He Kaupare. He Manaaki.
He Whakaora.
prevention. care. recovery.

SERVICE SCHEDULE FOR NON-ACUTE REHABILITATION PATHWAYS SERVICE

CONTRACT NO: _____

A. QUICK REFERENCE INFORMATION

1. TERM FOR PROVIDING NON-ACUTE REHABILITATION PATHWAYS SERVICE

1.1 The Term for the provision of Non-Acute Rehabilitation Pathways Service (Service) is the period from 1 July 2023 ("Start Date") until 30 June 2026 ("End Date") or such earlier date upon which the period is lawfully terminated or cancelled.

1.2 Prior to the End Date, the parties may agree in writing to extend the Term of this Service Schedule for one further term of one year. Any decision to extend the Term of this Service Schedule will be based on:

1.2.1 the parties agreeing on the extension, in writing prior to the End Date; and

1.2.2 ACC being satisfied with the Supplier's performance and delivery of the Services; and

1.2.3 all other provisions of this Service Schedule either continuing to apply during such extended Term(s) or being renegotiated to the satisfaction of both parties.

1.3 There is no obligation on the part of ACC to extend the Term of this Service Schedule, even if the Supplier has satisfactorily performed all the Services.

2. SPECIFIED AREA AND SERVICE LOCATION (PART B, CLAUSE 3)

_____

3. SERVICE ITEMS AND PRICING

Table 1: Inpatient Care Case Weight Cost (Package)

	From Home Group (3-6)			From Residential Care Groups (1-2)		
Injury Site	**Low (class A-D)**	**Med (class E)**	**High (class F-G)**	**Low (class A-D)**	**Med (class E)**	**High (class F-G)**
Service Item Code	NRP10	NRP11	NRP12	NRP15	NRP16	NRP17
Fracture of Femur	$16,596.27	$24,881.95	$37,707.47	$15,766.45	$23,637.87	$35,822.10
Service Item Code	NRP20	NRP21	NRP22	NRP25	NRP26	NRP27
Fracture lumbar spine, pelvis, shoulder, and upper arm	$15,511.72	$23,255.96	$35,243.34	$14,736.14	$22,093.16	$33,481.18
Service Item Code	NRP30	NRP31	NRP32	NRP35	NRP36	NRP37
Other fractures excluding “Fracture lumbar spine, pelvis, shoulder and upper arm” and “Fracture of Femur” groups	$14,309.76	$21,453.91	$32,512.44	$13,594.28	$20,381.22	$30,886.82
Service Item Code	NRP40	NRP41	NRP42	NRP45	NRP46	NRP47
Injured Upper & Lower Limbs	$14,106.62	$21,149.35	$32,050.87	$13,401.28	$20,091.87	$30,448.34
Service Item Code	NRP50	NRP51	NRP52	NRP55	NRP56	NRP57
Head, Neck, Thorax & Abdomen	$14,520.57	$21,769.97	$32,991.41	$13,794.54	$20,681.48	$31,341.85

	From Home Group (3-6)			From Residential Care Groups (1-2)		
Injury Site	**Low (class A-D)**	**Med (class E)**	**High (class F-G)**	**Low (class A-D)**	**Med (class E)**	**High (class F-G)**
Service Item Code	NRP60	NRP61	NRP62	NRP65	NRP66	NRP67
Burns and Complications of procedures	$17,476.62	$26,201.84	$39,707.70	$16,602.79	$24,891.75	$37,722.32

Note: For more information about how the Casemix Groups and Classes apply, see Operational Guidelines.

Table 2: Community Care Case-Weighted Prices

Service Item Community Codes	Service Item Description	Price	Pricing Unit
NRPC2A	NRP Community Rehab Single Allied Health	$932.86	Flat fee
NRPC2B	NRP Community Rehab Multi Allied Health	$932.86	Flat fee
NRPC3A	NRP Community Rehab Home Care: Light	$1,952.96	Flat fee
NRPC3B	NRP Community Rehab Home Care: Moderate	$1,952.96	Flat fee
NRPC3C	NRP Community Rehab Home Care: High	$1,952.96	Flat fee
NRPC4A	NRP Community Rehab Integrated Support: Light	$5,784.10	Flat fee
NRPC4B	NRP Community Rehab Integrated Support: Moderate	$5,784.10	Flat fee
NRPC4C	NRP Community Rehab Integrated Support: High	$5,784.10	Flat fee

Table 3: Transitional Care Case-Weighted Prices

Service Item Community Codes	Service Item Description	Price	Pricing Unit
NRPC5A	Case-weight package funding for community rehabilitation at the pre-injury level of residential care (Requires prior approval)	$529.48	Flat fee
NRPC5B	Case-weight package funding for community rehabilitation at a graduated level of residential care compared to pre-injury (Requires prior approval)	$529.48	Flat fee
NRPC5E	Case-weight package funding for community rehabilitation delivered in a temporary ARC facility	$2,051.13	Flat fee

Note: The Case-Weight price for NARP transitional care pathways do NOT include the bed day price. The Case-Weight price includes rehabilitation input only.

Table 4: Service Items and Prices for Exceptionally Complex Clients

Service Item Code	Service Item Description	Service Item Definition	Price (excl. GST)	Pricing Unit
NRP05	Exceptionally complex Top-up (Inpatient)	For a Client whose inpatient stay was 77 days and longer. Pricing unit applies to each day over 76 days i.e. from day 77 Requires prior approval from ACC.	$1,353.28	Per day
NRPTI	Treatment Injury - Inpatient	For reimbursement of a Client who has had an accepted treatment injury. Not to be used in conjunction with the case weighted inpatient packages from Table 1. Requires prior approval from ACC.	$1,353.28	Per day
NRPTC	Treatment Injury - Community	For reimbursement of a Client who has had an accepted treatment. Not to be used in conjunction with the community case weighted packages from Table 2. Requires prior approval from ACC	$165.63	Per day
NRPBI	Inpatient Rehabilitation – Serious Burns	Pricing applies to each day the patient is in inpatient care. Interruptions of care of more than three days must be excluded from billing. Cannot be used in conjunction with other codes from Table 1. Prior approval required after more than 76 days total.	$1,353.28	Per day

Table 5: Service Items and Prices for Exceptional Travel

Service Item code	Service Item Description	Price Rate	Pricing Unit
NRPTTA	NRP community travel time for Allied Health Applies if the distance travelled is greater than 100km per round trip to visit a claimant. Max 2 per visit.	$102.79	Per hour
NRPTTN	NRP community travel time for Nursing	$102.07	Per hour

Service Item code	Service Item Description	Price Rate	Pricing Unit
	Applies if the distance travelled is greater than 100km per round trip to visit a claimant. Max 2 per visit.		
NRPTTS	NRP community travel time for Support Work Applies if the distance travelled is greater than 100km per round trip to visit a claimant. Max 2 per visit.	$64.99	Per hour
NRPTD4	NRP distance travel Applies if the distance travelled is greater than 100km per round trip to visit a claimant.	$0.78	Per km
Note: Travel less than 100km is included in the case-weighted rates. Invoicing for exceptional travel starts from the 100km to the completion of the trip and excludes the first 100km.			

