service Users. The Service will enable Pacific Service Users to make healthy choices and facilitate access to other health and disability and social services.

## 6. Service Users

Service Users are Eligible<sup>14</sup> people who:

- are at risk of further deterioration in their health status without one or more of these services
- have assessed health support needs that can be safely and appropriately managed in a community setting and/or their normal living environment.

Service Users with mental health or addiction needs, or needs related to an injury or long-term disability are not excluded from having their physical health and support needs funded through these services if the support needs arise as the result of a short or long-term health condition and are not already covered by District funded mental health and addiction services, Ministry of Health funded services, or ACC.

People discharged from private medical or surgical hospital provider services are eligible to have their physical health and support needs funded through these services.

## 7. Access

### 7.1 Entry Criteria

Health status risk is the premise on which Service Users will be accepted for the Services.

The Service User's health status risk will:

- guide acceptance of referral to the Service
- guide the level of service to be provided, and
- form the basis for discharge.

The Service User will be accepted if they meet the Risk Assessment (see Appendix One) requirements of the Service (provided within the relevant Tier Two or Tier Three service specification) or, if:

- there is a need for the Service to assist a primary health care team to enable the Service User to be effectively managed in the community, or
- the Provider can assist another service provider eg, aged residential care services, through specialist assessment, advice, or interventions to prevent a Service User's further deterioration and/or admission to a public hospital.

The access criteria for the services linked to Community Health, Transitional and Support Services (Figure 1) are provided in the relevant Tier 2 and Tier 3 service specifications.

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<sup>14</sup>The eligibility criteria for publicly funded health and disability services are prescribed by Ministerial Direction. Refer [www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services](http://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services)

## 7.2 Referral to the Service

A Service User may be referred to the Service by a needs assessment and service coordination (NASC) organisation, primary health care team or other appropriately qualified health professional. A referral must include confirmation of the Service User's consent to be referred.

Self-referral or non-health professional referrals will also be appropriate for some services and in such instances, with approval of the Service User. Receipt and outcome of referral will be notified to their primary health care provider or medical home.

The referral is returned to the referrer where inadequate information is supplied and the referral appears to be for a Low Risk issue.

If the referral appears to be for a Service User with a Medium/High Risk issue and the referral information is inadequate, then the Service must contact the referrer immediately and ask for more information, and if necessary return the referral for completion.

## 7.3 Exit from the Service

Service Users will be discharged from the Service when:

- they no longer wish to receive the Service
- they no longer require the Service, as their needs have been met or are able to be met through alternative arrangements
- all attempts to enable safe service delivery (for the Service User and the Provider) have been exhausted
- they cease to meet the Entry Criteria (7.1 above)
- they transfer to another service provider
- they transfer to another country
- they are deceased.

## 7.4 Referral Response Time

The response time for each referral will be based on the level of risk of the Service User that will be assessed from the information given with the referral.

## 8. Service Components

### 8.1 Processes

SERVICE COMPONENT	DESCRIPTION
<b>Referral management</b>	<p>The Provider will operate an effective and efficient system to receive and prioritise all referrals into the Service including distribution of referrals to staff appropriately skilled and capable of dealing with the referral. The system will be operated by staff who understand the scope and nature of the Service.</p> <p>Prioritisation and triage for access to the Service will be operated by appropriately registered health professionals within the time frames in the Tier Two and Tier Three service specifications. A decision on acceptance or a decline of a referral will be communicated to the referrer and the GP if they are not the referrer.</p> <p>The Provider will regularly audit and report on referrals to determine whether these are equitable to ensure that people who would most benefit from services receive them.</p>
<b>Assessment</b>	<p>Best practice assessment tools will be used for the Service (eg, an interRAI<sup>15</sup> MDS Home Care Tool for allocation of funded long term support).</p> <p>The Provider will conduct and document comprehensive assessments appropriate to the specific function of the Service to establish:</p> <ul style="list-style-type: none"><li>• the clinical appropriateness and cost effectiveness of providing the Service to manage the Service User's health and disability related support needs</li><li>• the Service User's status, risk of deterioration, level of need, desired goals and outcomes (with set timeframes) and opportunities for self-management.</li></ul> <p>The Provider will conduct assessments in the most appropriate environment. The choice of environment will be determined by taking into account the Service User's level of risk, the specialist equipment required, the cost of service delivery, and as agreed by the Service User.</p> <p>Prior to such assessment, the Service will actively identify relevant assessment information that already exists in the system and use that information to inform further assessment. Duplication of assessment questions by different services is to be avoided where ever possible.</p> <p>The Provider will:</p> <ul style="list-style-type: none"><li>• ensure that the Service User understands the assessment process and the nature of services to be provided and how the information collected about them will be used</li><li>• take into account the Service User's cultural and linguistic diversity and access appropriate support and interpreter services to best meet their needs.</li></ul>

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<sup>15</sup> The use of interRAI assessments to allow access to long term publicly funded support services was mandatory from 30<sup>th</sup> June 2012.



