Community Health, Transitional and Support Services

Allied Health Services (Non Inpatient)

Tier 2

September 2024

Health New Zealand
Te Whatu Ora

Contents

1. Status

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

MANDATORY ☑ RECOMMENDED ☒

It is compulsory to use this Specification when purchasing services. No Districts should use a local service specification instead of this mandatory specification.

2. Review History

Review History	Date
First Published on NSFL	2003
Review of the Specialist Community Allied Health service specification (2003).	14 June 2012
Amendment: updated to align with the Resource and Capability Framework for Integrated Adult Palliative Care Services (Ministry of Health 2013) and the Tier Two Specialist Palliative Care service specification. Added key components of the Palliative Care – Community service specification. New purchase unit code M80013 Specialist Palliative care - community allied health.	August 2014
Amendment: removed reference to M80005, amended definition of M80013 to align with v20 of the Purchase Unit Data Dictionary	March 2015
Content moved to updated Health New Zealand format	September 2024
Consideration for next Service Specification Review	Within five years

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.

3. Introduction

The Tier Two Allied Health Services - Non Inpatient (the Service) service specification is used in conjunction with the Tier One Community Health, Transitional and Support Services service specification so that the total service requirements are explicit. The Tier One service specification contains principles and content common to all the tiers of service specifications below it and is applicable to all service delivery.

This service specification should also be read, as appropriate for relevant age groups, in conjunction with:

- the Age Related Residential Care (ARRC) services agreement
- the Resource and Capability Framework for Integrated Adult Palliative Care Services (the Resource and Capability Framework) (Ministry of Health 2013)
- the Guidance for Integrated Paediatric Palliative Care Services in New Zealand (Ministry of Health 2012), and
- the following service specifications: - Specialist Palliative Care Services, Community Assessment, Treatment and Rehabilitation, Disability Support Services - Child Development Services, and Equipment and Modification Services (EMS).

The Tier Two Allied Health Services service specification includes common elements specific to this service and generic requirements for the delivery of a range services described in the tier three service specification in the table below.

The following Tier Three service specification must be used with this Tier Two service specification:

Tier Three Service Specifications	Purchase Unit Code
Podiatry Services for at Risk, High Risk Feet	AH01006

4. Service Definition

This Service supports Service Users remaining in their own community by providing allied health services in a range of settings, if the Service User's health and / or disability needs can be managed in these locations in a cost effective manner. The following Allied Health Services are included in this Service: dietetics, health social work, occupational therapy, physiotherapy, psychology-non mental health, podiatry, and speech language therapy.

This Service is for all eligible people whose level of need is such that they require health and disability services delivered by allied health professionals or under the immediate direction of allied health professionals.

The Service provides allied health intervention and treatment:

- for people of all ages with long term, or chronic personal health problems and / or conditions, and for people with disabilities
- primary palliative care services provided by allied health professionals where it is not covered by other service specifications, and as agreed with the Funder
- specialist palliative care services provided by allied health professionals in the community (M80013), working in the context of an interdisciplinary team of palliative care health professionals
- support for end of life care, in collaboration with the primary palliative care provider.

An eligible person may be referred to the Allied Health Service for the following reasons:

- they experience a personal health problem or disability need that:
  - places them at risk of deterioration in health status or
  - resulted from or will result in a deterioration of functional ability, and
  - can be appropriately managed by the allied health service in a non-inpatient setting.

5. Service Objectives

5.1 General

See the Tier One Community Health, Transitional and Support Services service specification Section 4 Service Objectives.

The purpose of the Service is to work in partnership with Service Users and their family and whānau, where appropriate, to provide community based intervention and treatment for to:

- support preventable avoidable admission to hospital or long term residential care
- enable timely and appropriate discharge from hospital to minimise the impact of a personal health impairment or disability
- promote self-management of a person's condition to enable optimal independence and autonomy
- contribute to improving the quality of life for people in palliative care.

5.2 Māori Health

See the Tier One Community Health, Transitional and Support Services service specification Section 4.2. Māori Health.