3.1 Price Review

ACC will review the pricing on an annual basis. The factors ACC may consider during a review include, but are not limited to:

- claims volume
- casemix distribution
- case-weight
- Client outcomes related to service innovation and improvement
- general inflation
- changes in service component costs
- substantial changes in the market

If ACC finds that the factors that we considered have not had a significant impact on price, the prices will remain unchanged.

If ACC provides a price increase, the Supplier must agree any adjustment in writing. The price increase will take effect from a date specified by ACC.

4. RELATIONSHIP MANAGEMENT (PART B, CLAUSE 15)

Table 6: Relationship Management

Level	ACC	Supplier
Client	Recovery Team/Recovery Team Member	Individual staff or operational contact
Relationship and performance management	Engagement and Performance Manager	Operational contact/National Manager
Service management	Portfolio Team or equivalent	National Manager

5. ADDRESSES FOR NOTICES (STANDARD TERMS AND CONDITIONS, CLAUSE 23)

NOTICES FOR ACC TO:

ACC Health Procurement
16 Kate Sheppard Place (for deliveries)
Wellington 6011
P O Box 242 (for mail)
Wellington 6140
Marked: Attention: Procurement Specialist
Phone:0800 400 503
Email: health.procurement@acc.co.nz

NOTICES FOR SUPPLIER TO:

_____
_____
_____ (for deliveries)
_____
_____
_____ (for mail)
_____
_____ _____
Marked: “Attention: _____ _____, _____”
Phone: _____
Mobile: _____
Email: _____

TABLE OF CONTENTS

B. SERVICE SPECIFICATIONS FOR NON-ACUTE REHABILITATION PATHWAYS SERVICE

1. PURPOSE

1.1 The purpose of the Non-Acute Rehabilitation Pathways (NARP) Service is to return ACC Clients who require hospital level care to their pre-injury function or maximum independence by providing multi-disciplinary inpatient and community-based rehabilitation and support. The Supplier will deliver services that:

1.1.1 are high quality, flexible and that encourage the Client's autonomy and self-determination.

1.1.2 are tailored to the individual and responsive to their health and injury related needs.

1.1.3 are provided in a culturally safe way.

1.1.4 reduce the incidence of readmission for the same or similar injuries.

1.1.5 reduces the incidence of falls.

1.2 This Service enables the Supplier to enhance the quality of care across the hospital-community continuum while managing the overall demand on Inpatient and Community Services.

2. SERVICE OUTCOMES AND OBJECTIVES

2.1 ACC will measure the success of this Service based on the following Client outcomes:

2.1.1 the Services provided are reflective of the Rehabilitation Principles, defined in the Operational Guidelines.

2.1.2 the Client's function and independence is improved to the maximum extent practicable and reasonable.

2.1.3 the Client ultimately returns to their pre-injury place of residence wherever possible.

2.1.4 the Client follows the most cost-efficient and clinically appropriate pathway to achieve their outcomes; and

2.1.5 the Client is satisfied with the Services.

2.2 ACC will monitor the success of this Service based on the following objectives:

2.2.1 the Supplier is delivering services that are high quality, clinically appropriate, timely, and cost-effective.

2.2.2 injury related re-admission is minimised over the long term.

2.2.3 there is a reduced incidence of falls within the Suppliers coverage area.

2.2.4 the Client's length of stay in hospital is minimised through integrated care pathways.

3. SERVICE LOCATION AND SPECIFIED AREA

3.1 The Service will be provided by the Supplier for Clients who usually reside in the geographical areas as specified in Part A, clause 2.

4. SERVICE ELIGIBILITY

4.1 A Client is eligible for the Service if they:

4.1.1 have an injury that has been accepted for cover by ACC; and

4.1.2 have an injury that requires the Client to present to hospital; and

4.1.3 cannot safely return home with other support types covered by ACC; and

4.1.4 require rehabilitation primarily for that covered injury; and

4.1.5 are Ready for Rehabilitation; and

4.1.6 are capable and willing to Actively Participate in rehabilitation; and

4.1.7 have achievable rehabilitation goals that will improve their functional independence; and

4.1.8 have rehabilitation requirements that will be best met by this Service, or where it is most cost effective to deliver support under this Service.

4.2 Eligibility exclusions

4.2.1 When the primary cause of the injury is determined to be related to the Client's health condition/s, rehabilitation is covered and provided by Health Funding and not ACC.

4.2.2 Services may not be provided while a Client's covered injury is being managed acutely under Public Health Acute Services (PHAS) provisions of the Accident Compensation Act 2001 by any District Health Board/Te Whatu Ora district or other treatment provider commissioned by a DHB/Te Whatu Ora district to provide PHAS care.

4.3 Quality Review of Eligibility Decisions

4.3.1 ACC may review a sample of the Supplier's admissions to the Services to assess the accuracy of the Supplier's eligibility decisions. If ACC does a review, ACC will:

4.3.1.1 select the cases based on specific risk-factors agreed with Suppliers; and

4.3.1.2 at its own discretion, determine the frequency of the reviews.

4.3.2 The Supplier will provide all clinical notes for the reviews on request without charge and within the standard request timeframes. (see Terms and Conditions www.acc.co.nz)

4.3.3 Where ACC identifies the Supplier has made incorrect eligibility decisions ACC will, with the Supplier, agree an appropriate course of action which may include, but not be limited to the following:

4.3.3.1 expanding the review.

4.3.3.2 the Supplier developing, appropriate training for their staff.

4.3.3.3 recover funds where incorrect profiling has impacted on the Case-Weight funding.

5. REFERRAL PROCESS

5.1 Clients may be referred to NARP Services by a Registered Health Professional from the following:

5.1.1 An emergency department.

5.1.2 GP referral.

5.1.3 Acute care setting.

5.1.4 Inpatient rehabilitation setting.

5.2 The Supplier will:

5.2.1 determine eligibility by applying the ACC NARP Eligibility Tool (Appendix A); and

5.2.2 ensure the eligibility assessment is completed by a Registered Health Professional who has been trained to assess the Client for admission to this Service.

5.3 Where the ACC NARP Eligibility Tool has been applied and eligibility for entry to the Service remains unclear, the Supplier will discuss with ACC and reach agreement before the Supplier completes the Service.

