TBI Residential Rehabilitation Service

Operational Guidelines

Contract Start Date: 1 April 2021

This is a living document and will be updated and finalised with contracted Suppliers as and when required.

16 January 2023

Contents

Introduction

These Operational Guidelines support the service specification for the Traumatic Brain Injury Residential Rehabilitation Service (TBIRR or "the service") and provides a greater level of detail on the implementation of the service, including the philosophy, relationship and partnership expectations within the service.

Both the service specification and the Operational Guidelines should be read in conjunction with each other. If there is any disagreement between the service specification and the Operational Guidelines, then the service specification takes precedence. References to the TBIRR Service Specification have been provided to assist the reader. Any reference to a clause includes any sub clauses where appropriate.

Purpose

The TBIRR service supports clients who have sustained a moderate to severe traumatic brain injury (TBI) who require high intensity, comprehensive neurological rehabilitation, nursing and medical service in a specialist residential facility. The goal is to return these clients to active and meaningful participation in their community and, if appropriate, their place of work in a planned, timely, well supported and sustainable manner. ***(Part B Clause 1.1)***

Service Overview

The TBIRR service is a specialist service which uses a holistic interdisciplinary approach to rehabilitate clients. The client, their family and whānau, ACC and the Supplier work closely together through the development and implementation of an agreed rehabilitation plan to achieve the maximum level of independence for the client.

The TBIRR Service comprises three specialist rehabilitation services designed to meet the Client's needs:

- **Emerging Consciousness** - High intensity residential neurological stimulation rehabilitation and tailored therapies for clients who have a disorder of consciousness in order to preserve their function and to maximise their opportunity to return to consciousness. ***(Part B Clause 2.1.1)***
- **Residential Rehabilitation** - High intensity inpatient (residential) rehabilitation which supports clients to return to participation in their community and, if appropriate, their place of work in a planned, timely, well supported and sustainable manner. ***(Part B Clause 2.1.2)***
- **Day Rehabilitation** – High intensity outpatient (non-residential) rehabilitation, as an alternative to inpatient rehabilitation, to support clients to return to participation in their community and, if appropriate, their place of work in a planned, timely, well supported and sustainable manner. ***(Part B Clause 2.1.3)***

Service Objectives

ACC will measure the success of the Service based on the following objectives:

- All clients discharged from the service return to active and meaningful participation in their work and/or community or achieve a measurable improvement in their cognitive and functional abilities that maximises their independence and quality of life. ***(Part B Clause 3.1.1)***
- Services are delivered via an interdisciplinary team approach which is tailored to the individual clients' needsThe Services provided are:
    - Targeted towards achieving the Client's rehabilitation goals
    - Co-ordinated within the team of health professionals
    - Planned
    - Timely
    - Supportive of, and encourage the participation of, the Client and their family/whānau ***(Part B Clause 3.1.2)***
- Clients, their family and whānau are satisfied with the service. ***(Part B Clauses 3.1.3)***
- Clients and their families/ whānau are well informed about the impacts of the Client's injury and have the appropriate strategies to manage these impacts. ***(Part B Clauses 3.1.4)***

Useful contact numbers

Who to contact	Phone	Email
ACC Supplier Helpline	0800 222 070	providerhelp@acc.co.nz
ACC Client/Patient Helpline	0800 101 996	
Supplier Registration	04) 560 5211	registrations@acc.co.nz
ACC eBusiness	0800 222 994 Option 1	ebusinessinfo@acc.co.nz
Health Procurement If you have a question about your contract or need to update your details, please contact the ACC Health Procurement team.	0800 400 503	health.procurement@acc.co.nz
Engagement and Performance Managers	Engagement and Performance Managers can help you to provide the services outlined in your contract. Contact the Supplier Helpline or click on the link provided here for details of the EPMs in your region. Contact an Engagement and Performance Manager	
ACC TBIRR Service Portfolio Advisor	Contact the Supplier Helpline for details of the Portfolio Advisor	

Please report all health, safety and security risks or incidents in writing using the procedure on our website https://www.acc.co.nz/for-providers/report-health-safety-incidents

Responsibilities

The Public Hospital is responsible:

to…	for…
Clients	• Ensuring the client has correct diagnosis and cover has been accepted by ACC *(Part B Clause 6.5)* • Ensuring the client, family and whānau are informed of all options and strategies • Ensuring timely and accurate decisions by working with the TBIRR Supplier and ACC to ensure the early cover process outlined in the Accident Services: A Guide for DHB and ACC Staff 2018 (ASG) are complied with. • Transferring the client from the acute setting to the rehabilitation facility.
Supplier	• Notifying the Supplier immediately they are aware the client is likely to require residential rehabilitation *(Part B Clause 6.5 & 8.1)* • Completing inpatient assessments and decision making when planning the client's continuum of care *(Part B Clause 4)* • Ensuring there is a good working relationship between the TBIRR Supplier and ACC to ensure a smooth transition for the client between services. *(ASG)*
ACC	• Lodging the ACC45 promptly (within 3 working days) • Ensuring the ACC45 has a correct diagnosis and list of injuries • Ensuring the diagnosis is supported with clinical information such as reports, tests and assessments. *(ASG)*

Supplier

The Supplier is responsible:

to…	for…
Clients	• Ensuring they receive high quality rehabilitation services *(Part B Clause 1)*

to…	for…

	• Providing a comprehensive experienced interdisciplinary team ***(Part B Clause 9.4)***
	• Allocating a key worker who ***(Part B Clause 8.2)***
	  ○ facilitates the client's transfer from the acute setting
	  ○ coordinates the rehabilitation programme
	  ○ facilitates the client's transfer to the next stage of service after discharge
	  ○ is the main point of contact and communication with the client and their family and whānau
	• Ensuring the client's family and whānau have a good understanding of brain injury and its impacts in relation to their injured family member ***(Part B Clauses 8.3.10)***
	• Developing a rehabilitation plan that is individually tailored, culturally appropriate, outcome focused and reflects the client's goals and ensuring the plan also includes:
	  ○ goals that are specific, measurable, achievable, realistic and time framed
	  ○ a therapy plan within the rehabilitation plan which outlines what actions are required to meet the short, medium and long-term goals of the client
	  ○ a discharge plan which includes the transition supports ***(Part B Clause 8.3)***
	• Transporting the client to any outpatient visits and any activities provided as part of the rehabilitation programme. ***(Part B Clause 8.5.1.17)***

Public Hospital	• Working closely with the public hospital to determine if the client meets the eligibility criteria. ***(Part B Clause 6.5)*** • Ensuring the acute service has sent ACC all the appropriate clinical information to make a cover decision such as an up-to-date ACC45 and/or ACC18, clinical notes, lab results, MRI, CT reports that identify the client's injuries. (***ASG)*** • Ensuring ACC has made a cover decision that reflects the injury and rehabilitation needs of the client prior to discharge. ***(Part B Clause 8.1)***

to…	for…
	• Discussing with ACC the assignment of the appropriate case management staff to facilitate the client's transition and rehabilitation. • Acknowledging the notification. • Assessing the client's readiness for rehabilitation in conjunction with acute service clinical staff. ***(Part B Clause 4.1.2)*** • Assisting with the identification of all clients with moderate to severe TBI. ***(Part B Clause 8.1.1.1)***

ACC	• Notifying ACC when the client transfers from a public hospital to the rehabilitation facility. ***(Part B Clause 7.1.1)***
	• Providing ACC with an opportunity to be involved in the rehabilitation and discharge planning. ***(Part B Clause 8.3.1)***
	• Notifying ACC of any changes to the client's rehabilitation plan where those changes would impact the client's needs on discharge. ***(Part B Clause 8.3.8)***
	• Providing regular progress reports on the client's rehabilitation programme (no less than monthly)
	• Providing, from the time of admission, an up to date discharge plan which outlines the likely supports required, such as:
	  ○ Attendant care
	  ○ Community rehabilitation
	  ○ Housing modifications
	  ○ Rehabilitation Equipment
	This will enable ACC to have the necessary supports in place for the client on discharge. ***(Part B Clauses 8.3.8)***

Other service providers	• Communicating openly and supportively to ensure the client has a seamless transition ***(Part B Clause 8.8.5)*** • Ensuring that post discharge service providers have had the opportunity to engage with the client's family and whānau prior to the client's discharge. • Providing advice where appropriate to ensure the client receives a high standard of service ***(Part B Clauses 8.9.1)***

ACC

ACC is responsible:

to…	for…
Clients	• Ensuring the client, their family and whānau are fully aware of the client's options • Making timely decisions so their rehabilitation is not delayed • Ensuring the management of their case is a high priority • Ensuring the Supplier is providing a high-quality standard of service
Suppliers	• Participating in the client's rehabilitation planning and decision making so the client's rehabilitation programme is not delayed • Ensuring the discharge process is supported and ensuring the client's transition into the community is seamless, smooth and supported
Employers	• Working with the employer on the client's behalf to support a planned return to work
Other service providers, e.g. Home and Community Support, Training for Independence	• Ensuring Suppliers have the opportunity to make contact and coordinate areas of responsibility and transition arrangements • Ensuring the appropriate supports are arranged as agreed and in a timely fashion

Relationship Responsibilities

There is an expectation that:

- Suppliers and ACC staff will work together to ensure the client receives the appropriate rehabilitation *(Part B Clause 8.3)*
- All parties will respect each other's area of expertise
- Suppliers are experts in the rehabilitation of brain-injured clients and are responsible for achieving the service outcome for the client within the context of the TBI Residential Rehabilitation service (as defined in the Service Schedule)
- ACC staff are expert at managing the complex mix of rehabilitation services, entitlements, and compliance relating to claims

Eligibility Criteria

(Part B Clause 4.1)

The Supplier is responsible for ensuring the client meets the following eligibility criteria before entering the TBIRR service:

- Have an accepted ACC claim for personal injury with a clinical diagnosis that indicates a moderate to severe TBI acquired through trauma or hypoxia, and,
- Have been assessed as requiring Traumatic Brain Injury Residential Rehabilitation; and,
- Are aged over 16 or of a suitable maturity to participate in adult rehabilitation services; and,
- Are Medically Stable.

