Non-Acute Rehabilitation Pathways Service

Operational Guidelines

A variation of the Non-Acute Rehabilitation Service

This document is a living document and will be reviewed and updated as necessary.

Version update November 2023

Useful contacts and telephone numbers

Delivering Non-Acute Rehabilitation Pathways (NARP) on ACC's behalf is likely to involve you contacting a number of our teams. Here are their contact details:

Table 1: ACC contact details

ACC Provider Helpline	Ph: 0800 222 070	Email: Providerhelp@acc.co.nz
ACC Client/Patient Helpline	Ph: 0800 101 996	
Provider Registration	Ph: 04 560 5211	Email: registrations@acc.co.nz
	Fax: 04 560 5213	Post: ACC, PO Box 30 823, Lower Hutt 5040
ACC eBusiness	Ph: 0800 222 994, Option 1	Email: 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: Email: health.procurement@acc.co.nz Ph: 0800 400 503	
Engagement and Performance Managers	Engagement and Performance Managers can help you to provide the services outlined in your contract. Contact the Provider Helpline or acc.co.nz /for Providers for details of the Engagement and Performance Manager in your region.	
ACC Portfolio	Contact the Provider Helpline for details of the Advisor/Manager for Non-Acute Rehabilitation Services or email NARP@acc.co.nz	

The ACC website can provide you with a lot of information, especially our "for Providers" section. Please visit www.acc.co.nz

For Non-Acute Rehabilitation specific information click here

Contents

How to read this guide

The following documents may be helpful when reading this operational guide.

- ACC's Standard Terms and Conditions; and
- Non-Acute Rehabilitation Pathways Service Specification

This guide supports the Non-Acute Rehabilitation Pathways (NARP) Service schedule. If there are any inconsistencies between these operational guidelines and the service specification, the contract takes precedence.

ACC will work collaboratively with Suppliers to support the intended outcomes and to improve the operation of the service. We will keep this guide up to date with any improvements or refinements made.

About the Contract

Non-Acute Rehabilitation Pathways (NARP) is a Casemix funded model of services.

Non-Acute Rehabilitation Pathway (NARP) service funding is case-weighted packages.

These Operational Guidelines are for the NARP service schedule only.

Note: Where words are capitalised within a sentence the term has been defined in the Glossary.

Purpose

(Refer to Part B, Clause 1 of Service Schedule)

This guide provides information for hospital service managers and clinicians. It elaborates on clauses in the NARP Service Schedule.

The NARP service spans the patient journey, including inpatient and community services, transitional care and rehabilitation admission avoidance pathways. It supports best practice rehabilitation by acknowledging that rehabilitation in an inpatient setting is not always the best option for clients and by providing the opportunity for delivery of innovative rehabilitation within the community setting.

The NARP service is available to all injured Clients, without age restriction, where they meet the criteria to receive ACC funding for hospital provided rehabilitation and care. Flexibility of service delivery is one of the strengths of the NARP service model. NARP services enable hospitals to manage the Client's rehabilitation across the hospital-community continuum, so long as the Client is actively participating in rehabilitation. The delivery of NARP services is to be guided by the interdisciplinary team with the rehabilitation plan established by a registered health professional.

In the community setting, the NARP framework enables support workers/healthcare assistants/allied heath assistants to provide rehabilitation for NARP clients under the oversight of registered health professionals.

Under the NARP service contract, hospitals are responsible for the continuum of care across inpatient and community settings.

The purpose of the NARP Service is to return ACC Clients of all ages to their pre-injury function or maximum independence by providing inpatient and community-based rehabilitation and support.

Service funding and pricing

(Refer to Part A, Clause 4 of Service Schedule)

Entitlement to ACC Funding

The Supplier will:

- Liaise closely with their Emergency Department and Acute wards to identify Clients that would require inpatient, community rehabilitation or transitional care when the medical or surgical treatment is complete. The Client is ready (well enough) to participate, whether that be in the inpatient, community or transitional care setting.
- Determine if the eligibility criteria have been met.
- Ensure the Client has ACC claim cover before starting ACC funded services.
- Ensure that completion of the interRAI assessments happen only with staff trained and qualified to do so.
- Ensure that the eligibility assessment is reviewed by a Registrar or Consultant who is trained to assess the Client for admission to this Service.

Responsibilities

This section summarises the responsibilities ACC and the supplier have within this funding model.

The **Supplier** is responsible to ACC for:

- Accurate profiling of clients
- Completing the data collection accurately
- Participating in eligibility reviews when required
- Submitting admission and discharge data every month
- Participating in the governance of the service, when invited
- Maintaining a positive relationship based on;
    - Mutual respect
    - Meet all cultural safety practices and guidance, and where applicable, comply with ACC's cultural Safety expectations. See link
    - Open and transparent communication
- Ensuring they operate a robust business model focused on improving outcomes for clients and reducing operating costs by continually refining and improving services

ACC is responsible to the Supplier for:

- Analysing the data submitted in a transparent and open way
- Undertaking all required analysis when planned
- Periodically reviewing the case-weights
- Participating in the governance of the service which includes;

    - Collaboration
- Maintaining a positive relationship based on;
    - Mutual respect
    - Open and transparent communication
    - Being open to the trialling of new services
    - Paying invoices in a timely fashion

Case-weight funding

The case-weight funding aligns with the case-weight coding within the service schedule (Part A).

The NARP casemix model provides clinically meaningful descriptions of individuals and enables allocation into clinically similar groups. This provides a framework to enable flexibility of service delivery while minimising unwanted variation of administrative processes. 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.

Case-weight rates are the payment for claims accessing a pathway after the profile tool is administered by a health professional. Each client will have different rehabilitation needs. The case-weight rate is based on the average level of resource required across claims with that level of complexity.

The Casemix model is designed to accommodate for these individual differences by addressing the wider group as a whole.

Management of the Casemix Model

The management of the NARP Casemix funding model and contract is a shared responsibility between the Te Whatu Ora District Providers with the NARP contact and ACC.

It will include the following functions:

- Funding reviews
- Data monitoring
- Governance
- Annual Forums

Te Whatu Ora District Providers and ACC will work in collaboration to monitor the service and provide advice on refinements to the casemix model.

Data monitoring will review the case-weight pricing and distribution trends compared to the National averages. ACC Portfolio team will discuss any price variance with Te Whatu Ora District Providers when it is required.

An annual quality forum will be held with all Te Whatu Ora District Providers and ACC to report on NARP Rehabilitation data and outcomes and share quality improvement initiatives.

ACC will liaise with Te Whatu Ora District Providers to establish the most appropriate way in which for these discussions to occur moving forward.

NARP Forums will change as all hospitals transition to the NARP contract and Te Whatu Ora will be notified of these once finalised.

Monthly Invoicing

The supplier will invoice ACC at least monthly on discharge from each NARP pathway. This will be sent to ACC using Send Invoice or API portal.

Admission and discharge dates from the pathways are required for billing.

Table 1: NARP Invoicing

Invoice for	Method	Frequency	Due Date
Client Case-weight coding	Send Invoice or API	On discharge	at least monthly
Treatment Injury service item code	Send Invoice or API	As required	N/A
Exceptional Travel service item code	Send Invoice or API	As required	N/A
Inpatient exceptional length of stay	Send Invoice or API	As required	N/A

Note: Treatment Injury and Exceptional Length of Stay require prior approval and need to be invoiced against a purchase order

Service Location

(Refer to Part A, Clause 2 of Service Schedule)

The service can be delivered in the following locations identified in Table . The intent is that where a Client receives their rehabilitation, is determined by the individual needs of the Client, in a safe environment where they can **actively participate** in rehabilitation.

Table 2: NARP Service Location

	Supplier Facility/ satellite hospital	Client's home or family residence	Residential Facility /Satellite hospital
Rehabilitation Admission Avoidance		✓	✓
Transitional Care	✓		✓
Inpatient Rehabilitation	✓		✓
Community Rehabilitation		✓	✓

The Supplier must provide Community Rehabilitation across 90% of their geographical region.

Service Outcomes

(Refer to Part B, Clause 2 of Service Schedule)

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

- The reduction in Length of Stay within an inpatient pathway
- The Client ultimately returns to their pre-injury place of residence wherever possible; and
- The Client is satisfied with the services.

Service Eligibility

(Refer to Part B, Clause 5 of Service Schedule)

Eligibility Criteria

Following an acute presentation, the Client is assessed by a clinician for eligibility for ACC NARP services using the NARP Eligibility Tool (Figure 1). A client is eligible for NARP services if they:

Have sustained an injury that has been accepted for cover by ACC; and

Require rehabilitation that would traditionally require hospital inpatient rehabilitation primarily for that covered injury;

- While the Client may have accepted cover for an injury, that injury must be the predominant reason for the rehabilitation.

Is ready for rehabilitation;

- The Client's overall health and function is good enough that the Client can participate.
- Any medical treatment does not interfere with the Client's active participation.

Is capable and willing to actively participate in rehabilitation;

The Client is:

- **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're not just receiving rehabilitation therapy passively. They're consciously taking part in rehabilitation activities and therapies
    - A Client can actively participate while non weight bearing 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, can't or are unwilling to take direction, aren't in a rehabilitation programme as defined in this guide, so are not funded under this service.

Note: Unwillingness would not be the sole reason for ACC not funding as Providers are experienced at successfully encouraging Clients to actively engage.

Have achievable rehabilitation goals that will improve their functional independence.

- The main goal of the rehabilitation is to return the Client to their pre-injury function.
- An achievable rehabilitation goal is where it's reasonable to expect (based on the Client's overall presentation) that the Client's physical and cognitive function and their participation in the activities of daily living can be improved with the delivery of rehabilitation therapies. The goals are to be client centred and developed in discussion with the client.

Determining who pays for rehabilitation is complex and requires further consideration over "Does the Client need rehabilitation?" The clinician is required to determine if the rehabilitation need is primarily injury related or health related by completing a comprehensive assessment. As there are no shared funding arrangements for NARP, the test is that ***'in the main'*** the rehabilitation is needed for a covered injury and NOT a health or age-related need.

NARP eligibility critera is not met

If the primary cause of the need is determined to be the health condition/s the rehabilitation and support services are covered by Ministry of Health funding. For example: A client fainted at home which was recorded as a fall. The client's fainting episode was health related and no physical injury requiring rehabilitation was diagnosed. Therefore, this admission should not be under ACC funding and the client's needs should be met through Ministry of Health funding.

If incorrect funding decisions are made, ACC can and will seek to recover the funding on a case-by-case basis. Should there be ongoing entitlement errors, ACC will work with the Supplier to determine an appropriate solution.

Note: If clarification is required from ACC please contact ACC via claims@acc.co.nz or phone 0800 101 996.

Clinicians should use the diagram below to assess eligibility for ACC NARP services.

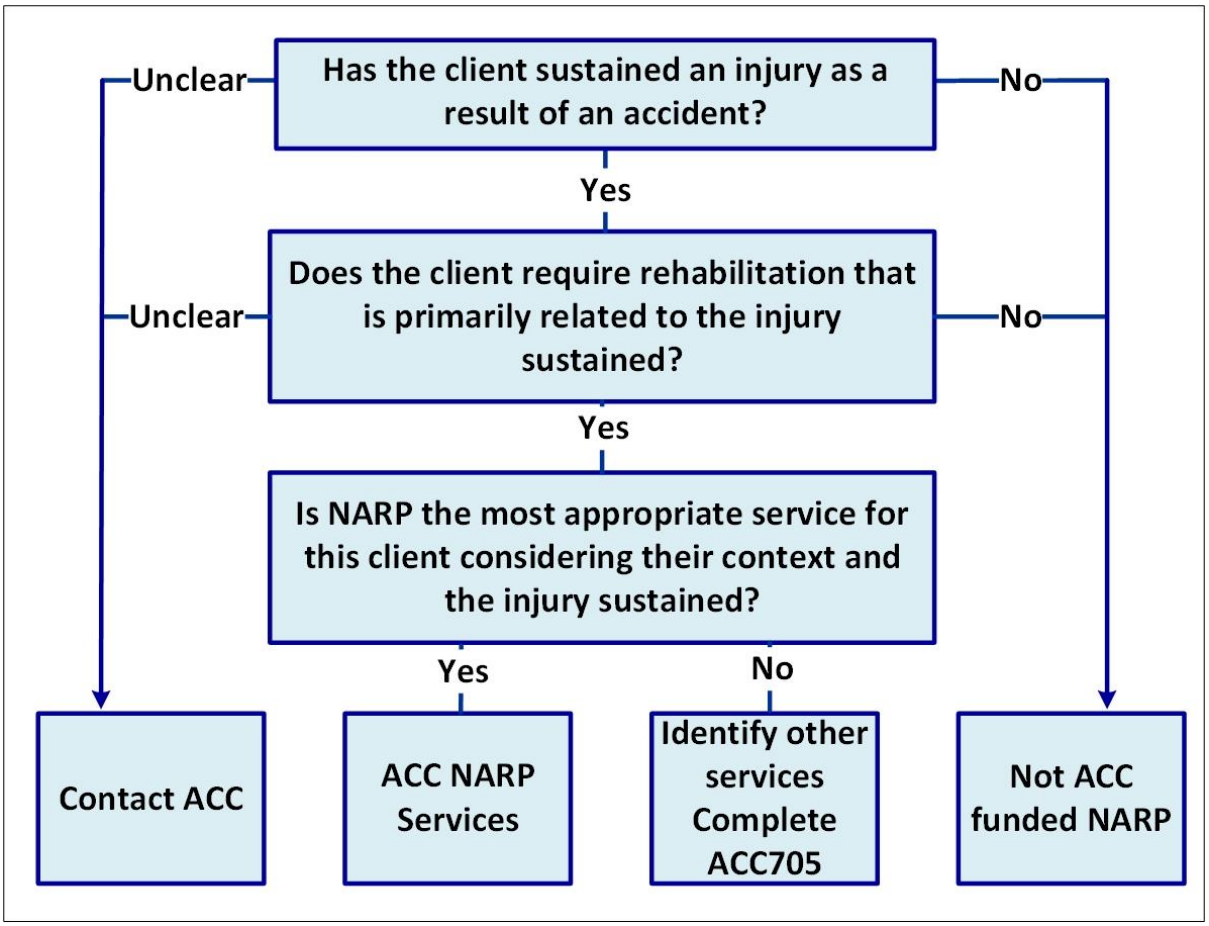


Figure 1: NARP Eligibility Tool

Referal Process

Clients may be admitted or readmitted to the Service from:

- General Practice,
- Emergency Department,
- Acute wards, or
- Rehabilitation ward

Note: Where a client is admitted into NARP services via a GP referral, the hospital is responsible for determining whether the client meets entry criteria to NARP services and to complete profiling for NARP pathway allocation.

