

Community health transitional and support services

**Needs assessment and service  
coordination (NASC) services for  
People with chronic Health  
Conditions Service Specification**

**Tier 2**

**September 2024**

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## 1. Status

May be amended as required.

**MANDATORY** ☒ **RECOMMENDED** ☒ **LOCAL** ☒

## 2. Review History

Review History	Date
First Published on Nationwide Service Framework Library	June 2011
<b>Amended:</b> to add front cover, include in title and reference the overarching TI Community Health Transitional and Support Services service specification.	June 2013
<b>Amended:</b> removed references to appendices that are no longer included in this service specification	November 2016
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

<p style="text-align: center;"><b>COMMUNITY HEALTH TRANSITIONAL AND SUPPORT SERVICES- NEEDS ASSESSMENT AND SERVICE CO-ORDINATION SERVICES FOR PEOPLE WITH CHRONIC HEALTH CONDITIONS SERVICE SPECIFICATION CHC007, CHC008</b></p>
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The overarching Tier One Community Health, Transitional and Support Services specification contains generic principles and content common to all the tiers of specifications below it. This Tier Two service specification for Needs Assessment and Service coordination Services for People with Chronic Health Conditions (the Service) is used in conjunction with the Tier One Community Health, Transitional and Support Services service specification.

#### Background

A suite of service specifications was prepared for Districts to assume funding responsibility on 1 July 2011 for the long term support services for people under the age of 65 years who have chronic health conditions. As part of the ongoing service specifications review programme it is intended to integrate these service specifications with other similar service specifications to simplify purchasing arrangements, but retain the purchase unit codes to preserve the capacity to track expenditure.

### 4. Service Definition

#### Person with Chronic Health Condition

NASC should ensure services are provided only to those people who are eligible to receive them, as required by the Guide to Eligibility for Publicly Funded Health and Disability Services in New Zealand. For the purposes of this service specification an eligible person is someone who has been identified as having a chronic health which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required.

Note: Subsequent references in this document to “the person” or “people” should be understood as referring to a person with a chronic health need.

Throughout this document the term “person” is taken to include, where appropriate, family/ whānau/ aiga and/or full-time carer. When the NASC is working with a child, that child is always considered within the context of the family/whānau/ aiga.

#### Carer

For the purposes of this specification, a full-time carer is someone who has principle, active responsibility for the ongoing and frequent care of a person, usually on an unpaid basis and according to the above definitions.

For the purposes of this specification needs assessment or service coordination is a process provided by a Needs Assessment Service Coordination (NASC) on behalf of the District. Needs assessment and service coordination provides the means for a

person to identify their prioritised disability support needs within the context of their own natural resources and existing supports, receive information on support options, including those which are government funded, and receive assistance with coordination of support services.

**The three key functions of NASC are:**

**Facilitated Needs Assessment**

Needs assessment is a process of determining the current abilities, resources, goals and needs of a person and identifying which of those needs are the most important. The purpose of the process is to decide what is needed to maximise a person's independence so that they can participate as fully as possible in society, in accordance with their abilities, resources, culture and goals. A person's needs will also include, where appropriate, the needs of their family/whānau and carers; their recreational, social and personal development needs; their training and education needs; and their vocational and employment needs. This does not assume Health New Zealand responsibility for funding of supports in relation to all of these needs, and particularly when they are the funding responsibility of other agencies.

**Service Co-ordination**

Service co-ordination is a process of identifying, planning and reviewing the package of services required to meet the prioritised assessed needs and goals of the person and, where appropriate, their family/whānau and carers. Service co-ordination also determines which of the assessed needs can be met by government funded services and which can be met by other services, and will explore all options and linkages for addressing prioritised needs and goals.

**Budget Management**

The NASC manages a defined indicative budget based upon an annual allocation. Performance against the budget will be reviewed on an agreed basis by the NASC and the District.

The NASC needs to ensure that people with the highest priority needs receive access to services first. The NASC must also ensure that commitments made to fund service packages for people are such that they will not exceed the indicative budget for the current and out years.

Budget management involves allocating cost effective packages of services within the indicative budget, according to the Support Package Allocation tool.

## **5. Service objectives**

### **5.1 General**

A fundamental objective of the NASC is to maximise and support the abilities of people by facilitating a process for them to identify their needs and goals, and make decisions on how these can best be met. To achieve this objective the NASC must maintain a clear vision of NASC as the dynamic combination of a service working in

partnership with people and the District to achieve the best possible outcomes within the available resources.

