



11 March 2026

Independent review of ACC's health services environment

In 2026 ACC released a report titled 'Health Services Environment and Spend Review' (dated November 2023) under the Official Information Act 1982 (the Act).

A copy of the review by Boston Consulting Group is attached to this letter. We note that some information was withheld from the report to enable ACC to carry on, without prejudice or disadvantage, upcoming tender negotiations. This decision was made under section 9(2)(j) of the Act. We consider that the public interest in releasing this information does not outweigh the reasons for withholding it.

Background information about the review

- In 2023 we appointed Boston Consulting Group (BCG) to carry out an independent review of our health services environment.
- The purpose of [the independent review](#) was to help us learn more about the dynamics of the health sector, including our own impact on it, and opportunities to improve how we procure and commission services.
- The report's findings provided us with important insights into increases in the cost of providing rehabilitation and treatment support for injured clients, what was driving those increases, and how our commissioning approach compares to overseas models.
- It highlighted significant variation in client experiences along their treatment journey, which have contributed to longer rehabilitation times and increased costs.
- The report also identified the need to collaborate with the sector to develop a more effective, outcomes-focused commissioning model that integrates clinical input throughout the client pathway.
- The report's findings and recommendations have been considered and applied as part of ACC's ongoing work to improve performance and achieve better recovery outcomes for injured New Zealanders.
- Over the past two years we've been engaging with the primary and secondary care sectors to understand how we can strengthen the way we commission key services and improve the way we work together to deliver better recovery outcomes.
- We have a range of work now underway based on what we heard from the sector. For example, we're working towards increased data sharing and transparency with providers through new return to work dashboards for surgeons and GPs; we've stepped up our focus on performance management of outlying providers; we're incorporating changes to contracts to improve clarity and measurement of recovery outcomes as contracts come up for renewal; and we're designing a new approach to the way we commission and deliver secondary care services, with input from the sector.

- We need support from the health sector, from providers, from employers, and from all New Zealanders, to get injured people better faster and ensure we protect the Accident Compensation Scheme for the long term.

Ngā mihi

A handwritten signature in black ink, appearing to read 'Chris Johnston', written in a cursive style.

Christopher Johnston
Manager Official Information Act Services
Government Engagement



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

Final Report

Health Services Environment and Spend Review

November 2023

RELEASED UNDER
OFFICIAL INFORMATION ACT



A note to the reader

This document represents the output from ACC's Health Services Environment and Spend Review, which Boston Consulting Group (BCG) supported over August – November 2023

While these findings and recommendations have been developed collaboratively with the staff and leadership of ACC, they do not represent ACC policy

The findings are informed by analysis of internal and external data sources, plus discussions with stakeholders, including internal ACC stakeholders, provider groups, overseas organisations and experts

This reports is the culmination of twelve weeks of work up until 27th November 2023

More comprehensive and detailed data, along with deeper engagement with relevant stakeholders and governmental agencies, will be required to validate and progress the high-level assessments and recommendations contained in this document – including the assumptions underpinning BCG's initial assessment of value impact

Executive Summary

The Health Services Environment and Spend Review focused on reviewing the commissioning model for health and rehabilitation services. Broader roles of ACC such as injury prevention, managing scheme boundaries, and investment have not been considered

ACC spending is growing significantly faster than the overall economy, increasing at 9% per annum over the FY19-23 period in nominal terms and reaching \$6.2Bn in FY23 across medical, rehabilitation and weekly compensation

- Spend increases are driven by an increase in the average spend per claim
- This spend growth has exceeded macro-economic factors over FY19-23
- Total claims numbers only increased 0.2% p.a. between FY19-23; 'new claims' registered in FY23 still lower than pre-Covid levels
- Health service spending grew in the last 5 years across most contract clusters; little growth in primary care

Advancing Huakina Te Rā using a 'Value Based Health Care' approach can release several hundred million in savings and accelerate return-to-work by 9-33%

- Internal benchmarking shows significant variation in injury duration and end-to-end costs, implying potential for significantly improved value (c.\$150-750Mn) through tighter compliance to evidence-based care and rehabilitation pathways
- External benchmarking of unit costs for specific services shows potential for c.\$150Mn in savings by matching average global benchmarks
- External benchmarking of commissioning approaches against leading organisations also shows significant opportunities to better manage for value

To realise this opportunity for better outcomes and increased health care value, the project team have developed six pragmatic recommendations with the ACC team:

- 1. Adopt a Target Commissioning Model** that is client-centred and outcome focused, devolving more medical treatment and rehabilitation decisions to providers, addressing up to 60-75% of in-year ACC claims spending
- 2. Implement client-centred care pathways managed by primary and community care including Kaupapa services** that reduce unwarranted variation, integrate rehabilitation teams and provide a consistent set of decision support tools across the country
- 3. Build capability to shape service delivery markets**, using strategic procurement to achieve better pricing, improved access and better outcomes
- 4. Develop data, reporting and evaluation tools** to support this new commissioning model
- 5. Work with Health New Zealand/Te Whatu Ora** to advance integrated pathways for the 13% of claims registered in Health New Zealand/Te Whatu Ora, to buy more effectively from the private sector and to jointly make investments in capacity to increase competition or serve underserved markets
- 6. Focus the Operating Model** on increasingly managing outcomes and risk through pathway design and provider performance management

The target commissioning model will require increased investment into primary care, data and technology, and some medical services but these will be more than offset by savings from better procurement, faster recovery and reduced claims handling expenses

A detailed action plan to implement these recommendations has been developed in collaboration with ACC staff. To move forward ACC should focus on:

- Immediately aligning on the way forward, including integrating with other strategic initiatives e.g., Rehabilitation Improvement Group
- Implementing 'no regrets' actions that signal intent and deliver impact
- Setting up to "flip the odds" of long-term success

Contents

1. ACC spending trends
2. Benchmarking Health Services Commissioning
3. Recommendations
4. Action plan

RELEASED UNDER THE
OFFICIAL INFORMATION ACT



1 | ACC spending trends

Summary | ACC in-year external spend is growing faster than the economy, increasing at 9% per annum (FY19-23) in nominal terms and reaching \$6.2Bn in FY23

ACC's in-year spend has increased 9% p.a. between FY19-23, driven by an increase in the average spend per claim

- Analysis is focused on all 'in-year spend' comprising both medical and non-medical costs with non-medical costs being the majority of spend
- Total spending has increased across Compensation (10.5%), Rehabilitation (8.9%) and Medical Treatment (7.8%) p.a. over 5 years
- Compensation spend increases are driven by the combination of longer average time on Weekly Compensation growing at 6.5% p.a. and increasing number of claims for compensation
- Increase in Rehabilitation spend is due to significant growth in costs per claim
- Increasing complexity of the claims mix contributes to growth in cost per claim, possibly driven by restricted access to registration channels for low complexity cases following Covid

ACC's spend growth has exceeded macro-economic factors over FY19-23

- Spend per claim growth exceeded CPI by 100% and the count of Compensation claims grew 50% faster than the rate of employment
- In-year spend increases have also translated to higher Outstanding Claims Liability expectations (\$65Bn in June 2023), which has increased at +5.2% p.a. before considering macro-economic factors

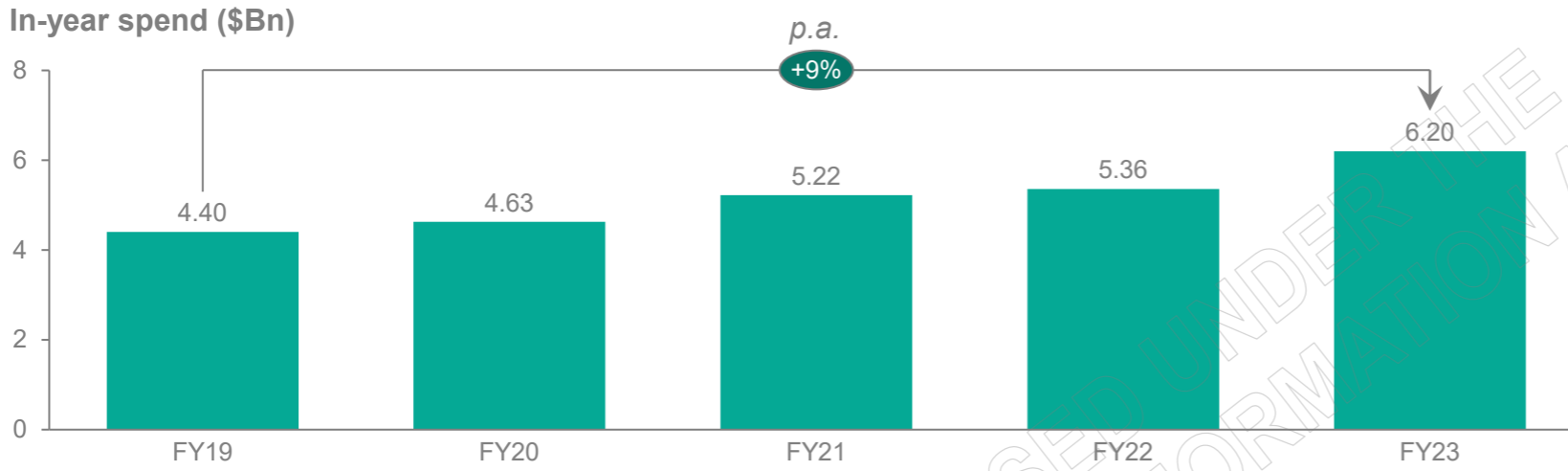
Total claims numbers only increased 0.2% p.a. between FY19-23, 'new claims' registered in FY23 still lower than pre-Covid levels

- Annual claims growth was higher in Compensation and Rehabilitation than in Medical
- Despite flat claims numbers, ACC's claims handling expenses have increased by 4.8% p.a.

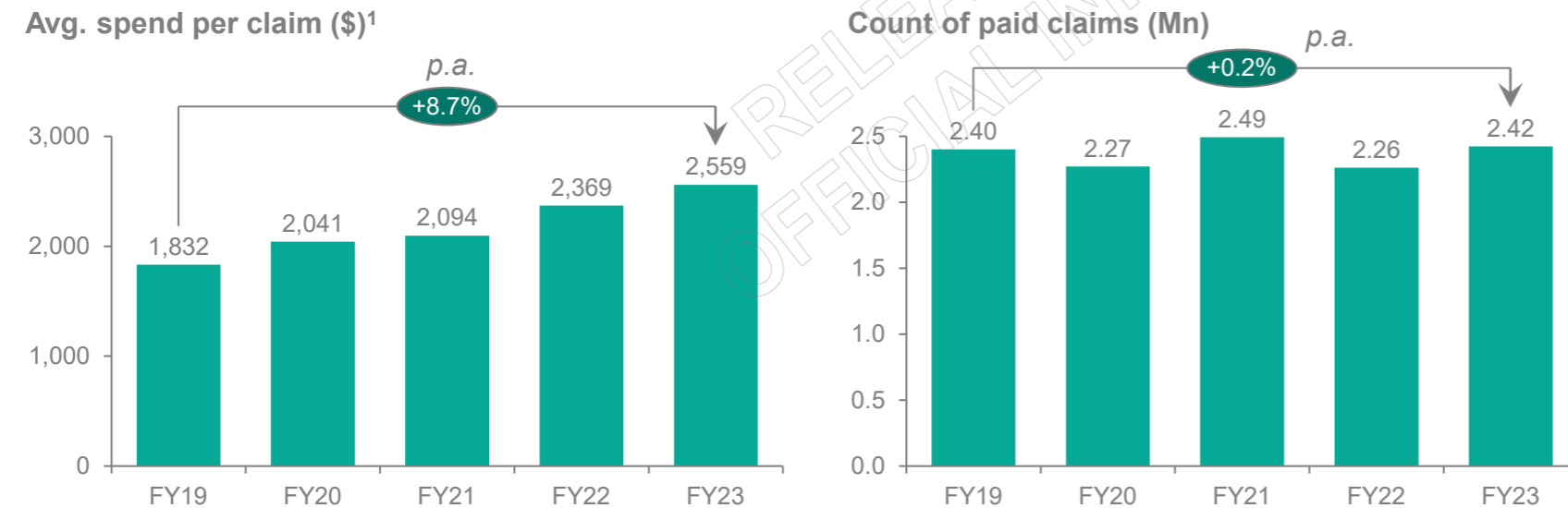
Health service spending grew in the last 5 years across most contract clusters; with least growth in primary care and vocational rehabilitation

- Spend growth was driven by non-surgical client/kiritaki journeys, particularly concussion, sensitive claims and non-surgical injuries
- Primary Care and Health NZ/Te Whatu Ora register 66% of claims & account for 74% spend by registration point; Primary Care only receive 6% of medical & rehab spend

ACC's in-year spend has increased at 9% per annum (FY19-23) to \$6.2Bn, driven by an increase in the average spend per claim



ACC's in-year spend has **increased at 9% p.a. between FY19-23**, reaching \$6.2Bn in FY23 (including bulk-funded)



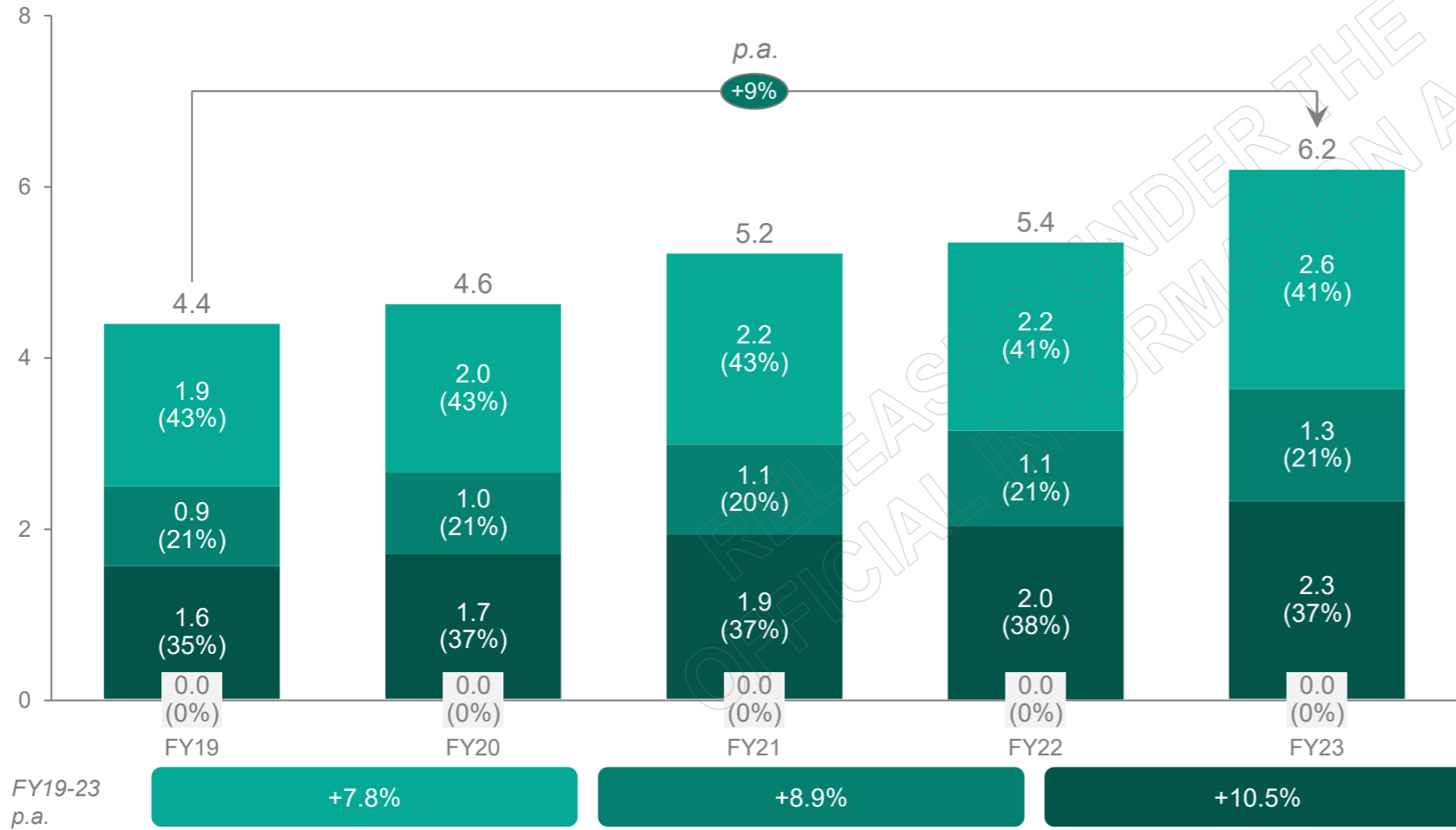
The increase is **overwhelmingly driven by a higher average spend per claim**, which has grown at 8.7% p.a. in the period

The number of paid claims has fluctuated, having been impacted by Covid, **growing at 0.2% p.a. in the period**

Source: ACC Finance Data; 1. Computed by dividing all spend (including bulk-funded) by the number of paid claims; Note: spend per claim is also affected by increasing complexity of the claims mix due to reduced access for low complexity claims to registration channels such as Primary & Community Care throughout and following Covid

Spending has increased in each spend category, with Compensation growing fastest

In-year spend (\$Bn)



Key Medical treatment Rehab Compensation Others

All categories have shown an increase, which led to an **aggregate 9% p.a.** in the period and reaching \$6.2Bn spend in FY23

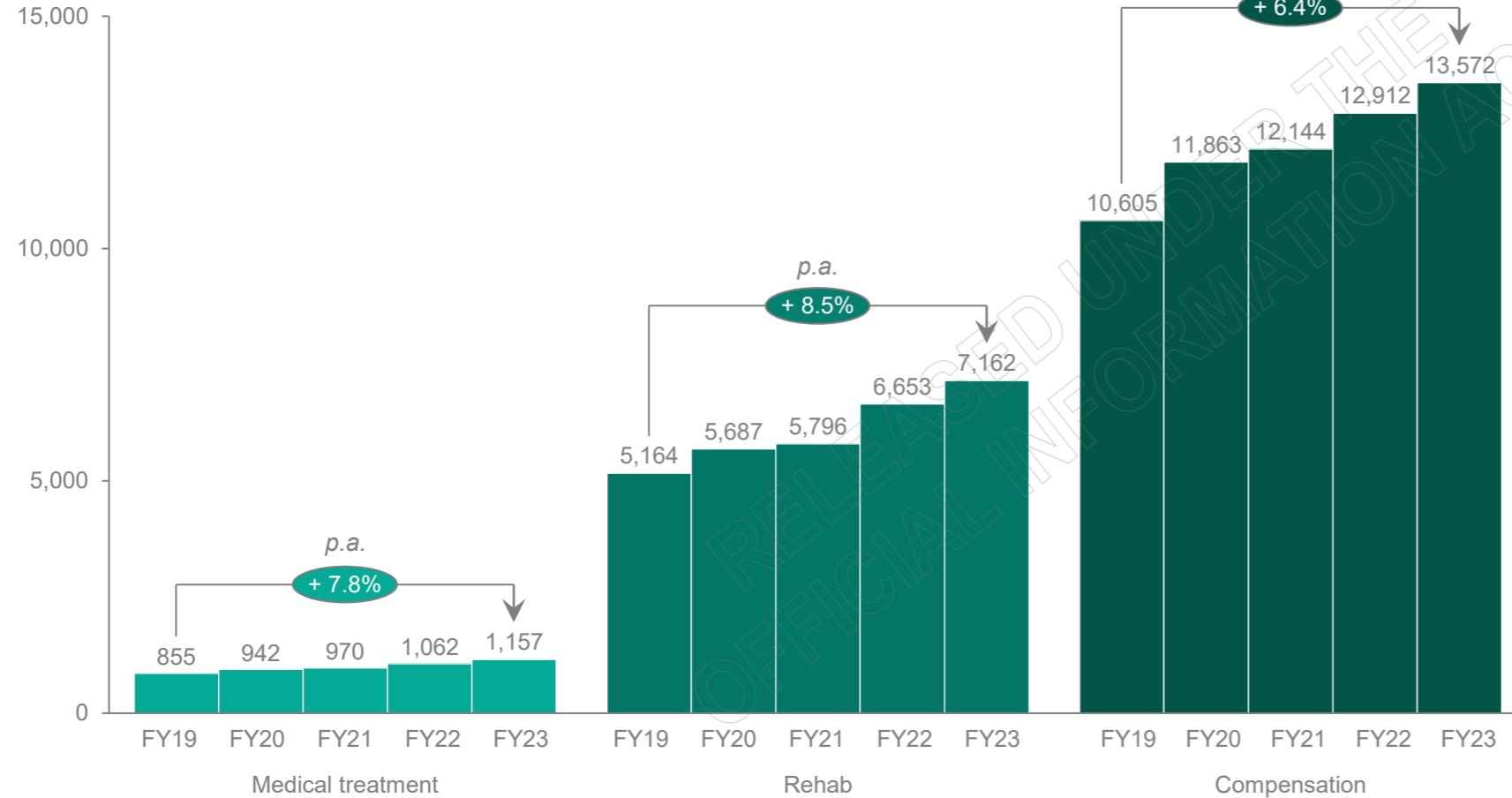
Compensation has been growing fastest (+10.5% p.a.), followed by Rehab (+8.9%) and Medical treatment (+7.8%)

Medical treatment accounts for most of the FY23 spend (41%), followed by Compensation (37%) and Rehab (21%)

Source: ACC Finance data; Note: Bulk-funded spend included in Medical treatment (PHAS, Road Ambulance, Air Ambulance, Healthline, others) and Rehab spend (Spinal cord, SAATS, others); 'Others' includes miscellaneous expenses not linked to any category (e.g., backdated spend, outsourced clinical advice, ...)

Each spending category per claim also grew, with Rehabilitation growing fastest

Avg. spend per claim (\$)¹



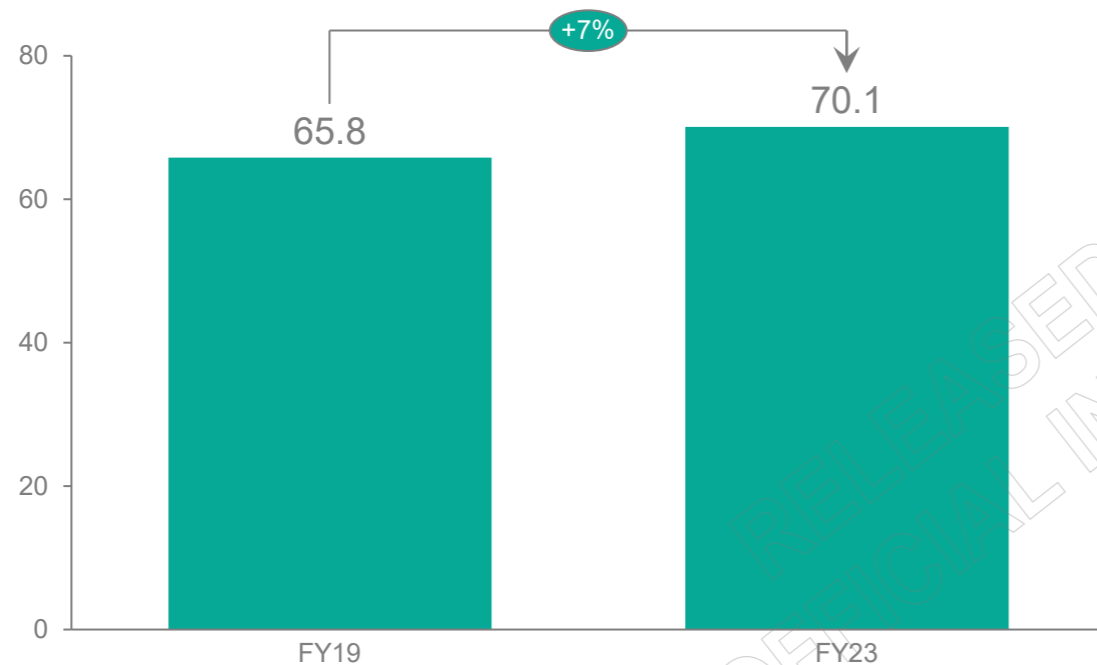
Rehab average spend per claim grew the most (8.5% p.a.), followed by Medical treatment (+7.8% p.a.) and Compensation (+6.4% p.a.)

Average Compensation spend per claim (c.\$13,500) is much higher than other categories, followed by Rehab (c.\$7,200) and Medical treatment (c.\$1,200)

Source: ACC Finance data. Note: The aggregate average spend per claim increase at 8.7% p.a. is the result of the number of claims in high-spend categories (e.g., Compensation: +3.9% p.a.) growing more than other categories (e.g., Medical Treatment: +0.16%). Includes bulk-funded spend; 1. Computed by dividing total Medical treatment/Rehab/Compensation spend by the total claims for that category

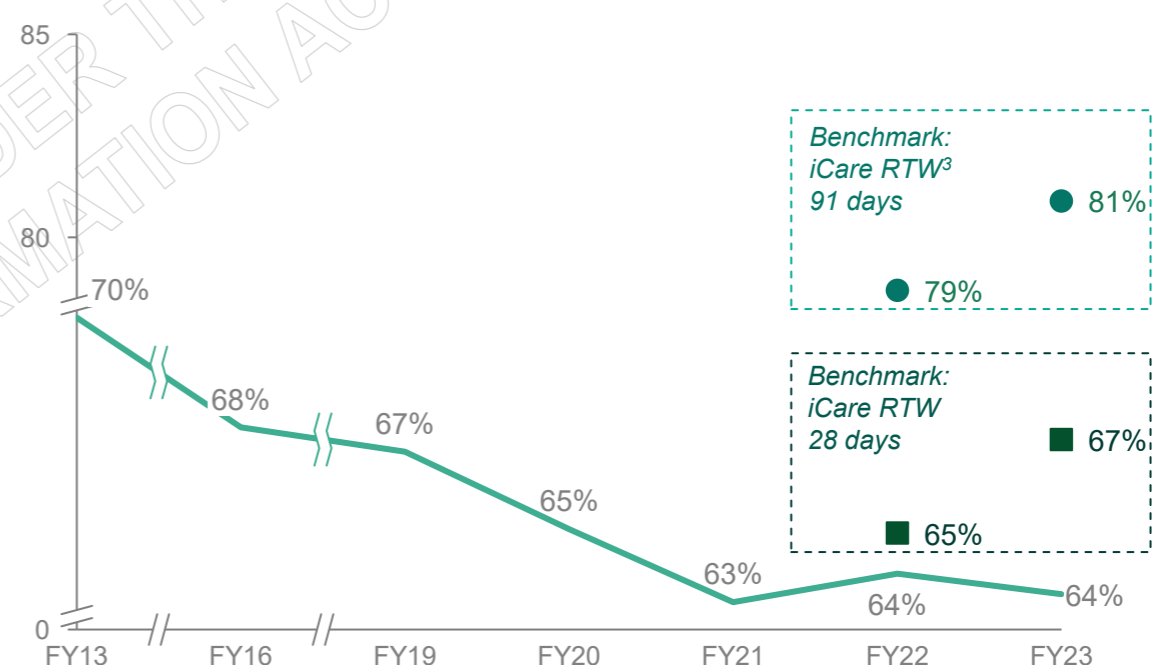
Clients are taking longer to return to work, showing a 7% increase in time on WC from pre-Covid levels and a constant reduction in clients returning to work within 70 days

Avg. Time on WC (days)¹



- **Average time on weekly compensation has increased by 7% from pre-Covid levels (FY19):** growing from 65.8 days to 70.1 days in FY23

% of client/kiritaki returning to work within 70 days²



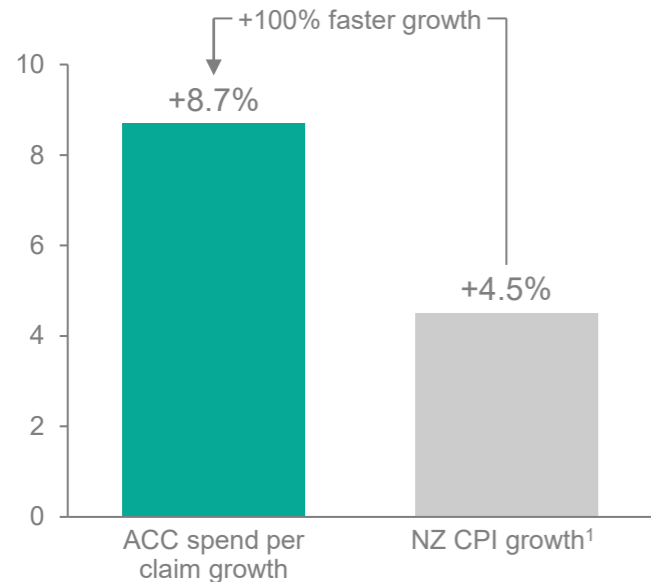
- **ACC clients/kiritaki are taking longer to return to work:** the percentage of client/kiritaki returning to work after 70 days has decreased by 6ppt (70% to 64%) in the last 10yr
- ACC client/kiritaki return to work is below iCare benchmarks³

Source: ACC Finance data; 1. Measured on exit from WC for client under 365 days. Consistent comparison not available before FY19; 2. 52 weeks rolling average, a client is considered to have returned to work five weeks after the cessation of weekly compensation payments; 3. iCare benchmark is a return-to-work (simple average of the FY) % for people injured in the workplace or on the roads in New South Wales for 4 weeks (28 days) and 13 weeks (91 days)

ACC's spend per claim exceeded CPI by 100% and the count of compensation claims grew 50% faster than the rate of employment

ACC average spend per claim – **New Zealand's CPI**

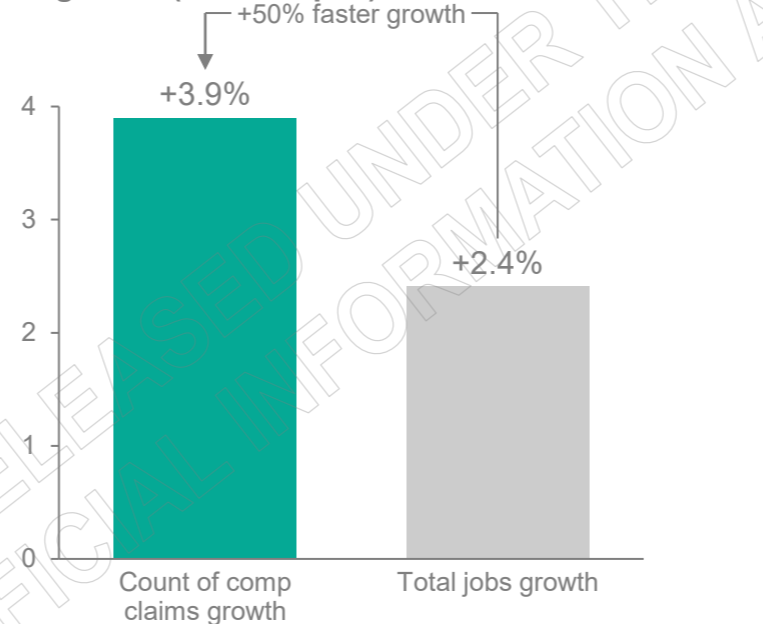
% growth (FY19-23 p.a.)



- **ACC's average spend per claim grew twice New Zealand's CPI index** between FY19-23 (+8.7% vs. +4.5% p.a.)
- Increase also due to factors including health inflation, increasing complexity of care and expanded cover (e.g., for sensitive claims)

ACC Compensation count of claims growth – **New Zealand's jobs growth**

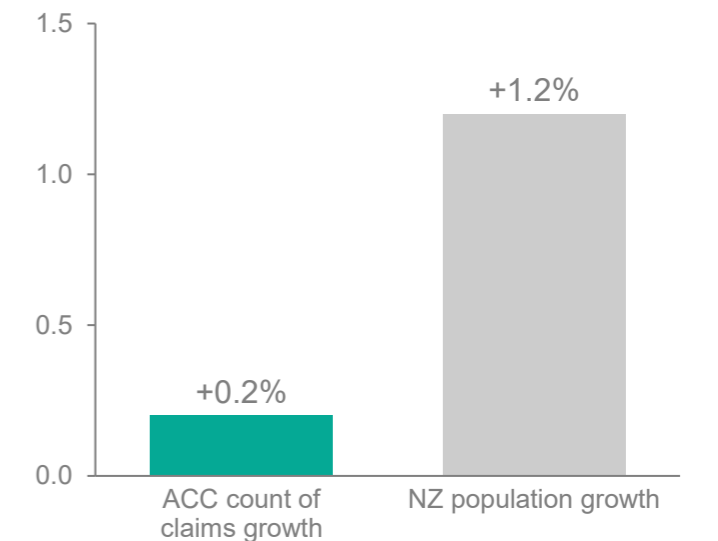
% growth (FY19-23 p.a.)



- **ACC's number of compensation claims grew more than total filled jobs in New Zealand** (+3.9% vs. +2.4% p.a.)

ACC count of claims growth – **New Zealand's population growth**

% growth (FY19-23 p.a.)



- **ACC's count of claims grew less than New Zealand's population** in the same period (+0.2% p.a. vs. +1.2% p.a.)

Source: ACC Finance Data, Reserve Bank of New Zealand, Stats NZ; Note: all economic indicators refer to June of that year; 1. Compound annual growth rate of the Consumer Price Index from June 2019 (1032) to June 2023 (1231)

Total number of claims only increased 0.2% p.a. between FY19-23, with 'new claims' registered in FY23 still lower than pre-Covid levels

Count of paid claims (Mn)



Paid claims have increased at 0.2% p.a. and reached 2.42Mn in FY23, without major increases in the period despite some Covid-related fluctuations

2.00Mn new claims have been registered in FY23, less than the 2.06Mn registered in FY19

Cost increases may also be driven by:

- Increases in minimum wage
- Inclusion of maternal birth injuries
- Pay Equity settlements (e.g., support workers)
- Sick leave and Matariki obligations
- Legislation change for minimum in-between travel comp.
- Changes to regulations incl. COTR

Source: ACC Finance Data; 'New' claims refers to registered claims; 'Closed claims' computed as Count of claims in FY_x - (Count of claims in FY_{x-1} + new claims in FY_x)

Annual claims growth was higher in Compensation (3.9%) and Rehabilitation (1.2%) than in Medical (0.2%)

	FY23 Count of claims	FY23 Avg. spend per Claim	Count of claims p.a.	Avg. spend per claim 4yr p.a.
Medical treatment	2.3Mn	c.\$1,200	0.16%	+7.8%
Rehab	0.19Mn	c.\$7,200	1.19%	+8.5%
Compensation	0.05Mn	c.\$13,500	3.90%	+6.4%
Aggregate	2.42Mn ¹	c.\$2,600	0.2%	+8.7%

High spend categories with higher claims growth¹

Higher aggregate growth in spend per claim

Compensation claims – having the highest average spend per claim (c.\$13,500 in FY23) – **have increased the most (+3.90% p.a.)**

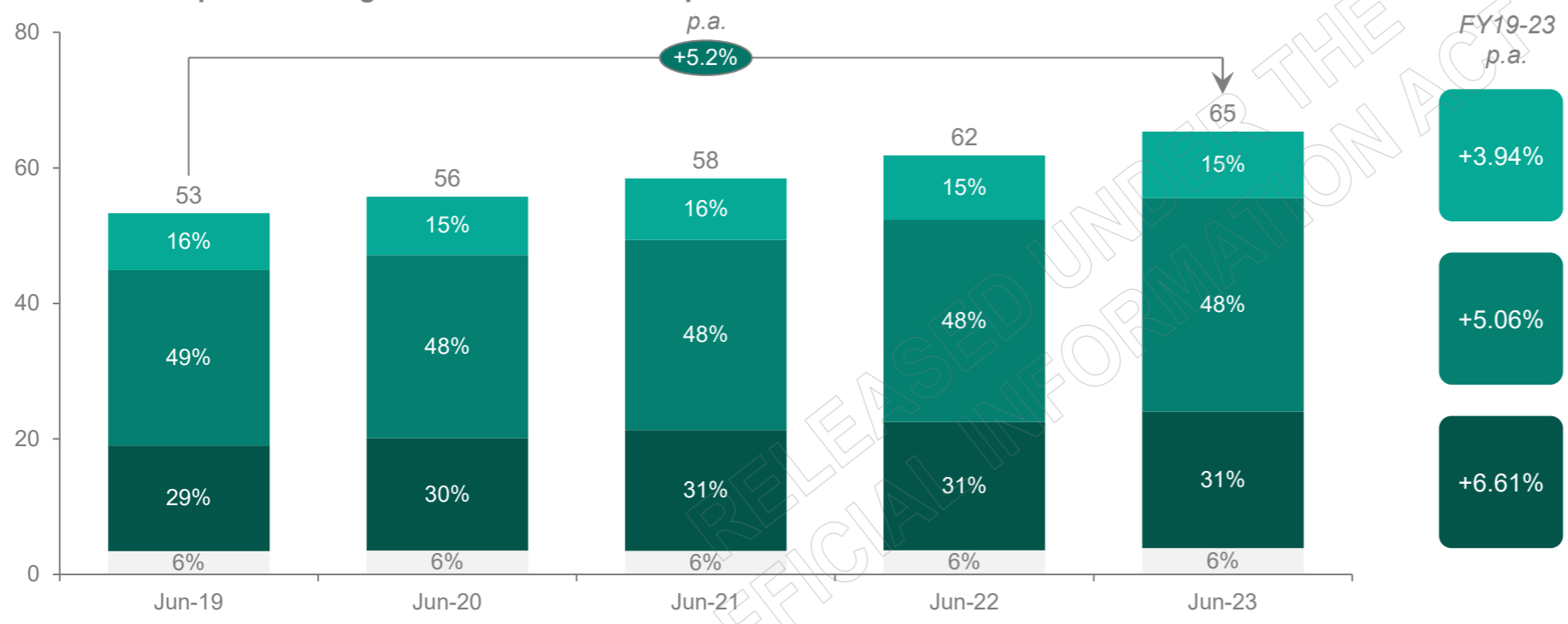
Medical treatment represents the **vast majority of claims (2.3Mn in FY23)** but has the lowest avg. spend per claim (c.\$1,200 in FY23)

With relatively more Compensation and Rehab claims, the **aggregate average spend per claim has increased even more (+8.7% p.a.)**

Source: ACC Finance Data; 1. Claims across multiple categories are counted in each category, Aggregate includes 'other' claims: miscellaneous expenses not linked to any category (e.g., backdated spend, outsourced clinical advice, ...)