Notification of NARP pathway to ACC

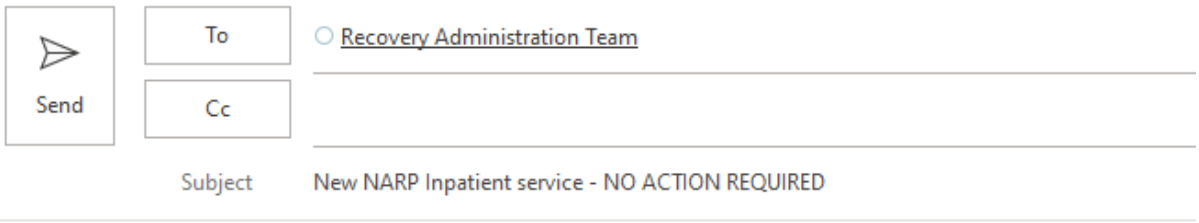
ACC needs visibility over claims to see what services a client is accessing, to mitigate duplication of services and enable clients to access additional services, as required, on discharge from NARP services.

On admission into NARP pathways, hospitals will complete the NARP Master Spreadsheet or alternative data capture with patient details.

Once the admission date is entered into the Master Spreadsheet, an email will auto populate a notification that must be sent to ACC. Simply check the details and send.

When hospitals are not using the Master Spreadsheet, they will need to email ACC with the admission details. The email address to be used is recoveryadmin@acc.co.nz This notification will be filed on the client's ACC claim.

Example of the auto populated email from Master Spreadsheet



Hi there,

We have just admitted Mickey Mouse for Inpatient Rehabilitation, their details are:

NHI Number: 33
First Name: Mickey
Surnname: Mouse
Claim Number: 99999
Inpatient Start date: 25/09/2023
Group / Class: 3A
Major injury type: Fracture_lumbar_spine_pelvis_shoulder_and_upper_arm
ICD10 Code: S32 Fracture of lumbar spine and pelvis

Regards,
Lakes District Health Board, Vendor number: 0, Provider number: T96203

Service Requirements

(Refer to Part B, Clause 6 of Service Schedule)

Minimum Service Requirements for all NARP Rehabilitation Pathways

The Supplier will need to be able to provide a seven-day service for all Rehabilitation Pathways, as required to meet client need, which includes but is not limited to;

- A pre-transfer visit, or consultation with acute team/GP to identify whether a Client is suitable for rehabilitation
- Rehabilitation Specialist oversight (inpatient) and input through active participation in weekly case conferences
- Rehabilitation Specialist oversight (community) should be available, as required. There must be appropriate access to a medical practitioner throughout NARP services and these services must be fully funded within the allocated case-weight.
- Consultations with specialists for any co-morbidities or other issues, as appropriate
- Rehabilitation from an interdisciplinary team, who have a shared philosophy and functional outcome goals

- All investigations, such as laboratory tests, X-rays (basic and specialised, i.e. CT, MRI) and angiography.
- Nursing cares, including pressure injury prevention
- Personal care services
- Medical consumable supplies and pharmaceuticals
- Any equipment required by the Client to meet their needs and to achieve a suitable rehabilitation outcome (this is funded outside of the NARP case-weights). Equipment requests must be made in accordance with ACC's MRES Operational Guidelines. These are available on the ACC website (www.acc.co.nz).
- Transport for tests, assessments, and rehabilitation while in inpatient care.
- Education for caregivers and/or family to enable them to care for the Client after discharge where required
- Planned safe admission and discharge from and to each NARP rehabilitation pathway service.
- Planned safe discharge, as outlined in Service Exit Process
- Access to information and education about injury prevention
- Referral into community or in-home strength and balance programmes, as required on discharge, to prevent injury
- Interpreter and advocacy services
- Māori Health/Liaison Worker and Pacific Island Health/Liaison worker
- Audiology, Optometry and Podiatry relevant to the Client's injuries
- Hotel services including hydration and nutrition (includes dietetics and nutritional advice) within an inpatient setting.
- All incidental services which are reasonable, and that Suppliers of similar services would provide to meet the physiological, cultural, spiritual and social needs of Clients while in the care of the Supplier.

Rehabilition Principles

The Supplier will provide high quality Rehabilitation and care services. (Part B clause 6 of Service Schedule)

Little 'r' versus Big 'R' rehabilitation

Rehabilitation can be described as big 'R' rehabilitation and little 'r' rehabilitation.

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.

When a Client is well enough to **actively participate** in Rehabilitation (big R), ACC purchases that rehabilitation directly through the NARP services.

Within the casemix service delivery, hospitals can use the flexibility of the funding structure to determine how to provide the right care response, in the right location, for individual clients.

Where appropriate in the inpatient and community setting, health care/therapy assistants can deliver aspects of rehabilitation with oversight, input and clinical decision making from registered health professionals. The input of different healthcare workers will vary according to client complexity and need. Hospitals are encouraged to provide innovative and efficacious solutions to deliver interdisciplinary rehabilitation that best align to individual client needs.

Rehabilition Plan

The rehabilitation plan will be developed with the Client, their family/whānau and primary carer. The plan will include achievable Client centred goals and the therapeutic strategies to attain those goals. The plan will be available to the Client on an ongoing basis in the Client's personal rehabilitation folder.

All Providers and support workers will have easy access to the rehabilitation plan, that describes what the Client will be doing and how Providers are to support the Client. It will include how many hours per day the Client should be participating in rehabilitation and what therapy will be delivered. The plan will be provided to ACC on request.

Pathways Management

(Refer to Part B, Clause 6 of Service Schedule)

The Supplier will manage the coordination and delivery of the Client's rehabilitation throughout the NARP service pathways, from when the Client enters, to when the Client exits the service.

A client's pathway may include various stages of the NARP rehabilitation service.

- Clients can access one or more of the NARP rehabilitation service stages per claim
- There is only one case-weight at the beginning of each of the NARP rehabilitation stages. Moving between the NARP rehabilitation services will only occur once, unless a readmission into the inpatient rehabilitation pathway is required, or the client requires transitional care.
    - Where a client is readmitted into inpatient rehabilitation, the inpatient profiling tool may need to be utilised a second time.
    - Following discharge from hospital, readmission into inpatient rehabilitation less than seven days is considered a failed discharge and no second inpatient case-weight can be invoiced.
    - Following discharge from hospital, readmission into inpatient rehabilitation between 8 days and 180 days for the same injury, following an inpatient interRAI or manual inpatient profiling tool reassessment a second case-weight can be invoiced.
    - Readmission into inpatient rehabilitation greater than 181 days post discharge will require Te Whatu Ora District Providers to complete the ACC 7985 Exceptional Circumstances form. ACC needs to give prior approval before a second case-weight can be invoiced.

  Where a client requires transitional care, the community profiling tool can be utilised a maximum of two times. However, NARP Community Pathway Group 4 cannot be used twice.

- Rehabilitation plans will provide the expected timeframes for the duration required for each pathway.

- When a client completes their NARP service pathway and further injury related rehabilitation needs are identified, the supplier will notify ACC using the ACC7985 Exceptional Circumstance form.
- When a client is discharged from inpatient care and is recommended to only require physiotherapy intervention provided by a private practice physiotherapist, notification to ACC is not required.
- When a client with cover for a Treatment Injury is readmitted to inpatient rehab for an injury related need, the supplier will notify ACC using the ACC7985 Exceptional Circumstances form.

Note: Treatment injury claims are outside of the contract service item code case-weights

See NARP service schedule Part A Table 4

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.	$1,278.55	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	$156.48	Per day

Service Pathway Assessment Profiling

(Refer to Part B, Clause 7.2. of Service Schedule)

The Supplier will determine the Client's service pathway by carrying out an interRAI assessment on admission to each stage of the pathway.

The purpose of the NARP interRAI assessment is to identify the most appropriate case-weight service item code and the package of care, based on the Client's needs. Following allocation to the most appropriate package of care from the interRAI assessment, the Supplier will develop a rehabilitation plan with the Client, their family/whānau and primary carer.

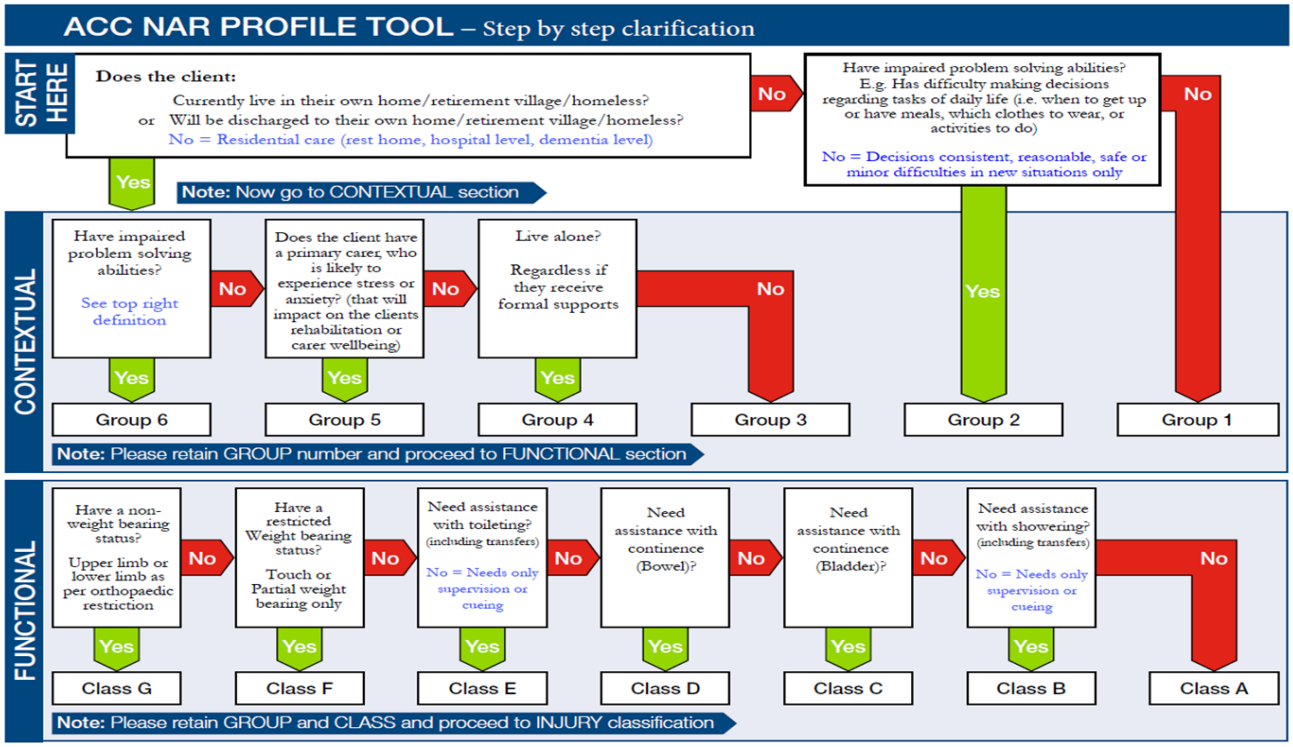
There are two manual profiling tools:

Inpatient profiling tool

The manual Inpatient profiling tool is embedded into the interRAI Acute Care Admission assessment and is no longer needed to be manually assessed, when District Providers are using interRAI.

The Inpatient Profiling tool is applied by a clinician in the inpatient setting as part of an interRAI comprehensive assessment. The tool considers the Client's living arrangement, contextual environment, level of functioning and injury. The Client is then allocated into a group and class which reflects the Client's needs. The Supplier will provide Inpatient Rehabilitation in line with the Minimum Services Requirements**.** (refer above page 13)

Inpatient Rehabilitation is location agnostic and can occur either in the hospital rehabilitation ward, a satellite hospital or a residential facility. All components of the inpatient rehabilitation pathway must be provided in any of the settings.



Note: Inpatient Rehabilitation profiling tool can be found on the [ACC NARP webpage]

Figure 6: Inpatient profiling tool - source Auckland University

Exceptions to the use of the Inpatient profiling tool

Exceptionally Complex clients **do not** require an interRAI assessment, as a case-weight service item code is not required, as they are paid on per day rate. Exceptionally Complex clients include:

- Treatment Injury - Inpatient
- Treatment Injury - Community
- Inpatient Rehabilitation - Serious burns
- Inpatient Rehabilitation – Specialised rehabilitation required for complex injuries, such as Spinal Cord injury or Severe Traumatic Brain injury, while awaiting transfer to specialised rehabilitation center.