For people with a chronic health need and full-time carers NASC is the means by which their strengths, resources and needs can be identified, their support options explored and support services accessed. In order to achieve these objectives a NASC needs to, at a minimum:

- be responsive to people and their communities
- be community focussed
- support the enhancement of the person's own natural strengths, resources and independence
- have minimal waiting times by adhering to timeframes set out in this specification.

Needs assessment and service co-ordination processes must be separated from the provision of support services. A NASC may not be the provider of support services, to ensure that no actual or perceived conflict of interest exists.

## **5.2 Responding to Communities**

The NASC will have mechanisms in place to gain the input of people and their communities. In line with the objectives of the Māori Disability Action Plan, He Ratonga Tautoko I Te Hunga Haua, the input of Māori in particular as mana whenua should also be sought. Examples of mechanisms that could appropriately demonstrate and achieve responsiveness to the community include community representation at the governance level of the provider and/or an advisory group to the NASC.

## **5.3 Māori Health**

An overarching aim of the health and disability sector is the improvement of health outcomes and reduction of health inequalities for Māori. Health providers are expected to provide health services that will contribute to realising this aim. This maybe achieved through mechanisms that facilitate Māori access to services, provision of appropriate pathways of care, which might include but are not limited to matters such as:

- referrals and discharge planning
- ensuring that the services are culturally competent and
- that services are provided that meet the health needs of Māori.
- that services improve the health and independence of Māori by delivering services to best meet Maori need, and where possible to provide services by Māori for Māori.

It is expected that there will be Māori participation in the decision making around, and delivery of, the Service.

## 6. Service Users

### 6.1 Inclusions

Service users are people with chronic health conditions and long-term support needs mainly aged under 65 who are eligible for publicly funded services<sup>1</sup>.

Service users must meet **all** of the following criteria to be eligible for this Service:

- the person is aged under 65 and has one or more chronic health condition(s) that is / are expected to continue for six months or more and
- has very high need for long-term support services. Very high need for this service is defined as:
  - requiring assistance<sup>2</sup> with activities of daily living at least daily to remain safely in their own home
  - the person's wellbeing and functional status is deteriorating, their needs are increasing and safety issues are becoming apparent, and
- the person has limited opportunity to participate in age appropriate activity. The person is assessed as needing support daily, but some or most of it may be provided by family, whānau or friends, and
- do not have an informal support system (family and whānau) or the caregiver is under considerable pressure and their ability to support the person is compromised.

Where people have complex needs that mean they are eligible for long term support services from more than one funder, joint funding arrangements may be considered.

### 6.2 Exclusions

- People who are covered under Accident Compensation Act 2001. ACC has been responsible since 1974 for funding support services for people whose disability is caused by injury or accident<sup>3</sup>.
- People aged 65 years and over
- People who have a long term impairment (ie physical, sensory, intellectual or cognitive disability that was acquired before the age of 65 years)
- People aged 65 years and over with a long term impairment who have been Health New Zealand funded but who have been clinically assessed by a District or needs assessor as requiring age related residential care.

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<sup>1</sup> Not all Service users who are referred or present to the Service are eligible for publicly funded services. The eligibility criteria for publicly funded health and disability services are prescribed by Ministerial Direction. Refer to <http://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services> for information on the latest eligibility criteria.

<sup>2</sup> Assistance refers to physical hands on care or close supervision. For children and young people this refers to significantly higher levels of care than would normally be expected for their age.

<sup>3</sup> Accident Compensation Act 2001 refers.

- People aged 50-64 years who have been assessed by a District or District needs assessor as "close in interest" to persons aged 65 years and over and whose needs would be best met by District integrated health and disability services.
- People who require an assessment solely as a result of a mental health need or addiction condition. These assessments are contracted for by the District through Mental Health Assessment Services or Community Mental Health teams.

### **6.3 Interface with NASC for people 65 years and over**

The NASC will maintain working relationships and agreed protocols with District NASC working with older people, if not the same agency.

### **6.4 Interface with Mental Health**

For those people with a dual diagnosis, that being a co-existing mental illness and chronic health need, the NASC will work in collaboration with the relevant Mental Health Service.

### **6.5 Interface with Disability Support Services**

If appropriate, for those people with a dual diagnosis, that being a co-existing disability, the NASC will work in collaboration with the relevant DSS NASC.

### **6.6 Interface with Other Agencies**

Depending on the needs of the person it may be appropriate for the NASC to jointly facilitate needs assessment with other appropriate agencies.

