PREVENTION. CARE. RECOVERY.

Te Kaporeihana Āwhina Hunga Whara

Pain Management Service

Guidelines for Providers

December 2017

Useful contacts and telephone numbers

Delivering Pain Management Service on ACC's behalf is likely to involve you contacting a number of our teams. Here are their contact details.

ACC Provider Contact Centre	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 Portfolio Advisor for Pain Management Service, or email us at Painmanagement@acc.co.nz	

The ACC website can provide you with a lot of information, especially our "Health and service providers" section. Please visit www.acc.co.nz

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

Contents

1. Introduction

Welcome to the Pain Management Service Operational Guidelines. This document is intended as both a guideline for those working to deliver pain management, and also as a framework document for ACC case owners.

These guidelines apply to all professions delivering services under this contract across all geographic regions.

These operational guidelines should be read in conjunction with the:

- Standard Terms and Conditions document; and
- Service Schedule for Pain Management Service ('your contract').

Your services must comply with your contract. Where there are any inconsistencies between the operational guidelines and your contract, the contract will take precedence.

These guidelines are a living document and will be updated in response to Supplier/Provider and client feedback, Provider service delivery issues, and as part of ACC's continuous improvement processes. You will be notified when each new version is issued and the latest version will be available on the ACC website at www.acc.co.nz.

1.1. What is pain?

The International Association for the Study of Pain (IASP) provides this definition: "Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage." [1]

Each person's pain experience is individual to them and varies in terms of frequency, intensity, and impact. Because pain is experienced, the quality of pain can only be defined by the person suffering from it. Pain can be a persisting symptom that affects a client daily, often for years, after the original injury. Many individual factors can affect the severity of pain a person feels and how much it impacts on their ability to participate in everyday life. A successful outcome for a client with pain may be that the person is able to manage their pain and lead a fulfilling life.

Intrusive or disabling pain is experienced by 20 per cent of the general population at any one time.[2] Despite experiencing pain, most people manage a range of activities and, with optimal management, will also manage participation in the workplace, place of education, and their usual activities.

1.2. Key principles of Pain Management Service

The Pain Management Service has been designed to improve clients' outcomes and experience by reducing the impact of pain following an injury. Key principles of the service include:

- ✓ **Good communication** between ACC, Suppliers/Providers, and the client is a cornerstone to working collaboratively towards the agreed goals.

[1] www.iasp-pain.org/Taxonomy.
[2] World Health Organisation supports global effort to relieve chronic pain Geneva (11 October 2004)

- ✓ **Right service, right time, first time**. Early recognition, acknowledgement, accurate assessment, and timely intervention can reduce the risk of pain-related disability, and significantly enhance the client's quality of life.
- ✓ **Tailored Pain Management Programme plan for every client.** The Pain Management Service is designed to offer a flexible multidisciplinary approach. An effective Pain Management Service considers the whole person, not just their injury, and is tailored to meet their individual needs.
- ✓ **Multidisciplinary and collaborative** approach to pain management. The Pain Management Service uses a multidisciplinary approach that considers the client's overall health and wellbeing and encourages them to actively participate in their rehabilitation plan.
- ✓ **Services are "outcome based".** It is vital that all treatment and rehabilitation efforts are targeted towards functional outcomes. Providers work alongside others involved in the client's rehabilitation to return clients to work or work readiness, education or independence.

2. Who is this service for?

The Pain Management Service is for clients who have:

- Persistent pain that is preventing them from undertaking their usual activities, including work
- Significant pain-related disability
- Those at risk of developing pain-related disability following an injury

The Pain Management Service is a specialist service. If the client's pain can be managed within an existing programme (eg a Stay at Work programme), there is no need to refer the client to the Pain Management Service. However, if more intensive input from a specialist service is required and the client meets the referral criteria, the client may be referred to the Pain Management Service.

2.1. Eligibility and entry criteria

Referrer	Criteria
GP / Primary Care Health Practitioner	• The client has a covered injury with ACC, **and** • Client has achieved a score of 50 or above in the short-form OREBRO when referred to the service by a primary healthcare provider, Or • If the client has achieved a score of less than 50 and the primary healthcare practitioner has clinical evidence the client would benefit from the pain management service, a referral can be considered via ACC. See ACC case owner as referrer for more information

ACC case owner	• The client has a covered injury with ACC, **and** • Client has been identified as high-risk on completion of ACC's Rehabilitation Progress Checklist (RPC) by the ACC case owner Or • Where the client has a score of less than 50 in the short-form OREBRO or were low-risk on completion of the Rehabilitation Progress Checklist, the client can be referred to the service if: ○ Recommended by an ACC Rehabilitation Advisor, Triage Manager, Branch Advisory Psychologist (BAP) or Branch Medical Advisor (This entry pathway may also be used for paediatric/child/youth referrals).

Note: The client needs to have a covered injury to have eligibility for the Pain Management Service. Chronic Pain is not an injury or a diagnosis. Where the diagnosis has been described as "Pain" or "Chronic Pain" the ACC case owner will refer to the normal internal processes for confirming the covered injury and the causal link between the covered injury and the request for entitlements.

3. Referrals

Referrals can be made into the Pain Management Services Group Education, Community Services or Tertiary Service Delivery by an ACC case owner, GP (or lead medical practitioner), primary health practitioner, or any ACC funded health practitioner.

Before a referral can be made to the Pain Management Service, screening must be completed using the short-form OREBRO (for health practitioners) or ACC's Rehabilitation Progress Checklist (for ACC staff). A referral can be made to the service if these screening tools identify that the client has:

a) A score of 50 or above in the short-form OREBRO or;
b) Been identified as "high-risk" on completion of ACC's Rehabilitation Progress Checklist (RPC)

3.1. Pain Management Service forms

All Pain Management Service forms are available on the ACC website

https://www.acc.co.nz/resources/

- ACC6271 Pain Management Service Referral (Referral from case owner)
- ACC 6273 Provider Referral for Pain Management Service form (note Orthopaedic Specialist referral may be via clinical letter)
- ACC 6272 Pain Management Plan, Review Update and Completion Report form
- ACC 4246 Interventional Pain Management Request

If the service is...	ACC referral	Health Practitioner referral
Group Education	ACC case owner can make a referral by completing the ACC6271 Pain Management Service Referral form.	The Health Practitioner completes the ACC6273 Provider referral for pain management service form and sends this directly to a Pain Management Service Provider. The Pain Management Service provider sends a copy of the ACC6273 to ACC and requests approval for the service.
Community Service Stage One (CSS1)	ACC case owner can make a referral by completing the ACC6271 Pain Management Service Referral form.	The Health Practitioner completes the ACC6273 Provider referral for pain management service form and sends this directly to a Pain Management Service Provider. The Pain Management Service provider sends a copy of the ACC6273 to ACC and requests approval for the service.
Community Service Stage Two (CSS2)	Transition to CSS2 is possible once all resources in CSS1 have been, or are likely to be, utilised. Therefore there is no direct referral to CSS2. The ways a transition is possible are: 1) Case owners identifies it will be a CSS2 from the beginning and makes a referral for both PN100 and PN200 2) Suppliers identify it will be a CSS2 from first assessment and request a CSS2, which case owner approves 3) Resources get used up in CSS1 due to unforeseen circumstances and an extension to CSS2 is requested 4) A Tertiary Service may assess and discharge a client to Community Services as their needs will be better met in the community.	Referrals to Community Services are made via CSS1.
Tertiary Service Delivery	ACC case owner can make a referral by completing the ACC6271 Pain Management Service Referral form. The case owner may seek advice	The Health Practitioner completes the *ACC6273 Provider referral for pain management* form and sends this directly to a Pain Management Service Provider.

	using internal ACC processes prior to referring to the Tertiary Service.	The Pain Management Service provider sends a copy of the *ACC6273* to ACC and requests approval for the service. Community Services may refer to Tertiary Service Delivery following a recommendation by Tertiary Support Service in instances where the Tertiary Support Service has identified that a client requires clinically complex or intensive services not available in the Community Service or outside the Community Services capability. The Community Service will make the referral directly to the Tertiary Service. On receipt of the referral, the Tertiary Service will seek approval from the ACC case owner.
Tertiary Support Service	Referrals to the Tertiary Support Service are instigated by Community Services. (Approval from case owner not required)	Community Service providers contact the Tertiary Support Services directly via email or phone. Community Services are responsible for documenting the advice provided by the Tertiary Support Service and updating the ACC6272 Pain Management Plan, Review Update and Completion Report form.

3.2. Referrals for non case-managed claims

Call our Provider Helpline on 0800 222 070 or email us at providerhelp@acc.co.nz

Let us know that your client is participating in a Pain Management Service and provide us with their claim number.

Our helpline staff will let you know who the case owner is or have one allocated and a case owner will be in touch with you.

3.3. Release of Client Information at Referral

ACC is able to send/release information to Providers at the early stage of referral before the Provider has contacted the client as the client has authorised this in their initial application for cover, and it is a purpose for which the information is provided (under the Health Information Privacy Code). This extends to the Provider asking ACC for further information at the time the referral is made.

3.4. Approving or declining a referral for Pain Management Service

Any request for entitlements to meet a client's need for a covered injury will follow the normal ACC processes and timeframes for entitlement decisions.

If a Supplier declines a referral, this must be discussed with the case owner and a rationale provided. Suppliers must also record the number of declined referrals as per the Reporting Requirements defined in the Service Specification.

3.5. Client not suitable for the Pain Management Service

If a client is assessed as not being suitable for the Pain Management Service, the Provider updates the ACC6272 Pain Management Plan, Review Update and Completion Report form and sends this to the case owner. This should detail:

- Why it is believed that the client should not enter or continue the pain service
- Any changes in the client's status
- Any other recommendations to support the clients rehabilitation

4. ACC's obligations under the Accident Compensation Act 2001

It is important that the client's eligibility is clarified before providing services because ACC may not be able to pay for services when:

- ACC cover is not accepted,
- the client has no entitlement for the service,
- services provided go over and above the service limits

The ACC case owner will confirm eligibility via email to the Provider.

The Accident Compensation Act 2001 describes ACC's responsibilities with regards to

1) **Determining cover** for an injury, and;
2) **The provision of treatment and rehabilitation support necessary and appropriate** to assist in restoring the client's health, independence and participation in regards to the covered injury.

It is important to note that under the Accident Compensation Act 2001, ACC is only responsible for provision of services related to the covered injury. Non-injury related factors (such as other health conditions or life circumstances) should be documented in the assessment and completion report as the pain condition must be considered in the context of a "whole person" view of the client's presentation. This does not mean that ACC or Providers have obligations or responsibilities to deliver services to directly address non-injury related factors.

Once a decision has been made that the client's pain condition is covered under the Accident Compensation Act 2001 and a decision has been reached regarding the provision of treatment and rehabilitation for that condition, the ACC case owner negotiates an Individual Rehabilitation Plan with the client.

5. The Individual Rehabilitation Plan (IRP)

The IRP is a document negotiated between the ACC case owner and the client. The IRP states the overall rehabilitation outcome and sets out the planned treatment and rehabilitation activities which are necessary and appropriate to achieve that outcome. For example, the IRP may state that the overall outcome for the client is to return to education, work or independence and the planned activity includes details regarding the referral to the Pain Management Service. A copy of the IRP should be sent to the Pain Management Provider.

