ACC & Long Term ~~Care~~ Support

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1. Abstract

The purpose of this paper is to describe the journey ACC has taken in terms of the way it manages seriously injured claimants. In doing so, some of the pitfalls, mistakes and lessons learned are highlighted so that others taking a similar journey in the future may learn from ACC's experience.

2. Overview of ACC

ACC is a Crown Corporation, set up by the New Zealand Government in 1974 to administer New Zealand's accident compensation scheme and provide comprehensive 24-hour, no fault personal accident cover for all New Zealand citizens, residents and temporary visitors to New Zealand. In return people do not have the right to sue for personal injury, other than for exemplary damages.
The scheme is governed by the Injury Prevention, Rehabilitation and Compensation Act 2001 and associated regulations ("the Act"). ACC is a statutory corporation administered under the Act and is governed by a Board of Directors appointed by the Minister for ACC.

ACC is a state run monopoly. Because the scheme is governed by the Act, ACC's business strategy must align with it. The Department of Labour oversees the day-to-day running of ACC and ensures that this is the case.

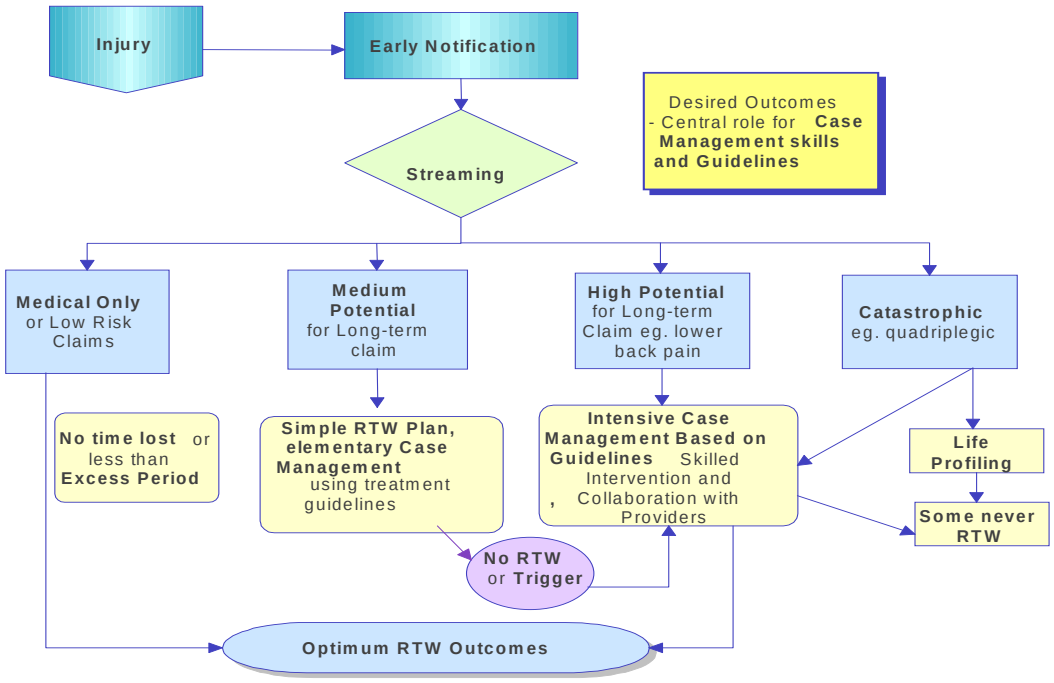
ACC has approximately 2,000 staff spread geographically and by business activity between Corporate Office, the Business Service Centre, 31 branch offices and four claim registration centres.

For further details on ACC please visit our website www.acc.co.nz or contact me directly on gavin.pearce@acc.co.nz

3. Approach to Claim Management

In 1999, the Funding and Pricing Unit of ACC undertook work to identify improvements to case management. One of the recommendations of that report was a model based on specialisation of case management activity.

Chart 1: Model for Injury Management



The model was developed based on a recognition that the goals of case management vary according to the needs and incentives of its diverse claimant population. Broadly, the goal is to effect positive, measurable outcomes. Issues considered included the case manager's effect on:

– Quality of life as perceived by the claimant;

– Functional improvement;

– Cost effectiveness;

– Claimant, employer and provider satisfaction;

– Quality of support;

– Compliance with support/rehabilitation;

– Fostering of independence;

– Ability to return to work; and

– Reduction of morbidity.