6. SERVICE PATHWAY DESCRIPTIONS

6.1 The Client's Journey through NARP Services may include one OR a combination of the following Rehabilitation Pathways, depending on the Client's clinical needs:

6.1.1 Inpatient Rehabilitation.

6.1.2 Transitional Rehabilitation.

6.1.3 Community Rehabilitation.

6.1.4 Rehabilitation Admission Avoidance.

6.2 The Rehabilitation Pathways may not overlap. A Client must be discharged from one Rehabilitation Pathway before being admitted to another Rehabilitation Pathway. See the Operational Guide for examples.

6.3 Inpatient Rehabilitation

6.3.1 Inpatient Rehabilitation refers to multidisciplinary care and rehabilitation that occurs within the Supplier's hospital facility and is required because of the Client's injury.

6.3.2 Facilities may include approved residential or transitional care facilities but must meet the minimum facility requirements:

6.3.2.1 Active rehabilitation programs available involving inter-disciplinary team including Allied Health (Occupational Therapists, Physiotherapists, Psychologists, Podiatrists, Social worker, Speech Therapist, Dietician) and experienced Registered Nurses.

6.3.2.2 Services overseen by accredited medical practitioners or physicians with special interest in rehabilitation medicine supported by a medical officer.

6.3.2.3 Active consultation with is available.

6.3.2.4 Medical Officer on call 24/7.

6.3.2.5 Clinical Service Manager.

6.3.2.6 Interpreter services available.

6.3.2.7 Has continuous quality improvement plan.

6.3.3 The Supplier must ensure all facilities have achieved certification against the 8134:2021 Ngā Paerewa Health and Disability Standards including any updates that occur and will provide ACC with evidence of the certification on request.

6.4 Transitional Rehabilitation

6.4.1 Transitional Care occurs when a Client no longer requires hospital level care but is not safe to return to their pre-injury residence. Additional rehabilitation is required when a Client is in a facility to support their transition back to their pre-injury place of residence.

6.4.2 Transitional Care can be provided in:

6.4.2.1 a Supplier facility such as a satellite hospital; or

6.4.2.2 a residential or aged care facility.

6.5 Community Rehabilitation

6.5.1 Community Rehabilitation is single or multidisciplinary care that supports the Client to return to pre-injury independence upon discharge from either Inpatient or Transitional Care (or where they are about to).

6.5.2 Alternatively, where a Client meets the criteria for Rehabilitation Admission Avoidance (see clause 9.25), they may transfer directly into Community Rehabilitation.

6.5.3 It can be provided in a location that best suits the Client, including one or a combination of the following:

6.5.3.1 The Client's own residence; or

6.5.3.2 The home of family or friends; or

6.5.3.3 Temporary or long-term residential facility; or

6.5.3.4 The Supplier's community rehabilitation centre.

7. SERVICE COMMENCEMENT

7.1 The Service commences when a Client is accepted for eligibility as outlined in clause 4.

7.2 Rehabilitation Pathway Profiling Tool

7.2.1 The Supplier will determine the Client's Pathway by assessing the Client's functional and contextual situation by use of the relevant Profiling Tool. There are two Profiling Tools - Inpatient and Community.

7.2.2 The Inpatient Profiling Tool is built into the InterRAI Acute Care Admission assessment and the Community Profiling Tool is built into the InterRAI Acute Care Discharge assessment.

7.2.3 The Profiling Tools may also be used independently of InterRAI in some scenarios outlined in this agreement.

7.2.4 The Profiling Tools allow the Supplier to develop best practice pathways for Clients with similar clinical and functional needs, while still enabling the Supplier to adapt services to meet Clients individual circumstances. (See Operation Guidelines for further information on the use of this Profiling Tool.)

7.3 The Supplier will ensure that each Client's Rehabilitation Pathway is determined:

7.3.1 on, or prior to, admission to NARP Services;

7.3.2 at each transition into another Pathway;

7.3.3 by an appropriately trained and qualified Registered Health Professional;

7.3.4 all Profile results are recorded by the Supplier for reporting and invoicing purposes.

7.4 On commencement of the Service, the Supplier will:

7.4.1 Provide information to the Client and, if consented, with their whānau, regarding the rehabilitation process, the expected outcomes, and the expected timeframes (if applicable); and

7.4.2 Allocate a key worker; and

7.4.3 Produce a rehabilitation plan developed by relevant members of the multi-disciplinary team that outlines:

7.4.3.1 Who the key worker is; and

7.4.3.2 The Client's pre-injury function; and

7.4.3.3 The Client's rehabilitation goals; and

7.4.3.4 What rehabilitation will occur during the Service, when and by whom; and

7.4.3.5 An estimated discharge date and plan.

8. SERVICE REQUIREMENTS

8.1 The Supplier will provide high quality rehabilitation and care services that include:

8.1.1 Delivery of Services that will best meet the Client's goals and minimise the Client's injury related support needs on discharge from the Service.

8.1.2 Coordination by an assigned Key Worker who is responsible for:

8.1.2.1 co-ordination of the Client's interdisciplinary team;

8.1.2.2 communication with the Client, their family/whanau, ACC and any other parties necessary to the Client's rehabilitation;

8.1.2.3 Identifying and working toward functional and participatory goals that enables the Client to reach their maximum level of independence;

8.1.2.4 Reviewing and updating the Client's Rehabilitation Plan on an ongoing basis in accordance with the Client's progress towards achieving their rehabilitation goals; and

8.1.2.5 ensuring the Services are culturally appropriate and dignity/mana-enhancing.

8.1.3 Assessment and oversight by a medical specialist appropriate to the Client's needs.

8.1.4 Rehabilitation to be delivered by trained Allied Health Assistants / Support Workers / Healthcare Assistants with close clinical oversight from the interdisciplinary team.

8.2 The Supplier will manage the coordination and delivery of the Client's Rehabilitation Pathway from when the Client enters the Service to the Client exits the NARP Services. The Supplier is responsible for ensuring Clients:

8.2.1 Receive education on how to rehabilitate safely and avoid further injury.

8.2.2 Can access one or more of the Service Pathways per claim as determined through the Profiling Tool.

8.2.3 Experience a safe admission and discharge from and to each NARP service component to ensure a seamless and integrated continuum of care.

8.2.4 Information is collected, stored and used in accordance with the clause 9 of the Standard Terms and Conditions.

Communication

8.3 The Supplier will:

8.3.1 Communicate with the Client through their rehabilitation journey to ensure they understand the process and timeframes.

8.3.2 Advise ACC immediately if the Supplier becomes aware of any matter which may change or delay the performance of the Services. The advice must include detailed particulars of the likely change or delay and recommendations to minimise any adverse effect from it.

8.3.3 Record and report to ACC any incidents, that:

8.3.3.1 are outside of accepted rehabilitation practices; or,

8.3.3.2 present an unacceptable risk to personal safety or security for either the Client or Supplier.

Operational Guide

8.4 The Supplier will ensure:

8.4.1 This Service Specification must be read in conjunction with the Non-Acute Rehabilitation Pathways Service Operational Guide (hereafter called the Operational Guide) available on ACC's website.