	<ul style="list-style-type: none"> <li>ensure that the initial assessment follows a planned process and that the process and outcomes are documented.</li> </ul>
<b>Planning and Provision</b>	<p>The Provider will:</p> <ul style="list-style-type: none"> <li>develop health goals in partnership with the Service User and according to their wishes, cultural needs and health and disability related support needs</li> <li>plan the service intervention with the Service User to optimise the Service User's health and disability status and self-management and meet their agreed developed goals</li> <li>agree the review period with the Service User (unless the Service has a specific review requirement)</li> <li>ensure that the service delivery plan, is written in such a way that it can easily be understood by the Service User and that the Service User has a written copy of the plan</li> <li>ensure service delivery planning promotes and demonstrates service integration to reduce duplication or fragmentation of services and plans or interventions by taking into account any other health or disability service plans that are current for the Service User (eg, Primary Health Care, Palliative Care, ACC, Disability Support Services, Mental Health and Addiction Services)</li> <li>ensure collaboration with other health professional services and Multidisciplinary Teams and Key Worker/Care Coordinator roles where they are established</li> <li>ensure that people receive the necessary range of services, care and support within the timeframes required to restore or maintain health and disability status including, as appropriate, input from any relevant external sources</li> <li>refer the Service User to other services as their health and disability related support needs requires, notifying the referrer and/or GP and/or other support services as appropriate</li> <li>where appropriate, provide, or arrange for, training on the use and application of equipment and/or supplies and provide self-care and carer education to restore health status, support adaptation, prevent deterioration, maximise independence and promote self-management</li> <li>adjust service provision according to the Service User's response and the need to optimise their health and disability status</li> </ul> <p>For every Service User the following will be documented:</p> <ul style="list-style-type: none"> <li>evidence that the initial assessment follows a planned process and the process, goals and expected outcomes of the Service are agreed with the Service User</li> <li>anticipated timelines for the plan and dates set to review long-term plans</li> <li>how, when, where and by whom the Service will be delivered</li> <li>the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process</li> <li>a discharge plan (if appropriate)</li> <li>evaluation of progress towards achievement of outcomes</li> <li>adjustments to service delivery plan in response to progress evaluation.</li> </ul>



<b>Palliative Care</b>	<p>Where palliative care is provided under this service specification it should be:</p> <ul style="list-style-type: none"> <li>• based on the Service User's need</li> <li>• be suitable whether death is days, weeks, months or occasionally even years away</li> <li>• available wherever the Service User may be</li> <li>• provided by all health care professionals, supported (where necessary) by specialist palliative care services</li> <li>• provided in such a way as to meet the unique needs of individuals from particular communities, including Māori, Pacific peoples and other ethnic minority groups, older people, people with disabilities, children and young people, immigrants, refugees, and those in isolated communities.</li> <li>• incorporated into Service User's Advanced Care Plan, if applicable.</li> </ul> <p>For further information see the Resource and Capability Framework for Integrated Palliative Care Services in New Zealand.<sup>16</sup></p> <p>In the last days of life, care should be guided by Te Ara Whakapiri, Principles and Guidance for the Last Day of Life<sup>17</sup>.</p>
<b>Key Worker / Care Coordinator</b>	<p>People with high and complex needs, that span health, disability and support services, disciplines and settings, should have a single Key Worker as agreed with the Service User. (A Key Worker/Care Coordinator may be provided by the Service, or by another service providing support to the Service User).</p> <p>If a Key Worker/Care Coordinator is provided by the Service they will:</p> <ul style="list-style-type: none"> <li>• be the focal point (health professional) for the Service User, their whānau and those important to them</li> <li>• liaise with all services and disciplines (including community mental health teams) relevant to the Service User to enhance service delivery and reduce duplication (eg, assessments)</li> <li>• ensure the Service User's goals (as defined by them) are shared with all relevant services and disciplines</li> <li>• enable the Service User to receive the necessary range of services, care and support within the time frames required by their health needs</li> <li>• assist the Service User with their transition between services to enhance their pathway across all settings</li> <li>• establish and maintain collaborative arrangements, as appropriate, with all other Services provided under this Tier One service specification.</li> </ul>
<b>Information, Education and Advice</b>	<p>The Provider will inform the Service User about available services, information, education, and where appropriate, learning opportunities to support self-management and facilitate access to these where appropriate.</p> <p>Specialist clinicians will support generalist clinicians across the continuum of care by providing information, education and advice as appropriate.</p> <p>Resources used are appropriate for population/target group in terms of health literacy and health messages.</p>
<b>Self-Management</b>	<p>The Service will, where appropriate, be a source of:</p> <ul style="list-style-type: none"> <li>• health and wellness education that contributes to population health gains eg, smoking cessation, falls prevention</li> </ul>

<sup>16</sup> [www.health.govt.nz/publication/resource-and-capability-framework-integrated-adult-palliative-care-services-new-zealand](http://www.health.govt.nz/publication/resource-and-capability-framework-integrated-adult-palliative-care-services-new-zealand)