Case management is concerned with maximising the cost-benefit or 'value' of support. In this context, 'value' includes the:

- Appropriateness of support;
- Effectiveness of support;
- Quality of outcomes and service; and,
- Cost

In practical terms the model works in the following manner:

- All claims are registered at one of ACC's claim registration centres. Claims are either registered electronically direct from the GP or registered health provider, or entered into the system manually.
- Claim streaming tool is a combination of an automated first stage and a manual risk assessment if necessary.
    - The automated first stage was developed using the results of an analysis of 6 years of ACC claims data to identify the types of claims likely to exceed 52 weeks duration. It takes into account diagnosis, gender, age, work type and previous claims history.
    - If required, the risk assessment, completed by the case co-ordinator or the case manager at the managing site, will identify further psycho-social risk factors that the streaming tool can not pick up.
- The streaming tool allows ACC to direct claims to the most appropriate resources and type/level of claim management:
- Low risk claims are not managed at all (basically opened, paid and closed)
- Medium risk claims are dealt with remotely by the contact centres
    - High risk claims are managed face-to-face by case managers in the branches.
- Obviously, the streaming tool is only as good as the information being fed in to it. So, data capture and accuracy is a big focus for ACC. And as ACC gathers more and/or better data the streaming tool will be refined.
- The risk assessment is completed again in the following situations:
    - optimum duration is exceeded
    - outcome date is exceeded
    - maximum duration is exceeded
    - "bad gut" feeling (intuition)

The purpose of this is to identify, at the earliest possible point, when low risk escalates to high risk so face to face case management can start immediately.

– The risk assessment is not a structured interview but the case co-ordinator's/case manager's impression after gathering information from the claimant, employer and treatment provider.

– The separating out of the catastrophic claims and the process of lifetime planning is a relatively new process and is covered in more detail below.

4. Serious Injury Claimants

ACC has defined claimants with serious injury as those that will have a lifelong relationship with ACC due to the nature of their injuries.

Serious injury profiling was established for both management and ACC reserving purposes. The injury profiles were constructed by an in-house team including the Corporate Medical Officer, Clinical Director, Specialist Rehabilitation staff, branch representatives and staff from the rehabilitation policy area. The profiles are based around commonality of needs. That is, claimants in the same profile should have similar sorts of needs.

The following table sets out ACC's current profiling system.

Injury profile	**Descriptor**
Profile 1 – High level tetraplegia	C5 and above (includes injury at C5/6 level), ASIA scale A, B or C Usually requires 24-hour support and has higher equipment costs.
Profile 2 - Low level tetraplegia	C6 –T1, ASIA scale A, B or C. Requires significant support.
Profile 3 - Paraplegia	T2 and below, ASIA scale A, B or C Can function relatively independently throughout the day with access to a support package - including equipment
Profile 5 – Severe brain injury	Should have full range of care / supervision for 24 hours.
Profile 6 – Moderate brain injury	Lifetime access to support is required. There is an assessed need for personal support / supervision.
Profile 8 – Comparable diagnosis	Conditions with comparable severity to other profiles. Examples: – Multiple amputations – Burns to at least 50% of the body – Blindness – Neurotoxicity – Meets the support requirements of other SI profiles.

Profile 10 - Incomplete spinal cord injuries	Incomplete spinal cord injury, ASIA D (any level) including clinical syndromes (e.g. cauda equina). Support required varies according to functional ability.
Profile 13 - Recent brain injury	Clinically severe or moderate brain injury where it is too early in the rehabilitation to determine long term needs. The claim will be monitored on a monthly basis and allocated a profile once needs are determined. Many may not remain in serious injury

The initial profiling system had 12 profiles, numbered accordingly. Some profiles are no longer used, including paediatric and mild brain injury (profiles 4, 7, 9, 11 and 12). Children and young adults with serious injury are allocated to their particular injury profile, as this was more useful for ongoing management, injury prevention and reserving purposes. Profile 13 is a recent addition, aimed at improving the profiling and management of traumatic brain injury claims. More details on this are set out under the “Lessons Learned” section.

Being in or out of the serious injury portfolio does not mean any difference in the level and/or types of entitlements a claimant will receive. For ACC, the serious injury profiling is about identifying people with whom we expect to have a life long relationship with flow on effects from both a claim management and actuarial perspective.

5. Past

Circa 1992 ACC started to focus more attention on seriously injured claimants. Initially, the focus was only on claimants defined as having a “complex personal injury” (i.e. required 24 hour attendant care).

