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

ICPMSK Webinar 4 – Performance monitoring and procurement

Questions and answers

This document includes answers to the questions raised at the ICPMSK webinar held on 24 August and further questions asked after the webinar. It also includes an updated answer to a question on hand-held dynamometry asked during Webinar 2, this update is marked and included below.

Service Design

I noted in Q&A webinar 2, 80% limb symmetry index was mentioned as satisfactory. This is a 20% loss of strength. I would consider myself professionally negligent sending an ACL patient back to sport at 80%. Where did the 80% come from?
The 80% limb symmetry index would be regarded as the minimum expectation. ACC's preference would be for kiritaki to be achieving as close to pre-injury function (100%) as possible, and ACC will have a view of suppliers achieving this. The research indicates that below 80% strength in limb symmetry likely exposes recovering kiritaki to increased risk of re-injury, and one of the reasons this threshold has been chosen is to look a bit closer at those re-injury metrics for ICPMSK.

In a previous webinar we discussed a pre-screen prior to ICP entry for some kiritaki, how will this be funded?
Pre-screens will be funded as an individual component, separate to triage and the service bundles. The level of funding for the pre-screen will be released in the service schedule.

Is this ICPMSK a fully ACC funded service or are there client co-payments required /expected?
ICPMSK is a fully funded service. There are no co-payments for kiritaki to access this service. The level of funding will be released in the service schedule.

What is the relationship between the new ICPMSK and seriously injured clients who have multiple injuries (e.g. incl. TBI).
ACC kiritaki whose injury (or injuries) meet the threshold for serious injury will not be included in the ICPMSK pathway.

Can the chiropractor within our clinic (physiotherapy clinic) operate under an ICP contract?
Chiropractors are not part of the core ICPMSK interdisciplinary team (IDT). The potential supplier may chose who is part of their wider IDT where there is value for their involvement based on the kiritaki needs, (including chiropractors). See the service schedule for more details once released.

Assume as long as we provide outcomes, can we use inline dynamometer over HHD?
We have chosen to use hand-held dynamometry for the purposes of this contract. You are welcome to record your own other strength or functional measures, but these measures are not required to be submitted to ACC.
UPDATED 30 August 2023: After consideration of the literature and consulting with experts in the field, we will be allowing hand-held dynamometry, inline dynamometry, and isokinetic dynamometry for the measurement of isometric strength of the knee.

Would ACC please comment on how kaupapa Māori services interface with ICPMSK and whether there will be a kaupapa Māori stream in the future?
Our rongoā Māori service is available to ACC kiritaki as standalone care or alongside other services and treatment. Kiritaki participating in ICPMSK can concurrently receive care from rongoā Māori practitioners.

We are developing new, regionally based Kaupapa Māori Solutions that include a hauora (health) and rehabilitation pathway to meet the needs of whānau Māori (Māori families), delivered by kaupapa Māori providers. Once designed, we expect this pathway to compliment ICPMSK, giving kiritaki options when they are in need of these supports.

The first hauora and rehabilitation services being designed under Kaupapa Māori Solutions will support kiritaki and whānau with complex injuries and a high level of need, including people who have experienced serious injuries and sexual violence. An expanded rehabilitation scope may be considered in future.

What processes are ACC putting in place where there may be multiple referrals (e.g. for VRS SAW and to ICPMSK; or COTR & ICPMSK) which have all commenced so as not to disadvantage those providers (e.g. with VRS referrals for SAW who do not hold the ICPMSK service or those using a traditional pathway with COTR and onward referrals etc.)?
Kiritaki eligible for ICPMSK require interdisciplinary input, which would be preferable to siloed care under COTR. More information about these interactions will be included in the Operational Guidelines for ICPMSK which will be released when the tender opens.

Performance Monitoring & Governance

Why so much emphasis on non-performance? Was it an issue during trial?
ACC's Huakina te Rā and the adoption of value-based healthcare creates a significant shift away from transactional nature of fee-for-service models towards a focus on enabling providers to work in innovative ways to improve outcomes for all injured New Zealanders. To enable this shift, we want to be clear and transparent regarding our high expectations for performance for ICPMSK.

There is a lot of monitoring, evaluation, outcome collection, and governance expected from the contract providers. It is a great model, taking over the role of ACC Case Managers largely and putting this in the hands of those who know the clients best; but needs to be very well remunerated. How is this funded? How much is put aside for this?
The aspects of navigation and supplier governance have been embedded in the service bundle funding and there will be more information available in the service schedule. Management of kiritaki claims will be a partnership between ICP Suppliers and ACC.