Increase of in-year spend has translated to higher Outstanding Claims Liability expectations, which has increased at +5.2% p.a.¹

Expected OCL as on June 30 of each year (\$Bn), without the impact of changes to economics assumptions

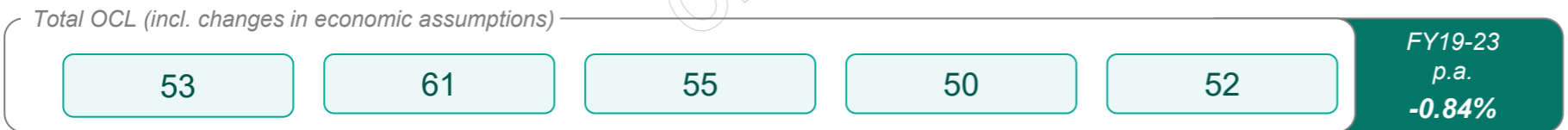


Expected OCL **without the impact of changes in economic assumptions** have increased from \$53Bn in June 2019 to \$65Bn in June 2023 **(+5.2% p.a.)**

In June 2023, Rehab accounted for most OCL (48%), followed by Compensation (31%) and Medical treatment (15%)

Compensation OCL grew the most in the period (+6.61%), followed by Rehab (+5.06%) and Medical treatment (+3.94%)

Total OCL (including the impact of changes in economic assumptions) show a decrease of **-0.84% p.a.** in the period



Key Medical Treatment Rehab Compensation Others

Source: ACC Actuarial data. June 2019 OCL include the impact of economic assumptions until that point in time; Note: Sensitive Claims Payment group allocated to Medical Treatment/Compensation/Rehab as per the FY23 payment split. 'Others' includes: Hearing Loss, Asbestosis, Ambulance, Provisions, Claim handling expenses

Despite relatively flat claims growth, ACC's internal claim handling costs have increased by 5% p.a. from FY19



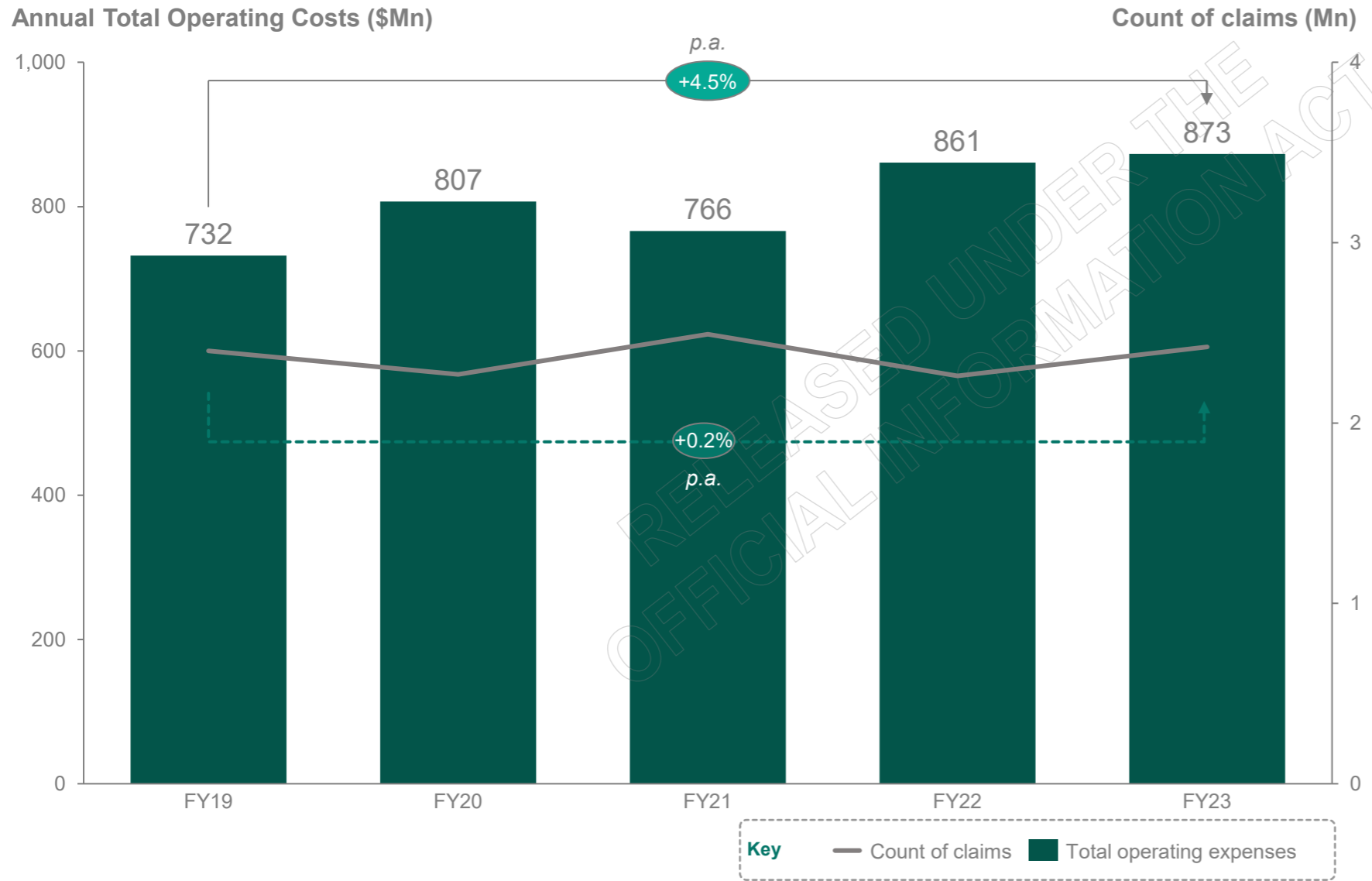
Claims handling costs¹ increased at +5% p.a. from \$480Mn in FY19 to \$579Mn in FY23

The increase in claims handling costs is not explained by an increase in claims paid, as the count of claims paid only grew by 0.2% p.a. from 2.4Mn in FY19 to 2.42Mn in FY23

The increase in **claims handling costs is still higher than CPI growth**, which has increased 4.5% p.a. since FY19²

Source: ACC Finance data; 1. Claims handling costs encompasses operational costs related to management of claims incl. lodgement costs, service delivery costs, treatment provider management costs and associated overhead costs; 2. Compound annual growth rate of the Consumer Price Index from June 2019 (1032) to June 2023 (1231)

ACC's total operating cost has increased at 4.5% p.a. from FY19



Total operating costs¹ increased at +4.5% p.a. from \$732Mn in FY19 to \$873Mn in FY23



70% of operating cost growth is due to increasing claim handling costs which is primarily being driven by increases in FTE in Service Delivery

Source: ACC Finance data; 1. Total operating expenses includes claims handling costs, other underwriting costs, investment costs and other costs; Note: Pay freezes in place 2020-22

Health spending in FY19-23 grew across all contract clusters; little growth in primary care

		Group	FY23 spend (\$Mn)	Largest contract classes	FY19-23 p.a. spend growth
Medical	1	Bulk-funded ¹	960	PHAS (750Mn), Road Ambulance (160Mn), ...	+10%
	2	Secondary & Tertiary Services ²	820	Elective Surgery (440Mn), HTI (120Mn), ...	+8%
	3	Allied Health ³	290	Allied Health services (140Mn), Physio (50Mn), ...	+3%
	4	General Practice and Nursing (Primary Care)	250	Urgent care clinics (80Mn), GP (50Mn), ...	+2%
	5	Mental Health Services ⁴	160	ISSC (130Mn), Psychology (14Mn), ..	+17%
Rehab	6	Care Pathways and Commodities Services	740	IHCS (380Mn), Home-based Rehab (130Mn), ...	+32%
	7	Ongoing Rehabilitation ⁵ (Serious injuries)	290	Residential support services (120Mn), Housing modifications (40Mn), ...	+14%
	8	Vocational Rehab (for return to work)	150	Vocational Rehab Services (50Mn), training for independence – Adult other inj. (35Mn), ...	+0%
	9	Concussion	25	Concussion (25Mn)	+18%
	10	Others	180	Non contracted purch. (40Mn), Ancillary Services (35Mn), Allied Health Rehab spend (30Mn), ...	-19%
		TOTAL	c.3,900		+8.2%

Bulk-funded (\$960Mn), Secondary & Tertiary Services (\$820Mn) and Allied Health (\$290Mn) are the largest groups of Medical contract classes

Care Pathways (\$740Mn) and Ongoing Rehabilitation (\$290Mn) are the largest groups of Rehab contract classes

All groups grew during the FY19-23 period, except Vocational Rehab (+ 0%) and 'Others' (-19%)

Care Pathways (+32%), Concussion (+18%) and Mental Health Services (+17%) grew fastest due to contract transitions

Source: ACC Finance data, figures are rounded; 1. 11Mn is Rehab – included in 'Others'; 2. 20Mn is Rehab – included in 'Others'; 3. 30Mn is Rehab – included in 'Others'; 4. 10Mn is Rehab – included in 'Others'; 5. 4Mn is Medical – included in 'Others'

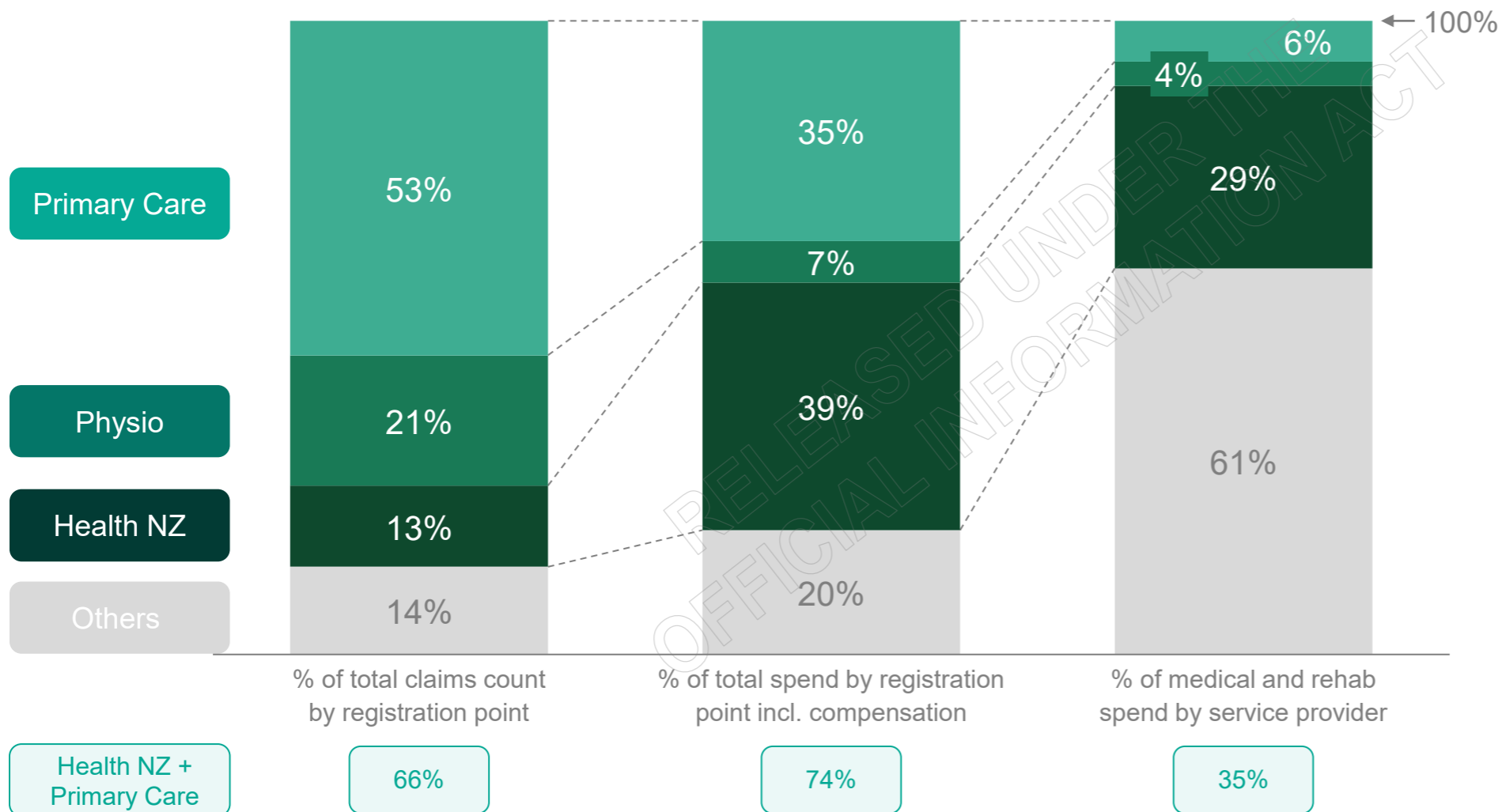
A client journey perspective shows that total spend growth is driven by non-surgical clients, particularly concussion, sensitive claims and non-surgical comp.

Journey	Elective surgery	IHCS + home-based rehab	HTI	Non ac. imp. rehab	RSS	Clinical serv.	Mgmt. of rehab equip.	Weekly Comp	Others	Total (\$Mn)	FY21-23 p.a. spend growth	FY23 spend / claim (\$) ¹	Spend / claim p.a.	OCL mult. ²	
Surgical top spend journeys <i>(33% of surg. journey spend)</i>	Knee arthroscopy	28	0	4	0	0	3	0	41	8	84	-5%	8,500	+11%	5-10
	Shoulder rotator cuff repair	26	1	1	0	0	1	0	41	4	74	-1%	22,000	+14%	5-10
	Lumbar fusion - 1 level	19	1	1	0	0	0	0	28	4	54	+5%	38,000	+14%	5-10
	Shoulder arthroscopy and proceed to Open repair	14	0	1	0	0	1	0	28	3	47	-4%	21,000	+15%	5-10
	ACL Repair	25	0	1	0	0	1	0	16	4	47	-6%	13,000	+12%	5-10
	Lumbar discectomy	8	0	1	0	0	1	0	25	4	40	+1%	19,000	+14%	5-10
	Shoulder Instability repair	19	0	1	0	0	1	0	17	2	39	-4%	18,000	+18%	5-10
	Knee joint replacement	18	1	0	0	0	0	0	12	3	35	+3%	20,000	+10%	5-10
<i>Other surgical (\$Mn)</i>	260	20	10	1	2	15	7	425	110	850	-	-	-	-	
Non-surgical top spend <i>(45% of non-surg. journey spend)</i>	Brain Serious Injury	2	135	0	0	74	0	12	80	130	434	+6%	100,000	+8%	20-25
	Spine Serious Injury	5	176	0	0	11	1	30	42	119	386	+6%	165,000	+7%	20-25
	Concussion	0	4	2	2	1	2	1	164	74	252	+13%	7,000	+8%	5-10
	Sensitive Claims	0	1	0	0	0	0	0	60	190	248	+12%	6,000	+5%	10-15
	Receiving WC (Lower Back/spine)	0	3	5	0	0	3	1	192	26	230	+11%	11,000	+6%	5-10
	Receiving WC (Shoulder)	0	1	3	0	0	2	0	105	13	124	+13%	10,000	+8%	5-10
	Receiving WC (Hand/wrist)	0	1	1	0	0	1	0	69	11	83	+12%	8,000	+9%	5-10
	Receiving WC (Knee)	0	1	2	0	0	1	0	68	9	81	+13%	8,000	+8%	5-10
<i>Other non-surgical (\$Mn)</i>	14	161	91	118	33	61	33	690	930	2,100	-	-	-	-	
TOTAL (\$Mn)	438	506	124	121	121	94	84	2,102	1,483	c.5,200	-	-	-	-	

Key
 - - High spend growth

1. Only includes FY23 spend, will be impacted by client at different journey stages; 2. High level estimation based on FY23 claim payment split by Payment Group, aligned with actuarial team; Note: Excl. bulk-funded spend and ECP. Journeys group all client who received a treatment/trait (e.g., Receiving ACL Repair) at any time and having any spend item in FY23. Internal adjustments can lead to minor differences in data representation 17

Primary Care and Health NZ/Te Whatu Ora register 66% of claims & account for 74% spend by registration point; Primary Care only receive 6% of medical & rehab spend



Primary Care¹ account for the highest % of claims registration (53%), the second highest spend by registration (35%) but **only receive 6% of ACC's medical and rehab spend¹**

Physiotherapists² account for 21% of claims registration, but generally represent injuries with low spend, accounting for 7% of total spend

Health New Zealand/Te Whatu Ora³ accounts for 13% of claims registration but 39% of overall spend due to more serious injuries being covered

Source: ACC Analytics Team, ACC Finance data; 1. 'Primary Care' includes claims originated with GPs and nurses and spend is via Urgent Care Contracts, COTR, Rural GP; 2. Physiotherapists spend identified with the following Service Types: 'Physiotherapy services', 'Physiotherapist'; 3. % of total spend by registration point for Health New Zealand/Te Whatu Ora includes PHAS and \$367Mn paid to former DHBs in FY23 for contracted services that sit outside the PHAS scope; Note: % of spend by service provider excludes compensation spend associated with claims



2 | Benchmarking Health Services Commissioning

Summary | Advancing Huakina Te **Rā using a 'Value Based Health Care' approach can** release several hundred million in savings and accelerate return-to-work by 9-33%

[s 9(2)(j)]

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

Value Based Health Care assesses value by comparing the outcomes that matter to clients/kiritaki to the cost of delivering them

$$\text{VALUE} = \frac{\text{Outcomes that matter to clients/kiritaki}}{\text{Cost of delivering these outcomes}}$$

- **Outcomes are defined by what matter to clients/kiritaki** – this includes clinical outcomes such as reinjury (secondary prevention), readmissions and complication rates – to include client-reported outcomes – such as pain, function, anxiety, side effects and wellbeing, and return-to-work
- **Costs are defined as the total end-to-end costs** of managing the condition, combining the costs of individual process steps and treatments

Summary | Internal Benchmarking highlights the opportunity to bring consistency to client/kiritaki journeys to reduce variation in cost and injury duration, improving return to work timing by 9-33% and saving \$150-750Mn

Analysis of end-to-end client/kiritaki journeys indicates significant potential to improve value by reducing variation

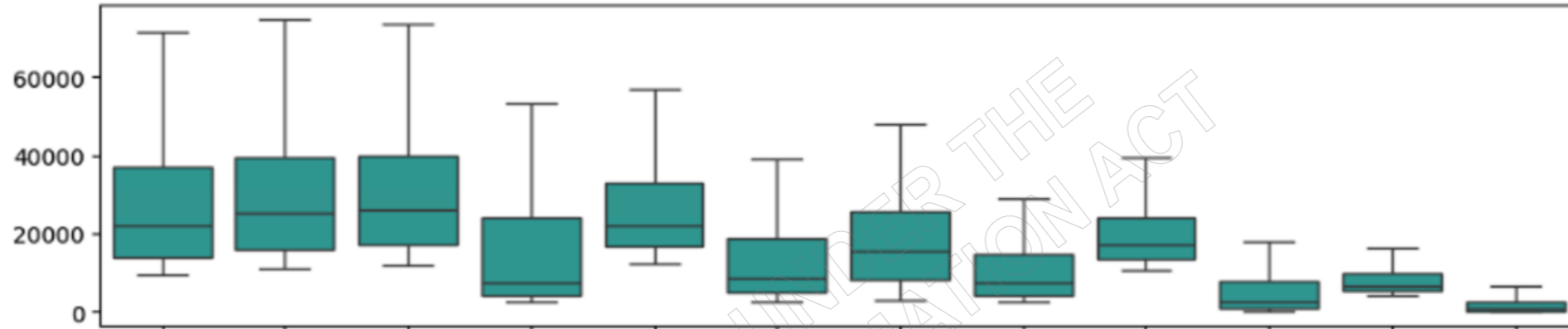
- Significant variation in cost and duration is observable
- Clients/kiritaki with similar injuries currently experience materially different care pathways or patterns of service-use
 - For example, clients recovering from shoulder rotator cuff injuries follow up to 12 different care paths with highly variable service duration and total claims spend
 - Māori and Pasifika clients/kiritaki experience additional variation within these 12 care paths, amplifying the need for additional measures to address equity
- Māori and Pasifika clients/kiritaki face significantly higher variation in their care journeys, facing longer rehabilitation durations and greater costs, as well as higher re-injury rates in many instances
- Reducing this variation would significantly advance Mana Taurite and the objectives of Huakina Te Rā
- Reducing variation would deliver more consistent health outcomes and improved equity
 - Return to work readiness 9-33% sooner and release \$150-750Mn in additional funds to invest in better outcomes
 - ACC data can be used to inform the care paths leading to best outcomes

Integrated planned pathways enabled by navigation support demonstrate the potential benefit of reduced variation

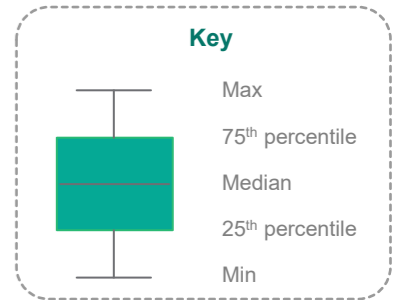
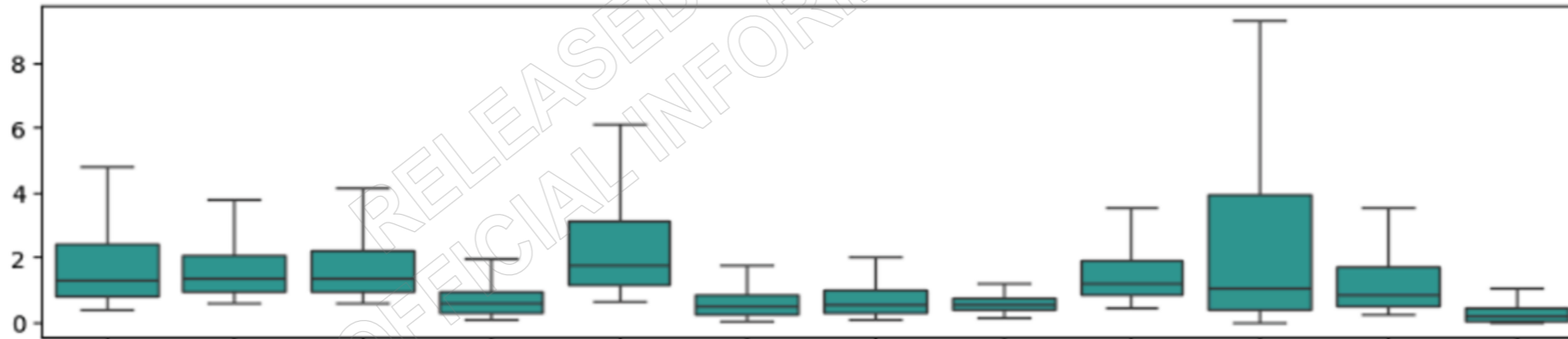
- ICP is demonstrating early positive results reducing median time on weekly compensation from 76 to 70 days, reducing median service duration from 238 to 94 days, and reducing re-injury rates by 8ppt

An end-to-end view of client/kiritaki journeys shows wide variation in duration and spend

Total journey spend (\$)¹



Service duration (years)²

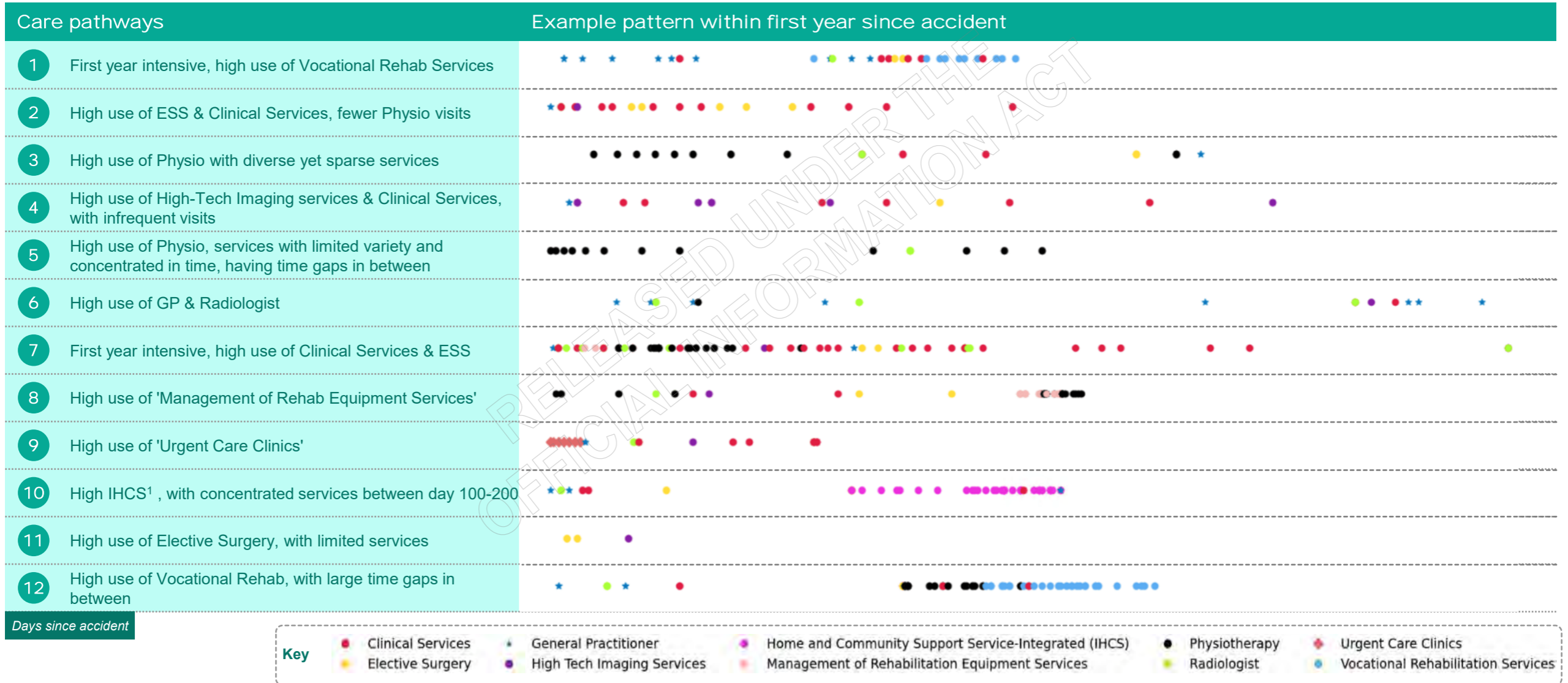


Top spend journeys

1. Total journey spend sums the payments for all services in the journey, excl. GST; 2. Service duration is calculated as the number of years from the lodgement date to the date of the last medical or rehabilitation service; Note: 'Completed' journeys with last medical or rehabilitation service provided between 2011 to 2023. They are considered to be 'completed' as no new services have been provided in the past 3 months before October 2023. Serious injury (spinal), serious injury (brain), lumbar fusion - 1 level, knee joint replacement are excluded from box plots as these journeys often last over 10 years and are unlikely to be fully captured from 2011 to 2023

Existing ACC data shows for the same journey the patterns of services are very inconsistent as to the treatments received and when they are provided

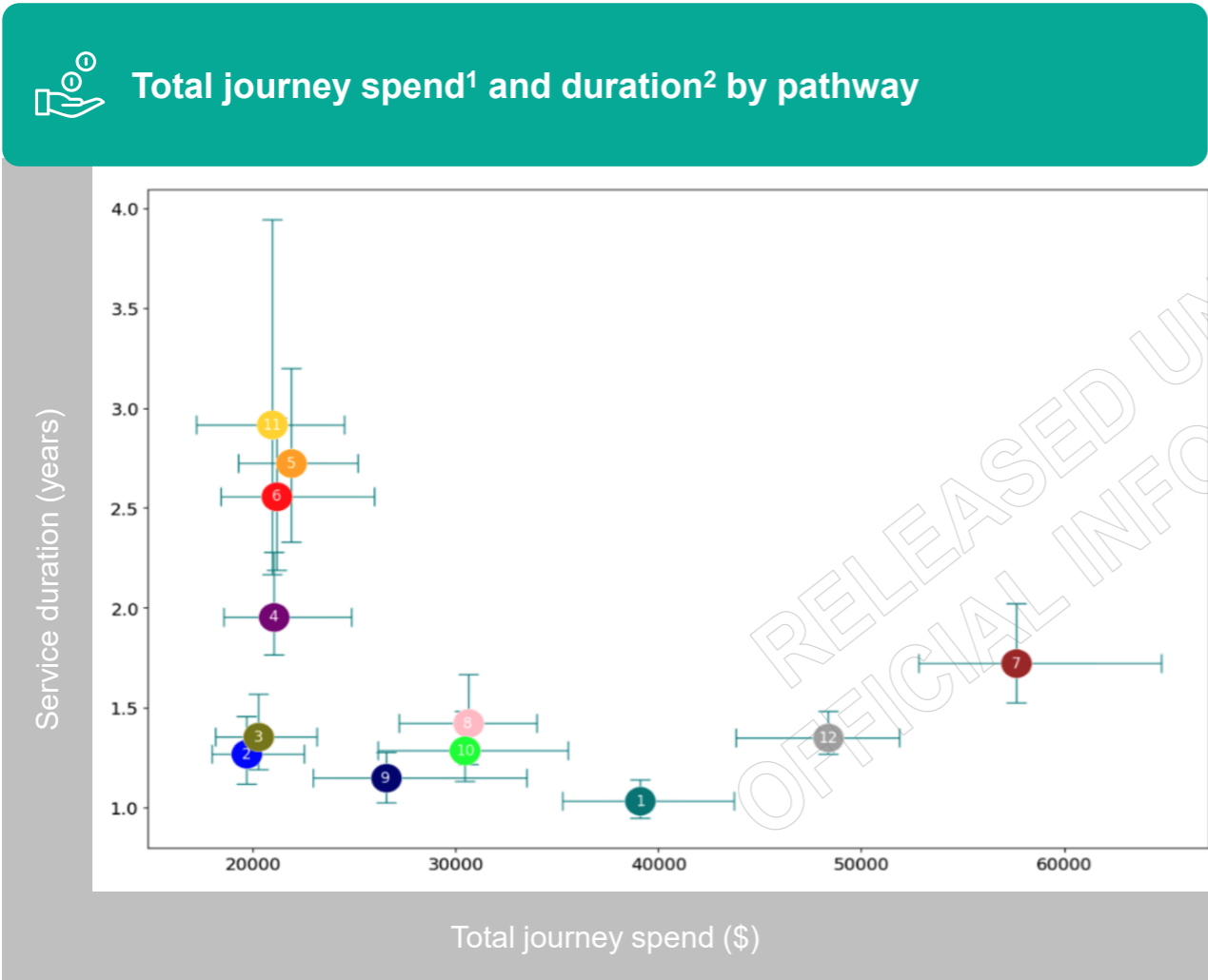
Example: Shoulder rotator cuff repair journeys



Source: 'Completed' journeys identified as 'shoulder rotator cuff repair' with last medical or rehabilitation service provided between 2011 to 2023. They are considered to be 'completed' as no new services have been provided in the past 3 months before October 2023; 1. Home and community support service-integrated

These service patterns lead to wide variation in total claim cost and duration

Example: Shoulder rotator cuff repair journeys



- 1 First year intensive, high use of Vocational Rehab Services
- 2 High use of ESS & Clinical Services, fewer Physio visits
- 3 High use of Physio with diverse yet sparse services
- 4 High use of High-Tech Imaging services & Clinical Services, with infrequent visits
- 5 High use of Physio, services with limited variety and concentrated in time, having time gaps in between
- 6 High use of GP & Radiologist
- 7 First year intensive, high use of Clinical Services & ESS
- 8 High use of 'Management of Rehab Equipment Services'
- 9 High use of 'Urgent Care Clinics'
- 10 High IHCS, with concentrated services between day 100-200
- 11 High use of Elective Surgery, with limited services
- 12 High use of Vocational Rehab, with large time gaps in between

Key

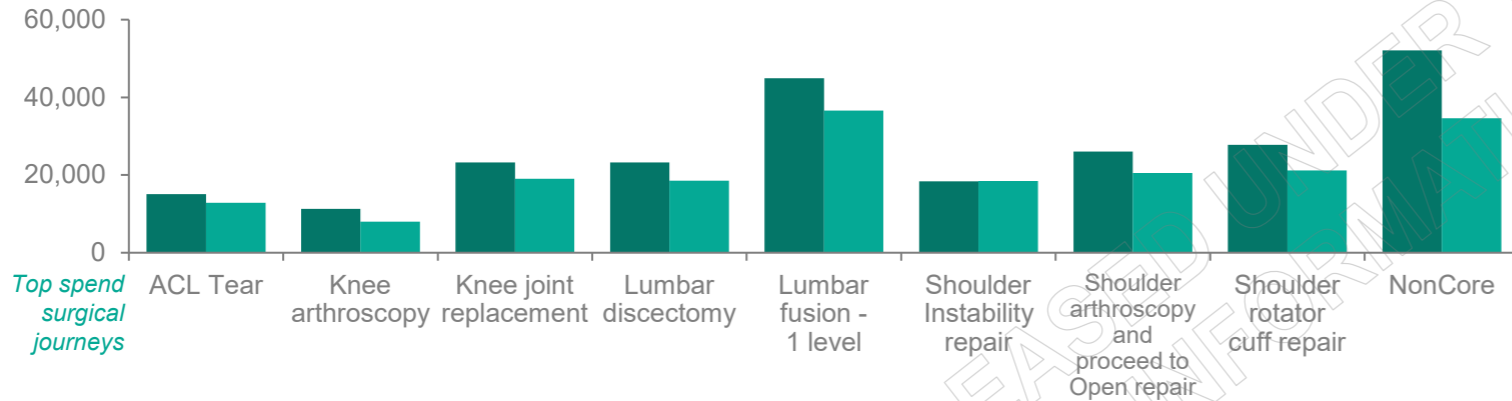
- Spread of total journey spend 40th to 60th percentile
- Spread of service duration 40th to 60th percentile

Source: 'Completed' journeys with last medical or rehabilitation service provided between 2011 to 2023. They are considered to be 'completed' as no new services have been provided in the past 3 months before October 2023; 1, Total journey spend includes services and compensation in the journey, excluding GST; 2. Service duration is calculated as the number of years from the lodgement date to the date of the last medical or rehabilitation service. Duration does not include time on weekly compensation after 3 months post-service provision