For those clients who have not regained consciousness and will be entering the emerging consciousness service must:

- Be assessed as either post-coma unresponsiveness or minimally conscious as defined in the Wessex Head Injury Matrix and / or Coma Recovery Scale

Cover

The client must meet the service eligibility criteria as set out in the service schedule. ACC will assess the client's clinical diagnosis and approve cover for the client's moderate to severe traumatic brain injury. Without a cover decision, the client cannot transfer to a residential rehabilitation facility. The classification can be made using either Read or ICD or SNOMED coding supported by clinical documents. ***(Part B Clause 4.1.1)***

Using SNOMED Clinical Terms

Clinical diagnosis - severity of injury

Clients diagnosed with a moderate to severe TBI are suitable for the service. The table below is used to categorise TBI acutely.

Severity of injury	Glasgow coma scale (GCS)	Duration of post-traumatic amnesia (PTA)
Moderate	9-12	1-6 days
Severe	3-8	7 days or more

Note:
Where the GCS and PTA do not correlate, then the client will be assigned to the greater of the two severity categories.

It is expected that the TBIRR Supplier will support the cover decision process by maintaining contact with the DHB to promote, encourage and prompt their timely notification to ACC of clinical information to allow the cover decision to be made. The TBIRR Supplier will also stay in contact with ACC to ensure timely decision making to facilitate the appropriate transition of a client to rehabilitation once all criteria are met. ***(Part B Clause 6.5)***

Where ongoing cover and entitlement is in doubt, the TBIRR Supplier should have a full discussion with ACC. For example, in cases of wilful self-harm, determining eligibility is complex. The ACC case owner will always seek clinical and legal advice to determine each client's eligibility.

Generally, ACC is only able to fund treatment services (this includes TBIRR services and medical treatment after discharge).

In most cases, ACC is not able to fund entitlements (for example vocational rehabilitation or other social rehabilitation services) in cases of wilful self harm. In these circumstances, it is important that early application for ongoing support is made to the health funder.

Age-limit

While the entry point for admission into the service is clients aged over 16yrs, there is flexibility to allow for younger clients who are mature for their age and who would be better placed in an adult service. Any decision about the suitability of the service for clients aged 16yrs and younger must be discussed and agreed between the following parties and documented by the TBIRR Supplier:

- The client and their family/whānau
- Acute Service
- TBIRR Supplier
- Paediatric service provider contracted under the ACC Child and Adolescent Rehabilitation Service
- ACC

The final decision remains the discretion of ACC. ***(Part B Clause 4.1.3)***

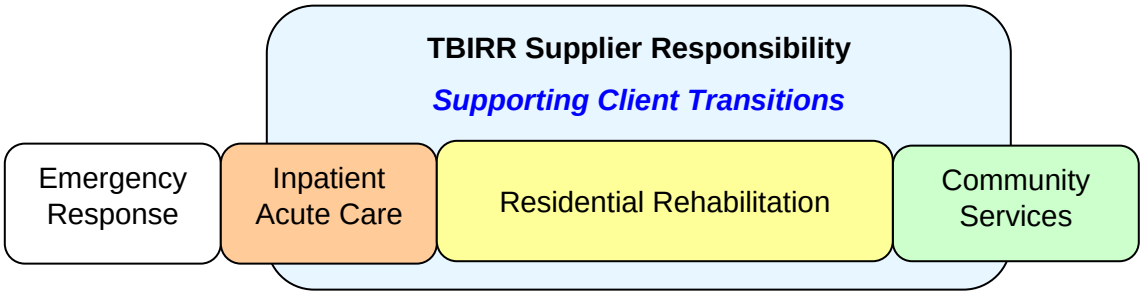
Medically Stable

To be eligible to enter TBIRR service, clients must be assessed as medically stable by the DHB. Medically stable means that the client:

- Is medically ready for rehabilitation which will significantly improve their functioning, and increase pre-injury related vocational and social activities
- Has stable vital signs
- Does not have an acute and/or unstable potentially life-threatening medical condition (ie does not need DHB input) as this is not paid for under this contract but is provided and paid for under Public Health DHB (PHAS) funding
- Does not have non-neurological medical sequelae of TBI requiring further acute medical treatment
- Does not have non-neurological medical co-morbidities that need acute medical management.

Admission to any service for clients who are not breathing independently must be agreed by DHB, the Supplier and ACC. The above criteria should also be read in conjunction with the Accident Services: A Guide for DHB and ACC Staff 2018 (ASG). ***(Part B Clause 4.1.4, 4.2, 4.3, 4.4)***

Supporting Client Transitions



The Supplier is responsible for ensuring the client's transition between services is *seamless* and *supported*. ***(Part B Clause 8.1)***

Transition

The meaning of "transition" in this context is:

- discharging from a public hospital and admission to TBIRR
- discharging from TBIRR into community services

Seamless Transitions

The Supplier is responsible for a **smooth transition processes** so the client, family and whānau perceive the transition to be smooth and continuous, with no apparent gaps between one service and the next.

This is achieved by ensuring strong coordination and communication between all parties involved in the client's transition.

Supported

The Supplier is responsible for providing services that ensures the client, family and whānau are **supported** during transition and rehabilitation.

This is achieved by ensuring that:

- the client and their family's needs for information and emotional support are met
- ACC has provided the appropriate entitlements
- other community supports have been accessed where needed such as mental health, drug and alcohol, chronic health management etc. and the appropriate referrals are made.

Population Responsibility (Coverage)

Suppliers are responsible for large areas of the New Zealand population via their primary relationship with the Ministry of Health's District Health Boards. The service responsibilities are slightly different depending on whether the Client is in:

- an acute trauma centre; or
- a regional public hospital; or
- the community.

ACC, MoH/public hospital's and ambulance services have destination policies that direct where clients will be delivered by ambulance services – see Major Trauma Network.

Clients with serious injuries will be delivered to the optimal place of care which, depending on the nature of their injuries, this may not be the local public hospital. It is anticipated that the majority of clients entering this service will be admitted to a trauma centre because of the nature and severity of their injury.

Each regional trauma centre has an association with the public hospitals across the region. This following table shows the TBI Supplier, Trauma Centre and associated Te Whatu Ora District.***(Part A Clause 2)***

Table 1: Trauma Centres

Te Whatu Ora District	Trauma Centres	Supplier
Northland Waitemata Auckland Counties Manukau	**Auckland District** (Auckland Hosp) – Neurology **Counties Manukau District** (Middlemore Hospital) – Orthopaedic & plastic (burns)	ABI Rehabilitation - Ranui
Bay of Plenty Lakes Tairāwhiti Hawke's Bay	**Waikato District** (Waikato Hospital)	ABI Rehabilitation - Ranui - Wellington
Taranaki Whanganui Midcentral Wairarapa Capital, Coast Hutt Valley Nelson Marlborough	**Capital and Coast District** (Wellington Hospital)	ABI Rehabilitation - Wellington
Canterbury Westcoast	**Canterbury District**	Out of Zone ABI Rehabilitation - Ranui - Wellington Southern - Pauwai Unit
Southern	**Serious Trauma** is sent to Canterbury **Less serious trauma** stay Southern District	Southern - Pauwai Unit

The Supplier will provide the following level of support within a DHB in the following ways;

	Trauma Centres	Regional DHB
Client Identification *(Part B Clause 8.1.1.1)*	Assist acute staff with the identification of Traumatic Brain Injuries in inpatient ACC clients.	- Respond to DHB or ACC notification of a potential client.
Support *(Part B Clause 8.5.1.2)*	- Facilitate client and family decision-making regarding rehabilitation through education, information and emotional support. - Maintain a supportive relationship with the client, their family and whānau.	Once notified - Facilitate client and family decision-making regarding rehabilitation through education, information and emotional support. - Maintain a supportive relationship with the client, their family and whānau.
Knowledge, Information and Decision Making *(Part B Clause* *- 4.1.2* *- 6.5.2* *- 8.1.1.2)*	- Participate in regular reviews (ward rounds) with the medical team and provide a comprehensive assessment of the clients' readiness for rehabilitation, where appropriate. - At the DHB's request, provide rehabilitation advice to DHB staff for clients with mild to moderate TBI. - Provide effective and efficient transition planning that will ensure clients receive a seamless transition to TBI residential rehabilitation - Have a good knowledge of community supports available and have knowledge of the available ACC contracts so that informed recommendations can be made. - Provide advice on discharge options and post discharge rehabilitation needs for clients not requiring residential rehabilitation.	- Provide a comprehensive assessment of the client's readiness for rehabilitation. This assessment will be by o A review of clinical information currently available in DHB, and/or o A clinical case review with medical, nursing and allied health staff either face to face or via other means as appropriate, and/or o Physical hands on assessment with the client - At the DHB request, provide rehabilitation advice to DHB staff for clients with moderate TBI that are likely to transition to TBIRR. - Provide effective and efficient transition planning that will ensure a seamless transition to TBI residential rehabilitation. -
Relationships and Administration	- Establish and maintain good quality relationships with o DHB: trauma co-ordinators, trauma team, ED, ICU and ward staff o ACC. - Support a seamless transition from DHB to residential or community rehabilitation by promoting coordination between the acute setting, ACC and the rehabilitation facility. - Be responsible for ensuring the client transfers to the rehabilitation service in a timely and appropriate way as measured by AROC.	- Establish and maintain good quality relationships with o DHB: trauma co-ordinators, trauma team, ED, ICU and ward staff o ACC. - Support a seamless transition from DHB to residential or community rehabilitation by promoting coordination between the acute setting, ACC and the rehabilitation facility. - Be responsible for ensuring the client transfers to the rehabilitation service in a timely and appropriate way as measured by AROC.

	Trauma Centres	Regional DHB
	- Follow up with the acute service to ensure all ACC45 forms are submitted to ACC within the agreed timeframes and include the required clinical information to enable accurate and timely cover decisions. - Regular business reporting to DHB and ACC on the operation of the Transition Service	- Follow up with the acute service to ensure all ACC45 forms are submitted to ACC within the agreed timeframes and include the required clinical information to enable accurate and timely cover decisions. - Regular business reporting to DHB and ACC on the operation of the Transition Service

Entering Rehabilitation - Admission

The process for entering rehabilitation includes the client, their family and whānau, the Supplier and ACC. This map outlines the coordination, communication and process to be followed.