Note: Suppliers must use the ACC7985 for Exceptional Circumstances

Community profiling tool

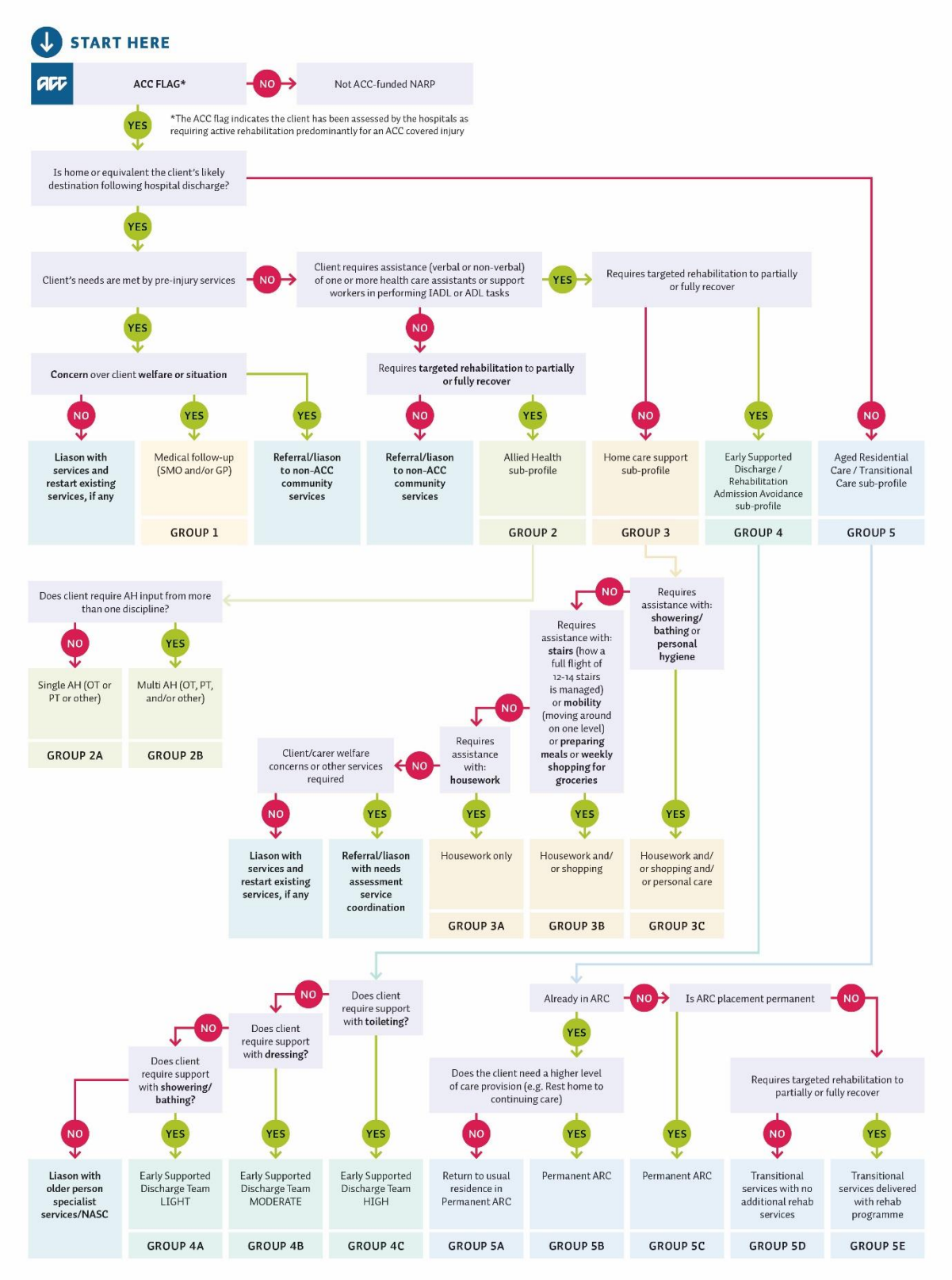
The purpose of the Community Profiling tool is to identify the most appropriate casemix grouping and thus community package of care based on the Client's needs.

The Community Profiling tool is utilised as part of a comprehensive assessment when the client is identified as being safe to move into the community setting. This can occur from an emergency department, acute ward or inpatient rehabilitation setting. The manual Community profiling tool is also embedded into the interRAI Acute Care Discharge assessment. When a client has had inpatient non-acute rehabilitation admission and the District Provider is using interRAI, this no longer needs to be manually assessed.

The tool considers the Client's living arrangement, contextual environment, level of functioning and injury. The Client is then allocated into a group and subgroup which reflects the Client's needs.

Where a client has had a NARP inpatient rehabilitation or transitional care episode, they can access all NARP community pathways.

Where a client has NOT had a NARP inpatient rehabilitation episode they can only access NARP community pathway 4 (This journey directly to community group 4 is called Rehabilitation Admission Avoidance).



Note: Community Rehabilitation profiling tool can be found on the [ACC NARP webpage]
Note: The ACC flag indicates the Client has been assessed by the hospitals as requiring active rehabilitation for an ACC covered injury only

Figure 7: Community profiling tool overview - source Auckland University

Service Pathways

(Refer to Part B, Clause 8 of Service Schedule)

The Client's journey through the NARP services may include one or a combination of the following Rehabilitation Pathways, depending on the Client's clinical needs for the accepted injury.

- Inpatient Rehabilitation
- Transitional Rehabilitation
- Community Rehabilitation
- Rehabilitation Admission Avoidance

Patient scenarios for Non-Acute Rehabilitation Pathway (NARP) services

NARP enables districts to move patients between services and settings to match their need. The client remains the responsibility of Te Whatu Ora until they exit all NARP services.

The following scenarios show four typical pathways for patients through the NARP service from acute admission to discharge.

Scenario one: Vijay – Inpatient and Community Rehabilitation Pathway

Vijay is an 83-year-old who sustained had a fractured neck of femur after falling off a ladder. He lives at home with his wife and is usually fully independent.
After his accident Vijay presented to ED and was admitted to the orthopaedics ward. Vijay had surgery to address his fracture.

After surgery, Vijay needed a two-person assist to transfer with a walking frame and assistance with personal care. Vijay's clinical team decided he would benefit from a period of rehabilitation and that he met eligibility criteria for NARP services. Vijay accessed inpatient rehabilitation, as well as community rehabilitation through NARP services.
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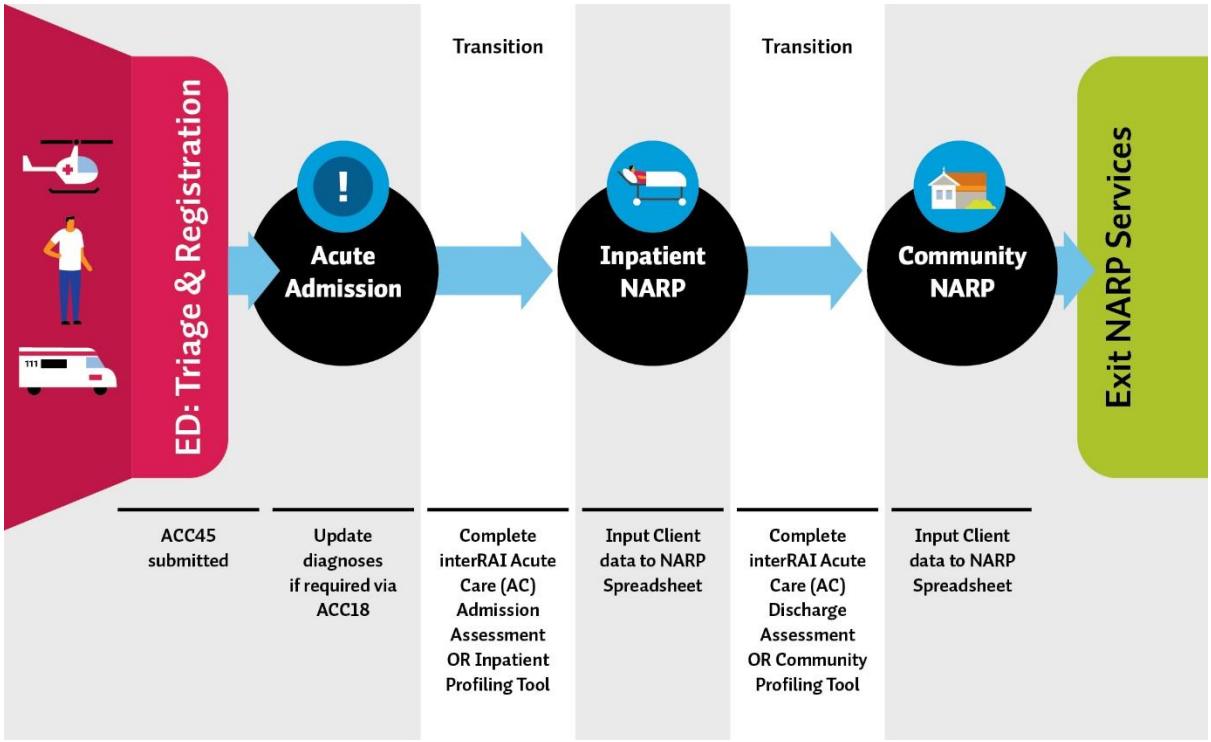


Figure 1: Scenario one -Vijay's Pathway through NARP services

Scenario two: Talita – Rehabilitation Admission Avoidance Pathway

Talita is a 75-year-old who fractured her left neck of humerus after she fell while gardening. She lives at home alone and is usually independent with all activities of daily living.
After her accident, Talita presented to ED and was admitted to the orthopaedics ward. She didn't need surgery, was treated conservatively and given a sling to wear. While Talita could walk independently for short distances and needed assistance with personal care and getting out and about in the community.

Talita met eligibility criteria for NARP services. Her clinical team decided that, with the support of a multidisciplinary community rehabilitation team, Talita could safely return home and finish her rehabilitation in the community without needing inpatient care.
In this scenario, the clinical team decided to use the Rehabilitation Admission Avoidance pathway. Talita is then able to access NARP Group 4 Rehabilitation Admission Avoidance service.

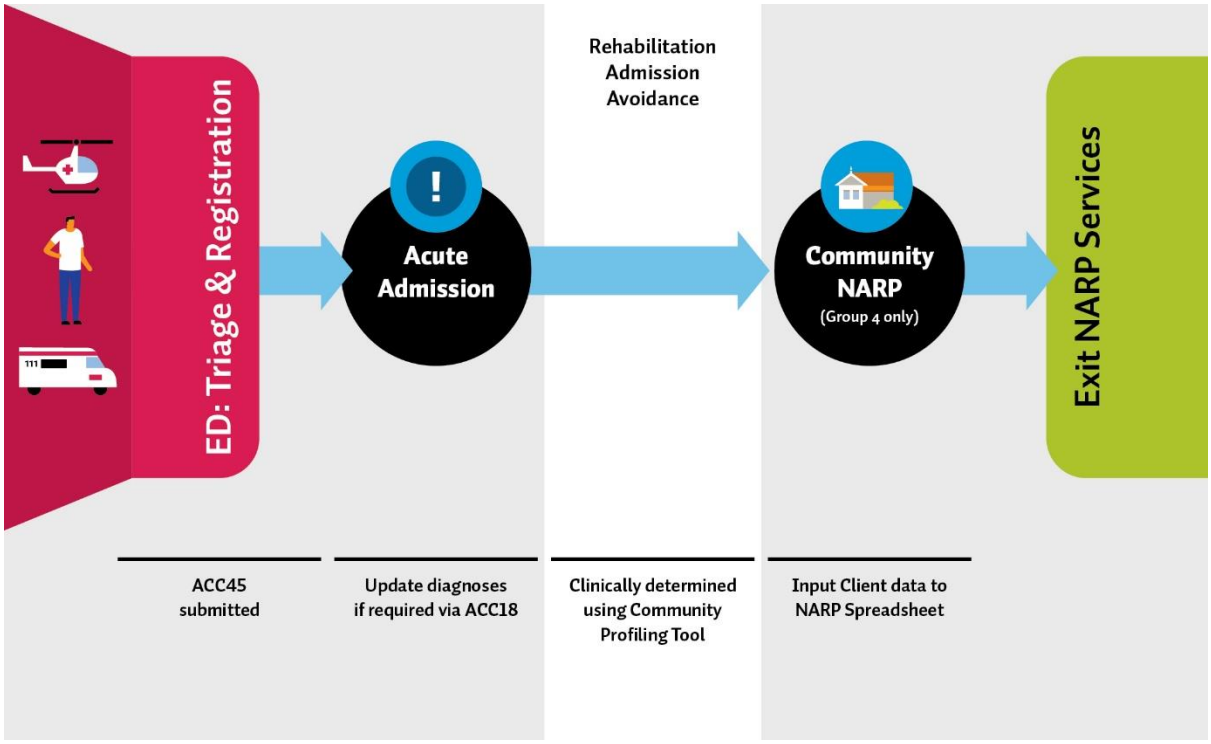


Figure 2: Rehabilitation Admission Avoidance Pathway

Scenario three: Wiremu – Transitional, Inpatient and Community Pathway

Wiremu is an 81-year-old who fractured his right neck of femur after a fall while walking on the beach. He usually lives at home with his wife and is independent with a walking stick.
After his accident, Wiremu presented to ED and was admitted to the orthopaedic ward. Wiremu had surgery and was required to be non-weightbearing for six weeks. He was able to transfer with a walking frame and assistance of one and needed assistance with all personal cares.

Wiremu's clinical team decided he would benefit from some time in transitional care and used the community profiling tool to determine the case mix. He met the eligibility criteria for NARP services.

After six weeks of transitional care, the clinical team determined that Wiremu needed inpatient rehabilitation. The inpatient profiling tool was used on admission to inpatients. Following this, the clinical team then determined that Wiremu needed a period of community rehabilitation, and the community profiling tool was used for the second time in Wiremu's NARP journey.