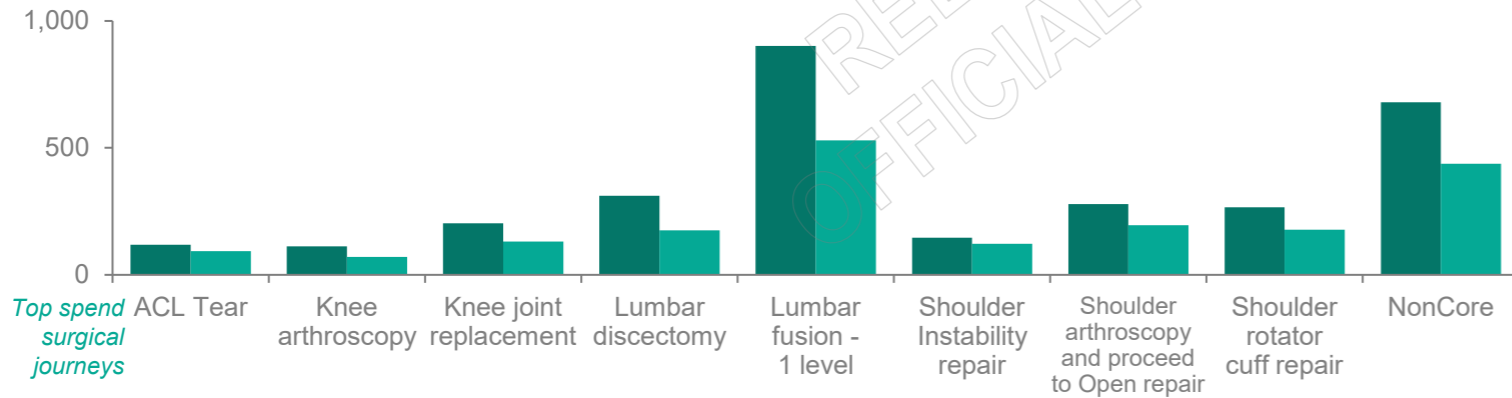
We observe significantly higher duration and spend outcomes for Māori and Pasifika across surgical journeys, requiring additional effort to address this need

Spend and outcome variability by all top spend surgical journeys

Avg. journey spend per claim (\$)



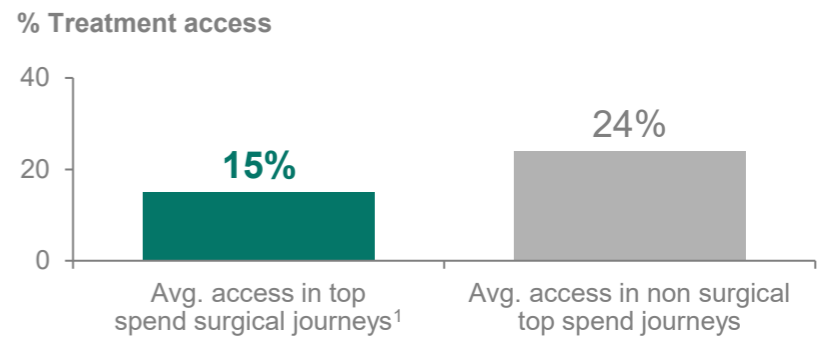
Median time on Weekly Comp (Days)



Key ■ Māori and Pasifika ■ Others

Māori and Pasifika treatment access

Min: Lumbar fusion (12%)
Max: Shoulder instability repair (22%)



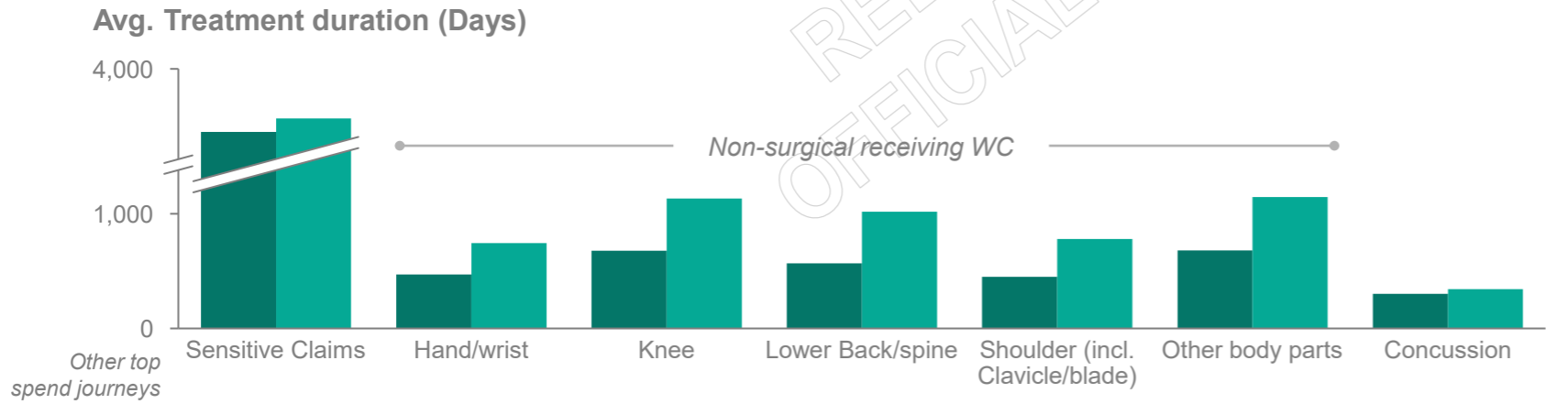
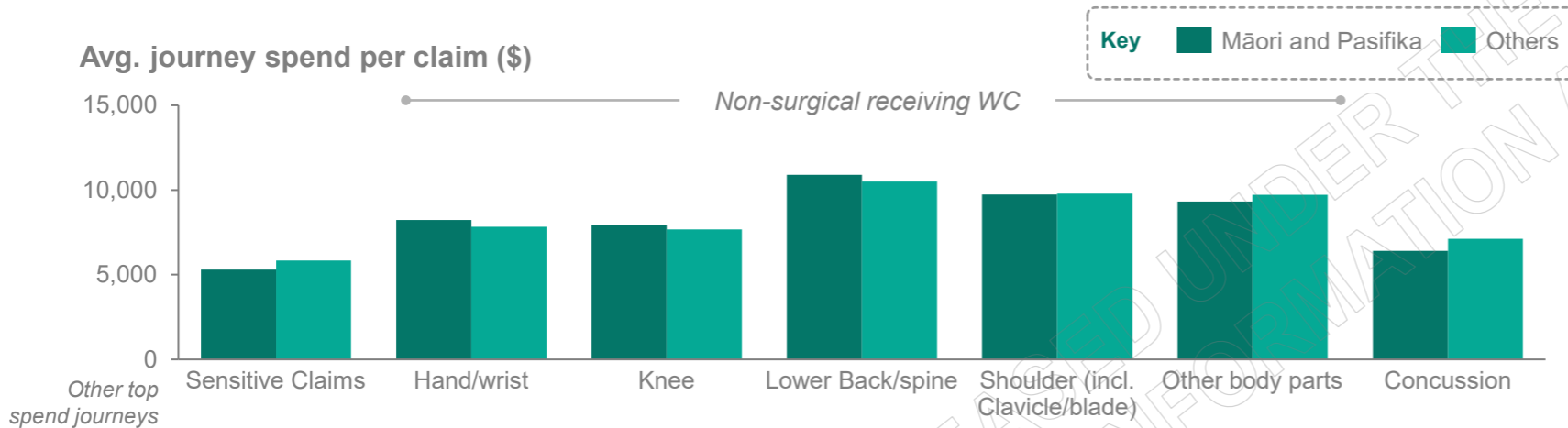
- Māori and Pasifika show **higher average spend** in all surgical journeys except Shoulder instability repair
- Māori and Pasifika show **longer time on WC in all surgical journeys**, which can signal worse outcomes from treatment or a harder return to work
- Māori and Pasifika have **lower access to top spend surgical journeys** – representing only 15% of claims, while c.25% in non-surgical journeys

Source: ACC data. Client cohorts are defined as all clients on a journey e.g., 'having Knee arthroscopy surgery' and having any spend item on that claim in FY23. Bulk-funded spend is not included; 1. Excl. ACL Repair claims as ACL treatments are being integrated in ECP

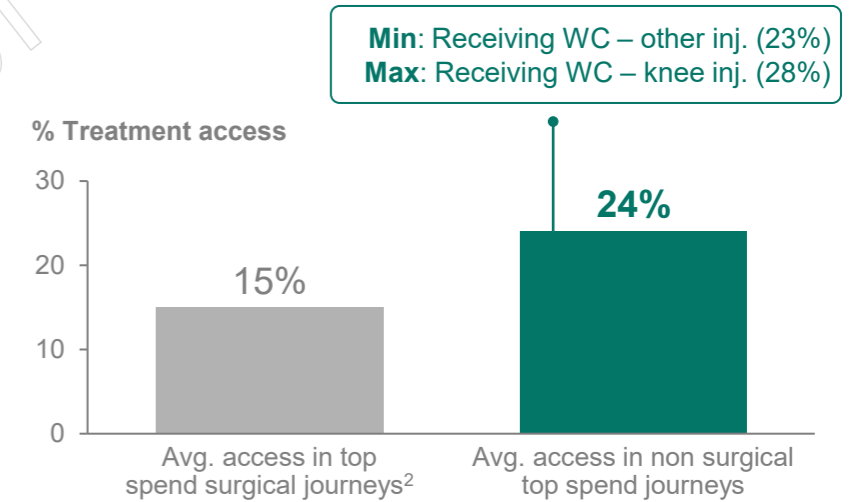
Non-surgical journeys also show higher spend outcomes for Māori and Pasifika in hand, knees and lower back journeys

Similar spend levels to the rest of the population, but lower treatment duration, in non-surgical journeys

Spend and outcome variability by non-surgical top spend journeys¹



Māori and Pasifika treatment access

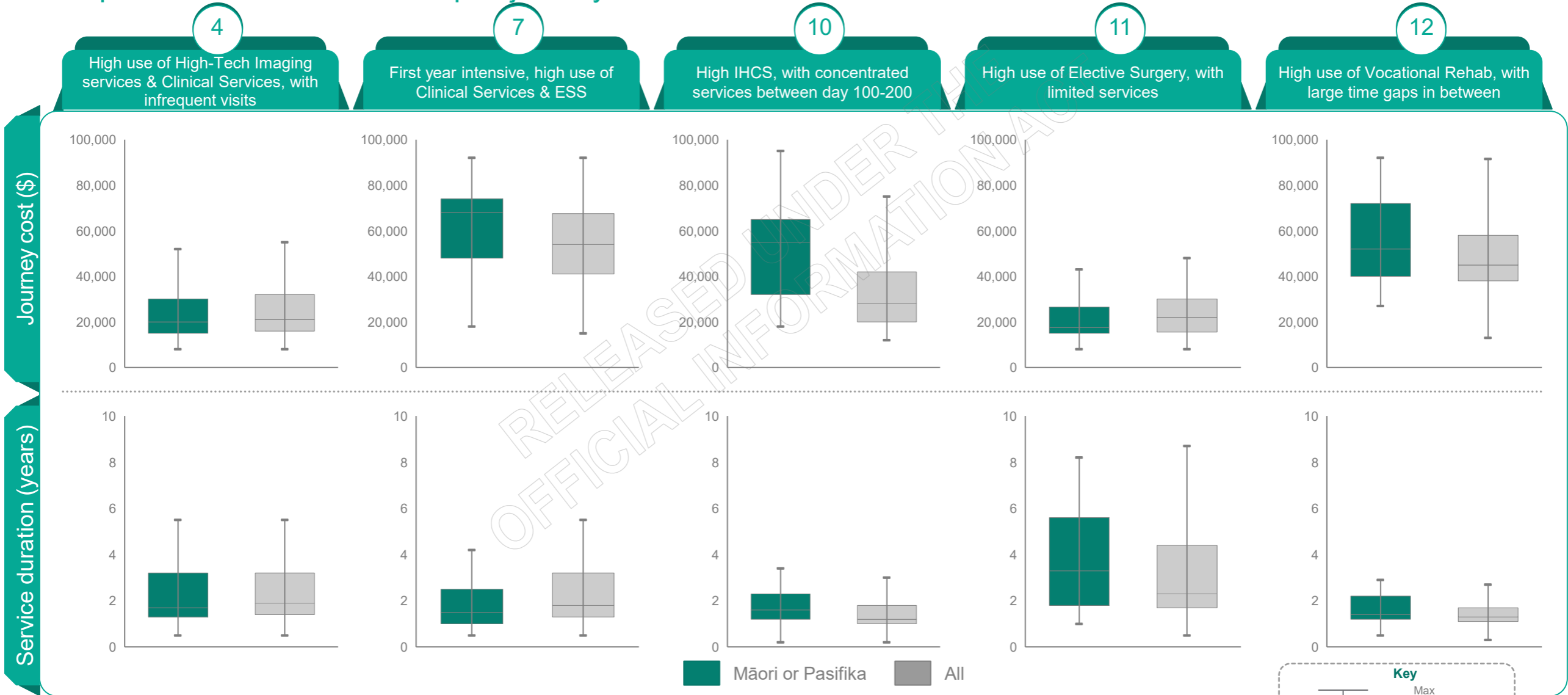


- Māori and Pasifika show **similar average spend** in all non-surgical top spend journeys
- Māori and Pasifika show **shorter treatment duration**, which can signal clients/kiritaki not completing treatment
- Māori and Pasifika have **higher access to non-surgical top spend journeys** – up to 28% for non-surgical knee injuries receiving WC

Source: ACC data. Client cohorts are defined as all clients on a journey e.g., 'having Sensitive Claims' and having any spend item on that claim in FY23; 1. Serious injuries (Brain and Spine) are not reported due to the nature of the injury; 2. Not considering ACL Repair claims as ACL treatments are being integrated in ECP, therefore potentially altering the results

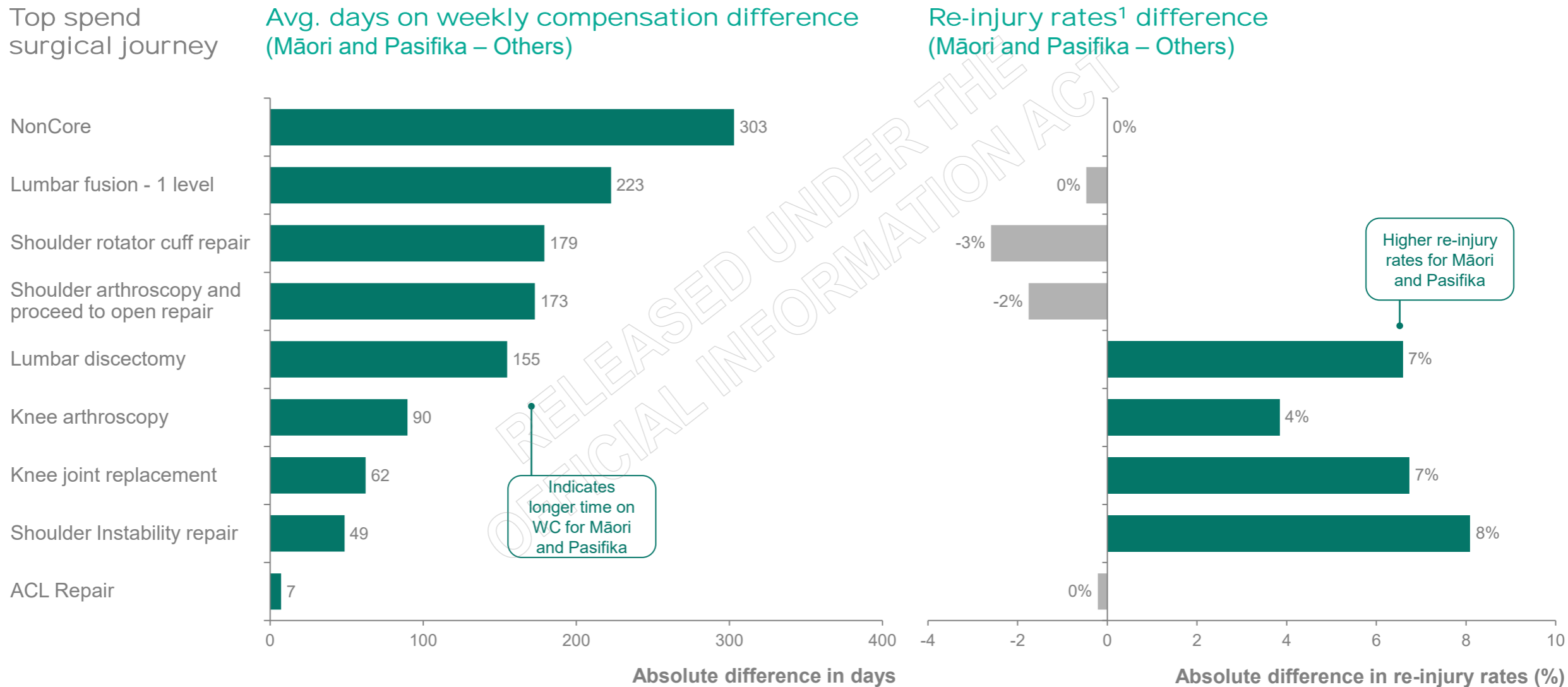
Māori and Pasifika clients/kiritaki in many cases experience greater variation or worse overall outcomes on the same pathways

Example: Shoulder rotator cuff repair journeys



Source: 'Completed' journeys identified as 'shoulder rotator cuff repair' with last medical or rehabilitation service provided between 2011 to 2023. They are considered to be 'completed' as no new services have been provided in the past 3 months before October 2023

In top spend surgical journeys, Māori and Pasifika populations show longer time on weekly compensation and generally higher re-injury rates



Source: ACC data. Client cohorts are defined as all clients on a journey e.g., 'having ACL Tear surgery' and having any spend item on that claim in FY23. Bulk funded spend not included; 1. Re-injury is defined as the no. of claims who at any stage had a subsequent claim on the same body site of the initial injury, divided by the total no. of claims in that journey

Backup | Journey spend and service duration benefit calculation

Cost savings

Potential annual cost savings of c.\$150-750Mn
 (c.7-39% reduction in overall costs) by bringing worst 10-25% cost outliers down to 90th and 75th percentile respectively

Applied to total FY23 journey spend¹ representing c.38% of total FY23 spend excl. PHAS

Potential to save on up to c.70% of total FY23 spend if incl. client-centred pathways and PHAS spend

Method

- % reduction calculated over 2011-2023 'completed' journey¹ spend
- Excl. journeys with cost <5th percentile and >95th percentile within each journey type
- Excl. serious brain and spine injuries², and 'other' non-surgical journeys³

Service duration savings

Potential c.4-14Mn additional weeks of health for journeys active in 2023
 (c.9-33% reduction in overall duration) by bringing worst 10-25% duration outliers down to 90th and 75th percentile respectively

Applied to total duration of all journeys with spend in 2023

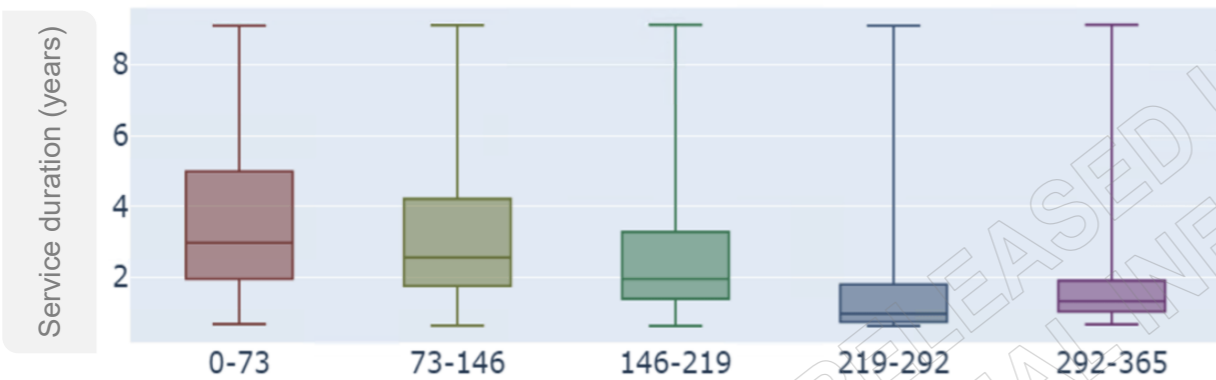
- % reduction calculated over 2011-2023 'completed' journey¹ duration
- Excl. journeys with cost <5th percentile and >95th percentile within each journey type
- Excl. serious brain and spine injuries², and 'other' non-surgical journeys³

1. 2011-2023 'completed' journeys have the last medical or rehabilitation service provided in 2011-2023, and with no new services provided in 3 months prior to October 2023; 2. Excl. serious brain & spine injuries due to risk of longer journeys not being fully captured in data; 3. Excl. 'other' weekly comp journeys (other than hand/wrist, knee, lower back/spine and shoulder) due to high variation in spend and duration

Existing ACC data can be used to identify how consistent journey management could deliver better outcomes

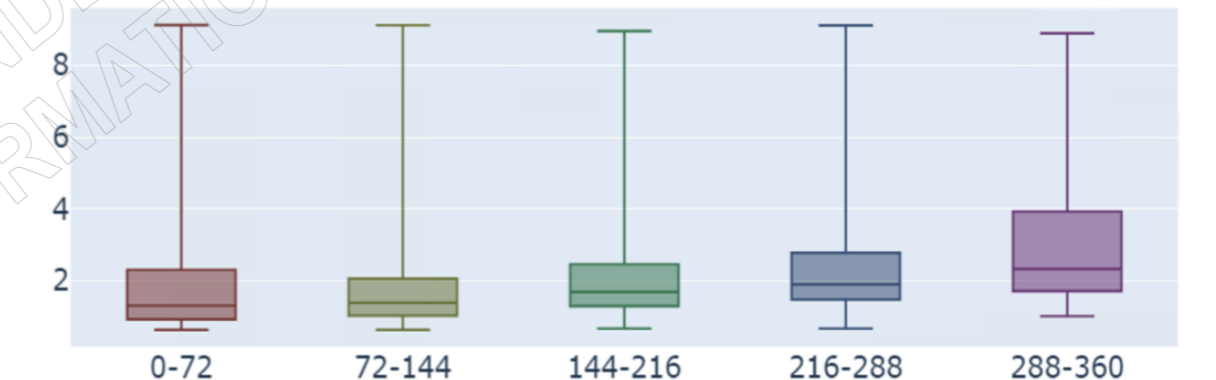
Example: Shoulder rotator cuff repair journeys

Days between first and last service in first year vs. service duration

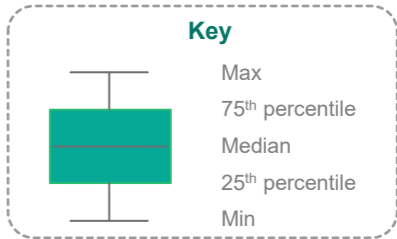


Clients/kiritaki who receive **medical/rehab services for shorter than a period of c.5-7 months** in their first year after an accident are likely to take longer to recover

Longest gap without service (days) vs. service duration



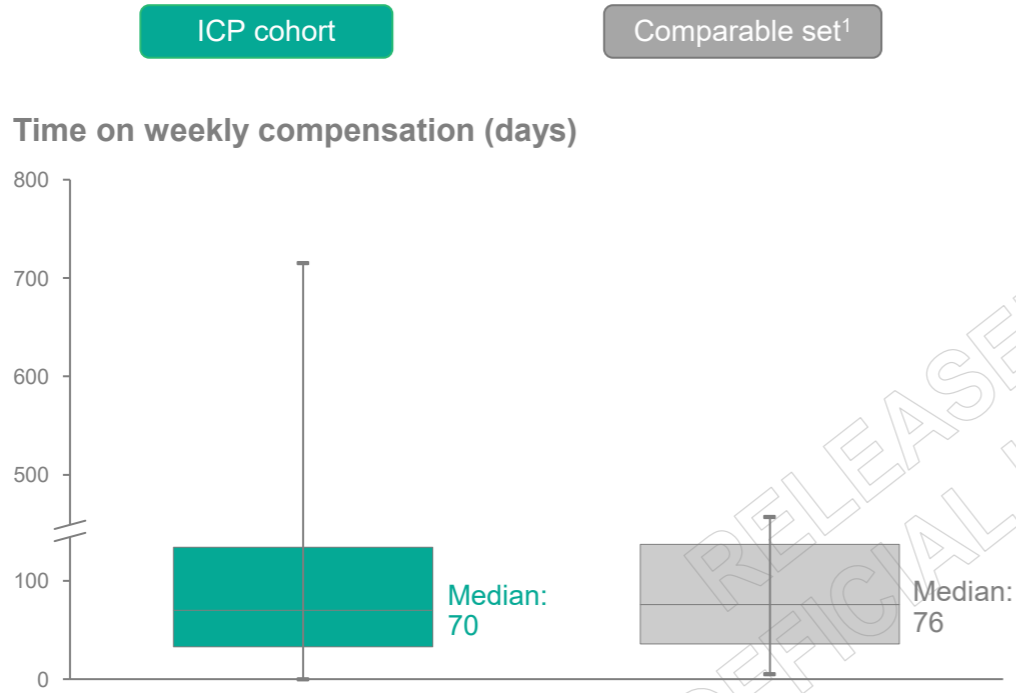
Clients/kiritaki who have **longer gaps without medical/rehab services** in their first year after an accident are more likely to take longer to recover



Source: 'Completed' journeys identified as 'shoulder rotator cuff repair' with last medical or rehabilitation service provided between 2011 to 2023. They are considered to be 'completed' as no new services have been provided in the past 3 months before October 2023

Early ICP results for ACL repair have reduced time on weekly compensation by 6 days and service duration by 144 days

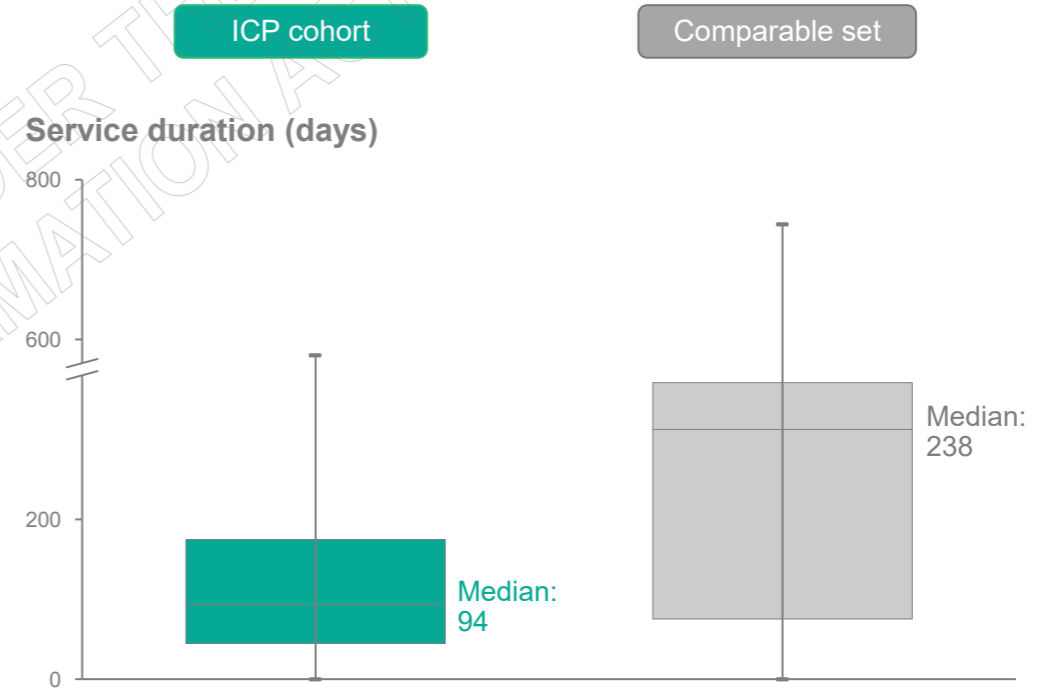
ICP cohort shows lower time on Weekly Compensation



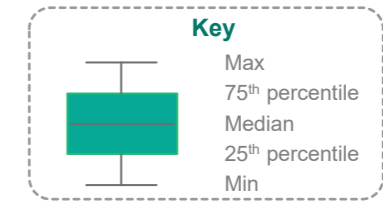
6 days Potential reduction in time on weekly compensation (i.e., difference of medians)

c.\$750 Potential WC savings² per claim

ICP cohort shows lower service duration



144 days Potential reduction in service duration (i.e., difference of medians)

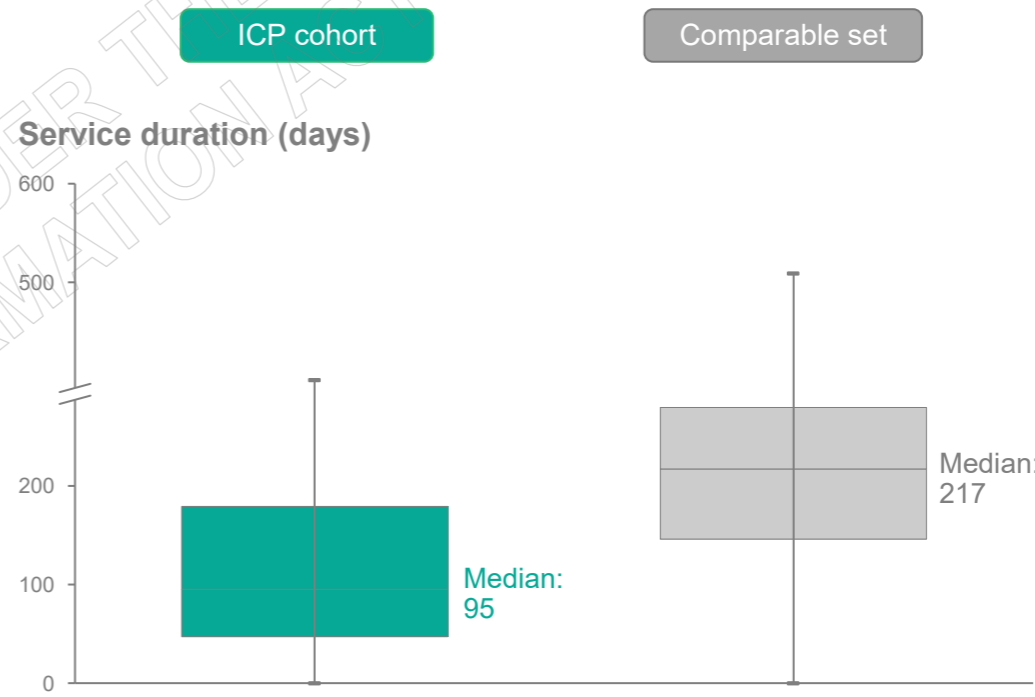
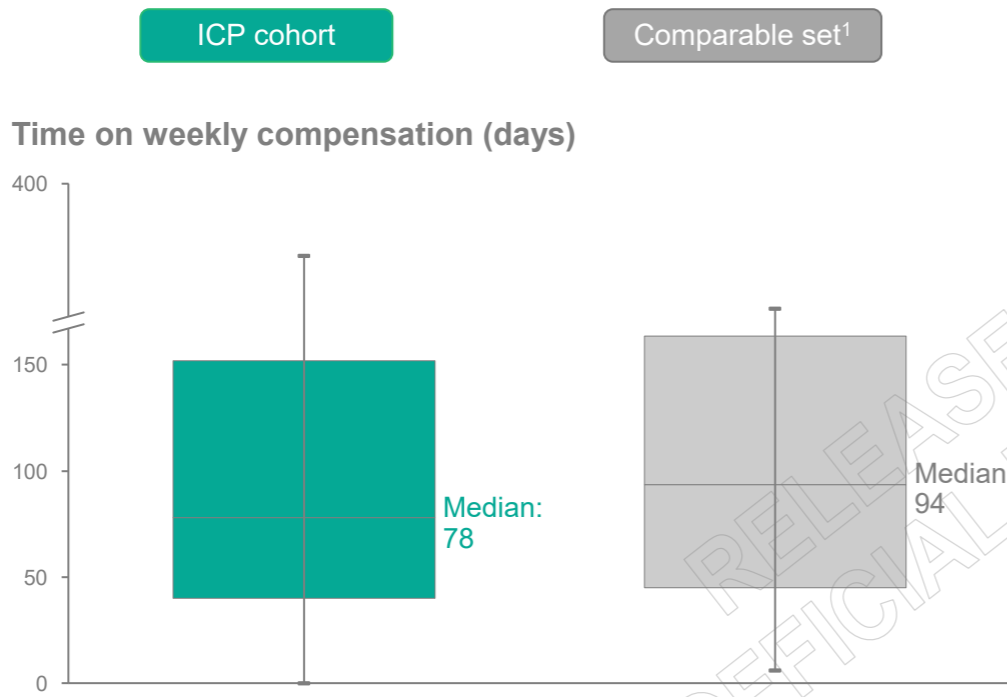


Source: ACC data; 1. Comparable set is comprised of similar ACC patients who undergo ACL repair but are not in the ICP cohort; 2. Computed as Avg. Daily Weekly Compensation spend (\$128) * Reduction in time on Weekly Compensation; 3. Time from the first to the last Medical treatment or Rehab service

Early ICP results for ACL repair have reduced Māori & Pasifika time on weekly compensation by 16 days and service duration by 122 days

ICP cohort shows lower time on Weekly Compensation

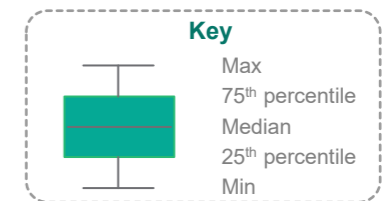
ICP cohort shows lower service duration



16 days Potential reduction in time on weekly compensation (i.e., difference of medians)

c.\$2,050 Potential WC savings² per claim

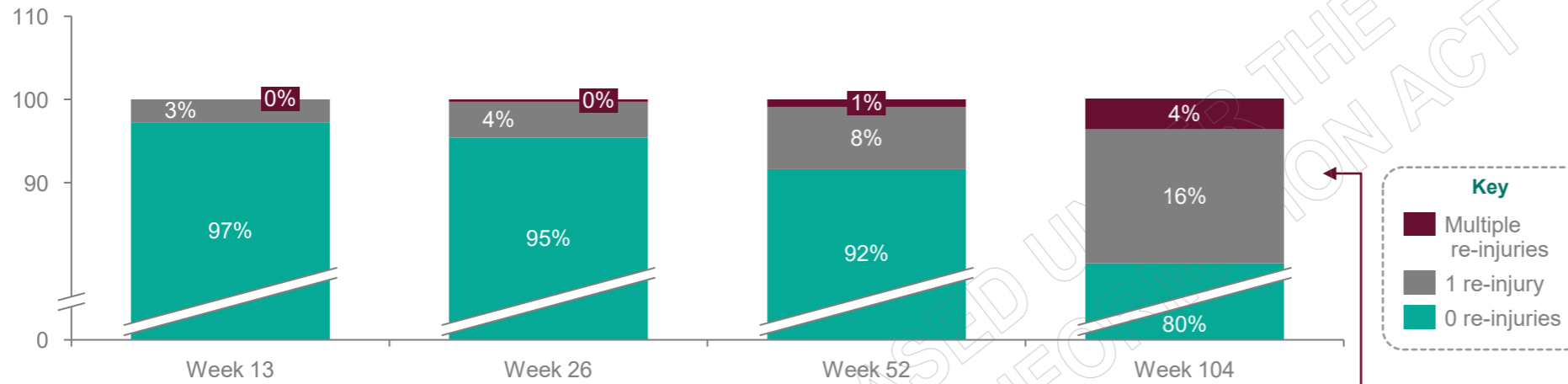
122 days Potential reduction in service duration (i.e., difference of medians)



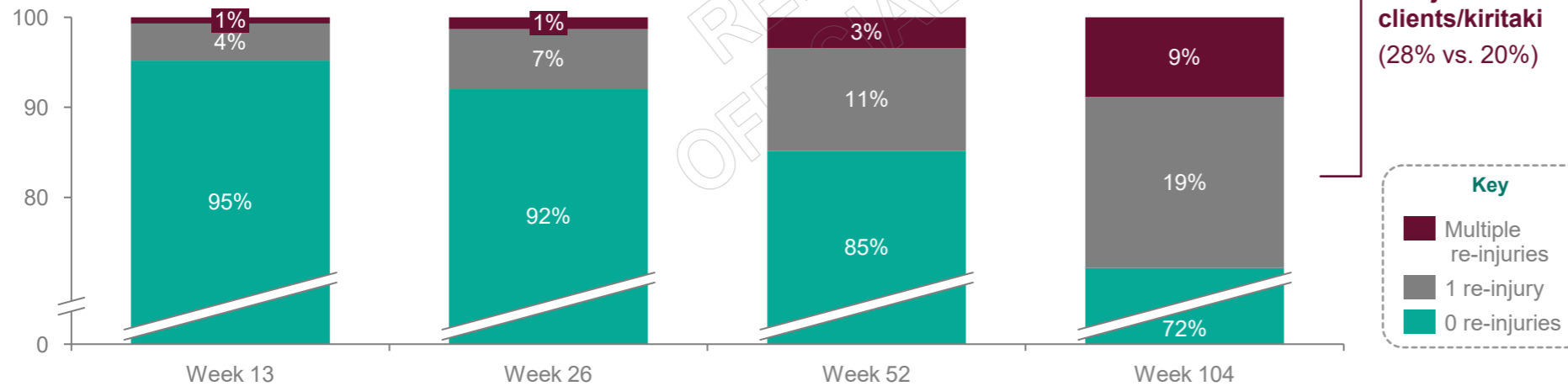
Source: ACC data; 1. Comparable set is comprised of similar ACC patients who undergo ACL repair but are not in the ICP cohort; 2. Computed as Avg. Daily Weekly Compensation spend (\$128) * Reduction in time on Weekly Compensation; Note: ICP cohort size for time on weekly compensation is N=671, with comparable set of N=280; ICP cohort size for service duration is N=1486, with comparable set of N=548