## **7. Access**

### **7.1 General**

Access to the Service is by authorised referral from the Referrer following confirmation of eligibility and an individual needs assessment process. The Provider must operate an effective and efficient system to receive and prioritise all referrals into the Service.

The assessment and service co-ordination processes followed by the Referrer will ensure that the criteria have been met for clients referred to the Provider

The NASC is expected to:

- encourage and enable the person to take an active role in the needs assessment and service co-ordination process

- ensure that there is full consideration of the person's chosen lifestyle in all aspects of the assessment and service co-ordination process
- determine with the person the appropriate level of NASC involvement. This may require full involvement by the assessment facilitator through to minimal involvement and advice where the person wants to take more responsibility for the process themselves, including accessing services which are funded or purchased outside the NASC process.

Needs assessment and service co-ordination will be conducted with the person in an environment comfortable to them.

The NASC will:

- provide information about the NASC service and work to ensure people, providers, GPs, other community groups and potential referrers are aware of NASC referral processes
- promote access to services by Māori and Pacific peoples
- identify, and build into the service, strategies to overcome known barriers to access for Māori, Pacific peoples, and other population groups with specific needs
- operate from premises that are appropriate, accessible and welcoming.
- have NASC premises open during normal business hours.

## 7.2 Referrals

The person may self-refer to the NASC. Any other person or organisation can make referrals.

Initial contact will be made within two working days of receipt of the referral. This contact may be by phone, letter or visit. The type of contact and response will be determined by the nature of the referral ie. urgency.

## 7.3 Prioritisation

The NASC will promote self-determination, quality of life and an environment that maximises community participation and independence for people. The NASC's role is to co-ordinate effective utilisation of support resources.

The NASC has a role in facilitating access, prioritising and allocating District funded resources. To achieve this, the NASC will:

- acknowledge and support the person's own natural resources and existing supports
- give the person accurate information on eligibility and the limitations and boundaries of LTS-CHC funded services
- meet the safety needs of the person and community wherever possible

- promote equity for people to achieve similar outcomes for similar needs and circumstances
- work to safely reduce any disparities in equity between population and disability groups
- recognise the need for, and support access to, appropriate supports for groups with specific needs.
- support the continued needs based shift to supported community-based options for people previously living in institutional care or unsupported in the community
- support the continued needs based shift from service based to support based delivery
- be efficient, including creative and innovative use of resources to meet needs
- establish greater trust and credibility in the NASC process
- work within the funding and policy boundaries of the District when allocating public resources.

The NASC will implement, and adhere to, consistent and transparent processes for priority setting and associated resource allocation.

#### **4.3 Inter- NASC transfers**

The NASC will provide service to all eligible people wherever they live, or subsequently shift to, within the NASC's specified geographic area.

The NASC will establish protocols and procedures with fellow NASC in other areas of New Zealand to ensure continuity of service for people moving into, and out of, the region. Such protocols should include but are not limited to:

- the timely transfer of relevant information including assessment, service and support planning records to the new NASC, subject to the provisions of the Health Information Privacy Code (Office of the Privacy Commissioner 1994).
- immediate commencement of services by the new NASC according to the person's transferred support plan until such time as a reassessment or review of the support plan are undertaken by the new NASC
- a process for, and agreement on, a transition plan developed by both NASC in conjunction with the person. This is particularly important in situations where different services are required and/or where particular services are not available in the new area
- a process for temporary moves between areas e.g. for education, holiday, study. Note: In this situation the original NASC retains responsibility for ensuring that the person's support needs continue to be met while away and as outlined in the support plan.

## **8. Service Components**

### **8.1 Screening**

The NASC will ensure that it has personnel and systems in place to determine the eligibility of people being referred to the NASC using the definition of Service Users in 3.1, the functions of NASC in 1.0, and consistent also with the *Support Needs Assessment and Service Coordination Policy, Procedure and Information Reporting Guidelines* (MOH 2002).

The NASC will advise those who make referrals that are not appropriate to NASC and assist with information to effect appropriate on-referral.

## 8.2 Facilitated Needs Assessment

The role of the needs assessment facilitator is to work directly with the person to identify the person's current abilities, resources, goals and prioritised needs. The outcome of the process is a comprehensive needs assessment report. The level of detail required in the needs assessment will depend upon the situation of each person.

The objectives of the assessment process are to:

- confirm eligibility – including the nature of the person's long term support needs, if appropriate
- work with the person to identify their current abilities, resources
- work with the person to identify prioritised needs and goals arising from their impairment
- refer to appropriate specialised assessment services including Assessment Treatment and Rehabilitation (AT&R) where appropriate.