The Provider's pain treatment plan supports the overall rehabilitation outcome goal as stated in the client's IRP and provides details of the treatment plan. While the IRP provides the overall case goals and activities, the pain treatment plan agreed between the Provider and client sets out the specific goals and activities provided by the Pain Management Service. The plan drawn up by the Provider links into the IRP drawn up by the ACC case owner.

There is an expectation that ongoing review of the efficacy of any treatment plan will be undertaken by the Provider.

Both the IRP and the Provider's treatment plan are updated throughout a client's rehabilitation journey. Changes to the IRP or the Provider's treatment plan will be discussed and communicated with the client, ACC case owner and other treatment providers involved in the client's care. Where required, a copy of the IRP will be provided to the Provider by the case owner.

6. Multidisciplinary Team

The Pain Management Service multidisciplinary team (MDT) works together to provide integrated, holistic support individualised to each client's needs. It is essential that the MDT collaborates and is guided by shared decision-making, where possible as part of team meetings and/or discussions. Members of the MDT must not deliver services in isolation or where there is limited discussion or collaboration between all members of the team, including interventional procedure providers.

The use of professions over and above the core multidisciplinary clinical team is at the Supplier's discretion and should be based on the client's need. The client's GP/primary health practitioner is a key member of the wider MDT involved in their care throughout the client's journey and it is expected that the Pain Management Service MDT team works collaboratively with the GP and any other client treatment or service providers.

6.1. Key Worker

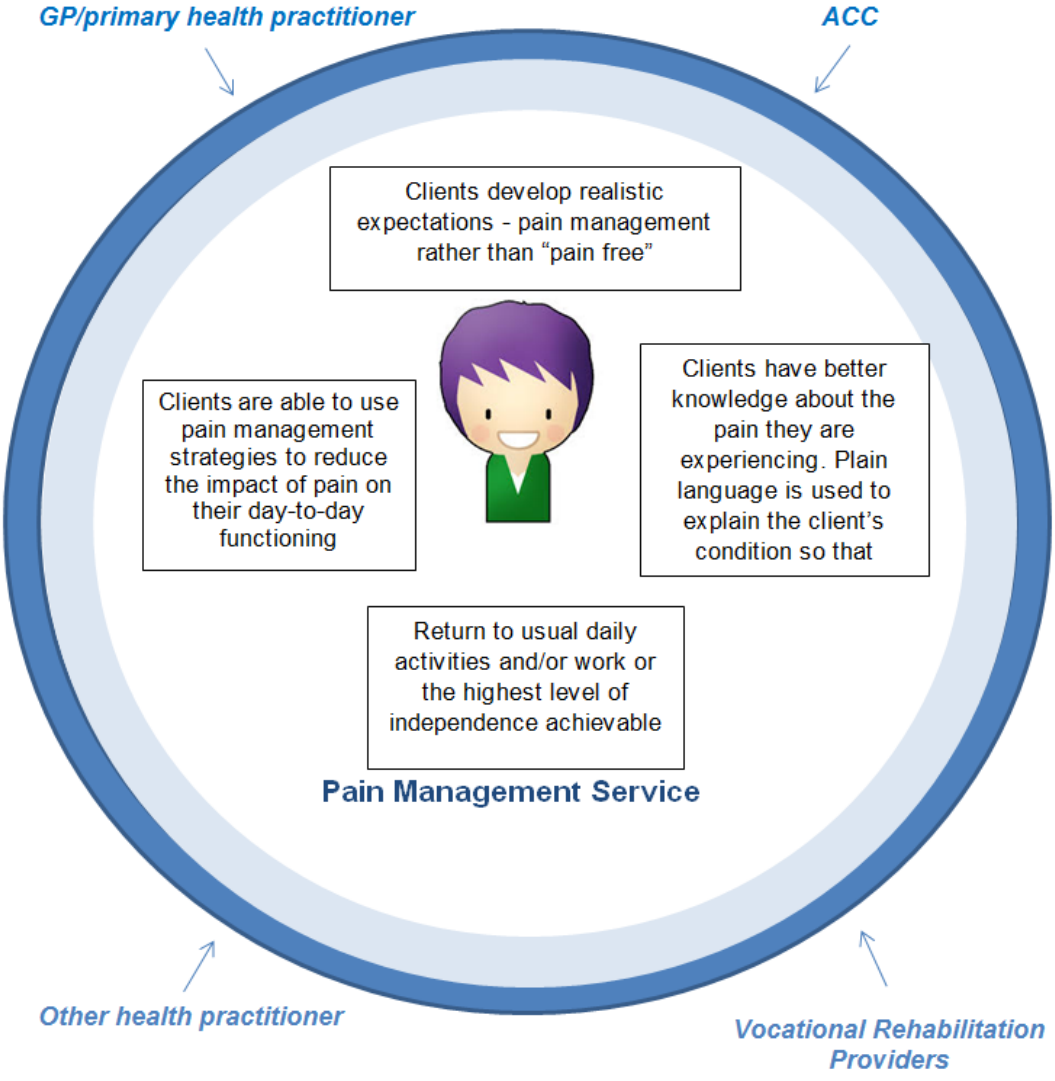
As there is more than one health practitioner is involved, the support must be collaborative to ensure an integrated experience for the client. The key worker is a significant contributor to the success of the service and is important to the achievement of client goals. For each client, One member of the core team (as noted in the service schedule) will be designated as the client's key-worker and is responsible for:

- holding, on behalf of the supplier and the interdisciplinary team, overall responsibility for the client's outcomes
- coordinating providers within the service to ensure the greatest efficacy and efficiency of the client's goals and outcomes

- informing ACC of issues with providing the service
- ensuring reports are provided on time and accurately reflect the service provided
- maintaining links with community groups and other organisations working with the client
- coordinating and liaising with ACC and non-ACC services to ensure the client receives smooth, supported transitions with integrated services
- maintaining an ongoing relationship with the client's ACC case owner to ensure high quality service and outcomes are achieved.

The key worker is most effective in their relationship with the client when they:

- are proactive in their contact with the client, family and whānau
- are responsive to their cultural needs
- maintain a supportive, open relationship
- provide a safe and trusting environment
- approach the relationship in a holistic, client and family-centred way
- are committed to working within the bio-psycho-social model
- work across agencies
- work with families' strengths and ways of coping.



6.2. Collaboration with other rehabilitation and health services

Communication should include all parties involved in providing the treatment and rehabilitation services to ensure that everyone is working toward the same outcome. This includes the client, GP/primary health practitioner, or specialist (where a GP/primary health practitioner is not involved), the ACC case owner, multidisciplinary team, and all other clinicians or people involved in the client's care. Liaison and collaboration is essential to create a client-centred, tailored pain management service.

The ACC case owner should advise the Pain Management Service of all the treatment providers the client is seeing at the time of referral and whenever the ACC case owner becomes aware that the client is participating in services outside the Pain Management Service.

Prior to writing up assessments, updates and completion reports, the multidisciplinary team must speak with the GP and any other treatment or service providers. The ACC case owner should be included in all communication, e.g. letters and emails.

It is intended that the Pain Management Service complements the work of any other rehabilitation being delivered to the client. For example, the Pain Management Service could take place alongside Vocational Rehabilitation Services. Providers need to ensure there is close communication between all parties.

6.3. Other rehabilitation services

Other rehabilitation services commonly used before, after or concurrently with the Pain Management Service may include, but are not limited to:

- Vocational Rehabilitation Services (VRS) for support to return to work and/or independence. If Return to Work is a goal, then the Pain Management Service should be delivered in conjunction with the Vocational Rehabilitation (VR) Provider. Each provider provides their own reports to the ACC case owner but collaborates and communicates with each other to ensure consistency of service delivery and outcomes
- Concussion Services
- Training for Independence for education, support, training, and rehabilitation with clients in the most appropriate setting for the client, e.g. their own home, community, or school
- Home and Community Support Services (HCSS) for home help, personal care, child care,
- Equipment
- Elective Services for clinical assessment and surgery
- Clinical treatment such as General Practice (GP) support, physiotherapy, osteopathy, acupuncture, elective surgery.

- Hospital treatment, such as Public Health Acute Services, which includes care in first six weeks of hospital discharge.

Where clients are already engaged with a Provider who is not part of the Pain Management Service MDT (e.g. a physiotherapist), the client is offered the choice to remain with their existing treatment Provider who will work collaboratively with the Pain Management Service or to transfer to the Providers who are contracted under the Pain Service. If the client has been referred for stand-alone Group Education, physiotherapy may continue so long as the services are deemed complementary.

Where the client receives conflicting medical or rehabilitation advice, the Provider should escalate their concerns to the ACC case owner. This could include advice the client is receiving from alternative or complementary treatment providers. The case owner will seek the advice using the ACC internal process of Managing Clinical Advice conflicts.

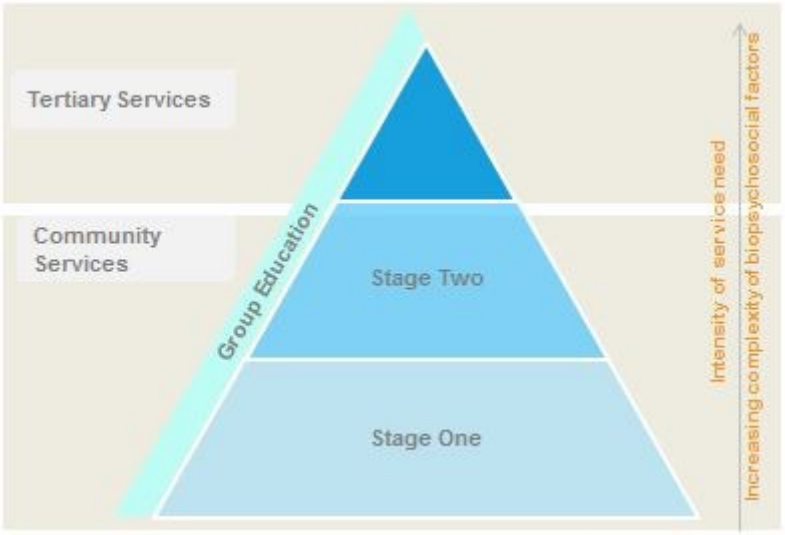
7. Overview of the Pain Management Service

The Pain Management Service consists of three components:

Group Education - is a specialised, stand-alone programme for clients who would benefit from education about pain and learning self-management strategies and who may not require more intensive Community or Tertiary Services. In exceptional cases the Group education may of benefit prior to or to prevent the need for a full pain management service or used as a refresher on pain management strategies following a community or tertiary service (not within 6-12 months of completion).

Community Services - consists of two stages. Community Service Stage One (CSS1) is for those with less complex needs or barriers to rehabilitation. Community Service Stage Two (CSS2) is for those clients with persistent pain concerns and complex barriers to pain rehabilitation and who will utilise more resources than available under CSS1.

Tertiary Services – is for clinically complex clients who require intensive multidisciplinary services to support them with long-standing persistent pain. Tertiary Services may also provide support to Community Service Suppliers through the Tertiary Support Service



More detailed information on these components is provided below.

7.1. Group Education

Education about pain and self-management strategies is an integral part the Pain Management Service, including Community and Tertiary services. The education component of Community and Tertiary services (funded within the capped rate) will be delivered in conjunction with other interventions, such as functional rehabilitation or cognitive behavioural therapy. Therefore a stand-alone Group Education programme is available for clients who may not require the more intensive input of Community or Tertiary Services. These clients can be referred directly to Group Education **instead** of Community or Tertiary Services.