ICP clients/kiritaki are showing ACL re-injury rates 8ppt lower after 2 years

% of clients/kiritaki by number of re-injuries – ICP ACL repairs



% of clients/kiritaki by number of re-injuries – BAU ACL repairs



8ppt¹ fewer re-injured clients/kiritaki (28% vs. 20%)

ICP clients/kiritaki are consistently showing lower re-injury rates after an ACL Repair than the comparable BAU set within ACC

After 104 weeks, ICP clients/kiritaki show 8ppt less re-injured clients/kiritaki than the comparable set

The rate of clients/kiritaki with multiple re-injuries are also lower in ICP: only 4% for ICP vs. 9% for BAU after 104 weeks

Source: ACC analyst data; 1. Percentage points

Summary | Based on international peer benchmarks, there is opportunity to free up c.\$150Mn if ACC could meet benchmark average unit prices for key services

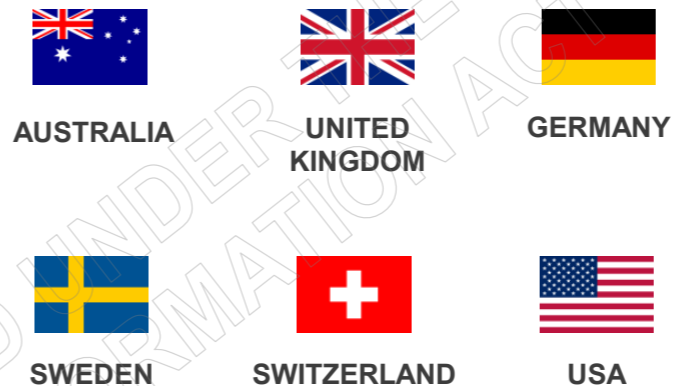
[s 9(2)(j)]

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

Benchmarking focused on top spend services within 7 categories

- 1 Elective surgery
- 2 High-tech imaging
- 3 Non-acute Inpatient Rehabilitation
- 4 Home & Community Support Services
- 5 Allied Health Services
- 6 Integrated Services for Sensitive Claims
- 7 Home-based Rehabilitation

... looking at a selected set of countries



- Comparability of health systems: Public and private, high quality
- Adequate data availability
 - Recency
 - Level of granularity
 - Comprehensiveness

... and deep diving on benchmarking within New Zealand

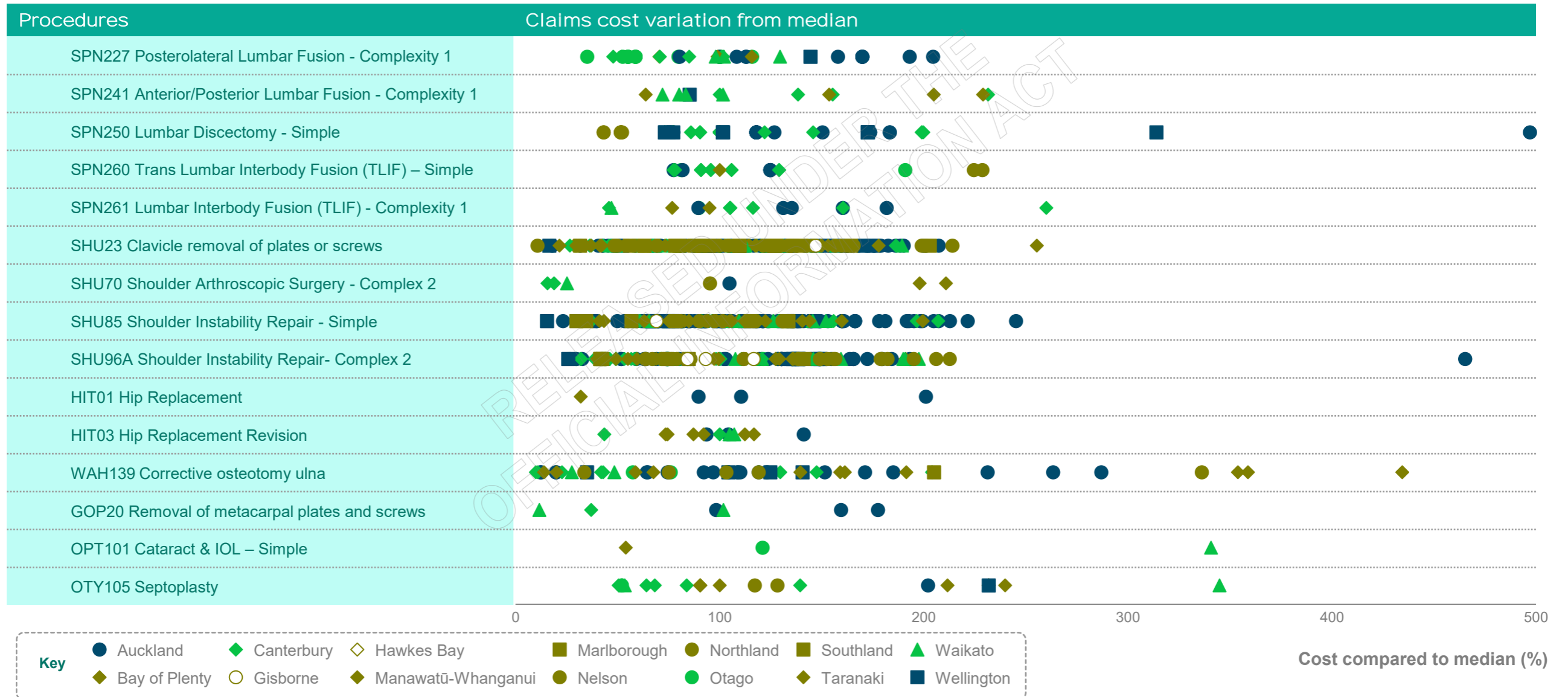
- Across ACC and Public Hospital cost of orthopaedic surgeries
- Within ACC claims pool of implantable costs by region and provider

[s 9(2)(i)]

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

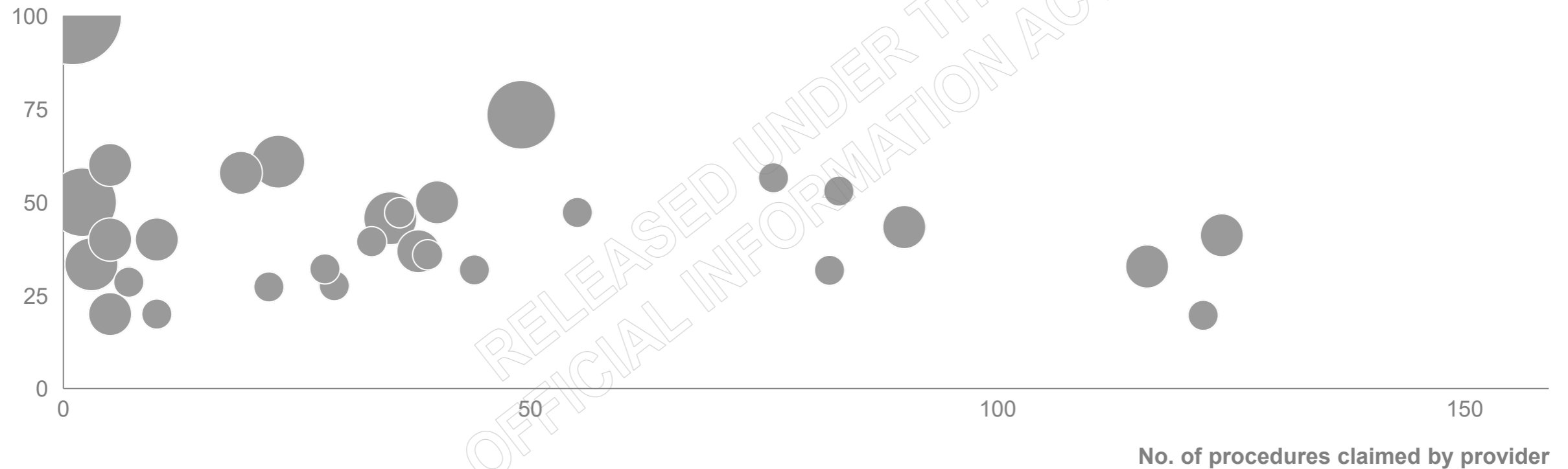
RELEASED UNDER THE
OFFICIAL INFORMATION ACT

ACC claims have a long tail of implantable costs, some x3-5 median for the procedure; urban centres show higher variation than others



Providers with higher claims volumes do not demonstrate lower implantable costs

Proportion of claims by provider that exceed 120% of median for procedure (%)



Key ● Number of claims x200% of median for procedure

[s 9(2)(j)]

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

[s 9(2)(i)]

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

[s 9(2)(j)]

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

[s 9(2)(j)]

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

Summary | Benchmarking **ACC's commissioning** process against global leaders highlights the opportunity to focus on three enabling capabilities: evidence-based pathway development, strategic procurement and the use of data and analytics

Global leaders rely on evidence-based pathway design while devolving streaming decision making to providers in line with pathways

- Orient the organisation towards the client/kiritaki journey rather than provider or services
- Drive end-to-end journey and pathway planning and delivery spanning all providers, with agreement of guardrails on low value services
- Provide evidence-based decision support tools at the point-of-care for consistency in pathways













Global leaders use their procurement function to understand provider markets, shape provider behaviour and better align incentives

- Analysis of the market, provider economics and incentives (e.g., price discovery) is essential to support the identification of strategic procurement opportunities to drive increased competition, shared value or support a diverse, resilient provider marketplace
- Adopt alternatives to fee-for-service payment models that better align provider incentives for value over the long term (e.g., bundles and capitation), and incorporates outcomes into the payment and performance management approach
- The commissioning cycle should be supported with cross-functional expert teams, with role clarity and consistent methodologies for how new services are commissioned

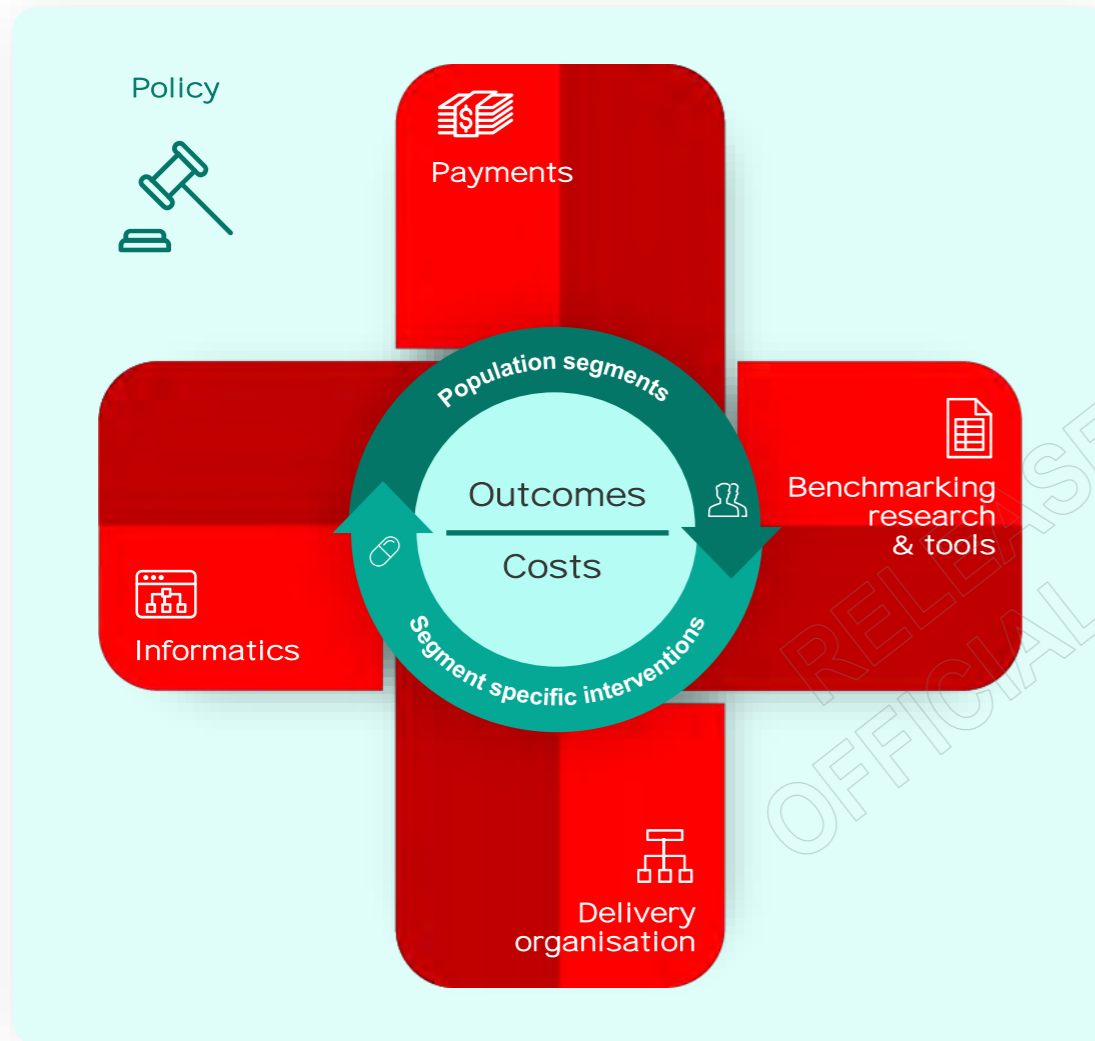
Global leaders routinely use outcomes data to support better clinical decision making with clients and to manage provider improvement and integrity

- Monitoring and managing to value (outcomes and resource use) along a journey will drive collaborative practices and competition on value to accelerate improvement
- Providing data, insights and decision support into the system, particularly at the point-of-care, is key to shaping decisions and delivering improvement
- Concerted effort must be made to improve the visibility and understanding of experience and outcomes for those who face barriers, including currently unmet need, to shape strategic procurement choices

We engaged with twelve global leaders in value-based commissioning to benchmark best practice

Organisation	Description
 KAISER PERMANENTE	<ul style="list-style-type: none"> US value-based integrated health care payer and provider – with a mixed model around provision of services (e.g., contracted services in some locations)
 Helsana	<ul style="list-style-type: none"> Swiss-based payer/insurer with experience in bundled care and payments to providers
 TAC Transport Accident Commission	<ul style="list-style-type: none"> Victorian payer of road traffic accident injury treatment and compensation
 MONASH University	<ul style="list-style-type: none"> Keeper of the Victorian trauma registry, working in conjunction with payers (e.g., TAC) and providers to share key outcome data
 QUT	<ul style="list-style-type: none"> Queensland institution working on development of a number of trauma registries with international collaboration
 NSW GOVERNMENT	<ul style="list-style-type: none"> Purpose built IT platform (HOPE) co-designed with consumers, clinicians and managers across NSW in partnership with the ACI, eHealth NSW and the NSW Ministry of Health
 LUZ SAÚDE	<ul style="list-style-type: none"> Portuguese insurer with a strong value-based focus in commissioning
 Discovery Health	<ul style="list-style-type: none"> South African insurer with mature benchmarking and outcome-based commissioning
 NHS England	<ul style="list-style-type: none"> UK central policy maker with experience commissioning to deliver equitable services across different regional areas
 Cancer Institute NSW	<ul style="list-style-type: none"> NSW organisation ensuring high-quality cancer outcomes across a number of provider types
 santeon	<ul style="list-style-type: none"> Dutch provider group implementing an VBHC approach
 suva	<ul style="list-style-type: none"> Swiss national accident insurance fund taking a VBHC approach

We also leveraged the World Economic Forum framework for a Value Based Health Care to structure our insights



Measure value

Systematically measuring health outcomes that matter to clients, and the costs to deliver outcomes across the full client journey

Clearly defining client segments, including specific outcomes and costs associated with each segment that address need

Developing customised interventions for each client segment to improve value based on their specific risks, needs and priorities

Informatics

Sharing standards and enhanced capabilities which enable the collection, sharing and analysis of outcomes data

Benchmark, research & tools

Benchmarking to identify variation and emerging best practices, direct continuous improvement and develop decision support tools

Payments

Introducing new forms of compensation and reimbursement that help to improve value and cooperation between providers along care pathways

Delivery organisation

Driving integrated care pathways and models of care
Promoting innovation by allowing providers/suppliers to engage in the development of new care offerings for clients

Global leaders focus on three key enabling capabilities

1 Evidence based pathways

Use pathways for all injuries and conditions; devolve decision making to those closest to clients

Define pathways to include only high-value treatments; provide clear guardrails on best value practices

Specify critical review and escalation points

Define streaming and stratification protocols to tailor pathways and treatments to specific risks and preferences at the individual client level, devolving more decisions to the care team

Support care teams to manage pathways with tools and software that support decision making and align with workflows

Plan and design from an end-to-end perspective, rather than optimising by individual provider

Develop pathways with clients and representatives of the care team (e.g., medical, nursing and allied health)

2 Strategic Procurement

Understand and consider features of the market including economics of providers, competitive forces and sources of advantage

Adopt alternatives to fee-for-service payment models that better align provider incentives for value over the long term (e.g., bundles and capitation), including investing in multi-year contracts to build trust and certainty

Incorporate outcomes into the payment and performance management approach, building buy-in for collection and improvement

Leverage scale and relative buying power to shape the market and achieve favourable commercial terms; use price discovery to ensure good value

Monitor equitable outcomes, tailoring incentives to address key gaps (e.g., supplemental payments, favourable payment terms)

3 Data and analytics

Monitor cost of service variation by providers, including their down-stream costs (e.g., referral rates that result in surgery)

Work closely with trauma registries and clinically-led data collection to collect and track outcomes data within existing workflows

Use analytics and machine learning to enhance predictive power identifying those at risk of poorer outcomes

Make insights available at the point of care decision making through support tools, next-best-action recommendations and population health risk analytics

Provide independent insights of outcome and practice variation into the system to drive continuous improvement

Use international tools and standards to measure PRMs including outcome metrics and collection mechanisms

Assessing ACC to global leading practices shows overarching opportunities throughout the commissioning cycle

1 Evidence based pathways

Currently siloed approach uses service/provider type lens without coordinating service types across a client/kiritaki journey, or making long term cost-benefit choices

Sometimes unclear what outcomes are sought by services making evaluation of tenderers challenging e.g., improving return-to-work outcomes; removing variance; understanding client/kiritaki cohort; prevention and education

Initial experimentation (e.g., ICP, ISSC, Kaupapa design) and some practice guidelines in place, though not at-scale or supported by systematic ACC-wide operations

Insight regarding client co-morbidities and risk factors is held by providers, but not well integrated into formal decision support tools for consistency in case or journey management

Difficulty understanding whether OCL/related benefits are being realised, and long-lead time to informing changes or improvements

2 Strategic Procurement

Limited analysis of market structures, provider economics and incentives, constrains opportunities to drive increased competition, shared value or support a diverse resilient provider marketplace

Lack of strategic prioritisation and frequent renewals focus bandwidth on procurement process rather than value potential or long-range market shaping

Predominantly fee-for-service based payments, potentially driving over-servicing and worsen access

Limited flexibility in contracting with high levels of prescription to achieve control and cost-containment within contract rather than across ACC

No consistent methodology or standard for how new services are commissioned (e.g., design approach, timelines, business case requirement)

Steps of commissioning lifecycle are fragmented and duplicated across the organisation (e.g., service design by portfolio managers and HART team)

3 Data and analytics

Currently not measuring outcomes extensively, limited to time on compensation; requires outcome framework and standards, including Māori dimensions of wellbeing

Initial use of PRMs collection (Heartbeat project), though not fully integrated into performance management and market shaping

Currently limited visibility of areas/priority populations experiencing unmet need due to accessibility, quality disparities or legacy of poor experiences

Limited real-time reporting on key process measures (e.g., referral rates); limited ability to performance manage including monitoring compliance to guidelines, access equity

Key cost-benefit and related risks not well integrated into other parts of the commissioning cycle, particularly inclusion of cultural capability and experience risks

Need for Te Tiriti KPIs; need to consider whānau first approach for some Māori (vs. Iwi-level data collection)

ACC currently has limited data insights on outcomes that matter to clients/kiritaki, and whether they are achieved

Current outcomes data insights are limited

ACC and the wider health system has limited data insights on outcomes that matter to clients/kiritaki

- Currently, only data on treatment duration and weekly compensation are available to inform assessments of variation in outcomes
- This provides only a limited perspective, with neither clinical nor client/kiritaki reported outcomes available to help judge the effectiveness of treatment

Current data is rarely looked at from an end-to-end perspective

- Reconstructing the end-to-end client/kiritaki journey is possible from current data sets, providing insights on variability in journeys for clients/kiritaki
- Current set-up means this view is rarely taken

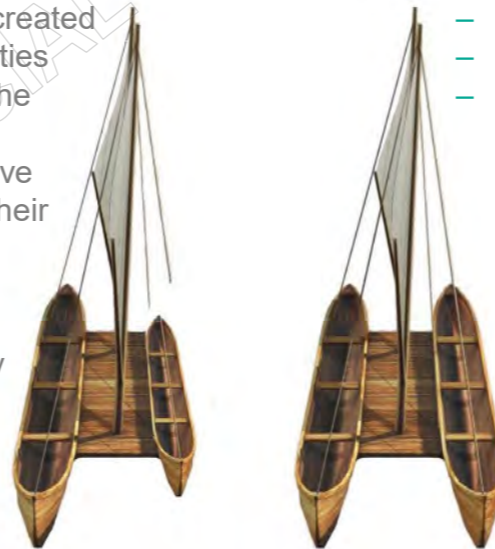
Understanding inequity demands data

Identifying variation and inequity requires robust data on the outcomes, experience and resource use of people who face barriers

With this understanding ACC can approach Mana Taurite:

- Levelling the playing field and addressing the root causes of inequity
- Avoiding systemic and historical factors that have created unequal opportunities and outcomes in the past
- Addressing negative experiences and their impact on help-seeking

Making the waka ready for the journey, fit-for-purpose



Tikoki | Unbalanced Taurite | Balanced

Outcomes monitored must reflect what matters to clients

Patient Reported Measures must be specifically designed to monitor outcomes that matter most to clients/kiritaki

These must include priorities of culture and wellbeing, in addition to health, psychosocial and employment outcomes of rehabilitation e.g.,:

- Purpose
- Identity
- Connection
- Belonging

Māori data and decision making must reflect Te Tiriti | The Treaty

Kiritaki/client outcome and experience data must capture outcomes and experiences that are important to Māori and their whānau

Data captured reflects Māori needs and assists to empower kaupapa-based decision making

Data also needs to be collected on access to services, including access to culturally appropriate and community designed and managed services

This data must be captured to ensure services can be measured and managed to deliver better outcomes for Māori



3 | Recommendations

Summary | An integrated set of pragmatic recommendations has been developed with ACC to capture the identified opportunity

There are six key recommendations that set the aspiration, define capabilities and pou of practical action, engage critical partners and define the operating model impacts:

- 1. Adopt a Target Commissioning Model that is client-centred and outcome focused**, devolving more decisions regarding treatment and rehabilitation to providers
 - Addresses the majority (c.60-75%) of ACC in-year spend through more devolved decision-making
 - Advancing Huakina Te Rā by ensuring more equal outcomes, reducing waste and strengthening provider capacity and competition to meet the needs of people who face barriers
- 2. Implement client-centred care pathways** managed by primary and community care that address variation, integrate rehabilitation teams and provide a consistent set of decision support tools across the country
 - Co-design pathways and related outcome scorecards with multi-disciplinary teams of those closest to the client and whānau, maintaining Te Tiriti priorities through Kaupapa Māori Solutions for decision making; leveraging international best practices rather than starting from scratch
- 3. Build ACC's capability to shape service delivery markets**, using both strategic procurement and data-driven provider management to achieve better pricing, improved access and better outcomes
 - Employ a variety of strategies including bundled pricing, purchasing capacity, investing to create new entrants, vertical integration, using tenders and other price discovery techniques, establishing new marketplaces and supporting continuous improvement by providers
- 4. Develop data, reporting and evaluation tools** to support this new commissioning model
 - Build capacity and capabilities through a prioritised list of data and digital use cases including decision support tools for primary and community care, scaling PRMs collection, alerts for next-best-action for those varying from best-practice pathways or at risk of poorer outcomes
- 5. Work with Health New Zealand/Te Whatu Ora** to advance integrated pathways for the 13% of claims registered in Health NZ/Te Whatu Ora, to buy more effectively from the private sector and to jointly make investments in capacity to increase competition or serve underserved markets
- 6. Focus Operating Model** on managing outcomes and risk through pathway design and provider performance management

Addressing these recommendations will realise the opportunities identified and set ACC up for success to bring value to the sector in a sustainable, value-based approach aligned to Huakina Te Rā. Continued refinement of risks and critical issues is essential throughout detailed design and planning

An integrated set of pragmatic recommendations has been developed with ACC

*Te Whaingā Matua:
Set the aspiration*

1 Define a client-centred, outcome focused target commissioning model that devolves more decisions to providers

Define required capabilities and Pou (Pillars) of practical actions

2 Implement client-centred care pathways managed by primary and community care

3 Build capability to shape service delivery markets

4 Develop data, reporting, analysis and decision support tools to enable better value care

Engage critical partners

5 Work with Health New Zealand/Te Whatu Ora to advance this agenda

Define operating model impact

6 Increase focus on pathway design and provider performance and risk management

Backup | An integrated set of pragmatic recommendations

1 Target commissioning model is client-centred and outcome focused and devolves more decisions to providers

Define a target state commissioning model to support the shift to a client-centred model of rehabilitation delivery, that achieves better outcomes and advances Huakina Te Rā

2 Implement client-centred, primary and community care managed pathways

- A focused multi-disciplinary team should define pathways and related outcome scorecards
 - Optimal pathways could be defined for c.70% of ACC's in-year spend
 - Optimal pathway guidelines are available for many injury types
- Primary and community care should primarily be responsible for managing clients/kiritaki to pathways, funded via new models
- Pathway navigation is supported by decision support tools, and monitored through variation analytics of outcomes and resource use
- The ICP model is consistent with this approach; referral to ICP would be via primary and community care applying a screening tool developed by ACC

3 Build capability to shape service delivery markets

- Market shaping requires both strategic procurement and provider management functions
- Drive value in clinical services using five strategies: (bundled pricing to integrated practice units, purchasing capacity, investing to create new entrants, vertical integration, using tenders and other price discovery techniques)
- Focus on immediate opp. e.g., HTI/ESS, ICP scale
- Drive value in non-clinical services using digital marketplaces
 - License marketplace technology and potentially outsource day to day operations
 - Focus on safeguarding markets, encouraging supply, esp. in thin markets
 - Focus on transport and home mods

4 Develop data, reporting & tools to support better value care

- Focus on implementing a prioritised list of data and digital use cases
 - Implement decision support tools for primary and community care to risk stratify and manage client/kiritaki journeys along defined pathways
 - Enable clients/kiritaki and their clinicians to use PRMs to inform treatment decisions and continuously improvement
 - Create analyses and alerts to identify clients/kiritaki and providers who are varying from best-practice pathways or at risk of poorer outcomes e.g., psychological complications
- Assess implications of TCM for core systems (e.g., Next Gen Case Mgt., Principal Client Record, EOS, MyACC, BusinessPartnersHub)

5 Work with Health New Zealand/Te Whatu Ora to advance this agenda

- Align on shared pathways for shared clients/kiritaki and clients/kiritaki transitioning to ACC;
- Agree on high value opportunities to use data and tools to support better transitions from public hospital system to ACC care
- Agree on opportunities for joint procurement (e.g., prosthetics, assessments); examine opportunities for sourcing services from public system in ways that build public capacity and increase market competition in underserved markets

6 Increase focus on pathway design and provider performance and risk management

Assessment of the operating model implications of the change (Organisation & People, Processes, Technology & Data, Partnerships, Services & Channels, Funding, Governance, Legislation) is required as part of any change process

Plan summary | Target commissioning model is client centred, outcome focused and devolves more decision making to providers

ACC currently predominantly commissions episodic, service-based care that reinforces provider fragmentation and siloed care. Tactical relationships with providers drive a focus on claims, coverage, contracting and COTR compliance. This commissioning approach means ACC has to take an active role in coordinating and case managing rehabilitation journeys, while having limited access to the broader social and health information that would enable effective risk stratification, streaming and needs-based interventions

Experimentation such as ICP, ISSC Evolution and concussion integrated services have sought to commission for more integrated journeys and pathways, though these cut across the dominant commissioning paradigm of the organisation. The Target Commissioning Model supports more decision-making being devolved to those closest to client and whānau, navigating pathways that have been co-designed with the sector. There is significant potential in this model to build long term partnerships with providers to manage outcomes, continuously improve journeys, and advance the sector. To fully develop this model and plan for the transition, more detailed strategic planning is required



1.1 Develop and detail business case

- Develop the change business case with disciplined investment logic
- Detail the investments required within ACC and within the sector to activate the change
- Detail the expected benefits to the system and to ACC including progress toward Huakina Te Rā

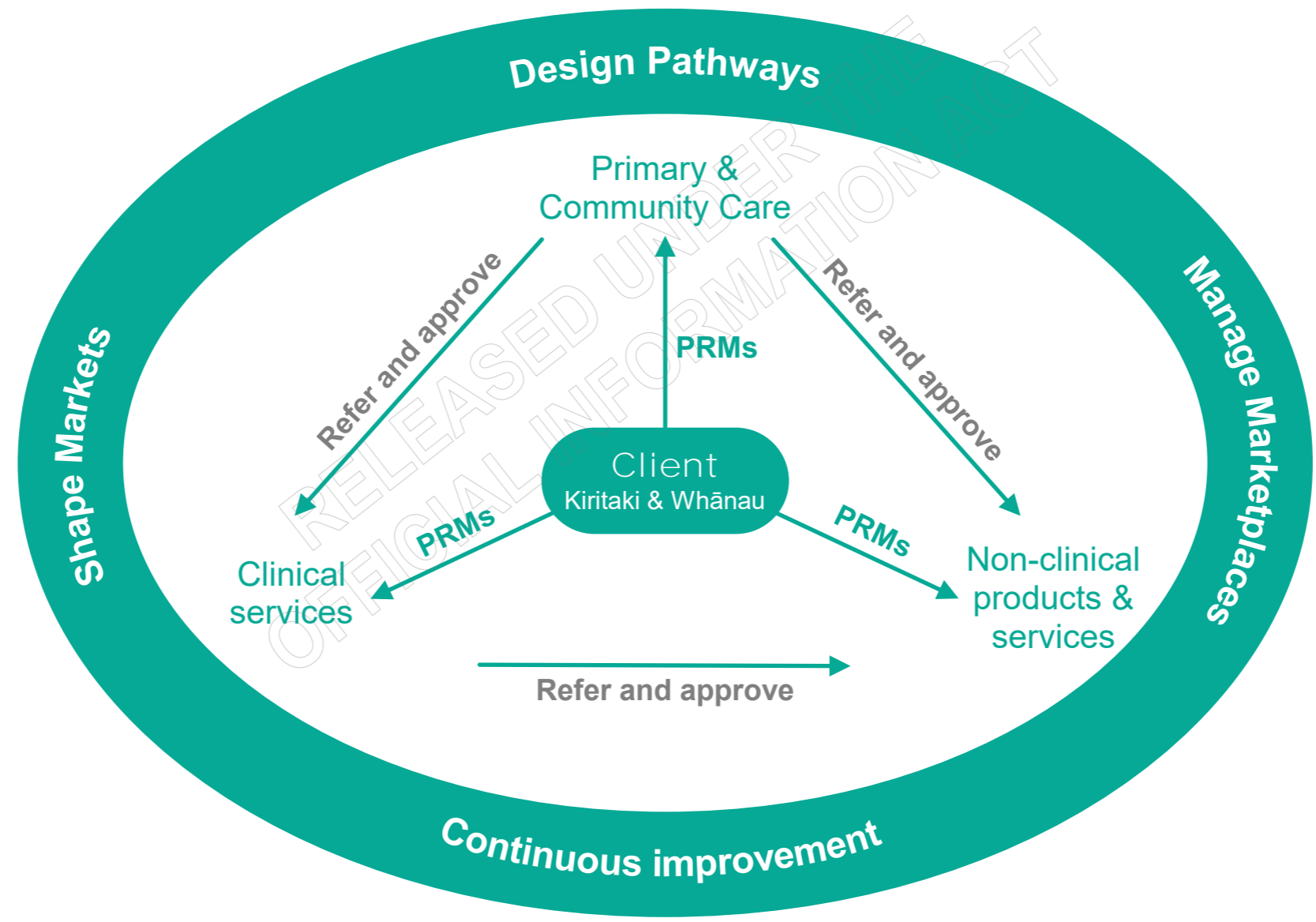
1.2 Develop strategic change narrative and engagement plan

- Develop the strategic change narrative for internal ACC change, building on previous work e.g., ICP, RIG, Māori-led design
- Design the external strategic change narrative for the clinical and non-clinical sector
- Detail the inter-governmental strategic narrative including Health New Zealand/Te Whatu Ora, MSD, MOH
- Activate ACC leaders as visible champions of change

1.3 Detail the implementation delivery plan for change

- Detail the delivery plan including phasing approach
- Establish or align to delivery governance mechanisms and benefits realisation plan
- Establish Program Office and change management capability
- Assess current change portfolio for what to stop/start/continue

Target Commissioning Model | The target is a client-centred, outcome focused commissioning model that devolves more decisions to providers



Backup | Providers will play different roles in the target model, supported by ACC

Primary & Community Care

Clinical Services

Non-clinical products & services

Role in target model

- Understand client/kiritaki priorities, needs and goals
- Use fuller understanding of clients/kiritaki to appropriately risk stratify and refer to appropriate services in line with defined pathways
- Monitor client/kiritaki progress and review/escalate where off track
- Encourage clients/kiritaki to report on outcomes and experiences

- Compete for ACC business on basis of value (outcomes and costs)
- Monitor outcomes and focus on continuous improvement
- Increasingly organise in IPUs, considering commercial risk

- Simple digital platforms enable multiple providers and SMEs to compete to offer
- Many providers competing, creating greater diversity
- Potential for ACC to enable price competition, ACC can accept different rates in different locations
- Clients/kiritaki have increased choice and control, can discipline poor performance by switching

ACC support

- Defines pathways incl. risk stratification
- Provides resourcing and decision tools to P&CC to understand need and manage client/kiritaki journeys
- Establishes and monitors PRMs
- Monitor pathways for equity and variation, across all priority populations, and those with unmet needs

- Shapes the market using strategic procurement mechanisms
- Monitors PRMs and supports ongoing service and system improvement

- Establish and manage digital marketplace
- Quality and safeguarding
- Encourage supply by diverse providers, support thin markets

Providers

- GPs and their teams including NPs, Physiotherapists, Pharmacists
- Kaupapa Māori

- Specialists
- Diagnostic imaging & radiologists
- Allied Health e.g., Physiotherapy, Psychology, OT
- Ambulance and Urgent Care
- Integrated practice units

- Personal care
- Vocational rehabilitation and work readiness services
- Transport
- Home modifications
- Aids and equipment

The Target Commissioning Model could address injuries that drive the majority of ACC in-year costs