6. Service Users

The Service Users are those eligible people with long term or chronic personal health problems or conditions, or people with disabilities, or people with assessed palliative care needs who meet one or more of the following criteria:

- require Allied Health services to improve their health status, or
- without allied health services they are at risk of further deterioration in their personal health status, or quality of life
- have a disability and their functional ability is compromised or at risk of deterioration, or
- are residents[1] living in Residential Homes / Care Facilities - they are eligible for allied health services, supplies and equipment under the same criteria as people living in

[1] Includes people with intellectual and / or physical disabilities, or mental illness and addictions.

their own homes, if these services are not funded through another service specification, or

- are residents of Aged Related Residential Care Facilities - they are eligible for allied health assessment and rehabilitation services including assessment for, and advice on, individualised customised equipment; but not for delivery of maintenance or ongoing treatment, supplies or provision of non-customised equipment, or
- require Allied Health Services assessment for necessary equipment or housing modifications to facilitate their discharge from hospital, or
- are assessed as having a need for Allied Health Services following their discharge from a hospital.

7. Access

7.1 Entry and Exit Criteria

The criteria by which the Service Users will be eligible for the Service is based on clinical assessment of health status risk and level of physical and disability need. The Risk Assessment Framework (Appendix 1) guides the determination of entry to the Service and priority for entry, and forms the basis for discharge or transfer of care from the Service.

7.2 Referral to the Service

Referral to the Service is by referral from a registered medical practitioner, a DHB approved needs assessment and service co-ordination organisation[2], appropriate health professional, self-referral or family member to the Service according to the access criteria.

In agreed circumstances, self-referrals may be received by the Service for assessment for the level of service required. In such instances, with approval of the person, receipt and outcome of referral will be notified to the person's primary health care provider. Additional information may be sought from the primary health care provider prior to the referral being accepted.

7.3 Referral Management Response Time

Receipt / acknowledgement of the referral by the Service to the Service User and the referrer will occur within 5 working days of receipt of the referral.

In the majority of situations, partial completion of assessment and development of a treatment plan will progress to the point where intervention(s) are clearly identified and allied health services commence within 15 working days of first contact.

Where not otherwise specified, the time from receipt of referral by the Allied Health

Professional to first contact with the Service User will meet the requirements below:

[2] See Glossary in Tier One Community Health and Transitional and Support Services service specification.

Urgency for initiation of Service provision according to risk level assessed from referral	Allied Health Professional response to assessed risk for provision of the Service
High or excessive level of risk	within 2 working days of receipt of referral, according to assessed need.
Medium risk	within 15 working days of receipt of referral, according to assessed need.
Low risk	within 3 months of receipt of referral according to assessed need.

8. Service Components

8.1 Processes

Additional detail to the generic information and principles applied to the service components in the Tier One Community Health, Transitional and Support Services service specification are provided in the table below:

Service Component	Description
Referral management	The referral system will be operated by staff who understand the scope and nature of Allied Health services.
Allied Health Assessment	The Service provider will: • on referral, identify the most appropriate Allied Health professional(s) to carry out the assessment/s[3] • ensure that a comprehensive assessment is conducted and documented that considers the holistic needs of the Service User • develop goals and desired outcomes in partnership with the Service User and that the agreed plan of care is commenced • liaise directly with the relevant services, health professional's DHB approved needs assessment and service coordination organisations, other referral agencies and other health professionals within the interdisciplinary team.
Provision of loan equipment (for personal health and disability need).	The Service provider will provide equipment for eligible people of all age groups who have been assessed as needing DHB funded short-term loan of equipment for the following reasons: • to allow people with personal health and disability needs to remain at home, where appropriate • to provide equipment for people to meet their assessed needs • as an interim solution whilst awaiting long-term loan equipment.

[3] This includes assessments carried out under the accredited assessment process working within the Ministry of Health Disability Support Services EMS Accreditation Framework by Physiotherapists, Occupational Therapists and Speech and Language Therapists in their roles as EMS assessors for DSS funded services accessed through Accessable (Auckland and Northland regions only). Enable New Zealand (for the rest of the country).