Process Map 1 - Admission

For clients progressing from hospital or referred from living in the community into residential rehabilitation (initial presentation or relapse).

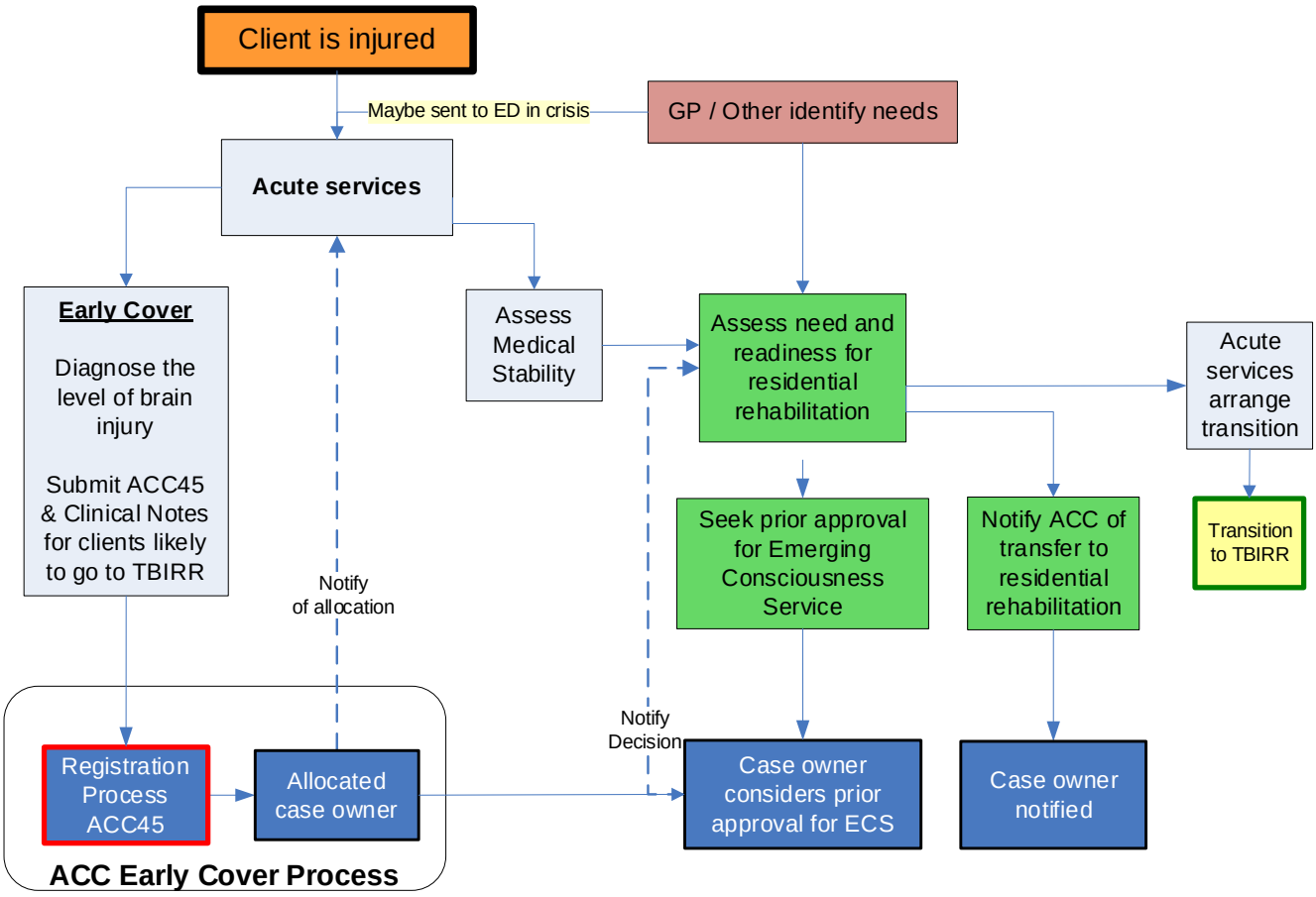


Table 2 – Admission Process

Step	Action
Client Injured	The initial TBI acute injury will require admission to hospital for acute management.
Hospital *(Part B Clause 4.1.2)*	The hospital will • Diagnose the client's injury and assess the severity based on GCS, PTA and other clinical assessments • provide treatment and rehabilitation care which may include emergency department and surgery, intensive / critical care, neurology and or orthopaedic wards.
Early Cover Process *(hospital)*	Submit ACC45 and clinical notes for clients likely to go to TBIRR

Step	Action
(ASG)	The acute service will • ensure the ACC45 is submitted promptly (within 3 days of admission) • email the clinical information to ACC to enable an early cover decision to minimise the delay in transfer notify the TBIRR Supplier of a likely admission Where a client is discharged home, the acute service should follow the usual discharge process.
Registration and Cover *(ACC)*	ACC receives the appropriate documentation and makes a cover decision. The claim is then sent to a case owner or team who will manage the claim.
Allocate case owner *(ACC)*	ACC may allocate a case owner (if required) who then makes contact with the hospital and the TBIRR Supplier to confirm the cover decision.
Assess Medically Stability *(Hospital)*	The hospital's medical specialist will assess the client's medical stability using the criteria in the service specification. Where the client is deemed medically stable the hospital will arrange for the assessment of readiness to rehabilitate with the TBIRR Supplier.
Community Admission *(GP, Supplier)*	clients who are in the community can be admitted to the TBIRR service where it has been identified that they need: • a period of residential stay to provide intensive rehabilitation to re-establish activities of daily living that will enable their return to the community, or • a comprehensive assessment programme, requiring the participation of the full interdisciplinary team, that is best undertaken in a stable environment The TBIRR service does not provide a crisis admission service as an alternative to mental health services. Clients may present to a hospital's acute service and the process is described in the Accident Services: A Guide for DHB and ACC Staff 2018 (ASG)
Assess need and readiness for residential rehabilitation *(Supplier)*	The TBIRR Supplier will assess the client to determine whether the admission criteria is met and that the client is ready for rehabilitation. For clients entering into the emerging consciousness service the client must be assessed by either the hospital or the TBIRR IDT using the Wessex Head Injury Matrix and/or the Coma Scale Revised (CSR) It is important that day rehabilitation Clients are assessed as safe to be discharged and that their post discharge supports are identified and are in place prior to discharge.
Seek prior approval For Emerging Consciousness Service	The Supplier will provide the appropriate referral to ACC seeking prior approval for clients entering the emerging consciousness service.

Step	Action
Notify ACC of Transfer	A client who meets the eligibility criteria can transfer to residential rehabilitation when appropriate. ACC should be notified by the supplier promptly. A specific report is not required.
Arrange Transition *(DHB)*	The DHB will organise the transfer of the client to the rehabilitation facility.

Notifications, Referrals, Approvals and Purchase Orders

There are only a few situations in which the supplier needs a purchase orders, but ACC must be kept informed.

Table 3 – Approvals and Purchase Orders

Service	Referral, Approval and Notification
Inpatient	
Residential Rehabilitation TRR06 Prior approval – No Notifying ACC - Yes Purchase order – No	No prior approval is required. A purchase order is not required. The client is transferred to rehabilitation once they meet <u>all</u> the eligibility criteria. If the client does not have cover for the brain injury, then they cannot transfer to this service. The Supplier is responsible for ensuring that ACC has been notified of the transfer within 24 hours. The notification can be made via email to the designated team/case owner. The Supplier will provide a full rehabilitation plan within 10 days of the client's admission. A maximum length of stay within the residential rehabilitation service is 180 days.
Residential Rehabilitation – Extension of time beyond 180 days for Residential Rehabilitation TRR06 Prior approval - Yes Purchase order - Yes	An extension of time for a period of up to two weeks may be requested on application to the case owner via email. The case owner will approve/decline the request based on the best interests of the client. Approval is required. A purchase order is required for extensions.
Emerging Consciousness TRE06 Prior approval - Yes Purchase order – No	A referral must be submitted to ACC on the ACC1151 form for prior approval. The appropriate clinical notes should be provided to support timely decision making. ACC will provide a decision within 2 days. The Supplier will provide a full rehabilitation plan within 10 days of the client's admission. Approval is required prior to the client's transfer from Emerging Consciousness to Rehabilitation. A purchase order is not required. A

Service	Referral, Approval and Notification
	maximum length of stay within the Emerging Consciousness service is 90 days.
Community Referrals Approval - Yes Purchase order – No *(Part B Clause 7.4)*	Where the client requires admission into residential rehabilitation from the community, the supplier must seek approval on the ACC1151 referral form and include the appropriate supporting documentation within 2 working days of the client's admission, ACC will provide a decision within 2 days. ACC may elect to provide services under other ACC contracts. In instances where the client has been referred from the community and is then subsequently declined by ACC, the client must be discharged from the TBIRR facility. Where the supplier has accepted the client in good faith using its experience of eligibility for this service, ACC will reimburse the bed nights from admission until the date the service was declined. Approval is required. A purchase order is not required.