More detailed profiling and case management of serious injuries started in 1999. The focus was very much on the “care and recovery” of the claimant primarily through interventions such as:

– Medical treatment

– Capital improvements

– Attendant care

At this time, case managers worked with “front-end”, “tail”, or “serious injury” claimants (i.e. three areas of expertise/segregation). The serious injury case managers developed what were referred to as Individual Rehabilitation Plans (IRPs) for their claimants. These IRPs:

– Were very much entitlement focused

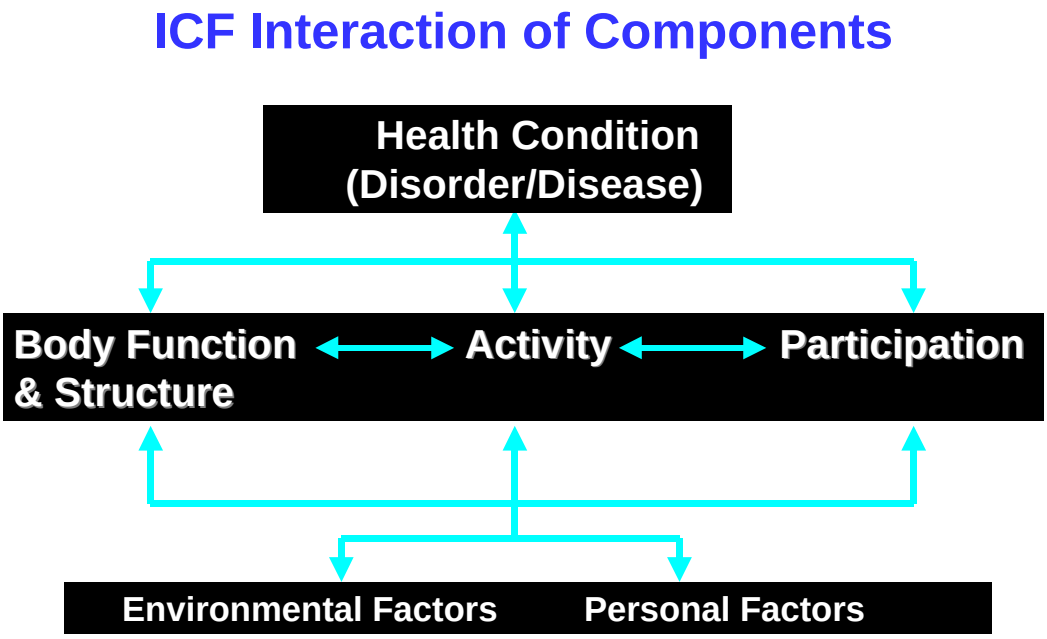
– Took a stepwise approach

– Looked at the here and now, with frequent reviews (i.e. no long term view).

– Did not detail expected outcomes

6. The ICF Model

The International Classification of Functioning, Disability and Health (ICF) Model:



The model shows that an individual's functioning in a specific domain is an interaction or complex relationship between the health condition and contextual factors (i.e. environmental and personal factors).

For more detail on the ICF Model the reader should visit
www.who.int/classifications/icf

7. Change within ACC

In 2000, a number of ACC's rehabilitation specialists, who identified a gap in the area of participation, drove the adoption and implementation of the ICF model within ACC. Implementation of the model was reflected in the drafting of the IPRC Act 2001 and subsequent ACC policy.

The question was asked "why just care for someone and not give them the ability to participate in their community?". There was the suggestion of it bordering on a human rights issue in that seriously injured claimants should have the right to participate in their community. The belief was that proving opportunities for claimants to participate more would ultimately lead to a reduction in support costs and if there were even a partial return to work then weekly compensation costs would also be reduced.

A report presented to senior management in January 2001, identified the following objectives of lifetime rehabilitation planning:

– To meet claimant and their family/ whanau needs with the best possible rehabilitation and support, so that the claimant receives consistent, comprehensive, cost effective rehabilitation now and in the future.

– To assist the claimant to identify community resources to support the claimant to reach their potential and assume as much responsibility for life as possible.

– To ensure that accountabilities and responsibilities are clearly defined and understood by all parties.

– To be pro-active and avoid complications, duplications and gaps in service

– To provide a basis for the reliable of forecasting claim costs, which assist in reserving funds to meet future costs.

In terms of getting buy-in:

– The Minister for ACC was in support of it. She was also Minister for Disability Issues.

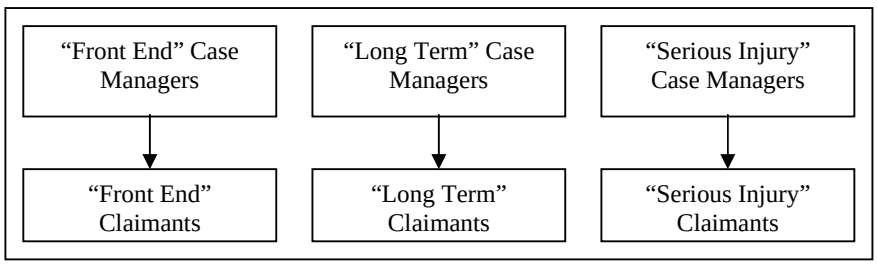
– ACC's medical officers also supported the model as they understood the idea of participation and were happy to move away from a purely medical model.