Service Component	Description
	Note: Following a needs assessment, the Ministry of Health funds or contributes to the cost of long-term equipment and modifications where a person with a disability meets specified criteria. DHB equipment for short-term loan will include, <u>but is not limited to</u>: **A. Standard mobility aids**: walking frames, walking sticks, crutches. **B. Basic wheelchairs**: transit and self-propelling wheelchairs **C. Standard personal care equipment:** • commodes, raised toilet seats, perch and shower stools, bath boards • portable rails and ramps • mobile patient lifters / hoists, bariatric equipment • nebulisers, transcutaneous electrical nerve stimulation (TENS) units • pressure / positioning mattresses, adjustable beds.
Treatment / Intervention	The Service provider will ensure that treatment and intervention is provided: • based on best practice • to assist in meeting the Service User's identified goals and review and evaluate the treatment programme against the goals at regular intervals • to meet the requirements of the agreed plan and as required, engage in advance care planning processes initiated by the primary palliative care provider • to deliver a palliative approach to patients with life-limiting or life-threatening conditions, assessment and symptom management.
Information, Education and Advice	Education of other health professionals and caregivers in this context relates only to the specific education that is required for an individual Service User and is focused on the treatment, management strategies or equipment for each Service User. The effective professional oversight of a Service User's needs, will sometimes require formal training of the health professional in a group setting.
Self Management and Wellness Education	The Service provider will work in partnership with the Service User, their family, whānau and carer to meet mutually agreed goals by being a source of: • health / wellness education and self-management information to support treatment and intervention to minimise the impact of illness or disability Includes initial training to Service Users, family and whānau, carers and other health professionals on profession-specific interventions. • initial training on the safe use of recommended equipment / supplies and housing modifications to maximise benefit for the Service User.
Evaluation - monitoring and assessment	See the Tier One Community Health, Transitional and Support Services service specification.

Service Component	Description
End of life care guidance	The Service provider will, as appropriate: • engage in and utilise an end-of-life pathway programme , such as according to the written management /care plan • collaborate in developing a systematic district approach to end of life care • implement end of life care in non-specialist settings.
Life long service provision	Where a Service User is recognised as being at a level of risk which requires infrequent, but regular lifelong specialist allied health assessment, support and / or treatment in order to maintain / optimise his / her health and / or functional status the Service will: • develop a maintenance plan in partnership with the Service User, including agreed goals and frequency of contact • provide the Service User, their family and whānau, relevant health professionals and carers (paid and unpaid) with information / education they require to meet the Service User's needs in an ongoing manner.
Discharge Planning	The Service will: • plan discharge in consultation with the Service User and agencies as appropriate • liaise, and share information, with the Service User's Primary Health Care Team to ensure a continuum of care • refer the Service User to other services as required and notify the Primary Health Care Team of the referrals • ensure that transition of responsibility of care for the Service User to other providers has occurred in a manner which promotes continuous care and minimises gaps in service provision wherever possible • make a written discharge report available to the Service User, the referrer and the GP.
Key Worker / Care Co-ordinator	See the Tier One Community Health, Transitional and Support Services service specification.

8.2 Settings

See the Tier One Community, Transitional and Support Services service specification Section 5.4 Settings.

8.3 Support Services

Support services are required to be provided as an integral part of the Service.

- Interpreting services including New Zealand Sign Language (NZSL) interpreters for Deaf people who communicate using NZSL.
- Māori and or Pacific Peoples advocacy and support services as required ensuring appropriate cultural responsiveness to Service Users.

8.4 Key Inputs

The Service may include, but not be limited to, the following appropriately trained health professionals and their assistants:

- dietitian
- health social worker
- occupational therapist
- physiotherapist
- psychologist – non mental health
- podiatrist
- speech – language therapist.

The Service's staff will participate in palliative care education programmes provided by specialist palliative care services, as required.

Allied Health professionals will meet professional standards of practice required by regulatory authorities as per the Health Practitioner Competence Assurance Act (2003) and the Health Social Workers Registration Act (2003), and relevant professional authorities for self-regulated professions.

9. Service Linkages

See Tier One Community Health, Transitional and Support Services service specification Section 8, Service Linkages. In addition, the Service will also maintain effective relationships with the following services to ensure seamless transfer of care for the Service User and their family and whānau, including but not limited to:

- Artificial Limb Centre
- Enable NZ / Accessable
- Maternal and perinatal mental health services
- Orthotics service providers
- Other DHBs
- Primary Health Care Providers
- Private service providers
- Primary and specialist palliative care providers.

10. Exclusions

See the Tier One Community Health, Transitional and Support Services service specification Section 3. Exclusions.

This Service will not duplicate services already contracted for by the Ministry of Health, Accident Compensation Corporation (ACC), or District Health Board (DHB).