Procurement

You've said that you are currently not going to limit the number of suppliers. This suggests that if you leave it too late and apply next year that the opportunity may not be there?
We will allow each potential supplier to determine if, and when, they want to apply for an ICPMSK contract within a region. Each potential supplier will have a clear understanding of what they feel is their market share within each region they apply for.

Can you initially tender for 1 region and then further regions in March 2024?
Yes. From 4 March 2024 the contract will open again where you can apply for more body sites or regions.

Do you need to cover all 3 body sites to be awarded a contract in a region?
No. A supplier can apply to hold the contract for one, two, or all three body sites.

Are the different body parts separate contract applications?
There will be one contract application. Within the application there will be body site specific components.

Are multiple specialists/surgeons required? eg for 3 different body sites. Or can one be used even if they don't normally operate or assess a particular body site. Specialists can obviously image any body part.

You will need to have the appropriate specialist aligned with the appropriate body site you are tendering for.

In the procurement process will there be consideration for delivering broader outcomes?
The evaluation process will consider wider outcomes.

Can we be under multiple contract holders?
You can be a contract holder or subcontracted to other contract holders within the region. How you want to form the relationships within the regions is entirely up to you.

If you are currently working with ECP providers in another DHB region - ie Christchurch surgeons for Dunedin clients, to continue with that relationship with surgeons etc. Are the contract holders going to have to have a tender covering the entire southern DHB?
You will need to have surgical capacity within that region for each body site that you tender for. However, we acknowledge some specialty surgeries may have to be completed outside your region.

Is there a document with these region boundaries so it is completely clear?
Can you please clarify the regions requirements.
This will be available in the service schedule.

What types of ACC treatment providers can apply? Surgeon? Physio?
You will need to meet the provider requirements as set out in the service schedule. The ownership structure can be determined by you, ACC will need one legal entity to form a contract with.

4 weeks is a short duration for a new service and the need for bringing teams together that you have set out in earlier webinars. Has consideration been given to the timeframes with multiple processes in play all at the same time?
ACC has given consideration to market requirements for tender during September. If you are unable to apply during this window, potential suppliers will have from March 2024 through to March 2028 to apply.

As the tender does not go-live until March 2024, would ACC please consider a longer period to submit the tender?
The application process includes two steps - Step 1 a written submission and Step 2, a virtual meeting with the evaluation panel if you pass Step 1. This process includes all necessary evaluation processes and successful candidates will be offered contracts in January 2024. To ensure contract holders are ready to provide services from March 4 2024 we are unable to extend the initial tender window. However, the contract will be open for tender again from March 2024 onward (for the life of the contract).

Please help everyone understand how pilot providers do not have an advantage over new entrants wishing to tender given:

a) **their extensive experience over four years**
   The ICPMSK service design has taken the six different service pathways and standardized a single pathway/service design.
   Complete details of the ICPMSK contract are being shared with the whole market at the same time.
b) **their relationships between providers including establishing new relationships with other professional groups who may need to be party to a tender vs. a professional relationship**
   A key element of ICPMSK is the relationships between a coordinated IDT. This is regular practice for many healthcare providers working in public and private health services, this would include other ACC contracts such as vocational rehabilitation, training for independence, concussion services etc.
c) **their knowledge of the outcome of the evaluation to date and learning from the pilot**
   The ECP pilot suppliers have considerably different service design and operational procedures. They have some understanding of the overall financial benefits of the ECP cohort measures, but the remainder is the intellectual property of the contract holders.
   The ICPMSK contract design is standardised based on ACC's learnings from different pathways designs and is being shared with the whole market at the same time.

d) **that to date ACC has provided limited information from the pilot including what has been learned about the variation between pilot providers that has worked or not worked**
As noted above the ICPMSK contract design reflects the learnings of the ECP pilot.
ACC has set the parameters of the contract. The nature of the contract and provider-led client management is to allow the contract holders/suppliers to innovate the way they work within their network to drive efficiency and improved kiritaki outcomes.
Further information that informed ICPMSK service design will be available on the ICPMSK website.

e) **the short time frames set for this first round tender**
If potential suppliers are unable to apply during this window, the tender will open again from March 2024 through to 2028.

f) **Pilot suppliers will be able to demonstrate experiential knowledge in the delivery of the service (or similar service). Generally, potential suppliers will not have readily established and proven processes to deliver the service and may need to provide "hypothetical" details of how their new service will be provided. It was clear during the Webinar on the 24th of August that "hypothetical" answers to questions will be marked down.**
Contracts will be awarded based on the potential supplier's ability to meet the criteria for the ICPMSK contract, and there is no limit on suppliers within a region.