<sup>17</sup> [www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life](http://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life)

<b>and Wellness Education</b>	<ul style="list-style-type: none"> <li>• training on the use and application of equipment and/or supplies to maximise benefit to the Service User</li> <li>• education of self-care to maintain health status, prevent deterioration and maximise self-management</li> <li>• support and educate carers to focus on carer safety and supporting the Service User to maintain health status, prevent deterioration and maximise their self-management</li> <li>• When undertaking education activities, the Service will recognise the culturally sensitive issues relating to these services and focus on the holistic: <ul style="list-style-type: none"> <li>• taha Māori perspective of health</li> <li>• community approach to health for Pacific Peoples' cultures, and</li> <li>• the cultural and linguistic diversity of all Service Users.</li> </ul> </li> </ul>
<b>Evaluation - (Monitoring and Reassessment)</b>	<p>The Provider will:</p> <ul style="list-style-type: none"> <li>• undertake and document a formal reassessment against the care goals and within the agreed time frames and will adjust the treatment programme according to the Service User's response and the need to optimise their health and disability status</li> <li>• undertake and document regular re-assessment of each Service User's health status to monitor the effectiveness, acceptability and appropriateness of continuing the provision of the service</li> <li>• monitor processes that will include developing a process for measuring the Service User's ability to independently manage</li> <li>• monitor and review the relationship between the Service User and care workers and the quality of support provided</li> <li>• monitor and review continuity of staff that are assigned to the Service User.</li> </ul>
<b>Lifelong service provision</b>	<p>Where a Service User is recognised as being at a level of risk that requires infrequent, but regular lifelong specialist community nursing and/or allied health services to maintain their health status the Provider will:</p> <ul style="list-style-type: none"> <li>• support the Primary Health Care Team to develop and deliver a maintenance plan that includes ongoing goals, frequency of contact and reassessment criteria, supply of prescribed consumable supplies or equipment and provision of reports to the Service User's GP and/or other health professionals</li> <li>• provide professional oversight as necessary of the care provided by the Service User's informal and formal carers for the range of services described in this service specification.</li> </ul>
<b>Discharge Planning</b>	<p>The Service will plan discharge in consultation with the Service User, their Primary Health Care Team and relevant agencies as appropriate.</p> <p>Specific requirements related to discharge planning are provided in the relevant tier two and three service specifications.</p>

## 8.2 Settings

The Service will be provided in a setting most appropriate for service delivery and will include (but not be limited to) issues such as cultural appropriateness, accessibility, including disability accessible, and the most effective and efficient use of resources, where the best

outcomes will be achieved. The setting will support the Service User's independence and social integration.

See the relevant Tier Two and Tier Three service specification for service specific details.

### 8.3 Consumable Supplies and Equipment

No co-payment will be sought from Service Users for supplies and equipment unless permitted under current Crown Funding Agreement Service Coverage Schedule for the Provision of Equipment and Modifications and other Services and Supplies.

Provision of equipment<sup>18</sup> and consumable supplies will usually be in accordance with the guidance given in each Tier Two or Tier Three service specifications. Assessment tools should be available to assist decision making about the appropriate prescription of product based on need.

Where there is a long-term need (ie. more than 6 months for equipment to maintain mobility or the activities of daily living not for treatment of the illness), then the Service User should be referred to Equipment and Modification Services (EMS) for assessment and provision<sup>19</sup>.

### 8.4 Key Inputs

The Provider will ensure that there is sufficient, appropriately trained staff available to safely meet the assessed needs of the Service Users within the timeframes set. Specific Key Inputs are detailed in each Tier Two service specification.

The Provider will ensure the Service User has access to:

- interpreting services, including New Zealand Sign Language (NZSL) interpreters for Deaf people who communicate using NZSL
- whānau and Pacific advocacy and support services as required.

## 9. Service Linkages

The Provider will develop relationships with other services and agencies to facilitate open communication and continuity of care to ensure that the following principles are acknowledged:

- a continuum of care from primary health care services to hospital and back, including those services funded via other funding streams
- liaise and work with other services (especially other services provided under this Tier One service specification – see Figure 1) to develop referral protocols, care pathways and establish care plans to ensure a seamless continuum of care for the Service User
- intersectoral linkages with social, education and voluntary services involved in the care and to support Service Users to access appropriate services

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<sup>18</sup> See Equipment and Modification Services Assessor Accreditation Framework Schedule [www.health.govt.nz/system/files/documents/pages/ems-assessor-accreditation-framework-dss1044c-feb2015.pdf](http://www.health.govt.nz/system/files/documents/pages/ems-assessor-accreditation-framework-dss1044c-feb2015.pdf)

<sup>19</sup> For residential care, this equipment must be to meet the specific needs of an individual, rather than adaptable equipment that is needed generally for residents.