8.4.2 ACC and the Supplier will operate this Service in accordance with the Operational Guide.

8.4.3 ACC may amend the Operational Guide from time to time in consultation with the Supplier.

8.4.4 Where there is an inconsistency or conflict between the Operational Guide and this Service Specification, the provisions of this Service Specification will take precedence.

Security / Screening

8.5 The Supplier must:

8.5.1 uphold the safety of ACC Clients by carrying out appropriate screening/vetting, including Police vetting, for all authorised persons who provide services under this Agreement; and

8.5.2 establish and maintain systems, processes and security screening practices, for all Supplier authorised persons, including subcontractors and collaborate with ACC, to uphold the safety of Clients; and

8.5.3 immediately notify ACC of any actual, possible or anticipated issues that could impact the safety of Clients.

8.6 If ACC receives any information from any source related to the safety of Clients, in relation to these Services, ACC may take steps to investigate and take appropriate action. If ACC considers on reasonable grounds that the safety of a Client or Clients may be impacted, ACC can, at its sole discretion, suspend or terminate all or any part of the Services, or this Agreement.

Diversity and Inclusion

8.7 The Supplier will:

8.7.1 Meet all cultural safety practices and guidance, and where applicable, comply with ACC's cultural safety expectations.

8.7.2 Monitor and record whether the Client's needs are being met by the Supplier and use Client evaluations to inform service delivery improvements. For example, evaluate Clients' experience of care (such as number of rehabilitations delivered, missed or incomplete appointments, preferred methods) between Māori and/or other ethnicities.

8.7.3 Identify and remove barriers to access where possible (e.g. drop-in sessions) to reduce inequalities.

8.7.4 Cultivate appropriate organisational and community linkages to inform the Supplier's cultural safety and responsiveness development.

Telehealth

8.8 Services by a registered health professional can be delivered by Telehealth, where clinically appropriate. Services delivered by Telehealth must:

8.8.1 meet the requirements of the ACC Telehealth Guide;

8.8.2 have Client or authorised representative consent (recorded in the clinical notes), and with the option of an in-person meeting if the Client prefers;

8.8.3 be preceded by an initial risk assessment to ensure client safety;

8.8.4 meet the same required standards of care provided through an in-person consultation;

8.8.5 have clinical records that meet ACC and professional body requirements;

8.8.6 meet the requirements outlined in the standards/guidelines of the health provider's relevant regulatory body. If there is a difference between the regulatory body statements and what is stated in this contract, then the contract conditions take precedence; and

8.8.7 have both the Client receiving the Telehealth service, and the provider delivering the Telehealth service, physically present in New Zealand at the time the Service is provided.

8.8.8 All services provided by Telehealth are funded within the allocated Case-Weight.

9. REHABILITATION PATHWAYS

9.1 The duration of NARP Services may differ between individual Clients despite similar Case-Weight groupings. The Supplier will manage the duration of service provision based on individual Client needs.

9.2 Similarly, the amount of clinical and other inputs required to achieve the Client outcome may differ between individuals to allow for a tailored and individualised response. The Supplier should be able to clearly articulate in the rehabilitation plan how inputs will achieve the intended Client outcome.

Inpatient Rehabilitation Pathway

9.3 In addition to the requirements outlined in clauses 7 to 8, the following clauses set out service requirements for Clients receiving Inpatient Rehabilitation.

9.4 On admission and discharge from Inpatient Rehabilitation, the Supplier will undertake a Client assessment using the InterRAI Acute Care Admission and Discharge assessments.

9.4.1 The Inpatient Profiling Tool is built into the Acute Care Admission assessment and will automatically generate an Inpatient Case-Weight.

9.4.2 The Community Profiling Tool is built into the Acute Care Discharge assessment and will automatically generate a Community or Transitional Care Case-Weight.

9.5 The Supplier will make available a seven-day service in line with the Client's need, which includes but is not limited to:

9.5.1 a pre-transfer visit to, or consultation with acute team to identify Clients suitable for rehabilitation.

9.5.2 Geriatrician or Rehabilitation Specialist oversight and input through active participation in weekly case conferences.

9.5.3 consultations with specialists for any co-morbidities or other issues as appropriate.

9.5.4 rehabilitation from an interdisciplinary team, who have a shared philosophy and functional outcome goals (see Operational Guide). Note that Allied Health professionals are not required to deliver all rehabilitation. Rather, it is expected that Allied Health will oversee rehabilitation with Support Workers or Allied Health Assistants delivering rehabilitation as appropriate.

9.5.5 all investigations such as laboratory tests, X-rays (basic and specialised i.e. CT, MRI) and angiography.

9.5.6 nursing cares including pressure injury prevention.

9.5.7 personal care services.

9.5.8 medical consumable supplies and pharmaceuticals.

9.5.9 hotel services including hydration and nutrition (includes dietetics and nutritional advice).

9.5.10 any equipment required by the Client to meet their needs and to achieve a suitable rehabilitation outcome.

9.5.11 transport for tests, assessments, and rehabilitation.

9.5.12 education for caregivers and/or family to enable them to care for the Client after discharge where required.

9.5.13 plan a safe admission and discharge from and to each NARP rehabilitation pathway.

9.5.14 plan a safe discharge as outlined in Service Exit Process in Part B, clause 12.

9.5.15 access to information and education about injury prevention.

9.5.16 referral into community rehabilitation or in-home strength and balance programmes as required on discharge to prevent re-injury.

9.5.17 interpreter and advocacy services.

9.5.18 Māori Health/Liaison Worker and Pacific Island Health/Liaison Worker.

9.5.19 audiology, Optometry and Podiatry relevant to the Client's injuries.

9.5.20 all incidental services which are reasonable, and Suppliers of similar services would provide to meet the physiological, cultural, spiritual and social needs of Clients while in the care of the Supplier.

9.6 Inpatient services will be provided for up to 75 days (excluding any interruptions of care). If the inpatient stay is greater than 76 days from the start date of the Inpatient Rehabilitation pathway and the Client still requires further inpatient rehabilitation, then the Supplier will notify ACC using the 'NARP Exceptional Circumstances form ACC7985'. The Supplier must advise ACC of the number of additional inpatient days required. If approved, the Supplier will invoice ACC using the NRP05 code (detailed in Part A, clause 4) for each day in hospital thereafter.

9.7 Where a Client is readmitted into Inpatient Rehabilitation after a successful discharge, the Inpatient Profiling tool may need to be utilised a second time, see section 11.4 for readmission rules.

Transitional Rehabilitation Pathway

9.8 In addition to the requirements outlined in clauses 7 to 8, the following clauses set out service requirements for Clients receiving Transitional Rehabilitation.

9.9 Transitional Rehabilitation may occur before and/or after an Inpatient Rehabilitation episode. The Community Profiling Tool may be used to identify transitional care a maximum of twice for any Client, noting the Pathway cannot be completed consecutively.