– In terms of getting the required changes to legislation (i.e. inclusion in the IPRC Act), it was more difficult getting buy-in from the Department of Labour ("DoL"). The DoL struggled with why ACC wanted to make such a philosophical shift in the way it treated seriously injured claimants and were possibly a bit weary of ACC's motives. ACC met with representatives from the DoL several times to talk them through the model and increase their understanding of it. In the end, the DoL agreed to support the adoption of the ICF model and to the required changes to legislation.

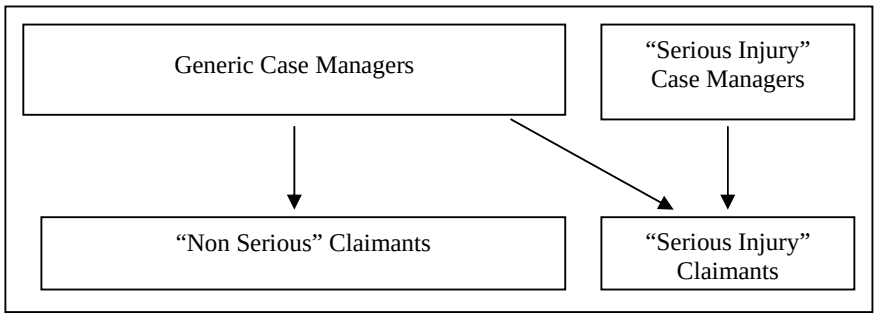
– Work was also required to get buy-in from the existing serious injury case managers, who saw themselves as an "elite group" of case managers. In fact, there still does not appear to be 100% commitment, as many of them still don't understand the philosophical change in the management approach to the seriously injured.

By 2003 ACC had in place a separate service model for the claim management of serious injuries, which included the introduction of lifetime rehabilitation planners.

In terms of the structure of the case management function, the change was from this:



To this:



Where lifetime rehabilitation planners provide planning services to the case managers.

8. Now

Management of Serious Injury claims

Serious injury claims are still managed within the branch network. However, rather than having a small number of dedicated serious injury case managers, all case managers can in theory manage serious injury claims.

Lifetime rehabilitation planners provide planning services in respect of all new serious injury claims and are working through the portfolio of existing claimants.

ACC recognises that assessing needs and planning to ensure that the present and future needs of claimants with a serious injury are met is a specialised skill, which requires comprehensive rehabilitation knowledge and experience.

Lifetime Rehabilitation Planning

To address these issues and provide the specialised skills required ACC introduced lifetime rehabilitation planning in February 2003. Prior to starting as lifetime rehabilitation planners, the staff underwent an accredited program provided by two American life care planners.

Lifetime rehabilitation planning involves a comprehensive assessment of the medical, support and vocational needs a person with a serious injury may have throughout their lifetime. These needs are based on the specific injury and the person's circumstances. They are documented in a lifetime rehabilitation plan, which provides a framework for their ongoing support and rehabilitation. Each plan goes through a peer review process,

ACC currently has 11 lifetime rehabilitation planners who are employed by the branch network to develop lifetime rehabilitation plans for serious injury claimants. The service is provided across New Zealand with lifetime rehabilitation planners operating in defined geographical regions.

One of the lifetime rehabilitation planners, because of her experience with children either undertakes the planning for children or provides advice to other planners.

Currently there are 341 people who are in or have had a lifetime rehabilitation plan completed. This accounts for 12% of those with a serious injury. Plans are being developed for all new serious injury claimants prior to discharge from the residential rehabilitation facility and over time about one third to a half of theses claimants (the most disabled) will have plans prepared for them.

Lifetime rehabilitation planners are also developing plans for existing serious injury claimants. There are a number of people with serious injuries who, because of the length of time since their injury, now have to make changes to their lives. Many of these are now being provided with a lifetime rehabilitation plan that allows them to investigate change not only in terms of the immediate situation but also in terms of future needs.

Lifetime rehabilitation planners are making providers more accountable as they are asking questions such as:

– Why are certain services being provided?

– What are the expected outcomes?

– How do these services and outcomes align with the claimant's aspirations?

Life time planning has been described as:

– Having a focus on rehabilitation and participation rather than care and recovery. In particular, focusing on all aspects of participation including the work place, social environment/community and at home.

– Identifying support needs rather than care needs

– Supporting how claimants want to live their lives = facilitator/enabler

– Moving away from a "systems" approach

– Talking to claimants early on about aspirations rather than entitlements and benefits

– Checklists/Packages of Support

9. Results

A Lifetime Rehabilitation Planning Review was conducted earlier this year. The following are some of the review's findings:

– It has resulted in more cost-effective outcomes.

– It was recognised by the international trainers that it takes approximately 6 months before people have the competency to do effective planning. This information is based on the trained observations of people who had been experienced case managers

– Assessors have found that for the first time their assessments have been critiqued and sometimes rejected. Extensive work has been undertaken by Lifetime

Rehabilitation Planners (LTRPs) to set clear expectations about quality with assessors.