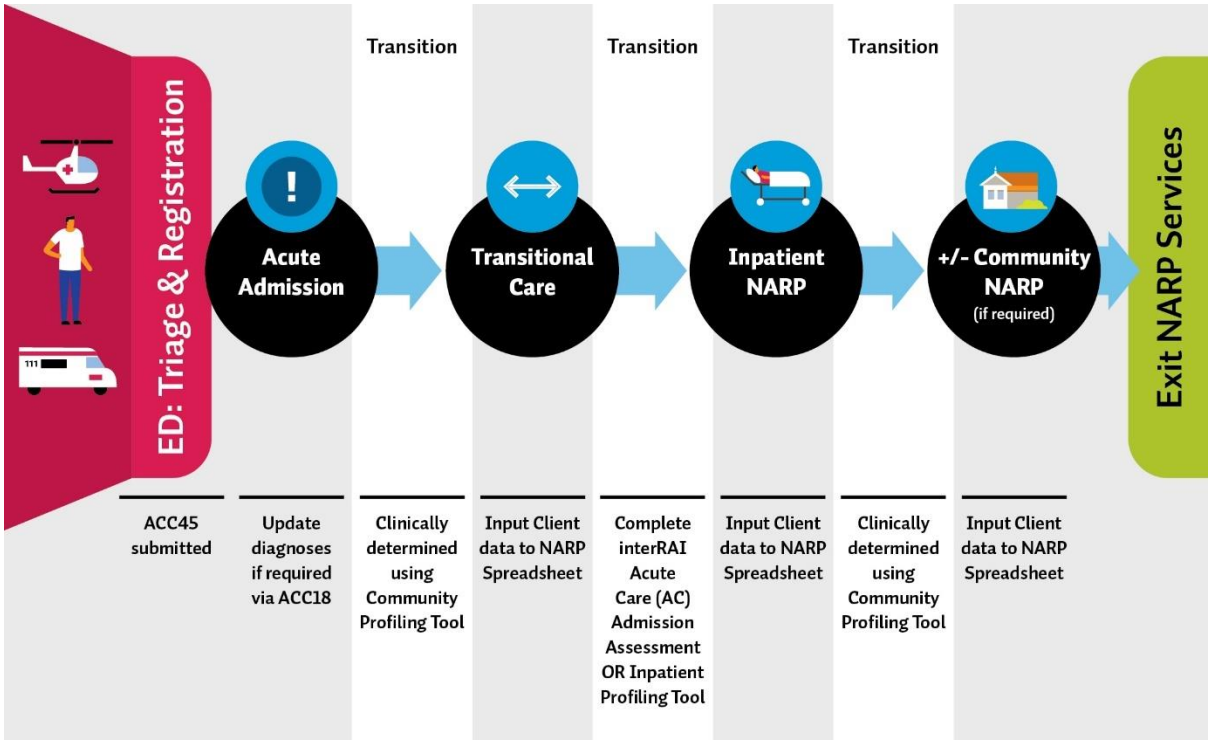


Figure 3: Transitional, Inpatient and Community Pathway

Scenario four: Agnes – Transitional and Community Pathway

Agnes is a 78-year-old who fractured her right neck of femur in a car accident. Agnes usually lives at home with her husband and walks independently without an aid.
Agnes presented to ED and was admitted to the orthopaedic ward where she had surgery. Agnes was required to be non-weightbearing for six weeks. Her clinical team decided that Agnes would benefit from a period of transitional care where she could actively engage in rehabilitation.

Six weeks' later, Agnes was cleared to weight bear as tolerated. Agnes was profiled again using the community profiling tool to establish which community pathway would be used.
Agnes could begin her community rehabilitation while in transitional care which enabled a supported transition back home.

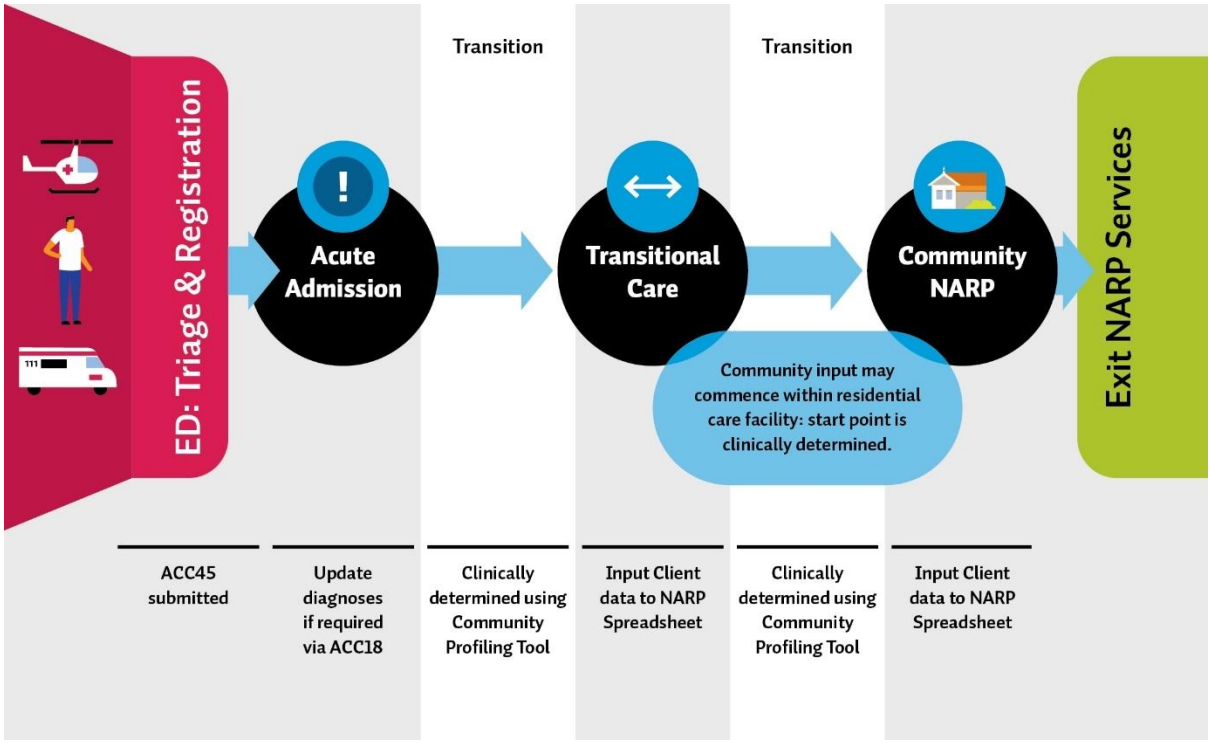
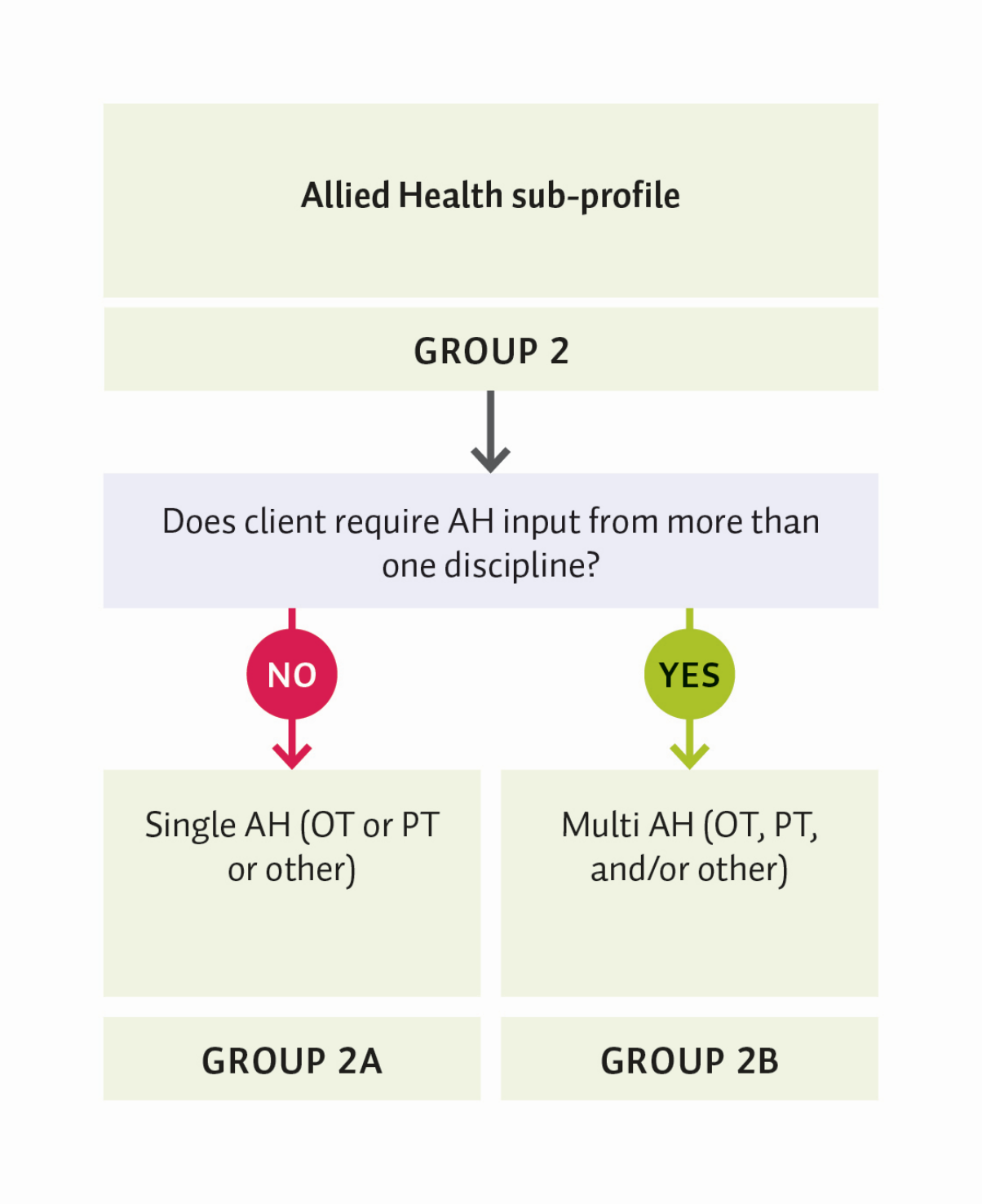


Figure 4: Transitional and Community Pathway

Community Group breakdown with scenarios

This section describes the sub-sections of the community profiling tool.



Community profiling tool group 2 (2a and 2b) *– source Auckland University*

Group 2 Client Scenario: (NRPC2A and NRPC2B)

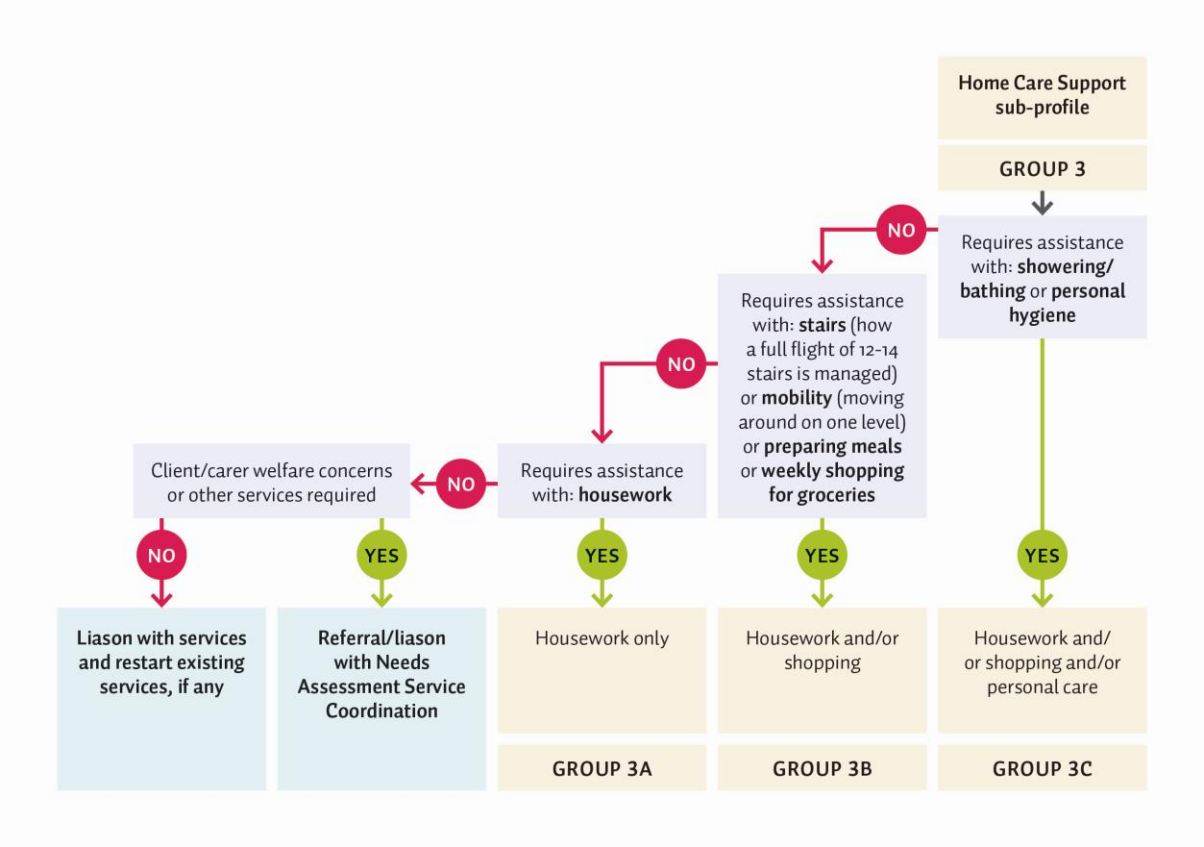
A 75 year old female had a fall at home after tripping over a mat, she sustained an ankle fracture. She is walking independently with a walking frame and is independent with personal

cares and activities of daily living. She has been cleared for discharge home from inpatient rehabilitation where she lives alone and has a steep driveway and four steps to access the house. She requires rehabilitation to progress her mobility (progressing off walking aids, accessing the home, mail box and local dairy). In this scenario the client would be classified as a Group 2a.

NOTE: Where the client has had a NARP inpatient rehabilitation or transitional care episode, the need for community allied health would be funded under NARP. Where the client has NOT had an inpatient rehabilitation or transitional care episode and there is a need for rehabilitation, ACC requires notification and will provide the appropriate rehabilitation.