The NASC will have a clear auditable separation in their business between the function of assessment facilitation and service co-ordination. The purpose of this separation and transparency is to demonstrate objectivity and show identification of the person's needs irrespective of resource availability.

The NASC will demonstrate that:

- they have in place qualified and competent staff or sub-contracted assessment facilitators to provide choice of assessment facilitators and adequate coverage of the entire geographic area contracted for, including remote and rural areas
- access is facilitated to specialised assessment and/ or referral for treatment and followed up to ensure timely response from that assessor.

Outcomes of the needs assessment process may be either:

- a needs assessment is completed and service co-ordination commenced
- a needs assessment is partially completed and service co-ordination commenced to arrange access to urgent support needs
- a needs assessment is partially completed awaiting the outcome of specialised assessment

At the end of the assessment process the person, or their delegated advocate/representative, will sign off the completed assessment and receive a copy for their records.

### **8.3 Cultural Component of Facilitated Needs Assessment**

The purpose of the cultural component of assessment is to jointly identify, the person's cultural needs. This may include issues of social/cultural, spiritual, psychological and physical need, and strengths, assets, and support systems to assist in planning support.

The NASC will have the capacity to include a cultural component into the facilitated needs assessment process.

### **8.4 Specialised Assessment**

The assessment facilitator may refer the person to a specialised assessor for a specialised assessment. The purpose of a specialised assessment is to obtain detailed information and knowledge to accurately assess the person's need and identify a range of possible options including treatment. Such assessments are generally funded directly by the District (in most instances provided by a District) and will not be a charge on the NASC budget. Occasionally, in the absence of any District funded specialised service, the NASC may need to access privately provided specialized assessment. Purchase of such assessments will be a charge against the budget managed by the NASC for purchase of services and must be in line with the prioritisation principles set out in section 4.2, and within available resources.

Specialised assessments include, but are not limited to, clinical, diagnostic or other assessment, the purpose of which is to:

- establish the physiological basis, extent and implications of the chronic health need (eg. testing, diagnosis and medical/physical prognosis)
- gain access to medical treatment and/or rehabilitation or habilitation (eg. AT&R, corrective surgery, exercises, treatment or child development)
- determine the person's suitability for a specific service or type of assistance, including environmental support
- make recommendations on how specific needs of the individual can be met (e.g. communication support, activities of daily living (ADL), mobility assistance)
- provide advice on how support services can assist in furthering the rehabilitation process

The NASC will also identify and facilitate access to assessors funded by other government departments e.g. education, vocational.

## 8.5 Service Co-ordination

The NASC is required to undertake service planning and service co-ordination, and agree a support plan with the person that indicates how prioritised needs will be met.

The service co-ordinator will ensure that, wherever possible, the person has a choice of service options, including involvement of family, community, voluntary or private (personally funded) services. The service coordinator will support and/or arrange innovative and flexible individually focussed service packages. Where appropriate services are not available the service co-ordinator and the person will consider other possible options for meeting the support needs.

Consideration of natural supports will be included in assessment and coordination processes for all people, including Hunga Haua (people with disability). Natural supports include but are not limited to friends, both outside and in service settings; immediate and extended whānau members including hapu and iwi; community activities/groups/education and courses; neighbours; workplaces.

The place of natural supports in a person's life is likely to be an important part of Mauriora. Hunga Haua should be encouraged to think about who or what these supports might be and should be supported to have contact with them, or, where no supports exist, should be supported to explore the possibilities of developing them.

Service co-ordination will:

- Commence immediately following completion of the needs assessment. However, as the NASC is accountable for meeting the safety needs of the person, service co-ordination may need to commence before the completion of the assessment. Access to support services that maintain the safety and/ or dignity needs of the person should not be delayed where the completion of the needs assessment is subject to delays e.g. time involved in accessing or completing specialised assessments
- confirm financial eligibility for support services
- provide information to the person on all their options, including available service providers. The person should have the opportunity to choose the support service provider from whom they will receive services. The NASC will then refer the person to the chosen service provider.
- develop an individualised support plan with the person, focusing on support for prioritised needs and goals
- prioritise access to publicly funded services
- ensure that the service package is cost effective, affordable and equitable and can be provided within the NASC defined budget and the LTS-CHC guidelines.
- ensure that all aspects of the package of services are co-ordinated and that services made available through the NASC budget are accessible by the

person. The NASC should ensure, to the extent possible, that services provided by external agencies are co-ordinated and not duplicated.