- effective regional linkages and coordination of services to ensure Service Users access appropriate services
- timely clinical consultation and referral to services that support clinical pathways and integrated care
- emergency management and disaster response is available and appropriate across the continuum
- linkages with other funders and providers, including community and social services, ensuring seamless service delivery and continuity care is maintained.

Where Service Users are receiving services from other agencies, the Provider will collaborate in coordinating the Service provision.

These linkages may include, but are not limited to the following:

Service Provider	Accountabilities
ACC case managers.	Liaise and work with this service to establish care plans and ensure a seamless continuum of care for the Service User.
Acute health and support services eg, Specialist Medical and Surgical Services, Maternity Services, Accident and Emergency, Mental Health and Addiction Services for all ages.	Actively manage the entry/exit interface for the Service User.
Community mental health teams (multidisciplinary teams of health and social services professionals (psychiatrists, social workers, community psychiatric nurses, psychologists and mental health therapists)	Develop and implement protocols for relationships with each of these services/agencies as appropriate to facilitate open communication, continuity and smooth referral, follow-up and discharge processes.
Māori and iwi organisations and communities Māori health and disability support services Māori advocacy services.	Liaise with local iwi and Māori communities to provide advice and guidance into service delivery to ensure cultural appropriateness and accessibility to services.
Other community and social services, marae, church based services, voluntary agencies and consumer support/advocacy groups and services such as Advocacy and Elder Abuse prevention services, Violence Intervention Programme: Family Violence, Child Protection and Partner Abuse services.	Develop and implement protocols for relationships with each of these services/agencies as appropriate to facilitate open communication, continuity and smooth referral, follow-up and discharge processes.
Pacific and other ethnic group providers, Pacific people advocacy services.	Liaise with Pacific and other ethnic communities to provide advice and guidance into service delivery to ensure cultural appropriateness and accessibility to services.

Service Provider	Accountabilities
Specialist Palliative Care services <sup>20</sup> .	Refer and accept referrals as appropriate.  Work collaboratively as participants using an integrated team approach.
Population health programme providers.	Liaise and work with these services to develop referral protocols and establish care plans to ensure a seamless continuum of care for the Service User.
<p>Primary Health Care Providers including:</p> <p>Allied Health primary health care services eg, audiology, dietetics, health social work, occupational therapy, optometry, orthotics, physiotherapy, podiatry, speech language therapy</p> <ul style="list-style-type: none"> <li>• Nurse Practitioners and Clinical Nurse Specialists and other medical specialists</li> <li>• Nutrition services, oral health services</li> <li>• Primary health care practices /GPs primary health care teams</li> <li>• Primary Health Care palliative care teams</li> <li>• Community Pharmacy Services such as Pharmacy Facilitators</li> <li>• other providers eg, Orthotic service.</li> </ul>	<p>Work collaboratively as participants using an integrated team approach</p> <p>Improve access, support seamless service delivery and continuity of care is maintained and to ensure appropriateness and accessibility to services.</p>
<p>Publicly funded disability or long-term support services for Service Users with co-existing disabilities /conditions who meet other funding stream eligibility criteria such as NASC organisations.</p> <p>For example: Ministry of Health funded disability support services for people under 65.</p>	<p>Effective local and regional linkages are in place to facilitate appropriate referrals.</p> <p>Support people who need to access these services who move to be closer to family and whānau services.</p> <p>Liaise and work with these services to establish a smooth transition between services when appropriate.</p>
<p>Aged Related Residential Care service providers.</p> <p>Residential support services for people with intellectual, physical or sensory disabilities, and/or mental illness or drug and alcohol issues.</p> <p>Mental Health Services for Older People.</p>	Refer/accept referrals from and liaise with providers as appropriate

<sup>20</sup> For guidance, see the Resource and Capability Framework for Integrated Adult Palliative Care Services in New Zealand at [www.health.govt.nz/publication/resource-and-capability-framework-integrated-adult-palliative-care-services-new-zealand](http://www.health.govt.nz/publication/resource-and-capability-framework-integrated-adult-palliative-care-services-new-zealand) and New Zealand Palliative Care Glossary at [www.health.govt.nz/publication/new-zealand-palliative-care-glossary](http://www.health.govt.nz/publication/new-zealand-palliative-care-glossary)



Service Provider	Accountabilities
Transport services including ambulance services.  National Travel Assistance (NTA), travel and accommodation services.	Improve access, support seamless service delivery and continuity of care is maintained and to ensure appropriateness and accessibility to services.

## 10. Exclusions

Funding for the Service will not duplicate the services that are already funded by the District under other service specifications, the Ministry of Health or the Accident Compensation Corporation (ACC). Funding by multiple funders for Services may be put into place for Service Users, for example with District mental health and addiction services, Ministry of Health Disability Support Services, and ACC.

The Ministry's Disability Support Services is responsible for planning and funding disability support services for people who present for initial assessment before the age of 65 who have a physical, intellectual, or sensory disability or a combination of these, that is likely to last for 6 months or more.