Proportion of in-year spend

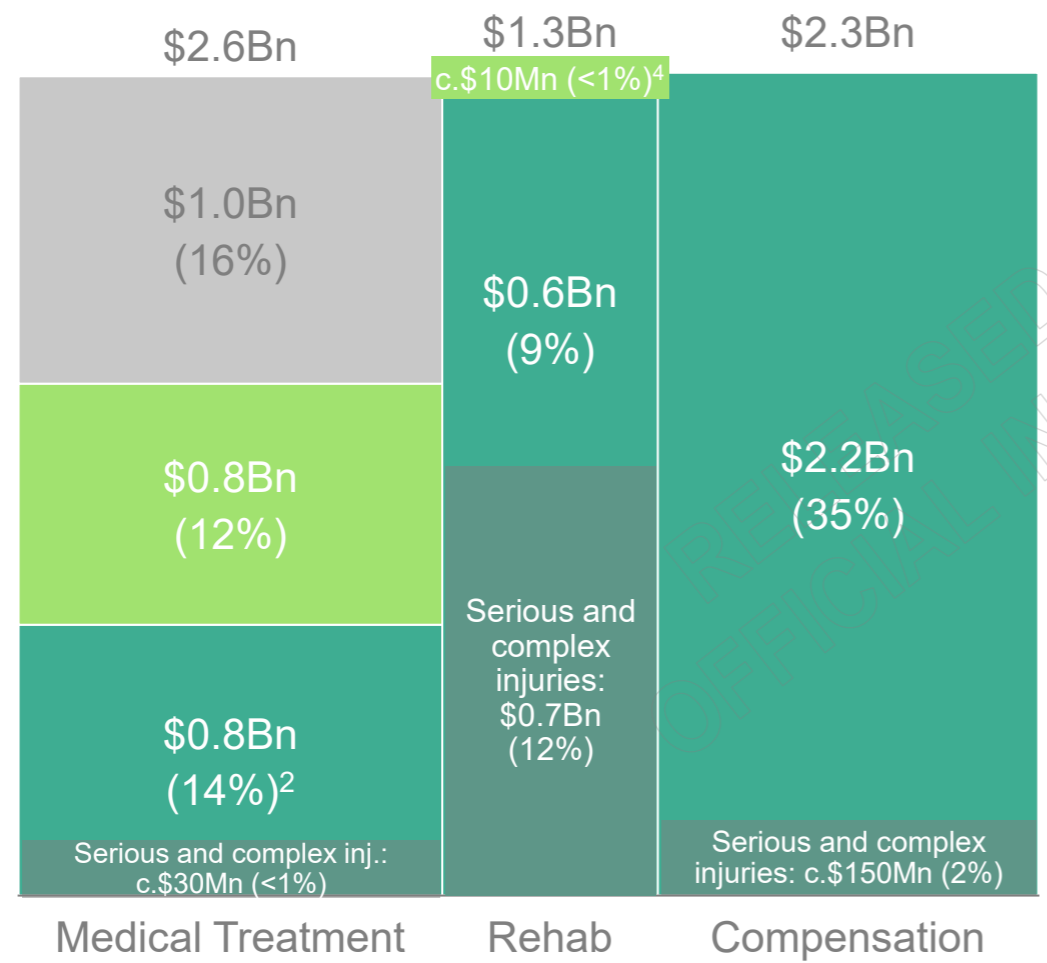


Focus of Target Commissioning Model

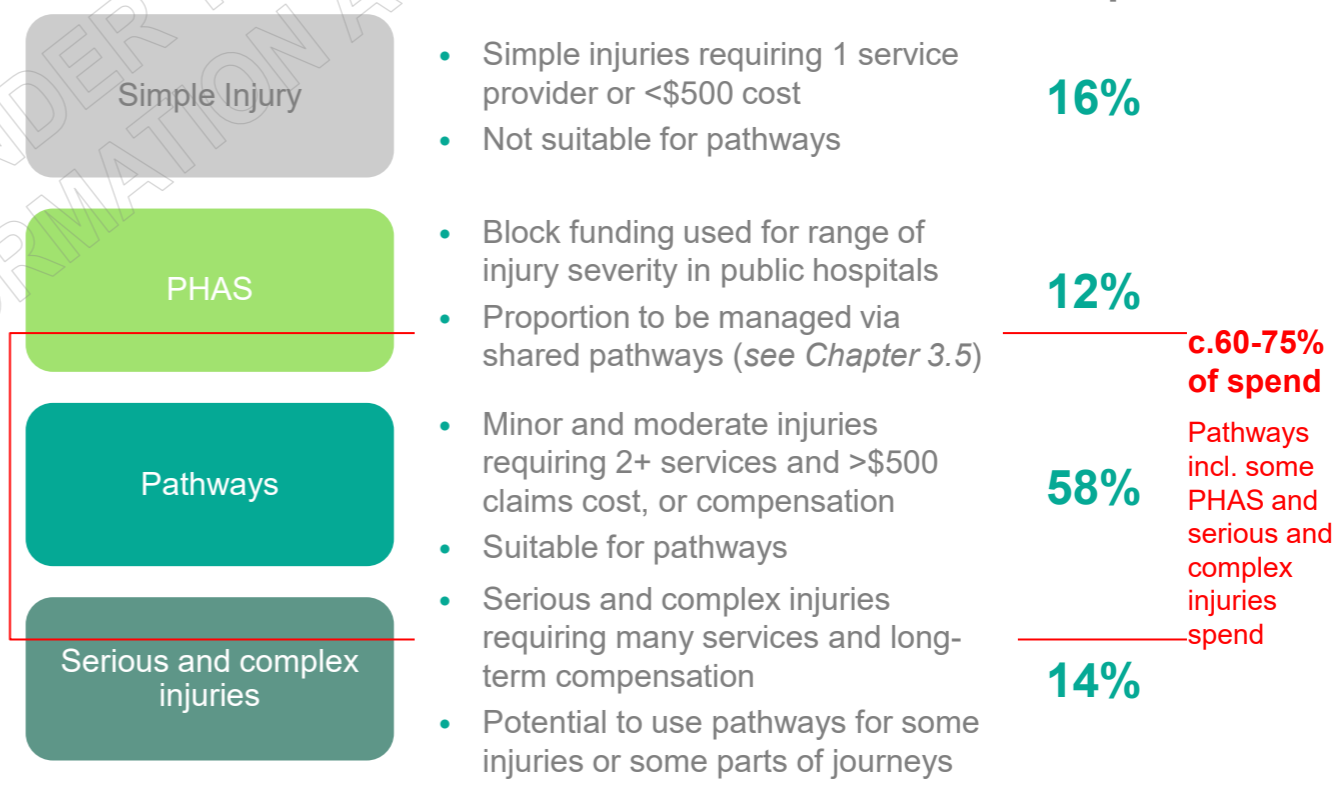
- ACC devolves treatment and rehabilitation decisions made in line with pathways to providers
- ACC continues to manage scheme boundaries and entitlement decisions
- ACC addresses appeals, escalations, requests for alternative treatments not included in the pathways, and clients not suitable for provider management

Backup | ACC could aim to commission well over 60% of in-year spend along client-centred pathways

In-year spend by type of spend and severity



Definition of injury severity and suitability for pathways



1. In-year spend; 2. Pathways could also be used for some serious and complex injuries; 3. Count of service types and overall claim spend performed on FY21 and adjusted to FY23 using Medical Treatment, Rehab & Compensation actual year-on-year growth; 4. Incl. adjustments (e.g., Non-acute Rehabilitation Demonstration)

The Target Commissioning Model responds to and reinforces Huakina Te Rā

Huakina Te Rā objectives

Mana Taurite *Equity*

- 1 Reduce unwarranted outcome variation by implementing evidence-based pathways that have been co-designed with providers, kiritaki/clients and whānau, including those who face barriers
- 2 Ensure more equal outcomes by using pathway tools that incorporate co-morbidities and social factors, and by focussing on outcomes that matter to kiritaki/clients and whānau in the treatment pathway
- 3 Ensure treatment pathways are inclusive of non-western understanding of wellbeing and treatment (e.g., Rongoā, karakia and mirimiri) supporting access and integration along the journey for priority populations

Ringa Atawhai *Guardianship*

- 4 Reduce waste by monitoring and responding to variation between providers in terms of excessive resource use through over-servicing or other forms of excessive deviation from pathways
- 5 Reduce unit cost to ACC of specific items of service along pathways through more strategic procurement approaches
- 6 Increase recovery speed & reduce re-injury by measuring delivery of outcomes that matter to kiritaki/clients and whānau, including return-to-work goals, and increasingly using bundled payments to integrated teams

Oranga Whānau *Safe and resilient communities*

- 7 Address under servicing of people who face barriers including geographic access, gender, sex, race or intersectional considerations by measuring relative outcomes across journeys and reducing co-payments
- 8 Encourage provider diversity through new procurement approaches that encourage whānau based and Kaupapa Māori services, and providers owned and operated by Māori, Pasifika, women etc.,
- 9 Strengthen the provider network by driving continuous improvement of the system, based on patient reported measures (PRMs) (including cultural dimensions of wellbeing), with more devolved decision making

Equity | The TCM advances equity including for priority populations via system change

Access Challenges

Including financial barriers to access (co-pay), availability of services in rural areas and at times that are accessible for a range of employment types

Pathways provide structured risk assessment and streaming into services to better meet need for priority populations including quality of experience priorities

Strategic procurement approaches enable providers to invest in expansion (geographically, or service hours) and diversification of services to meet the needs of priority populations

Contractual approaches and payment models to Primary and Community Care including Kaupapa services can remove or reduce financial barriers to access for priority populations

Enhanced monitoring of system performance will provide greater insight of the under-servicing of priority population and direct research into the barriers to access

Experience Challenges

Including lack of culturally appropriate services or practices, provider biases, limited availability of services in languages other than English, and inadequate recognition of whānau and informal carers

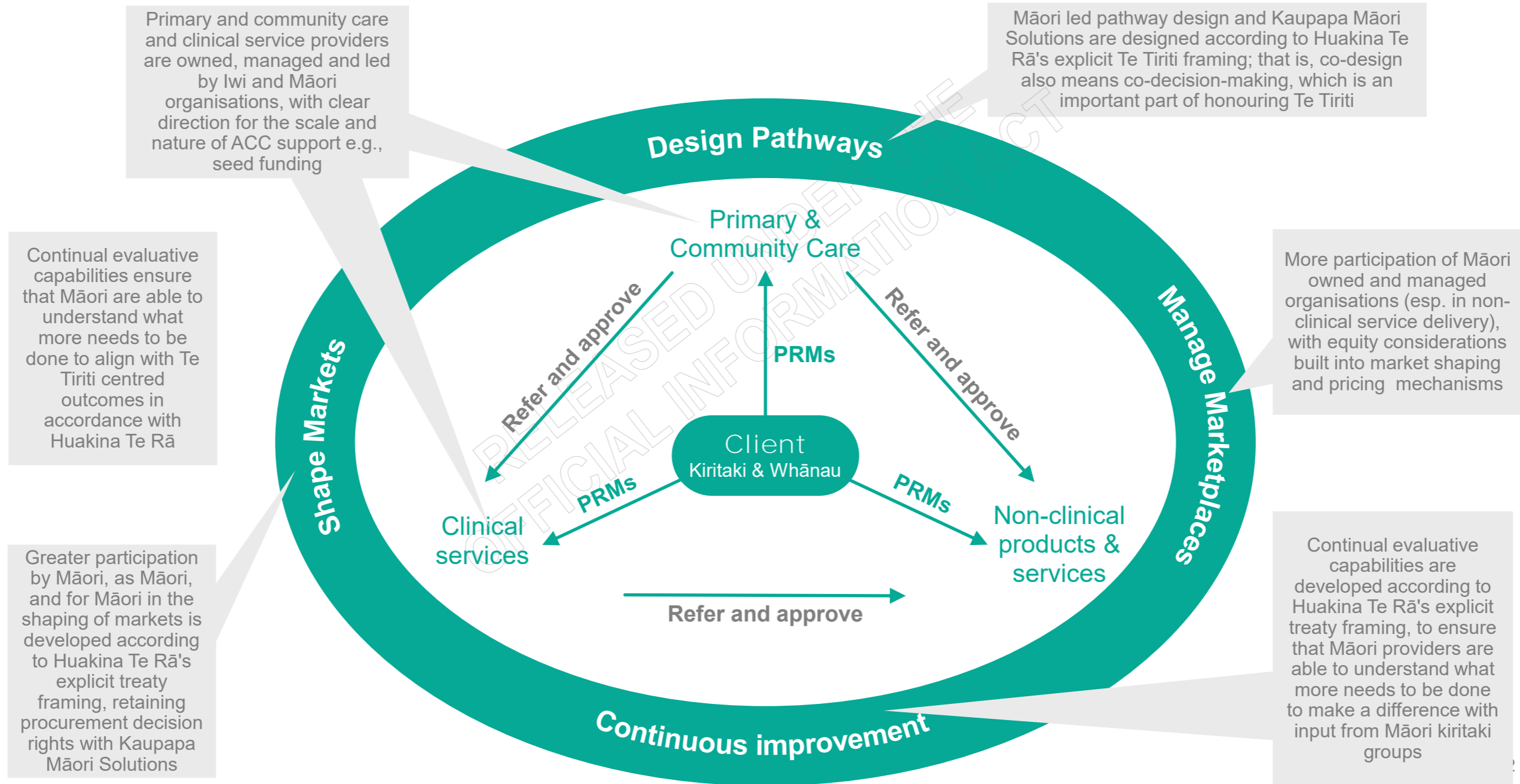
Engaging priority population communities in the design of pathways and outcome scorecards will incorporate their priorities for experience

Incorporating PRMs specifically designed to monitor outcomes that matter most to clients/kiritaki including priorities of culture and wellbeing

Monitoring and managing provider performance to these outcome scorecards, reinforces continuous improvement of experiences for priority populations

Kaupapa Māori Solutions and Iwi decision-making provides pathways specifically designed around Māori needs

Te Tiriti | The TCM is consistent with Te Tiriti approach



Return-to-work and recovery-at-work approaches are consistent with the target commissioning model, but could be extended and expanded

Key Features of RTW	Alignment to TCM
Navigator role	Consistent, TCM designates P&CC as principally accountable to refer to RTW providers TCM sets clear expectations that P&CC share rehabilitation plan and expected durations with Employers
Pathway focus	Consistent, TCM designs pathways based on agreed best practices including vocational training and vocational rehabilitation, and incorporate employers in co-designing outcome scorecards and tool development
Outcome focus	Fully aligned, ACC incorporates RTW outcomes (e.g., safety, timeliness, reinjury rates) to system performance management including contracts and provider and network management
Risk based RTW	Consistent, TCM supports P&CC with decision aids, risk identification and referral pathways Employer contributes, to occupational risk assessment by RTW provider to understand recovery-at-work potential
Integrated Practice Units	Fully aligned
Interoperable data	Consistent, TCM reinforces variation analysis in RTW outcomes and underlying drivers
Treatment of escalations	Consistent, TCM retains ACC accountability for some escalations from P&CC e.g., Vocational Independence process Service designers may define higher escalation thresholds based on the pathway

Backup | Return-to-work and recovery-at-work is supported by P&CC, vocational rehabilitation providers and employer, enabled by ACC

Description

Intake & Assessment		Rehabilitation		Escalation
P&CC	Recovery-at-work & Return-to-work	Treatment	Recovery-at-work & Return-to-work	
<p>P&CC identifies clients/kiritaki at risk of poor RTW outcomes (including biopsychosocial risk), referring to pathways to reduce risk</p> <p>P&CC certifies injury and duration of compensation</p>	<p>RTW provider conducts occupational risk assessment</p> <p>RTW provider develops plan recovery-at-work or return-to-work plan as required</p>	<p>P&CC refers along rehabilitation pathway integrating services e.g., clinical services, rehab aids, home mods</p> <p>P&CC monitor, escalate care or transfer pathways</p>	<p>RTW provider assesses work type and possible modifications to support a safe RTW</p> <p>Employer supports recovery-at-work when possible, maintain social connection when not</p> <p>ACC supports employers with employment conditions and contracts to simplify RTW</p>	<p>P&CC triggers escalation of RTW support given progress, if RTW and recovery-at-work are not successful</p> <p>P&CC refers to Assessor directly or via ACC, for Vocational Independence Assessment</p> <p>ACC retains case management role for exceptional cases</p>

Key differences

<p>ACC supports P&CC with decision aids, risk identification and referral pathways to Vocational training</p>	<p>Employer contributes, to occupational risk assessment by RTW provider</p>	<p>ACC facilitates co-design inclusive of the employer</p> <p>ACC incorporates RTW outcomes to core performance management</p> <p>P&CC share rehabilitation plan and expected durations with Employers</p>	<p>P&CC refer to RTW providers e.g., voc. training, voc. rehabilitation</p> <p>ACC understands variation in RTW outcomes and commissions to address underlying drivers</p>	<p>ACC supports P&CC with escalation trigger thresholds based on analytics</p>
---	--	--	--	--

Target commissioning model requires investment into primary and community care, data & technology, some medical services; more than offset by savings and benefits

Dimension	Impact of target commissioning model	Size of impact (p.a., indicative only)
Primary and community care spend	Increased	Low \$100Mn's
Data and technology spend	Increased	\$10-50Mn
In-year medical spend	Increased	Up to \$200Mn
End-to-end spend per client (medical, rehab, weekly compensation)	Decreased	\$150-750Mn+
Unit cost on key services	Decreased	Low \$100Mn's
ACC claims handling costs	Decreased	Low \$100Mn's

Non-financial benefits

- Tighter management to pathways lowers average duration of treatment
- Management of more clients to pathways narrows spread of spend and duration, improving equity for priority populations
- Better matching of suppliers to clients enabled by marketplace ensures higher access
- Better matching of suppliers to clients enabled by marketplace ensures access to more appropriate services
- Lowered barriers to entry as a supplier enable higher participation rates from SMEs

Adopting the Target Commissioning Model has several risks that should be explored during detailed design

	Risks	Target Commissioning Model Mitigations
Readiness of Primacy & Community Care	P&CC is currently under significant pressure and requires investment to prepare for their new mandate	Resources the sector with additional funding structured for certainty to expand and invest in new resources
Data interoperability across the provider network	Data interoperability and PRMs collection is essential to safeguarding the system	Establishes standards for data architecture, working closely with software vendors to operationalise tools
Personal privacy concerns and participation	Secondary use and sharing of personal health data may trigger public discourse of risk and trust	Adopts a devolved data architecture retaining information at its source, leveraging interoperability and APIs
Provider uncertainty of financial and risk impact	Providers are resistant to the change due to changes in payment models and risk sharing	Activate provider autonomy through engagement model; establish feedback loop addressing concerns
Pace and priorities of change in Health New Zealand	Priorities and strategic alignment with Health NZ/Te Whatu Ora does not cascade through its organisation	Shared priorities are established with supporting governance to maintain alignment at strategic and operational levels
Unintended market consequence	Strategic Procurement approaches, result in unintended market shifts or changes in provider dynamics	Invests in thorough market analysis and scenario planning; align with other govt buyers and policy makers; consider commercial risk of IPU based models

Plan summary | Define client-centred pathways through co-design; manage them through Primary and Community Care

Clients/kiritaki with similar injuries currently experience materially different care pathways and significant variation in outcomes achieved and resources used. Designing journeys with an end-to-end perspective of rehabilitation, brings together the currently fragmented perspectives and contracted services of those treating the client along the care journey. Leading global organisations use structured pathways to drive value. For many injuries there is a wealth of published clinical care guidelines that could inform much more structured pathways and identification of need. Well over 60% of ACCs in-year spend is suitable for a pathway approach (i.e., include multiple services, requires risk stratification, represents >\$500 claim value). Co-design of these pathways is critical to provider adoption

The most complete and comprehensive information about the care needs and risks of kiritaki/clients is available in Primary and Community Care teams including Kaupapa services. These teams also have the critical role of ongoing continuity of care and are more attuned to the performance and practices of the local service delivery provider ecosystem, and specific barriers for priority populations. These strengths of the current system could be better leveraged to support, empower and incentivise P&CC to manage kiritaki/clients on the pathway rather than duplicate these functions within ACC



2.1 Focus on journeys with high variation

Reorient 71% of spending along pathways to drive sector collaboration along journeys and quickly move to reduce variation while considering a balanced portfolio of existing alignment and new work required

Sequence this transition based on spend, return to work variability, high use of Primary and Community Care and re-contracting horizons; working with Māori-led service design team on areas of collaboration and lesson sharing

2.2 Establish pathway co-design capability

Re-orient service design teams to lead pathway co-design with teams comprising providers, clients/kiritaki, analysts; continue Māori-led service design approach in parallel

Pathway design teams to identify approaches to risk stratification, referral pathways, escalation and review; align on key outcome metrics

Designs should be informed by objectives of Huakina Te Rā

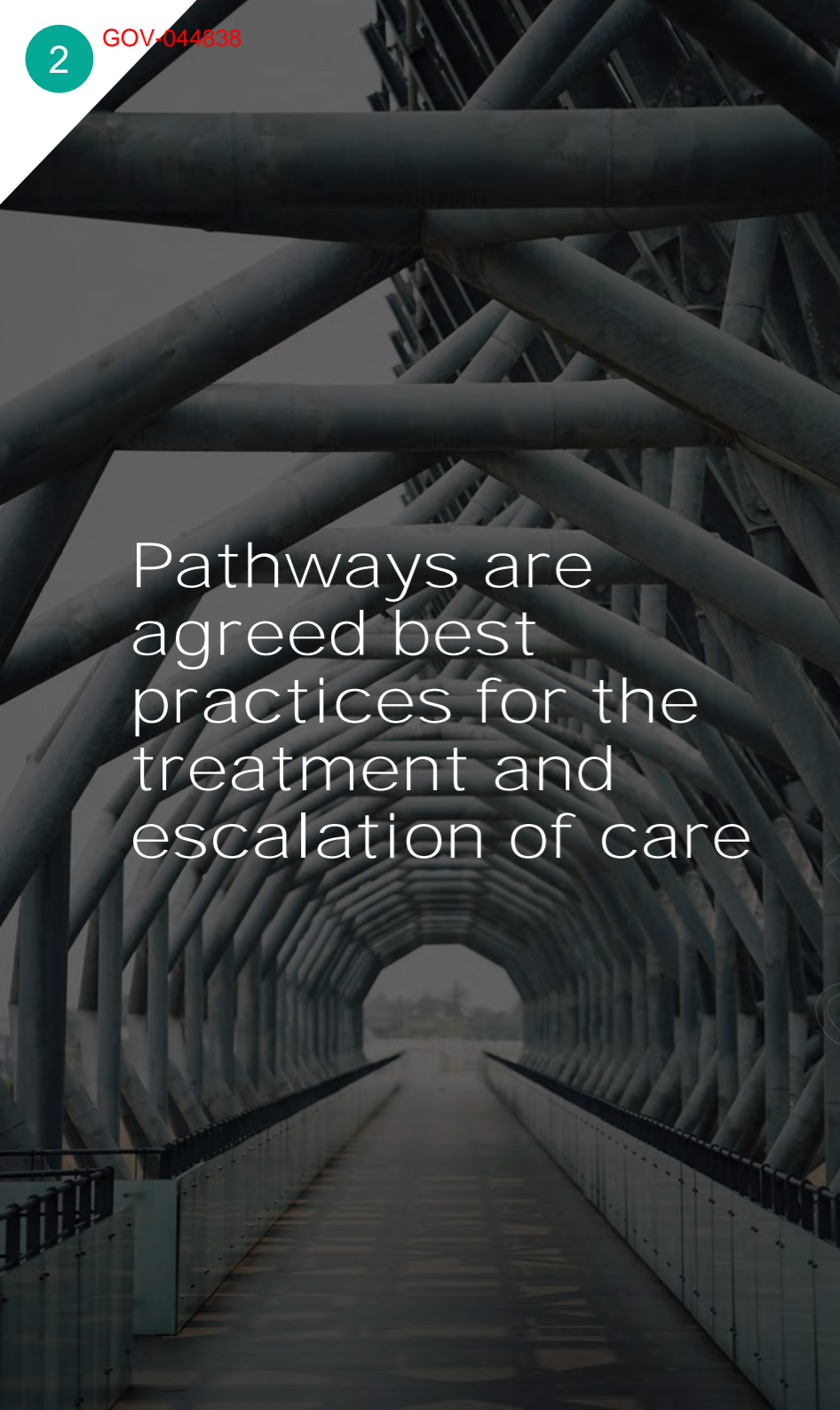
2.3 Build new relationship with Primary and Community Care

Develop new contract for Primary and Community Care focused on the role of managing injury pathways

Build decision support, referral, approval and reporting tools to support P&CC to manage pathways

Develop payment model for P&CC that aligns incentives and enhances resources available

Develop performance management approach



Pathways are agreed best practices for the treatment and escalation of care

Reflects evidence-based standards of care

Addresses multiple treatment services that are more effective with integrated practices

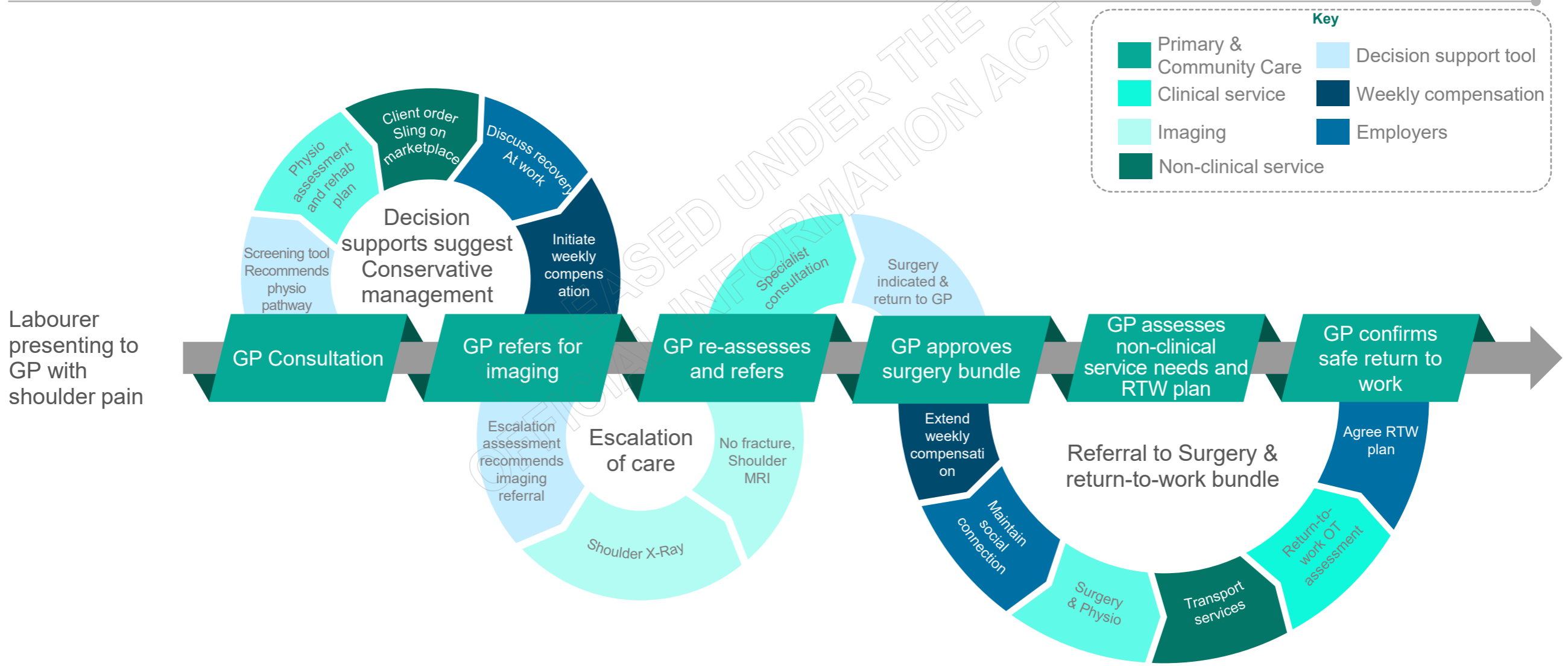
Requires navigation and continuity of care that integrate whole of health risk-factors

Represents material resource use and spend (>\$500)

RELEASED UNDER THE OFFICIAL INFORMATION ACT

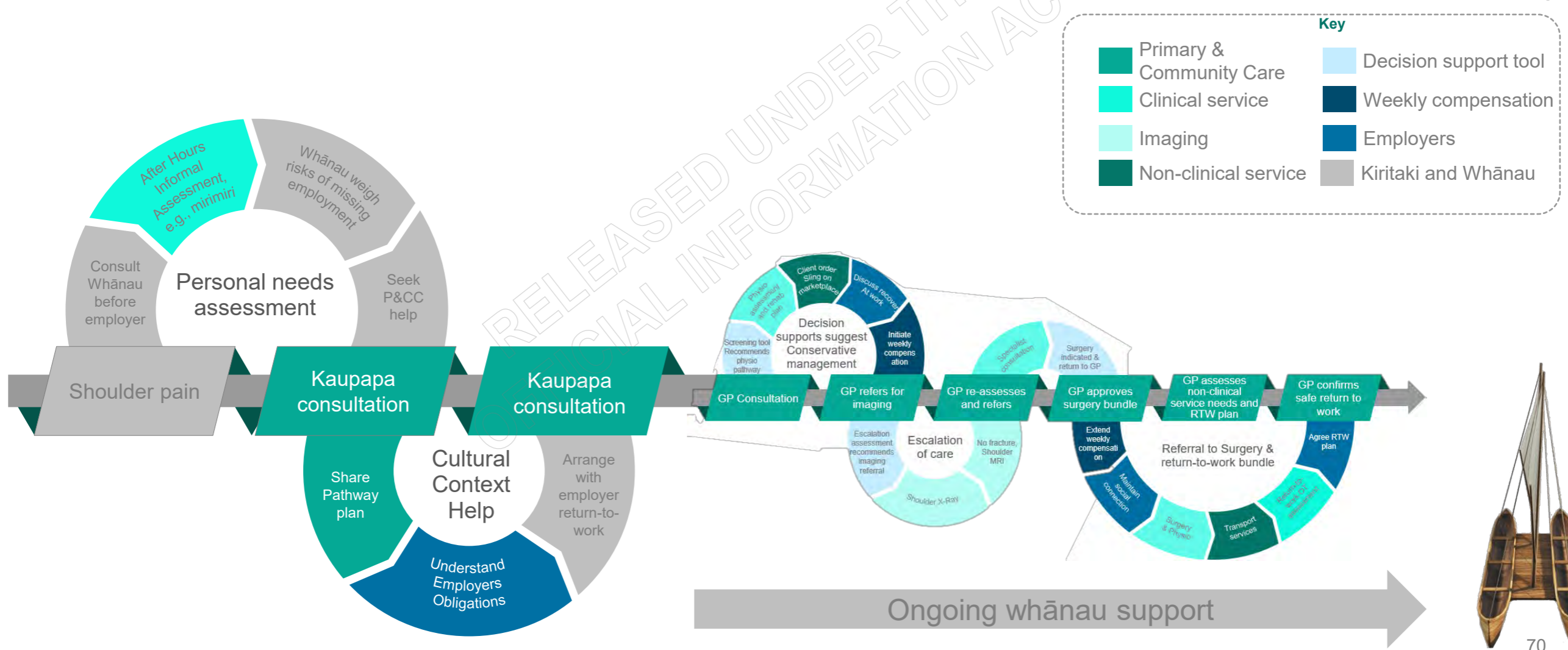
Backup | Pathways define best practices to treat a patient condition based on specific context & client needs

Illustrative journey and pathways for Shoulder Pain in a Primary Care-led pathway



Mana Taurite | Māori and Pasifika engagement in pathway co-design will highlight key pre-pathway needs for culturally sensitive nurturing

Illustrative Māori & Pasifika pre-pathway for Shoulder Pain



ICP approach is broadly consistent with the target commissioning model, but other service designs would also be consistent

Key Features of ICP	Alignment to TCM
Pathway focus	Fully aligned
Outcome focus	Fully aligned
Bundled Payment	<p>Consistent, TCM can also use other payment methods</p> <p>Service designers may choose to avoid bundled payments if market lacks depth of providers that can manage the risk and assure access</p>
Navigator role	Consistent, TCM focuses on P&CC as navigators who will assess risk and stream clients to different pathways (which could include being managed by an IPU or ICP navigator)
Integrated Practice Units	Consistent, but not necessary in all pathways
Interoperable data	<p>Consistent, TCM expands timely collection and sharing of information</p> <p>Service designers may extend data sharing and tools to the wider care team; Insights relating to system performance are shared for other key stakeholders e.g., PHOs, peak bodies, prevention</p>
Treatment of escalations	<p>Consistent, TCM retains ACC accountability for some escalations</p> <p>Service designers may define higher escalation thresholds based on the pathway</p>

Primary & Community Care is best positioned to have an oversight role in most of ACC client/kiritaki pathways, other providers could navigate specific pathways

Primary and Community Care and Kaupapa Services are best positioned to navigate most pathways

Have a central, end-to-end role initiating and referring throughout rehabilitation journeys seeing 50% of clients/kiritaki

Have local connection and performance insight into the rehabilitation service ecosystem

Provide a key clinical checkpoint to reduce waste and over-servicing due to misaligned incentives of provider referrals

Have the pre-existing relationship (97% registration) and information on client/kiritaki histories, risks and co-morbidities

Understand modifiable risk factors for each clients/kiritaki to address secondary prevention and reinjury rates

Are responsible for continuity of care and serving high client volumes, benefiting most from streamlined care pathways

Other providers are key to Primary & Community Care IPUs

Allied Health providers (e.g., OT, Physiotherapists) and culturally appropriate providers can **navigate specific pathways based on client/kiritaki needs**. The choice between GP and other providers taking the lead navigation role should be determined by the co-design group according to the guardrails agreed with ACC:

- E.g., psychologist led sensitive claim journey
- E.g., physiotherapist led minor sprain

Change will require investment to shape the market

To support Primary and Community Care in this transition, ACC should **directly invest in the sector** with commensurate funding, support to **define pathways including escalation thresholds**, provide **risk stratification and support tools**, and **monitor outcomes** to share best practices and ensure **continuous improvement**

This investment should also be used to drive change **in the nature of P&CC practices to integrated practice units (IPUs)**. Currently 58% of practices employ NPs, 48% employ health improvement practitioner, and 72% employ a clinical pharmacist

ACC must **shape the strategic narrative to address the existing sentiment against administrative burden** and clearly articulate the reduced requirements in the target state

Plan summary | Market-shaping capabilities will be essential to improving client/kiritaki experiences, improving outcomes and managing costs

Benchmarking analysis shows ACC pays high unit prices vs. benchmarks for some services and potentially funds overservicing in some areas. At the same time, clients/kiritaki often face delays and challenges accessing timely services and culturally appropriate care. Past approaches to commissioning have seen increased consolidation among providers and reduced diversity. New pathways are likely to require service delivery models that don't currently exist, such as Integrated Practice Units (IPUs). A strategic procurement capability would empower ACC to shape markets, influence care delivery models and manage pricing. This capability must remain committed to Huakina Te Rā, shaping markets and procurement approaches to address inequity for providers and incorporating innovative approaches to support their sustainability



3.1 Incorporate alternative procurement strategies for clinical services¹

Adopt a broader range of procurement tools, including bundled pricing, pre-purchased capacity, direct investments, vertical integration and price discovery

Align incentives between providers and ACC and support continuous improvement

3.2 Establish marketplaces for non-clinical products and services

Establish more diverse marketplaces connecting clients/kiritaki and providers, and empowering clients/kiritaki with greater choice and control

Stimulate supply, particularly in thin markets, to enhance responsiveness and foster a diverse provider landscape

3.3 Build a strategic procurement centre of excellence

Build strategic procurement capability in form of centre of excellence to enable effective implementation of changes

Build an agile and multi-disciplinary team to involve a full range of functional expertise

Work with inter-governmental entities on shared commissioning objectives and practices

3.4 Build a provider network management capability to focus on continuous improvement

Build a provider network management capability aligned to specific provider groups e.g., General Practice, Surgical Specialists

Establish clear performance management and benefits realisation frameworks

Design of data and analytics approach to support variation analytics including provider management, integrity and peak body collaboration

1. Referring to all medical treatment and rehabilitation services

[s 9(2)(i)]

RELEASED UNDER THE
OFFICIAL INFORMATION ACT






Non-clinical services | ACC can introduce digital marketplaces to empower clients with choice & control, foster provider diversity and increase responsiveness to clients

Non-clinical product and service marketplace concept

Platform streamlining process of connecting ACC clients/kiritaki with approved providers of select non-clinical products and services (e.g., travel, personal care, equipment, home modifications):

- **Provider participation:** Providers able to join marketplace if compliant with quality and safety standards, and provider diversity fostered by ACC
- **Transparency:** Detailed information included about providers, services, costs and ratings, ensuring transparent decision-making
- **Client/kiritaki access:** Access to specific products and services enabled by primary and community care or other clinical service providers, in line with ACC guidelines and pathways
- **Provider selection:** clients/kiritaki free to choose providers based on personal preferences, needs and provider information, and to provide rating/feedback on products and services

Global examples of successful digital marketplaces

	Transport	Personal care	Home mods	Equipment
 Five.Good.Friends.	✓	✓	✓	✓
 Homage	✓	✓		
 mable	✓	✓		
 myagedcare	✓	✓	✓	
 Uber	✓			

Strategic procurement | A Strategic Procurement Centre of Excellence can work alongside Pathway & Service Design & Improvement and Network & Provider Mgmt.

