SERVICE SPECIFICATION
Assessment, Treatment & Rehabilitation Services

Purchase Unit Codes
DSS214, DSS235 DSS215, DSS216, DSS217

Services Covered funded by the Ministry under this specification:
DSS214, DSS215, DSS216 and DSS217

Philosophy

The aim of this service specification is to build on the vision contained in the New Zealand Disability Strategy (NZDS) of a fully inclusive society. New Zealand will be inclusive when people with impairments can say they live in:

'A society that highly values our lives and continually enhances our full participation.'

With this vision in mind, disability support services aim to promote a person's quality of life and enable community participation and maximum independence. Services should create linkages that allow a person's needs to be addressed holistically, in an environment most appropriate to the person with a disability.

Disability support services should ensure that people with impairments have control over their own lives. Support options must be flexible, responsive and needs based. They must focus on the person and where relevant, their family and whanau, and enable people to make real decisions about their own lives.

Note: Subsequent references in this document to "the person" or "people" should be understood as referring to a person/people with impairment(s).

1. Definition

The hall mark of AT&R services is a coordinated multidisciplinary response that is customised to meet the complexity of needs of people with disability and/or aged related disorders in order to restore their functional ability and enable them to live as independently as possible.

The AT&R process occurs across the spectrum of settings including specialist inpatient units, services to people in their usual living or working environments, outpatient clinics and day hospital. This Service Specification covers all services.

The service functions as an accessible expert team and links with and provides a resource of expertise and advice to acute medical/surgical and

other hospital services, general practitioners, home and community care providers, residential care and voluntary groups.

2. Service objectives

2.1 General

The aims of an AT&R service are to simultaneously and in an integrated manner;

- Provide specialised and clinical assessment of a persons needs,
- apply appropriate clinical treatment/s (particularly to reversible conditions or conditions in which symptoms can be minimised)
- restore/optimise a persons functioning
- and to facilitate the person in reaching their full potential and maximising their ability to participate in their community of choice.

The following definitions apply to the various components of AT&R services and recognise that whilst the initial focus for many people will be of a clinical nature, the primary role of an AT&R service is to ensure that people can participate at an optimal level in their communities.

Assessment:
The process of systematic evaluations with the person and their family/whanau and a multidisciplinary team which;

- identify the persons medical, physical, cognitive, cultural, social and emotional needs and where possible, causative factors (including the implications of any conditions which are chronic or will cause ongoing physiological or functional deterioration),
- and link them to an overall plan for treatment, rehabilitation, education, long term management options and support needs appropriate to the needs and circumstances of the person and their family/whanau/hapu/iwi.

Treatment:
Part of a co-ordinated, multidisciplinary process, which occurs at the same time as rehabilitation and assessment. The aim is where possible, to address reversible conditions, minimise symptoms and/or identify appropriate management strategies for people whose conditions are not reversible (e.g.). For older people this may be a larger component of the service.

Rehabilitation:

For the purposes of defining this component of an AT&R service, rehabilitation is a multidisciplinary approach to facilitating;

- the maximisation and/or
- the development and/or

- the restoration, of a person's functional, communication and social skills to the optimal functional and participatory level for that person (appropriate to their age, their stage of life and their condition).

This may include therapies or support to;

- restore the person to their maximum possible level of function
- teach the person adaptive and compensatory skills
- increase the level of safety for self and others
- increase capacity for self care or assistance with self care
- provide assistance for maintaining life roles
- promote a greater understanding/clarification for the person and the family/whanau /hapu / iwi to assist them to adjust to the impact of their disability
- educate the person and the family/whanau /hapu / iwi about the rehabilitation pathway and how to integrate, into all activities of daily living, practices that restore and/or preserve the persons optimal functional level.
- provide input into the assessment of support needs of people.