Outpatient

Day Rehabilitation Prior approval - No Purchase order – No Extension Approval - Yes	No prior approval is required. A purchase order is not required. Entitlement to 14 days of rehabilitation is automatic if the client meets the admission criteria. Once cover has been given, the hospital and the supplier will notify ACC of the transfer within 24 hours. If an extension of time, beyond 14 days, is required, the Supplier must seek approval by submitting a rehabilitation plan within ten days of admission. A purchase order will be required if the Day Rehabilitation programme is longer than 14 days.
TRRT6 Travel costs Prior approval - No Purchase order – No	**Regular screen versus pre-assessment** **Screening** The supplier undertakes regularly screen to identify TBI clients in the trauma units listed earlier. The goal is to identify clients whose TBI might have been missed due to their other injuries. The cost of that regular attendance is normal business and included in the bed day rate. **Requested – Pre-admission Assessment** When the supplier is requested by the acute unit or GP in the community to assess a specific client who is further than 20 kilometres from their facility, they may seek reimbursement of their travel costs irrespective of the client being admitted to the TBIRR service. **Note: Most common journeys** • ABI Metcalf Road to Auckland Hospital = 19.6kms ✘ • ABI Metcalf Road to Middlemore Hospital = 32kms – 20kms ✓

	• ABI Metcalf Road to Waikato Hospital = 140kms – 20kms ✓ • ABI Hospital Road, Porirua to Wellington Hospital = 23kms = 20kms ✓ Travel costs do not cover the hourly rate of the clinician as this is included in the bed day rate. Payment is made on submission of an invoice.
Travel calculations	Distance will be calculated from the start point of the journey to the end destination, e.g, If the provider travels from their home to undertake a pre-admission of a client and returns to their home address, the kms travelled are from their home and return, **minus 20kms**. If the provider travels from the TBIRR facility to undertake a pre-admission of a client and returns to the TBIRR facility prior to returning home at the end of the day, the kms travelled are calculated from the TBIRR address and return to the TBIRR facility, **minus 20 kms.** **Air travel, parking, taxis and accommodation** Fair and reasonable costs associated with travel will be met (accommodation and parking etc) – excluding parking infringements etc. Costs should be divided by the number of clients seen during the pre-admission assessments, e.g., a flight to Te Whatu Ora: Canterbury District to see three clients, and one client in Waikato District on the same trip. The total flight costs are divided by four. This amount (equal portion) is invoiced against each client separately. Receipts should be held by the supplier and be able to be traced to an individual client claim number.

Forms

This service uses the following ACC forms. These forms request basic data which should be supplemented with additional information when appropriate. ACC requires up to date information to be able to make timely and accurate decisions that support the client.

ACC1151 Referral Form

This form is completed by the supplier to request prior approval to admit a minimally conscious client to the emerging consciousness service.

The clinical assessment of consciousness using the Wessex Head Injury Matrix (WHIM).

ACC7435 Provider Referral to Training for Independence

This form is used by the supplier to refer clients to Training for Independence programmes when the client is being discharged from the TBIRR facility. Prior approval is not required to refer clients to TI-TBI services.

ACC7422 Early Cover Form

This form is completed by the hospital to ensure a patient with a moderate to severe traumatic brain injury, spinal cord injury or multi-trauma has a cover decision early. The early cover decision is so that a recovery team member can be assigned to

- make contact with the family to provide any supports required
- contribute to discharge planning before the client's discharge from hospital.

Rehabilitation

Process Map 2 – Rehabilitation planning

For clients in residential rehabilitation including emerging consciousness and day rehabilitation

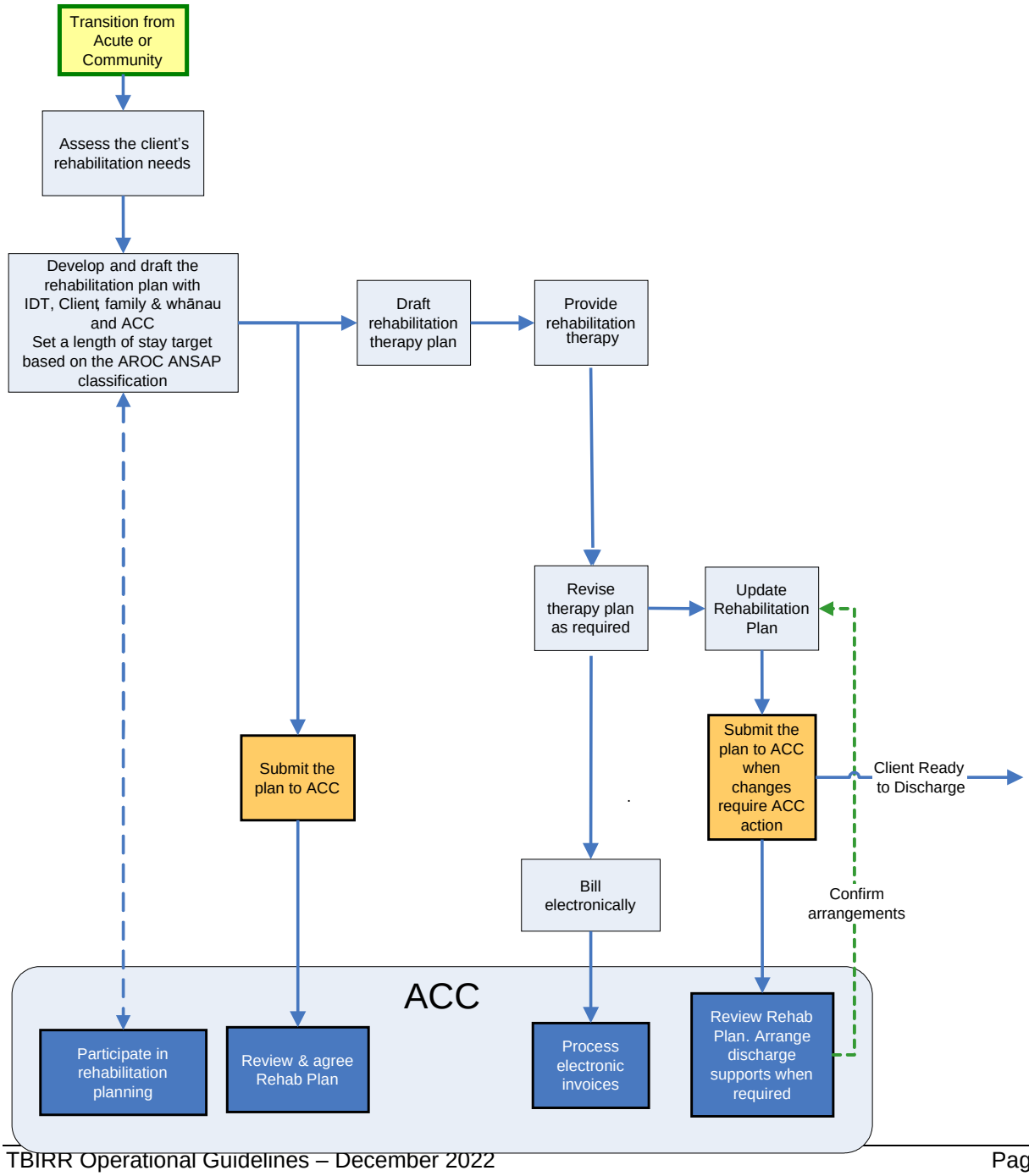


Table 5 – Process Table

The following is a description of process map 2.

Step	Action
Assess the client's needs	The TBIRR Supplier will undertake a full bio-psycho-social assessment of the client using the appropriate clinical tools to provide a comprehensive picture of the client's strengths, abilities and opportunities etc. The TBIRR supplier will work with the client, family/whānau to identify areas that are important to the person including cultural, religious/spiritual beliefs.
Develop and draft a rehabilitation plan ***(Part B Clause*** - ***8.3.1*** - ***8.9.1***	Based on the assessment of the client's needs the supplier will develop a rehabilitation plan with the interdisciplinary team, the family/whānau and ACC A comprehensive rehabilitation plan includes: • short, medium, and long term goals • therapy required to achieve those goals • discharge plan including expected discharge date, destination and supports required to achieve a safe discharge Note: The rehabilitation plan is written on a template provided by the Supplier.
Submit the Rehabilitation plan to ACC ***(Part B Clause 8.3.3)***	The rehabilitation plan should be submitted to ACC within 10 days of the client's admission.
Draft the therapy plan ***(Part B Clause 8.3.6)***	The therapy plan should link to the client's goals and outline the: • specific rehabilitation therapies the client will participate in including the different disciplines (Nursing, OT, PT, SLT, therapy assistant, etc) • amount of time the client will participate in therapy on a daily basis (7 day plan) • expected gain from those therapies
Provide rehabilitation therapies	The client's daily plan should reflect the rehabilitation and therapy plan and the therapies should be provided according. The therapies should be provided 7 days a week and the rehabilitation activities are varied to maintain and reflect the client's interest and capacity to participate.
Record all services provided	Client clinical notes including records of care, nursing and therapy, medical notes and all services delivered in the rehabilitation programme must be kept.
Update the therapy and rehabilitation plan	Based on the client's progress, the therapy and rehabilitation plans are refined and adapted to support the client's recovery.

Step	Action
Submit the up to date Rehabilitation plan to ACC	The updated rehabilitation plan should be submitted to ACC only when the goals have changed the client's ACC entitlements, services and supports e.g. • the discharge date has been amended • the client's discharge destination has changed • the client's needs on discharge have changed
Progressing to discharge	See the Transition discharge map

Service Expectations

Each of the three services are aimed at meeting the needs of different client groups. This requires slightly different programme responses. The following sections outline the different expectations.

Emerging Consciousness Service (ECS)

The ECS is for clients who are in a minimally conscious state but are not in a coma. The Supplier is expected to have expertise in this area and will ensure the ECS provides a comprehensive rehabilitation, nursing and medical service which is based on international best practice and which includes:

- Stabilising the basal functions such as
    - Nutrition
    - Skin integrity
    - Pulmonary function
    - Infection control
    - Weaning and removal of technical aids such as tracheal tube and catheters
- An environment with a structured daily rhythm and diverse activities which, when combined, leads to an everyday life pattern
- Active therapy involvement including diverse therapies including but not limited to physical and occupational therapies and if indicated speech therapy
- An individualised stimulation programme that provides the systematic presentation of diverse sensory and/or cognitive stimulation
- An inclusive family program that includes intensive social work and support of the direct relatives providing education, professional support during the grieving process, and guidance in the post treatment trajectory.
- Research and program evaluation.

Residential Rehabilitation

This service is for the majority of the moderate to severe TBI clients who require high intensity, high quality, comprehensive neurological rehabilitation, nursing and medical service in a specialist

residential facility. The service is not limited to the minimal expectation described in the service specification. Rehabilitation services are tailored to enable the client to achieve their goals in the most effective and efficient way. This includes working with the client to assist them to return to work, or work related activities (where the client was in employment pre-injury). While the supplier is not expected to provide extensive vocational rehabilitation services, the rehabilitation planning should include activities that contribute to the client returning to their pre-injury work activities to the maximum extent possible.