Further information on the process and requirements for delivering service co-ordination is provided in the *Guidelines for Service Co-ordination* (MOH1995), *Standards for Service Coordination* (MOH 1999) and *Support Needs Assessment and Service Coordination Policy, Procedure and Information Reporting Guidelines* (MOH 2002), including the Support Allocation Tool (SPA).

## 8.6 Intensive Service Co-ordination

The NASC is responsible for providing intensive service co-ordination for the small number of people with high and complex needs, usually requiring the involvement of multiple providers and ongoing problem solving. Intensive service co-ordination requires an ongoing relationship between the person and the co-ordinator. The decision that intensive service coordination is needed will be made by the service co-ordinator following assessment.

The tasks of intensive service co-ordination include:

- Negotiating the most appropriate means for achieving the desired outcomes and respective responsibilities with service providers and other sectors, for example education, justice, police, High and Complex Needs Unit MSD for children.
- arranging interim and crisis service provision pending further assessment
- involvement with specialised services eg. Mental Health, for assessment and treatment planning, including joint needs assessment and service co-ordination for people with a dual diagnosis of intellectual disability and mental health
- convening or participating in meetings as required with the person and those involved in the development and/or implementation of a support plan
- monitoring the delivery of the support plan, review of needs and revision of the support plan at regular, specified intervals.

The NASC will:

- ensure that intensive service co-ordination is offered only to people with high and complex needs
- work with others involved in supporting the person to ensure all participants have a common understanding of the needs and goals of the person and are working together to achieve these

- regularly review the needs of the person and the purpose of intensive service co-ordination to ensure that it is appropriate.

## 8.7 Review and Reassessment

**Review:** The NASC is responsible for determining an appropriate time frame with the person to review their support package. The interval will be indicated by the person's needs and the package of supports. Generally it is expected that a person's supports will be reviewed at least annually. However, a person may at any time seek a review if the service is not meeting their needs or their eligibility has changed or expired eg. eligibility for community services card, carer support. Review periods for people with high or complex needs or those in a crisis period may be considerably shorter.

**Reassessment:** Should the person's needs or circumstances undergo significant change and the support plan no longer meets their needs, a reassessment of needs will be required.

If it is likely that a person's support needs will increase or decrease over an identified period of time, a reassessment may also be required. This can be indicated when setting a timeframe for review.

The NASC will facilitate a reassessment at least every three years if the person has not been reassessed in the interim.

## 8.8 Crisis Response

The NASC will provide a crisis response service when required. It will have a 24 hour emergency call system available through which people, families, or carers experiencing genuine emergencies can access services such as respite care when required.

To fulfill this function the NASC will need to be able to source crisis response options.

## 8.9 Māori Service Components

The NASC will recognise health as all encompassing as depicted in the Whare Tapa Wha model:

- Te Taha tinana – physical body
- Te Taha wairua - spirit
- Te Taha whānau – the family
- Te Taha hinengaro - the mind.

The NASC will establish and implement a Māori Service Plan that covers governance, management, organisational competencies, Māori health and disability gain, assessment and coordination practices, and how these will contribute to improving outcomes for Māori through the needs assessment and service coordination process.

In developing the plan the NASC will take into account Health New Zealand's strategic direction for Māori health and disability. This plan should incorporate the minimum requirements for Māori health and disability based on the Treaty of Waitangi, the Crown objectives for Māori health and disability and any specific requirements negotiated from time to time with Health New Zealand.

The NASC will specify how it intends to implement this plan. In particular, the NASC will identify those services it will deliver as explicit contributions to reducing inequalities and other additional opportunities that may exist for improvements for Māori with disabilities.

The NASC will be an Equal Employment Opportunity organisation and will ensure that they recruit, train and develop Māori, and in so doing ensure provision of a more culturally competent service appropriate to Māori.

The NASC will:

- have the capacity to include a cultural component in the facilitated needs assessment
- facilitate improved access for Māori to support services by ensuring the equitable distribution of resources
- provide the NASC service in Te Reo Māori where necessary or appropriate or specifically requested by the person.

The NASC is required to ensure:

- that needs assessment facilitators and service co-ordinators have a basic understanding of Māori cultural values and beliefs, in particular Te Reo Māori and Tikanga Māori
- that people have access to needs assessment facilitators and service co-ordinators who have a strong understanding of the Māori holistic concept of health (taha wairua, taha tinana, taha hinengaro and taha whānau) and are able to articulate this understanding in service implementation

- that needs assessment facilitators and service coordinators have appropriate cultural competencies and/or support from cultural experts and resources
- that people have access to kaumātua (respected elder) who can be instrumental in cultural assessment and application of tikanga
- that Māori are offered the choice between Kaupapa Māori services and generic services, or a combination of both
- that the NASC can demonstrate progress toward implementation of cultural competencies to be developed by Health New Zealand during the term of this contract.