2.2 Maori Disability

The Maori Health Policy and requirements are outlined in the Standard conditions and Provider Quality Specifications. In addition, the provider will develop and implement an annual strategic plan that outlines how it will contribute to Maori Health Gain for the services contained in this service description. The Plan should include:

- how links with primary care – general practice, community providers and Maori providers will be enhanced;
- how discharge planning and rehabilitation processes will meet the needs of Maori;
- links with the provider Quality Plan and other contractual quality specifications, especially consultation with Maori

3. Service users

3.1 Inclusions

There are a number of client groups that may be included within this service. These are as follows:

- Frail elderly
- People with psychogeriatric conditions
- People with neurological conditions including stroke, multiple sclerosis, motor neurone disorder, Parkinson's disease,

epilepsy, muscular dystrophy, anterior lateral sclerosis, traumatic brain injury
- People with physical disabilities
- People with sensory impairment
- People with intellectual disabilities and challenging behaviour
- People with co morbidities

3.2 Exclusions

Client type

The following people are specifically excluded from this service. Any person;

- whose disability is as a result of an accident, trauma or injury and/or who has entitlement for payment under the Accident Insurance Act 1998.
- who has a short term acute illness and is expected to rapidly return to their former level of function.
- who has had surgical intervention and is expected to rapidly return to their former level of function.
- who is severely multiply disabled or terminally ill where it is unlikely that there will be an improvement in the level of the persons function or it is unlikely that the AT&R process will assist carers to care for the person at home.
- who requires maintenance services only and not an multidisciplinary rehabilitation programme.
- Who requires day care or placement to provide respite to family members.
- Whose service needs are covered under another service specification

Service type

- AT&R services of the nature described above are not intended to provide services such as personal support or therapy for long term maintenance. These may be purchased as a discrete service, or as a component of community health or community support services.
- Acute Medical or Surgical Management services.
- Convalescence following acute medical or surgical admission.
- Palliative care for people who are terminally ill.
- Long term care for frail aged.
- Day care or ongoing day programmes
- Any services delivered to a person whose disability is as a result of an accident, trauma or injury and/or who has entitlement for payment under the Accident Insurance Act 1998.

4. Access

4.1 Entry and Exit

These entry criteria are generic for all AT&R services.

Admission to these services from the community (either own home or residential care setting) or from an acute hospital setting may occur where the person:

- Has an age related or other disability (as defined in attached definitions),

- Has been assessed by the AT&R team and it has been determined that the person;
  - Is considered likely to have their health status and degree of independence improved by the Assessment Treatment and Rehabilitation process.
  - Would make demonstrable rehabilitation gains from admission to an AT&R service by virtue of requiring;
    - Early intervention to arrest a potentially deteriorating situation or,
    - Intervention to maximise /maintain functional skills in the presence of a degenerative condition or
    - Intervention to restore or maximise functional skills following a recent medical, social or other episode.
  - Is considered to be at risk without this intervention.

Exit from the service occurs when achievable goals, agreed upon by the client, family/whanau, and AT&R team, are met. It is expected that subject to the Health Information Privacy Code, appropriate information will be made available to other service providers so that a smooth transition will be made in the provision of services.

4.2 Access

- AT&R services will serve the population of a defined geographical area.

- The service will ensure that there are no barriers to access whether they be through age, gender, disability, ethnicity or sexual orientation.

- You will ensure and demonstrate that Maori access services based upon an accurate needs analysis of the Maori population within your service coverage area.

- Referrals to this service can be from a range of sources. These include: general practitioner, HHS assessment service, medical specialist, support needs assessment and support service co-ordination, other health professional, community groups, family/whanau, or self-referral.

5. Service components

5.1 Processes

The service will ensure that there is a client/family/whanau centred approach using a multidisciplinary team. Service components include:

Service Component	Description
Referral management	The Service provider will: • Assess referrals to ensure clients meet entry criteria • Identify the most appropriate service for the person to be directed into for full assessment. • Operate an effective and efficient system to receive and prioritise all referrals into the service. This system will be operated by staff who are knowledgeable of the scope and nature of the AT&R service.
Assessment and Planning	The Service provider will: • Ensure that the client and caregiver/family/whanau understand the assessment process • Conduct assessments in the environment most appropriate to the individual client, ie in an inpatient setting, in the persons home, a community setting, or an outpatient centre. The choice of environment will be determined taking account of the client's level of risk, the specialist equipment required, the cost of service delivery and the client's choice. • Ensure that a thorough assessment is conducted which determines; ➢ The health status and disability needs of each person ➢ The persons risk of deterioration of functional level ➢ The persons potential for functional improvement ➢ The nature of any programme of treatment and/or rehabilitation needed. • Liase with the relevant NASC provider regarding the persons use of support services at the time of referral tot he service (e.g. permanent residential care placement, personal care hours, home help, day care, respite care etc.). • Take account of Maori cultural requirements and include Maori whanau, advocacy and support services as required by the Maori client • Where appropriate, use Pacific assessors or Pacific assistance in assessment, taking account of Pacific people's cultural needs, and include Pacific advocacy and support services as required • Conduct ongoing assessment of each client's health status or functional level to monitor the effectiveness, acceptability, and appropriateness of continuing the provision of AT&R services.
Provision of Treatment	The Service Provider will;

Service Component	Description
and Rehabilitation Services	• Develop a goal orientated treatment and/or rehabilitation plan agreed between the client/family/whanau and the multidisciplinary team which identifies goals and timeframes • Provide a multidisciplinary treatment and/or rehabilitation programme in the most appropriate setting for the client • Provide services to treat reversible conditions, minimise symptoms and/or identify appropriate management strategies for people whose conditions are not reversible. • Provide allied health professional services to work directly with the person to facilitate their rehabilitation programme. • Educate the person and their caregivers/family/whanau on how to integrate, into all activities of daily living, practices that restore and/or preserve the persons optimal functional level. • Carry out systematic reassessment of client's progress during rehabilitation with the adjustment of treatment and rehabilitation programmes to maximise positive outcomes. • Adjust the treatment and/or rehabilitation programme according to the client's response and the persons achievement of clinical or functional benefit. • Ensure that the client, and their caregiver or family/whanau understand the manner in which the treatment and/or rehabilitation plan will be delivered. • Ensure that the services that will be provided during the treatment and /or rehabilitation programme and the manner in which they will be delivered (eg by whom, when etc) are understood by · the Maori client/whanau, advocate and support service as required by the Maori client · the Pacific Islands client, advocate and support service as required by the Pacific Islands client
Education	The Service will be a source of: • Rehabilitation education eg promoting a model of rehabilitation to service providers, support communities, families, whanau, hapu, iwi, • Training on the use and application of equipment to maximise benefit. This will include training caregivers (paid and unpaid) on the appropriate use of long term loan equipment provided for people with disabilities (consistent with the expectations outlined in the Enable NZ / "accessable" Equipment Manual)

Service Component	Description
	• Self care and carer education to optimise functional level, prevent deterioration and maximise self-management. This will include training caregivers (paid and unpaid) on how to incorporate exercises, reinforce appropriate movement patterns and facilitate functional skills into all daily living activities. • Educational activities that will recognise the culturally sensitive issues relating to these services and focus on •the holistic taha Maori perspective of health •the holistic community approach to health for Pacific Islands cultures
Discharge Planning	The Service will: • Ensure that early and comprehensive discharge planning is undertaken and aimed at smooth transition in place of residence and resumption of life roles. This will require direct liaison with the relevant NASC provider. • Discharge the client from the service when, on formal assessment, the client has obtained identified goals and outcomes, or are not receiving clinical or functional benefit from the AT&R service. • Plan discharge in consultation with the client, caregiver/family/whanau and agencies as appropriate • Make a written discharge report available to the client, and the referrer and/or GP and the relevant NASC provider. • Ensure that transition of responsibility for the client management to other providers has occurred • Provide consultation and advice to secondary care facilities, general practitioners, community allied health professionals and residential care facilities, community support teams, voluntary groups, family/whanau, as it relates to an individual client's needs.
Specialised Assessments (for people who have disabilities) for the provision of long term loan equipment. NB: Specialised Assessors are defined in the context of DSS NASC as follows; **Specialised Assessor / Service**	This includes the assessments carried out during a persons AT&R episode, by Physiotherapists, Occupational Therapists and Speech and Language Therapists in their roles as Specialised Assessors (Accredited and or Registered Assessors) for DSS funded environmental support services accessed through Enable NZ or "accessable" (Auckland only). As such this is an integral part of the AT&R service. Environmental Support Services includes housing modifications and long term loan equipment for mobility (wheelchairs, walking frames, walking sticks etc.), personal care, pain management, household management, seating and postural support, communication etc.