Day Rehabilitation

This service is for clients who would benefit from a residential rehabilitation service but may choose not to be resident in the rehabilitation facility. The rehabilitation programme is managed and delivered to the same expectation and standards as though the client is resident (see Residential Rehabilitation above).

Managing Rehabilitation

Planning and Implementation

The supplier's interdisciplinary team will meet regularly to assess, discuss and plan the client's rehabilitation programme. An identified problem list from which to formulate goals is helpful as this clearly identifies the client's impairments and fits with the ICF model of Physical Functioning. Best practice rehabilitation has:

- active management of the client's rehabilitation including the monitoring and adaption of therapy and rehabilitation provided
- a focus on high intensity therapy that maximises neuro-plasticity to achieve the best gains for the client.

Rehabilitation plan

The rehabilitation plan is a living document that represents the current plan for the client at the time of submission. There is no ACC specified template for the rehabilitation plan.

***Table 6** - The rehabilitation plan should include the following sections:*

Assessments *(Part B Clause 8.3.3)*	The appropriate clinical assessments that evidence the client's physical and cognitive function and support the client's need for specialist neurological rehabilitation.
Goals *(Part B Clause 8.3.4)*	Long, medium-, and short-term SMART rehabilitation goals ***S**pecific, **M**easurable, **A**chievable, **R**ealistic **T**ime framed and aspirational to maximise the client's motivation.*
Therapy Plan *(Part B Clause 8.3.6)*	Current therapy plan to achieve the client's goals outlining the specific therapy by type, intensity and the expected gains.
Discharge Plan *(Part B Clause 8.3.8)*	The discharge plan will grow more detailed and accurate as the client's rehabilitation progresses. The plan will include: - Date of discharge based on AROC benchmarking

	- client's place of discharge or transition
	- Potential supports required including any trials
	  o Care/Support
	  o Rehabilitation
	  o Community Assessments
	  o Equipment
	  o Access/Housing
	  o Transportation
	- Non-ACC supports such as
	  o Mental health services
	  o Chronic health services such as diabetes, cardiac etc
	  o Housing NZ
	  o Work and Income
	  o Any other agency required to ensure a durable discharge

Monitoring Rehabilitation Efficacy

The supplier is expected to undertake regular clinical assessments appropriate to the needs of the client to monitor the client's progress. Those assessments will assist in measuring the efficacy of the rehabilitation programme and will assist in the review and refinement of the client's therapy plan on an on-going basis. ***(Part B Clause 8.3.8)***

Clinical Measures

ACC requires specific measures to be completed to assist in the management of the client's case. The assessment tools available to the Suppliers should include but are not limited to the following list of routine clinical measures. ACC may request a copy of the full assessment.
(Part B Clause 8.3.9)

Table 7 – Routine Clinical Measures

Name	Description
Glasgow Coma Scale (GCS)	Measures the level of consciousness in the acute setting. Provides an indicator of severity but is a poor predictor of client outcome.
Wessex Head Injury Matrix (WHIM)	Provides accurate assessment of clients in (and emerging from) a coma and in the vegetative and minimally conscious states. The 62-item observational matrix can be used to assess the patient and set goals for rehabilitation from the outset of coma. Designed to pick up minute indices demonstrating recovery and provide objective evidence, the WHIM provides a sequential framework of tightly defined categories of observation covering: • Communication ability • Cognitive skills • Social interaction

Name	Description
	The matrix can be used to collect data by observation and by testing tasks used in everyday life.
Modified Oxford Post Traumatic Amnesia Scale (MOPTAS)	12 item test measuring: - orientation (8 items) - anterograde memory (4 items) Note: ACC TBI Guidelines suggest this measure has some qualitative advantages to the Westmead PTA
Westmead Post Traumatic Amnesia Scale (Westmead)	To measure the period of post-traumatic amnesia for patients with a closed head injury. - May be useful for people with a history of psychiatric illness, developmental or intellectual disability, substance abuse, previous head trauma or nervous system disease – but its usefulness for these groups remains undetermined. - Can be used with people with complex communication needs. - Not suitable for people with penetrating or missile head trauma, as well as the brain damage caused by hypoxia or stroke.
Galveston Orientation and Amnesia Test (GOAT)	Measures orientation to person, place, and time, and memory for events preceding and following the injury.
Functional Independence Measure (FIM)	Provides a uniform system of measurement for disability based on the International Classification of Impairment, Disabilities and Handicaps; measures the level of a patient's disability and indicates how much assistance is required for the individual to carry out activities of daily living. Contains 18 items composed of: • 13 motor tasks • 5 cognitive tasks (considered basic activities of daily living) Tasks are rated on a 7-point ordinal scale that ranges from total assistance (or complete dependence) to complete independence Scores range from 18 (lowest) to 126 (highest) indicating level of function Scores are generally rated at admission and discharge Dimensions assessed include: • Eating • Grooming • Bathing • Upper body dressing • Lower body dressing • Toileting • Bladder management • Bowel management • Bed to chair transfer • Toilet transfer • Shower transfer • Locomotion (ambulatory or wheelchair level) • Stairs • Cognitive comprehension • Expression • Social interaction • Problem solving • Memory

Table 8 – Optional Clinical Measures

Overt Behavioural Scale (OBS)	Measures verbal and physical aggression, sexually inappropriate behaviour, repetitive behaviour and degree of initiative and wandering and absconding.
Goal Attainment Scale (GAS)	Measures if and how well the goal was achieved.
Agitated Behaviour Scale (ABS)	Measures the nature and extent of agitation during the acute phase of recovery. It allows serial assessment of agitation by treatment professionals who want objective feedback about the course of a client's agitation.

Absences or interruptions to rehabilitation – Service Deferral

ACC must be kept updated and informed about the client's progress, including any changes to the client's whereabouts at all times. Any absence is considered an interruption to rehabilitation - this includes when the client has a planned or unplanned absence. The supplier must notify ACC either via email or via the ACC6232 form. ***(Part B Clause 8.6)***

Summary Table

When a client is absent from the facility, ACC will pay for each day of absence up to seven nights to retain a bed for a client, after which the client is considered discharged. The absence is defined as the client not being in their bed or in the facility at midnight.

Type of Absence	Specific Rate	Bed Retention Rate
Home Trial	Up to 3 nights – TRR11	Balance, up to 7 nights – TRR10
Significant complications (including return to acute services)	Up to 2 nights – TRR12	Balance, up to 7 nights – TRR10
Absent without leave (e.g. AWOL)	Up to 2 nights – TRR13	Balance, up to 7 nights – TRR10
Unable to participate	Usual day rate – TRR06	Not applicable
Short Notice/Planned Leave e.g. Family commitments	Not applicable	Up to 7 nights – TRR10
Did not attend Day Rehabilitation	No funding	No funding

Home Trials

The rehabilitation/discharge plan should identify any home trials required. Home trials should be planned, monitored, reviewed and should clearly outline the goals and objectives. Home trials must

be approved by ACC and the Supplier must advise ACC of the outcome of the home leave trial. This is to ensure that the case owner is kept up to date with the client's progress. A purchase Order is not required.

Weekend Leave

Planned absences e.g., to attend family commitments and regular weekend leave should be limited as TBIRR is a high intensity rehabilitation service that provides rehabilitation seven days a week. Regular weekend leave can slow the rehabilitation process.

Return to Acute services due to significant complications

Clients receiving TBIRR services may occasionally develop a complication or unrelated illness that requires readmission to a public hospital (e.g. pneumonia, pulmonary embolism, myocardial infarction, further emergency surgery, acute psychiatric illness). The Service Schedule categorises this as a "significant complication".

Notes:
A planned return to the acute hospital for surgery is being included in the definition of a 'significant complication'.

ACC does not fund acute treatment under this agreement. Funding will be provided either through Ministry of Health as acute treatment, or a public health acute service section 7 of the Injury Prevention and Rehabilitation Compensation Act.

When a significant complication requires readmission into a public hospital the supplier will:

- Arrange the transfer as clinically appropriate
- Notify ACC within two working days of the client's return to acute care to the ACC client service staff member

The supplier will notify ACC when the client is clinically stable and ready to resume rehabilitation.

The client may be absent for up to seven days before the supplier must discharge the client from the service. They may be re-admitted later but are considered to be a new admission not a continuation of the early admission.

Absent without leave

The supplier must have a policy in place for staff to follow which describes the process if a client is absent without leave, i.e., the client has left the facility without telling anyone (AWOL).

This will include:

- Initiating a search for the client
- Notifying family/whānau, ACC, and the appropriate authorities in a timely manner.

The supplier will keep ACC informed during the absence period.

If the client is considered to have self-discharged, the supplier will discharge the client from the service and send the discharge report to ACC.

The client may be absent for up to seven days before the supplier must discharge the client from the service.

Unable to participate

An interruption to rehabilitation is any situation in which the client is not actively participating in TBIRR funded rehabilitation, due to reasons such as: mental health symptoms, ill health, behavioural issues, for example. In all situations ACC must be informed of the interruption.

Notification of Unplanned Absences

ACC must be notified of all unplanned absences. The supplier should provide an updated rehabilitation plan outlining the impact of the absence on the client's rehabilitation programme and, if appropriate, what therapy will be provided to re-establish the client's rehabilitation programme.

Leaving Rehabilitation - Discharge

Discharge Planning

Discharge planning should commence on admission of the client into the service. The supplier will discuss potential outcomes and discharge options with the client, family/whānau and ACC. ***(Part B Clause 8.8)***

The supplier will work closely with the client, family/whānau and ACC to plan and coordinate the client's successful long-term transition from the TBIRR facility.

The client may be discharged when:

- ACC, in consultation with the Supplier, agree that the client no longer requires the service as a result of:
    - having achieved their rehabilitation goals/outcomes; and/or
    - progress can suitably be continued in another setting; and/or
    - the client has plateaued in their rehabilitation; or
- The client voluntarily exits the service; or
- The client has not regained consciousness after 90 days* at the facility; or
- An independent assessment obtained by ACC identifies that the client no longer needs the Services; or
- The client is discharged from the Service following an interruption to service provision; or
- The client dies

Self-Discharge

Where a client has indicated an intention to discharge, no bed retention nights are funded by ACC.