## 8.10 Pacific Service Components

The Pacific Health and Disability Action Plan (the Action Plan) sets out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities between Pacific and non-Pacific peoples. It is directed at the health and disability service sectors and Pacific communities, and aims to provide and promote affordable, effective and responsive health and disability services for all New Zealanders.

The Action Plan is a working document. It provides a foundation for priorities now and sets the direction for the future. The NASC is required to recognise the key principles of the Action Plan:

- dignity and the sacredness of life are integral in the delivery of health and disability services
- active participation of Pacific peoples in all levels of health and disability services is encouraged and supported
- successful Pacific services recognise the integral roles of Pacific leadership and Pacific communities
- Pacific peoples are entitled to excellent health and disability services that are co-ordinated, culturally competent and clinically sound.

The NASC is required to ensure:

- they can demonstrate progress toward implementation of cultural competencies to be developed by the Health New Zealand during the term of this contract.

## 8.11 Other Cultures

NASC are expected to provide facilitated needs assessment and service coordination in a manner culturally appropriate for people of other cultures in their populations, including new migrants who meet eligibility criteria and people with the status of refugee. Interpreters will be engaged as necessary.

## 8.12 Information Management

Access to information is a vital function to support people's independence and is an integral component of the NASC business. The NASC will have the dual role of both providing information and acting as an information broker.

It is expected that the NASC will capture and store data according to specifications provided by the District and will use any system, designated funded and supported by the District or its agents that is developed during the course of the contract.

The outcome of the management of information will be:

- effective service outcomes for people
- people's privacy is maintained
- efficient systems for quality, budget management and reporting
- equitable and consistent allocation of available resources.

NASC are responsible for providing and facilitating a range of information to and from a number of sources. Information managed by NASC will include:

- information about individuals eg. needs assessment and service coordination information
- information for individuals regarding NASC processes e.g. information on NASC service users' rights and complaints processes
- information on service availability eg. contracted providers for support services and occupancy information
- information for business management e.g. information for provider payment, and information for budget management
- information on service issues including service gaps and/or boundary issues, quality issues regarding contracted providers.

### 8.12.1 Individual Information

Management of information on individuals is a core function of NASC. NASC must comply with the *Health Information Privacy Code 1994*.

NASC are required to work to key principles and practices under the code.

At a minimum:

Information must be

- necessary
- collected lawfully
- stored securely
- accurate, up to date, complete, and not misleading.

People must be informed:

- of what information is collected
- of the purpose of collecting the information
- of and agree which agencies will receive the information collected
- how to access information kept on them
- that they have the right to correct inaccurate information about themselves

NASC should not keep personal information for longer than necessary and information should be disposed of in a secure manner.

Further information on the collection and management of personal information is provided in *Support Needs Assessment and Service Coordination Policy, Procedure and Information Reporting*, (MOH 2002).

### **8.12.2 Disability Sector Information**

(where appropriate) NASC have the role of referring on to, and advising people and their families/whānau on, sources of further information. It is expected that general information will be readily available to the person and their family/whānau, at least, on:

- chronic conditions
- eligibility and entitlement to financial assistance, and benefit information
- details of the nature, type and quality of services available – both services accessed through NASC and services available from other sources, including how to access those services, expected outcomes and approximate costs of services
- referral paths for people who are not eligible for LTS-CHC funded support services but have support needs e.g. palliative care
- other agencies where further specific and detailed information may be obtained regarding their impairment.

The NASC is not expected to compile and duplicate specific detailed information already available from other disability information agencies in their area. However the NASC will maintain effective networks and linkages with a wide range of appropriate organisations resulting in current, reliable information from which to advise and make referrals.

The District considers it important that people:

- are supported through the process by having relevant information
- have a co-ordinated and comprehensive method for accessing information.

### **8.12.3 Provider Information**

The NASC will provide support services with sufficient information to enable them to provide service to people referred to them. To ensure this happens NASC must provide the minimum information detailed in *Support Needs Assessment & Service Co-ordination Policy, Procedure and Information Reporting Guidelines* (MOH 2002), consistent with the requirements of the *Health Information Code* (Office of the Privacy Commissioner 1994).

Additionally, NASC must have Memoranda of Understanding with providers to cover such things as:

- specifying what information is to be provided by NASC
- timeframes in response to service requests
- timeframes for notification of a change to people's service, change in service levels, and/or the amount of service
- processes for passing on information regarding a change in need of a person.