Clients who have completed a Pain Management programme and require refresher training about applying the pain management strategies they have learned, may also be referred to a Group Education programme

Group Education provides a specialised, stand-alone programme, delivered through weekly workshops over a period of 6-8 weeks. Group education must be delivered using the **Stanford Chronic Pain Self-Management**[3] programme format or an equivalent model.

Group Education sessions provide clients with education about their pain, pain management and provide coping and self-management strategies in addition to providing clients with group support. Group Education classes are highly participative to ensure that clients are actively engaged in their learning and rehabilitation. The programme gives participants the skills to coordinate all the things needed to manage their health, as well as to help them keep active in their lives.

Example:

John is referred to Community Services and is assessed as not requiring the level of input provided within Community Services. However the supplier believes John would benefit from learning more about pain and self-management strategies within a structured education programme. John is referred on to Group Education.

Group Education sessions will:

- Educate clients about their pain (including nutrition, pacing activity and rest)
- Provide information about pain management including appropriate use of medications
- Provide the client with coping and self-management strategies such as:
    - Techniques to deal with problems such as frustration, fatigue, isolation, and poor sleep
    - Appropriate exercise for maintaining and improving strength, flexibility, and endurance

[3] Stanford Chronic Pain Self-Management Programme: http://patienteducation.stanford.edu/programs

    - Effective communication with family, friends and health professionals
- Provide group support

Suppliers contracted to deliver the Pain Management Service may deliver Group Education themselves or may sub-contract to another other healthcare provider e.g. a Primary Health Care Organisation in the community. Where the Supplier sub-contracts for Group Education, the Supplier will seek payment from ACC and manage the payment to the third party.

Where Suppliers wish to use an alternative equivalent model, prior approval must be gained from the ACC Portfolio team who will determine whether the programme meets the standard of the Stanford model. Suppliers will need to provide information about results achieved and any changes to the programme or personnel etc. when appropriate and on request by ACC Portfolio team

Add-ons

There are no add-ons to the stand-alone group education.

7.2. Community Services Stage One (CSS1)

Community Services Stage One (CSS1) is for those clients with less complex needs or barriers and can be used as a stand-alone service or as an add-on to other ACC services. CSS1 is for clients who have, or are at risk of developing pain related disability following an injury. An ACC6273 Pain Management Service Referral form is completed by the Provider (or an ACC6271 is completed by an ACC case owner) and sent to the CSS1 Provider.

The outcomes of CSS1 are to:

- Educate the client about their pain, and set realistic expectations.
- Work with the client to develop self-management strategies to manage their pain.
- Return the client to work (before or in conjunction with the Vocational Rehabilitation Service), independence, and manage their pain to the best extent possible

Assessment

An initial assessment will be carried out by relevant members of the multidisciplinary team to determine the client's goals, identify any pain rehabilitation barriers and develop an action plan to overcome these barriers to achieve an outcome.

Time frame

Because it is based on the needs of the client, delivery of services for CSS1 is not time limited.

Add-ons

There are no add-ons to Community Services Stage One.

Example:

Brian is referred to Community Services and is seen by James, a Physiotherapist, and Kelly, a Psychologist. Based on Brian's goals, James and Kelly develop a 12-week programme of functional rehabilitation and cognitive behavioural therapy. At six-weeks Brian's progress is reviewed by James and Kelly who also consult with the medical practitioner on their team. Everyone is happy with the progress Brian is making – Brian is on-track to achieve his goals. At week 12 Brian has achieved his goals and is discharged – James, the Key Worker, has a conversation with Brian's GP about the great progress he's made and the self-management strategies Brian has been taught to manage his pain.

7.3. Community Services Stage Two (CSS2)

Community Service Stage Two (CSS2) expands and builds on the services delivered in CSS1. CSS2 is for clients with **persistent pain concerns and complex barriers** to their pain rehabilitation and who require additional resources to the services delivered in CSS1.

CSS2 must include medical practitioner input and a medication (pharmaceutical) review. Where a pharmacist has completed the medication review the report is received by the MDT team. If the recommendations require psych or allied health input and follow up (not medical), then medical input is not required into the medication review.

The outcomes of CSS2 are to:

- Help the client develop self-management strategies to manage their pain
- Return the client to work (before or in conjunction with the Vocational Rehabilitation Service), independence, and manage their pain to the best extent possible.
- Improve the client's quality of life and functioning.

Assessment: Transition from CSS1 to CSS2

Should a client need to transition to CSS1 from CSS2, a brief multidisciplinary review by relevant members of the team is undertaken when the need is identified. This is then discussed with the case owner who will approve or decline CSS2. Once approved a more detailed revised plan will detail how the CSS1 resources were used and why additional resources are required to achieve the outcome(s) stated on the new action plan.

In some cases the initial assessment for CSS1 may immediately identify the need for more resources than available in CSS1. If this is the case the Supplier needs to discuss this with the case owner and request CSS2 approval immediately. The initial plan then becomes that of a CSS2 pain rehab programme.

The following table sets out the expectations of the assessments:

If….	Then...
The CSS1 initial assessment identifies the client will need additional resources and a transition to CSS2	The CSS1 initial assessment includes the request for additional hours under CSS2. The provider may commence services using CSS1 resource while awaiting approval of the additional CSS2 resources. CSS1 Completion report code should not be claimed in this scenario. The CSS2 Reassessment (assessment and report)

If….	Then...
	code can be used to complete a mid-point review for this programme.
The need for additional resources and a transition to CSS2 is identified toward the end of the CSS1programme	The need is discussed via phone and/or email as a progress update. Once approved the CSS2 Reassessment code is used to submit the request to ACC the updated action plan. CSS2 resources must be approved by ACC before commencing service provision.

Example one:

Marie, an Occupational Therapist, is completing an initial assessment under CSS1 with her client, Sarah. Due to a number of barriers Marie involves John, a Psychologist, in the assessment. Marie also consults with the Pain Specialist on their team following the assessment. The team believe more resources than available in CSS1 will be required to achieve the goals they've agreed with Sarah.

Marie discusses this with the ACC case owner who approves CSS2 on the purchase order. Marie then completes the initial assessment report with input from the multidisciplinary team. The report to ACC sets out how the CSS1 +CSS2 resources will be used. If there is a time delay Marie and the team may commence treatment under CSS1 while waiting for ACC to consider the request for CSS2.

Example two:

Susan has received CSS1 Pain Management Service and is approaching the end of her programme. Cath, her key worker, thinks that Susan will require additional services to achieve the goals they've set. Cath arranges for a multidisciplinary review and the team agrees additional input is required. Cath discusses this with ACC case owner who approves CSS2. Cath then updates the action plan, details what input was delivered under CSS1, and provides details why additional resources are required to achieve the outcomes stated on the action plan. The updated assessment and plan is sent to the ACC case owner.

If the Medical Practitioner determines that Susan would benefit from an interventional procedure, a request for approval of the procedure can be sought at any time once transition to CSS2 has been approved by ACC (further information about interventional procedures can be found in section 9.2).

Time frame

Because it is based on the needs of the client, there is no set timeframe for CSS2.

Add-ons

Select interventional procedures (excluding neuromodulation) may be purchased as an add-on to the multidisciplinary programme. More information on the process to apply for an interventional procedure can be found in Section 9.2 Interventional Procedures.

7.4. Tertiary Services

Tertiary Services consist of three components:

1. Tertiary Service **Delivery** will provide clinically complex or intensive services to support clients with long standing persistent pain and significant pain-related disability. This can be delivered as:
    a. An **Out-patient** programme, or
    b. A **Residential** Programme.
2. Tertiary **Support** Service is a liaison service to give clinical advice (via phone or email) to Community Service Suppliers for complex cases.

In really exceptional cases it may be identified during a Tertiary Out-patient or even a Community Service that the client may benefit from a Residential programme. This can be arranged upon discussion between Suppliers and ACC case owner.

7.5. Tertiary Service Delivery

Tertiary Service Delivery is for clients with **long-standing persistent or clinically complex pain** that require intensive pain management. The multidisciplinary team in Tertiary Service Delivery is led by a vocationally registered Specialist Pain Medicine Physician. Tertiary Service Delivery can be provided by either outpatient or inpatient services.

While clients are not expected to move through Community Services into the Tertiary Service, in the event this does occur the Tertiary Service is able to utilise the resources available in the Tertiary Services.

The outcomes of the Tertiary Service Delivery are to:

- Encourage their re-engagement in work and everyday activities
- Work with the client to develop self-management strategies so that the client is able to manage their pain
- Assist the client in preparing for a return to employment and/or every day activities
- Promote a return to independence by helping the client to improve their level of function and quality of life

Tertiary Inpatient/Residential Service

As part of Tertiary Service Delivery the client may be assessed as requiring an inpatient residential service. The Residential Tertiary programme is an intensive three week programme. The client has interaction with the team of clinicians for at least five hours per day for five days per week. The purpose of the residential programme is to work with the client on improving their function and help the client with modifying their response - despite the presence of pain. Sessions are conducted individually as well as in a group environment.

The client works with the MDT to manage their pain through:

- The use of multimodal activity, behavioural activity, behavioural intervention, education and vocational rehabilitation
- Adopting a self-management approach in the management of pain-related disability
- Enhancing the level of independence and participation in usual activities such as work and/or home tasks as identified in the client's IRP; and

- Communication and liaison with relevant key stakeholders to provide a safe, collaborative and seamless service and to support the client's reintegration and participation in their community.
- Costs for Accommodation, food and transport for clients attending the Tertiary Residential Programme are paid pro rata for the days attended. Payment is made directly to the Supplier.
- The case owner is responsible for organising the client's travel from their home to the DHB and return where the client does not live locally and this is paid outside of the provisions of the Tertiary Residential programme.

Assessment

Tertiary Service Delivery includes a comprehensive multidisciplinary assessment undertaken by relevant members of the multidisciplinary team. It identifies the client's goals and rehabilitation needs and develops a pain programme that aims to provide pain education and self-management strategies addressing a client's long-standing and complex pain needs.

Time frame

Because it is based on the needs of the client, delivery of services for Tertiary Delivery outpatient services are not time limited.

Add-ons

Select interventional procedures (including neuromodulation) may be purchased as an add-on to Tertiary Service Delivery. More information on the process to apply for an interventional procedure can be found in section 9.2 Interventional Pain Management.

Example:

Robert has significant pain-related disability and is referred to Tertiary Services. The Tertiary Service completes a comprehensive multidisciplinary assessment with input from a Physiotherapist, Nurse, Psychologist and Pain Specialist. Jane, Robert's key-worker, collates the assessment findings and recommends to ACC that an outpatient programme over a specified period is needed in order to achieve the goals which have been developed with Robert.

7.6. Tertiary Support Service

The key objective of the **Tertiary Support Service** is to allow community services to seek specialist advice from a range of professional disciplines in order to support the delivery of services to clients in the community. The Tertiary Support Service does not act as part of the Community multidisciplinary team or deliver any component of the community service, such as assessment or medication review.

Key features of the Tertiary Support Service

- Receives and responds to email or phone requests from Community Service Providers with advice relevant to the clinical presentation of the client
- Provides support by attending a case conference via telephone to provide advice and input into the clinical discussions

- Reviews and provides recommendations to rationalise the number of interventions if appropriate
- Allows Tertiary Service Delivery Suppliers to recommend to ACC that a client currently receiving CSS1 or CSS2 services be referred to the Tertiary Service Delivery for more complex or clinically intensive services
- Allows Tertiary Service Delivery Providers to liaise with a client and Community Service Providers when the client has been discharged from the Tertiary Delivery Service into a CSS1 or CSS2 programme.