If the supplier is able to encourage the client to return within 24 hours of their departure the supplier may consider the client's stay uninterrupted. If the supplier is unable to return the client to the facility, then the last day funded is the night immediately following the last day the client was resident in the facility. ***(Part A Clause 3 Table 1 Note)***

Process Map 3 - Discharge

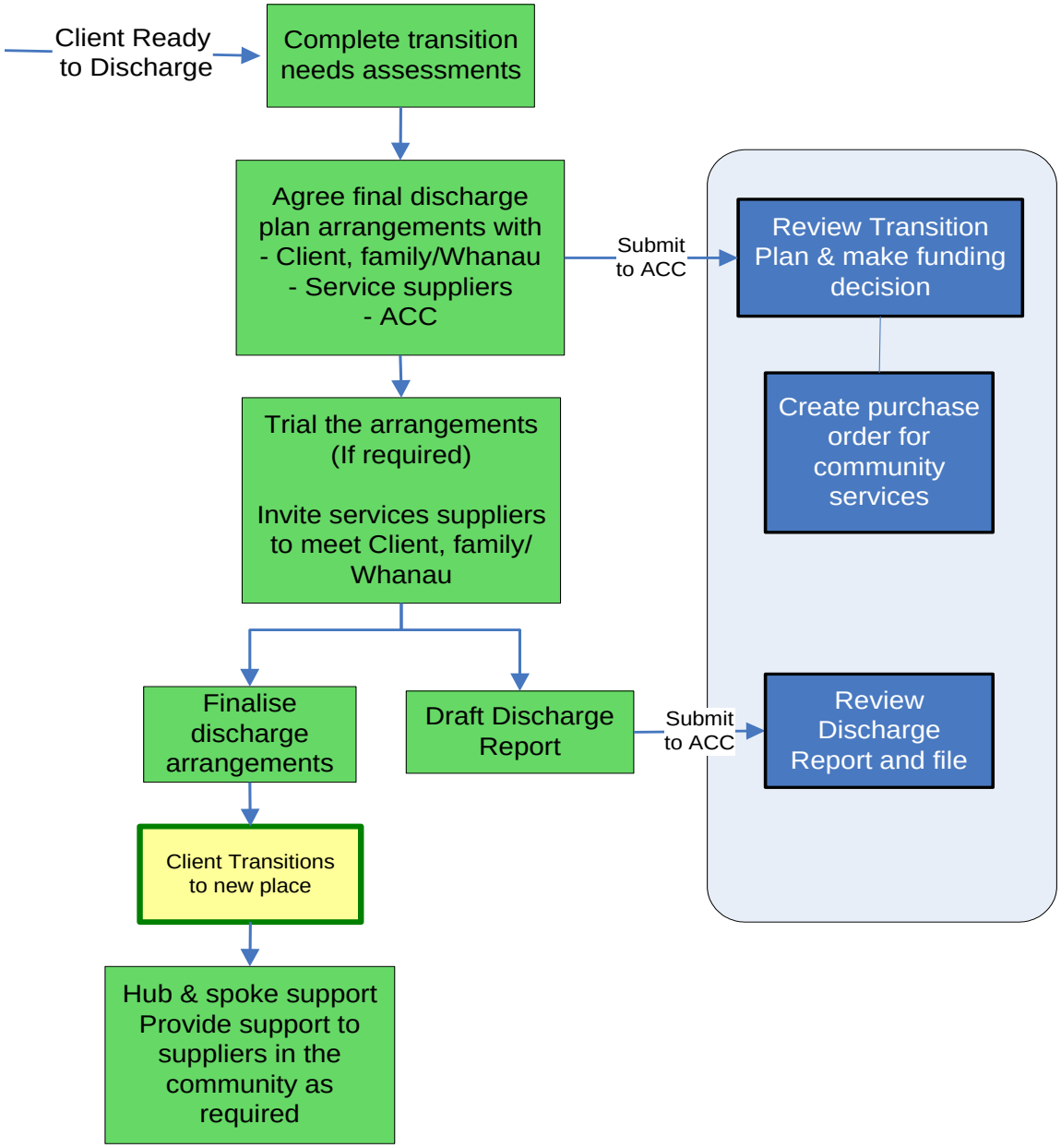


Table 10 – Discharge process

The following is a description of the previous process map. ***(Part B Clause 8.8)***

Step	Action
Complete transition needs assessment	The Supplier will determine the supports required to ensure a safe and enduring discharge by • Using the appropriate clinical assessment tools • Visiting the client's home where feasible The Supplier will work with community-based assessment services, (where these are in place) to ensure a coordinated discharge.
Agree final post discharge supports	The Supplier will work with the client, their family/whānau and with ACC to finalise the discharge plan. This should consider what supports may be required including but not limited to: - Natural supports - Equipment - Residential providers - Care providers in the home - Community rehabilitation providers - Social work - Support agencies etc Undertaking a trial of any of the above options should be considered. Initial and subsequent medical specialist follow up consultation, as clinically necessary.
Submit the finalised plan to ACC	The discharge plan will be submitted to ACC within the time fames outlined in the service specification to allow sufficient time for the arranging of the goods and services required. (The discharge plan is written using the Supplier's own template). ACC will consider the plan and approve as appropriate. ACC will arrange for needs assessments once the client is settled in their own home.
Trial arrangements	Once the discharge plan is approved by ACC, the TBIRR Supplier will liaise with the approved service Suppliers to ensure the transition is efficient, effective and seamless for the client, family/whānau. This may include planned visits by residential, care and community rehabilitation Suppliers prior to discharge. Any on-going rehabilitation plan should be discussed between the TBIRR Supplier, community services and ACC to ensure continuity of care. Where appropriate, the client may participate in trials to ensure the new arrangements meet their needs and to make refinements to the

Step	Action
	discharge plan. The trial/s will be approved by ACC prior to commencement.
Finalise discharge arrangements	The finalised discharge arrangements can be finalised by submitting the final discharge section of the rehabilitation plan. Once everyone is in agreement that the client is ready and the transition is in the client's best interests, the client will transition.
Submit Discharge Report *Part B Clause 8.8.6*	This discharge report summarises the client's - Rehabilitation programme - Gains made during the stay - Status at discharge - On-going issues that require management - Any referrals to other organisations - Supports which the case owner needs to be aware of
Hub and spoke support	The Supplier will provide two levels of support in the Hub and Spoke model. The Supplier will, during the discharge process, build the appropriate links with service providers in the community including allied health, GP, medical specialist or any other service provider the client may need. **Client level** – The Supplier will provide advice to community suppliers and family members providing care and support to the client for up to twelve hours over a period of up to six months, as the need arises. Interactions must be documented in the client records. The supplier invoices for this service using the service item code TRR20. **Centre of Excellence** – The supplier will provide rehabilitation advice and support on TBI to the sector. This means TBIRR suppliers provide advice and support to the sector about diagnosis and care of patients in the community with a TBI. For example, the TBIRR supplier provides advice and support to GPs about medication and treatment of depression related to TBI, or will make knowledge and advice available to a TI-TBI supplier about community rehabilitation.

Long Term Equipment

The Supplier will develop equipment solutions to support the client's discharge home by identifying any challenges, barriers and risks by:

- Visiting the client's home and other community locations such as employer
- Talking with the client's family/whānau
- Working with ACC and community assessors (where appropriate)
- Completing a full specialised assessment (where appropriately contracted) as requested. Only where the client lives within a reasonable distance.

ACC retains the right to select an appropriate assessor.

Supporting Transition

Where appropriate, the supplier should co-ordinate all supports which will be provided in the community to the client. The Supplier will invite the community providers to visit the client prior to discharge. This will allow the client and their family/whānau to build rapport with the people they will have close relationships with when they return home. It is important that where multiple supports will be required at discharge, that this information is shared with all providers so that the client does not have to tell their story multiple times.

The supplier will ensure all supports are listed on the discharge plan. The supplier will also ensure that all supports which require ACC approval have been approved (e.g. Integrated Home and Community Support Services, or TI TBI where approval is required). ***(Part B Clause 8.8)***

Supporting family and whānau

The very best client outcomes are achieved when the client is highly motivated and well supported. When the family/whānau are involved and committed to the rehabilitation programme the opportunity for achieving the best outcomes is greatly improved.

The supplier will ensure the client's family/ whānau:
- Understand their injured family member's brain injury and the opportunity for recovery.
- Have all the facts so they can make good decisions
- Are empowered to participate in the rehabilitation planning
- Are involved in discharge planning

Post Discharge Support Services

Clinical Advice

Once the client is discharged, a maximum of twelve (12) hours over six months are available to provide clinical advice and support to the community based TBI service suppliers as well as family members providing care and support to the client. The Supplier may choose whichever members of the IDT are appropriate to provide this advice and support, either allied health, nursing and/or medical advice.

Examples where the TRR20 service item may be utilised:
- To assess a client's medical status (eg in cases where a client is medically examined to determine if they are fit to travel in an aeroplane)
- Advice by TBIRR supplier to a GP re the care of a client and any follow up required
- Provision of health care advice (eg concerning use of equipment) to a family member who is caring for a client

Post Discharge Medical Specialist Follow-ups

The post-discharge medical specialist follow-up assessments are for clients who have discharged from the inpatient service with the supplier within the last 12 months.

The need for the client to have a follow-up has to have been identified during the discharge planning. The client meets one or more of the following criteria because they:

- have medical symptoms that need monitoring

- their living arrangements and/or discharge supports in the community were somewhat unstable
- need a review of medicines that maybe outside of the GPs scope

The follow-up assessment is not to provide the medical specialist with the assurance that everything is OK. The client must need the follow-up due to assessed and documented risk.

The service includes one initial consultation and one subsequent consultation where no purchase order is required. There is a further subsequent consultation available, which requires a purchase order from ACC. Any request for a purchase order must include an explanation of the risks to the client's wellbeing if the assessment is not done.