- Providers have found the introduction of lifetime planning challenging because vague outcomes from the delivery of a service have been questioned. Recognition and acceptance by providers of the changes that are part of lifetime rehabilitation planning has required extensive negotiation by planners.

- Case managers and team managers, especially of serious injury teams, have found the changes have highlighted some practices that were not consistent with ACC policy. These practices have ceased, as they were often expensive with no rehabilitation outcomes. Some serious injury case managers have felt threatened by the introduction of lifetime planning. Generic and new case managers have welcomed lifetime rehabilitation planning. LTRPs have had to spend energy building effective relationships and clarifying roles and responsibilities.

- Crucial to ensuring both consistency of entitlement and response to the claimant's needs and aspirations is the process for peer approving plans. Many LTRPs initially found the degree of scrutiny of their plans difficult. It does add time but it is important to ensuring a quality product, and identifying and managing LTRPs particular training needs.

- Development of the forms and support documentation to be used by LTRPs has taken longer than anticipated. This work is now complete although Informe requires modification because of the final changes to the process.

- Changes to the way in which lifetime rehabilitation planning operated occurred throughout 2003. The referral process changed because in some situations the planning was starting too early. ACC was being criticised for being over anxious to start the planning process before the person or the clinical team was ready.

- The response from claimants has been extremely positive. They believe that greater consideration has been given to their individual needs resulting in greater clarity around their future entitlements and that the primary focus is maximising their independence.

- During 2003, extensive training and support has been undertaken, especially while the LTRPs were in a developmental phase. It is now expected that the required level of expertise has been achieved and so clear performance targets have been set. These are monitored regularly with specific feedback to each LTRP.

10. Valuing Serious Injury Claims

Valuation Method

The current methodology employed in valuing serious injury claims involves the use of an annuity based individual case estimate model. For each claimant, this model estimates the social rehabilitation benefit costs in aggregate only. There is no separate estimation of the four major cost components of social rehabilitation benefits - care, capital, assessment and other. This may change in the future and there are plans to analyse capital costs separately next year.

Benefits other than social rehabilitation are not valued separately for serious injury claims. The reason social rehabilitation costs are valued separately is that it is believed there is a significant difference in the payment levels and patterns for this benefit type between seriously injured claimants and non-seriously injured claimants. The other benefit types may exhibit differences in duration but the levels of entitlement should be similar between the two groups. The consequence of this is that there is no estimate of the total lifetime cost of a serious injury claim. The separate projection of other benefit types for serious injury claims is under consideration.

Inclusion in the serious injury case estimate model is based on the profile of the claimant. Profiles 4, 7, 9, 12 and 13 are excluded from the model as they are no longer classified as serious injuries. Claims with profiles 4, 7, 9 and 12 are either re-profiled to place them in an "active" profile for modelling or treated as non-serious and excluded. Profile 13 claims are not modelled until it is determined which of profiles 5 or 6 they belong in. Claims with profiles 5 or 6 that have been closed for reasons other than death are also excluded from the model. This was done so that claims that are no longer classified as serious are not modelled. With the introduction of profile 13 there should be very few of these exclusions in the future.

The serious injury case estimate model includes all of the serious injury claims not listed as excluded in the above paragraph. This means that closed claims and claims relating to deceased claimants are included in the model. This allows the payments relating to these claims to be used to set the assumptions used in the model while also preventing them from influencing the projected payments for non-serious injury claims.

The case estimate model uses a combination of payment assumptions to project future payments. First, average payment levels are determined for each profile and at various durations since the date of accident. These are based on the historic payments made in respect of claims with each profile. The average payments are used in conjunction with the actual payments received by each individual claim in the last two years to establish estimated future payment amounts. The weighting between the profile average and the individual payments is based on the recent payment history of the claim being considered. The more stable the recent payment patterns the greater the weight that is given to the individual payments and hence the lower the weight given to the profile average payment levels.

Projected payments are based on claimant mortality and this mortality is loaded for each profile to reflect the impact of the injury on the claimant's life expectancy. These payments are inflated and discounted to the valuation date giving the outstanding liability for each claimant. The full liability is included in the valuation results for claims which are open on the valuation date. For claims that were closed on the valuation date, but where the claimant is still alive, a liability of 50% of the liability that would otherwise have been projected for them is included in the results. This is to allow for the possibility that these claims will reopen or that they will be replaced by new claims that have been incurred but not yet reported.