Example:

Trudy is participating in a Community Service in the Hokianga in the far north, with supplier, ABC Rehab. ABC Rehab's medical practitioner, Lance, is concerned about Trudy's progress and is keen to speak with a Pain Specialist about her progress, but they don't have one on their team. Lance contacts the Tertiary Support Service and arranges a time to have a case conference with the Pain Specialist and Trudy's team at ABC Rehab. ABC Rehab and the Pain Specialist from the Tertiary Support Service review Trudy's progress and update the treatment plan accordingly. With the input from the Pain Specialist, ABC Rehab are now confident that they can manage Trudy's rehabilitation in the community – this means Trudy won't have to travel for four hours to see the Tertiary Service for more intensive input.

The relevant key-worker in the Community Service is responsible for documenting the advice and support received from Tertiary Support Service:

The key-worker will:

- Document the discussions and any recommendations
- Amend the client's action plan as appropriate
- Share the amended plan with all stakeholders.

Time Frame

A maximum of 10 hours per client is available for the Tertiary Support Service. (Tertiary Supplier can only bill once, at the end of the support service).

7.7. Contact details for Tertiary Support Services:

Auckland District Health Board

Jayanthi Mohanakrishnan, ACC Manager Business Development.

Building 13, Level 4 Green Lane Clinical Centre, Green Late (West) Auckland 1051.

(09) 6380398

jayanthim@adhb.govt.nz

Capital and Coast District Health Board

Dagmar Hempel, Team Leader, Pain Management Service

(04) 918 6567; or main reception (04) 3855 344

Pain.consultation@CCDHB.org.nz

Canterbury District Health Board

(03) 3836831

TertiaryAdvice.PMC@cdhb.health.nz

7.8. Exclusions

The Pain Management Service should be the primary method of supporting individuals with, or at risk of developing persistent pain. Other services or contracts should not be used to supplement the Pain Management service where the ability exists to deliver this input under the Pain Management Service. For example, Psychological Services should not be used concurrently with the Pain Management Service. The exception to this condition is detailed under point 6.3 above, where a client elects to stay with an existing treatment provider who will work collaboratively with the Pain Management Service.

The following services are not provided under the Pain Management Service:

- Vocational Rehabilitation Services (VRS)
- Vocational Medical Services
- Medical Case Review – including reviews to determine causation, cover or entitlements
- Training for Independence Services
- High-Tech Imaging
- Clinical Services
- Gym based Strengthening Programmes for clients who are not suffering from pain and who do not meet the screening criteria.

Where a client's goal includes return to work it is expected that this is led by the Vocational Rehabilitation Service, with support from the Pain Management Service. Input from the Pain Management Service should be limited to those professional disciplines not available through the Vocational Rehabilitation Service.

8. Reporting

8.1. Initial assessment and plan

All referrals begin with an initial assessment working with the client to develop goals and identify all barriers to recovery. The initial assessment and plan will include the agreed action plan to overcome the barriers and achieve the agreed goals.

The provider completes an Initial Assessment and Action Plan on an ACC6272. The initial assessment and action plan will include:

- Client's presenting problems
- Client's goals and rehabilitation needs
- Identify pain and non-pain related barriers to recovery
- A programme or action plan which sets out the client's treatment and rehabilitation, including pain education and self-management strategies to address their pain needs.

Further information about client assessments is set out further in this document - see section 8.1.4 requirements for free-text field.

8.2. Diagnosis

The basis for good rehabilitation and treatment is accurate diagnosis/es. Considerations include:

- Critically reviewing the information provided.
- Using your own examination and observations when confirming or determining the diagnosis.
- Making recommendations based on your own diagnosis/es.

If you conclude that the current diagnosis is incorrect, is not clear, or there are additional diagnoses that have not been considered, you need to indicate this in the diagnosis section of your report.

Any change to the initial diagnosis needs to be clearly outlined as a difference to the diagnosis on referral; otherwise it may affect the basic premise of the assessment. Please include non-injury factors and/or any barriers or flags related to the client's pain condition.

The purpose of reporting is to provide clear information to the ACC case owner about the client's current status. This will help the ACC case owner to manage the client's overall claim and respond to client queries. The following reporting is expected from the Provider.

8.3. Initial Reports

If the service is:	The initial report:	ACC Case Owner
Group Education	Includes a brief assessment and plan which is developed and documented on the ACC6272 then sent to the ACC case owner. This includes the client's presentation, goals and rehabilitation needs and a rationale for the Group Education service.	The case owner reviews the plan to make sure it: • Provides clear diagnosis/es with rationale or supporting information. • Forms a plan of action that includes frequency of sessions, MDT members involved and the anticipated length of the programme • Has identified the appropriate programme components the client has been involved in determining (based on the initial assessment and knowledge of the client and their needs) • Establishes functional goals
CSS1	Includes a brief assessment by relevant members of the multidisciplinary team to determine the client's goals and identifies any pain rehabilitation barriers and an action plan to overcome these barriers and achieve the goals. This plan is developed and documented on the ACC6272 which is sent to the ACC case owner.	
CSS2	Includes a multidisciplinary review by relevant members of the team that either:	

	builds on the assessment undertaken in CSS1 and revises the action plan, OR Sets the initial action plan if CSS2 is identified before or during the initial assessment. If this is the case a progress report is expected at the point CSS1 resources are used or the mid-point of the programme. This plan is developed and documented on the ACC6272 which is sent to the ACC Case Owner	that relate to restoring independence and, if appropriate, their return to work • Identifies any pain-related disability factors and how the programme will assist the client to address these • Outlines the therapeutic programme to be completed, including any education and skills training • Details what education will be provided including self-management strategies the client will be assisted to develop • Interprets any questionnaire scores • Reflects the whole picture of how the client is coping with their life including non-injury related barriers to recovery.
Tertiary	Tertiary Service Delivery completes a comprehensive multidisciplinary assessment by relevant members of the multidisciplinary team. It identifies the client's goals and rehabilitation needs and develops a comprehensive multidisciplinary pain programme that identifies any pain rehabilitation barriers and an action plan to overcome these barriers and achieve the goals. This plan is developed and documented on the ACC6272 which is sent to the ACC case owner.	

8.4. Goal Setting

Many clients receiving rehabilitation services have multifactorial, complex problems that often require multiple interventions delivered by different people, frequently in a specific sequence. This requires coordinated actions by a team, a process that depends upon setting interdisciplinary goals that are specific, clear and personal to the client.

Goal setting with clients can take time and end up vague if the providers are not targeted in their approach. Good goal setting stresses the need for a specific goal rather than a more general one. Effective goals are clear and unambiguous. They document exactly what's expected, why it's important, who's involved, where it's going to happen and which attributes are important.

The supplier will:

- develop the pain rehab programme with the client, their family/whānau and anyone else the client wants
- regularly review the goals with the client so they reflect the current expectations and circumstances
- provide the client with a current version of their goals to support the pain rehab plan
- Goals are jointly developed between the client and the Provider

- Goals are directly related to the stated service outcomes which need to reflect the client's needs in relation to pain management
- Goals are SMART (Specific, Measurable, Achievable, Results driven and Time-framed).
- The outcome date is the date the goals are anticipated to be achieved.

8.5. Developing S.M.A.R.T. goals

The following outlines an approach to writing SMART goals (specific, measurable, achievable, realistic/relevant and timely). A SMART goal is built up by using four parts:

- Target activity
- Identify the support needed
- Quantify the performance expected
- Specify the time period to achieve the desired state.

The supplier ensures the pain rehab plan outlines the programme to be provided to the client, family/whānau or carer (depending on the goals). The plan will present the entire programme and show the path the programme will take. It must be robust and reflect the client's needs.

A specific goal will usually answer a series of questions:

- What does the client want to accomplish?
- Why does the client want this goal? Do they have specific reasons, purpose or benefits of accomplishing the goal? Can the goal be achieved in different ways?
- Who is involved?
- Where will the rehabilitation take place?
- How will the objective or goal be attained? Are there any requirements and constraints?
- When does the client want to achieve this goal?

8.6. Example of a SMART goal

Type of goal	Specific step objective	Vague/General
Physical	I will be able to walk to my letter box (10 metres down 3 stairs on a level path) to get my mail with no walking stick within three weeks (3 June)	I will improve my mobility. I will try to be more active. I will do two active things every day.
Psychological	I will be able to show I can use at least two ways of helping myself if I am distress and self-soothing when I am during sessions with my therapist within 4 weeks	I will be able to help myself when distressed

Prevention	My therapist and I will develop a clear written plan to prevent my relapse during my sessions, incorporating: • An outline my physical sensations, thoughts, and behaviours that make up my depression and anxiety and the thoughts and behaviours that can act to maintain these.	We will have a plan so I don't relapse by end of my programme

8.7. Mandatory minimum requirements for free-text field

The ***ACC6272 Pain Management Plan, Review Update and Completion Report*** form includes a free-text field. This free-text field gives providers the flexibility to include information which may be relevant to their assessment, but may not be elicited through a more prescriptive template.

At a minimum, ACC expects that this field will include the following information:

- Relevant history
- Current state of pain (sites, intensity etc.)
- The pain diagnosis/es with supporting data and the likely attributing cause/causes.
- Current medication and outcome of any medication review
- Client's reported experience and symptoms
- Relevant factors influencing the pain condition e.g. psychological, psychosocial, functional, medical, pre-existing, non injury factors etc.
- Issues or barriers affecting rehabilitation e.g. functional, psychosocial or other health or non-injury conditions. This should also include any new issues or barriers that have emerged that have not been previously identified
- Willingness of client to engage
- Previous strategies that may have been used and their efficacy e.g. medication, behavioural approaches, physical activity, education etc.
- Effectiveness of treatment

8.8. Review update

At the mid-point of the service delivery, the Provider may complete or be requested by ACC case owner to complete, a programme review update using the ***ACC6272 Pain Management Plan, Review Update and Completion Report*** form.

This form may also be used to update the ACC case owner on any changes to the treatment or rehabilitation plan.

If the service is:	The mid-point review completed by the Provider:	The ACC case owner:
CSS1 **CSS2** **Tertiary**	Includes information relating to the: • Client's participation in the service • Progress being made towards achievement of goals and whether the programme completion date remains realistic • Education undertaken and any self-management strategies, including examples of the client's ability to use these outside of the service • Any changes/amendments to the action plan	Reviews the report to ensure: • The client is participating in the service • The client's independence is increasing and being encouraged • Consistent progress is being made towards achievement of goals • Education has been provided • The Provider is preparing the client to self-manage their pain and there is evidence of use of these strategies
Group education	No mid-point review required	Not applicable

8.9. Exception reporting

The Provider will provide an exception report via email to the case owner where they have sufficient evidence to determine the outcomes will not be met, or at least two weeks before the end of the programme, whichever is sooner.

The exception report email must:

- Include evidence/explanation of the exception
- Provide an updated action plan for consideration and, if appropriate, a clinical rationale for the recommended changes.

The following table shows what the possible exceptions are and an example of each.

Reason for exception	Definition	When this can happen
On hold	Programme stops for a defined period of time agreed with the case	When the major components of the service, such as functional rehabilitation, psychology sessions or group education, can't continue due to a change in

	owner.	the client's circumstances, e.g. a new injury or surgery.
Transfer	Change from the initial level of service to another.	In the case of a request to transfer from Community Services to Tertiary or from Tertiary to Community Services. Request is made via email and accompanied with an ACC6272 to ACC case owner providing an update.