The timing of the assessments is at the supplier's clinical discretion, but generally the initial assessment would be completed within six to 12 weeks of the client's discharge from the supplier's residential facility. Any subsequent assessments would be completed up to 24 months after the client's discharge from the inpatient service.

If the client is readmitted to inpatient TBIRR rehabilitation:

- within 12 months after discharge, the post-discharge medical specialist follow-up entitlement remains the same.
- 12 months or more after their original discharge for further rehabilitation, **and** they stay longer than 14 days, the entitlement for post-discharge medical specialist follow-ups renews.

Note: Suppliers cannot request medical case reviews from ACC. They may identify, in a report to ACC, the client's risks and suggest a need for a medical case review. ACC may then choose to request the supplier's medical specialist to conduct a medical case review or to refer the client to another medical specialist.

Service Administration

Recording Keeping

(Part B Clause 14.3)

The Supplier will keep comprehensive records of all services provided to the client during their stay.

The data collected by the Supplier will be used in the

- Mapping of the rehabilitation journey by AN-SNAP (RCS modelling)
- Verifying treatment, rehabilitation and care provided
- Input of AROC data

Service Includes/Excludes

(Part B Clauses 8.5)

The Supplier is expected to have the appropriate resources to meet all the client's TBI injury assessment and rehabilitation needs.

The Supplier will provide:

- Consumables
- Equipment
- Other types of medical assessments and treatments
- Research participation

Consumables

All consumables that are required for the management of high needs client in a specialist facility including but not limited to:

Table 11 – Consumables

Category	Description
Fluids & irrigation products	Fluids, IV sets, needles and syringes, luers, sharps containers
Gloves and protective garments	Gloves, sterile gloves, aprons, bibs, gowns, masks
Incontinence	Pads, lubricants, nappies, urinal bottles, bowls, nappy wrappers, wipes, deodorants, non-prescription laxatives, glycerol suppositories, disposable and non-disposable underpads, uridomes, strips for uridomes, catheter change packs
Nutrition	Thickener and thickened fluids, nutritional supplements, fluids for enteral feeding, drinking straws (including one way), vitamin and mineral supplements, antacids
Skin care and dressings	Stockings, bandages, cotton wool, swabs, dry dressings, film dressings, tapes, skin cleaners, lotions, creams, antiseptics, wipes, eye pads, toothbrushes, mouthwash, mouth swabs, lip balm, sterile dressing change packs
Hearing	Standard hearing aid batteries
Rehabilitation	Ultrasound gel and electrodes, therapeutic putty, crutch tips, digi caps, digi sleeves
Other	Rubbish and waste bags, scissors, specimen containers, litmus paper, swab sticks, measuring containers, forceps
Enteral feeding	Feeding tubes, gastronomy products, bottles and containers
Ostomy	Pouches (closed and drainable), wafers and flanges, belts and support garments
Incontinence	Intermittent and indwelling catheters, drainage bags, connector and leg bag accessories, enemas, irrigation equipment, suspensory garments, stoppers and plugs, disposable and non-disposable briefs, swimmers, pull ups, fixation pants
Respiratory	Oxygen therapy tubing and masks, suction equipment, traches, trache accessories, filters
Specialist dressings and wound care	Hydrogel dressings, hydrofiber dressings, hydrocolloids dressings, alignates dressings, foam dressings, antimicrobial dressings.
Other	Haberman bottles, cast covers

Botulinum toxin for spasticity management may be invoiced separately using the code available in the TBIRR Service Schedule. Only the cost of the pharmaceutical is invoiced – not the time of the person administering the botulinum toxin nor costs of any consumables listed in Table 11.

Equipment

All equipment that is required for the management of high needs client in a specialist facility including but not limited to:

Table 12 – Equipment

Category	Description (included but not limited to)
Bed	Bed specific to the client's needs Pressure management
Care aids	Shower beds, lifting equipment (hoists, slings etc)
Physical Rehabilitation	Wheelchairs, walking frames, walking sticks etc Gym and therapy equipment such as treadmills, ceiling hoists, etc
Cognitive Rehabilitation	Computers, adapted computers and educational equipment
Activity Equipment	Game machines, board games, music stereo etc and other participation equipment as appropriate.

Other Types of Medical Assessments and Treatments

The supplier will fund the provision of all medical assessments and treatments that relate to the client's TBI.

The supplier is not responsible for funding separate (non-supplier provided) assessments and treatments that may be required for a client's non-TBI related injuries such as fractures, spinal, internal organs etc.

The Supplier can request that the service be purchased from the client's recovery team member with the accompanying rationale and clinical information.

Research Participation

The supplier will participate in any ACC initiated research into any component of the TBIRR service.

Pricing During the first year and periodically thereafter, the supplier will participate in service input information to assist in the costing of the service.

Clinical Suppliers are encouraged to develop research programmes within their clinical area. This research may be within their own organisation or across all three Suppliers. ACC will provide data within the constraints of client privacy and subject to the appropriate ethical approvals.

Quality Management

Service Monitoring

(Part B Clauses 13 and 14)

This service will be monitored according to performance measurements outlined in the service specification. The supplier is responsible for reporting on all required measures.

Table 13 – Service monitoring

Check	Goal, Risk and Action
Client records	Clinical notes reflect all treatment, care and rehabilitation services provided to the client and provide evidence of involvement of family and liaison with community service providers and agencies.
Reporting and submission timeliness	All reports and plans are sent to ACC within the timeframes specified in the services schedule. If there is a delay in meeting the timeframes, the supplier will email the case owner and advise them of the delay.
Rehabilitation review and refinement	Client's clinical notes are reviewed regularly to identify - timeliness of client records - the frequency of updating the rehabilitation plan - ensure functional assessments are current - where the plans changed, was there any impact on the client's discharge and needs? And was ACC informed promptly? - involvement of family/whānau and other support services and agencies - discharge planning is underway and is appropriate to the client's needs

Audits

(Part B Clause 14.3.2)

From time to time, ACC may audit suppliers' client records and other documents related to the delivery of this service, to confirm that the services delivered are appropriate. ACC will expect robust evidence of all services delivered including (but not limited to) personal cares, nursing, therapy and medical services.

Suppliers must notify the Engagement and Performance Manager of the outcome of any certification audits, including any corrective actions and the outcome of those actions, during the life of the contract. *(Part B Clause 14.2 Table 6)*

Australasian Rehabilitation Outcomes Centre (AROC)

(Part B Clause 9.2.1.2)

The Australasian Rehabilitation Outcomes Centre AROC is a joint initiative of the Australian and New Zealand rehabilitation sector (providers, funders, regulators and consumers).

The purpose and aims of AROC are:

- Develop a national benchmarking system to improve clinical rehabilitation outcomes in both the public and private sectors.
- Produce information on the efficacy of interventions through the systematic collection of outcomes information in both the inpatient and ambulatory settings.
- Develop clinical and management information reports based on functional outcomes, impairment groupings and other relevant variables that meet the needs of providers, payers, consumers, the States/Commonwealth and other stakeholders in both the public and private rehabilitation sectors.
- Provide and coordinate on-going education, training and certification in the use of the FIM and other outcome measures.
- Provide annual reports that summarise the Australasian data.
- Develop research proposals to refine the selected outcome measures over time.

The supplier will collect and submit client level episode data as outlined by AROC.

Quality Forums

(Part B Clause 9.5)

The goal of quality forums is to promote and encourage a philosophy of continuous improvement in clinical practice and service provision.

All TBIRR suppliers will attend a quality forum held every six months. The meeting will focus on:

- Outcome results provided by AROC
- Bench marking results to replicate top performance
- Planned quality improvement initiatives undertaken by the suppliers
- Any challenges, lesson or improvements made

The quality forums will be hosted on a rota system with each supplier and ACC having an opportunity to host.

Customer satisfaction survey

(Part B Clause 9.7)

The supplier works with many stakeholders. As part of a continuous improvement process the supplier will, where appropriate, survey those stakeholders to gain insight into where improvements can be made. The surveys can be found:

- Client, Family/Whānau Satisfaction Survey
- ACC Case Owner Satisfaction Survey
- Residential and Community Provider Satisfaction Survey

The results will be reported to ACC annually via the annual report.

Reporting

(Part B Clause 14.2)

The supplier will provide the following reporting to ACC:

- Annual Report
- AROC

- Certification Audits
- Exceptions

Table 14 – Reporting

Report	Information required	How reported	Frequency
Annual Report	Number of clients who received service	Number	Annually, within one month of the end of the financial year (30 June)
	Age, gender, ethnicity	Percentage	
	Average length of stay	Number	
	Referral origin	Percentage	
	Transition, in reach, out reach (break down of numbers of clients who transitioned into TBIRR from acute care, numbers of clients referred from the community, number of clients attending the day programme only, and number of clients assessed in the community)	Number	
	Highlights and achievements for past year	Description	
	Cultural capability	Description	
	Health and Safety issues	Description eg: Outline of any H&S issues that may have occurred during the year, including a description of the process taken to resolve those issues. These issues may include: • Sentinel events such as a serious injury or death • Communication or access issues	
	Workforce development	Description	

	Service Satisfaction Surveys (Client and Family/Whānau, public hospital, ACC, Residential/Community Provider)	Summary of results for each target group surveyed • Client, family and whānau • Public Hospitcal • ACC Client Services staff • Residential Support Services and Community Suppliers The information provided will include: • The number of surveys issued • The response rate • Percentage of satisfaction of responders • Very Satisfied • Satisfied • Dissatisfied • Very dissatisfied	
	Quality improvement initiatives	Summary An outline of any short, medium and long term actions planned as part of a • response to the satisfaction survey results; and • continuous improvement processes	
	Research	Summary	
AROC	AROC data for each client	Entered into AROC database	At client discharge

Certification audits	Outcome of any certification audits, including any corrective actions and the outcome of those actions, during the life of the contract.	Suppliers to notify Engagement and Performance Manager	Following completion of audit
Reporting by Exception	It is expected that the Supplier and case owner will work closely together to keep each other informed of the client's progress against the agreed goals. Once there is an agreed rehabilitation plan in place the Supplier is expected to report when there is an exception to the rehabilitation plan. ***(Part B Clauses 8.3.7, 8.3.8)***	To ACC via telephone or email	As occurs

Appendix A – Satisfaction Surveys

Client, Family/Whānau Satisfaction Survey

What is this survey about?