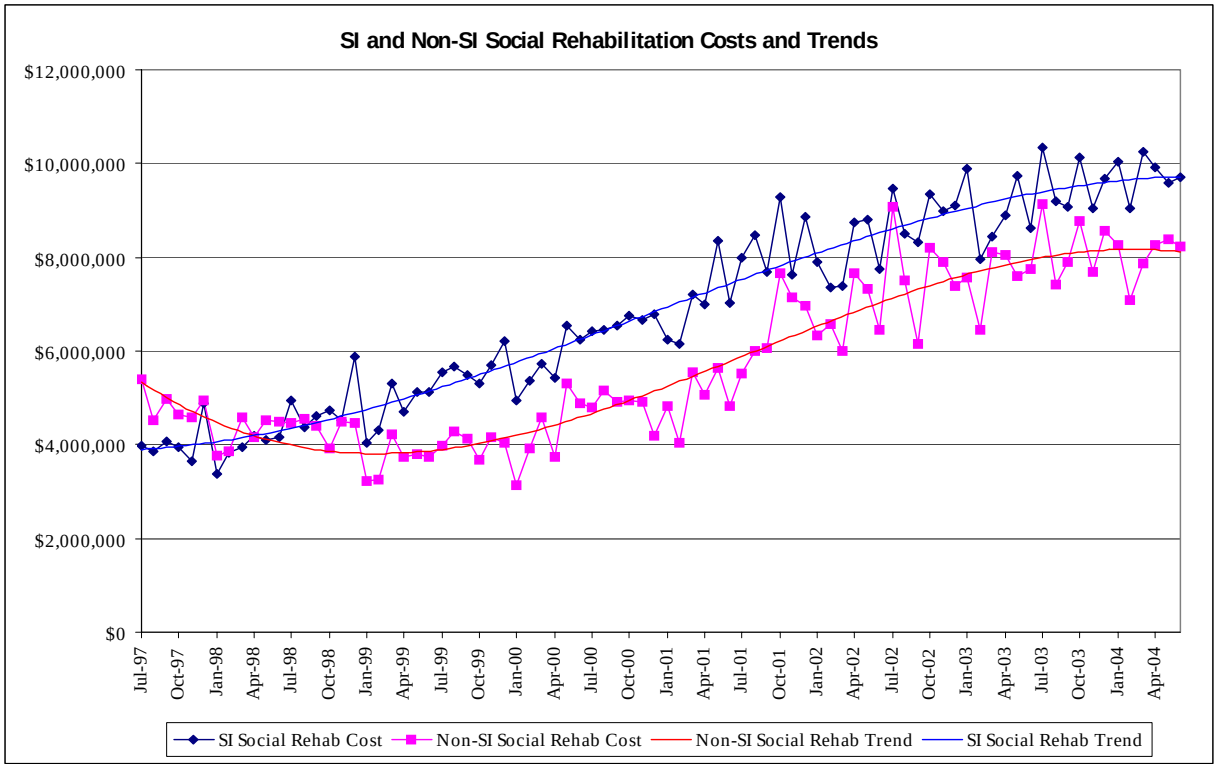
As at 30 September 2004 the estimated serious injury liabilities by profile and fund are shown in the following two tables:

Group	Profile	Estimated Ongoing Annual Social Rehab Cost per Person	Number of Claims	Social Rehab Reserve ($M)	Social Rehab Reserve per Person ($M)
A. Spinal Cord Injuries	1. High level tetraplegic	$84,234	299	$421.62	$1.41
	2. LL tetraplegic/HL paraplegic	$46,957	223	$174.81	$0.78
	3. Paraplegic	$17,392	539	$162.70	$0.30
	10. Incomplete spinal cord injury	$11,259	374	$57.23	$0.15
C. Brain Injuries	5. Severe Brain injury	$76,103	456	$695.49	$1.53
	6. Severe to moderate brain injury	$36,706	928	$665.84	$0.72
D. Dual injuries	8. Comparable diagnosis	$24,816	189	$55.00	$0.29
	11. Psychiatric	$18,645	21	$0.32	$0.02
TOTAL			3,029	$2,233.02	$0.74

	Fund							
	Self-Employed	Residual	Employers	Motor Vehicle	Non-Earners	Earners	Med Ms	Total
Discounted Rehab Reserve ($M)	$8.562	$250.652	$15.760	$987.235	$634.076	$164.685	$172.046	$2,233.017
%	0.4%	11.2%	0.7%	44.2%	28.4%	7.4%	7.7%	100.0%
Number of Cases	17	528	37	1,322	688	265	172	3,029
%	0.6%	17.4%	1.2%	43.6%	22.7%	8.7%	5.7%	100.0%

Social Rehabilitation Costs

The figure below shows the total annual rehabilitation costs by serious injury and non-serious injury. For both groups the growth rate has been slower in recent months than in the previous 12 months.



A number of drivers have contributed to this increase. These include:

– The increased longevity of the claimants.

– ACC taking responsibility for the funding of non-acute rehabilitation in April 2002. This was previously funded through the public health acute services agreement between ACC and the Ministry of Health. That is, there has been a cost shift from one payment type to another, rather than an overall cost increase to the scheme.