9.10 The Supplier will identify Clients who meet eligibility criteria for NARP Services, and

9.10.1 are medically stable; and

9.10.2 do not or no longer require inpatient management; and

9.10.3 are deemed temporarily unsafe to be discharged to their usual place of residence; and

9.10.4 have potential to engage in inpatient or community rehabilitation after a period of transitional rehabilitation with the aim of returning to their usual place of residence.

9.11 Clients may be profiled into any of the following Transitional Rehabilitation sub-profiles to be eligible for NARP funding:

9.11.1 5a – Rehabilitation at the pre-injury level of residential care (Requires prior approval)

9.11.2 5b - Rehabilitation at a graduated level of residential care compared to pre-injury (Requires prior approval)

9.11.3 5e – Temporary placement into a transitional care facility with additional rehabilitation (No prior approval required).

9.12 Clients profiled into any of the following transitional care sub-profiles are not eligible for NARP funding. Rehabilitation, if required, is provided as part of the residential funding:

9.12.1 5c – Permanent placement into residential care

9.12.2 5d – Temporary placement into residential care with no additional rehabilitation required.

9.13 The Supplier under this Pathway will ensure:

9.13.1 Services are provided for as long as clinically indicated.

9.13.2 Clients identified as meeting criteria for the Transitional Rehabilitation Pathway have access to rehabilitation that matches their Transitional Rehabilitation profile.

9.13.3 Clients requiring Inpatient or Community rehabilitation after completing their Transitional Rehabilitation pathway are Re-Profiled.

9.14 Under the Transitional Rehabilitation Pathway, the bed day rate is funded via a separate service such as Residential Rehabilitation Service.

Community Rehabilitation Pathway

9.15 In addition to the requirements outlined in clauses 7 to 8, the following clauses set out service requirements for Clients receiving Community Rehabilitation.

9.16 The Supplier will identify Clients who meet eligibility criteria for Community Rehabilitation services; and

9.16.1 have had a NARP inpatient rehabilitation or transitional care episode (unless they meet the criteria for Rehabilitation Admission Avoidance as outlined in Clause 9.27);

9.16.2 are likely to achieve all rehabilitation goals within 12 weeks;

9.16.3 do not (or no longer) require inpatient or transitional management; and

9.16.4 are deemed safe to be discharged to a community environment.

9.17 Three Community Rehabilitation sub-profiles with expected timeframes are detailed in Table 7 below:

Table 7: Community Rehabilitation Pathways Service Requirements Summary

Community Profiling Group	Sub-profile	Descriptor	Expected Timeframes for completion
Group 2	Allied Health	Where Client requires predominantly Allied Health Input Group 2a: single Allied Health (OT or PT or other) Group 2b: multiple Allied Health (OT, PT, and/or other)	Maximum 12 weeks from start date
Group 3	Home Care Support Services	Where Client requires predominantly Home Care Support Services Group 3a: Housework only Group 3b: Housework and / or shopping delivered. Group 3c: Housework and / or personal care delivered	Maximum 12 weeks from start date
Group 4	Early Supported Discharge	Requirement for Allied Health and Home Care Support Services [Early Supported Discharge (ESD) type service] Group 4a: ESD - light Group 4b: ESD - moderate Group 4c: ESD - high	Maximum 12 weeks from start date

9.18 Clients identified as meeting criteria for the Community Rehabilitation Pathway must have access to rehabilitation which meets the Service Requirements as outlined above.

9.19 Where a Client has accessed Transitional Rehabilitation and is now able to participate in rehabilitation fully and actively, the Community Profiling tool can be used while the Client is still in Transitional Care to enable a transition home. The point at which Community Rehabilitation begins is clinically determined and may differ between Clients. The maximum timeframe for Community Rehabilitation (12 weeks) remains, regardless of the date they leave the transitional care facility.

9.20 Where the Supplier identifies that the Client is likely to need Community Rehabilitation for more than 12 weeks at the time of discharge from the hospital setting, they may refer directly into ACC services using the 'NARP Exceptional Circumstances form ACC7985' (see Part B, clause 10).

9.21 Where the Supplier has delivered 12 weeks of Community Services and has identified the Client continues to need services beyond that timeframe, they will notify ACC of the ongoing injury related needs via the 'NARP Exceptional Circumstances form ACC7985' (see Part B, clause 10).

9.22 The Supplier will not refer the Client for other ACC funded community-based rehabilitation programmes within the 12 weeks from Community Rehabilitation Pathway commencement.

Rehabilitation Admission Avoidance Rehabilitation Pathway

9.23 In addition to the requirements outlined in clauses 7 to 8, the following clauses set out service requirements for Clients receiving Rehabilitation Admission Avoidance.

9.24 Rehabilitation Admission Avoidance is clinically determined by the Client's hospital-based care team while the Client is still in acute care.

9.25 The Supplier will identify Clients who meet eligibility for NARP Services but who are medically stable and could successfully rehabilitate in their usual place of residence with timely input from a multidisciplinary community rehabilitation team (Group 4 on the Community Profile).

9.26 Clients will be manually selected into one of the following sub-groups (further definitions provided in the Operational Guide):

9.26.1 Group 4a – Early Supported Discharge – light

9.26.2 Group 4b – Early Supported Discharged – Moderate

9.26.3 Group 4c – Early Supported Discharge - High

9.27 Clients identified as meeting criteria for the Rehabilitation Admission Avoidance Rehabilitation Pathway will have access to rehabilitation for up to 12 weeks from discharge from a hospital setting.

9.28 If the Supplier determines that the Client needs further support after 12 weeks, they will complete a 'NARP Exceptional Circumstances form ACC7985' (see Part B, clause 10).

10. SERVICE SPECIFIC QUALITY REQUIREMENTS

10.1 In addition to the requirements specified in clause 8 of the Standard Terms and Conditions, the Supplier will ensure the following requirements are met.