See *Appendix Two* for clarification of health support funding responsibilities.

## 11. Quality Requirements

The Provider must comply with the Provider Quality Specifications described in the current Operational Policy Framework<sup>21</sup> of the Crown Funding Agreement.

The Provider will:

- participate in an evidence based quality improvement programme that is able to measure and report the service performance and progress
- have a process for resolution of disputes over the level of service delivery
- report as required to the funder on the development and implementation of the quality improvement plan and compliance with standards
- undertake regular evidence based outcome monitoring, process review, clinical and process audits and peer review relevant to the Service
- meet professional standards of practice required by regulatory authorities as per the Health Practitioners Competence Assurance Act (2003) and the Health Social Workers Registration Act (2003), and relevant professional authorities for self-regulated professions.

### 11.1 Acceptability

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<sup>21</sup> <https://www.health.govt.nz/about-us/new-zealands-health-system/overview-and-statutory-framework/accountability-arrangements>

Ensure Service Users have their health and disability related support needs met in a manner that respects and acknowledges their individual health needs, cultural values and beliefs and meets the health literacy needs of the Service Users.

Ensuring that the Service is acceptable to Service Users will be supported by their participation in on-going evaluation of the Service and annual Service User experience surveys/feedback that will assess their experience of:

- the quality and outcome of services they received such as services being easy to access and navigate
- the effectiveness of their health worker communication
- receiving clear and relevant health messages that empower them to make informed choices
- their level of involvement in the planning and delivery of their care, including their transition into and discharge from the service
- how well their cultural and linguistic needs were recognised and met.

Services will have a process for complaints and resolution of disputes over the level of Service delivery.

## **11.2 Safety and Efficiency**

The Service provider will ensure that all employees who supply, provide or assist in the provision of this Service are competent, appropriately qualified and, where relevant, currently registered with or licensed by the appropriate statutory and/or professional body.

Services based in a facility should be provided from facilities that are easily accessible to the Service User and should meet New Zealand Standards 4121: 2001 Design for access and mobility – Buildings and associated facilities.

The Service provider will have an incident management and monitoring process in place.

Providers will take all reasonable steps to ensure that at all times:

- Service Users are aware of their Health Practitioners current scope of practice as set by the relevant Responsible Authority, and of any changes to their scope of practice.
- the relevant Responsible Authority is informed whenever a Health Practitioner employee resigns or is dismissed from their employment or under their contract for reasons relating to competence
- risks are mitigated to ensure a safe care environment for the Service User and the Provider's employees.

## **12. Purchase Units and Reporting Requirements**

### **12.1 Purchase units**

Purchase Unit (PU) codes are published in the Purchase Unit Data Dictionary on the Nationwide Service Framework Library. PU codes for the service specifications within the suite of the Tier One Community Health, Transitional and Support Services are listed in the tables below.

#### **COMMUNITY HEALTH SERVICES**



## Specialist Community Nursing Services

PU Code	PU Description
DOM101	Community Services - professional nursing services
DOM103	Community Services - stomal services
DOM109	Community Services - enteral feeding
M80012	Specialist Palliative care- community nursing

### 12.1.1 Allied Health Services (Non Inpatient)

PU Code	PU Description
AH01001	Dietetics
AH01003	Occupational Therapy
AH01005	Physiotherapy
AH01006	Podiatry
AH01007	Social Work
AH01008	Speech Therapy
AH01010	Psychologist Services - Non Mental Health
M80013	Specialist Palliative care - community allied health

### 12.1.2 Community Oxygen Therapy Services

PU Code	PU Description
DOM102	Community Services - community oxygen therapy

### 12.1.3 Orthotic Services

PU Code	PU Description
DOM110	Orthotic Services (non inpatient)

### 12.1.4 Continence Services

PU Code	PU Description
DOM104	Community Services – continence services

### 12.1.5 Podiatry Services for People with At Risk/High Risk Feet

PU Code	PU Description
AH01006	Podiatry

## TRANSITIONAL SERVICES

PU Code	PU Description
COOC112	Community Residential Services for people with Chronic Health Conditions
CHC0004	Household Support Services for People with Chronic Health Conditions
CHC0005	Personal Care Services for People with Chronic Health Conditions

PU Code	PU Description
HOP1001	Transitional care: Facility Based Level 1
HOP1002	Transitional Care: Facility Based Level 2
HOP1003	Transitional Care: Home-Based Level 3
HOP1004	Restorative Home based support Level 1
HOP1005	Restorative Home based support Level 2
HOP1007	Care Coordination Centre
HOP1008	Accredited Visitor Service
HOP1009	Household Support Services for People with Age Related Disability
HOP1010	Care Services for People with Age Related Disability
HOP1013	Carer Support
HOP1020	Quality Improvement Initiatives
HOP2004	Needs Assessment
HOP2004D	NASC Discretionary Funding
HOP2005	Service Coordination
HOP2006	Care Manager
HOP160	DIAS National Contracts
HOP214	ATR Inpatient
HOP215	ATR Outpatient – Clinics
HOP216	ATR Outpatient - Day Hospital & Day Programmes
HOP217	ATR Outpatient – domiciliary assessments & education sessions
HOPR130	AT & R (Assessment, Treatment & Rehabilitation) - Hospital at Home
HOPR131	Geriatric – Early Intervention, Preventative, Comprehensive Assessment