Service Component	Description
An individual or a team with a specific range of expertise, who work alongside the client to assess their particular needs (cognisant of causation and implications) then develop options that respond to those particular needs. The client may require one or many specialised assessments to adequately assess a diverse range of needs. The collective feedback from these will inform the needs assessment summary and process of Service Co-ordination.	The provider will ensure that in undertaking the provision of specialised assessments for environmental support services the Allied Health Professionals; • are suitably qualified and competent to complete specific types of specialised assessment * • will comply with all requirements laid out in the relevant Manuals for provision of environmental support services (Enable NZ / "accessable" Equipment Manual and Housing Manual) • have sufficient administrative support to facilitate the completion of all relevant paperwork and the co-ordination of all associated individuals and agencies involved in the assessment, trial and supply of environmental support services (i.e. equipment suppliers, draftspeople and/or architects, builders, Enable NZ or "accessable". etc.). *(The development of a competency framework for Specialised Assessors sponsored by DSS, is currently in progress. It is anticipated that the implementation of a new framework will commence from July 2001. Whilst the details and scope of this framework is not yet confirmed it will replace or upgrade the Accredited and Registered Assessors framework).

5.2 Settings

These AT&R processes occur across the full spectrum of the settings i.e. hospital inpatient, hospital outpatient, in the home or residential facility, day patient facility, workplace or other community facility ie marae based clinic.

5.3 Level of Service

Configuration of service delivery varies throughout New Zealand. This configuration ranges from:

- being part of an acute general hospital
- a stand alone facility on a base hospital site
- a stand alone facility not on a base hospital site
- services provided in a home situation.

Acuity and complexity will vary according to the degree of ease of access to diagnostic and other treatment services.

Services should have response times that ensure the function and health status of clients does not deteriorate while waiting for a service. A comprehensive multidisciplinary team be available to meet client needs, including cultural specific needs.

Appropriate nursing and medical care will be available 24 hours per day, 7 days per week for inpatient services.

Service Type	Service Definition
AT&R Inpatient	Multidisciplinary inpatient assessment treatment and rehabilitation for people with complex medical, cognitive, functional and social needs with the aim of ultimately enabling them to live as independently as possible in the community. Inpatient services will have a greater, though not exclusive, focus on assessing and treating for reversibility, meeting short term rehabilitation goals and establishing medium and long term rehabilitation goals in preparation for discharge. Discharge should be planned in advance and occur when rehabilitation is sufficient and appropriate environmental supports are in place to enable the client to return safely to their home or appropriate other residential setting. Includes physical and sensory AT&R services and Mental Health Services for the Elderly. However this agreement only includes physical and sensory AT&R services, funded by the Ministry
AT&R Outpatient – Clinics	Components of AT&R services provided in a non-home setting by a health professional. Includes services delivered: (1) within HHS campus (2) outreach services (not within HHS campus - i.e. involves some