Please confirm if ACC is engaging a probity auditor to support this tender.
Yes. A probity auditor (Jess Thomas from Grant Thornton) has been engaged to support the ICPMSK tender.

Regional Requirements

- **Can you go through the "can cover a region" requirement - can you give a few examples of what does and doesn't meet this requirement?**
- **What is meant by being able to provide a service across an entire ACC region? Does this mean single site locations won't be accepted or do multiple single site organisations need to come together in order to tender? Or does this not matter if there will be multiple single site location ICPMSK providers located within a single ACC region?**

How you bring your team together to meet the requirements of the contract is up to you, provided you meet the requirements outlined in the service schedule. There is a requirement for each contract holder to cover the specified region they have applied for. The supplier must maintain a service location or service locations to ensure coverage across the whole region / rohe in a manner that does not require Kiritaki to travel an unreasonable distance to receive the services.

ECP Outcomes

- **What can ACC share about the highs and lows in the trial period?**
- **Is there a document available that summarises the outcome of the pilot and case studies for each pilot?**
- **If the team are able to take learnings from the pilot to design this service can these learnings be made available for transparency?**

We have previously published some information on the benefits seen in the ECP pilot here:
About Integrated Care Pathways
Integrated Care Pathways, a new service coming soon
ECP pilot continues to show positive benefits
ECP pilot showing positive benefits

We are releasing an internal document (Developing ICPMSK) that was used to map and inform components of the ICPMSK service design. This document includes key learnings we gained from the ECP pilot. Please note this document represents a point in time and does not necessarily represent the final ICPMSK service schedule and operational guidelines. This will be available on the following webpage How to apply for the ICPMSK service contract, under the Webinar 4 section.

The data for injuries in the regions was mentioned as having been released - is this specific to ICPMSK eligible injury numbers only - and can you provide a link to this data?

This is available on the following webpage How to apply for the ICPMSK service contract, under the Webinar 4 section.

Please provide a copy of the evaluation (or the partial evaluation or series of evaluation/progress reports) of the ECP that would have been done to inform the ACC Board decision.
This will be made available on the ICPMSK website. The benefit profile measured in ECP (reinjury, subsequent surgery, weekly compensation, long term claim costs) are measured over a 2 year timeframe from the kiritaki's date of entry. As a result, the data takes time to mature/accrue benefit. ACC will continue to review this data for a significant period of time after the ECP conclusion.

Please help everyone understand why ACC is tendering a service when the pilot has not been concluded and a full evaluation is yet to be completed and then made available to providers ahead of a tender process
The ECP pilot for kiritaki with identified injuries that may require surgery has demonstrated positive benefits which has given confidence to take this cohort (knee, lower back and shoulder) back to market without a delay between services.

The ECP pilot will continue up until the launch of ICPMSK. This will ensure there is no service gap prior to ICPMSK start date. Kiritaki will continue in ECP for the duration of their recovery and not transfer into the ICPMSK service.

Other

Could ACC comment on the long term vision for ICPMSK and how this might impact on other services including cost of treatment regulations?
ICPMSK will be a new way of working for ACC and the broader sector. To determine whether there are any future impacts to other existing services, we need to understand this way of working approach once implemented. As the service matures, we will continue to review the scope and direction of ICPMSK. Other ACC services will still be available for ICPMSK kiritaki if deemed more appropriate – including contracted and regulation services.

Could ACC comment on the relationship of ICPMSK to Huakina Te Rā at a practical level?
The ICP MSK service aligns with the strategic outcomes and goals outlined within Huakina Te Rā. Expanding the ICP MSK service throughout Aotearoa / New Zealand and targeting all supplier groups, with a particular focus on sourcing community-focused supplier groups, will allow ACC to deliver services to all and support and improve access to the scheme for Māori and priority populations. We will improve the service experience by offering kiritaki an increased range and flexibility of services that will support Mana Taurite | Equity.

We will build on the insights and service design tested within the ECP pilot. We will continue to grow trust and confidence in the scheme as ACC builds meaningful partnerships with suppliers, providers, kiritaki, and with tāngata whenua. ACC observed that kiritaki enrolled in ECP pilot had reduced rates of surgeries, re-injury rates, days on weekly compensation, and long-term rehabilitation reactivation costs. These reductions will aid with the sustainability of the scheme for future generations and align with our dual goal of Ringa Atawhai | Guardianship.

As we embed the ICP MSK service within regional communities, improved whānau safety and resilience will enable ACC to achieve Oranga Whānau | Safe and Resilient Communities. ACC will focus on preventing and mitigating the impacts of injuries by ensuring that community-focused supplier groups, are not excluded from funding while investing in community, initiatives, and primary prevention activities, enabling communities to thrive and flourish.