An 80 year old male fell while out walking on the beach and sustained a fractured neck of femur. He is walking independently with a walking frame and has been discharged home from inpatient rehabilitation. He is able to complete personal cares and activities of daily living with adaptive equipment. He requires rehabilitation to progress off walking aids and return to completing personal cares and activities of daily living without equipment. In this scenario the client would be classified as a Group 2b

NOTE: Where the client has had a NARP inpatient rehabilitation or transitional care episode, the need for community allied health would be funded under NARP. Where the client has NOT had an inpatient rehabilitation or transitional care episode and there is a need for rehabilitation, ACC requires notification and will provide the appropriate rehabilitation.



Community profiling tool group 3 (3a, 3b and 3c) *– source Auckland University*

Group 3 Client Scenarios: (NRPC3A, NRPC3B and NRPC3C)

An 82 year old female sustained a significant open wound to the hand after a fall in the garden. On discharge from inpatient rehabilitation she is able to walk independently and complete all personal cares independently. She already has established support for shopping to address non injury needs however as a result of the wound requires assistance with household tasks such as making the bed, doing laundry and doing the dishes. It is expected that as the wound heals the client will return to full independence without the need for any specific rehabilitation. In this scenario, the client would be classified as a Group 3a.

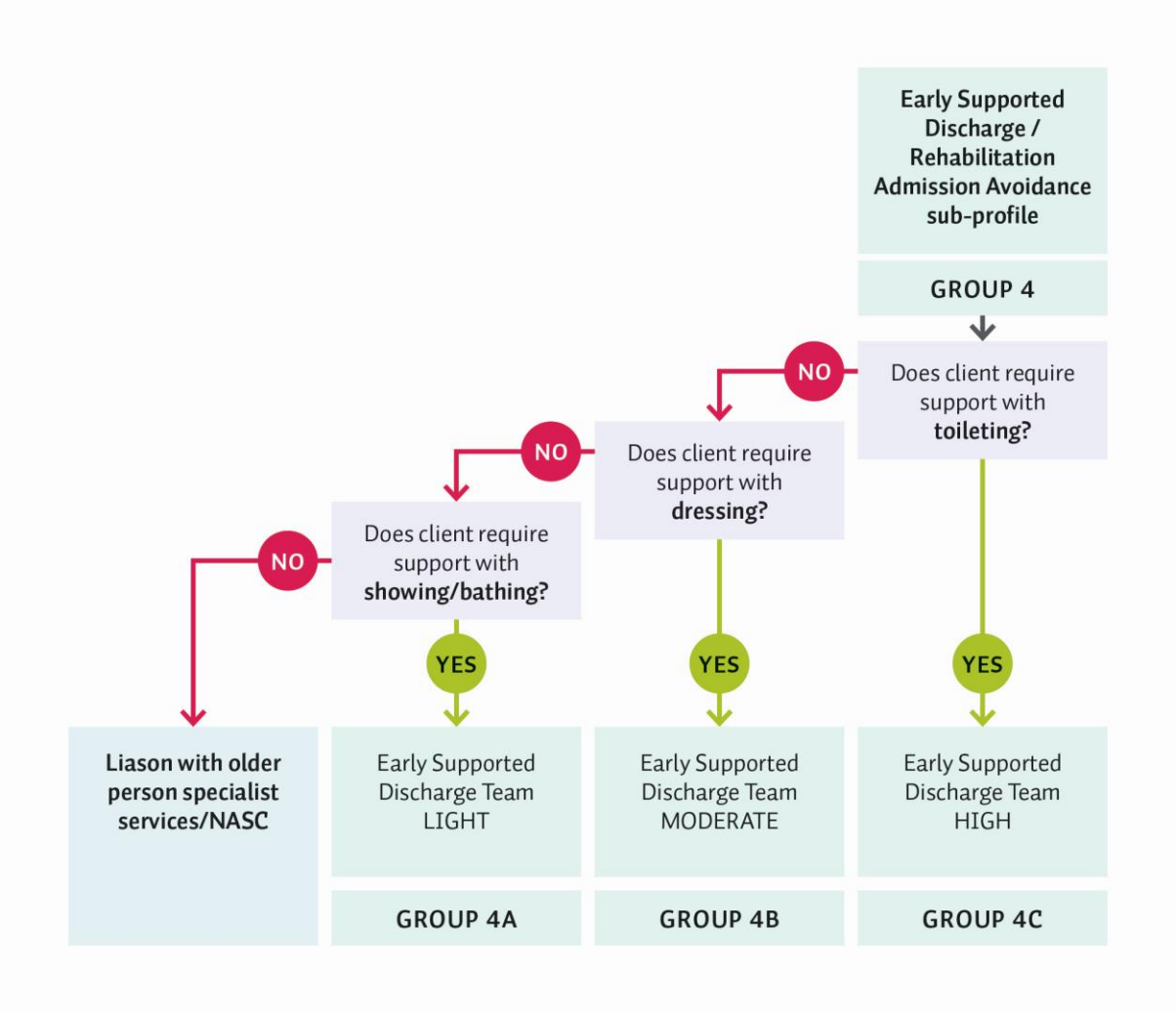
NOTE: Where the client has had a NARP inpatient rehabilitation or transitional care episode, the need for community home supports would be funded under NARP. Where the client has NOT had an inpatient rehabilitation or transitional care episode the need for community home supports would be funded through ACC's home and community support services.

A 78 year old male slipped on a ladder and sustained a rib fracture. On discharge from inpatient rehabilitation he is able to walk independently unaided however is unable to lift heavy items and lives alone. He is able to complete personal cares independently but needs assistance with transporting shopping. It is expected that as the rib fracture heals the client will return to full independence without the need for any specific rehabilitation. In this scenario, the client would be classified as a Group 3b.

NOTE: Where the client has had a NARP inpatient rehabilitation or transitional care episode, the need for community home supports would be funded under NARP. Where the client has NOT had an inpatient rehabilitation or transitional care episode the need for community home supports would be funded through ACC's home and community support services.

A 65 year old female was involved in a road traffic accident and sustained a number of significant lacerations affecting the upper and lower limbs. On discharge from inpatient rehabilitation she is able to walk very short distances indoors independently however requires assistance with getting in and out of the shower and with washing. She also requires assistance with doing laundry, cleaning the home and accessing the local shops for groceries. The client lives alone. It is expected that as the lacerations heal, the client will return to her fully independent baseline without the need for specific rehabilitation. In this scenario, the client would be classified as a Group 3c.

NOTE: Where the client has had a NARP inpatient rehabilitation or transitional care episode, the need for community home supports would be funded under NARP. Where the client has NOT had an inpatient rehabilitation or transitional care episode the need for community home supports would be funded through ACC's home and community support services.



Community profiling tool group 4 (4a, 4b and 4c) *– source Auckland University*

Group 4 Client Scenarios: (NRPC4A, NRPC4B and NRPC4C)

A 73 year old male sustained a tibial plateau fracture after a cycling accident. He is able to mobilise independently using elbow crutches and has been deemed safe for discharge home. He requires assistance with transferring in and out of the shower however is able to dress himself and toilet independently. The client will require rehabilitation input to progress off elbow crutches and increase lower limb strength and range of motion however would be expected to complete a home exercise programme independently. In this scenario, the client would be classified as a Group 4a as the input required from the early supported discharge team would be considered light.

A 72 year old female sustained multiple pubic rami fractures after a fall while walking her dog. She is able to walk short distances with a walking frame independently and has been deemed safe for discharge home. She is able to toilet independently however requires assistance with dressing and showering. She also requires rehabilitation input to progress off the walking frame and return to independence with personal care tasks. In this scenario the client would be classified as a Group 4b as the input required from the early supported discharge team would be considered medium.

A 60 year old male sustained bilateral wrist fractures as well as an avulsion fracture of the left ankle managed in moonboot a result of a motorbike accident. He is able to mobilise

independently short distances and had been deemed safe to return home with supports in place. He requires assistance with toileting, dressing and showering as well as rehabilitation. Given nature of the client's injuries and requirement for support and rehabilitation, in this scenario the client would be classified as a Group 4c.

Note: The Light / Moderate / High sub-groups within Group 4 relate to the level of clinical input required, the complexity of the injury and how long the Client may take to recover.

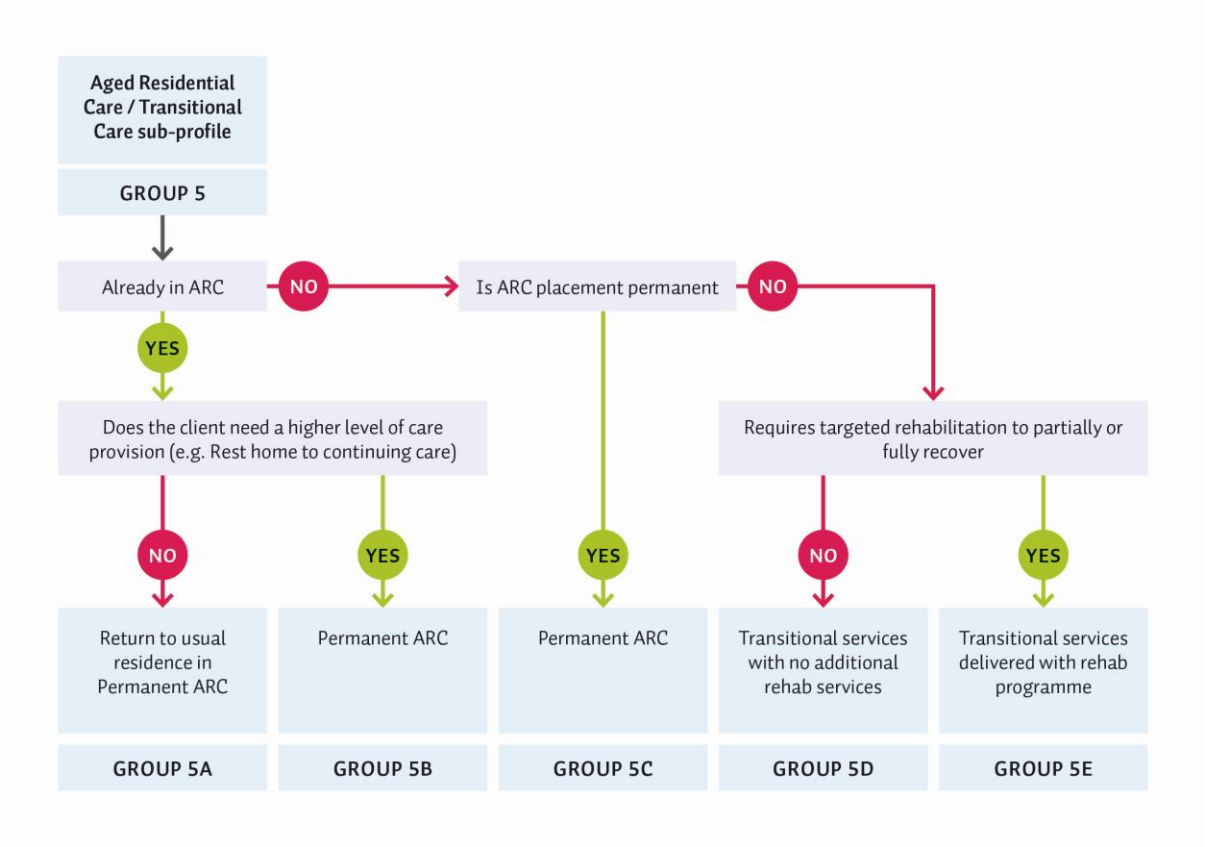
Rehabilitation Admission Avoidance (AA)

Use of the Rehabilitation Admission Avoidance pathway is based on clinical decision making.

The Rehabilitation Admission Avoidance pathway is for Clients who, with timely input from a multidisciplinary community rehabilitation team, (Group 4 only) can avoid inpatient rehabilitation and can go straight to receiving community rehabilitation.

Table 3: Rehabilitation Admission Avoidance Pathways Service requirements summary

Rehabilitation Admission Avoidance Profiling Group	Sub-profile	Descriptor	Expected Timeframes
Group 4 AA	Multi-Disciplinary Team - Early Supported Discharge/ Rehab Admission Avoidance	Where the client requires Early Supported Discharge (ESD) or Rehab Admission Avoidance Group 4 a: ESD/RAA Team – light *(client requires targeted rehabilitation input and can toilet and dress themselves but requires support with showering/bathing)* Group 4 b: ESD/RAA Team – moderate *(client requires targeted rehabilitation input and can toilet themselves but requires support with showering/bathing and dressing)* Group 4 c: ESD/RAA Team – high *(client requires targeted rehabilitation input and requires support with toileting, showering/bathing and dressing)*	Maximum 12 weeks from start date



Community profiling tool group 5 (5a, 5b, 5c, 5d and 5e) and case studies *– source Auckland University*

Group 5 Client Scenarios: (NRPC5A, NRPC5B, NRPC5C and NRPC5E)

NOTE: Clients allocated into groups 5a, 5b and 5e ARE eligible for ACC NARP funding. Clients who are allocated into groups 5c and 5d are NOT eligible for ACC NARP funding. Hotel costs for all clients who require residential care following an accident are covered under the Residential Support Services contract (RSS) contract. Where there is a need for allied health for clients in groups 5c and 5d it is expected that these needs will either be met through the RSS contract or allied health input is purchased separately.

Group 5a

If a client resided in residential care prior to the accident event and is able to return to the same level of care, however, has an identified need for targeted community rehabilitation, the client may be eligible for NARP services. Where the client has had a NARP inpatient rehabilitation episode, the need for community allied health would be funded under NARP.

This scenario would align with NARP community group 5a and requires completion of the ACC7985 Exceptional Circumstances form and ACC approval. Where the client has NOT had an inpatient rehabilitation episode and there is a need for targeted community rehabilitation, ACC requires notification and will provide the appropriate rehabilitation.