	travel). Within (1) & (2) these will include medical specialist, allied health and multidisciplinary clinics. These clinics are intended to provide planned assessment, review and evaluation of clients status and progress rather than having a focus of repeated or regular intervention. Includes physical and sensory AT&R services and Mental Health Services for the Elderly. However this agreement only includes physical and sensory AT&R services, funded by the Ministry
AT&R Outpatient – Day Hospital	Multidisciplinary assessment treatment and rehabilitation programme for people with complex needs with the aim of improving their ability to live as independently as possible in the community Day Hospital definition includes attendance lasting 3 hours or more and services delivered directly to the person by at least 2 health professionals with a focus of facilitating rehabilitation goals and establishing a programme of education for instigation in home or other residential setting. Attendance at day hospital should be for a designated period of time to achieve rehabilitation goals as negotiated with the person, their family and whanau. It is not intended to be a venue for respite relief, day care or ongoing day programmes. It does not include diversional-type therapy or recreational groups run by aides and assistants.
AT&R Outpatient – Domiciliary	A contact in the persons residential situation (person's own home or other residential setting) to determine the requirement for or provide treatment or rehabilitation. Services to be delivered in the person's residential setting by allied health staff or medical or other specialist staff who belong to the ATR team. This component of service is most commonly, though not exclusively, the visit of a Medical Specialist, an Occupational Therapists, Physiotherapist and/or Speech and Language Therapist, who is/are working directly with the client to facilitate their rehabilitation goals. It includes; • Medical assessment • direct therapy interventions, • specialised assessment and recommendations for environmental

	support services and • education for the person, their family whanau and other caregivers about the integration of rehabilitation initiatives into all daily living activities.

5.4 Equipment

Access to a wide range of equipment and appliances is required while clients are accessing AT&R services.

Access to a short term loan pool for equipment and appliances for up to three months post discharge from the service should be arranged for people when it is anticipated their recovery will not necessitate long term loan or as an interim solution whilst awaiting long term loan equipment.

Applications to Enable NZ for long term loan equipment or housing modifications will be generated following assessment by allied health professional who are Accredited or Registered Assessors. These assessments will be completed as part of the discharge planning.

5.5 Support Services

The following services are included as support services:

- diagnostic imaging including MRI, CT scan, ultrasound, fluoroscopy
- pathology including tests referred to community laboratories
- supplies and equipment including prostheses, contact lenses, hearing aids, artificial limbs, wheelchairs and other equipment
- sterile supply
- pharmacy
- commercial support services
- hotel accommodation

5.6 Facilities

Inpatient, outpatient and day patient facilities must have appropriate physical access for people with disabilities and appropriate areas for rehabilitation activities (e.g. physiotherapy gymnasium, occupational therapy assessment areas, hydrotherapy etc).

5.7 Key Inputs

The key input is the multidisciplinary team that will include:

- Medical staff (including Geriatricians, Rehabilitation Physicians, Psychiatrists and where possible Psychogeriatricians).
- Allied Health Professionals (including Physiotherapists, Occupational Therapists, Speech and Language Therapists, Social Workers)
- Nursing staff (including gerontology, rehabilitation, psychiatric, as appropriate)
- Maori Health workers

The following staff inputs may assist the multidisciplinary team as part of key inputs:

- Podiatry
- Neurodevelopmental therapy
- Psychiatry
- Psychology
- Orthotics
- Audiology
- Optometry
- Interpreter Services

Mechanisms should be in place which ensure effective working relationships between these groups.

Cultural Advice including Maori advocate, Maori support worker, Maori Primary or Community Care Provider, Kaumatua support as identified by the client/whanau is available.

The composition of the multidisciplinary team is dependent upon the nature of the client group.

6. Service linkages

Services should be well coordinated with other community services/disability services as well as being well known to local providers and people. Services should enable the full participation of the client and the relevant support people in care decisions. Services should also be complementary to the client's related needs.

The provider is required to demonstrate links with the following services, for which separate service specifications apply:

- Individual support needs assessment and service coordination services
- Other DHB Services including Medical and Surgical services, Emergency Department and other acute assessment units, Mental Health services, Community Services.
- Private Audiology services
- GP's

Significant interfaces exist with:

- Maori community care services
- Other appropriate Maori organisations
- Consumer advocacy services, including Maori advocacy services
- Home support care providers
- Residential care providers
- Equipment Management Services
- Family Court
- Work and Income
- Accident Compensation agencies
- Special First Education Services
- Client/Carer Support
- Chaplaincy

Links may be required with:

- Disability Information Centres
- Consumer support groups
- Educational and vocational services
- Child and Family Service
- Other relevant disability support services.

These relationships will be of greater or lesser importance depending on the type of AT&R service being provided.