10.1.1 Service Providers

10.1.1.1 The following table outlines the qualifications and experience required of the Supplier's authorised personnel.

Table 8: Summary of Service Provider Qualifications and Experiences

Service Provider	Qualification and Registration
Rehabilitation Specialist	Current vocational registration in and practising within rehabilitation Medicine – Fellow of the Australasian Faculty of Rehabilitation Medicine

Service Provider	Qualification and Registration
	OR - Internal medicine with a focus on Geriatric medicine with a minimum of two years' experience in a rehabilitation environment providing similar role, with an interest in rehabilitation. Where the Supplier cannot provide a rehabilitation specialist long term, they must notify ACC while making every effort to engage the appropriate clinical professional.
Key Worker	The role of a Key Worker can be fulfilled by any of the medical or allied health professionals who are experienced in coordinating an interdisciplinary team. A minimum of two years' experience in rehabilitation environment providing similar role, with an interest in rehabilitation.
Registered Nurses, Enrolled Nurses and Nurse Practitioners	Current registration with their relevant professional body Current Annual Practising Certificate, where appropriate
Allied Health: Occupational Therapist Physiotherapist Speech Language Therapist Social Worker	Current registration with their relevant professional body Current Annual Practising Certificate, where appropriate A minimum of two years' experience in rehabilitation or training in rehabilitation with supervision until the Provider has gained two years' experience. The supervisor must be a suitable qualified health professional with a minimum of 5 years' experience in rehabilitation
Support Workers /Health Care Assistant	NZQA level 3 support qualification

10.1.2 The Supplier must ensure that a Rehabilitation Specialist, who meets the qualifications outlined in Table 8 above, is part of the interdisciplinary team in the inpatient setting and is available to provide advice and guidance as required on the:

10.1.2.1 delivery of the rehabilitation programme; and

10.1.2.2 Client's service needs.

10.1.3 Where the Supplier's medical practitioner is not vocationally registered in internal or rehabilitation medicine, the Supplier will ensure a medical specialist who is qualified is available on request to provide advice, coaching and support to the medical practitioner and interdisciplinary team.

10.1.4 Where the Rehabilitation Specialist will not be available temporarily the Supplier will nominate another medical practitioner to work within the interdisciplinary team.

10.1.5 When Clients are receiving rehabilitation in the community setting there must be appropriate access to a medical practitioner who meets the Client's rehabilitation needs (this can include the Client's General Practitioner if deemed appropriate). This input must be fully funded within the existing allocated Case-Weight funding.

10.2 Service Notifications and Timeframes

10.2.1 The Supplier will meet the following timeframes relating to notifying ACC:

Table 9: Service Timeframes

Report or Notification	Action Required	Responsibility	To go to	Timeframe
ACC7985 NARP Exceptional Circumstances	Notifying ACC of an Exceptional Circumstance.	Supplier	ACC	In writing within two Business Days of the exceptional circumstance.
ACC705 Support Services on Discharge	Notifying ACC of Client needs on Discharge that are not met under this Service Schedule (excluding exceptional circumstances).	Supplier	ACC	No less than five Business Days prior to discharge.
Email or phone call	Suppliers to report any privacy or health and safety breaches as it relates to this Service.	Supplier	Engagement and Performance Manager	Within 24 hours of an incident/breach occurring.

10.3 Quality and Outcomes Framework

10.3.1 The Supplier will be responsible for the accurate submission of InterRAI assessments to support the ongoing development of a quality and outcomes framework.

10.3.2 The Supplier will ensure that their InterRAI assessments are inter-operable with the platforms specified by Te Whatu Ora – InterRAI Services, who administer the InterRAI assessment, to ensure the data can be benchmarked.

10.3.3 The Supplier agrees to their InterRAI data being used for benchmarking purposes, without individual Client details being made available.

10.3.4 The Supplier is committed to data quality and where issues with data quality are identified, work with ACC to make improvements.

10.3.5 The Supplier will participate in quality forum(s) with ACC and other suppliers to focus on improving the quality of rehabilitation and improving Client outcomes.

11. PATHWAY EXCEPTIONS

11.1 The following sub-sections detail processes involved for Clients who may not align with the primary NARP pathways described above.

11.2 NARP Exceptional Circumstances

11.2.1 The following circumstances are considered exceptional circumstances within NARP Services and require an ACC7985 form to be sent to ACC (additional detail can be found in the Operational Guide):

11.2.1.1 extended inpatient length of stay beyond 76 days

11.2.1.2 transfer to ACC Claims Management

11.2.1.3 readmission after 181 days after discharge for the same injury

11.2.1.4 treatment injury as main reason for requiring NARP

11.2.1.5 Clients profiled as Group 5a OR Group 5b

11.3 Interruption of Rehabilitation

11.3.1 If the Client is unable to participate in injury related rehabilitation due to health or age-related issues the Supplier will transfer the Client to health funding for the total time that the Client is not participating in rehabilitation. Interruptions of care do not count towards the total 76 days included in the payment rate.

11.3.2 The Supplier will notify ACC via email claimsdocs@acc.co.nz that the rehabilitation has been interrupted. Interruption of care that is of three days or less does not require notification to ACC or a transfer of funding.

11.3.3 Where an interruption of rehabilitation occurs, an additional Case-Weight profile is not generated.

11.3.4 Interruptions can include surgery, medical illness, offsite health related investigation where the Client will be gone longer than three days, any situation where the Client is unable to participate in rehabilitation activities.

11.4 Readmission into the Inpatient Rehabilitation Pathway

11.4.1 Readmission into the Inpatient Rehabilitation pathway may occur if the Client has been discharged from the NARP Service in line with the exit criteria in Part B, clause 11 and there is a need for further inpatient rehabilitation for the same ACC injury within 181 days of discharge.

11.4.2 Clients will be reassessed upon readmission to inpatient rehabilitation and a new inpatient profile will be generated and assigned to the Client.

11.4.3 Readmission to inpatient rehabilitation for the same injury within seven days of discharge is considered a failed discharge and no additional Case-Weight is assigned for this admission – refer to Operational Guide.

11.4.4 Readmission to inpatient rehabilitation between eight and 180 days for the same injury can be reprofiled without requiring ACC prior approval.

11.4.5 Readmission to inpatient rehabilitation for the same injury beyond 181 days of discharge is considered an exceptional circumstance and requires ACC approval using the 'NARP Exceptional Circumstances form ACC7985'.

11.4.6 Readmission is only available for the Inpatient Rehabilitation Pathway (i.e. not community, rehabilitation admission avoidance or transitional care pathways).

11.5 Requests for Family/Whanau care

11.5.1 When a Client wants family/whānau to provide home supports, this is at the Supplier's discretion. The Supplier will provide the appropriate training to family/whānau and risk management. Payment to family/whānau must be managed by the Supplier and funding must be utilised from within the existing Case-Weight price.

11.5.2 The Supplier is responsible for ensuring that rehabilitation is provided by Providers outlined in Table 8. Suppliers will monitor the quality of care being provided by family/whānau to ensure it meets the standards required under the contract.

11.5.3 Funded support should complement, not replace, the support provided by a Client's Natural Support network. The Supplier must consider the extent to which home supports, including Home Help, Attendant Care and Childcare, can reasonably be provided on an unpaid basis by household family/whānau members, or other family/whānau members, without significant disruption to their employment and everyday activities.

11.5.4 Natural Supports include Family/whānau members, friends and neighbours, and community, church, social and school groups that are readily available and reasonably accessible for a Client requiring help at home and in the community.

11.6 Treatment Injury

11.6.1 Where a Client has had a Treatment Injury accepted after service delivery has occurred, the Supplier can claim reimbursement of both inpatient and community rehabilitation (if delivered) using the Service Items in Part A, Table 5. This requires ACC approval using the 'NARP Exceptional Circumstances form ACC7985'.