– Regular comprehensive assessments that have identified previously unmet need.

– Existing claimants whose carers can no longer continue to provide care or who are now 15-20 years post injury and their support needs have increased. It is difficult to estimate the future support and cost paths, as people with the degree of severe injury of many of the claimants did not previously live as long as they currently are.

– Increased range of services has provided families with acceptable alternatives to them providing the care and support.

– Technological advances, although more expensive have greatly assisted the independence of people with serious injury. Technological advances will continue and the cost of these advances is expected to continue to increase. Expenditure on technology often enables a reduction in support, which while initially more costly in long term is less costly with greater independence for seriously injured people. While acknowledging this there are some people who see equipment as taking control of their lives and so reject technological solutions.

11. Lessons Learned

1. As discussed earlier, ACC has seen a trend of increasing social rehabilitation benefit costs. However, most of this increase is a result of the significant change in ACC's approach to the management of serious injury claims over the last 4 – 5 years. The emerging costs are very much a function of poor understanding a decade ago of the dynamics of major injury and disability. Any new scheme which anticipates these issues and builds them into the cost model and legislation is less likely to be subject to this type of cost escalation.

2. The impact of an injury on a claimant's participation needs to be clearly identified. That is, we need to determine where ACC's responsibilities lie or start and end. Some examples of this are:

– If a child with a brain injury wants to take ballet lessons ACC will not pay for the lessons, as this cost is the parent's responsibility.

– If a claimant wants to get involved in archery, ACC will pay for the services and products required to remove the barriers to participation (e.g. a wheelchair) but not the archery equipment.

– Employers have to provide their employees with reasonable access to their place of work (e.g. ramps for wheelchairs).

– Modifying a claimant's kitchen so they can cook for themselves removed the requirement for them to have home help to prepare meals. The fact that they had limited time to prepare meals because they were also working wasn't a participation issue and therefore not something ACC was responsible for.

3. When looking at the claimant's level of current and potential participation, the claimant needs to be involved so they are aware of the risks they are going to be taking. Basically, it's a case of "participate in life, with some associated risks" or live in an institution.

4. ACC also needs to be clear about whose needs we are trying to meet, especially with young claimants. We need to be careful that we are meeting the claimant's needs and not the parents'.

5. ACC contracts the services of a number of social rehabilitation assessors. We have found that some provide better service (i.e. (understand the ICF model) than others (i.e. still coming from a functional limitation perspective).

6. Early on, all mild traumatic brain injury (TBI) claimants were placed in the serious injury portfolio. This blanket approach was not appropriate for a number of cases. Because early on the focus was still on the injury rather than participation, this led to these claims being "catastrophised", when in fact not all of them end up in a life long relationship with ACC. Corrective action has been taken via the inclusion of the profile 13 category. By placing recent brain injuries in profile 13 until they have stabilised and a reasonable assessment can be made, ACC retains a higher level focus on them without using up scarce lifetime planning resource until deemed necessary. In managing profile 13 claimants, temporary interventions are usually sought until the situation has stabilised.

7. Serious injury case managers have struggled with the change to the life planner role under the ICF model. Observations include:

– "Throwing" extra benefits at claimants, not on a needs basis and with no participatory requirements.

– Inconsistent decision making, with no rationale for the differences.

– A significant range of benefits/costs for similar injuries.

More education and training is required in this area.

8. Management of some cases has highlighted the potential to put in place detailed, permanent and costly interventions before stability has been reached both in terms of the injury and the claimant's state of mind. Serious injury claimants usually need time to adjust to a very different way of life post accident. As an example. Consider the case of a 20 year old living alone who moves back in with his parents after the accident (often at the parent's insistence) so they can look after him. It may not be appropriate to make significant modifications to the parent's

house because the 20 year old may decide, after regaining some independence, not to live with them anymore. In these cases temporary interventions are put in place until such time as a reasonably good assessment of the claimant's future and their aspirations can be made.

9. Initially when projecting the future costs of the seriously injured, a projection period of 40 years post accident was used. The shortcomings of this have been evident over the last few years as ACC has seen a number of seriously injured people, especially young males involved in car accidents 20 to 30 years ago, still on the scheme and only in their 40's and 50's. ACC now assumes benefit payments will continue until death, with some mortality loading by profile type, especially for the very seriously injured.

10. Changes to post-acute rehabilitation for serious injuries were made in 2000. This had most impact on brain injuries (profiles 5 and 6).

    There was a movement away from care in hospitals/homes and towards residential care and support. This included independence training to enable the claimant to become more self-supporting and hence eventually lower the level of care they require. Setting up this process and providing residential care has increased costs for these claimants. Now that the process is in place costs should stabilise and may even decrease.