8.10. End of service

It's important and beneficial for the client's recovery to understand how to independently manage their pain symptoms and have a plan for returning to their everyday life which could include work, school, or every day activities.

At the end of services, a Completion Report is submitted to ACC.

The Pain Management Service may end due to a number of scenarios including:

- The client has achieved the agreed outcomes and is equipped to manage their pain during their usual activities
- The client has not achieved the agreed outcomes and needs other rehabilitation or treatment (please outline your recommendations for ongoing support)
- The client has successfully completed the Group Education programme
- The client has been provided with the Pain Management Service and during the service it is determined that the client is no longer requiring pain services for a number of reasons e.g. change of location, no progress being made and client does not wish to continue or participate
- The Provider has delivered all necessary treatment and further intervention will not be recommended (the client will likely not be "pain-free")
- The client has declined further Pain Management Services
- ACC withdraws the referral e.g. cover or entitlement is declined, client declines service

8.11. Completion report

At the end of the service the provider must complete the ACC6272 Pain Management Plan, Review Update and Completion Report form and send this to the case owner. The completion report should detail:

- The outcomes achieved, including comment on function
- Client participation in the service and activities
- Tools and strategies the client has developed to manage their pain
- Comment relating to return to work plan (if applicable)

- Sustainable levels of activity the client will be able to maintain in a work setting, place of education or their activities of daily living, including any adaptation or modifications required
- Any recommendations for further rehabilitation or reviews, including medication reviews.

8.12. Quality of reports

In the event that reports do not meet quality requirements, ACC may request additional information be provided. Where a review of a report has been requested, reports will be resubmitted with amendments within two days of a request being made by a case owner.

8.13. Long-term or future treatment

Best practice indicates that all pain services have an end point to treatment. A client may require ongoing clinical intervention for their pain from time to time to help maintain their level of function.

For example, a client may require some additional short-term psychological treatment periodically to reinforce their pain self-management strategies.

Any requirement for ongoing rehabilitation or treatment needs to be clearly outlined in the completion report, with rationale provided and any specific requirements and timeframes.

Up to two follow-up sessions can be used at any time following the completion of the pain management programme. These sessions are included in the funding cap but are not considered part of the formal pain programme i.e. programme can complete/close at the point of service delivery cessation. The focus of the follow ups should be on reinforcing strategies learnt during the programme to ensure the long-term sustainability of the outcomes achieved. This may be conducted face-to-face or via telephone

Any subsequent requests for the Pain Management Service must be sent to ACC as a new referral. If the request is for repeat interventional procedures these can be submitted through an updated ARTP with reference to the original purchase order number.

9. Components of the Pain Management Service

Each pain management service should be **tailored to the unique needs of each individual and their context**. There are some components of the service that are mandatory or restricted to certain levels – these requirements are detailed below:

Type of intervention	Requirement
Education on pain and pain management	Mandatory at all levels
Learning self-management strategies and the client's ability to utilise these independently	Mandatory at all levels
Medication review and optimisation Medical practitioner input. This must include clinician to client consultation (face-to-face or via telehealth)	Can be included as part of CSS1 but are mandatory for CSS2 and Tertiary Services.

Interventional procedures	Restricted to CSS2 and Tertiary Services
Neuromodulation (TARPS and Burwood only) **Residential programmes**	Restricted to Tertiary Services

With the exception of interventional procedures, neuromodulation and residential services, clients can receive the same components in Community Services Stage One as they would do in Community Services Stage Two or Tertiary Services. The key difference between the levels is the amount and intensity of each component provided.

Where interventions outside of the scope of the Pain Management Service (e.g. imaging or a bone density scan) the Provider must contact the ACC case owner to discuss this request.

9.1. Medication (pharmaceutical) review

A medication review is a process to cover adherence, safety, appropriateness and outcomes of a client's medication plan. A review of the client's medication is **mandatory at Community Services Stage Two and also at the Tertiary level of service provision.** The medication (pharmaceutical) review is not limited to pain medicine only.

The whole medication regime should be checked and not just the pain medicines. The client's GP/primary healthcare provider should be kept informed of any adherence advice or medicine therapy changes made. Clients may require support to adhere to the medication strategy.

The outcome of a medicine review should be sustained patient medicines-use adherence, no adverse effects/interactions in the regime, a safe medicine regime and improved therapeutic outcomes.

A medication review includes:

- Medicines reconciliation (listing all the prescribed and non-prescribed medications the patient uses to manage all of their health conditions).
- Assessing the client's understanding of all their medicines, checking adherence and identifying reasons for non-adherence.
- Medicines education to support adherence.
- Checking the complete regime (pain and non-pain medicines) for interactions, adverse effects, appropriateness and safety and making changes to either the regime, strengths and doses or duration of use (including the stopping of unnecessary medicines).

A medication review also incorporates the use of interventional pain management. It is a total review of medicines, regardless of who the prescriber is, or the method of administration and includes medicines the client may self-purchase.

Because technology and interventions change regularly, it is recommended that patients requiring medication such as morphine refills be referred to a review by the MDT annually. The purpose of the review is to identify whether refill only or other services/medicines changes are needed.

Although some of these patients may be long-term and stable, others are often complex. Regular checks with a Tertiary Service Provider may be of rehabilitation value to them and provides clients with an opportunity to have their needs re-assessed via the MDT and a medicines review undertaken in collaboration with their GP/primary healthcare provider. These patients are then discharged back to their GP/primary care provider with an ongoing personal management plan. These clients would not need to be referred back into an MDT more than once a year.

Any changes made to a regime should be monitored by the MDT to ensure adherence, safety and effectiveness before care is transferred back to the client's primary care Provider. On discharge a complete medicines report should be provided to the primary care Provider with a copy to the client outlining the review, changes, outcomes from monitoring and a complete multimodal plan for continued pain management strategy implementation by the client, their whanau and community-based Providers.

The medication review report should specify:

- All medications used by the client
- Name, strength, dose and duration of use
- Indications for use
- Adherence assessment
- Reasons for any change in medicines (including stopping of medicines)
- Recommendations for ongoing medicine use
- Monitoring of ongoing medicine use and progress to identified rehabilitation goals
- Reporting to the primary care prescriber

Further information may be found on the Pharmaceutical Society of NZ Inc website: www.psnz.org

9.2. Interventional Pain Management

Interventional Pain Management (IPM), such as steroid injections, may be delivered as part of a multidisciplinary programme by a Community or Tertiary Service. For example, where diagnosis is unclear and an intervention is required for clarification; or interventions would enable the client to be able to participate in rehabilitation. Clinically complex interventions, such as neuromodulation/spinal cord stimulators, are available in Tertiary Service only.

One procedure of the following select IPM procedures is available to clients without ACC approval.

- Spinal Injections (codes IN02, IN03, IN04, IN06 and IN07)
- Peripheral Nerve blocks (codes IN10, IN11, IN13)
- Joint Injections (codes IN30, IN31).

Prior approval for all other IPM services (and subsequent procedures) is required from the ACC case owner who will receive clinical advice as to whether the intervention is appropriate and necessary for the treatment of the covered injury.

Where a provider seeks IPM treatment for a client, the provider completes the ***ACC4246 Interventional Pain Management Request*** form and sends to the ACC case owner. The ACC4246 form will be read in conjunction with the ***ACC6272 Pain Management Plan, Review Update and Completion Report form*** so the information on the ACC4246 does not need to cover information already provided on the ACC6272. ACC will consider how the request for IPM fits in with the multidisciplinary plan for the client.

The case owner will follow the usual ACC approval process and will issue a decision to approve or decline the request and advise the Pain Service Provider and the client.

Any assessment or post-intervention consultation costs will be met out of the clinical hours available in Community Services Stage Two or Tertiary Services

It is expected the Interventional practitioner becomes a member of the pain multidisciplinary rehab team for the duration of their involvement and input in the client's rehab.

9.3. Children and young people

Children and young people are clients who are:

- under 16 years of age, or
- aged between 18 and 21 and still at school at the time of receiving services

Children's experience of pain is different to adults and treatment of pain in children is a specialised area of medicine. Providers may deliver services for children and young people at a community level as long as the Provider holds a Pain Management Service contract and liaises with a Tertiary level paediatric pain service provider and **all** treatment providers involved in the child's care (this may include the GP/primary health practitioner, Paediatrician, Child Psychologist etc.). Telehealth technology may be used.

It is expected that the Tertiary Service Pain Management Service Provider will have appropriate links and affiliations to the paediatric services which can provide expert paediatric advice where required.

9.4. TeleHealth

The primary method of delivery of the Pain Management Service is face-to-face, clinician to client. In situations when a medical practitioner or psychologist is unable to be present with the client, an initial consultation and/or review by Telehealth by these practitioners may be completed via telehealth.

The Supplier must ensure that a client has support available when Telehealth Services are delivered. This ensures that support and consistent rehabilitation guidance is provided to the client.

Providers are required to comply with the current New Zealand guidelines, regulations and standards for telehealth which may be found on each discipline's website (where available).

For example, the Medical Council (www.mcnz.org.nz) has issued a Statement on Telehealth and the standards expected for doctors (June 2016). Where discipline-specific information is not available Suppliers must be able to demonstrate that they meet the Guidelines for Establishing and Maintaining Sustainable Telemedicine Services in NZ. http://telehealth.co.nz/implementation/video-conferencing.

In summary, the Supplier should ensure that:

- The patient understands how Telehealth works and agrees to participate. Obtaining consent from a patient/carer before Telehealth consultation is important where research or storage of digital information is involved.
- Careful consideration is given to which clients are suitable for Telehealth. The New Zealand guidelines suggest avoiding booking patients who require a physical examination and suggest not including people with visual or hearing impairment as well as psychiatric patients. Providers should clarify who is going to take care of a patient after consultation including who is going to write a prescription, and provide follow-up, especially when multiple clinicians are involved.
- Client Privacy and confidentiality is maintained. Privacy during Telehealth consultations must be maintained both in the environment where Telehealth consultations take place and for data transfer during Telehealth consultations.
- Compatible devices for consultations are used. Suppliers should consider having a help desk and other options for resolution of technical failure issues during Telehealth consultations; and use of certified providers to make sure that equipment works securely and effectively.

The New Zealand TeleHealth Resource Centre has a variety of resources available to practitioners and is able to assist providers. Please refer to:

http://www.telehealth.co.nz/resources/regulations-standards

10. Culturally competent services

The Pain Management Service is client-centred and tailored to meet the cultural needs of clients. Services delivered will recognise and respect individual cultural and spiritual values and beliefs to improve client health and wellbeing. Providers will check with clients that information is communicated in a way clients and their family understand.

10.1. Meeting the cultural needs of Maori clients

Providers will ensure services are delivered to Maori clients in a way that recognises and respects Maori values and beliefs and that information is communicated in a way that they and their family/whanau understand.

For further information see: *Guidelines on Maori Cultural Competencies for Providers* - ACC1625 can be downloaded from the acc.co.nz website. Adhering to the requirements of these guidelines will assist you in meeting your responsibilities for cultural competence and deliver positive health outcomes for Maori clients.

10.2. Clients who require an interpreter

If there are any interpreting or cultural needs identified, the Provider should discuss these with the case owner to ensure the appropriate services are identified and provided.