12. SERVICE EXIT

12.1 An exit from ACC NARP Services occurs when the Client no longer has injury related rehabilitation needs OR has reached the maximum timeframe for that service pathway OR the Client self-discharges from NARP Services OR the Client dies.

12.2 The Supplier will:

12.2.1 notify ACC of any additional injury related rehabilitation needs on service exit using the 'NARP Exceptional Circumstances form ACC7985'.

12.2.2 transfer rehabilitation to health funding if the Client still has ongoing needs that are predominantly health related rather than injury related.

13. EXCLUSIONS TO NARP SERVICES

13.1 ACC will fund NARP Services through the Case-Weight funding mechanism outlined within Part A, clause 3 of the Service Schedule. The Supplier is responsible for appropriate service delivery as outlined within Part B, clause 8 of the Service Schedule.

13.2 The following services (without limitation) are NOT funded under ACC NARP Services:

13.2.1 Acute secondary care services i.e. medical, paediatric, and surgical services

13.2.2 General practice medical services

13.2.3 Specialist nursing services

13.2.4 Dentistry

13.2.5 Outpatient assessment such as orthopaedic

13.2.6 Long term equipment for independence e.g. orthotics, prosthetics (artificial limbs), wheelchairs

13.2.7 Vocational rehabilitation services

13.2.8 ACC pre-approved long-distance escort or transport

13.2.9 ACC funded specialist social rehabilitation assessments

13.2.10 Post discharge medical consumables

13.2.11 Spinal Cord Injury Rehabilitation - all Clients with confirmed acute spinal cord injury must be referred to either Auckland or Burwood Spinal Injuries Services (depending on the Client's place of residence) as soon as practical

13.2.12 Traumatic Brain Injury - all Clients who require specialised rehabilitation under the TBI Residential Rehabilitation or Residential Support Services must advise ACC that the Client requires such services as soon as practicable. Clients with a TBI who do NOT require specialist services may be eligible for this Service.

14. LINKAGES

14.1 Upon exiting NARP Services, the Supplier will consider linking the Client with the following Services:

14.1.1 General practice medical services

14.1.2 Drug & Alcohol services

14.1.3 Mental health services

14.1.4 Māori health providers

14.1.5 Other appropriate ethnic and cultural groups

14.1.6 Government departments and agencies such as Police, Work and Income, Ministry of Social Development, Housing NZ, Ministry of Justice

14.1.7 Disability consumer groups

14.1.8 Community based day programmes, independent of those that may be operated by the Supplier.

15. REPORTING AND PERFORMANCE MANAGEMENT

15.1 ACC and the Supplier will assess and discuss the Supplier's performance by analysing information from ACC's database, the Supplier's invoicing, InterRAI and other sources considered appropriate.

15.2 Outcome and performance measurement will evolve over time and will be developed to ensure the Service delivers to its purpose (Part B, clause 1).

15.3 Utilisation of the different service components will be monitored using billing data.

15.4 ACC will monitor performances to identify any cases of:

15.4.1 Inappropriate billing (i.e. more than one community pathway, inpatient reprofiling within seven days of the initial admission).

15.4.2 Billing for additional ACC services within 12 weeks of community rehabilitation commencing.

15.4.3 Billing for NARP pathways for injuries that are unlikely to need rehabilitation (e.g. minor abrasions).

15.4.4 This data may be discussed with the Supplier to identify possible improvements.

15.5 The Supplier's performance against the Client outcomes (Part B, clause 2) and Service Objectives (Part B, clause 3) will be measured as shown in Table 10 – Performance Measurement and Reporting.

Table 10: Performance Measurement and Reporting

Objective	Performance measure	Frequency	Data Source
The Client's function and independence is improved to the maximum extent practicable and reasonable	Improved function as measured by InterRAI functional scores	Live data	InterRAI
The Client returns to their pre-injury place of residence wherever possible	95% of all Clients	Live data	InterRAI
The Client is satisfied with the service	Clients surveyed on discharge are satisfied	Annual	Supplier survey
The Service delivered is of a high quality and clinically appropriate	Readmission for further services are the same or less than other suppliers	Annual	Supplier data submitted to ACC
The service is cost-effective	Average cost per claim is comparable to other Suppliers	Annual	ACC billing data

15.6 ACC will monitor the quality and timeliness of data submission from suppliers. When there are issues, ACC will work collaboratively with suppliers to support improvements.

15.7 When no improvements are evident ACC has sole discretion to withhold payment until improvements occur.

16. PAYMENT AND INVOICING

16.1 In addition to the Standard Terms and Conditions, clause 10, ACC agrees to pay the prices set out in Part A, clause 3 for the Services provided in accordance with this Service Schedule.

16.2 The prices set out are the entire amount chargeable to ACC in relation to the Services and no additional amount may be charged to ACC, a Client or any other person for Services under this agreement.

16.3 The Supplier must submit a GST invoice electronically using one of ACC's prescribed methods (available on the ACC website). Invoices must be submitted within 12 months of the service start date. ACC may, at its discretion, decline to pay invoices outside this timeframe.

16.4 Separate service items for the same Client and claim can be invoiced separately. Each service item must contain an accurate admission and discharge date and the dates for each service pathway must not overlap.

16.5 ACC will release payment on receipt of an invoice that contains an accurate admission and discharge date for each service component. Where information is missing, ACC may, at its discretion, withhold payment.

16.6 The Supplier will only invoice one service pathway per claim, unless the following applies:

16.6.1 The Client has been readmitted and reprofiled to Inpatient Rehabilitation as per clause 9.5

16.6.2 The Client has required no more than two, non-consecutive Transitional Care episodes.

17. GOVERNANCE

17.1 ACC may invite the Supplier to work in a NARP Steering Group that will:

17.1.1 Review benchmarking reports and provide feedback on any refinements

17.1.2 Oversee the operation of the Service

17.1.3 Provide feedback on innovations

17.1.4 Undertake additional activities as required.

17.2 The Terms of Reference for the NARP Steering Group will outline the specific purpose of the steering group and may change from time to time. (See Operational Guide).

18. DEFINITIONS AND INTERPRETATION

18.1 In this Service Schedule the following terms have the defined meaning:

Table 11: Service Schedule terms and definitions

Term	Definition
Acute Services	Emergency Department, short term acute assessment units, medical and surgical acute wards that provide acute treatment.
Actively Participate	Clients are capable and willing to actively participate in rehabilitation; and; Capable – Their overall physical and cognitive function is such that they can and do take part. Willing – They want to participate. They demonstrate motivation to participate. Actively Participate – They are not just receiving rehabilitation therapy passively. They are consciously taking part in rehabilitation activities and therapies. A Client can actively participate while not bearing weight on the affected limb such as using a walking frame and supporting their weight on the uninjured limb. Most Clients will not be on bedrest but there can be some situations where a Client is actively participating while on bedrest. Clients who are unwell, cannot or are unwilling to take direction are not in a rehabilitation programme so are not funded under this Service.