### SUPPORT SERVICES

#### Short term Residential Care Services for People in Contracted Residential Facilities Services

PU Code	PU Description
CHC0009	Short-term Care (Day) for People with CHC- Residential Facility
CHC0010	Short-term Care for People with CHC- Residential Facility Rest Home Level Care
CHC0011	Short-term Care for People with CHC– Residential Facility Hospital Level Care
CHC0012	Short-term Care for People with CHC and Dementia- Residential Facility Dementia Level Care

<b>PU Code</b>	<b>PU Description</b>
CHC0013	Short-term Care for People with CHC- Residential Facility Specialised Psycho-geriatric Level Care
CHC0014	Emergency/Unplanned Short-term Care for People with CHC- Residential Facility
CHC2620	Supported Living- CHC
HOP228	Emergency/Unplanned Care for older people- Residential Facility
HOP236	Short-term Care (Day) for People without Main Carer-Residential Facility
HOP237	Short-term Care for People without Main Carer- Residential Facility Rest Home Level Care
HOP238	Short-term Care for People without Main Carer- Residential Facility Hospital Level Care
HOP239	Short-term Care for People without Main Carer- Residential Facility- Dementia Level Care
HOP240	Short-term Care for People without Main Carer- Residential Specialised Psycho-geriatric Level Care
HOP1042	Short-term Residential Care (Day) for People with Main Carer- Residential Facility
HOP1043	Short-term Care for People with Main Carer- Residential Facility Rest Home Level Care
HOP1044	Short-term Care for People with Main Carer- Residential Facility- Hospital Level Care
HOP1045	Short-term Care for People with Main Carer- Residential Facility- Dementia Level Care
HOP1046	Short-term Care for People with Main Carer- Residential Specialised Psycho-geriatric Level Care

#### **Services for People with Chronic Health Conditions**

<b>PU Code</b>	<b>PU Description</b>
CHC0004	Household Support Services for People with Chronic Health Conditions
CHC0005	Personal Care Services for People with Chronic Health Conditions
CHC0007	Chronic Health Conditions Needs Assessment
CHC0008	Chronic Health Conditions Service Coordination
CHC0019	Community Residential Services in Aged Care Facilities for people with CHC - Rest home level care
CHC0020	Community Residential Services in Aged Care Facilities for people with CHC - Hospital level care
CHC0021	Community Residential Services in Aged Care Facilities for people with CHC - Dementia level care
CHC0022	Community Residential Services in Aged Care Facilities for people with CHC - Special Hospital care
COOC112	Community Residential services for people with Chronic Health Conditions

### Community Palliative Care Services

PU Code	PU Description
COPL0004	Intensive End of Life Support
COPL0005	Short-term Rest home Level Care – residential facility
COPL0006	Short-term Hospital level care - residential facility

### Community Activity Programmes

PU Code	PU Description
CHC0017	Community Activity Programme for people with CHC - Non-Residential Care Facility
CHC0018	Community Activity Programme for People with CHC- Residential Care Facility
HOP241	Community Activity Programme for Older People - Non-Residential Care Facility
HOP242	Community Activity Programme for Older People - Residential Care Facility
HOP243	Dementia Community Activity Programme for Older People

### Meals on Wheels Services

PU Code	PU Description
DOM106	Meals on wheels

### Home and *Community* Support Services-

PU Code	PU Description
DOM105	Community Services - Home help
DOM107	Community Services - personal care
HOP1009	Household Support Services for People with Age Related Disability
HOP1010	Personal Care Services for People with Age Related Disability

### Other Services

PU Code	PU Description
DOM111	Home Visiting

## 13. Glossary

See also: New Zealand Palliative Care Glossary<sup>22</sup>

**Carer:** includes the carers (informal and formal) of a Service User

**Care coordination:** a service delivery process that links Service Users with services in coordinated ways, and is facilitated by a Key Worker.

**Continuity of care:** A single health practitioner takes responsibility for coordinating and principally providing the Service User's health care, and clearly documenting that planned care. The health practitioner may have a designated back-up practitioner.

**Eligible Person** Any individual who:

- a. is in need of the Services as determined by an authorised needs assessment coordination service; and/or
- b. meets the essential Districts' eligibility criteria and other criteria, terms or conditions which, in accordance with the Health and Disability Services Eligibility Direction current at any time, or any other Crown Direction that must be satisfied before that individual may receive any Services.

**District Health Board (DHB)** established under the New Zealand Public Health and Disability Act 2000.

**Disability:** is described as a reduction in independent function lasting longer than six months to the extent that a person requires support that may be due to an age related or a personal health condition.