Recently you or your family member left rehabilitation with [*Supplier Name*] in [*region*]. This survey to get your feedback on the service received. Your opinion is important to us.

		Please circle your answers:			
		Very Dissatisfied	Dissatisfied	Satisfied	Very Satisfied
1.	With regards to discharge planning: How satisfied are you that we involved you in the discharge planning process?	1	2	3	4
2.	With regards to brain injury education: How satisfied are you that we provided you with enough knowledge about	1	2	3	4
	Your (or your family members) brain injury	1	2	3	4
	The impact of brain injuries in general	1	2	3	4
	The rehabilitation journey	1	2	3	4
3.	With regards to communication from our staff: • How satisfied are you that you were kept well informed throughout you or your family member's rehabilitation?	1	2	3	4
	• How satisfied are you that you were you satisfied that you understood what you were being told by our staff?	1	2	3	4
4.	With regards to your involvement: How satisfied were you with the level of involvement you had in your family member's rehabilitation?	1	2	3	4
5.	With regards to your overall satisfaction: How satisfied were you with the service we provided?	1	2	3	4
Do you have any comments or suggestions for areas of improvement?					

Public Hospital Satisfaction Survey

What is this survey about?
ACC's TBI Residential Rehabilitation has two contracted suppliers who provide a national rehabilitation service for clients with moderate to severe TBI. The service is early intervention, high intensity and highly specialised.

The purpose of this survey is to give you an opportunity to provide feedback on our TBI Rehabilitation pre-admission service. Results of this feedback help to guide our quality processes.

Please rate your satisfaction with the preadmission service you received as part of the Traumatic Brain Injury Residential Rehabilitation (TBIRR) ACC Service.	Please circle your answers:			
	Very Dissatisfied	Dissatisfied	Satisfied	Very Satisfied
1. Regarding patient screening: How satisfied are you with the assistance we provide in screening patients with moderate to severe traumatic brain injury?	1	2	3	4
2. Regarding referral response time: How satisfied are you with the time it takes for us to respond to a referral?	1	2	3	4
3. Regarding patient transfers: How satisfied are you with the way we facilitated your patients transfer to residential rehabilitation?				
– Planning of the transfer	1	2	3	4
– Timeliness of the information	1	2	3	4
– Content and accuracy of the information	1	2	3	4
4. Regarding patient centred focus: How satisfied are you that our service is patient centred?	1	2	3	4
5. Regarding your overall satisfaction: How satisfied are you with the overall service we provide?	1	2	3	4
Do you have any comments or suggestions for areas of improvement?				

ACC recovery team member Satisfaction Survey

Recently a case you managed entered the TBI Residential Rehabilitation provided by [*Supplier Name*] in [*region*]. To continuously improve our service, we would like your feedback on the service you received		Please circle your answers:			
		Very Dissatisfied	Dissatisfied	Satisfied	Very Satisfied
1.	Regarding family/whānau meetings: On a scale from 1 to 4 (1 being very dissatisfied and 4 being very satisfied), how satisfied were you with the amount of notice you were given for participation in the client,family/whānau meetings?	1	2	3	4
2.	On a scale from 1 to 4 (1 being very dissatisfied and 4 being very satisfied), how satisfied were you with the options available for participating in the client, family/whānau meetings (e.g. in person, telephone, video link)?	1	2	3	4
3.	Regarding the rehabilitation plan: On a scale from 1 to 4 (1 being very dissatisfied and 4 being very satisfied), how satisfied were you that the rehabilitation plan clearly outlined the steps that needed to be taken to achieve the proposed outcomes?	1	2	3	4
4.	Now, regarding progress updates: On a scale from 1 to 4 (1 being very dissatisfied and 4 being very satisfied), how satisfied were you with the amount of information we provided on your client's progress?	1	2	3	4
5.	Regarding the discharge process: On a scale from 1 to 4 (1 being very dissatisfied and 4 being very satisfied), how satisfied were you that our discharge process identified the supports required for transfer to the community?	1	2	3	4
6.	Regarding communication: On a scale from 1 to 4 (1 being very dissatisfied and 4 being very satisfied) how satisfied are you with the communication you receive from us in terms of: Frequency	1	2	3	4
	Content	1	2	3	4
	Method (e.g. email, phone)	1	2	3	4
7.	Regarding decision making:	1	2	3	4

	On a scale from 1 to 4 (1 being very dissatisfied and 4 being very satisfied) how satisfied were you that you were included in the decisions that were made with the client?				
8.	Regarding your overall relationship with us: On a scale from 1 to 4 (1 being very dissatisfied and 4 being very satisfied) how satisfied are you with the relationship you have with us?	1	2	3	4
	We would be interested in any other comments you would like to make, ie anything that might improve our service. Please comment here:				

Residential and Community Provider Satisfaction Survey

Context: ACC's TBI Residential Rehabilitation has 3 contracted Suppliers who provide a national rehabilitation service for clients with moderate to severe TBI. The service is early intervention, high intensity and highly specialized. This survey is to gain feedback from Suppliers who receive clients from these contracted Suppliers and is part of the continuous improvement of the service.

Recently a client was referred to you by [*Supplier Name*] in [*region*]. To continuously improve our service, we would like your feedback on the service you received during the transition of clients into your service:	Please circle your answers:			
	Very Dissatisfied	Dissatisfied	Satisfied	Very Satisfied
1. Regarding discharge planning: How satisfied were you with the level of involvement you had in the lead up to the patient's discharge?	1	2	3	4
2. Regarding the information we provided: How satisfied were you that you received the information you needed prior to discharge?	1	2	3	4
3. Regarding the quality of the information we provided: How satisfied were you with the quality of information that we provided?	1	2	3	4
4. Regarding follow up support: How satisfied are you with the post discharge support we provided?	1	2	3	4
5. Regarding your overall satisfaction: How satisfied are you with the overall service we provided?	1	2	3	4
Please comment here if you have any suggestions for areas of improvement:				

Appendix B – Provider Qualifications

Service Provider	Qualification and Registration	Experience
Rehabilitation / Medical Specialist (Programme Leader)	Must have current vocational registration in any of the following: - Rehabilitation Medicine - Neurology - Internal Medicine with a special interest in traumatic brain injury	Must have a minimum of three years' full time equivalent experience post vocational qualification in acquired or traumatic brain injury management
Clinical Neuropsychologist	Must have completed a university based graduate or postgraduate course in Clinical Neuropsychology Must be a registered Psychologist in New Zealand with a Clinical Scope of Practice and a current Annual Practicing Certificate with the New Zealand Psychologist Board. Must be a current member of at least one of the following: - New Zealand Psychological Society; or, - NZ College of Clinical Psychologists; or, - An International Neuropsychological Society acceptable to ACC	Must have a minimum of two years' full time post qualification experience in supervised neuropsychological assessments and rehabilitation. Must be able to demonstrate knowledge of, and competency to use and interpret, neuropsychological tests to assess executive, attention, memory, language and spatial functioning and have an appropriate knowledge of the relevant neurophysiology and issues involved in neuropsychological assessment Must have arrangements in place for ongoing supervision with an appropriately qualified and experienced supervisor. Interns and those under provisional status must meet the criteria set by ACC and be approved by ACC.
Psychologists	Must be a registered Psychologist in New Zealand and a current Annual Practicing Certificate with the New Zealand Psychologist Board.	Must have a minimum of two years' full time post registration qualification experience in acquired or traumatic brain injury rehabilitation.

Service Provider	Qualification and Registration	Experience
	Must be a current member of at least one of the following: - New Zealand Psychological Society; or, - NZ College of Clinical Psychologists.	Interns and those under provisional status must meet the criteria set by ACC and be approved by ACC. Psychology intern approval form
Registered nurses Nurse specialists Occupational therapists Physiotherapists Speech-language therapists Social workers Dietitian	Must have current registration with the relevant professional body and a current Annual Practicing Certificate, where appropriate.	Must have: - A minimum of two years' full time post qualification experience in acquired or traumatic brain injury rehabilitation; or, - Training and supervision in brain injury until the provider has gained two years' experience. The supervisor must be a suitably qualified health professional with a minimum of five years' experience in acquired or traumatic brain injury. - Allied Health interns must be under the direct supervision of the relevant fully qualified IDT member. ACC approval is not required for Allied Health interns.
Key Worker	Must have current registration with the relevant professional body and a current Annual Practicing Certificate, where appropriate.	The key worker role may be fulfilled by any of the above listed health professionals who are experienced in communication and coordination with: - the interdisciplinary team - the client, family and whānau - other providers and suppliers - ACC - the client's employer, - the client's General Practitioner - any other party necessary to the rehabilitation of the client

Service Provider	Qualification and Registration	Experience
		Must have a minimum of two years' experience in providing similar co-ordination and key worker role in a health setting.
Care, Rehabilitation or Therapy Assistant	Have or be working towards NZ Certificate in Health and Wellbeing (Rehabilitation Assistance)	Experience in residential brain injury rehabilitation providing similar services or is in training under the guidance of suitably qualified staff.

Version Log

Version 2 - April 2021		
Reference	Change	Amended wording
TRRT6 Travel	Travel costs to undertake pre assessment of a client	ACC will fund travel costs for preassessment of a client who is 20kms or more from the nearest TBIRR facility irrespective of the client being admitted to the TBIRR service.
Table 1	Laura Fergusson Trust removed	No longer provides TBIRR services
Table 14	Clarification of reporting	Definition of "Transition, In Reach, Out Reach"
Table 4 and Service Item Consumables	Botulinum Toxin for Spasticity Management	Clarification that only Botulinum Toxin may be invoiced using the code available in the Service Schedule
Version 3 – December 2022		
Absences	More absences are being funded at the standard day rate.	Clarified the differing situations of absences or non-participation.
Post Discharge Medical Specialist Follow-ups	Added in a new post-discharge follow-up service. Transferring the service delivery from the Clinical Services contract using the same framework and rates.	New