11. A new key performance indicator (KPI) was introduced for case managers in 2002. The KPI was implemented to increase the contact between case managers and claimants. The result of this was an increase in the numbers of assessments for many claimants. This in turn led to increases in entitlements offered and consequently an increase in the costs of these claims.

    Now that the case managers have, in most cases, got their assessments up to the levels required for the KPI this increase in costs should stabilise and possible even reduce. More regular assessments should result in consistent levels of assessment costs and more stable entitlement costs.

12. ACC took back the management and payment of claims resulting from non-acute in-patient rehabilitation (NAIR) in April 2002. Prior to this these claims were funded through the bulk funded acute levy, paid by ACC to the Ministry of Health, and as such were not attributable to individual claims.

    The bulk of the costs for NAIR treatments occur in the early stages of a claim (1-2 weeks post injury in most cases, and up to 2 years for some brain injuries). The result is a spike in claims costs right after the accident that was not there in claims prior to April 2002.

    While this is expected to continue the effect should be reasonably stable over time. That is, it is not an increasing claim cost trend that will continue into the future. Rather it is an increase in the overall level of claims costs that should continue at approximately the same level into the future.

    If the NAIR costs are to be projected then it should be remembered that they are usually very short-tailed costs with an expected duration of around 2 weeks.

13. In 2003 community care costs increased. This was caused by retrospective attendant care payments being made in cases where family members had been caring for seriously injured claimants at no cost to the scheme. This caused a spike of payments that are not easily identified, as they are not given general ledger (GL) classifications that allow them to be singled out.

    There should be fewer retrospective attendant care costs in the future and the current care costs should now stabilise. Thus projecting the increases from historical payments would overstate future care costs.

14. In 2002 life coaches were introduced. These life coaches were intended to provide care and assistance to gain the skills required for independence. It is therefore only appropriate for claimants that have the potential for a degree of independence to receive care from a life coach. The cost of care from a life coach is approximately $35 per hour compared to the cost of care from other carers, which is approximately $15 per hour.

    In 2003 a project was undertaken to identify cases were life coaches were caring for claimants who were not capable of attaining independence. A number of cases were identified where this was happening and better procedures were put in place to prevent this from happening in the future. The effect of this was increased costs of care through the inappropriate allocation of life coaches, which has not been stopped. In fact, the use of life coaches is about to be stopped altogether.

15. There are a number of serious injury claimants who are reaching the 30 years post injury phase. These claimants are all approximately 50 years old. Due to their age and injuries these claimants are starting to suffer from reduced function and consequently higher claim costs are arising.

    This mainly effects profiles 3 and 10.

    These higher costs will probably be maintained over time but should not increase at their initial rate (or if it does it will be a short-term effect). This will happen because the population should be reaching a steady state with respect to the age distribution. So, as the ageing claimants leave the serious injury group through death others will reach the older age groups which will then be replaced by younger claimants. The general issue of New Zealand's ageing population will effect this slightly but reasonable stability should still be achieved.

12. The Future

The Ministry of Social Development has a project under way to develop a Framework for Long Term Disability Support. The aim of developing this framework is to provide a consistent approach in respect of long term disability support across different areas (mainly Work and Income, Ministry of Health and ACC).

As a result of the ageing of ACC's serious injury portfolio, we will be reviewing our serious injury case estimate model in February next year. Currently, the model assumes uniform payments after an initial period post accident. Experience now shows that this is not the case for older claimants as we are now seeing cost increases

at approximately 10 to 15 years post injury. The model will be modified in light of this experience.

As alluded to earlier, the Ministry of Health manages interventions in the early/acute period under its public health acute services (PHAS) contract with ACC. Issue have been identified regarding the quality and timing of support in this period and the fact that ACC has no control over them. Work is planned on investigating these issues and recommending alternative arrangements and/or processes.

Work will also be undertaken in the near future on vocational rehabilitation strategies (i.e. return to work strategies) for serious injury claimants. The aim is identify current policies and services in this area that may need to be changed.

As mentioned earlier, training and education programmes are planned for the branch network aimed at getting and/or increasing buy-in of staff. ACC will also be continuing to upskill its Lifetime Rehabilitation Planners.

One other area of future work is in the area of minimum "packages of support". The idea being to identify minimum levels and types of entitlements by profile (not necessarily all profiles) and make the process of delivering these as simple as possible rather than complicating the situation and spending money unnecessarily on assessments when the claimants (minimum) needs are reasonably clear cut.

13. Further Information

Anne Hawker is ACC's Improvement Manager – Rehabilitation and was instrumental in the implementation of lifetime rehabilitation planning to ACC as well as on-going improvement of our rehabilitation process. Anne is more than happy for people to contact her if they have any queries. Anne's email address is anne.hawker@acc.co.nz