This includes the transfer of personal and service information that may be used by support service providers as they plan their services e.g. information on unmet needs and service gaps etc.

As part of maintaining effective networks the NASC will provide information to other support service providers on trends, unmet needs etc, for the purpose of fostering creative, innovative, flexible services.

### **8.13 Monitoring of Support Service Delivery**

The NASC will report quarterly to the District on service delivery by support service providers contracted by Health New Zealand. It is expected that the NASC will implement a process of monitoring:

- negotiated and actual delivery timeframes
- actual delivery of the support plan as negotiated between the NASC and support service provider
- whether services being delivered are able to meet the needs of the person. The NASC might comment on the willingness of the service provider to understand the person's needs and be flexible, within reason, on how these are met
- gaps in services available from providers, particularly services that are being purchased in significant volumes outside of Health New Zealand contracted providers (using discretionary funding for example). The District will meet with the NASC at least annually to jointly plan the possible development by Health New Zealand of services to fill the identified gaps
- any unresolved issues, problems or complaints and significant risks with service delivery by contracted providers.

The NASC will report to the District any major risk or complaint within 24 hours of it occurring.

### 8.14 Reviews

The NASC will make available to all people information detailing the procedure by which people may request a review of the outcome of a part, or the whole, of the assessment or service co-ordination process. Such procedures are to include the following elements:

- ability to screen out, or resolve through discussion, complaints arising from misunderstandings
- further assessment or a new support plan using assessment facilitators or staff members not involved in the previous assessment
- access to a second level of review within the NASC if the person remains dissatisfied

The NASC is required to ensure

- that the protocol for these Reviews, as included in the NASC Managers' Manual (2005), is known, consistently applied and monitored.

The above steps will be at the NASC's expense. If a complaint still exists, the District may be requested to provide further review. The standard review procedure provided by the District at that time will be followed.

### 8.15 Key Inputs

The NASC will:

- provide staff with the competence and confidence to professionally undertake the separate roles of needs assessment facilitation and service coordination
- be an Equal Employment Opportunity organisation
- provide for the cultural aspects of the NASC Service Components
- fulfill the responsibilities of budget management
- have systems to provide access to the NASC service, fulfill the quality, information and monitoring requirements of this specification, and maintain records and reporting.

The NASC will ensure that staff are supported to develop and maintain competence and undertake formal training and qualifications as they are developed.

## **9. Service Linkages**

The NASC will develop and maintain effective relationships with other organisations providing services to people. These relationships will reflect the population profile served and their communities and will include community organisations, voluntary groups, support service providers and other public sector agencies. These will include, but not be limited to, Environmental Support Services; and Child, Youth and Family (CYF); Group Special Education (GSE); Housing New Zealand Corporation; Work and Income.

The District will require the NASC to demonstrate effectiveness of relationships. For key agencies or providers the NASC should have in place Memoranda of Understanding, protocols and other liaison mechanisms that agree how the relationship will be conducted. These will be subject to audit.

The NASC will demonstrate effective linkages with the community (e.g. disability groups, support networks, advocacy), and Māori and Pacific peoples' groups. Relationships will be managed with regard to the interrelationships that exist between people, their networks and social support systems.

In relation to Hunga Haua these need also to include, but not be limited to, Marae, Kohanga Reo and Kura Kaupapa Māori; local Māori disability, health and social service networks, including local and regional services; primary health care providers, including Marae based and Primary Health Organisations; and Te Puni Kokiri, as appropriate. All linkages must enable, support and promote Whānau ora (healthy families) and Mauriora perspectives, responsiveness to individual need and respect for the rights and opinions of the Hunga Haua.

## **10. Exclusions**

NASC services for people excluded under the Service User criteria, are not provided under this specification.

## **11. Quality Requirements**

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

### **11.1 Quality Standards**

## National Health & Disability Sector Standards

Only specific parts of the Health and Disability Sector Standards (HDSS) are relevant to NASCs. All NASCs are required to meet the standards and criteria to be identified in the HDSS.

### 11.2 Quality Requirements

#### 11.2.1 Access

##### Timeframes

First contact with the person will be made within two working days of receipt of the referral or enquiry on behalf of the person.

Time to complete needs assessment should be:

- following acknowledgement of referral in the remaining 20% of cases within 24 hours in a crisis where a person's safety is at risk
- within 24 – 48 hours for urgent referrals, depending on the degree of urgency
- within 5 working days following acknowledgement of referral in 40% of cases
- within 14 working days following acknowledgement of referral in 40% of cases
- within 20 working days

Time to complete service co-ordination should be:

- within 10 working days of the completion of the needs assessment in 80% of cases
- within 20 working days of the completion of the needs assessment in the remaining 20% of cases.