The cost of the interpreter service is met by ACC. Payment is conditional on ACC's prior approval being given that an interpreter is needed, cost effective and appropriate.

11. Clients who have a mental injury as a result of sexual abuse

During the referral or assessment process, a Provider may identify that a client has suffered a mental injury as a result of sexual abuse. In these instances the Pain Management Service key-worker should discuss a referral to an Integrated Services for Sensitive Claims (ISSC) Provider with the client and case owner.

Also during the referral or assessment, a Provider might become aware that a client of the Pain Management Service is already receiving services under the Integrated Services for Sensitive Claims (ISSC) contract. In this instance the Provider, with consent of the client, should make contact with the ISSC key-worker.

Comprehensive best practice guidelines for Providers of services to people who have experienced sexual abuse can be found on acc.co.nz by searching for *ACC4451 Sexual abuse and mental injury practice guidelines for Aotearoa NZ.* Providers delivering the Pain Management Service to clients who have experienced sexual abuse are expected to incorporate the principles and best practice guidelines outlined in the document into their assessment.

12. Requirements of Supervision

Clinical supervision is a formal process of professional support and learning which enables practitioners to develop and expand their knowledge and competence in their professional domain. Supervision facilitates compliance with professional and organisation standards and practices and providing safe and effective client service.

Most professions are expected to engage in supervised peer review as part of their membership to their professional body. In addition to the supervision required by professional membership, ACC requires providers who have less than two years' full time work equivalent in the context of pain management to receive supervision from a health professional of the same discipline and who is experienced in pain management.

It is the Supplier's responsibility to ensure clinicians who have less than two years' fulltime work equivalent in the context of pain management receive specific pain management supervision. The supervisee needs to work with their supervisor to determine their learning needs in relation to pain management with a specific supervision programme drawn up. Supervision may be provided by a supervisor based in a different geographical region.

When a rehabilitation professional has less than two year's experience in pain management and is under specific pain management supervision, the following requirements apply:

- Supervision is ongoing, regular and documented. The supervision plan needs to be outlined and provided to ACC on request.
- Supervision should be specific to all tasks, relationships, judgements, and all other relevant areas that clinicians would be exposed to in a pain management service

Providers with less than two years experience in pain management:

- Can draft programme plans and reports, but they must be signed off by their supervisor.
- May not deliver a Pain Management Service programme unsupervised until they have obtained two years experience.

Any queries relating to the requirements for Pain Management Service supervision can be referred to the Pain Management Service Category Advisor.

13. Urgent medical attention required during the Pain Management Service

If during providing services you are made aware of a physical or mental condition that requires either urgent medical attention or contact with the client's normal treating practitioner, you should act accordingly. For example:

- Arrange for immediate hospital assessment or treatment – and/or urgent consultation with the client's normal practitioner and ensure the client has transport there
- Inform the client of any urgent findings, your proposed response and get their consent for this.
- If the client experiences a mental health crisis, and urgent care is needed to keep the client safe, the Provider will contact Acute Mental Health services.

The Medical Council of New Zealand has information regarding this on the MCNZ website www.mcnz.org.nz - A *doctor's duty to help in a medical emergency*.

14. Working with clients who may pose a health and safety risk

ACC may not always have access to detailed information concerning a client's history, but if a client has been identified as posing a risk, the case owner will be able to provide information relevant to your role in managing the claim to help you mitigate health and safety risks to service providers and others.

ACC clients who meet **two** or **more** of the following criteria are considered to pose a potential risk to safety, and will have a Care Indicator activated by ACC:

- Have continued to demonstrate intimidating and/or offensive behaviour (e.g. body language and verbal dialogue has made employees feel unsafe)
- Been abusive, verbally or in writing
- Made racist or sexist comments
- The current actions being undertaken on their claim by ACC are known to have caused, or are expected to cause a significantly negative response from the client. For example, Prosecution, Fraud Investigation, cessation of Weekly Compensation, etc.

Clients who meet any one of the following more serious criteria are also considered a hazard and will also have a Care Indicator activated:

- Have been or are physically violent (this unacceptable behaviour may not have occurred directly towards ACC employees)
- Have a history of violence or aggressive behaviour, have known convictions for violence

- Made threats previously against ACC, ACC employees or agents acting on ACC's behalf
- Intimidated an employee through written abuse or verbal abuse (face-to-face or over the telephone) to the extent they felt unsafe
- Exhibited homicidal ideation.

14.1. Communication regarding care indicated (risky) clients

The case owner of a care indicated client will advise you in writing, either:

- Prior to your initial contact with the client, or
- If you are already providing services to the client, as soon as possible when ACC receives new information about client risk.
- Please report any threatening behaviour to the police immediately if you feel that it is warranted in the circumstances and advise ACC and any other parties that are at risk as soon as possible.
- All threats by ACC clients or their representatives must be reported to ACC in writing using the online form on our website. We ask that you report these to us so that we can do our part to protect the safety of our staff and other providers that are working with the client.

Supplier safety is a priority and any assessment should be terminated if the Client, their advocate or support persons make you to feel threatened or unsafe in any way. Please notify:

- The Client's case owner as soon as possible and fully document the reasons for the termination of the assessment in your report.
- The police, if you feel that is warranted in the circumstance.

If you choose to continue with assessment of a care indicated client, and wish to employ a security guard then please contact the case owner.

14.2. Reporting health and safety risks and incidents

Health and safety risks and incidents including notifiable events (as defined by WorkSafe); threats and other health and safety risks must be reported to ACC using the procedure and online form on our website:

https://www.acc.co.nz/for-providers/report-health-safety-incidents.

15. Privacy and storage of client health information

You are bound by the Health Information Privacy Code 1994 in regard to collecting and storing health information. This means that:

- Health information may only be gathered for the purpose for which it is required and must be as accurate as possible.
- The client must be informed about why the information is being asked for and give their consent for this information to be gathered.
- The client has the right to see their information and correct any information which is

factually incorrect.

- Care must be taken with the storage of client health information and there are limits on the disclosure of this information.
- ACC requires clients to complete an ACC6300 Authority to collect medical and other records form

15.1. Practical meaning of the code

- Check you've been sent the right information.
- Use a secure email address for correspondence which includes personal client health information. Secure email is an email account with password and security features that only you and authorised people can access.
- Check every email address to ensure that the email is going to the intended recipient.
- Documents which are password protected may be blocked by ACC's fire wall.
- Remember not to discuss health issues with the employer. The employer needs to know about time frames and fitness for work, supports and accommodation. It's not necessary for the employer to have personal health information.

- **Clinical notes -** ACC only requires medical notes which are relevant to the treatment of the covered injury or rehabilitation goals. Provision of required clinical notes is included in the payment rate. Please do not send full medical files.
- Store information responsibly. For example, personal client information shouldn't be left unattended in your car or unsecured at your personal residence.

- Further information and advice on ACC's requirements for Supplier storage of personal and health information can be found on our website: http://www.acc.co.nz/about-acc/procurement/WPC133871.

16. Performance monitoring

16.1. Key performance indicators and service monitoring

Key performance indicators (KPIs) are specified in the service schedule. Suppliers can expect to receive regular reporting to support performance improvement initiatives.

In addition to the supplier KPIs, the overall effectiveness of the Pain Management Service will be monitored as outlined in the service schedule. Suppliers are required to undertake a satisfaction survey of all ACC clients that have used their services. Minimum requirements for the content of satisfaction surveys will be provided to suppliers by ACC.

16.2. Supplier reporting to ACC

ACC will receive annual reports from the supplier and be available to provided contract specific data upon request. Suppliers may also be required to complete outcome tools to measure specific outcomes. Service reporting will also be submitted to ACC on an annual basis. Details of the required supplier reporting can be found in the Service Schedule.

A variety of methods will be used to collect the data required for both KPIs and monitoring measures, including data from the current system and processes, suppliers and the Electronic Persistent Pain Outcome Collaboration.

The Suppliers annual report will cover the period of 01 July – 30 June, being due to their Engagement and Performance Manager within 10 working days of 01 July (For example, 12 July 2019, 14 July 2020, 15 July 2021).

16.3. Electronic Persistent Pain Outcome Collaboration (ePPOC)

ePPOC is an electronic benchmarking tool that assists services with continuous improvement initiatives. Suppliers will be responsible for completing ePPOC within specified time frames.

ACC will fund membership and facilitate the access to ePPOC for Suppliers who are awarded the pain contract.

Formal reporting is provided to Suppliers by ePPOC on a six-monthly basis, however services are able to extract their own information from the ePPOC system on an as-needed basis. Reporting provided by ePPOC is de-identified, with each service being told which number (or alias) has been assigned to their service. Services will be encouraged to learn from other pain services that perform well across a number of benchmarks taking into consideration case mix.

ePPOC is only available in English. However, ePPOC does include an indicator which identifies when an interpreter was used in order to determine the impact on access to services and interventions.

16.4. Customer Satisfaction Survey

The purpose of the Customer Satisfaction Survey is to:

- Gather feedback from clients on their experience of the Pain Management Service provided
- Provide information for continuous improvement opportunities
- Help ensure consistency across the Pain Management Service.

ACC will provide a template for suppliers to distribute to all clients on completion of their programme regarding their satisfaction with services they have received. The supplier is required to collate the responses and provide a report to ACC as part of the six-monthly Supplier reporting to ACC. How this survey is administered is determined by the supplier.

17. Service Management

17.1. National PNS Meeting

In April and October each year a National PNS Meeting will be hosted by ACC in partnership with Suppliers. This national meeting will combine the ePPOC Quality Forum and Supplier Days. Due to the geographical spread of our Suppliers the National Meetings will change in venue and location and have the following standard agenda items which can be adapted in consultation with Suppliers.

Meetings will be held in the third week of the identified month

Standing agenda items:

Agenda item	Description
PSD Update	An update from Provider Service Delivery Leadership Team and/or Portfolio on what's happening from a Health Sector Service/Provider Service Delivery.
Service Performance	Supplier will receive their ePPOC and PNS National KPI reports at least 3 weeks before the meeting. The ePPOC national outcome data will be discussed A national quality discussion will be included.
Operational concerns/opportunities	Session dedicated to hearing from Suppliers any operational concerns and to collectively explore the opportunities to remedy. I.e branch trends, contractual discrepancies
Supplier Presentation	At each meeting Supplier(s) has a session to discuss or present on a topic of their choice. E.g. innovation, success story, sector development, case study
Any Other Business	Other topical business to discuss

17.2. Supplier Teleconference

ACC Provider Service Delivery will host a Supplier teleconference in the quarters between National meetings for Suppliers to connect with ACC and each other between face to face meetings. Teleconference will be held in the third week of the identified month (January and July).

17.3. Engagment and Performance Manager meetings

Engagement and Performance Managers (EPM) monitor the supplier's performance requirements as set out in the contract. Your EPM will meet with you regularly and discuss your performance measures throughout the reporting cycle.

Suppliers should expect that your EPM understands the PNS and can hold robust discussion regarding your performance against the contract KPI's.

18. Payment and invoicing

18.1. Electronic invoicing

Our method of invoicing for this service is electronic billing which makes the process faster, easier, and more efficient. For more information on working electronically with ACC, see For Providers/Set up and work with ACC/Work online with ACC.

There are a number of ways electronic invoicing can be done. The eBusiness team will help to determine which method is best for you.

Their contact details are:

- Telephone: 0800 222 994 (option 1)

- Email: ebusinessinfo@acc.co.nz

The Provider Helpline will answer queries relating to payment of invoices please free phone 0800 222 070.