**Health Literacy:** relates to the service providers responsibility to make their services easy to understand and to support Service Users to find, interpret and use information and health services to make effective decisions for health and wellbeing.

**Integrated Care:** an integrated collaborative approach to health service delivery, developed between health professionals across a range of service providers that ensures effective information sharing and a seamless continuum of care from primary health care services to hospital and back. Includes services funded via other funding streams and maintaining ongoing effective inter-sectoral linkages and effective regional service links. The key elements of an integrated approach are:

- collaborative and integrated models of care are developed between multidisciplinary teams, specialist community nurse teams, allied health teams, community support service teams, and general practice and other primary health care teams
- ensuring effective information sharing and smooth transition between services
- specialist clinician support of generalist clinicians across the continuum of care
- ensuring a seamless continuum of care from primary health care services to hospital and back to primary health care services, including those services funded via other funding streams

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<sup>22</sup> [www.health.govt.nz/publication/new-zealand-palliative-care-glossary](http://www.health.govt.nz/publication/new-zealand-palliative-care-glossary)

- identifying safety concerns for at-risk Service Users and communicating those concerns to other relevant providers
- developing risk mitigation plans with Service Users and all relevant service providers
- maintaining ongoing effective inter-sectoral linkages with social, education and voluntary services involved in the care and support of the Service User, their family and whānau
- maintaining effective regional service links.

These principles require service providers to address the barriers to, and put in place the enablers for, integrated service delivery. There is literature available that documents the barriers and enablers and ways to overcome the barriers, eg, Making the Shift: key success factors, by Debbie Singh, July 2006, University of Birmingham, Health Services Management Centre.

**Key Worker/Care Coordinator:** an identified health professional who takes a coordinating role across specific services that are provided to Service Users.

**The Multidisciplinary Team:** a group of health professionals/care workers who are members of different health disciplines, who work together collaboratively to provide specific services to the Service User

**The Ministry:** The Ministry of Health; includes the Minister of Health and the Director-General of Health and any delegates of such person.

**Older people:** people aged 65 and over or aged 50 to 64 with age related needs.

**People with personal health conditions:** are people with long term health conditions or people with short-term support needs (usually less than six months duration eg, following surgery or a medical event).

**Responsible Authority:** sets the Health Practitioners current scope of practice and their scope of practice. Responsible authorities are bodies corporate legislated for by the Health Practitioners Competency Assurance Act 2003.

**Needs Assessment:** is when the needs assessment facilitator meets with the Service User, to work out and then prioritise the Service User's needs. This may take several, or ongoing, meetings. The purpose of the process is to decide what a Service User needs to achieve and maintain independence in accordance with their abilities, resources, culture and their goals.

**Needs Assessment Service Co-ordination Services:** These services may be funded by the DHBs or the Ministry. Their roles are first to assess Service User's needs, and then to coordinate other services to meet those needs.

**Service Provider:** service provider a health service or service organisation/agency that provides services to a client group described in this service specification

**Service User:** includes the Service User, and their family and whānau, their caregiver, advocate, or support service as appropriate.

**Transitional Services:** are services that provide time limited assessment treatment and rehabilitation in either a hospital, residential facility or community setting. The service is provided by inter-professional teams with advanced competence in physical and/or psychiatric conditions and interventions to treat, rehabilitate or maintain functional capacity.

The services consist of:

- assessment, treatment and rehabilitation for people with multiple or complex health or disability support needs; and

- consultation and liaison with other services - providing information, advice, knowledge transfer and, where appropriate, shared planning and management of ongoing treatment and rehabilitation

The definition excludes short-term medical or surgical hospital treatment and long-term health or support services.



## 14. Appendices

### 14.1 Appendix One - Risk Assessment Framework

#### **High Risk:**

##### **Failure to provide the service may result in the client:**

- Being in unnecessary pain, or distress
- Imminently being admitted as an in-patient for treatment and/or symptom control
- Experiencing irreversible deterioration of their health status requiring long-term inpatient management
- No longer being able to stay in their own residence

#### **Medium Risk:**

##### **Failure to provide the service may result in the person:**

- Being unable to self-manage with resulting dependency on alternative options which may compromise their health status
- Having to be referred to a specialist for consultation and/or management of a health condition
- Continuing with compromised health status that is not life-threatening but if left permanently un-managed would lead to more extensive and/or additional problems
- Being unable to self-manage thus placing significant pressure on the family/caregiver that may cause their health status to be compromised
- Being admitted to short-term inpatient/respite or long term residential care.

#### **Low Risk:**

##### **Failure to provide the service may result in the person:**

- Living with a limited degree of compromised health status which is not in any way life threatening but intervention would enable them to return to optimal health status and/or function safely and independently

This framework is presented as a continuum of risk in terms of Service User's health. Therefore, there will be Service Users who will not be eligible for service as a result of the assessment, or reassessment of their risk.