Key elements of a commissioning approach

Pathway & Service Design & Improvement

*Covered in
previous section*

Network & Provider Management

*Covered in
previous section*

Strategic Procurement – ACC Centre of Excellence

Purpose:

- Develop procurement strategy and conduct procurement of products and services

Full range of capabilities and expertise:

- **Strategy:** Develop procurement strategy, monitor execution of strategy and track performance metrics
- **Market analysis:** Monitor market trends, competitive dynamics and underlying provider economics to inform procurement strategy and negotiations
- **Demand analysis:** Use historical data and trends to predict future demand
- **Procurement:** Understand procurement techniques, evaluate and execute appropriate technique based on needs and desired outcomes
- **Negotiation:** Understand key levers of negotiation, define negotiation strategy and effectively negotiate contracts
- **Legal & contract:** Ensure contracts adhere to relevant regulations and policies
- **Clinical:** Ensure products and services meet clinical standards/requirements
- **Financial analysis:** Assess financial aspects including spend analysis and budget management, and identify opportunities for savings
- **Impact:** Promote diversity and inclusion by providing opportunities and potentially additional support for minority-owned (e.g., Māori & Pasifika, woman, disabled, LGBTQ+) and environmentally conscious providers (e.g., scaling existing support such as funding for independent contract advice)

Provider Network Management | Pathway Design & Improvement can share data, support peer learning and set performance standards to support continuous improvement

A. Share outcomes & resource-usage data

- **Collect and share data** on outcomes and resource-usage
- **Provide regular, automated feedback** to providers on performance against peers and national/global benchmarks
- **Identify and provide insights** on variations and areas for improvement using analytics

B. Support peer learning and best practice-sharing

- **Establish a medium** (e.g., online platform or community) where providers can connect, share information and collaborate
- **Organise forums** where providers can discuss successes and challenges, and exchange best practices and resources
- **Provide educational resources** and training on best practices

C. Set performance standards for off-track providers

- **Flag providers** performing below established benchmarks using data and analytics
- **Collaborate with off-track providers** to create customised performance improvement plans and set specific targets for improvement
- **Continuously monitor progress** against improvement plans and provide regular feedback and support

Plan summary | Enhancing data, analytical capabilities and tools will enable ACC to deliver the Target Commissioning Model and deliver better value care

ACC's current data set enables analysis of overall journey length and variation, however this is not routinely analysed or used. In addition, in order to manage the system and improve equity that ACC understands the outcomes and experiences that matter to clients and whether or not they are being delivered

Leveraging a use case driven approach will enable ACC to identify and prioritise the required data, analytical capabilities and tools to deliver the Target Commissioning Model and support better value care. In this process, ACC will both develop internally and enable its partners (especially Primary & Community Care) to use data for more informed decisions



4.1 Enable Primary & Community Care to manage client pathways

Develop decision support tools to enable Primary & Community Care to direct clients/kiritaki across pathways leveraging historic data and client/kiritaki complexity

Develop screening tools to enable Primary & Community Care to manage lines of treatment and deviations, including comprehensive assessment of needs

4.2 Enable clients & clinicians to use PRMs to inform treatment decisions

Co-design and embed PRMs, clinical outcome measures and client/kiritaki defined targets in clinical processes to inform treatment decisions

Identify and support clinical best practices along pathways using historical data & newly defined outcome measures

Ensure data sharing between P&CC – clinicians – ACC

4.3 Create analytics to manage outliers, support continuous improvement

Measure variation across pathways and providers; create alerts and processes to intervene in case of significant outliers, and understand the experience of priority populations

Develop transparent providers benchmarking to drive continuous improvement

Provide last resort case management after Primary & Community Care; approve services beyond pathways limits

4.4 Assess implications for current core systems & define technology roadmap

Assess implications of the Target Commissioning Model for core systems (e.g., Next Gen Case Mgt., Principal Client Record, EOS, MyACC, BusinessPartnersHub)

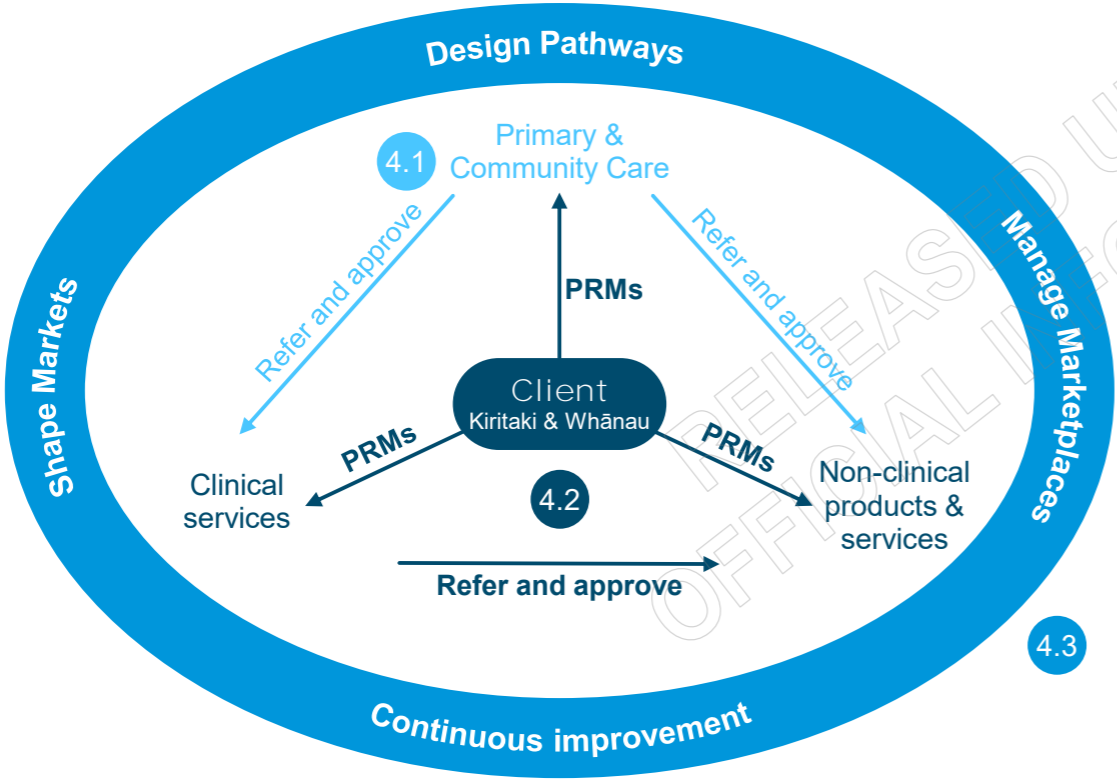
Run keep/stop/start analysis on current technology roadmap

Redefine technology roadmap to include analytics and digital build capabilities required by the TCM

Four priority areas identified to deliver the Target Commissioning Model, additional use cases will support ACC's service model

The Target Commissioning Model heavily leverages data, analytical capabilities and digital tools/solutions

4 priority areas emerging to support the Target Commissioning Model, 2 to support Service Delivery



- 4.1 Enable Primary & Community Care to manage client/kiritaki pathways
- 4.2 Enable clients/kiritaki and clinicians to use PRMs to inform treatment decisions
- 4.3 Create analytics to manage outliers, support continuous improvement
- 4.4 Assess implications for current core systems and define technology roadmap
- 4.5 Establish a digital front door to receive additional client/kiritaki data and directly manage low complexity clients/kiritaki
- 4.6 Set up a booking tool to enable Primary & Community Care and clients/kiritaki to make appointments along pathways

Managing treatment decisions with Primary & Community Care will **reduce ACC's data requirements & overhead** (e.g., claims & case management, ...)

Commissioning model

Service model (RIG)

ACC can leverage a use case approach which starts small, delivers value early, and matures organisational capabilities and tech as we go, aligning with **Huakina Te Rā**

Oranga Whānau Safe & Resilient Communities

Ringa Atawhai

Transform organisation

Scale to solution

Build, test, iterate

Define use cases to deliver the TCM

Mana Taurite

Define the target future state



Target Commissioning Model



- Business and value focus
- Pilots with available data and tech

- Practical application of adv. Analytics (e.g., ML for early predictors)
- Well defined projects (e.g., scaling select PRMs)

- Iterative tech scale up
- Purpose-fit tools from existing technologies (e.g., integration to PMS)

- Data and analytics integrated in ACC and providers processes
- Supporting org structure in place
- Data sharing with providers defined in contracts and interests aligned

Use case approach accelerates path to value delivery through:

- Scalable approach (e.g., action with available data and tech)
- Targeted value delivery (e.g., measured and justified investments for clearly defined initiatives)
- Clear roadmap (e.g., improved prioritisation)
- Operational efficiencies (e.g., recognition of inter-dependencies between teams)

Plan summary | Working with Health New Zealand/Te Whatu Ora will improve client/kiritaki transitions and outcomes, procurement costs and services accessibility

ACC's third largest entry point for clients are those originating with Health New Zealand/Te Whatu Ora, accounting for 13% of claims registered in FY23. These claims tend to be more serious and complex, with hospital originating claims accounting for c.27% of total spending (40% including PHAS). Some clients transition to ACC and experience sub-optimal outcomes¹. Global leaders have shown that early engagement between early carers and long-term managers of clients results in improved client outcomes

Health New Zealand/Te Whatu Ora is the largest health services purchaser and often the only funder of providers in underserved markets. As such there are opportunities for ACC to work more closely with Health New Zealand/Te Whatu Ora, including interagency coordination from a Māori perspective, to buy more effectively from the private sector and to jointly make investments in capacity to increase competition or serve underserved markets



5.1 Align on pathways for shared clients/kiritaki

Involve Health New Zealand/Te Whatu Ora in pathway plans for complex fractures, spinal cord and traumatic brain injuries

Enhance early notification procedures with strategic alignment to enable better client/kiritaki management

5.2 Partner on procurement of surgical implants

Engage with Pharmac to enable ACC providers access to Pharmac's national surgical implant contract for Health New Zealand/Te Whatu Ora, to leverage scale and price benefits

5.3 Invest in shared capacity in underserved markets

Coordinate with Health New Zealand/Te Whatu Ora to increase accessibility for elective surgery and high-tech imaging services for mutual benefit, through initiatives to increase investment into, and capacity of, these services

5.4 Utilise trauma registry data to drive better outcomes

Support better data collection by Health New Zealand/Te Whatu Ora during client/kiritaki pathways

Improve access to trauma registry data to inform process improvements for better long-term client/kiritaki outcomes

1. AROC (Australasian Rehabilitation Outcomes Centre) ACC Brain Dashboard for FY22 and FY23 shows that ACC contracted services are below Australia and NZ specialist benchmarks with more delayed start times, and more days between when a client is clinically rehab ready and start dates

Aligning on complex fractures, spinal cord and traumatic brain injury pathways could improve outcomes for shared or transitioning clients/kiritaki

13% of ACC claims originate with Health New Zealand/Te Whatu Ora. Managing client/kiritaki transitions more collaboratively and efficiently could result in better and more timely care for a number of clients/kiritaki, especially for more serious injuries that require more intensive, higher-cost and/or longer durations of care with ACC

The three key injury pathways with modifiable outcomes comprise c.48% of ACC's spend for clients/kiritaki originating from Health New Zealand/Te Whatu Ora¹

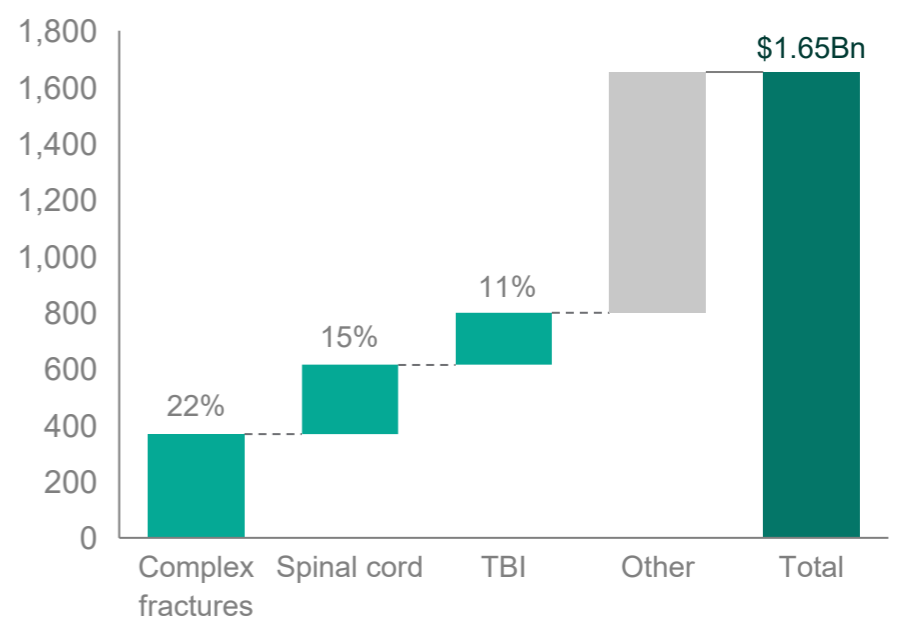
Spinal cord and traumatic brain injuries comprise 26% of spend and have the greatest variation across clients³

- 22%
Complex fractures: with recoveries >12 weeks and/or complex social situations². Putting clients/kiritaki on the right rehabilitation pathway modifies outcomes through reduced delays in recovery and workforce return
- 15%
Spinal cord injuries: assessments identify clusters of clients/kiritaki with consistent rehabilitation pathways, extended journey durations and the opportunity to modify outcomes through home modifications and support
- 11%
Traumatic brain injuries: clients/kiritaki have extended or lifetime relationships with ACC, and require a high degree of coordinated and sequenced rehabilitation measures, with the greatest opportunity through home support and modifications

... with the opportunity to align earlier to reduce unnecessary delays in client/kiritaki pathways and ensure adequate and sequenced care management to improve outcomes



FY23 in-year spend (\$Mn) on claims originating in Health New Zealand/Te Whatu Ora by pathway¹



Source: ACC Analytics data; 1. Excludes PHAS bulk funding; 2. Complex fractures defined as those with service durations (starting from either the first service date or registration at a hospital) of 12 weeks or longer. Percentage of ACC complex fracture claims spend originating in Health New Zealand/Te Whatu Ora calculated by multiplying FY23 total fracture claim cost by the FY21 percentage of total claims that are complex fractures (to account for clients with journeys beginning in FY23 who have not been captured in full due to ongoing treatment); 3. Variation is measured across identified journey types (unclassified journeys were not included)

[s 9(2)(i)]

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

[s 9(2)(j)]

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

Utilising trauma registries for better data collection and process improvement could support client/kiritaki transitions and long-term outcomes

Current situation

- Client/kiritaki data sets from ACC and Health New Zealand/Te Whatu Ora (NMDS) are not currently integrated with trauma registry data to allow for a better understanding of client/kiritaki needs across the client/kiritaki pathway
- ACC currently funds multiple registries, but trauma registry data is inaccessible at the client/kiritaki level (anonymised data only) due to HDEC¹ restrictions for research registries, which do not apply to clinical quality registries
- ACC is currently engaging with the National Trauma Network to finalise a trauma registry data sharing agreement to enable access to client-level data

Opportunity

- Engaging with Health New Zealand/Te Whatu Ora and the National Trauma Network to **set outcome measure collection standards** (e.g., PRMs) in the trauma registry will allow for more informative data to highlight best practices
- Using registry data to **unlock key process improvements** for shared client/kiritaki pathways with Health New Zealand/Te Whatu Ora could enable better client/kiritaki outcomes and inform strategies to improve equity of access to health care services for priority populations
- There is an opportunity to align with Health New Zealand/Te Whatu Ora to ensure ongoing access to registry data (e.g., migrate the trauma registry from a research registry to a clinical quality registry to enable ACC access to client-level information)

Plan summary | The operating model will shift to increasingly manage outcomes and risk by focusing on system design and provider performance

The current ACC operating model has been designed and refined to support ACC's existing approach to delivering value for the sector and discharging its statutory role. As the growth in claims and related spending has grown unsustainably, so too has ACC's role in the system. ACC is now the largest funder of social services in New Zealand and represents 17-20% of health care spending

To support the Target Commissioning Model, ACC's approach to delivering value for the sector must be adapted and updated. This requires operating model redesign. Key dimensions of the operating model must include:



6.1 Reorient Sector Engagement & Partnership

Plan and detail realignment of supplier and provider relations activities and channels including increased coordination and CRM

Plan for deeper PHO and P&CC engagement and performance model

Redesign the organisational structure and required capabilities

Address key legislation, governance and funding changes relating to more devolved model

6.2 Build enabling shared services

Assess the impacts of the change on each shared service function and plan for internal service model including Strategic Procurement, integrity analytics, People and Culture

Detail the shared services support model, resource allocation and service levels

Align governance, finance and delegation framework with the range of strategic procurement levers

6.3 Redesign change governance

Establish activist PMO, and build standards, tools, escalations, routines for change initiatives, and portfolio wide roadmaps and benefits tracking

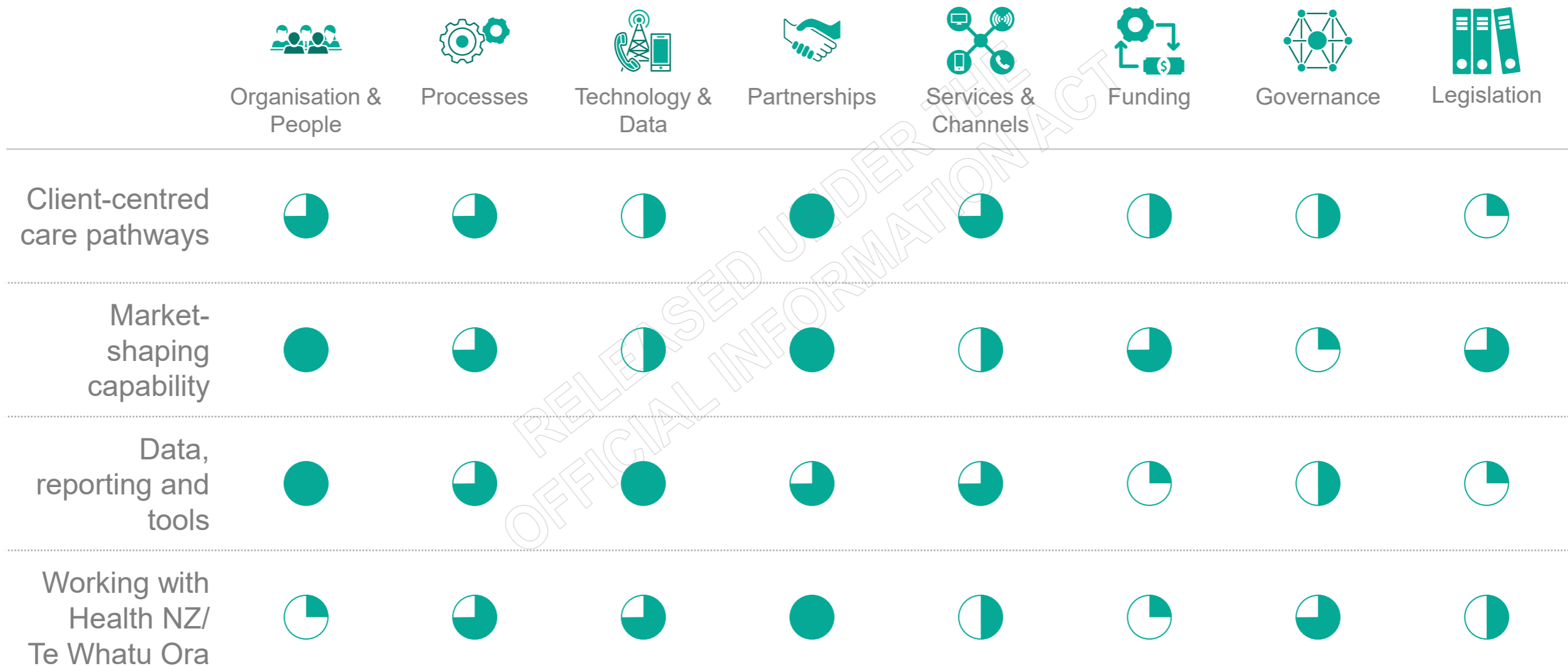
Conduct stop/start/continue of current change portfolio and roadmaps

Define new governance framework, providing necessary support to sponsors and projects owners to govern change effectively

ACC operating model will shift to increasingly manage outcomes and risk by focusing on system design and provider performance

- I **Primary and Community Care (P&CC)** make critical treatment decisions, identify need for reviews and escalate care in line with defined pathways, supported by ACC tools and PRM data
- II **Service design** function enables co-design of optimal pathways to drive commissioning, provider relationships and kiritaki/client experience
- III **Strategic procurement** function shifts from procuring services from existing market structures to actively shaping markets to drive value in line with pathway design
- IV **Operations** teams increasingly focus on supporting decision making with tools and systems that support providers to care for clients while maintaining ACC's role in managing scheme boundaries, escalations, appeals and matters that can't be devolved
- V **Data** is gathered and consolidated when it directly informs ACC and the care system on pathway effectiveness and performance
- VI **Provider relationship management** shifts from transactional relationships focused on claims, coverage and contracting to data-informed engagement on outcomes, resource use and continuous improvement
- VII **Collaboration** with Health New Zealand/Te Whatu Ora increases for service delivery planning, data and procurement
- VIII **Change** is rigorously prioritised and defined as one portfolio, tightly aligned to ACC priorities and governed to deliver benefits

Partnerships, People and Processes of the operating model will create the most impact for delivering the Target Commissioning Model and Pou



The Target Commissioning Model and Rehabilitation operating model are integrally related

Commissioning model describes how ACC shapes the rehabilitation service system

Rehabilitation operating model describes how ACC supports individual client journeys through the rehabilitation system

Today

- Service design focused on service types
- Activity focused payment and contract management
- High variation in client treatment pathways
- Competing incentives between providers and ACC

Today

- ACC manages risk and compliance through approval of specific requests
- High ACC involvement in 'on-track' journeys
- ACC focused on transactional support of providers

Future

- Service design focused on evidence-based pathways that have been co-designed
- Outcome focused payment and contract management
- Tight compliance to pathways monitored by outcomes scorecards
- More aligned incentives between providers and ACC

Future

- Limited ACC involvement in 'on-track' journeys other than providing tools to support more devolved treatment and rehabilitation decision making
- ACC manages risk and compliance by monitoring provider performance vs. pathways and outcomes,
- ACC focuses effort on journeys requiring escalation, exception, appeal, scheme boundaries, and the segment of clients not appropriate for provider management



4 | Action plan

Summary | Bringing this change to life requires a coordinated approach and diligent action planning

This review is only part of a broader ACC investment in building a detailed understanding of the current state and its challenges

- Rehabilitation Improvement Group, ISSC Evolution and Kaupapa Service design have led extensive discovery phases to listen to clients/kiritaki, staff and provider insights
- These efforts have identified a similar set of challenges and pathways forward, but questions remain about how to apply it in practice

Moving to the target commissioning model will require an integrated change approach from ACC that activates its people and supports them to deliver

- Head | Hinengaro: Envision the future and focus on bringing to life the cornerstones of the future e.g., develop business case, revise data and digital roadmap, launch journey co-design, reshape the organisation
- Heart | Ngākau: Inspire and empower people, compelling purpose and action e.g., develop change narrative, launch P&CC model with early adopters
- Hands | Ringa Atawhai: Execute and enable with agility to reorient organisational focus onto highest value activities e.g., review current change portfolio, set up change governance and implementation plan, address short-term opportunities

Three categories of action are required to drive implementation, each with their own challenge for ACC

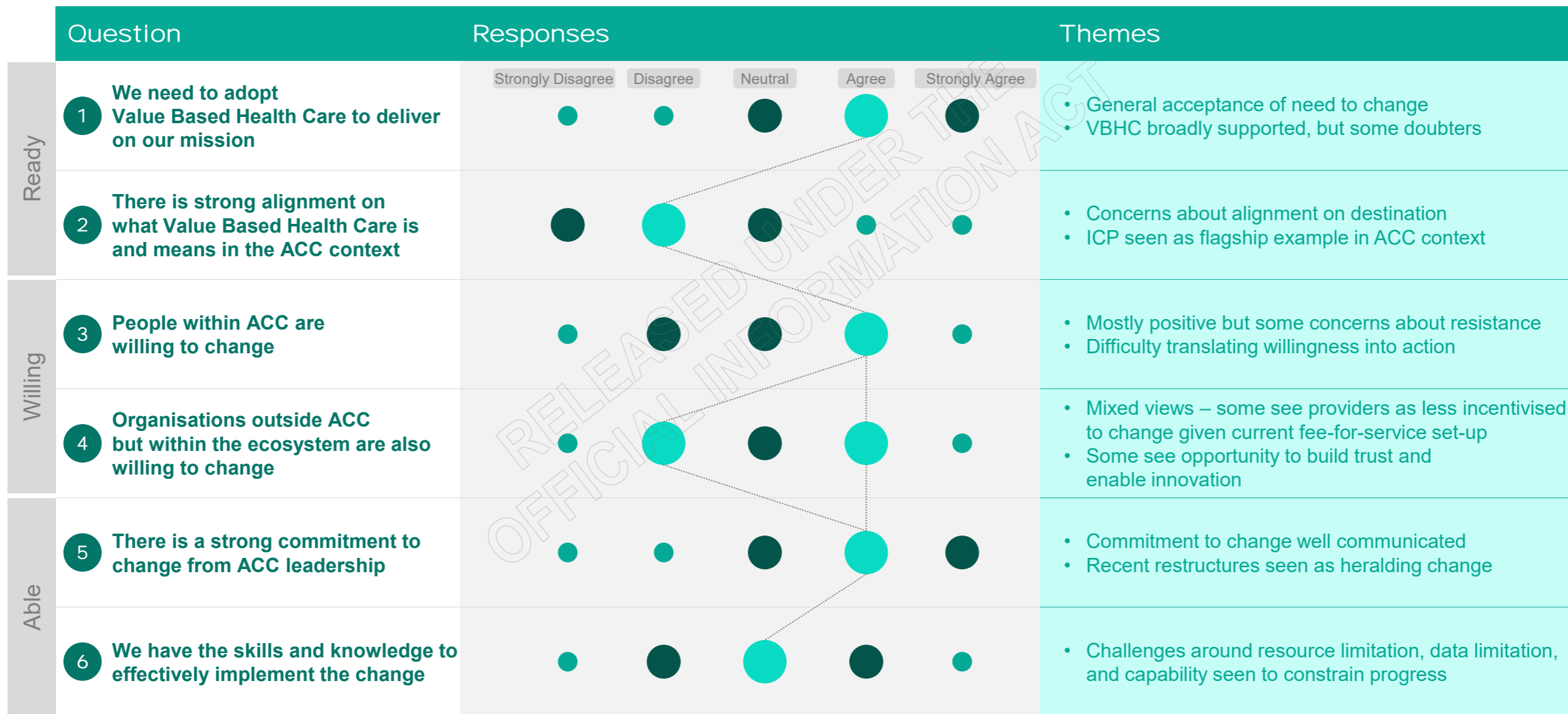
- Rapid alignment on the way forward across the multiple programs of work
 - Aligning the narrative and recommendations of RIG and Health Services Review (and ICP roll-out)
 - Reviewing current projects and programs for opportunities to stop or pivot
 - Aligning with Board and Government
- Implementing no regrets actions that signal intent and deliver impact
 - E.g., HTI and ESS strategic procurements, transport marketplace platform development, PRM design and implementation, pathways/alignment of ICP with pathways approach
- Setting up to “flip the odds” of long-term success
 - Developing the business case and key metrics and targets for tracking change
 - Developing the high-level implementation approach, pathway, sequencing
 - Implementing change governance, accountability and reporting structures – reviewing and aligning current models
 - Reviewing and resetting the digital and data strategy to align to the new model

Te Ara Poutama lays a path for attaining the Target Commissioning model



'Te Ara Poutama' is a traditional Māori tukutuku (woven lattice) design that recounts the story of Tāne-mahuta ascending the aka (vine) to obtain three baskets of knowledge from the primordial origin. Te Ara Poutama is a visual metaphor that describes the way knowledge is layered together in steps to achieve wisdom and enlightenment

Initial internal interviews revealed a high level of alignment on the importance of value for ACC, but questions about how to apply it in practice



Key: (n=47) ≥14 votes ≥5 votes <5 votes



Achieving this target commissioning model will require a 'head, heart and hands' approach from ACC

Head | *Hinengaro*

Envision the future and focus on the critical activities

Heart | *Ngākau*

Inspire and empower people

Hands | *Ringa Atawhai*

Execute and enable with agility

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Three categories of action required to drive implementation, each with their own challenge for ACC

- 1 Rapid alignment on the way forward**
 - Align the narrative and recommendations of RIG and Health Services Review (and other reviews)
 - Review current projects and programs for opportunities to stop or pivot
 - Finalise Board Paper, align with Board and Government
- 2 No regrets actions that signal intent and deliver impact**
 - HTI and ESS strategic procurements
 - Transport marketplace platform development
 - PRM design and implementation
 - Initial Pathways/Alignment of ICP with Pathways approach
- 3 Setting up to “flip the odds” of long-term success**
 - Develop business case and key metrics and targets for tracking change
 - Develop high-level implementation approach, pathway, sequencing
 - Implement change governance, accountability and reporting structures – review and align current models
 - Review and reset the digital and data strategy to align to new model

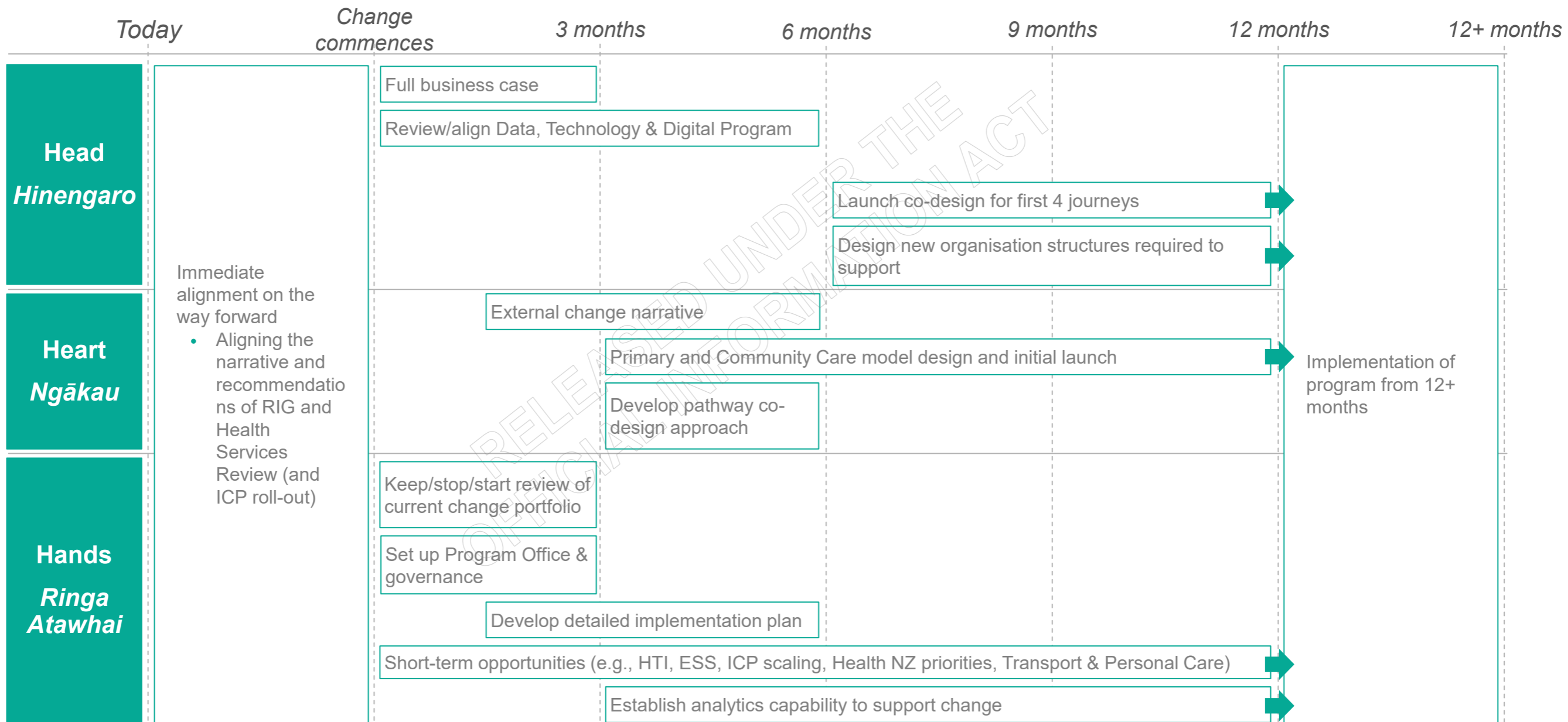
Critical challenges for ACC

Need to complete rapidly to maintain momentum

Capabilities required are in short supply

Need to change behaviours, processes, culture

After alignment is completed, the following 12months+ should focus on the critical activities and short-term opportunities to ensure evolution towards the target state






Target Commissioning Model | 12-month action plan

Key ◆ Illustrative milestones

Change commences	3 months	6 months	9 months	12 months
Business Case development	Develop business case <ul style="list-style-type: none"> Develop the change business case with disciplined investment logic Detail the investments required within ACC and within the sector to activate the change Determine and schedule the required critical governance path for ratification and approval 	Ratify and Approve <ul style="list-style-type: none"> Navigate required ratification and approval governance stages Establish benefits management approach and required infrastructure <p style="text-align: center;">◆ Business Case Approved</p>	Monitor performance to and alignment with business case <ul style="list-style-type: none"> Translate business case investment and governance rationale into the operational design e.g., governance bodies, risk frameworks, financial management, benefits management 	
Strategic change narrative development	Develop change narrative for ACC & Govt <ul style="list-style-type: none"> Develop the strategic change narrative for internal ACC change, building on previous work e.g., ICP, RIG, Kaupapa solution design Detail the inter-governmental strategic narrative including Health New Zealand/Te Whatu Ora, MSD, MOH Activate ACC leaders as visible champions of change 	Develop change narrative for the system <ul style="list-style-type: none"> Design the external strategic change narrative for the clinical and non-clinical sector Align external communications around the new strategic change narrative 	Champion and remain aligned to the narrative <ul style="list-style-type: none"> Communicate the narrative through all channels and interactions Return to the narrative to remain aligned with its purpose 	
Implementation and delivery plan	Detail the delivery plan <ul style="list-style-type: none"> Detail the delivery plan including sequencing approach Assess current change portfolio for what to stop/start/continue 	Develop implementation infrastructure <ul style="list-style-type: none"> Establish or align to delivery governance mechanisms and benefits realisation plan Establish Program Office and change management capability <p style="text-align: center;">◆ Delivery Plan approved</p>	Ongoing implementation and delivery <ul style="list-style-type: none"> Deliver to plan with executional certainty 	

Journey co-design | 12-month action plan

Key  Illustrative milestones

	Change commences	3 months	6 months	9 months	12 months
Variation based prioritisation	<p>Validate tranche 1 journeys</p> <ul style="list-style-type: none"> Review and validate prioritisation data, aligning on tranche 1 Conduct Viability and Feasibility assessment including assessing current contract position <p> Tranche 1 agreed</p>	<p>Build prioritisation methodology</p> <ul style="list-style-type: none"> Establish ongoing prioritisation framework Define permanent data architecture approach to transform data from claims to journeys 	<p>Prioritise</p> <ul style="list-style-type: none"> Embed ongoing prioritisation approach to iteratively build out subsequent tranches 		
Co-design approach & capability	<p>Develop co-design infrastructure</p> <ul style="list-style-type: none"> Stand up core team of Pathway Designers as interim team Consult with peak bodies on direction of travel Establish co-design and improvement infrastructure and processes, learning from RIG, ICP, ISSC, Māori-led design 	<p>Prepare for co-design</p> <ul style="list-style-type: none"> Detail the co-design methodology Articulate the change narrative and communicate that to the sector Align governance, accountabilities and delegations to empower design Seek and onboard participants from the sector for the Pathway Design teams Assess Channel Strategy to clarify contacts and escalation points 	<p>Commence journey co-design tranche 1</p> <ul style="list-style-type: none"> Commence tranche 1 of journey designs (4 journeys) including participant selection, international practice research, current state system analytics, co-design workshops Consult sector wide on the strategic narrative for changes including employers and AEP claims managers Develop long term tranche plan to address all journeys Consult with Iwi on the pending changes and the interactions with Kaupapa Māori Solution design <p> Co-design commences</p>		
Primary & Community Care role transition	<p>Design initial approach for P&CC role</p> <ul style="list-style-type: none"> Stand up interim ACC team to lead the discovery, design and implementation Scenario plan for support and funding models to catalyse P&CC, including COTR changes Consult with peak P&CC bodies & PHOs on the proposed model, plan wider consultation approach Consult with PMS vendors on the roadmap and areas of focus 	<p>Detailed Design of P&CC role</p> <ul style="list-style-type: none"> Detail design of funding and contracting model to build capacity and capability in the sector, including COTR changes Lead wider sector consultation specifically including HCH and GP chains, in partnership with the peaks Prioritise data and systems investment roadmaps 	<p>Plan implementation for P&CC role change</p> <ul style="list-style-type: none"> Assess Practice resource and capability variation and implications for implementation planning Align P&CC role transition with Journey Design timelines Reinforce and reskill a small capability of highly skilled case managers for exception-based cases of the future state Launch new P&CC role where aligned to specific parallel efforts e.g., ICP scaling <p> Initial launches commence</p>		