Term	Definition
	Note: Unwillingness would not be the sole reason for ACC not funding as Providers are experienced at successfully encouraging Clients to actively engage.
Active Rehab while a Client is in RSS / ARC / respite care	Must be greater than the level of input a Client would usually be provided in residential care AND Client must be able and willing to engage in rehabilitation AND the Client must be actively working towards a specific rehabilitation goal (not maintenance of function).
ARC	Aged Residential Care facility
Case-weight	Each Client will have different rehabilitation needs. The case weight is based on the average level of resource required across claims with that level of complexity.
Case-weight rates	Case-weight rates are the payment for claims accessing a pathway after the profile tool is administered by a health professional.
Casemix	Casemix models are guided by two principles; clinically meaningful assessment profiles and case-weights based on rehabilitation needs. Casemix profiles are established to describe Client complexity and for allocation into clinically similar groups. The Casemix model is designed to accommodate for these individual differences by addressing the wider group as a whole.
Client	The term Client refers to a person who has an ACC covered injury. Note: A Client may have ACC cover, but that covered injury may not entitle them to funding under this Service.
Community	Any location that is not the Supplier's acute or rehabilitation facility (hospital).
Continuum of Care	Services provided from post-acute care until the Client no longer needs injury related rehabilitation and/or care or has met the maximum timeframes of the Service.
Discharge	The Client has completed all NARP service components and exited the Service. The Supplier is no longer responsible for on-going injury needs.
DHB/Te Whatu Ora district	Te Whatu Ora districts (formerly District Health Boards) are the contracted suppliers of the NARP Service. There are twenty districts who are part of New Zealand's Public Health Service. They have a legislative responsibility to deliver health services in specified areas that provides full cover across the country.
Early Supported Discharge	Refers to the early transition from Inpatient to Community. -is for Clients who are medically stable, and their early discharge from an inpatient setting improves their potential for a functional recovery. provides a community-based goal directed programme of functional rehabilitation delivery by an interdisciplinary rehabilitation and care team.

Term	Definition
Exceptional Circumstances	The funding covers services required to meet the Client's individual needs up to a specific point: 76 days for inpatient 12 weeks for community After these timeframes, the pathway is considered exceptional and the exceptional circumstances pathway should be followed.
Estimated Discharge Date (EDD)	The date calculated by inpatient profiling tool after the Client's data has been submitted.
Family/Whānau	The people with a close personal relationship with the Client.
Health funding	Health funding is where the Client's service need is due to age or illness (not injury) reasons.
Interdisciplinary team	A team of clinicians and support staff working within a team: Team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities The team together with the patient/Client, undertakes assessment diagnosis, intervention, goal setting and the creation of a rehabilitation plan The patient, their family and carers are involved in any discussions about their condition, prognosis, and rehabilitation plan
InterRAI	InterRAI is a suite of clinical assessment tools used internationally to improve the quality of life of for vulnerable people.
Interruption of Care	When a Client receiving NARP is no longer able to participate in their rehabilitation due to a non-injury related condition or event, or returns to acute care for any reason.
Journey	The combination of different service components a Client may receive in this Service depending on their needs. For example, a Client may need Inpatient Rehabilitation followed by a period of Community Rehabilitation, this is referred to as the Client's pathway.
Managed Rehabilitation Equipment Services (MRES)	The purchase of Rehabilitation equipment (reusable aids that assists a Client with their daily living activities) through ACC's National Equipment Supplier.
Operational Guide	The Non-Acute Rehabilitation Pathways Service Operational Guide describes the operation of this Service in detail and supports the Service Schedule.
Pathways	This refers to the different elements within the NARP Journey ie Inpatient, Community, Transitional Care.
Patient	The term Patient refers to people whose funding source has not been determined or has been determined not to be ACC.

Term	Definition
PHAS	Public Health Acute Services is ACC's funding contribution towards acute care.
Profiling /Profiling Tool	The NARP Inpatient and Community Profiling Tools can be found in the Operational Guide.
Provider	The person delivering services to the Client.
Ready for Rehabilitation	The Client's overall health condition does not need acute medical intervention to maintain their health and wellbeing and is unlikely to deteriorate. It also means the Client is sufficiently well that they can actively participate in Rehabilitation.
Rehabilitation	Evidence-based treatment or treatments designed to facilitate the process of recovery from injury to as normal a condition as possible and includes restoring some or all of the Client's functionality and assisting the Client to compensate for deficits that cannot be reversed medically. There must be differentiation between big 'R' rehabilitation and little 'r' rehabilitation. Little 'r' describes rehabilitation where there is a focus on preventing complications. The Client is assisted and encouraged to move as able to prevent the consequences of prolonged lack of movement. The need for rehabilitation intervention is usually short term and may be particularly needed after surgery. The Client usually recovers function quickly and generally does not need intensive or ongoing rehabilitation. Big 'R' describes rehabilitation where there has been significant loss of function. There is a need for therapist guided intervention which gradually progresses the Client's functional abilities over time and may require the Client to learn to complete a functional activity in a new way either temporarily or permanently.
Rehabilitation Admission Avoidance	Where a Client, who would normally be admitted to inpatient rehabilitation, is able to bypass admission to access a range of community services. The community services must be safe and provide a viable rehabilitation and support service delivered by dedicated teams.
Residence	Where the Client is residing temporarily or permanently.
Residential Support Services	ACC's funded residential care service. For more information, go to acc.co.nz.
Supplier	The District holding a contract with ACC to deliver Non-Acute Rehabilitation Services. They are responsible for ensuring all the Services are delivered in accordance with this contract.
Telehealth	The use of information or communication technologies to deliver health care when Clients and care providers are not in the same physical location. Relates to real-time videoconferencing interactions and telephone consultations.

Term	Definition
	Telehealth excludes electronic messaging, e.g. texts and emails. A Telehealth consultation is to replace an in-person visit, it does not include a quick triage or check-in phone calls (unless specified).
Transfer / Transition	The Client is changing from one service component to another but within the NARP Service. This can also refer to a Client transfer to ACC case management.
Transitional Care	Where a Client is temporarily not safe to be discharged back to their previous place of residence as a result of the covered injury and is transferred to an interim facility (usually located in a residential care facility).

19. APPENDICES

APPENDIX A: NARP ELIGIBILITY TOOL

Clients are eligible for NARP Services when they have an accepted injury with ACC (i.e. have an accepted ACC45) and health and age-related reasons are NOT the main reason for admission.

Clinicians should use the diagram below to assess eligibility for ACC NARP Services:

Figure 1: NARP Eligibility Tool