Scenario:

68-year-old female fell down some stairs and sustained an ankle fracture. The client has Parkinson's disease and was previously living in Rest Home level care. She mobilised with a stroller frame and had supervision with showering and dressing. The fracture was managed conservatively with a moon boot and the client was able to weight bear as tolerated. She

was deemed safe to return to Rest Home level of care as she was able to mobilise independently short distances with her stroller frame and manage showering and dressing from a seated position with supervision. The client requires physiotherapy input to progress out of the moon boot and prescribe and exercise programme for ankle range of motion and strengthening.

In this scenario the client would be classified 5a requiring targeted rehabilitation.

Group 5b

If a client was in residential care prior to the covered accident event and requires an increased level of care as a result of the ACC covered injury (temporary increased level of care or permanent), ACC funding for residential care would initially be provided via short term non contracted codes. If there is an identified need for targeted community rehabilitation, the client may be eligible for NARP services. Where the client has had a NARP inpatient rehabilitation episode, the need for community allied health would be funded under NARP. This scenario would align with NARP community group 5b and requires completion of the 'NARP Exceptional Circumstances form ACC7985' and ACC approval.

Where the client has NOT had an inpatient rehabilitation episode and there is a need for targeted community allied health this requires notification to ACC, and appropriate rehabilitation services will be put in place by ACC.

If after the six-week period the client is determined as needing a permanent increase in level of care as a result of the ACC covered injury, the Residential Support Services process must be followed.

If the client's pre-injury residential facility is unable to provide the increased level of care required by the client because of a covered injury, ACC will provide funding at another appropriate residential facility. Where there is a need for the client to temporarily move to another residential facility to enable the required level of care to be provided **and** ACC was funding the residential facility, ACC will continue to contribute funding to that residential facility to enable the client's pre-injury residential bed to be held. Further information can be found in the Residential Support Service Operational Guidelines which will be available on acc.co.nz from 1 October 2021.

Scenario:

82-year-old male fell down in the garden and sustained a fractured neck of femur. The client had surgery and was cleared to weight bear as tolerated. Prior to the accident event the client was from Rest Home level of care and could walk with a stroller frame independently.

Post injury the client requires a standing hoist for all transfers and assistance with all personal care tasks. The client now requires Hospital Level of Care however the client has been noted to have potential to return to Rest Home Level of Care with targeted rehabilitation.

In this scenario the client would be classified as 5b requiring targeted rehabilitation. The client's increased level of residential care would be funded by ACC either via the Residential Support Services Contract, or via the temporary care codes (if the facility does not hold a contract with ACC).

Group 5c

If a client can no longer return to independent living due to the ACC covered injury and has been assessed as needing to reside permanently in a Residential setting, the ACC funding will be determined as per the Residential Support Services Contract. The client is not eligible for NARP services. This scenario would align with NARP community group 5c.

Scenario:
76 year old female fell down a flight of stairs and sustained a subarachnoid haemorrhage. The client previously lived at home and was fully independent. After the accident event the client engaged in a period of inpatient rehabilitation after which the client was assessed as needing Rest Home level care. In this scenario the client would be classified as 5c and any future therapy input would be expected to be slow stream and be covered by the RSS contract. The client is not eligible for community NARP funding.

Group 5d and 5e
When following an Acute discharge, a client temporarily cannot return to their home due to the covered ACC injury and the client is not appropriate for inpatient rehabilitation, the TE WHATU ORA can transition the client to a Residential setting where they will receive transitional care. If the residential facility holds an ACC contract, the bed night rate will be specified in that contract. If the residential facility does not hold an ACC contract, the bed day funding is paid via non contracted codes at the usual TE WHATU ORA rate. Further information can be found in the Residential Support Service Operational Guidelines.

These situations would align with the NARP community groups 5d and 5e (only clients classified as 5e are eligible for NARP services, clients who are classified as 5d are not eligible)

Once the client is able to fully engage in active rehabilitation (i.e. weight bearing restrictions change) the Supplier will determine whether the client requires inpatient rehabilitation OR whether the client could return directly to their usual pre-injury place of residence with community rehabilitation. Profiling using the community profiling tool and commencement of community rehabilitation can occur while the client is still in transitional care where appropriate to enable support of the client transitioning home. The point at which community rehabilitation begins is clinically determined and may differ between clients.

After a period of transitional care if a client is assessed as requiring permanent residential care as a result of the covered ACC injury, funding will be determined as per the Residential Support Services Contract.

Where a client wishes to remain in residential care and there is no longer an injury related need for residential care, ongoing funding will not be provided by ACC.

Scenario:
83 year old male was a passenger involved in a motor vehicle accident and sustained a tibial plateau fracture. The client was required to be non-weightbearing for a period of 6 weeks. Prior to the accident event the client lived with his daughter and was able to walk short distances with a walking stick. The client has significant cognitive impairment and requires prompting and supervision with most tasks. The client was unable to engage in active rehabilitation while non-weightbearing due to high pain levels and his pre-existing cognitive impairment. The client was transferred into transitional care for the non-weightbearing period.

As the client is unable to engage in rehabilitation, in this scenario the client would be classified as 5d. Although ACC will meet the cost of the client's residential care the client is not eligible for community NARP funding. Maintenance of function would be covered under the Residential Care bed day rate.

Group 5e
A 90 year old male sustained a neck of femur fracture and multiple lacerations due to a fall. He underwent surgery to address the fracture and is medically stable however is non-

weightbearing for four weeks. The client was previously living in a retirement village and required meals on wheels and support from family for shopping. The client was previously able to mobilise short distances with a walking stick independently and was independent with washing and dressing. The client has been transferred to a residential care facility while non-weightbearing.

The client is fully able to participate in rehabilitation while in residential care and functional goals have been identified including being able to get in and out of bed independently and reducing the need for assistance with showering and dressing. The physiotherapist and occupational therapist provide the client with a rehabilitation programme and the allied health assistant and support workers in the residential care facility help the client complete the programme exercises and practice strategies the client has been taught. The physiotherapists will continue to have oversight and monitor progress.

In this scenario, the client would be classified as Group 5e. Interim care would be funded under the provisions of ACC residential care bed day rates and targeted rehabilitation would be funded under NARP services.

NARP Transitional Care (Group 5e NRPC5E)

The NARP Transitional care pathway is for Clients who are stable, willing, and able to actively participate in a rehabilitation programme (**big R**), do not have any illnesses or comorbidities that would require a hospital stay, but are not safe to be at home.

It is also an interim pathway for non-weight bearing Clients who can actively participate in rehabilitation (big R) which is over and above that which would normally be provided in a transitional care setting.

Please note: clients who require an interim pathway who are NOT able to actively participate in “big R” rehabilitation are able to access transitional care (Group 5c and 5d) through the Residential Support Services Contract and are not eligible for NARP services during this period.

Transitional Care is generally provided in a residential care setting or equivalent (e.g. other hospital setting). The hospital will work closely with the residential supplier/s to ensure rehabilitation and care plans are maintained and the performance of the residential care supplier/s achieve quality outcomes.

The Transitional Care pathways are captured in the community profiling tool.

Where a client has accessed Transitional Care prior to Community Rehabilitation, the Community Profiling Tool can be used while the client is still in Transitional Care, once the client is fully able to actively participate, to enable support for the transition home. The point at which community rehabilitation begins is clinically determined and may differ between clients. The maximum timeframe for NARP Community Rehabilitation (12 weeks) remains. The timeframe for Residential Transitional stay remains at 6 weeks.

Table 4: Transitional Rehabilitation Pathway services requirement summary

Transitional Profiling Group	Sub-profile	Descriptor

Group 5e (only)	Aged Residential Care / Transitional Services	Where the client requires Aged Residential Care / transitional services and allied health

Community Care and Rehabilitation

When a client is receiving Community Rehabilitation Pathway services, there is an expectation that no other ACC funded rehabilitation services are being concurrently utilised under any other contract (with the exception of Residential Support Services and Rongoā Māori services)

If during the Community Rehabilitation pathway, it is identified that the client has exceptional circumstances relating to the injury, the Supplier will complete a 'NARP Exceptional Circumstances form ACC7985'.

Table 5: Community Rehabilitation Pathways services requirement summary

Community Profiling Group	Sub-profile	Descriptor	Expected Timeframes for Completion of Services
Group 2	Allied Health	Where client requires predominantly Allied Health input Group 2 a: single Allied Health (OT or PT or other) Group 2 b: multi 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 3 a: Housework only delivered by HCSS Group 3 b: Housework and / or shopping delivered by HCSS Group 3 c: Housework and / or personal care delivered by HCSS	Maximum 12 weeks from start date
Group 4	NARP Early Supported Discharge	Where the client requires Early Supported Discharge (ESD) Group 4 a: ESD Team – light *(client requires targeted rehabilitation input and can toilet and dress themselves but requires support with showering/bathing)* Group 4 b: ESD Team – moderate *(client requires targeted rehabilitation input and can toilet themselves but requires support with showering/bathing and dressing)* Group 4 c: ESD Team – high *(client requires targeted rehabilitation input and requires support with toileting, showering/bathing and dressing)*	Maximum 12 weeks from start date
Group 5	Allied Health	Where client requires predominantly Allied Health input Group 5a or 5b: single Allied Health (OT or PT or other) Group 5e: Allied Health	Maximum 12 weeks from start date

Service Specific Quality Requirements

(Refer to Part B, Clause 11 of Service Schedule)

The Supplier is responsible for ensuring the Providers in this service meet the following criteria and/or an appropriate equivalent.

Table 6: Service Specific Quality Requirements

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

Quality Management Plan

ACC acknowledges that the Supplier is a hospital and has its own quality and risk management plans and processes. The following is not intended to replace or add to those, rather it states a minimal expectation.

Every Supplier is expected to have a quality management plan that ensures all Clients receive the highest quality service delivery including:

- timely services
- professional and highly competent Providers
- excellent communication
- rapid and comprehensive problem resolution.

In addition to the requirements of the Standard Terms and Conditions, the Supplier will assess the Client's health, safety and outcomes risks throughout the service delivery and will develop strategies to mitigate and minimise those risks. Where significant risks and mitigations exist, the Supplier will inform the ACC Engagement and Performance Manager of their plan to manage those risks and will keep the EPM updated on any issues or developments.

The Supplier's complaints management system will be consistent with the Health and Disability Commissioner's Code of Rights.

If, for some reason, the usual service cannot be delivered, the Supplier will arrange alternative service as part of contingency planning for the Client, so that they receive any services essential for safety.

Suppliers are responsible for ensuring they or their staff report all incidents and adverse events in the online tool available at www.acc.co.nz/for-Providers/report-health-safety-incidents within 24 hours of identifying the issue or risk.

The Supplier will have a documented Quality Improvement Plan for their service delivery.

The Supplier will have a documented Risk Management Plan which will include evidence of management and mitigation of any identified risks to:

- Clients.
- Service Providers' health and safety; and
- Service delivery.

The Supplier will provide its Quality Improvement and Risk Management Plans to ACC on request.

Other service requirements

(Refer to Part B, Clause 11 of Service Schedule)

Exceptional circumstances

(Refer to Part B, Clause 11 of Service Schedule)

Exceptional circumstances include:

- Extended inpatient stay
- Inpatient Rehabilitation - Highly complex injury
- Inpatient Rehabilitation – Serious Burns
- Transfer of care to ACC from NARP community pathway (completion of 3 months)
- Readmission after 181 days of discharge for the same injury

- Treatment Injury requiring inpatient rehabilitation.
- Treatment Injury requiring community rehabilitation.
- Group 5a and 5b clients in residential care requiring targeted single discipline rehabilitation.

Exceptional circumstances require **prior-approval for funding by ACC**. The tables below provide further information. It is important to alert ACC early to process this.

Table 7: Exceptional circumstances

Exceptional circumstances: Extended inpatient stay		
Topic	**Rule**	**Comment**
Extended Inpatient stay (beyond 76 days)	Where a Client has had one or more admissions that collectively add up to 76 days or more, if there is an injury related need for extended inpatient admission, the hospital will apply to ACC for approval. The hospital must provide ACC with the number of additional inpatient days being requested. Where ACC approves the application a purchase order for the additional days will be provided – from day 77 onwards.	Application to ACC is required via the 'NARP Exceptional Circumstances form ACC7985'. ACC will determine if the Client's ongoing need is injury related or age and/or health related. If health related, ACC declines funding. If injury related, ACC approve the purchase order for the requested number of days.
Exceptional circumstance: Transfer to ACC claims management		
Topic	**Rule**	**Comment**
Request funding for NARP Inpatient due to Highly complex injury	When a client has sustained a severe traumatic brain injury or high-level spinal cord injury that requires specialist care beyond what is usually provided under NARP services Following approval, ACC approve funding inpatient rehabilitation per day.	Application to ACC is required via the 'NARP Exceptional Circumstances form ACC7985'. • Client is deemed clinically to be highly complex and outside of the NARP entry criteria.
Exceptional circumstances: Extended Inpatient Rehabilitation –Serious Burns		
Inpatient Rehabilitation –- Serious Burns	When a client has serious burns that are: • Greater than 30% total body area; and/or	Application to ACC is required via the 'NARP Exceptional Circumstances form ACC7985'.