ACC requires one account per supplier for payment of invoices. This means there is one supplier identification, one address for all correspondence (i.e. purchase orders and remittance advices) and one bank account number per supplier.

This requirement is to enable transparency of transactions for monitoring purposes by ACC.

18.2. What you'll need to include in electronic invoices

- Invoice number
- Invoice date
- Relevant ACC purchase order number
- Contract number
- Name and claim number of the client receiving the Pain Management Service
- Appropriate service codes
  - Number of the Provider who delivered the service
  - Date on which the service was provided
  - Comments in the comment field of the service items ending in A, P and M with advice on the scope of practice of the practitioner involved. i.e. PN1A - Physiotherapist, PN2P – Clinical Psychologist.
  - Comments in the general comment field where this will provide clarification to the payments team eg: PNDNA should state what service; where more than 8 hours in one day is being invoiced

18.3. Pricing schedule

The prices set out in the service schedule are inclusive of rehabilitation inputs associated with the delivery of the service. This includes direct and indirect staff time, overheads such as administration, information systems and reporting.

Interventional procedures are separate items to enable provision as and when required.

The pricing rates for the codes listed in Section 18.5 below will be considered as indicative rates, allowing suppliers some flexibility for the rates invoiced.

Suppliers are responsible for determining the appropriate service mix and remuneration for their providers within the specified resource limit for each stage.

18.4. How ACC purchases pain management services

Case owners have five items they can purchase for their clients and is the same as Part A of your Service Schedule. Therefore on the referral form you will receive approval for a Service Stage with the funding approved as the maximum amount. This is not intended to be your target. It is the upper limit that ACC is willing to fund for that level of PNS service.

It is up to you to manage the funds appropriately and to ensure the client receives appropriate rehabilitation to achieve their desired outcome/goal within the agreed timeframe (between case owner and provider).

If you have clinical reason to believe the level of service is not appropriate to meet the pain rehabilitation needs of the client, then contact the case owner to discuss the rehabilitation plan to ensure the client receives the appropriate rehabilitation.

ACC generated purchase orders/referrals will be for the following:

Service Item Code	Service Item Description	Maximum *(inc. GST)*
PN100	Community Service Stage One	$3,144
PN200	Community Service Stage Two	$3,646
PN300	Tertiary Delivery Services – Outpatient programme	$6,752
PN350	Tertiary Delivery Services – Residential Programme (3 week programme)	$8,929
PN402	Group Education (course payment)	$630

18.5. Billing Service Items (Sub/Alias Codes)

Sub codes have been developed to simplify paying you at cost (up to the capped price) for the services you deliver within each client's pain management programme.

The following tables advise you on which sub codes are to be used for the various components of delivering these programmes:

Community Services: Stage one – simple pain programme

Service Item Code	Service Item Description	Recommended Price *(excl. GST)*	Pricing Unit
PN102	Community Stage one – Initial Assessment and report/plan	$395.85	One-off
PN1A	Community Stage one – Allied Health	$111.32	Hourly
PN1P	Community Stage one – Psychologist	$156.64	Hourly
PN1M	Community Stage one – Medical Practitioner	$297.35	Hourly
PN132	Community Stage one – Completion report (*not required if transitioning to Stage 2)*	$200.97	One-off
PN140	Follow up health check *(not required if transitioning to Stage 2)*	$111.32	One-off

Community Services: Stage two – moderate to complex programme

Service Item Code	Service Item Description	Recommended Price *(excl. GST)*	Pricing Unit
PN202	Community Stage two – (Re)Assessment & report/plan *(considered the progress report and new plan if transitioning from Stage 1)*	$342.37	One-off
PN2A	Community Stage two – Allied Health	$111.32	Hourly
PN2P	Community Stage two – Psychologist	$156.64	Hourly
PN2M	Community Stage two – Medical Practitioner	$297.35	Hourly
PN232	Community Stage two – Completion report	$200.97	One-off
PN240	Community follow up health check	$111.32	One-off

Tertiary Services: Complex and Intensive programme

Service Item Code	Service Item Description	Recommended Price *(excl. GST)*	Pricing Unit
PN302	Initial comprehensive multidisciplinary assessment, report, rehabilitation plan & service administration *(including all costs relating to the assessment and report for ACC i.e. communication with other professionals working with the client)*	$2,140.53	One-off
PN303	Assess & discharge *(only to be used if client has been assessed and found their pain rehabilitation needs are better met in the community or by other services, therefore transitioned and discharged by the Tertiary Service)*	up to $565.31	One-off
PN3A	Outpatient Programme – Allied Health	$111.32	Hourly
PN3P	Outpatient Programme – Psychologist	$156.64	Hourly
PN3M	Outpatient Programme – Medical	$297.35	Hourly
PN332	Tertiary Completion report	$200.97	One-off
PN340	Tertiary follow up health check	$111.32	One-off

Tertiary Delivery Services – Residential Programme
(all components prorated if clients programme ceases during the 3 weeks)

Service Item	Service Item Description	Recommended	Pricing

Code		Price (excl. GST)	Unit
PN351	Tertiary Residential (three week) Programme	up to $5,515.65	One-off
PN352	Client accommodation, food, transport where these are provided off-site for the period of the residential programme	$150.00	Per day

Tertiary Service Support

Service Item Code	Service Item Description	Recommended Price *(excl. GST)*	Pricing Unit
PN375	Tertiary Support Services	up to $1,575.90	One payment per claim

Group Education

Service Item Code	Service Item Description	Recommended Price *(excl. GST)*	Pricing Unit
PN402	Group Education Programme	$548.00	Course payment fee

18.6. Submitting Invoices

When submitting invoices we expect you to advise (in the comments section of your invoice) the scope of professional who delivered that component of the programme as noted in Part B, Section 6.5 of your Service Schedule and listed below.

Where there are two or more professionals involved in the programme from the same group please split them across two or more service lines. i.e. Physiotherapist on line 1 and Occupational therapist on line two, both using PN2A and the relevant cost associated.

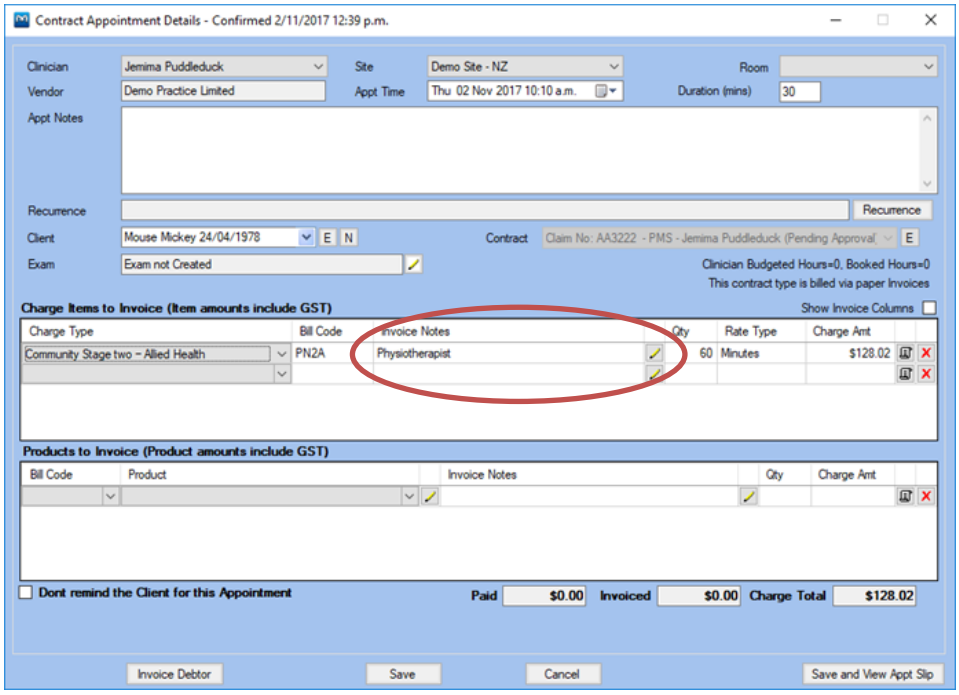
*Please note data collected from this field will only be valid if everyone fills it in consistently.

Service Item Code	Comment field on invoice
PN1A, or	Chiropractor
PN2A, or	Counsellor
PN3A	Dietician
(Allied Health)	Occupational Therapist
	Osteopath
	Pharmacist

	Physiotherapist Registered Nurse Social Worker
PN1P, or **PN2P, or** **PN3P** **(Psychology)**	Clinical Psychology Health Psychology Psychotherapist
PN1M, or **PN2M, or** **PN3M** **(Medical Practitioner)**	Pain Medicine Anaesthesia Internal Radiology Musculoskeletal Occupational Medicine Paediatrics Palliative Medicine Psychiatry Rehabilitation Medicine Rheumatology (Internal medicine)

Gensolve

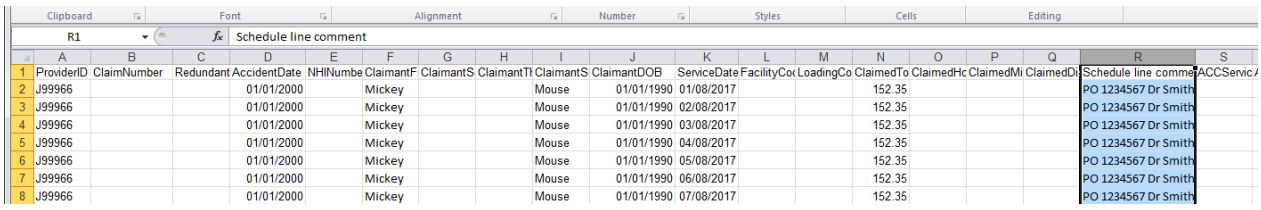
Gensolve doesn't have a specific screenshot available for this but have confirmed you would have to add in the scope of practice details into the "Inv Notes" section which would then pass through to the comments field in your invoice lines and be collected by ACC's Medical Fees Processing system. We have pulled a demo screenshot as an example:



XML Builder

With XML builder, the users will put all the invoicing details into a spreadsheet which is then uploaded into the XML builder to submit to ACC. The scope of practice advice is required to be put into column R (highlighted in the screenshot below) – i.e. Physiotherapist, Clinical Psychologist or Musculoskeletal.

The details are then passed through to the schedule line comments field within ACC's Medical Fee Processing system.



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1	ProviderID	ClaimNumber	Redundant	AccidentDate	NHINumbe	ClaimantF	ClaimantS	ClaimantTI	ClaimantS	ClaimantDOB	ServiceDate	FacilityCo	LoadingCo	ClaimedTo	ClaimedHc	ClaimedMi	ClaimedDi	Schedule line comme	ACCServic
2	J99966			01/01/2000		Mickey			Mouse	01/01/1990	01/08/2017			152.35				PO 1234567 Dr Smith	
3	J99966			01/01/2000		Mickey			Mouse	01/01/1990	02/08/2017			152.35				PO 1234567 Dr Smith	
4	J99966			01/01/2000		Mickey			Mouse	01/01/1990	03/08/2017			152.35				PO 1234567 Dr Smith	
5	J99966			01/01/2000		Mickey			Mouse	01/01/1990	04/08/2017			152.35				PO 1234567 Dr Smith	
6	J99966			01/01/2000		Mickey			Mouse	01/01/1990	05/08/2017			152.35				PO 1234567 Dr Smith	
7	J99966			01/01/2000		Mickey			Mouse	01/01/1990	06/08/2017			152.35				PO 1234567 Dr Smith	
8	J99966			01/01/2000		Mickey			Mouse	01/01/1990	07/08/2017			152.35				PO 1234567 Dr Smith	

This will allow ACC to monitor in real time what the case mix of professionals involved in various stages of the service, and will share this in the service's National KPI reports for informational purposes. This will be particularly useful for continuous improvement and service development in future years.