In addition, the following services are excluded from this Service:

- services for people whose service needs are covered under another service specification such as:
  - Coordination of Family Violence Intervention Programme Services
  - Doctors for Sexual Abuse Care (DSAC) Services
  - Termination of Pregnancy Counselling Services (covered under Section 8 Maternity Notice
  - Child Development Services
  - Generic training packages for Home Support service providers.

11. Quality Requirements

11.1 General

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

The Service must comply with the following Standards New Zealand standards[4], and their subsequent revisions:

- NZS 8171:2005 Allied Health Services Sector Standard, that specifies consistent dimensions of safety for allied health service providers in terms of consumer focused services, organisational management, pre-entry to services, service delivery, managing service delivery and provision of a safe and appropriate environment, and
- NZS 8158:2003 Home and Community Support Sector Standard[5] that establishes the minimum requirements that should be attained by providers. It is limited to health and disability services provided in the environment of a person's home or in their community, by individuals working as support workers accountable to a home and/ or community support service provider.

11.2 Monitoring Waiting Times

The Service's audit programme should include a regular audit of Service Users' individual plans and their outcomes, measure response times to referrals, and waiting times according to the Service User's risk level that was assessed from referral. Refer to the Appendix One Risk Assessment Framework.

11.3 Acceptability

You will report annually to the Funder on:

- current utilisation of services by Māori Service Users
- planning and implementation of processes which improve the responsiveness of the Service to Māori.
- activities that recognise the culturally sensitive issues relating to the Service and focus on:
  - the holistic taha Māori perspective of health
  - the holistic community approach to health for Pacific Peoples' cultures.

[4] The New Zealand Standards may be purchased from Standards New Zealand through their webpage links. **NZS 8171:2005** http://www.standards.co.nz/web-shop/?action=viewSearchProduct&mod=catalog&pid=8171%3A2005%28NZS%29&searchId=1382077&searchOrderingIndex=1&searchSessionId=67502CE027747621D564C817F571A6EA

NZS 8158:2003 http://www.standards.co.nz/web-shop/?action=viewSearchProduct&mod=catalog&pid=8158%3A2003%28NZS%29&searchId=1382135&searchOrderingIndex=1&searchSessionId=67502CE027747621D564C817F571A6EA#none

12. Purchase Units

Purchase Units (PU) are defined in the joint DHB and Ministry's Nationwide Service Framework Purchase Unit Data Dictionary. The following Purchase Units apply to this Service.

PU Code	PU Description	PU Definition	Unit of Measure	Reporting to National Collections
AH01001	Dietetics	Dietician services provided in an outpatient or domiciliary setting to DSS, HOP and personal health clients. Includes post discharge services and other DHB referrals as well as community-referred clients.	Contact	National Non-admitted Patient Collection (NNPAC)
AH01003	Occupational Therapy	Occupational Therapy services provided in an Outpatient or domiciliary setting to DSS, HOP and personal health clients. Includes post discharge services and other DHB referrals as well as community-referred clients.	Contact	NNPAC
AH01005	Physiotherapy	Physiotherapy services provided in an Outpatient or domiciliary setting to DSS, HOP and personal health clients. Includes post discharge services and other DHB referrals as well as community-referred clients.	Contact	NNPAC
AH01006	Podiatry	Specialist podiatry services provided in an outpatient or community setting for people with at risk high/ risk feet.	Contact	NNPAC
AH01007	Health Social Work	Social work services provided in an Outpatient or domiciliary setting to DSS, HOP and personal health clients. Includes post discharge services and other DHB referrals as well as community-referred clients.	Contact	NNPAC
AH01008	Speech Therapy	Speech therapy services provided in an Outpatient or domiciliary setting to DSS, HOP and personal health clients. Includes post discharge services and other DHB referrals as well as community-referred clients.	Contact	NNPAC
AH01010	Psychologist Services - Non Mental Health	Psychology services provided by Psychologists in an Outpatient or domiciliary setting to personal health clients. Includes post discharge services and other DHB referrals as well as community-referred clients. Excludes services provided for Mental Health. See also COOC0074	Attendance	NNPAC