	• Full thickness burns to the face, hands, feet, genitalia, or perineum; and/or • Significant burn through an inhalation injury; and/or • Due to a high-voltage electrical burn; and/or • Due to a significant chemical burn Following approval, ACC approve funding inpatient rehabilitation per day	• Client is deemed to have Serious Burns outside of the NARP entry criteria.
Exceptional circumstance: Transfer care to ACC from NARP community pathway		
Transfer care to ACC from NARP following three months community rehabilitation	The hospital has provided three months of community care and the client has ongoing injury related needs that requires ACC to consider additional supports. Note: When no community rehabilitation pathway has been implemented, hospitals will use the ACC705 form for any discharge needs	Example: Client has actively participated in Community rehabilitation for three months, however, due to the complex nature of the injury the client's needs will exceed three months.
Exceptional circumstance: Readmission after 181 days of discharge		
Topic	**Rule**	**Comment**
Readmission after 181 days of discharge	Where the Client has an injury related readmission against the same claim number after 181 days since first discharge, ACC preapproval for funding is required.	Application to ACC is required via the ACC7985 Exceptional Circumstances form. ACC will determine if the Client's need for rehabilitation is injury related or age and/or health related. If the exception is approved, the inpatient stay is profiled and a case-weight is allocated
Exceptional circumstance: Treatment Injury		
Topic	**Rule**	**Comment**
Accepted Treatment Injury requiring Inpatient Rehabilitation	When a treatment injury is accepted by ACC and there is a need for inpatient rehabilitation	Application to ACC is required via the ACC7985 Exceptional Circumstances form. (NRPTI Treatment Injury Inpatient per day rate.

	Funding will be considered for the specific number of inpatient rehabilitation days requested.	
Accepted Treatment Injury requiring Community Rehabilitation	When a treatment injury is accepted by ACC and there is a need for community rehabilitation Funding will be considered for the specific number of community rehabilitation days requested.	Application to ACC is required via the ACC7985 Exceptional Circumstances form. NRPTC Treatment Injury Community Rehabilitation per day rate)
NOTE: Treatment Injury-not accepted by ACC	When a Treatment Injury claim has been lodged however ACC has not issued a decision as to whether the Treatment Injury has been accepted or not, any rehabilitation required is not funded under the NARP model	In this circumstance if Treatment Injury cover is accepted after rehabilitation services provided, the hospital will contact ACC for retrospective reimbursement.
NOTE: Treatment Injury -readmission - accepted claim	When a Client is readmitted to inpatient rehabilitation and admission is for the same Treatment Injury Funding will be considered for the specific number of inpatient days requested.	Application to ACC is required via the ACC7985 Exceptional Circumstances form.
Exceptional circumstance: Group 5a or 5b Requiring Targeted Rehabilitation		
Topic	**Rule**	**Comment**
Group 5a or 5b client requiring targeted rehabilitation	Where a client is classed as 5a or 5b (that is, they were living in a residential facility prior to their injury and are returning there) AND a clear need for targeted rehabilitation through single discipline allied health input is identified, above and beyond what is normally provided in such a facility, the client may be eligible for NARP services.	Completion of the ACC7985 Exceptional circumstances form and ACC approval is required

Interruption of Inpatient Rehabilitation

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 hospital funding for the total time that the Client is not participating in rehabilitation.

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 or funding.

Where an interruption of rehabilitation occurs, an additional case-weight profile is NOT generated.

Interruptions can include surgery, medical illness, offsite health related investigation where the Client will be gone longer than 24 hours, any situation where the Client is unable to participate in rehabilitation activities.

ACC will monitor interruption of inpatient rehabilitation with data showing more than one inpatient case-weight package per client less than 76 days. Engagement and Performance Managers will highlight any performance issues during their monthly meetings.

Readmission into the inpatient rehabilitation pathway

When a client has been discharged from NARP rehabilitation pathways and it has been identified that further rehabilitation is required within 8-181 days of discharge, the client can re-enter the inpatient pathway only.

On admission the client is re-profiled and if another inpatient case-weight for the same injury is needed ACC prior approval is required.

The Client cannot re-enter back into Rehabilitation Admission Avoidance, Community or to Transitional services. Any additional needs will be addressed outside of NARP services via ACC705 or 'NARP Exceptional Circumstances form ACC7985'.

Inpatient rehabilitation – Serious Burns

If a client has sustained a serious burns injury, exceptionally complex client service codes can be billed. This is funded on a per day basis for clients that meet the following criteria:

- Greater than 30% total body area; and/or
- Full thickness burns to the face, hands, feet, genitalia, or perineum; and/or
- Significant burn through an inhalation injury; and/or
- Due to a high-voltage electrical burn; and/or
- Due to a significant chemical burn

The interRAI acute care assessment does not need to be used for these clients, as the case weight service code is not required. For these clients, an appropriate client assessment tool can be used to determine client need. Service item code NRPBI is used for inpatient rehabilitation for each day of active rehabilitation.

General Travel

The NARP contract requires coordination of client services, and all reasonable steps should be taken to minimise the travel required by clients and suppliers.

The case-weighted rate allocates funding for healthcare providers to travel to facilitate client rehabilitation, including shopping. It is important that hospitals manage this efficiently by looking at the most cost-effective options:

- Shopping for essential items
- Shopping online with delivery
- Click and collect
- Family or friends able to do the shopping

When a client's ability to travel has been impacted by the covered injury and there is a requirement for the client to travel independently to attend tests or assessments, ACC may contribute towards the ancillary services that help the client get to those tests or assessments, such as a taxi. This requires ACC pre-approval and clients contacting ACC on Ph: 0800 101 996. Where transport assistance is requested to enable attendance of NARP community rehabilitation, the location of rehabilitation must be the most appropriate setting for the individual client.

Exceptional Travel

The non-exceptional travel, less than 100km per round trip for community rehabilitation is included in the case-weighted rates and cannot be claimed by suppliers.

Exceptional Travel Time and Distance can be claimed if the round trip of a visit exceeds 100km. Invoicing starts from the 101st km to completion of trip – e.g. not from the first km to the completion of the trip.

Exceptional travel is funded based on actuals recorded and claimed based on the following formula:

Time: (Hourly rate/60) x number of minutes travelled.
Distance: Km rate x number of kilometres travelled.

Travel time and distance should be rounded to the nearest whole minute or km.

Exceptional travel may be claimed where no other option is available to meet the specific needs of the client.

Travel can be invoiced for when:

- All reasonable steps to minimise travel costs have been considered.
- The travel is necessary in order to provide services covered under the NARP Community pathway
- Travel is paid to the end point when travel is deemed as exceptional from the last client of the day
- Travel is made in the most direct practical route from the last place of service or start point

Travel cannot be invoiced for:

- Travel provided to non-ACC clients
- Travel time or distance spent between appointments that does not relate to travelling to an ACC client
- Travel on a date when a service was not provided to the client
- Travel where no legitimate / accurate records have been kept identifying that the amount claimed is reasonable

Table 8: Exceptional Travel codes and definition

Service Item code	Service Item Description	
NRPTTA	NRP community travel time	Allied Health
NRPTTN		Nursing

NRPTTS	Applies if the distance travelled is greater than 100km per round trip to visit a claimant. Max 2 per visit.	Support Worker
NRPTD4	NRP distance travel Applies if the distance travelled is greater than 100km per round trip to visit a claimant.	Over 100km (101km)

Equipment

NOTE: PHAS includes the following services:

Outpatient medical practitioner appointments, **equipment**, high tech imaging and other radiology services, for up to six weeks after discharge from acute care**.** The exception to this is Client receiving Non-Acute Rehabilitation Pathways services from the hospital. For these clients, hospital clinicians can order equipment **at any stage** to support the transition home if the equipment is needed for longer than six weeks and is injury related.

While a client is receiving NARP inpatient services the hospital will provide any equipment required by the client to meet their needs (including pressure relief needs) and to achieve a suitable rehabilitation outcome. This is funded outside of NARP case-weights. Allied Health (Physiotherapist and Occupational Therapist) assessors can request Managed Rehabilitation Equipment Services (MRES) simple list equipment however the equipment must relate to the injury-related need.

Equipment requests must be made in accordance with ACCs MRES Operational Guidelines. These are available on the ACC website.

When registering as an MRES user on the Enable site please select **Non-Acute Rehab Pathway** as the Organisation.

If a need is identified that a client requires MRES standard, complex or non-list equipment the Supplier must inform ACC who will arrange a specialist assessment service to undertake the needs assessment.

Requests for Family/ Whānau care

When a client wants family/whānau to provide home supports, this is at the Suppliers discretion. The Supplier will provide the appropriate training and risk management to family/whānau.

Payment to family/whānau must be managed by the Supplier and funding must be utilised from within the existing case-weight price.

The Supplier is responsible for ensuring that rehabilitation is provided by Providers outlined in Table 6. Suppliers will monitor the quality of care being provided by family/whānau to ensure it meets the standards required under the contract.

Funded support should complement, not replace, the support provided by a Client's Natural Support network. Hospitals 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.

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.

Telehealth

Telehealth consultations can be provided to clients where it is determined by the provider as a clinically appropriate consultation method to meet the treatment and rehabilitation needs of their client. These services are funded within the allocated NARP case-weight and in addition to hospital specific criteria the following criteria must be met:

- meet the requirements of the ACC Telehealth Guide
- have client or authorised representative consent (recorded in the clinical notes), and with the option of an in-person meeting if the client prefers.
- be preceded by an initial risk assessment to ensure client safety.
- meet the same required standards of care provided through an in-person consultation.
    - have clinical records that meet ACC and professional body requirements.
    - meet the requirements outlined in the standards/guidelines of the health provider's relevant regulatory body.
    - 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.

Cultural Safety and Responsiveness

In recognition of the need for culturally safe and responsive service delivery to support injured clients and whānau the Supplier will:

- Meet their profession's relevant cultural safety practice guidance, where available and comply with ACC's expectations.
- Monitor and record whether Māori and Pasifika needs are being met by the Supplier and use these evaluations to inform service delivery improvements. For example, evaluate clients' experience of care between Māori, Pasifika and other ethnicities.
- Identify and remove barriers to access where possible to reduce inequalities.
- Support the development of a Māori and Pasifika workforce and monitor how well staff reflect the Service User population, where applicable.
- Demonstrate how the Supplier will cultivate appropriate organisational and community linkages to inform the Supplier's cultural safety and responsiveness development.
- See additional resources ACC Kawa Whakaruruhau (Cultural Safety) Policy

Rongoā Māori services:

Access to rongoā Māori services (traditional Māori healing) are enabled to provide whānau Māori with the option to access a familiar service that aligns with tikanga Māori practices and principles. These services can be accessed in conjunction with NARP services. The Rongoā Service is a programme by Māori, with Māori, for Māori and available to people of all ethnicities. The service incorporates a holistic, kaupapa Māori approach to wellbeing that includes ā tinana (physical), ā wairua (spiritual), ā hinengaro (mental and emotional), ā whānau (family and social). For more information about this service and how to access please follow the following links:

For clients: www.acc.co.nz/rongoa
For practitioners: https://www.acc.co.nz/for-providers/provide-services/working-with-us-as-a-rongoaa-maaori-practitioner/

Quality and Outcomes Framework

Previously, ACC required hospitals to use the Australasian Rehabilitation Outcomes Centre (AROC) assessment tool in the inpatient setting.

Through the NARP Demonstration, the Joint Working Group and hospitals selected the acute interRAI assessment tool to underpin the casemix model. The interRAI assessment tool was considered a better assessment solution particularly as it builds on the other interRAI assessment tools used in the spectrum of care delivered to elderly.

Once individual hospitals have implemented the interRAI Acute Care assessment tools, there will no longer be an ACC requirement to complete the AROC assessment tool. ACC will work with Suppliers as they transition from AROC to interRAI.

In time, a new quality and outcomes framework will be developed that will be used to inform the annual quality forums and this document will be updated accordingly.

Performance Management

(Refer to Part B, Clause 15 of Service Schedule)

When the admission and discharge dates are recorded from each NARP pathway, hospitals will be required to submit data through the master spreadsheet to ACC for monitoring of the service and invoicing purposes. This data will assist with the ongoing refinement of the casemix model.

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.

Other monitoring will take place by hospitals doing their own Client surveys.

Table 2: Performance requirement

Service 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 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	Invoicing data
The service is cost-effective	Average cost per claim is comparable to other Suppliers	Annual	Invoicing data

Service Exit

(Refer to Part B, Clause 12 of Service Schedule)

Exit from NARP services.

An exit from ACC NARP services occurs when the Client no longer has injury related rehabilitation needs or has reached the maximum timeframe of 76 days inpatient rehabilitation or 12 weeks in the Community Rehabilitation pathway.

If the client has ongoing injury related needs requiring further supports, the ACC7985 Exceptional Circumstances form will need to be completed and sent to ACC (See Table 11).

When Te Whatu Ora Districts do not have Community Pathways operationally embedded, exit from inpatient rehabilitation with ongoing injury needs will be noted on the ACC705 (see Table 11)

Note that the Client may still have ongoing health related needs and meeting these needs is the ongoing responsibility of Manatū Hauora, Ministry of Health/Te Whatu Ora -Health New Zealand (formerly District Health Board) funded services.

Exclusions

(Refer to Part B, Clause 14 of Service Schedule)

Not all Clients services can be managed under NARP - Services excluded from NARP:

- Acute secondary care services i.e. medical, paediatric, and surgical services
- General practice medical services
- Specialist nursing services
- Dentistry
- Outpatient assessment such as orthopaedic
- Long term equipment for independence e.g. orthotics, prosthetics (artificial limbs), wheelchairs
- Vocational rehabilitation services
- ACC pre-approved long-distance escort or transport
- ACC funded specialist social rehabilitation assessments
- Post discharge medical consumables
- 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.
- Traumatic Brain Injury – all Clients who require specialised rehabilitation under the TBI Residential Rehabilitation or Residential Support Services must be referred to those services directly from acute treatment. The Supplier will refer such Clients to the appropriate service and/or advise ACC that the Client requires such services as soon as practicable. Note: clients with a TBI who do not require specialist services may be eligible for this Service

Linkages

(Refer to Part B, Clause 15 of Service Schedule)

The Supplier must ensure that linkages are maintained with the following Services:

- General practice medical services
- Drug and alcohol services
- Mental health services
- Education sector
- Māori health sector
- Other appropriate ethnic and cultural groups
- Government departments and agencies such as Police, Work and Income, Ministry of Social Development, Housing NZ, Ministry of Health, Ministry of Justice
- Disability consumer groups such as the Brain Injury Association of New Zealand (BIANZ)
- Community based day programmes, independent of those that may be operated by the Supplier.