18.7. Payment for Group Programmes

Where stand-alone group education is provided this is invoiced using *PN402 Group Education*.

If a supplier delivers part of the Community or Tertiary Service in a group format this should be invoiced using the relevant code for the professional discipline delivering the group (e.g. *PN1A Community Stage One – Allied Health*) on a pro-rata basis.

Example:

> ABC Rehab is delivering Community Service to four clients. As part of the rehabilitation programme each client is undertaking, ABC Rehab decides that a group format will be the best way to deliver the education component of the programme for these four clients.
>
> ABC Rehab's Psychologist, Michelle, delivers the group programme to the four clients in two, two-hour blocks, each a week apart. As Michelle spent a total of four hours delivering the group programme to four clients, ABC Rehab should invoice one hour of PN1P Community Stage One – Psychologist per client.

18.8. Payment of incidentals

We do not usually fund client incidentals i.e. gym memberships, pool passes and education resources as they are considered the personal responsibility of a client and they are not included in the funding of the Pain Management Service.

We acknowledge clients may need access to these facilities/resources to optimise participation in their pain rehabilitation. As such, Case Owners may fund these through a separate purchase order if both the following apply:

- needed to introduce and allow the client to participate in physical, recreational, social or community activity as part of their pain rehabilitation programme, and
- limited to a specific timeframe

Should we decide to fund the gym membership/pool pass the case owner should create a purchase order for the service that is separate to the Pain Management Service. It is not the supplier's responsibility to fund the membership fee and we would not expect to see the hourly rates adjusted to cover these costs.

18.9. Timing of invoicing and payments

Invoicing requirements are set out in the service schedule and below. It is important for suppliers to include the start and end date of the service as these dates will be utilised to measure various durations as part of monitoring.

A supplier must bill for all services in a timely manner. This should always be within one month of the completion of services for each client. Late billing will interfere with service monitoring which disadvantages suppliers.

ACC also reserves the right not to pay invoices which are dated more than 12 months after the completion of services.

18.10. Non-attendance fee

Clients have responsibilities to participate and co-operate in their rehabilitation. Clients should notify their ACC case owner or the Provider if they are unable to keep their appointment, or where there are unexpected changes in their circumstances.

Where clients appear unwilling to participate in the Pain Management Services, Providers will determine the best way to manage this situation. Ongoing non-attendance or lack of engagement in Pain Management Services is a flag that Providers are expected to discuss with the ACC case owner.

ACC expects that Providers will make all reasonable efforts to remind the client of the appointment such as an appointment card, a reminder letter, a phone call the day before and a text message on the day to the client.

Providers can invoice ACC for a client non-attendance fee if the client does not attend their appointment and fails to give 24 hours' notice (see your contract for details):

The Provider must:

- Make every effort to contact the client to determine why they did not attend.
- Notify ACC case owner within 24 hours of the non-attendance by email.
- The price for client non-attendance fees is 40% (for onsite) and 60% (for offsite) of the provider hourly rate as specified in the service schedule.

18.11. Travel

Guidelines for provider travel can be found on ACC's website, see For Providers/Invoicing and Payment/Supplier travel service: Travel guideline and calculator tool

Given the requirement for Supplier to maintain a multidisciplinary team in each region, travel will not be paid between regions. However, travel will be paid between Territorial Local Authorities (TLA's) within a region. It is our expectation that the Supplier will take all reasonable steps to minimise travel costs including the use of telemedicine where appropriate.

19. Working with ACC – resolving issues

Providing excellent service to our Suppliers and Providers is important. Providers should contact the ACC case owner in the first instance if there are any matters requiring clarification. Examples could include:

- Poor or inadequate information in the referral
- You require verbal instructions to be put into writing
- You need a change to a purchase order (e.g. more time, units, date change)
- Prior approval is required
- Clarification of requirements, or expectations have changed
- Issues between treatment Providers. For example where a client is engaging in treatment services (outside of Pain Management Services) which are offering inconsistent advice and treatment to the Pain Management Service providers.

When a Provider or Supplier raises an issue with ACC about a case managed claim, and the issue is not able to be resolved directly with the case owner, it may need to be escalated to a senior staff member, e.g. a team manager, ACC Engagement and Performance Manager. If required they will seek advice and guidance from the Portfolio Advisor

If the issue cannot be resolved by a Team Manager or Engagement and Performance Manager you must follow line management escalation processes for that issue, e.g. escalate the issue to an area leader, engagement and performance manager, Portfolio or Health Procurement. This is especially important for any issue with the potential to be high risk, involves risk to a client, or risk to ACC's reputation. (Please see list of contacts at beginning of this document).

If there has been a high risk or adverse event, such as a:

- Privacy breach
- Personal or client harm or safety issue
- Contract breach
- Media risk

The Provider or Supplier must tell ACC immediately by either:

- Contacting the Engagement and Performance Manager
- Contacting the Provider Helpline on 0800 222 070.

It is important to make contact and not just leave a message. For issues not able to be resolved using the process outlined above please refer to ACC's website and/or your Standard Terms and Conditions http://www.acc.co.nz/for-Providers/resolving-issues/index.htm

20. Appendices

20.1. Glossary

BAP – ACC Branch Advisor Psychologist

BMA – ACC Branch Medical Advisor

BM – ACC Branch Manager

Case owner – The ACC case co-ordinator, case manager or case worker who is co-ordinating the client's treatment and rehabilitation

Incapacity - The term incapacity is specific to the client's pre-injury occupation and their inability to perform their pre-injury employment and hours worked. If a client is found to have incapacity, they are no longer able to engage in their pre-injury employment.

Key- Worker – One member of each MDT must be nominated as the key-worker. This provides a contact reference for the client, other Providers and ACC

Limitations – refer to what the client is simply unable to do ie existing constraints upon their physical or mental capacity to perform required tasks. The assessment of limitations needs to be based on objective findings considering physical, cognitive, social interaction and endurance/tolerance factors where relevant.

Multi-Disciplinary Team (MDT) - A Pain Management Service Supplier must establish and maintain a multidisciplinary team of staff that includes all of the following: physiotherapist, occupational therapist, registered psychologist, and a registered medical practitioner. The multidisciplinary team can also include other professional disciplines as listed in the service specification.

Non-injury related factors - ACC must consider non-injury related factors. This includes non-injury related disabilities or health conditions. Injury and non-injury factors should be clearly differentiated in any reports. This is essential to ensure that all treatment provided is targeted towards treatment and rehabilitation of the covered injury.

Stanford Chronic Pain Self-Management Programme – A six-week self-management programme developed by Stanford School of Medicine's Patient Education Research Centre and delivered by accredited providers.

TLA – Territorial Local Authority. This refers to areas within a region.

20.2. Relevant Forms

These forms can all be found at on the ACC website https://www.acc.co.nz/resources/

- OREBRO Short-form
- ACC 6273 Provider Referral for Pain Management
- ACC 6271 Pain Management Service Referral Form (ACC case owner use)
- ACC 6272 Pain Management Plan, Review Update and Completion Report
- PAI01 Approve Pain Management Service (ACC case owner use)
- PA110 All About Pain Management Service – Client Information Sheet (ACC case owner use)
- ACC 4246 Interventional Pain Management Assessment Report and Treatment Plan

20.3. OREBRO Musculoskeletal Pain Screening Questionnaire: Short Form (Linton et al. 2010)

Name: **Date:**

1. How long have you had your current pain problem? Tick (√) one.

□ 0-1 weeks [1] □ 1-2 weeks [2] □ 3-4 weeks [3] □ 4-5 weeks [4]

□ 6-8 weeks [5] □ 9-11 weeks [6] □ 3-6 months [7] □ 6-9 months [8]

□ 9-12 months [9] □ over 1 year [10]

2. How would you rate the pain that you have had during the past week? Circle one.

0 1 2 3 4 5 6 7 8 9 10 [ ]

No *Pain as bad as it*

For items 3 and 4, please circle the one number that best describes your current ability to participate in each of these activities.

3. I can do light work (or home duties) for an hour.

0 1 2 3 4 5 6 7 8 9 10 (10-)[ ]

Not at all *Without any difficulty*

4. I can sleep at night.

0 1 2 3 4 5 6 7 8 9 10 (10-)[ ]

Not at all *Without any difficulty*

5. How tense or anxious have you felt in the past week? Circle one.

0 1 2 3 4 5 6 7 8 9 10 [ ]

Absolutely calm and *As tense and anxious as I've ever*

6. How much have you been bothered by feeling depressed in the past week? Circle one.

0 1 2 3 4 5 6 7 8 9 10 [ ]

Not at all *Extremely*

1. In your view, how large is the risk that your current pain may become persistent?

0 1 2 3 4 5 6 7 8 9 10 [ ]

No risk *Very large risk*

8. In your estimation, what are the chances you will be working your normal duties (at home or work) in 3 months

0 1 2 3 4 5 6 7 8 9 10 (10-)[ ]

No chance *Very Large Chance*

9. An increase in pain is an indication that I should stop what I'm doing until the pain decreases.

0 1 2 3 4 5 6 7 8 9 10 [ ]

Completely *Completely agree*

10. I should not do my normal work (at work or home duties) with my present pain.

0 1 2 3 4 5 6 7 8 9 10 [ ]

Completely *Completely agree*

SUM:_____

20.4. Client Satisfaction Survey template

Introduction

This survey is given to all clients at the end, or near the end, of completion of the pain management service.

This survey is asking about your experience with the **Pain Management Service** only.

Your responses are anonymous. All survey results are aggregated together so that individuals are not identified.

Q1 We would like to know about your experience with the Pain Service

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
I was seen for pain management at the right time for me (1)	❍	❍	❍	❍	❍
The support I was given helped me manage my pain (2)	❍	❍	❍	❍	❍
I felt involved in making decisions about my pain management (3)	❍	❍	❍	❍	❍

Q2 Throughout my pain management

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
Easy to understand language was used for communication (1)	❍	❍	❍	❍	❍
I felt comfortable asking questions (2)	❍	❍	❍	❍	❍
I received enough information to help me manage my pain (3)	❍	❍	❍	❍	❍

Q3 Have you received care from more than one healthcare professional during your pain management?

❍ Yes (1)
❍ No (2)

If Yes is selected (you received care from a number of specialists during your pain management), go to Q4.

Q4 We would like to know more about your experience with receiving care from more than one healthcare professional

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
I felt listened to (1)	❍	❍	❍	❍	❍
I was given consistent advice/information (2)	❍	❍	❍	❍	❍
I felt they knew my story (3)	❍	❍	❍	❍	❍

Q5 Please tell us how satisfied were you with the Pain Service that you received

- ❍ Extremely satisfied (1)
- ❍ Somewhat satisfied (2)
- ❍ Neither satisfied nor dissatisfied (3)
- ❍ Somewhat dissatisfied (4)
- ❍ Extremely dissatisfied (5)

Thank you for participation in this client satisfaction survey about your experience with the Pain Management Service.

Please talk with your pain management health professional if you have any questions about this survey.