Specific definitions of a Service User's assessed needs are defined in the Tier Two service specifications.

## 14.2 Appendix two: Vote Health support funding responsibilities

The Crown Funding Agreement Service Coverage Schedule<sup>23</sup> is updated annually and is the key document that describes at a high level, the responsibilities for funding support services within Vote: Health.

### Funding responsibilities

Terms used in this service specification for funding purposes are as follows:

- older people are defined as people aged 65 and over or aged 50 to 64 with age-related needs
- personal health conditions are defined as people with long term health conditions or people with short-term support needs (usually less than six months duration eg, following surgery or a medical event)
- disability<sup>24</sup> is defined as a reduction in independent function to the extent that a person has been assessed as requiring support services due to an age related or a personal health condition.

The following outlines responsibilities for funding support services within Vote: Health. These responsibilities are split between DHBs and the Ministry of Health. Funders also have specific criteria that determine eligibility for specific supports.

### DHB responsibilities

DHBs are responsible for planning and funding:

- Disability Support Services (DSS) for people who first present for assessment for DSS at age 65 or over (older people) [CAB Min (03) 5/5 refers]
- DSS for people who first present for assessment for DSS between ages 50 and 65 who are clinically assessed as having health and support needs because of long-term conditions more commonly experienced by older people (the 'close in interest' group) [CAB Min (03) 5/5 refers]
- long-term support for people under age 65 with support needs due to chronic health conditions, including 'medically fragile children' (children with high health needs and/or multiple impairments whose health status has not yet stabilised and for whom a physical, sensory and/or intellectual disability with associated ongoing support needs has not been identified)
- support for people who are most severely affected by mental illness or addictions and require specialist mental health and addiction services (including psychiatric disability services)<sup>25</sup>

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<sup>23</sup> <https://www.health.govt.nz/about-us/new-zealands-health-system/overview-and-statutory-framework/accountability-arrangements>

<sup>24</sup> The Government's definition of 'person with a disability' for the purpose of accessing disability support services [Service Coverage Schedule at 4.3 <https://nsfl.health.govt.nz/accountability/service-coverage-schedule> refer to CAB (94) M 16/4 (3e)]

<sup>25</sup> Currently the expectation established in the National Mental Health Strategy is that specialist services (including psychiatric disability services) will be available to 3% of the

- support to address short-term needs ie, less than six months duration eg, following surgery or medical events
- aged residential care for Ministry DSS clients who have been reassessed by a DHB needs assessor as requiring this service [CAB Min (03) 5/5 refers]
- support for needs arising from conditions in the palliative stage
- needs assessment and service coordination services for people who present for assessment and have not accessed DSS support services prior to age 65 years, are now over 65 years and have a long-term disability that is likely to remain
  - even after provision of equipment, treatment and rehabilitation
  - continue over up to six months, and
  - result in a need for long term support services that were not needed prior to turning 65 years of age
- assessment treatment and rehabilitation services DHB provided multidisciplinary services delivered in a range of settings) for people with disabilities over the age of 65. They include specialised and clinical assessment, treatment and rehabilitation to enable people to participate in daily activities and fulfil valued roles in their home and community.

## **Ministry of Health responsibilities**

### DSS accessed via Needs Assessment and Service Coordination (NASC)

The Ministry's DSS Group is responsible for planning and funding DSS for people who present for assessment for DSS before the age of 65 and have a physical, intellectual, or sensory disability or a combination of these, which is likely to:

- remain even after provision of equipment, treatment and rehabilitation
- continue for at least six months, and
- result in a need for ongoing support.

### DSS generally accessed without needs assessment via NASC

#### *Environmental Support Services (ESS)*

The Ministry funds ESS for a broader group than DSS accessed via NASC. This includes: people with physical, sensory and intellectual disabilities; people with disabilities associated with aging; and people aged under 65 with disabling chronic health conditions.

#### *Disability Information and Advisory Services (DIAS)*


The Ministry funds DIAS, which provides information for people with disabilities and other members of the community on: how to find support and advocacy groups, NASC services or community support organisations; specific information related to particular disabilities; and other topics related to disability.

#### *Child development services*

The Ministry funds the allied health component of Child Development Services - multidisciplinary community-based services that provide specialist assessment, intervention

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population. A focus on early intervention strategies will mean services may be delivered to people who are at risk of developing more severe mental illness or addiction. Mental health services will not exclude eligible people on the basis of underlying disabilities or chronic health conditions where the presenting issue(s) relate(s) to mental illness.



and management services for young children (mostly pre-schoolers) who have disabilities or who are not achieving developmental milestones.

*Assessment, Treatment and Rehabilitation Services (AT&R)*

The Ministry funds AT&R services (DHB provided multidisciplinary services delivered in a range of settings) for people with disabilities under the age of 65. They include specialised and clinical assessment, treatment and rehabilitation to enable people to participate in daily activities and fulfil valued roles in their home and community.