Reporting Requirements

(Refer to Part B, Clause 17 of Service Schedule)

Business and Administration Rules

This section includes information on:

- Collecting and entering NARP data
- Rules on collecting data
- Forms required

Collecting and Entering NARP Data

The Supplier is responsible for collecting the data from profiling and entering it into a master spreadsheet that is provided by ACC or alternative data portals used by Districts.

Data points required include:

Provider ID

NHI

Client First Name

Client Surname

ACC Claim Number

Service (Inpatient/Community/Transitional)

Code/Group Class

Major Injury Type

- Burns_and_Complications_of_procedures

- Fracture_lumbar_spine_pelvis_shoulder_and_upper_arm
- Other_fractures
- Head_Neck_Thorax_and_Abdomen_Non_Fracture
- Fracture_of_Femur
- Inured_Upper_and_Lower_Limbs

ICD10 Code

- Service Start Date (Pathway start date)
- Service Discharge Date
- DHB Invoice Number
- Inpatient EDD (Calculated. This is built into both the master spreadsheet and interRAI)

Also to be included if not using the Master Spreadsheet (the Master Spreadsheet auto populates this field).

- Cost (case weight)

This data will be used to create an admission and discharge CSV file that hospitals will be required to submit to ACC either through the integrated data exchange (IDE) or SendInvoice.

Whether using CSV or another billing method, the same formal is required. The comments field needs to be set out in this format:

Group Class; Major Injury Type; ICD10 Code; Discharge Date; EDD

For example:

4A;Fracture_lumbar_spine_pelvis_shoulder_and_upper_arm;S32 Fracture of lumbar spine and pelvis;25/07/2023;9/07/2023

The Master Spreadsheet and Data Exchange Guide can be found here.

A report can be pulled from interRAI to capture all new assessments. This does not need to be done one claim at a time.

The Supplier is responsible for their internal processes to collate the required data into the master spreadsheet. The rules on collecting data are covered in the next section.

The information from profiling is entered into a master spreadsheet. This spreadsheet:

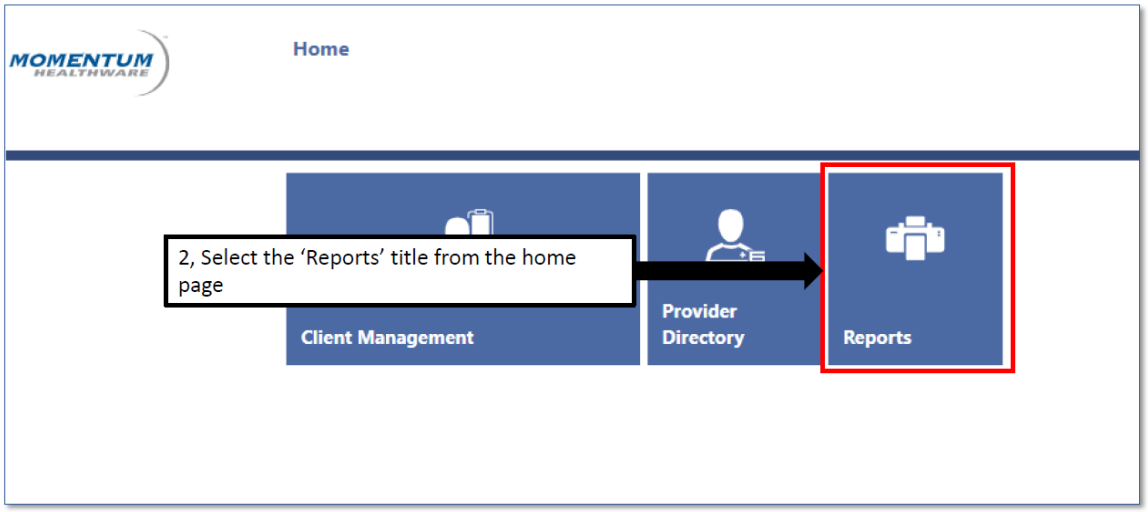
- collects service information
- captures the case-weight grouping
- collates time stamps to support service monitoring and outcomes reporting

Entering the inpatient profiling information into the master spreadsheet signals the expected date of discharge which supports care and discharge planning.

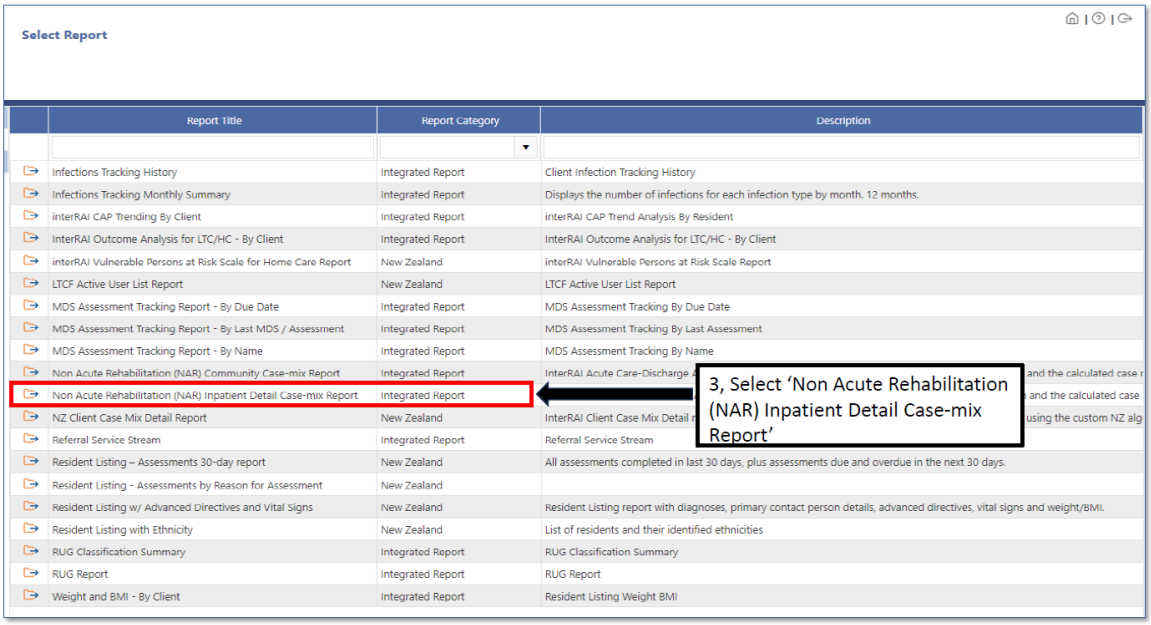
ACC will monitor the quality and timeliness of data submission and from suppliers. When there are issues, ACC will work collaboratively with Suppliers to support improvements ACC will make prompt payment on receipt of the monthly master spreadsheet.

How to access Non Acute Rehabilitation Inpatient Detail Case-mix Report

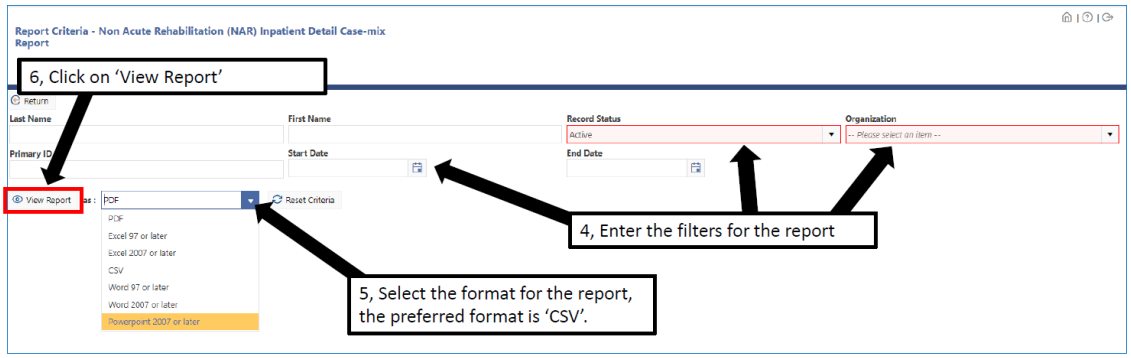
- Log into interRAI/Momentus
- On the Home screen, click on 'Reports' icon



- Select 'Non Acute Rehabilitation (NAR) Inpatient Detail Case-mix Report' OR 'Non Acute Rehabilitation Community Case-mix Report'



- Select View Report
- Select the format for the report, the preferred format is "CSV'
- Enter the filters for the report



Rules on collecting data

The table provides the rules and explanation for data collection for inpatient care.

Table 10 Inpatient rules

Topic	Rule	Comment
Adding an admission	The hospital will assess and profile the Client using the appropriate profiling tool. The profiling information will be collated into the admission spreadsheet when the Client enters the service.	Admission date to NARP (Start active rehab) is the day the Client first started participating in rehabilitation which may or may not be the day the Client came into the unit.
Interruptions in care	Interruptions in care of three days or less are ignored. An interruption of care of greater than three days requires notification to ACC and the client is to be transferred to hospital funding for the duration of the interruption.	These will be absorbed into the inpatient length of stay of the Client. The hospital will notify ACC via email claimsdocs@acc.co.nz
Readmission **0 – 7 days after the 1st discharge**	Failed discharge: Any injury related readmission against the same claim within 7 days of discharge from inpatient NARP is seen as a failed discharge. When the Client is discharged again the existing line in spreadsheet is updated with new discharge date. There will be no further case-weight assigned.	Each admission has a corresponding discharge.
Readmission **Between 8 – 180 days after 1st discharge**	Any injury related readmission against the same claim between 8-180 days after 1st discharge from inpatient NARP services the client will be readmitted under the same injury and will be profiled again using the inpatient profile tool for access to a secondary case-weight code payment and the readmission tab on the master spreadsheet will need to be updated.	Note that only the 1st admission profile is included in the admission and discharge invoice. Any subsequent admissions will require the discharge date for 2nd inpatient invoicing

Readmission 181 days after 1st discharge	Any injury related readmission against same claim number greater than 181 days since 1st discharge is seen as an exception and needs to be pre-approved by ACC.	Please use the 'NARP Exceptional Circumstances form ACC7985' to apply for this exception
Inpatient discharge date	The date of discharge from NARP inpatient rehabilitation is captured to allow invoicing to occur.	Both admission and discharge dates are required to send invoice. This information will allow collection of data on inpatient length of stay

Forms required

(Refer to Part B, Clause 11 of Service Schedule)

Table 3: NARP Service forms

Form number and name	Purpose	Explanation	Example scenario
ACC7985 Exceptional Circumstances Notifications	This form informs ACC that there is an exceptional circumstance which requires ACC approval	When a hospital identifies that one of the exceptional circumstances outlined in Table 7 has occurred they will complete the form and send to ACC	See Table 7 for further detail on exceptional circumstances
ACC705 Referral for support services on discharge	This form outlines the support the Client requires for injury related needs on discharge from supplier's care. This form should be used for patients when the NARP services criteria are not met and specific ACC services are required; i.e.: equipment, notification that the client requires residential support.	The ACC705 is used to notify ACC of client needs or circumstances not addressed in the ACC7985 Exceptional Circumstances form. Suppliers without Community Rehabilitation pathways in place will use this form to notify ACC of any discharge injury needs.	The client is discharging from inpatient or community rehabilitation pathway and requires home modifications or complex equipment: i.e. Wheelchair, permanent ramp

NOTE:

ACC NARP webpage is where you find the forms in table 11. These will be updated as needed so it is important to ensure the correct version is being used. Using outdated forms increases the risk of delays in process requests.

Glossary

(Refer to Part B, Clause 18 of Service Schedule)

This list is in addition to those outlined in the service specification.

Table 4: NARP Glossary

Term	Description
AROC	The Australasian Rehabilitation Outcome Centre based at Wollongong University provides a clinical data set that records rehabilitation episodes for Australasia to provide outcome measurement and benchmarking.
Acute Services	Emergency Department, short term acute assessment units, medical and surgical acute wards that provide acute treatment.
Active Participation	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. 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).
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.

Term	Description
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/ kiritaki	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 pathway and exited. The hospital is no longer responsible for on-going injury needs. This does not refer to discharge from one ward to another ward.
Early Supported Discharge (Rehabilitation Admission Avoidance NARP pathway)	A service pathway that: -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 buy an interdisciplinary rehabilitation and care team
Estimated Supported Discharge Date (EDD)	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
Family/Whānau	The people with a close personal relationship with the Client.
Health funding	Health funding is where the Client's service needs is due to age or illness (not injury) reasons.
Interdisciplinary team	A team of clinicians and support staff working within a team with an approach including: -Team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities

Term	Description
	-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
Managed Rehabilitation Equipment Services (MRES)	Simple List Equipment -is low cost (under $1000), easy to use, non-customised, requested often (and is able to meet the needs of the majority of clients), durable and able to be easily reissued, e.g. bath boards, walking frames, shower stools, chair raisers and kitchen trolleys.
Operational Guide	The Non-Acute Rehabilitation Pathways Service Operational Guide describes the operation of this service in detail and supports the Service Schedule
Pathways	The different service journeys a Client may receive in this Service depending on their needs such as inpatient rehabilitation, community rehabilitation or community support services
Patient	The term Patient refers to people whose funding source has not been determined or has been determined not to be ACC.
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.
Residence	Where the Client is residing temporarily or permanently.
NARP Service or Services	The inpatient and community rehabilitation/support services delivered under Non-Acute Rehabilitation Pathways (NARP)

Term	Description
Supplier	Te Whatu Ora -Health New Zealand holding a contract with ACC to deliver Non-Acute Rehabilitation services. They are responsible for all the services delivered and all actions taken.
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. 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)."
TE Whatu Ora – Health New Zealand (formerly District Health Board)	Hospitals are the contracted suppliers of the NARP service. There are twenty hospitals 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
Transfer	The Client is changing from one service to another but remains the responsibility of the Supplier for NARP service. This can also refer to a client transferring 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).