He Kaupare. He Manaaki. He Whakaora.
Prevention. Care. Recovery.

Non-Acute Rehabilitation Pathways (NARP)

ACC cover and NARP Inpatient eligibility

Questions and answers

Does ACC have a minimum expectation of what 'MDT' team input looks like? For example, the number of different health professions that treat a patient, or an expected number of patient contacts during the NARP Inpatient stay?

NARP provision should be based on clinical best practice to meet the individual patient's rehabilitation plan goals, therefore a minimum expectation or service input is not set within the NARP contract.

However, it is expected that the volume of input will be above that of normal assessment and care for discharge planning, and reflect the required intensive inpatient rehabilitation (that cannot be provided in the community). A rehabilitation plan will be formulated that outlines the intended inputs with the patient and Whanau.

NARP pathways are designed to be provider lead, allowing flexibility to deliver tailored rehabilitation for the patient's individual needs. Each hospital will have variations in how they apply the contract depending on services they have available.

If a patient has a medical event such as a stroke and sustains orthopaedic injuries when they fall, do the orthopaedic injuries meet the criteria for ACC NARP?

As there are no shared funding arrangements between Health NZ and ACC for NARP Inpatient rehabilitation, the test is that 'in the main' the rehabilitation is needed for a covered injury and not a health or age-related need for the inpatient stay.

In the scenario above, the orthopaedic injuries are likely to be covered by ACC and be eligible for treatment e.g. #hip, acute surgical management.

The eligibility for NARP Inpatient rehab will depend on the main reason for which the patient requires inpatient rehabilitation. For example, is the presenting hemiplegia the main functional limitation, or the covered physical injury?

Are patients who usually live in Aged Residential Care eligible for ACC NARP, if they have functional goals to reach?

Yes, as long as the patient meets the eligibility criteria for the relevant NARP pathway.
For example, ACC inpatient NAR profiling tool: Group 1 - do not have impaired problem-solving abilities AND are able to meet other NARP eligibility criteria, requiring rehabilitation for the injury related need.

Please explain the approval process when a patient has an ACC covered treatment injury and requires rehabilitation because of the treatment injury?

When a patient has an existing ACC covered treatment injury and requires rehabilitation relating to the accepted treatment injury, the ACC7985 Exceptional Circumstances form needs to be completed and sent to ACC for approval.

Further information on how to fill out the form is available on ACC's website: User-Guide-for-ACC7985-Exceptional-Circumstances-form.pdf

How does the admission avoidance pathway differ from little 'r' rehabilitation? Can you provide a case study example?

The Rehabilitation Admission Avoidance pathway is for patients who meet eligibility for NARP Services but who are medically stable and could successfully rehabilitate in their usual place of residence with timely input from a multidisciplinary community rehabilitation team.

This includes patients who would normally be admitted to Inpatient rehabilitation but are able to bypass admission with access to a range of community services delivered by an interdisciplinary rehabilitation and care team.

For example, a patient presents to ED with a fractured neck of humerus following a fall. The injury can be treated conservatively without surgery, but the patient needs assistance with personal care and accessing the community. It is safe for the patient to return home and finish rehabilitation without needing Inpatient care.

Can patients receive NARP Inpatient rehabilitation before and/or after accessing the Community and Transitional Pathways?

Yes, if they meet eligibility criteria for NARP Inpatient rehabilitation and this is a necessary and appropriate rehabilitation pathway. It is anticipated that this would be a rare occurrence and require clear clinical rationale for a second Inpatient rehabilitation episode. A return to inpatient setting for discharge planning (setting up home environment) is not considered 'Big R' rehab.

For example, if the patient cannot achieve independence for discharge home, from interim care facility (with NARP Transitional allied health input), a return to inpatient rehabilitation may be required for specialist MDT rehabilitation for the injury-related need. However, this scenario would be rare and require a clear clinical rationale for the second episode of NARP Inpatient rehabilitation.

Who is responsible for providing maintenance rehabilitation during the Transitional Pathway when a patient is staying in interim residential care?

Interim care in an ARC facility is a separate contract to NARP - this is for assistance with personal care and day-to-day activity e.g. showering assistance and supervision with mobilising.

A patient should only be referred for ACC funded Interim care (at an ARC facility) when they cannot safely discharge home due to their injury. NARP Transitional Care can be provided during this time if the patient is willing and able to actively participate in the rehabilitation plan.

While the ARC facility may have access to Allied health staff for maintenance rehabilitation as part of their interdisciplinary team, it is the hospital's responsibility to provide 'Big R' rehabilitation as part of the Transitional pathway.

If the hospital team are unable to provide Transitional rehabilitation while a patient is in interim residential care, this should be noted in section 6 of the ACC705 for ACC to arrange a community therapy programme with an external supplier, for example Training for Independence. In this scenario, the patient will not be eligible for Transitional NARP.

Are patients who have not had NARP Inpatient rehabilitation still eligible for the Community or Transitional Pathways?

A Community pathway can only be referred if:

- The patient meets the NARP eligibility criteria; **and**
- the patient has had a NARP Inpatient Rehabilitation or NARP Transitional Care episode; **or**
- the patient meets the criteria for Rehabilitation Admission Avoidance.

Transitional rehabilitation (Allied health input while the patient is in interim residential care) is part of the community pathways. It can be referred when a patient is in an interim care ARC facility, and requires rehabilitation input to transition back to their pre-injury place of residence.

Note: Interim care (ACC funded ARC facility bed night) can be referred when a patient no longer requires hospital level care, but temporarily is not safe to return to their pre-injury residence due to the covered injury e.g. unable to mobilise while non weight bearing (lower limb) and cannot progress until able to weight bear.

If a patient has been in residential care for NARP Transitional rehabilitation but over time it becomes apparent that the need for residential care is not wholly injury related, who is responsible for deciding if ongoing residential care should be funded by ACC or MOH?

ACC is legislatively only able to assist with injury related need. It is the responsibility of the treating health professional (referrer) to clinically assess if the initial need for short term Residential Care (ACC funded Interim Care) is primarily due to injury related need.

At any point during their stay in residential care, either agency may identify that the clients' need to stay in residential care is no longer wholly related to their injury. This should prompt a discussion between agencies as to whether a portion of the need for care is still injury-related.

Once dual needs are identified, each agency must decide on the apportionment of funding. MOH may elect to initiate a NASC referral at this point in collaboration with the ARC.

Further resources and information about the NARP service can be found on ACC's website:
Non-Acute Rehabilitation Pathway service