Market-shaping capabilities | 12-month action plan

Key ◆ Illustrative milestones

Change commences	3 months	6 months	9 months	12 months	
Clinical services Current HTI contract expiry (31/07) Current ESS contract expiry (31/10)	Decide what to start, stop, continue <ul style="list-style-type: none"> Define strategic vision and conduct start/stop/continue analysis on clinical service commissioning strategic initiatives Engage with providers on transformation 	Develop detailed procurement plan <ul style="list-style-type: none"> Validate suitable procurement strategies for each product/service Develop plan to review procurement of contracts as they expire 	Shift to alternative procurement approaches and support continuous improvement <ul style="list-style-type: none"> Engage with providers to shift/renew contracts as they come to expiry, in alignment with strategic procurement plan Establish clear definition of excellence and build function to support continuous improvement (share data, support peer learning and set performance standards) ◆ Renegotiate expiring contracts		
	Develop strategy to address HTI & ESS price disparities <ul style="list-style-type: none"> Build understanding of HTI & ESS market, competitive dynamics and provider economics to inform strategy/negotiations Articulate strategic objectives and develop strategy to address HTI & ESS price disparities 		Execute HTI & ESS strategy <ul style="list-style-type: none"> Engage providers and execute strategy 		
	Scale ICP priority pathways <ul style="list-style-type: none"> Engage P&CC to shift to defined funding solution for priority pathways as ICP is scaled; Consider extending access to AEP claims managers 				
Non-clinical products & services	Decide what to start, stop, continue <ul style="list-style-type: none"> Define strategic vision and conduct start/stop/continue analysis on non-clinical product and service commissioning strategic initiatives Begin engaging providers on transformation ◆ Provider engagement	Validate priorities and develop roadmap <ul style="list-style-type: none"> Create team to lead marketplace initiative Validate priorities, identify client/kiritaki needs and preferences for each, and conduct feasibility study Develop 3yr roadmap to deploy marketplaces ◆ Marketplace plan		Develop business plan and design <ul style="list-style-type: none"> Develop comprehensive business plan for priority marketplaces outlining vision, objectives and strategies Design core marketplace features and user interface elements 	
Strategic procurement capability	Plan for and design CoE <ul style="list-style-type: none"> Clarify CoE definition, mission, vision, and align on guiding principles and scope Design CoE op. model, governance, ecosystem and performance metrics Determine op. budget/resources required 	Allocate resources and build team <ul style="list-style-type: none"> Allocate CoE budget and resources Recruit or assign team members with necessary expertise Create training plan for team members to develop required skills and knowledge ◆ CoE	Develop best practices, share knowledge and monitor performance <ul style="list-style-type: none"> Identify and document strategic procurement methodologies, tools, approaches and best practices that can be standardised across ACC Facilitate training sessions, workshops and seminars to share knowledge across ACC Continuously monitor CoE performance and adjust model and strategy accordingly 		
Provider Network Management	Plan for and establish capability <ul style="list-style-type: none"> Define role and scope of Provider Network Management function Determine operating model including resources required, and interactions with CoE, pathway design, integrity etc. 	Build team and establish frameworks <ul style="list-style-type: none"> Recruit or retrain for new capability Establish necessary frameworks for contract and performance management, benefits realisation peak body liaison and integrity analytics 	Transition model, develop best practices, share lessons and monitor performance <ul style="list-style-type: none"> Plan and commence transition of relationships, performance mgt. and contract mgt. Identify and document operational methods to underpin performance management and benefits realisation frameworks e.g., methodologies, tools, approaches and best practices for provider management Liaise with data stream to establish or adapt performance monitoring analytics 		

Enhancing data, analytics & tools | 12-month action plan

Key ◆ Illustrative milestones

Change commences	3 months	6 months	9 months	12 months
Enable P&CC to manage client/kiritaki pathways	Define use cases in current pathways <ul style="list-style-type: none"> Continue working with P&CC in current pathways (ICP, Concussion) to identify use cases to support Assess solutions with PMS providers to integrate tools in P&CC processes Expedite Concussion pathway pilot 	Design initial support tools <ul style="list-style-type: none"> Create teams with providers to develop initial decision support & screening tools Define target state tools & integrate them in the new technology roadmap Build relation & strategic pathway with the PMS sector, to identify integration of data & tools in clinical processes 	Integrate decision support tools, extend P&CC model to other pathways <ul style="list-style-type: none"> Analyse historic treatment & outcome data in current pathways with client/kiritaki complexity to identify predictors of good/bad outcomes Leverage ML models pilots to inform P&CC of high-risk clients in current pathways Use complexity data to inform definition of new pathways Integrate decision support & screening tools in clinical processes in current pathways Define clear processes & response between P&CC & ACC leveraging tools (e.g., managing different lines of treatment, escalations to ACC, ...) 	
	Support ICP go-live <ul style="list-style-type: none"> Automate PRM & outcome data collection & reporting for ICP go-live Create teams including sector bodies to define culturally appropriate PRMs in current pathways & prepare provider adoption 	Define PRMs & data roadmap <ul style="list-style-type: none"> Identify key client journeys in which to start recording PRMs & other data Create cross-functional ACC, external teams to support the scale-up of PRMs Incorporate learnings from ICP, pilots to include PRMs solutions within the updated technology roadmap 	Integrate PRMs into providers PMS & start informing treatment decisions <ul style="list-style-type: none"> Integrate automatic PRM collection & recording in additional pathways/treatments (e.g., Concussion pathway) leveraging existing tools where possible Leverage ICP learnings thus far, global examples to define best practices (e.g., integrating in providers' PMS, ensuring high response rate) Continue providers engagement to make sure PRMs and other data are leveraged effectively in clinical processes Define solutions to provide visibility of PRMs & progress along the pathway to clients 	
Create analytics to manage outliers, support cont. improvement	Define measuring, benchmarking priorities <ul style="list-style-type: none"> Define for which injuries to start screening outliers, and what data to use Define priority areas & initial data to be used for providers benchmarking Initiate provider discussions 	Initiate providers benchmarking <ul style="list-style-type: none"> Define guardrails & processes to act on identified outliers in priority injuries Create ACC team & initiate benchmarking on identified priorities Include required tools/solutions in the updated technology roadmap 	Measure & act on variation, ensure continuous improvement <ul style="list-style-type: none"> Create clear processes with responsible ACC teams to measure & act on client/kiritaki variation; automate variation measuring & include new outcome data (e.g., PRMs) Integrate complexity, PRMs, client/kiritaki defined targets and clinical outcomes into providers benchmarking and define what good looks like Initiate cycles of discussions with providers and refine benchmarking accordingly Use data along current pathways and priority injuries to identify best practices 	
	Decide what to keep, stop, start <ul style="list-style-type: none"> Assess implications of the TCM on current core systems¹ Conduct keep/stop/start analysis on current core systems & reporting tools Seek legal advice on the secondary use data, Māori data sovereignty, privacy 	Define the new Technology roadmap <ul style="list-style-type: none"> Replan tech & investment roadmap, incl. implications on insurance management, integrated reporting, benefits model, data governance, privacy and security 	Establish analytics and digital build capability to support change, progress on roadmap <ul style="list-style-type: none"> Establish analytical capability & teams to enable ACC's role in this transition and progress on defined roadmap 	◆ New Tech. roadmap

1. Incl. Next Gen Case Mgt., Principal Client Record, EOS, MyACC, BusinessPartnersHub




Working with Health New Zealand/Te Whatu Ora | 12-month action plan

Key ◆ Illustrative milestones

	Change commences	3 months	6 months	9 months	12 months	
Establish strategic alignment with Health NZ senior leadership & sequence work	Align on shared client/kiritaki pathways	Enhance early notification procedures <ul style="list-style-type: none"> Establish early buy-in from Health New Zealand clinicians and ACC leadership Improve early notification procedures for complex fractures, spinal cord and traumatic brain injuries to align with clinical processes Support Health NZ development to ensure timely and comprehensive early notifications/referral; enable sharing of comprehensive injury input data Enable HIRA to securely share client/kiritaki identification and history data (NMDS) Understand services required in selected injury pathway to enable design 		Involve Health New Zealand/Te Whatu Ora in pathway design, operationalise <ul style="list-style-type: none"> Operationalise functional pathway team within ACC (incl. contract and relationship mgmt.) Establish expectations with Health NZ for clients/kiritaki in identified injury pathways Develop a clinical and case management team to create plans from initial client interaction Start test-and-learn model for client/kiritaki pathways Develop a platform for collaborative pathway input and management Develop view on good long-term care practice, including subsequent services to refer into Share back data and outcomes with Health New Zealand to drive continuous improvement 		
		Engage with Pharmac <ul style="list-style-type: none"> Ascertain legal position of accessing Pharmac contract from third party (incl. Commerce Act considerations) Engage with Pharmac to determine access for ACC providers to the national contract or pricing only Setup joint governance process with Health New Zealand/Te Whatu Ora as required Develop external narrative to ensure buy-in from providers and wider NZ 		Implement contract changes, monitor outcomes <ul style="list-style-type: none"> Implement the changes to existing elective surgery contracts Monitor the changes and measure outcomes, utilisation, unintended consequences etc. 		
	Invest in shared capacity in underserved markets	Understand and align on combined capacity issues <ul style="list-style-type: none"> Understand the current deficit and future demand of surgical and high-tech imaging facilities Involve Health New Zealand/Te Whatu Ora in prioritisation of additional capacity opportunities based on value/returns 		Build and implement investment/procurement plan <ul style="list-style-type: none"> Determine best mechanism of coordination in accessing additional capacity Develop the business case to jointly procure services from the private sector or co-invest in new capacity Develop and execute implementation plan 		
		Support capturing of current trauma data set <ul style="list-style-type: none"> Support completion of National Trauma Network data sharing agreement Analyse retrospective data to understand data gaps Provide input with Health New Zealand/Te Whatu Ora into preferred outcome measures which would inform client/kiritaki pathway improvements 		Future-proof data sharing agreement, enable process improvement <ul style="list-style-type: none"> Engage with Health NZ/Te Whatu Ora and National Trauma Network to set outcome standards, perform regular analysis, and provide guidance on pathway improvements Agree on process to enable identified improvements to shape future pathways Engage with Health NZ/Te Whatu Ora to identify a strategy which ensures ongoing data sharing with ACC (e.g., migration of the trauma registry into a clinical quality registry) 		

Operating Model | 12-month action plan


Key  Illustrative milestones



Change commences	3 months	6 months	9 months	12 months
Sector Engagement & Partnership	Plan provider relations <ul style="list-style-type: none"> Detail the transition plan for interim provider related interactions including stop/start/continue Plan and detail the future state realignment of supplier and provider relations activities and channels Seek legal advice on more devolved model, automation, and auditing Assess current CRM against support required in the future state 	Revise provider processes <ul style="list-style-type: none"> Reset provider and peak interaction norms per transition plan Plan for PHO analysis and P&CC navigation resourcing model Revise risk management approaches and tolerances to reflect an exception-based approach Assess cyber security and resilience approach for shared sector data assets  <p>Provider Relations Realignment</p>	Test and refine engagement model <ul style="list-style-type: none"> Test and refine the operating model supporting the pathway co-design launch Redesign the organisational structure and required capabilities Assess scenarios of policy, regulation and legislation change for organisational resilience Optimise the CRM and provider and network relationship management coordination processes Detail and develop investment cases for the option set of permanent future state functions e.g., lesson sharing mechanism, peak body collaborations, clinical registry funding 	
Shared services enablement	Assess Shared Services model <ul style="list-style-type: none"> Socialise the TCM and strategic narrative of change Assess the impacts of the change on each shared service function and plan for internal service model Liaise with MSP and Health NZ/Te Whatu Ora; align ACC contribution to the SSCAP with target commissioning model Seek legal advice on Commerce Act exemption 	Detail shared services design <ul style="list-style-type: none"> Detail the shared services support model, resource allocation and service levels; consider the resourcing implications of Service Delivery Team Establish necessary tools, templates and processes Plan for realignment of resources Align governance, finance and delegations framework with the range of strategic procurement levers 	Transition shared services support <ul style="list-style-type: none"> Commence transition to new shared service model for: People & Culture, Finance, Commercial & Legal, Intergovernmental affairs, Actuarial, Legislation, Analytics etc. Align funding, governance (executive oversight and risk management) to drive collaboration and business partnering from shared services Redesign the organisational structure and required capabilities <p> Shared Services realignment</p>	
Change & Governance redesign	Establish change program <ul style="list-style-type: none"> Develop strategic narrative for change Establish activist PMO Conduct stop/start/continue of current change portfolio and roadmaps Align with Health New Zealand/Te Whatu Ora, MSD, etc. on change agenda and potential areas of collaboration  <p>Change portfolio locked</p>	Build PMO processes and tools <ul style="list-style-type: none"> Build PMO standards, tools, escalations, routines for change initiatives, and portfolio wide roadmaps and benefits tracking Define new governance framework 	Transition to revitalised governance <ul style="list-style-type: none"> Establish Health New Zealand/Te Whatu Ora, MSD etc. shared cascade mechanisms for collaboration on shared priorities Establish executive governance enablement program including executive coaching Revise the delegations and responsibilities framework as required 	

Action plan supporting detail

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

Target Commissioning Model | 12-month action plan

Key  Illustrative milestones

Change commences	3 months	6 months	9 months	12 months
Business Case development	Develop business case <ul style="list-style-type: none"> Develop the change business case with disciplined investment logic Detail the investments required within ACC and within the sector to activate the change Determine and schedule the required critical governance path for ratification and approval 	Ratify and Approve <ul style="list-style-type: none"> Navigate required ratification and approval governance stages Establish benefits management approach and required infrastructure <p style="text-align: center;"> Business Case Approved</p>	Monitor performance to and alignment with business case <ul style="list-style-type: none"> Translate business case investment and governance rationale into the operational design e.g., governance bodies, risk frameworks, financial management, benefits management 	
Strategic change narrative development	Develop change narrative for ACC & Govt <ul style="list-style-type: none"> Develop the strategic change narrative for internal ACC change, building on previous work e.g., ICP, RIG, Māori-led design Detail the inter-governmental strategic narrative including Health New Zealand/Te Whatu Ora, MSD, MOH Activate ACC leaders as visible champions of change 	Develop change narrative for the system <ul style="list-style-type: none"> Design the external strategic change narrative for the clinical and non-clinical sector Align external communications around the new strategic change narrative 	Champion and remain aligned to the narrative <ul style="list-style-type: none"> Communicate the narrative through all channels and interactions Return to the narrative to remain aligned with its purpose 	
Implementation and delivery plan	Detail the delivery plan <ul style="list-style-type: none"> Detail the delivery plan including sequencing approach Assess current change portfolio for what to stop/start/continue 	Develop implementation infrastructure <ul style="list-style-type: none"> Establish or align to delivery governance mechanisms and benefits realisation plan Establish Program Office and change management capability <p style="text-align: center;"> Delivery Plan approved</p>	Ongoing implementation and delivery <ul style="list-style-type: none"> Deliver to plan with executional certainty 	

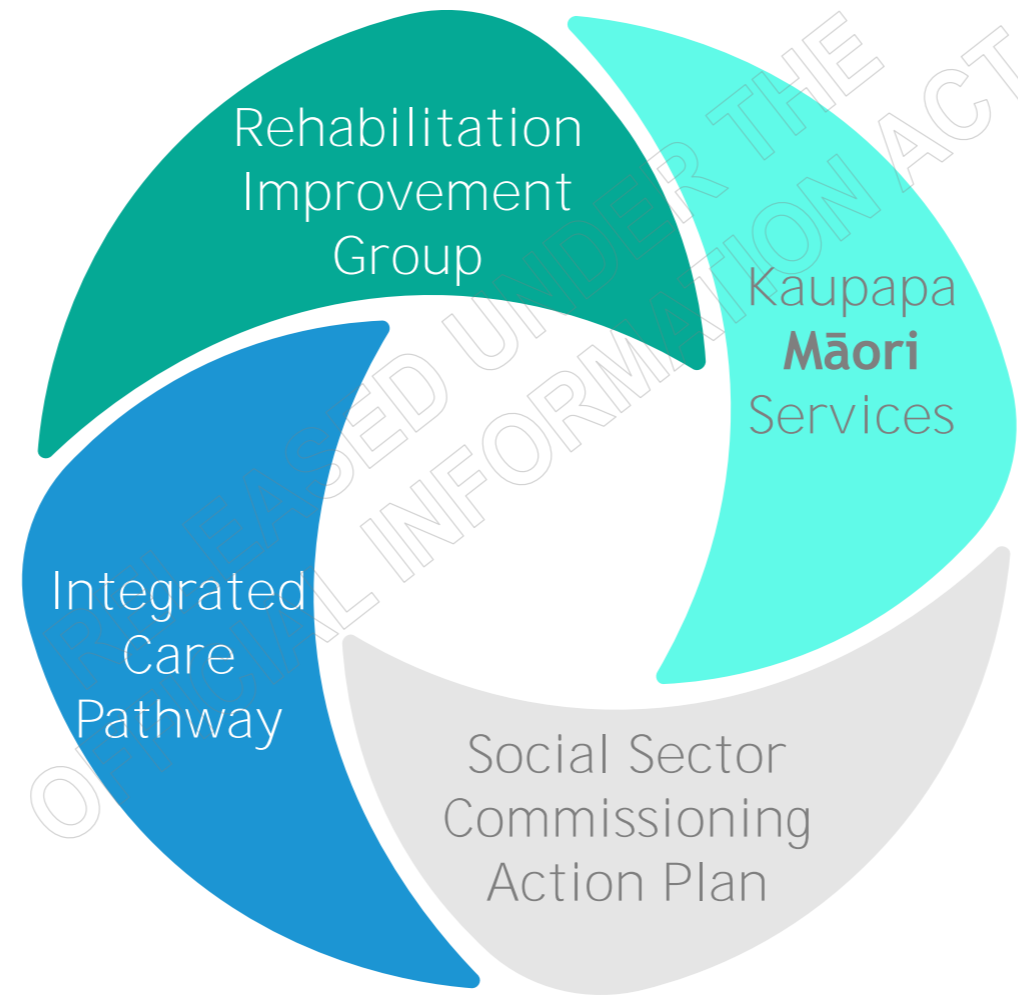
TCM is consistent with other efforts though requires concerted effort to align, prioritise and sequence change

Consistencies:

- Aligning the future direction of ACC role to support system coordination
- Planning integrated client/kiritaki journeys incorporating multi-disciplinary teams
- Incorporating outcome measures and transparency to drive care decisions and performance improvement

Consistencies:

- Utilising bundles of care as one useful approach to journey implementation
- Focusing on consistent, interoperable data collection from all providers along the journey
- Providing flexibility to those closest to the client/kiritaki to manage care, while monitoring outcomes and variation



Consistencies:




- Empowering teams closest to the client/kiritaki to develop pathways supported by ACC data, insights, benchmarking, environmental scans and scheme design considerations
- Measuring service performance by the outcomes that matter most to kiritaki/client and whānau

Consistencies:

- Grounding all work in the needs and outcome goals of our clients/kiritaki
- Prioritising trusted relationships between commissioners and providers with clear accountabilities
- Increasing communication from Crown entities to the sector on strategic direction and openness to co-design

Journey co-design | 12-month action plan

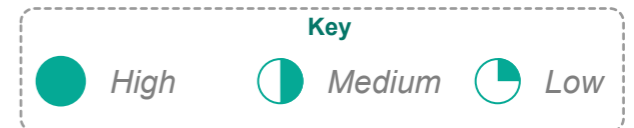
Key  Illustrative milestones

	Change commences	3 months	6 months	9 months	12 months
Variation based prioritisation	<p>Validate tranche 1 journeys</p> <ul style="list-style-type: none"> Review and validate prioritisation data, aligning on tranche 1 Conduct Viability and Feasibility assessment including assessing current contract position <p> Tranche 1 agreed</p>	<p>Build prioritisation methodology</p> <ul style="list-style-type: none"> Establish ongoing prioritisation framework Define permanent data architecture approach to transform data from claims to journeys 	<p>Prioritise</p> <ul style="list-style-type: none"> Embed ongoing prioritisation approach to iteratively build out subsequent tranches 		
Co-design approach & capability	<p>Develop co-design infrastructure</p> <ul style="list-style-type: none"> Stand up core team of Pathway Designers as interim team Consult with peak bodies on direction of travel Establish co-design and improvement infrastructure and processes, learning from RIG, ICP, ISSC, Māori-led design 	<p>Prepare for co-design</p> <ul style="list-style-type: none"> Detail the co-design methodology Articulate the change narrative and communicate that to the sector Align governance, accountabilities and delegations to empower design Seek and onboard participants from the sector for the Pathway Design teams Assess Channel Strategy to clarify contacts and escalation points 	<p>Commence journey co-design tranche 1</p> <ul style="list-style-type: none"> Commence tranche 1 of journey designs (4 Journeys) including participant selection, international practice research, current state system analytics, co-design workshops Consult sector wide on the strategic narrative for changes including employers and AEP claims managers Develop long term tranche plan to address all journeys Consult with Iwi on the pending changes and the interactions with Kaupapa Māori service design <p> Co-design commences</p>		
Primary & Community Care role transition	<p>Design initial approach for P&CC role</p> <ul style="list-style-type: none"> Stand up interim ACC team to lead the discovery, design and implementation Scenario plan for support and funding models to catalyse P&CC, including COTR changes Consult with peak P&CC bodies & PHOs on the proposed model, plan wider consultation approach Consult with PMS vendors on the roadmap and areas of focus 	<p>Detailed Design of P&CC role</p> <ul style="list-style-type: none"> Detail design of funding and contracting model to build capacity and capability in the sector, including COTR changes Lead wider sector consultation specifically including HCH and GP chains, in partnership with the peaks Prioritise data and systems investment roadmaps 	<p>Plan implementation for P&CC role change</p> <ul style="list-style-type: none"> Assess Practice resource and capability variation and implications for implementation planning Align P&CC role transition with Journey Design timelines Reinforce & reskill a small capability of highly skilled case managers for exception-based cases of the future state Launch new P&CC role where aligned to specific parallel efforts e.g., ICP scaling <p> Initial launches commence</p>		

In this transition, ACC can prioritise pathways with high spend, high outcomes variation, modifiable outcomes and high use of Primary & Community Care

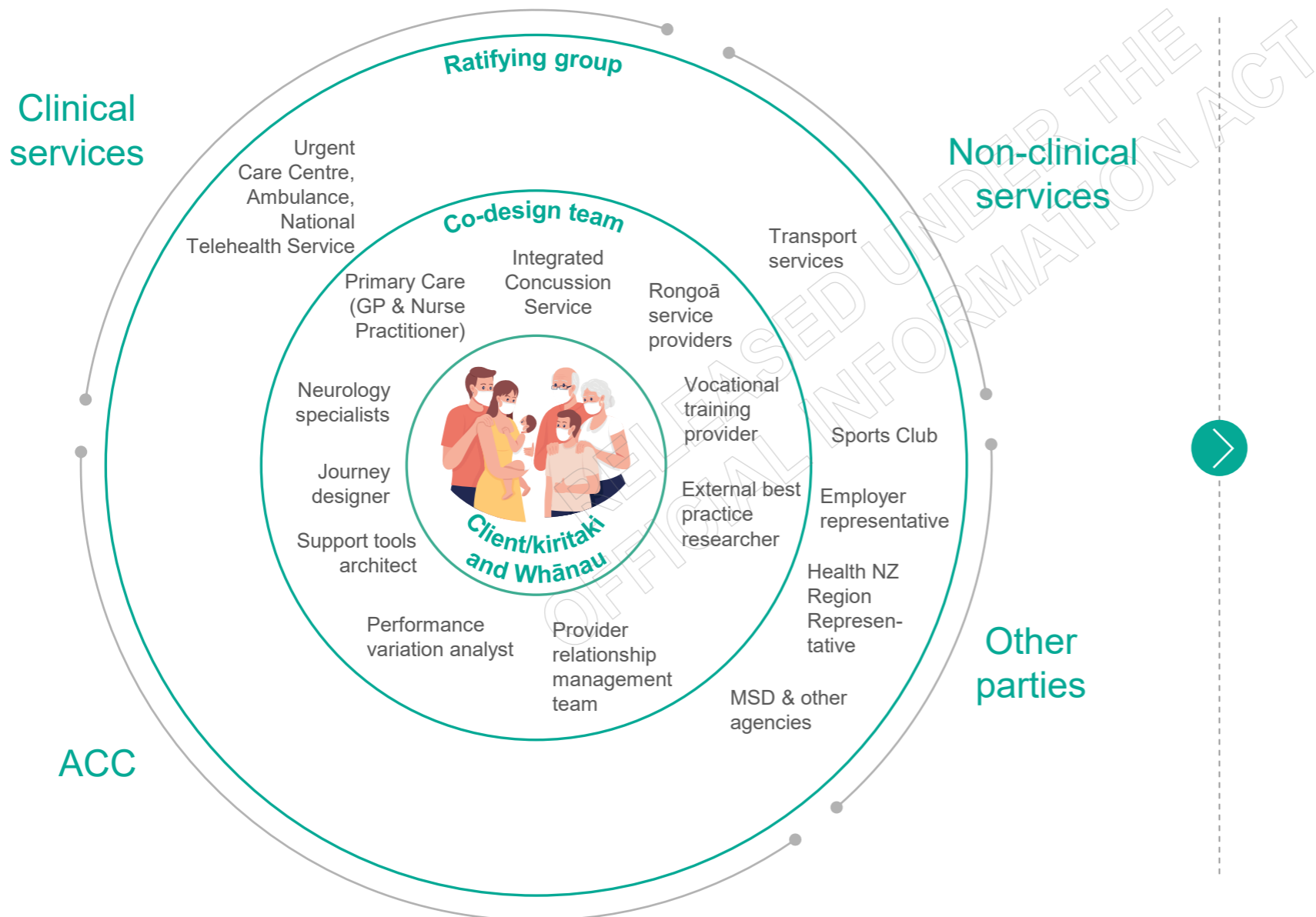
ID	Pathway	Cumulative Spend %	FY23 Spend (\$Mn)	Outcomes variation ¹	Modifiable outcomes ²	P&CC use ²	Comments
1	Non-surgical MSK with recurrent incidents	24%	1258	98%			<ul style="list-style-type: none"> Highest spend pathway, high outcomes variation, modifiable outcomes and high P&CC use Includes lumbar, neck, shoulder and ankle sprains
2	Moderate complexity MSK where causation is unclear	28%	185	91%			<ul style="list-style-type: none"> High variation, modifiable outcomes and high P&CC use Integration with providers underway with ICP
3	Concussion + Mild TBI	31%	190	84%			<ul style="list-style-type: none"> High variation, modifiable outcomes and high P&CC use Concussion pathway currently in pilot
4	Moderate to high complexity MSK with no cover issues	35%	222	108%			<ul style="list-style-type: none"> High variation and modifiable outcomes, with lower P&CC use Integration with providers underway with IC
5	Fractures & dislocations	50%	776	81%			<ul style="list-style-type: none"> High spend and modifiable outcomes, with lower P&CC use
6	Sensitive claims	55%	249	74%			<ul style="list-style-type: none"> Medium spend and outcomes variation Workforce shortages (e.g., counsellors) to be considered in prioritisation
7	Serious injuries	72%	878	57%			<ul style="list-style-type: none"> High spend, medium outcomes variation³
8	Pain syndromes	72%	24	95%			<ul style="list-style-type: none"> High outcomes variation, low spend

Note: alignment of sequencing with Māori-led service design should be considered in validation phase; 1. Measured as relative variation (absolute standard deviation/Mean) of time on Weekly Compensation for finished claims; 2. Qualitative measured based on discussions with ACC clinical advisors; 3. Due to the nature of the injury, people often stay on WC for longer periods & with lower variation



ACC will lead the co-design of pathways; bringing together perspectives of Primary and community care, clinical providers, non-clinical providers, clients/kiritaki and **whānau**

Illustrative for Concussion and mild TBI



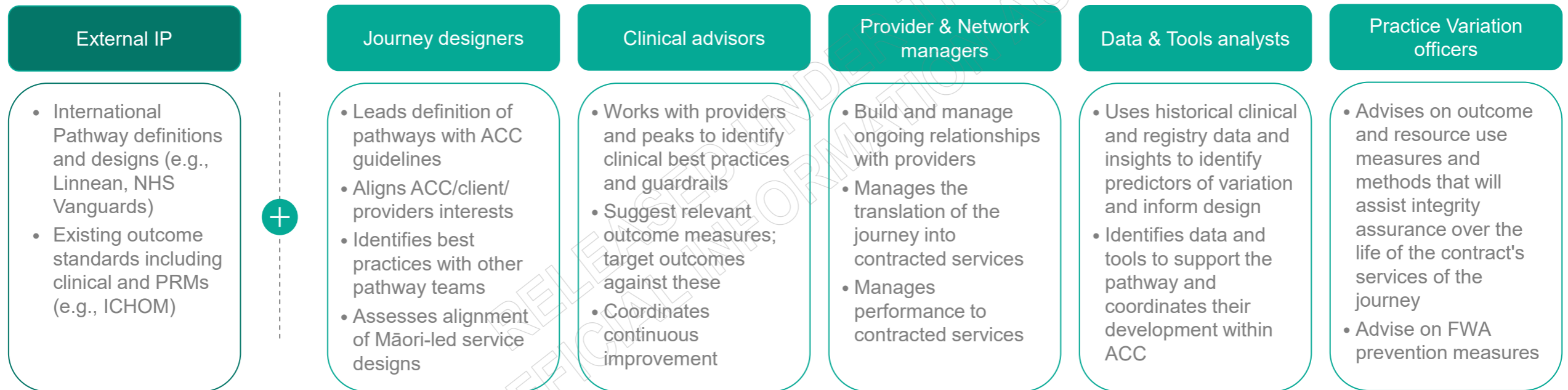
Collective expertise and insight

- International practice exemplars and protocols
- Lived experience of the journey
- System level insight on outcomes and resource use
- Clinical expertise of the medical issues
- Culturally inclusive service design and delivery experience
- Rehabilitation expertise on the return-to-work journey

ACC must bring international best practices and a cross-functional team to support these pathway design groups

Design phase: define pathways with multi-disciplinary teams and leveraging external IP

Potential roles for one team defining one client/kiritaki pathway



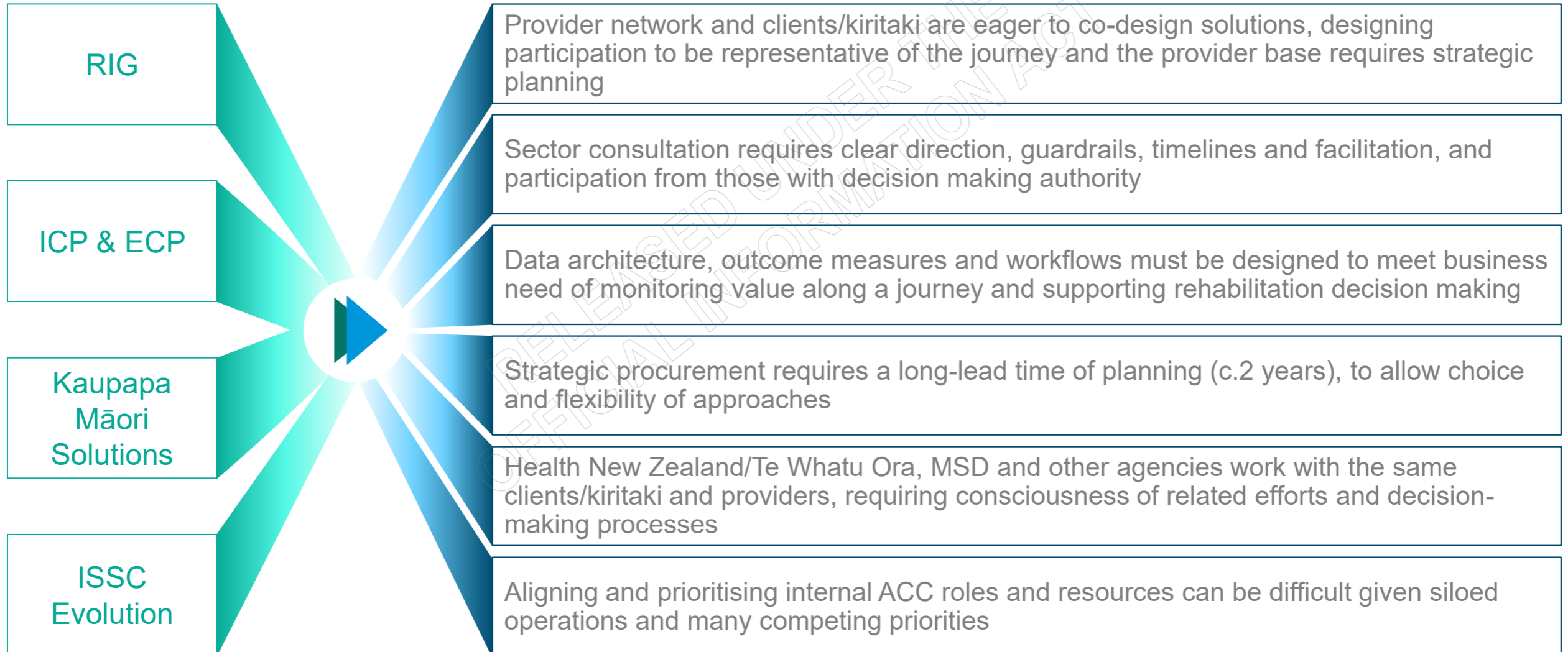
System monitoring phase: Ensure continuous improvement on the defined pathways

Once pathways are defined, the Journey Team should regularly evaluate system performance to **ensure drive continuous improvement**

The Journey team will need to make key choices; and ACC will need to plan the corresponding strategic commissioning approach

	Set up	Pathway Design Phase	System Monitoring Phase
Co-Design Team	<ul style="list-style-type: none"> Who should Co-Chair? Who must co-design vs. ratify? What efforts are in-progress across the wider system? 	<ul style="list-style-type: none"> Which services are core to this journey? What sequence/duration? Where will value be obtained from learnings? What tools would support decision making? Care escalation? E.g., newly built or refining and scaling existing tools What complexity and comorbidity data is required to identify risk? Which client/kiritaki types are indicated for journey variations? E.g., co-morbidities, ethnicity or cultural background, geography, employment type, etc. What measures will be used for journey monitoring and improvement? How are they captured in the workflow? What are measure targets? E.g., PRMs, Clinical outcomes, vocational readiness, time to return-to-work, resource use How aligned is the current provider market to deliver these services? 	<ul style="list-style-type: none"> What are sources of outcome and resource use variation? Are these modifiable? What unintended consequences need to be addressed? E.g., demand shifting, delays to care, unmet need How to scale and embed high performing practice? What pathway adaptations would create value?
ACC	<ul style="list-style-type: none"> What analysis will make design efficient and action-oriented? How will pathways interact with others (overlapping providers, clients, business partners)? 	<ul style="list-style-type: none"> Which commissioning models best stimulate markets to provide services in this journey context? What commercial mechanisms adequately share risk for clinical and return-to-work outcomes? What integrity/performance management mechanisms will guardrail expected behaviour? Are the objectives of Huakina Te Rā being met? 	<ul style="list-style-type: none"> What incentives are required to accelerate improvement? What requires intervention for fraud, waste and abuse? How are employers and employment outcomes responding?