7. Exclusions

Nil

8. Quality Requirements

The service is required to comply with the General Terms and Conditions and the Provider Quality Specifications. The following specific quality requirements also apply.

8.1 General

The provider is responsible for implementing a strategy for planning, implementing and reviewing service delivery to clients, from a client perspective. All clients should be involved in the development of their service plan and personal outcome objectives. In addition, outcome measures should be developed for each client, their family and whanau.

8.2 Access

Services should be provided in an environment that is easily accessible to the client.

8.3 Acceptability

The service should be provided in a way that is sensitive to the needs of the community within which the provider operates and should have effective working relationships based on co-operation with a range of relevant community and support link groups.

Client satisfaction surveys should explicitly measure satisfaction with the service.

In addition, acceptability to Maori should be included in the review conducted by the provider in conjunction with Maori. Support services to Maori requiring your services should be proactively offered and available.

8.4 Safety and Efficiency

The provider will ensure that all persons who supply or 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.

9. PURCHASE UNITS

Purchase Unit Description	Purchase Measure	Purchase Measure Definition
AT&R Inpatient	Bed-days	Total number of beds that are occupied each day over a designated period. For reporting occupancy purposes, count beds occupied as at 12 midnight of each day.
AT&R Outpatient – Clinics	Client Attendances	Number of times a client attends a clinic

AT&R Outpatient – Day Hospital	Day Attendances	Number of times a client attends a day session on any one day lasting 3 hours or more.
AT&R Outpatient – Domiciliary	Visit	Visit by allied health professionals to a client's place of residence

10 REPORTING REQUIREMENTS

10.1 The following information is to be reported on as the Information and reporting Requirements:

Purchase Unit Code (PUC)	Purchase Unit	Purchase Unit Measure	Frequency Reports Received	Reporting Requirements
DSS214	ATR Inpatient	Bed days	Quarterly	1. Number of clients on waiting list (waiting to access service) by month 2. Average time on waiting list (days) by month
DSS215	ATR Outpatient Clinics	Attendances	Quarterly	7. Total number of attendances by month 8. Number of clients by month by • Gender (male, female) • Ethnicity (Maori, Pacific Island, Other) • Disability type (age-related, psychiatric, intellectual, physical/sensory) Number of clients on the waiting list (waiting for entry to service) by month Average time in days from when referral first received until client attends by month
DSS216	ATR Outpatient Day Hospital	Day attendances	Quarterly	Total number of attendances by month Number of clients by month by • Gender (male, female) • Ethnicity (Maori, Pacific Island, Other) • Disability type (age-related, psychiatric, intellectual, physical/sensory) Number of clients on the waiting list (waiting for entry to

				service) by month. Average time in days from when referral first received until first contact by month.
DSS217	ATR Outpatient Domiciliary	Visits	Quarterly	Total number of visits by month Number of clients by month by • Gender (male, female) • Ethnicity (Maori, Pacific Island, other) • Disability type (age-related, psychiatric, intellectual, physical/sensory) Number of clients on the waiting list (waiting for entry to service) by month. Average time in days from when referral first received until first contact by month.

1. Narrative reports can be submitted at any time if there are issues that you wish to raise e.g. unmet need (as per template).

2. Templates supplied to you will require a monthly information breakdown but will be submitted quarterly.

3. Certain inpatient information will be available to us via coding to the National Minimum Data Set. This information includes:

- Number of discharges by Health Speciality Code
- Average and median length of stay
- Total number of clients accessing service
- Number of admissions by source (Transfer, Routine admission)
- Number of admissions by Ethnicity Classification

9.1 Service Planning Information

The management of this service should be mindful of how the service ensures responsiveness to Maori, for example, through availability of Maori support services.

The provider should collect and report ethnicity data that demonstrate Maori utilisation of services as specific to the service specification.

This service is under review as part of the national HFA AT&R project. Service development that occurs as part of this project and that results in changes to purchasing strategy for this service may be implemented in due

course. This includes continued development of comprehensive and nationally consistent service specifications.