

# Meeting Briefing

Health New Zealand  
Te Whatu Ora

## Meeting with Access Community Care

<b>Due to MO:</b>	15 September 2025	<b>Reference</b>	HNZ00096521
<b>To:</b>	Hon Simeon Brown, Minister of Health		
<b>From:</b>	Martin Hefford, Director Living Well, Planning, Funding and Outcomes		
<b>Copy to:</b>	N/A		
<b>Security level:</b>	In Confidence	<b>Priority</b>	Routine
<b>Consulted:</b>	N/A		
<b>Proactive Release:</b>	This title is proposed by Health NZ for proactive release		

### Contact for further discussion

Name	Position	Phone	1st contact
Martin Hefford	Director Living Well		x
Tim Wood	Group Manager Planned and Unplanned Care - Living Well		

### Attachments

**Appendix 1:** Biographies of attendees

## About the meeting

<b>Purpose</b>	Access Community Health has requested to meet with you to discuss its contribution as an in-home and community healthcare provider in improving access to healthcare and health outcomes.
<b>Date</b>	17 September 2025
<b>Time</b>	4.20pm to 4.40pm
<b>Venue</b>	Minister's office, Wellington
<b>Attendees</b>	Androulla Kotrotsos, Chief Executive, Access Community Health Simon Cox, Chief Commercial Officer Jo Goodfellow, National Service Delivery Manager Note, biographies are attached as Appendix 1
<b>Health New Zealand   Te Whatu Ora officials</b>	Martin Hefford, Director Living Well Tim Wood, Group Manager Planned and Unplanned Care
<b>Media</b>	No media are expected

## Purpose and context

1. Access Community Health (Access) has requested a meeting to discuss its role as an in-home and community healthcare provider in improving access to healthcare and health outcomes.
2. Access wish to demonstrate how its services complement and strengthen existing GP and hospital care structures and promote a model of care.

## About Access Community Health

3. Access is one of New Zealand's largest providers of home-based healthcare (including home and community support service (HCSS)) supporting over 36,000 people nationwide. Access has a mobile and flexible workforce of around 4,000 (including 250 nurses, 3,500 support workers, and 200 allied health staff) and delivers a wide range of services - such

as home care, disability support, complex clinical nursing, and serious injury rehabilitation.

4. Access receives approximately \$79million per year from Health NZ.
5. The organisation emphasises its alignment with government priorities with a focus on increasing efficiency in primary and secondary care, reducing wait times, and supporting care in under-served areas.
6. Access say they are focused on developing “a person-centred, culturally responsive approach that is supported by innovative service pathways and digital health integration (including telehealth)”. They consider this approach to be particularly beneficial for those living in rural and remote communities, where geographic isolation and workforce shortages challenge equitable access to care.
7. Access will look to demonstrate the progress they have made in facilitating early supported discharge from hospitals, streamlining transitions, and supporting urgent and unplanned care through redesigned in-home services, including extended Primary Options for Acute Care (POAC) pathways and timely discharges from emergency departments.

### Support for urgent and unplanned care

8. Access is particularly keen to discuss how it has redesigned its in-home services to better support urgent and unplanned care. This includes:
  - extending POAC pathways
  - facilitating timely discharges from ED, and
  - supporting urgent care providers to keep people well in their communities.
9. Note the Extended Primary and Community Care (EPCC) programme is replacing POAC. EPCC introduces consistent, regionally aligned and clinically sound acute care packages, underpinned by HealthPathways guidance. EPCC supports general practice and other community providers to deliver timely, community-based care for patients who would otherwise require ED or hospital-level intervention.
10. As the EPCC programme develops it will be working towards enabling providers, such as Access, to provide additional support to patients accessing care in settings more convenient to them.
11. The EPCC development team has had some early conversations with Access on potential opportunities. You have received advice on Health NZ’s EPCC programme as part of [H2025067084].
12. Access’s role aligns with Health NZ’s Urgent and After-Hours Framework as a complementary service. Their workforce can contribute to post-decision community care, helping to:
  - act as a telehealth extender – providing same/next-day nurse or allied health visits after a virtual GP/urgent care consult
  - enable earlier hospital and ED discharge – by giving clinicians confidence that patients will receive safe, in-home follow-up (wound care, monitoring, or community-based treatment) to reduce readmissions

- support safe discharge back home from urgent care clinics with same or next day follow up and linking in with usual primary care providers for follow up care as and when needed.

### **Mobile diagnostic technology delivered through Home Support Equity pilot**

13. Access has been part of a Home Support Equity pilot (the Pilot) in the Central Hawkes Bay. The Pilot supported over 150 tāngata, rural and socially isolated, collaborating closely with primary care providers and community services to improve access to essential care.
14. This service extended the role of the HCSS registered nurse to deliver health promotion activities such as diabetes annual reviews and support diagnostic procedures like blood tests and blood pressure monitoring.
15. As part of the pilot, Access has developed mobile diagnostic technology to improve integration with primary care services. This includes:
  - enabling direct communication of in-home assessments into general practice patient management systems – improving integration of care and information sharing (this is a current expectation in the delivery of restorative HCSS)
  - supporting telehealth consultations where a nurse is physically present in the home, while a remote GP leads the consult online
  - leveraging mobile health tools and digital platforms to enhance care coordination, workforce mobility, and real-time communication, including portals for families and patients
  - using data-driven insights to support early intervention and proactive care.