PU Code	PU Description	PU Definition	Unit of Measure	Reporting to National Collections
M80013	Specialist Palliative care - community allied health	Specialist palliative care delivered to outpatients and in the community by specialist allied health professionals (includes grief and loss counselling). Excludes primary palliative care services funded under the AH series purchase unit codes.	Client	NNPAC

Unit of measure	Unit of measure definitions
Attendance	Number of attendances to a clinic/department/acute assessment unit or domiciliary.
Client	Number of clients managed by the service in the reporting period (period is annual 1st July - 30th June) i.e. caseload at the beginning of the period plus all new cases in the period. 'Client' and 'Service User' are interchangeable.
Contact	The number of face to face contacts between a health professional and client or group of clients, for the provision of clinical services/interventions described in the services specification. A contact is equivalent to a visit. A contact excludes: phone consultations, discussions between health professionals about a client's care, and where the sole purpose of the contact is provision of supplies or consumables. Where a service is provided to a group of people simultaneously by one health professional it will be counted as one contact, one event.

13. Reporting Requirements

There reporting requirements are for the National Non-Admitted Patient Collection (NNPAC).

DHB Hospital service providers should comply with the requirements of national data collections. Service Users receiving specialist palliative care delivered in the community by community allied health professionals are counted against the purchase unit code M80013 and are able to be reported to NNPAC. Primary palliative care contacts provided by community allied health professionals are included in the relevant AH series codes listed in the table 9.1, above.

Additional Information and Reporting Requirements

A core set of information will be collected and provided on request to the Funder for monitoring of service provision purposes to support national consistency for service development and benchmarking.

For each Service User, record the following information (not available from NNPAC)

a. Service User complexity (high, medium or low) as defined in Appendix 1, The Risk Assessment Framework
b. the referring Practitioner's name
c. the number of days the Service User waited before being assessed by an allied health professional – longer than 14 days, or longer than 30 days or longer than 90 days
d. the reason for referral (accident / non accident / other)
e. Type of Service provided (a different data entry will be completed for every service a Service User receives)

The Service must collect all data relevant to the business of the Service in line with the National Specialist Palliative Care Data Definitions Standard[6]. This data must be readily available, at Service User/patient activity level, upon request by the DHB or the Ministry of Health.

14. Glossary

Not Required

15. Appendices

[6] HISO standards are periodically reviewed to assess and maintain their currency and new editions are published. Visit HISO website http;//w3ww.ithealthboard.health.nz/who-we-work/hiso

15.1 APPENDIX 1 RISK ASSESSMENT FRAMEWORK

HIGH RISK **Failure to provide the service may result in the Service User:**	MEDIUM RISK **Failure to provide the service may result in the Service User:**	LOW RISK **Failure to provide the service may result in the Service User:**
• being admitted as an in-patient for symptom control or as the result of injury • experiencing irreversible and fast deterioration of their health or functional status • no longer being able to safely stay in their own residence (for want of targeted service delivery or appropriate environmental adaptation) • unable to be discharged from an inpatient environment in a timely and appropriate manner.	• being unable to undertake activities of daily living in a safe manner, and there is no help readily available • continuing with compromised functional status which is not life-threatening but if left permanently unmanaged would lead to more extensive and/or additional problems • losing functional skills to a degree that places significant pressure on the family / caregiver which may cause their health status to be compromised • being admitted to short-term care to provide respite for the caregiver while awaiting services.	• 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 or to function as independently as possible.

This framework is presented as a continuum of risk in terms of a Service User's health and disability status. There will, therefore be clients who will not be eligible for service as a result of assessment, or reassessment of their risk. This would relate to Service Users who on assessment, or reassessment present with needs which are:

- **beyond** those suggested in the Framework as 'High Risk'. They have excessive and complex needs requiring:
  - management in an alternative environment e.g. palliative care, long term residential care
  - intervention by a clinical team which includes specialist medical involvement e.g. inpatient facility
- **below** those suggested in the Framework as 'Medium Risk'. They are functionally independent and a level of compromised health status which does not require specialist services. The services to meet their level of need could appropriately be provided by the GP and / or practice nurse or co-ordinated by needs assessment and service coordination organisations for people who have disabilities.
- **below** those suggested in the Framework as 'Low Risk'. They are Service Users for whom the sole purpose of the service would be to provide comfort, convenience or emotional security for them and / or family but for whom no clinical benefit would be gained by the provision of the Service.