Note: It is anticipated that in the majority of situations partial completion of needs assessment and service co-ordination will progress to the point where immediate support needs are clearly identified and services put in place within 14 working days of first contact. Service co-ordination in this context refers to the development of a support plan and arranging access to services. It is recognised that the full service co-ordination role may extend over a much longer period as services are reviewed, and adjusted to meet the needs of the person. The intent of the time lines for completion of service co-ordination is to ensure that access to available services occurs in a timely manner once needs and goals have been identified.

Information will be transferred to another NASC within five working days of the transfer request being received.

### **11.2.2 Person/ Family/ Whānau/ Aiga Involvement**

The person, family/whānau/aiga members, support workers and advocates should be central to service delivery. This requires:

- the person be given a choice of who is involved in their needs assessment and service coordination processes
- the person, family/whānau/aiga members, support workers and advocates be provided information on how they can be involved in the needs assessment and service coordination processes
- the person, family/whānau/aiga members, support workers and advocates be notified of complaint procedures
- the family/whānau/aiga is involved in a culturally appropriate manner.

### **11.2.3 Acceptability**

Acceptability of services will be monitored on an ongoing basis. This monitoring will use a range of methods to gather this information on the acceptability of services provided. All surveys will follow the guidelines for consumer surveys contained in the NASC managers' manual, 2005. The methods used will identify the acceptability of, at least, the following areas of service as indicated by the person, support service providers, support staff, family/whānau and the person's advocates:

- information distribution
- staff professionalism
- staff cultural sensitivity
- staff communication skills
- respect for privacy
- rights of the consumer
- level of choice
- informed consent
- participation in community-based activities
- ease of use of NASC's services
- reduction of barriers that enable easier access to the NASC 's services
- complaint and feedback systems.

## **11.3 Safety**

The NASC will have documented operational programmes/policies/protocols and guidelines that identify and minimise risk areas for the NASC. The use of these

systems is to be included as part of the NASC Quality Improvement system. These areas must include, but are not limited to:

- abuse incidents, policy, protocols for response and reporting
- poor service delivery identification and how this will be reported to the District
- service gap identification and how this is reported to the District
- protocols if support service provider withdraws services to people and reporting this to the District.

## 11.4 Reporting Change

The NASC is required to advise the District of any significant change in the organisational structure or capability of the NASC, and of any other matters significantly affecting, or likely to affect, NASC function and quality.

## 12. Purchase Units and Reporting Requirements

**Purchase Units and Reporting Requirements** The service will be purchased for the eligible population of the region of coverage for a contract price.

PU Code	PU Description	PU Definition	PU Unit of Measure	PU Unit of Measure Definition	National Collections and/or Payment Systems
CHC007	Chronic Health Conditions Needs Assessment	A Needs Assessment is a process of determining the current abilities, resources, goals, and needs of a person with a disability. Service users are people with chronic health conditions and long-term support needs mainly aged under 65	Assessment	Number of assessments. Initial assessments and reassessments should be counted separately.	NNPAC and CMS (as per contract)
CHC008	Chronic Health Conditions Service Coordination	Service Coordination is the process of identifying and planning the package of services required to meet a person's assessed needs. Service users are people with chronic health conditions and long-term support needs mainly aged under 65	Assessment	Number of assessments. Initial assessments and reassessments should be counted separately.	NNPAC and CMS (as per contract)

## 12.1 Reporting Requirements

Note: Rather than include other reports on a monthly basis, Health New Zealand may, from time to time, seek exception reporting of the NASC.

## 12.2 Monthly Reports

PU Code	PU Description	Reporting Requirements	
		Frequency	Reporting Units
CHC007	Needs Assessment	Quarterly	<a href="#">Quantitative Reporting</a> 1. Number of Assessments by: <ul style="list-style-type: none"> <li>• New clients*</li> <li>• Client transfer</li> <li>• Receiving service but no prior assessment</li> <li>• Re-entry after break</li> <li>• Total of above</li> </ul> 2. Number of reassessments* 3. Number of people waiting for first assessment 4. Number of people waiting for a reassessment
CHC008	Service Co-ordination	Quarterly	5. Number of people waiting for service co-ordination  6. Number of service reviews completed 7. Number of people waiting for a service review* 8. Number of requests for a service review following allocations