### **Supporting older New Zealanders to access care**

16. Access delivers a combination of restorative casemix bulk funded and traditional fee for service Home and Community Support (HCSS) to older New Zealanders and people with Chronic Health Conditions in all Health NZ Regions.
17. As part of delivering restorative HCSS, Access provides the contact interRAI assessment for non-complex clients whilst the Needs Assessment and Service Coordination (NASC) organisation performs the interRAI Home Care assessment for the complex clients.
18. Access develops the individual support plan (ISP) for each client and coordinates the delivery of support services. This includes actively collaborating with NASC, primary care and community providers to ensure restorative support is delivered effectively, with the aim to:
  - engage and work with both formal and natural supports
  - ensure a proactive restorative focus through flexible service delivery that promotes client independence using a 'doing with' rather than a 'doing for' model, where appropriate
  - deliver responsive and flexible services to meet fluctuations in health and support needs. (This may require working closely with whānau, hospice, community health specialist nurses and primary care during times of unstable need or at end of life)

## In Confidence

- provide services that support falls prevention by delivering evidence-based activities; such as strength and balance exercises which are guided by current best practice, or the advice of an allied health professional
  - share information and data with Primary Care to support service delivery.
19. The individual ISP includes service delivery expectations that arise from interRAI clinical assessment measures. InterRAI clinical assessment protocols (CAPS) identify patient problems such as cognitive loss, lack of informal support, falls risk, pain medication management and undernutrition. These activities are extended in the Home Support Equity pilot, described above, by increasing the nursing resource in the HCSS team.
  20. Restorative HCSS requires the provider develops and promotes integrated client pathways, including Early Supported Discharge pathways, in collaboration with Secondary health services. This service strengthens and complements existing GP and hospital care delivery.

## Home and Community Support Service Development

### Aged Care Funding and Service Model Review update

21. The Aged Care Funding and Service Model Review (the Review) is a significant part of the Health NZ response to challenges across the Aged Care Sector. The Review has involved two phases.
22. Phase one involved the production of a report from Sapere which outlined the current state of New Zealand's aged residential care (ARC) and home and community support services (HCSS).
23. Phase two included extensive stakeholder engagement, hearing from over 2,000 people and receiving more than 10,000 pieces of feedback. The report; 'Future of Aged Care – Engagement Themes 2024' was developed which outlines the key themes of that engagement. This report was recently released on the Health NZ website.
24. Phase two also included the production of the second Sapere report, *The Aged Care Service Model and Funding Review: Phase 2: Modelling options for improved funding and service models* (the Phase two Sapere report).
25. The report focusses on developing service volume modelling scenarios and assessing the funding required to meet current and future demand. It also models and estimates the impact of moving all regions to restorative casemix bulk funding and is based on the impact of previous district transitions and demonstrates potential service delivery efficiency.
26. Modelling is also provided to demonstrate the impact on HCSS service delivery if ARC residents who are assessed as low acuity have their service needs met through HCSS instead of entering ARC. This is a measure of the potential impact only. Further investigation of this cohort is being undertaken.
27. The Phase two Sapere report supports the case for transitioning from a traditional Fee-for-Service (FFS) and funding model to bulk funding based on a restorative case-mix service model.

## HCSS

28. Nationally, HCSS are currently delivered through two different service and funding models. The traditional fee for service model delivers household management and personal care. There is no registered health professional oversight and hours of service delivery are set by the NASC based on needs assessment. Over the last 10 years this funding and service model has been progressively replaced by a Restorative casemix bulk funded model. This model of care includes registered health professional oversight and is based on person centred goal attainment and a rehabilitation philosophy to encourage independence.
29. A national restorative service specification has been developed and over the next 24 months it is expected that all regions will transition to this service model. Casemix driven bulk funding has been proven to significantly reduce service expenditure growth compared to fee for service funding due to providers being incentivized to deliver efficient service
30. In districts where the HCSS funding model is bulk funded the provider will flex service provision up or down to meet the changing needs of the client. The goal of restorative support is that once a client has improved and no longer needs support they will be discharged from the service. This approach reduces impact of learned helplessness and encourages independence.

## Appendix 1: Biographies of attendees



### **Androulla Kotrotsos. Chief Executive**

Androulla has held senior roles with Green Cross Health, Ministry of Health, Pharmacy Council, and pharmaceutical companies, as well as in professional support and governance roles in the health sector.

Androulla joined Access as Chief Operating Officer in 2019 and was appointed as CEO in 2023.



### **Simon Cox. Chief Commercial Officer**

Simon is responsible for operations, information technology and contract management for the business.

Prior to joining Access, Simon worked in investment consultancy and accountancy. In addition, he was a psychologist providing rehabilitation services as well as business consultancy.



### **Jo Goodfellow. National Service Delivery Manager**

Jo is an experienced health care manager with a clinical background in Physiotherapy, Jo has worked both in the UK and NZ in healthcare leadership roles including St John and Auckland Regional Public Health Service.

With a strong interest in patient/tāngata led integrated care, Jo is focused on bringing together different parts of the health and social care systems to provide seamless support to our communities.