ACC approaches to date have provided lessons on journey and pathway co-design approaches, shaping the future state design



Investing in Primary & Community Care, including Kaupapa services, to navigate pathways is key to building their capability and capacity to deliver this new role

Provide annual pre-payment for all rehabilitation navigation for all enrolled clients/kiritaki

ACC pays an annual fee to compensate practices for all navigation and primary and community care services for their enrolled population. Navigation bundles established for New Zealanders and visitors without a registered Primary Care team, and those attending practices other than their registered practice

Preferred; pending P&CC consultation

Use lump sum payments to provide certainty, underpinning resource investment and growth

ACC pays an upfront, lump sum based on pathway type, to support P&CC to navigate the agreed pathways, deliver primary and community care services of the pathways, utilise ACC support tools, and share data back into the system for continuous improvement

Continue fee-for-service and add navigation service items

ACC and providers retain a fee-for-service model for every navigation or primary and community care service; must include mechanism (funding or service condition) to encourage ACC tools and provide data

All funding models allow for the addition of outcome-based bonus and/or malice payments for Primary & Community Care to align incentives e.g., recovery-at-work

Advantages:

- Provides greatest certainty of income for Primary and Community Care to invest in support resources within their practice
- Promotes preventative measures and cost-efficient use of clinical resources and reduces overservicing

Disadvantages:

- Risk of care rationing unless outcomes measurement is part of payment and performance management structure
- Add complexity of payment administration and equity risks for those who are unregistered (74% Māori), visiting or attending outside their registered practice

Advantages:

- Increases certainty of income for Primary and Community Care to invest in support resources within their practice
- Promotes cost-efficient use of clinical resources and reduces overservicing

Disadvantages:

- Risk of care rationing unless outcomes measurement is part of payment and performance management structure

Advantages:

- Simplest transition, allowing focus on pathway approach and supporting tools and data

Disadvantages:

- Providers incentivised to see a single client/kiritaki multiple times, possible overservicing
- Providers not able to capacity plan as effectively as capitated funding

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

Non-clinical services | ACC can build and operate a platform, outsource the build and operations, or outsource the first build and then transition in-house

	Building & operating a platform in-house allows ACC to maintain direct control and maximum flexibility	Outsourcing build & operations allows ACC to benefit from external capabilities and focus on safeguarding markets	Outsourcing first build and then transitioning in-house allows ACC to benefit from external expertise before obtaining direct control
Role of ACC	<ul style="list-style-type: none"> • Build platform in-house and ensure compliance with regulation, and data security and privacy standards • Vet potential providers based on quality and safety standards, and onboard providers • Set and manage transparent and competitive pricing structure • Promote and educate clients on platform use • Monitor provider performance, gather client feedback and establish star rating system • Collect and analyse data to gain insights on client/kiritaki behaviour and experience • Address user issues, concerns or inquiries • Enforce safety and quality standards, and undertake disciplinary action as needed 	<ul style="list-style-type: none"> • Outsource build and day-to-day operations to 3rd party • Establish policy for provider selection, pricing management, and quality & safety standards and assurance • Manage any issues requiring direct ACC intervention • Set strategic direction and work with outsourcing partner to align day-to-day operations with strategy • Promote platform and educate clients/kiritaki on use • Receive and act upon data reports and analysis 	<ul style="list-style-type: none"> • Outsource first build and operations to 3rd party while establishing policies, setting strategic direction, promoting platform, etc. • Build capabilities and transition in-house, undertaking full responsibility of build and operations e.g., vet potential providers, set and manage pricing, etc.
Considerations	<ul style="list-style-type: none"> • Allows ACC to maintain direct control and full flexibility over all aspects of platform, in cost effective manner • Requires strong capability build • Unlikely to find ready-made solution or white label product, but most capabilities required available off-the-shelf (via PaaS, SaaS, etc.) 	<ul style="list-style-type: none"> • Avoids overextending ACC's scope and capabilities • Allows ACC to maintain governance and policy control while benefitting from external expertise • Creates 3rd party intermediary between ACC and clients/kiritaki 	<ul style="list-style-type: none"> • Allows ACC to initially benefit from external expertise, and creates time and space to develop required in-house capabilities • Enables direct control and full flexibility over platform once transfer complete

Non-clinical services | ACC can stimulate supply, particularly in thin markets, by engaging providers and establishing a capability build team

Engage providers to encourage participation & success on marketplace

- **Conduct research to identify gaps** and unmet needs in market, and actively engage providers to create transparency about opportunities
- **Provide support and training** to educate providers on using platform
- **Collect and share data** on user behaviour, and ratings & feedback from clients/kiritaki to support provider continuous improvement
- **Collect and act on feedback** from providers on marketplace platform, policies and procedures

Establish a capability build team dedicated to SMEs in underserved areas

- **Provide training and resources** in areas where SMEs may lack skills or knowledge
- **Offer feedback and guidance** on performance and compliance with safety and quality standards
- **Organise forums or pair experienced providers with SMEs** to facilitate peer learning and best practice sharing

[s 9(2)(j)]

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

Priorities | **Comprehensive** understanding of market and supplier landscape is key to inform choice of path and to define detailed procurement strategy

Illustrative questions to build clear understanding of market and supplier landscape

Market overview & trends

Run research on key market trends/dynamics and identify growth patterns:

- How big is the supply market and by how much is it growing or declining?
- Who are the main buyers in the market?
- Is the market geographically homogeneous?
- Is the product or service a commodity or a specialty product or service?
- What are recent and expected industry trends?

Cost structure

Define the cost structure and cost drivers:

- What are the main elements of the suppliers' cost structure (e.g., salaries, equipment)?
- What factors are driving these cost elements?
- How high are supplier margins?

Competitive analysis

Understand the impact of internal and external factors in shaping market dynamics:

- How much leverage do suppliers have in setting prices and terms?
- How much influence do buyers have in negotiating prices and terms?
- Are there entry barriers for new suppliers?
- Are there any substitutes for the product or service?



Supplier analysis

Review existing suppliers, compare them with top suppliers in the market and identify new entrants

- Who are your current suppliers?
- Which other suppliers are available (new and upcoming or established)?
- Can you consider suppliers abroad?
- What is the geographic reach of suppliers?

Enhancing data, analytics & tools | 12-month action plan

Key  Illustrative milestones

Change commences	3 months	6 months	9 months	12 months
Enable P&CC to manage client/kiritaki pathways	Define use cases in current pathways <ul style="list-style-type: none"> Continue working with P&CC in current pathways (ICP, Concussion) to identify use cases to support Assess solutions with PMS providers to integrate tools in P&CC processes Expedite Concussion pathway pilot 	Design initial support tools <ul style="list-style-type: none"> Create teams with providers to develop initial decision support & screening tools Define target state tools & integrate them in the new technology roadmap Build relation & strategic pathway with the PMS sector, to identify integration of data & tools in clinical processes 	Integrate decision support tools, extend P&CC model to other pathways <ul style="list-style-type: none"> Analyse historic treatment & outcome data in current pathways with client/kiritaki complexity to identify predictors of good/bad outcomes Leverage ML models pilots to inform P&CC of high-risk clients in current pathways Use complexity data to inform definition of new pathways Integrate decision support & screening tools in clinical processes in current pathways Define clear processes & response between P&CC & ACC leveraging tools (e.g., managing different lines of treatment, escalations to ACC, ...) 	 Define new pathways
Enable clients & clinicians to use PRMs to inform treat. decisions	Support ICP go-live <ul style="list-style-type: none"> Automate PRM & outcome data collection & reporting for ICP go-live Create teams including sector bodies to define culturally appropriate PRMs in current pathways & prepare provider adoption 	Define PRMs & data roadmap <ul style="list-style-type: none"> Identify key client journeys in which to start recording PRMs & other data Create cross-functional ACC, external teams to support the scale-up of PRMs Incorporate learnings from ICP, pilots to include PRMs solutions within the updated technology roadmap 	Integrate PRMs into providers PMS & start informing treatment decisions <ul style="list-style-type: none"> Integrate automatic PRM collection & recording in additional pathways/treatments (e.g., Concussion pathway) leveraging existing tools where possible Leverage ICP learnings thus far, global examples to define best practices (e.g., integrating in providers' PMS, ensuring high response rate) Continue providers engagement to make sure PRMs and other data are leveraged effectively in clinical processes Define solutions to provide visibility of PRMs & progress along the pathway to clients 	
Create analytics to manage outliers, support cont. improvement	Define measuring, benchmarking priorities <ul style="list-style-type: none"> Define for which injuries to start screening outliers, and what data to use Define priority areas & initial data to be used for providers benchmarking Initiate provider discussions 	Initiate providers benchmarking <ul style="list-style-type: none"> Define guardrails & processes to act on identified outliers in priority injuries Create ACC team & initiate benchmarking on identified priorities Include required tools/solutions in the updated technology roadmap 	Measure & act on variation, ensure continuous improvement <ul style="list-style-type: none"> Create clear processes with responsible ACC teams to measure & act on client/kiritaki variation; automate variation measuring & include new outcome data (e.g., PRMs) Integrate complexity, PRMs, client/kiritaki defined targets and clinical outcomes into providers benchmarking and define what good looks like Initiate cycles of discussions with providers and refine benchmarking accordingly Use data along current pathways & priority injuries to identify best practices 	
Assess implications on current core systems & align roadmap	Decide what to keep, stop, start <ul style="list-style-type: none"> Assess implications of the TCM on current core systems¹ Conduct keep/stop/start analysis on current core systems & reporting tools Seek legal advice on the secondary use data, Māori data sovereignty, privacy 	Define the new Technology roadmap <ul style="list-style-type: none"> Replan tech & investment roadmap, incl. implications on insurance management, integrated reporting, benefits model, data governance, privacy and security 	 New Tech. roadmap	Establish analytics and digital build capability to support change, progress on roadmap <ul style="list-style-type: none"> Establish analytical capability & teams to enable ACC's role in this transition and progress on defined roadmap

Deep dive | Enable Primary & Community Care to manage client/kiritaki pathways

End state target

Primary & Community Care refers clients/kiritaki on care pathways co-defined with ACC basis diagnosis, client/kiritaki complexity and client/kiritaki preferences leveraging decision tools co-developed with ACC

Primary & Community Care reports pathway allocation, diagnosis, and treatments to ACC, clinical providers

Primary & Community Care approves clinical and non-clinical products & services within the pathway (within limits defined by ACC)

Primary & Community Care screens clients/kiritaki along the pathway with tools developed by ACC, manages client/kiritaki deviations from the pathway (incl. escalations to ACC) and different lines of treatment

Data, Analytical capabilities & Tools/solutions required to reach the end state

Data

- ☆ **Diagnosis, treatment and outcome data:** (e.g., time on WC, re-injury) already collected by ACC, to test pathways efficacy & identify early predictors of good/bad outcomes
 - **Client/kiritaki history, co-morbidities and psychosocial factors:** used by P&CC to define client/kiritaki complexity, leveraging decision tools co-developed with ACC
 - **External client/kiritaki data** (e.g., trauma registries, HIRA) for further client/kiritaki knowledge, shared pathways¹

Analytical capabilities

- ☆ **Use treatment, outcome data to identify services/best practices leading to good outcomes & inform pathways definition**
 - Identify early predictors of good/bad outcomes (e.g., using machine learning)
 - Define pathway limits within which P&CC can directly approve services
 - Risk-stratify clients/kiritaki using P&CC data & identify pathway variations for high-risk
 - Screen clients/kiritaki to identify variations from client/kiritaki pathways and recommend a different line of treatment/escalation
 - Analyses should fit into replicable processes & ownership by ACC teams (e.g., multi-functional teams to support pathways)

Tools / solutions

- ☆ **Risk stratification and decision support tools for P&CC to allocate clients/kiritaki on pathways, manage lines of treatment leveraging ACC analyses, integrated in clinical processes**
 - Screening tools and clear action guidelines for Primary & Community Care to identify client/kiritaki deviations, integrated in clinical processes
 - Data sharing solutions from P&CC to ACC (e.g., diagnosis, pathway allocation, treatment data) and clinical partners (e.g., diagnosis, pathway)
 - Notification solutions/data sharing from Health NZ/Te Whatu Ora to enable shared pathways¹

☆ Can start executing with current data

1. See section on working with Health New Zealand/Te Whatu Ora

Deep dive | Enable client/kiritaki & clinicians to use PRMs to inform treatment decisions

End state target

ACC and providers use PRMs, clinical outcome measures and client/kiritaki defined targets to jointly define clear best practices and guidelines for clinicians to follow along client/kiritaki pathways

Clinicians leverage defined guidelines and provide treatment along the pathway allocated by Primary & Community Care

Clinicians collect and leverage PRMs, client/kiritaki defined targets and clinical outcome measures co-defined with ACC to inform treatment decisions

Clinicians report treatment, Patient Reported Measures, client/kiritaki defined targets and clinical outcome data to ACC and Primary & Community Care

Clients/kiritaki can see the pathway defined for them, review their progress on PRMs, targets and clinical outcomes, and compare with other clients/kiritaki in the same pathway

Data, Analytical capabilities & Tools/solutions required to reach the end state

Data

- ☆ **PRMs, RTW outcomes, clinical outcome measures** from ICP pilots and trauma registries to test clinical treatment efficacy and identify early predictors
 - **Patient Reported Measures** to inform treatment decisions around client/kiritaki priorities. Develop culturally relevant PRMs for Māori and priority populations (e.g., aligned with the 4 aspects of wellbeing¹). ACC can leverage global IP in identifying target PRMs
 - **Clinical outcome measures and Patient Defined Targets** to test treatment efficacy alongside pathway – measures to be co-designed by ACC, clients/kiritaki and providers

Analytical capabilities

- ☆ **Use PRMs, clinical outcome data and existing treatment/outcome data to inform pathways definition**
 - Use PRMs, clinical outcome data and client/kiritaki defined targets to inform treatment decisions along pathways
 - Definition of 'what good looks like' for defined measures
 - Analyses should fit into replicable processes and ownership by ACC teams (e.g., multi-functional team to support select pathways)

Tools / solutions

- ☆ **Decision support tool for clinicians to leverage PRMs to inform treatment decisions**
 - Data sharing solution to receive referrals and pathway guidance from P&CC
 - Data collection solution integrated in P&CC and clinicians' PMS to ensure sufficient and high-quality data collection (to be defined with PMS providers leveraging ICP pilots)
 - Data sharing solutions to share data to ACC and other providers (including non-clinical) e.g., RTW provider, employer
 - Client-facing solution to see progress on defined pathways & PRM/targets

- ☆ **Can start executing with current data**

Deep dive | Create analytics to manage outliers, support continuous improvement

End state target

ACC leads pathways definition (receiving inputs and discussing with providers); ensures continuous improvement

ACC overviews client/kiritaki outcomes along pathways and providers, engages with providers in case of significant variation

ACC acts as last resort case management when client/kiritaki fall outside pathway guidelines and P&CC has already intervened

ACC approves clinical and non-clinical treatments beyond pathway limits

ACC provides transparent providers performance benchmarks (including client/kiritaki complexity) and enables discussions to ensure continuous improvement

Data, Analytical capabilities & Tools/solutions required to reach the end state

Data

- ☆ **Diagnosis, treatment & outcome data** already collected by ACC; to test pathways efficacy and identify early predictors of variation (targeting high impact moments e.g., <7m rehab)
 - **Pathway allocation** from Primary & Community Care
 - **Patient Reported Measures, patient defined targets** from Primary and Community Care, Clinicians
 - **Clinical outcome measures** from Clinicians
 - **Treatment & spend data** from non-clinical marketplaces

Analytical capabilities

- ☆ Pathways co-design leveraging treatment data, outcomes, PRMs (as they become available), discussions with providers and existing global IP
- ☆ Outcome variation measuring along pathways, including definition of 'acceptable variation', creation of alerts and responses
 - Definition, review of spend limits and guidelines for clinical and non-clinical services, including honing risk stratification (including employment context) and next-best-action recommendations
 - Pathways continuous improvement basis outcomes, PRMs and other data e.g., RTW
 - Definition of comparable outcomes to ensure provider benchmarking (e.g., clinical outcomes/PRMs linked to complexity and pathways)

Tools / solutions

- ☆ **Recurrent processes, analysis & reports to manage clients/kiritaki along pathways (incl. payments, levies, OCL computation, ...)**
 - Scalable and secure data sharing solutions in place to receive data (incl. treatment, outcomes, PRMs) from P&CC, Clinicians and non-clinical services
 - Clear processes to approve treatments and services beyond guidelines
 - Integrated dashboards visible to providers comparing outcomes along pathways

☆ Can start executing with current data

Deep dive | Assess implications for current core systems and align roadmap

End state target

The knowledge of the client/kiritaki is built ensuring inter-operability between providers and managing treatment decisions where most client/kiritaki information is already available (e.g., P&CC)

ACC has a clear roadmap to collect data, develop analytical capabilities and tools to support use cases which enable the transition to the TCM

ACC has a robust benefits model to track advancement towards strategic goals and measure business implications, incl. impact on insurance and OCL

ACC teams manage outliers and providers leveraging integrated data reporting solutions and clear processes

Data, Analytical capabilities & Tools/solutions required to reach the end state

Data

- Technology roadmap enabling the collection of new sources of data (e.g., PRMs, clinical outcome measures, patient defined targets) and linked to clear business outcomes (e.g., via use cases)
- Data governance, privacy and sovereignty implications of the new TCM considered (including equity implications for priority populations)

Analytical capabilities

- Technology roadmap ensuring the right analytics and digital build capabilities
- ACC teams including data analysts to support pathways definition and creation of support tools
- ACC teams including data analysts to manage outliers and providers

Tools / solutions

- Core systems enabling client/kiritaki view along the pathway, and ensuring inter-operability with providers along the pathway
- Integrated data reporting solutions to manage outliers and providers
- Robust benefits model to track advancement towards strategic goals

[s 9(2)(i)]

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

Enhancing notification procedures and collaborative pathway design for complex fracture, spinal cord and traumatic brain injuries are key to effective client transitions

A. Enhance early notification procedures

- Improve early notification procedures to align with clinical processes and enable effective transitions to free up hospital bed capacity quicker
- Engage with the National Trauma Governance Group to draw on findings to improve early trauma notifications
- Support training and development for Health New Zealand/Te Whatu Ora as a Primary and Community Care provider to ensure early notification procedures are timely and comprehensive
- Enable sharing of comprehensive injury input data (e.g., comorbidities) through early notification procedures
- Engage with Health NZ/Te Whatu Ora to securely share client/kiritaki identification and history data using HIRA

B. Involve Health New Zealand/Te Whatu Ora in pathway plan design

- Establish clear expectations with Health New Zealand/Te Whatu Ora as the Primary and Community Care provider for clients/kiritaki in complex fracture, spinal cord and traumatic brain injury pathways
- Develop a team of case managers and clinical experts to create synchronised plans following a client's initial interaction with Health New Zealand/Te Whatu Ora
- Define clear roles and responsibilities across the pathway
- Develop a platform for collaborative pathway input and management

[s 9(2)(j)]

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

[s 9(2)(j)]

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

Engagement with Health NZ/Te Whatu Ora to influence data collection and embedding analysis into process improvement will enable better shared client/kiritaki outcomes

A. Engage with Health New Zealand/Te Whatu Ora to influence trauma registry data collection and accessibility




- Engage with Health New Zealand/Te Whatu Ora on the National Trauma Network data sharing agreement to completion
- Analyse trauma registry data to identify gaps in data collection
- Provide input with Health New Zealand/Te Whatu Ora into preferred outcome measures which would inform client/kiritaki pathway improvements

B. Develop a plan to embed process improvement into client/kiritaki pathways

- Engage with Health New Zealand/Te Whatu Ora to set outcome standards, perform regular analysis, and provide guidance on pathway improvements
- Establish regular process to enable discussion between Health New Zealand/Te Whatu Ora, ACC and National Trauma Network on data findings and to highlight potential process improvements
- Agree on process to enable identified improvements to shape future client/kiritaki pathways
- Engage with Health New Zealand/Te Whatu Ora to ensure data sharing agreements are future-proof (e.g., support migration of trauma registry from research registry to clinical quality registry)

Operating Model | 12-month action plan

Key  Illustrative milestones

Change commences	3 months	6 months	9 months	12 months
Sector Engagement & Partnership	Plan provider relations <ul style="list-style-type: none"> Detail the transition plan for interim provider related interactions including stop/start/continue Plan and detail the future state realignment of supplier and provider relations activities and channels Seek legal advice on more devolved model, automation, and auditing Assess current CRM against support required in the future state 	Revise provider processes <ul style="list-style-type: none"> Reset provider and peak interaction norms per transition plan Plan for PHO analysis and P&CC navigation resourcing model Revise risk management approaches and tolerances to reflect an exception-based approach Assess cyber security and resilience approach for shared sector data assets  <p>Provider Relations Realignment</p>	Test and refine engagement model <ul style="list-style-type: none"> Test and refine the operating model supporting the pathway co-design launch Redesign the organisational structure and required capabilities Assess scenarios of policy, regulation and legislation change for organisational resilience Optimise the CRM and provider and network relationship management coordination processes Detail and develop investment cases for the option set of permanent future state functions e.g., lesson sharing mechanism, peak body collaborations, clinical registry funding 	
Shared services enablement	Assess Shared Services model <ul style="list-style-type: none"> Socialise the TCM and strategic narrative of change Assess the impacts of the change on each shared service function and plan for internal service model Liaise with MSP and Health NZ/Te Whatu Ora; align ACC contribution to the SSCAP with target commissioning model Seek legal advice on Commerce Act exemption 	Detail shared services design <ul style="list-style-type: none"> Detail the shared services support model, resource allocation and service levels; consider the resourcing implications of Service Delivery Team Establish necessary tools, templates and processes Plan for realignment of resources Align governance, finance and delegations framework with the range of strategic procurement levers 	Transition shared services support <ul style="list-style-type: none"> Commence transition to new shared service model for: People & Culture, Finance, Commercial & Legal, Intergovernmental affairs, Actuarial, Legislation, Analytics etc. Align funding, governance (executive oversight and risk management) to drive collaboration and business partnering from shared services Redesign the organisational structure and required capabilities <p> Shared Services realignment</p>	
Change & Governance redesign	Establish change program <ul style="list-style-type: none"> Develop strategic narrative for change Establish activist PMO Conduct stop/start/continue of current change portfolio and roadmaps Align with Health New Zealand/Te Whatu Ora, MSD, etc. on change agenda and potential areas of collaboration  <p>Change portfolio locked</p>	Build PMO processes and tools <ul style="list-style-type: none"> Build PMO standards, tools, escalations, routines for change initiatives, and portfolio wide roadmaps and benefits tracking Define new governance framework 	Transition to revitalised governance <ul style="list-style-type: none"> Establish Health New Zealand/Te Whatu Ora, MSD etc. shared cascade mechanisms for collaboration on shared priorities Establish executive governance enablement program including executive coaching Revise the delegations and responsibilities framework as required 	

P&CC makes critical treatment decisions, identifies need for reviews and escalates care in line with defined pathways, supported by ACC tools and PRM data

Target State Activities

- **Develop a toolkit** of assessment and risk stratification criteria, example care plans and treatment escalation indicators for use by P&CC
- **Provide population health analytics** to PHOs and P&CC providers on their enrolled populations and local area, sharing with Health New Zealand/Te Whatu Ora, Ministry of Health and Ministry of Social Development as relevant
- **Provide benchmarking of** a care team's client/kiritaki cohort (enrolled in the practice etc.), using standardised outcome measures to enable self-discovery of improvement opportunities
- **Provide on-demand clinical advisory services to P&CC** to provide guidance on pathways and exceptions (e.g., phone-a-friend)
- **Facilitate regular lesson sharing opportunities** (e.g., practice networks, knowledge hub) between near-and-peer P&CC providers
- **Collaborate with P&CC peak bodies** on strategic priorities for the sector's role in rehabilitation journeys

Requirements for the operating model

- **P&CC pathway & service design and improvement capabilities** with clinical credibility to recommend practice, facilitate lesson sharing and provide advice for pathway navigation
 - Separate from Clinical review or audit of coverage and claims
 - Operating at both the Practice and PHO organisational levels
- **A funding and contracting model** that is fit-for-purpose to build capacity and capability in the sector
- **Data integration and analytics capabilities** that draw together data from P&CC, other providers and clients/kiritaki, provide meaningful population level analysis and share back to P&CC within legal constraints
- **Strong working models with PMS vendors** to develop, release and embed new decision tools, analytics displays and interoperable data APIs
- **Strategic relationships with P&CC peak bodies**, particularly RNZCGP and the Federation, to discover frontline trends and cascade communications from ACC



Service design function enables co-design of optimal pathways to drive commissioning, provider relationships and kiritaki/client experience

Target State Activities

- **Lead pathway co-design** with teams comprising providers, clients/kiritaki, Health New Zealand/Te Whatu Ora, relevant interest groups, best practice analysts, the Ministry of Health and ACC teams of journey designers, clinical advisors, data and tools developers and integrity officers
- **Identify pathway approaches and guardrails** to risk stratification, referral pathways, escalation and review
- **Align on key outcome metrics and collection methodologies** to monitor performance including PRMs, clinical, psychosocial and employment and injury prevention performance
- **Ensure the objectives of Huakina Te Rā** are meaningfully brought to life in the pathway design approach
- Review and assess the **alignment of Māori-led service designs** with other service designs to understand pathway intersections and unique characteristics
- Monitor alignment of service designs with the needs and priorities of **Business client/kiritaki relationships** including return to work support, acceleration, modification and adjustment assistance

Requirements for the operating model

- **A pathway co-design and improvement methodology**, that learns from leading health systems and experiences of ICP, RIG, Māori-led service design and ISSC
- **An ACC Pathway & Service Design and Improvement capability** including Clinical Advisors, Project Managers, Data Analysts, Provider and Network Relationship managers, Provider performance managers, Integrity and Māori Health Partnerships
- **A participant selection process** that draws on peak body relationships, contracted providers, and established relationships including Kaumatua and Iwi leaders
- **Aligned governance, accountabilities and delegations** that provide the authority to transform the service design into commissioned services
- **Data standards and architecture** integrate outcomes measures (including PRMs) and collection methods into workflows
- A fit-for-purpose **channel strategy** to clarify contacts and escalation points of kiritaki/clients, P&CC, providers and business partners
- A close relationship with Policy and Legislation functions to **assess scenarios of policy, regulation and legislation change** proposed throughout the design process (e.g., scope of practice change)



Strategic procurement function shifts from procuring services from existing market structures to actively shaping markets to drive value in line with pathway design

Target State Activities

- Translate the **pathway design concept into a portfolio of commissioned services**
- Understand the **current market** through environmental scans, demand forecasts (ACC and other demands), market growth assessments and **identify priority areas of intervention**
- Operate **strategic procurement services** including commissioning approach selection, GTM strategy, negotiation strategy, value-for-money assessment, bid evaluation and delegation framework
 - Use a range of strategic levers including bundled pricing, pre-purchased capacity, direct investments, vertical integration and price discovery
- Manage **provider performance** to contracted obligations, administer contracts
- Work with the provider market to **simplify contracting to ACC** and streamline processes to reduce administrative burden
- Establish **non-clinical product and service digital marketplaces** to diversify supply and empower clients/kiritaki with choice

Requirements for the operating model

- A **Strategic Procurement Centre of Excellence within ACC** to provide procurement-as-a-service across the organisation including resourcing with strategic procurement experts such as legal, negotiation, and establishing necessary tools, templates and processes
- Formalised, elevated relationships with Health New Zealand/Te Whatu Ora and the Social Services Commissioning Framework to allow sharing of **best practices**, accelerated learning and aligned technology investments
- A clear vision and performance management model for **COTR services** including mechanisms that drive activity into contracted services or modernise drafting of COTR regulations
- An aligned **governance, finance and delegation framework** with a range of strategic procurement levers to right-size oversight based on strategic importance and risk to rehabilitation market
 - (e.g., lower scrutiny on long-term low-risk contracts, higher scrutiny on strategic capacity purchasing and innovation incubation funding)



Operations teams supports more devolved decision making with tools, automation and systems while maintaining ACC's role in scheme boundaries

Target State Activities

- Maintain alignment of Enterprise Architecture vision and solution design with the **strategic priorities of ACC**
- Translate **provider support tool concepts** into pilots and systematised products (e.g., risk assessments, screening tools, next best action recommendations, booking and eReferrals)
- Develop use cases of **advanced automation of workflows** that fit within the pathway guardrails, and escalation mechanisms when anomalous
- Build and refine **reconciliation tools** that verify services were provided and paid for within the scope of commissioned service agreements
- Establish **non-clinical product and service digital marketplaces** to diversify supply and empower clients/kiritaki with choice
- Collaborate with **Health NZ/Te Whatu Ora, PMS vendors & others** to accelerate tool development, reusing architectures where helpful
- Strengthen **descriptive, predictive and prescriptive analytics** to support decision making of ACC and pathway design and improvement teams
- Provide **exception-based case management** after Primary and Community Care; approve services beyond pathways limits

Requirements for the operating model

- Use cases for Salesforce (Next Gen Case Mgt.), Principal client/kiritaki Record and EOS **end-to-end automation** that reduce provider and ACC claims management burden
- **Risk management approaches and tolerances** that reflect an exception-based approach based on advanced analytics and preventative integrity measures
- A **feedback and iteration process to improve the success of the tools, considering feedback from solution design, analytics and Pathway and Service Design Improvement team**
- **User interfaces that simplify and streamline** the experiences of clients/kiritaki, P&CC, providers and business partners (e.g., MyACC, BusinessPartnersHub, non-clinical provider digital marketplace)
- Financial and resource investments that focus on **systems and processes that steer away from anomalous behaviour** (e.g., waste prevention, long-waitlist referrals)
- Confirmed **legal standing of automation and devolution** of claims management in the context of the ACC Duty (s165 & s262)
- More **highly-skilled case managers** to address the low volume of high complexity exception-based coverage, and cases; including potential lifetime client/kiritaki cohorts



Data is gathered and consolidated to inform ACC and the care system on pathway effectiveness and performance

Target State Activities

- Co-design and embed **outcomes and PRMs** in care pathway to inform care teams of pathways allocation, referrals and treatment decisions
- Ensure **data sharing** between primary care – clinicians – ACC to deliver better care throughout client/kiritaki journeys
 - Ingest only data required from clinical teams and clinical registries to train analytical models in support of developing tools that will be deployed to care teams (e.g., historic data, client/kiritaki complexity, PRMs)
- Monitor service use and outcomes to power **population health analytics and variation analysis**
- Provide analytics back to the care system including creating alerts and processes to intervene in case of significant variation
- Monitor **provider level referral and treatment behaviours** to predict and understand fraud, waste and abuse behaviours including demand shifting between various contracted services and COTR

Requirements for the operating model

- **Greater ACC analytics capabilities**, including for tool development and integrity monitoring, and the optimal teaming model (e.g., corporate shared service, integrated functions) to reduce duplication and accelerate learning
- **Data standards and a data sharing and data governance framework** for ACC, PMS & EMR vendors, and all related data sharing entities particularly Health New Zealand/Te Whatu Ora and other government agencies
- Data sharing agreements with remaining **Clinical Registries**, funded by ACC
- A mechanism to share population health analytics and variation analysis **insights with providers**, care teams and ACC performance and integrity functions
- Greater emphasis on collecting **representative data including equity measures**, requiring adaptive approaches as needed
- **Legal advice on the secondary use of health data** and scaling of the 'Dynamic Lodgement' consent project
- An assessment of the **cyber security and resilience** of ACC and the sector to initiate any required remediation



Provider relationship management shifts from focus on claims, coverage and contracting to data-informed engagement on outcomes, resource use and improvement

Target State Activities

- Establish a **relationship of trust** and autonomous decision making with providers
- Liaise with journey teams, peak bodies and relevant providers on sector-led **continuous improvement, lesson sharing and bottom-up learnings** on caring for clients/kiritaki on pathways
- Represent **ACC analytics insights** to relevant providers and journey teams (e.g., population health analytics, variation analysis, systemic integrity concerns)
- Provide **an ongoing, sustained relationship** to client/kiritaki advocacy groups, providers and employer partners, integrating local knowledge and networks
- Integrate **provider insights into ACC operations** (e.g., priority tool development, contracting pain points)
- Understand the provider landscape and partner with strategic procurement Centre of Excellence to **plan for thriving, diverse and resilient markets**

Requirements for the operating model

- **The Health Partnerships capabilities** to match priority provider types and peak body alignment
- **Interdisciplinary provider relationship teams** that incorporate clinical advice, relationship management, performance management and analytics
- Prioritised and **allocated effort** for the provider relationship management function, including **geographic distribution and oversight** (i.e., continuation of the hub model interoperability with Health New Zealand/Te Whatu Ora and SSCF)
- A **regular relationship management processes** for individual providers, collective provider groups and peak bodies, harmonised to ACC operations
- Feedback mechanisms embedded into ACC operations and opportunities to **improve provider experience**
- A **digital CRM** to coordinate provider relationships
- Collaboration with **provider regulatory bodies** on provider performance and systemic concerns (e.g., low value care, bias or discrimination)



Three ACC capabilities combine to support the shift to long term provider relationship management

Strategic Procurement

- Develops procurement strategy
- Leads strategic procurement execution with Provider Management and Pathway & Service Design and Improvement functions
- Manages pipeline of contract renewals
- Collaborates with public sector procurement and commissioning entities

Shared service within ACC

Provider & Network Management

- Administers contracts
- Manages performance to contracted services
- Liaises with Integrity Services on investigations
- Accountable for benefits realisation of contracted services and resource use
- Liaises with peak bodies on systemic themes

Spans specific provider groups e.g., General Practice, Surgical Specialists

Pathway & Service Design and Improvement

- Leads pathway co-design and improvement
- Supports continuous improvement of clinical practice
- Provides clinical advice on-demand
- Accountable for outcomes and improvement

Spans a journey, working with providers that contribute to rehabilitation care e.g., ACL repair, concussion, sensitive claims

Collaboration with Health New Zealand/Te Whatu Ora increases for service delivery planning, data and procurement

Target State Activities

- Establish and review **shared strategic priorities** for the broader health and rehabilitation sector and the roles that Health New Zealand/Te Whatu Ora and ACC can play to address them, particularly in relation to Equity and Pae Ora strategies
- **Plan for strategic procurement** of shared or overlapping products and service in the health and social care sectors including ACC investment in Health New Zealand/Te Whatu Ora services
- **Strategically manage Health New Zealand/Te Whatu Ora** as a key partner in **hospital originated claims**
- Steer the **technology and data standards of the sector** for dual benefit, and modernisation

Requirements for the operating model

- Regular executive and operational joint bodies that **cascade shared strategic priorities and decisions** from leadership throughout operational decision making including:
 - Data standards & Technology roadmap
 - Clinical change when transferring care
 - Joint strategic procurement
 - Peak body relations
 - Population health and system performance analytics including registry optimisation
- A Provider and Network Management **team with Health New Zealand/Te Whatu Ora** and regional groups
- **Resolved legislative limitations** on joint strategic procurement actions (e.g., Commerce Act)



Change is rigorously prioritised and defined as one portfolio, tightly aligned to ACC priorities and governed to deliver benefits

Target State Activities

- **Set strategic priorities** for ACC to best support the sector to deliver, and define which changes are required to support these priorities, deprioritising those that are not
- **Allocate resources and investment** to change initiatives, demonstrating clear investment logic and line of sight to strategic priorities
- **Govern change initiatives for impact** and with discipline, holding initiative owners accountable
- **Maintain benefits realisation processes** following change delivery to monitor impact and support continuation/roll-back decisions
- **Reinforce a culture that faces challenges** as an opportunity to improve, transparently communicating with leadership

Requirements for the operating model

- A strengthened, activist **Portfolio Management Office**, empowered to create standards, tools, escalation and routines for change initiatives, and portfolio wide roadmaps and benefits tracking
- A revised **delegations and responsibilities framework** that more closely links the authority to deliver with accountability for benefits realisation including role of shared services for supporting delivery
- **Executive oversight** of both change and operations functions to balance short-term and long-term priorities, and strengthen executive governance using **agreed methods such as Strategic Questioning**
- **Support to deliver, and leadership culture that is supportive of frank and fearless advice**
- **Reskill governance discipline** for those planning, delivering and overseeing change including critical decision making, data literacy





Appendix

Chapter 1 | ACC spending trends

Supporting materials

High severity claims drive the majority of ACC's spend, accounting for 71% of in-year spend and 10x lifetime compensation spending compared to mid severity claims

Category	Unit	High severity <i>(serious injury claims¹ + claims with >=\$20,000)</i>	Mid severity <i>(total expenditure >\$1,500 and <\$20,000)</i>	Low severity <i>(claims with total expenditure <=\$1,500)</i>	Total
Medical treatment	Spend in-year (\$Mn)	\$630Mn	\$560Mn	\$450Mn	\$1.6 Bn
	Count of claims (in-year)	113,350	340,560	1,925,360	
	Avg. in-year spend per claim	\$5,520	\$1,630	\$230	
	Avg. lifetime spend per claim	\$15,000 ← 5x	\$3,000	\$270	
Rehab	Spend in-year (\$Mn)	\$1,150Mn	\$150Mn	\$5Mn	\$1.3 Bn
	Count of claims (in-year)	67,620	102,300	24,100	
	Avg. in-year spend per claim	\$17,000	\$1,400	\$270	
	Avg. lifetime spend per claim	\$20,000 ← 6x	\$3,300	\$300	
Comp.	Spend in-year (\$Mn)	\$1,900Mn	\$330Mn	\$10Mn	\$2.3 Bn
	Count of claims (in-year)	84,900	78,540	18,500	
	Avg. in-year spend per claim	\$23,860	\$4,650	\$620	
	Avg. lifetime spend per claim	\$50,000 ← 10x	\$5,300	\$630	
		\$3,700Mn (71%)	\$1,050Mn (20%)	\$465Mn (9%)	\$5.2Bn (100%)

High severity claims represent 71% of FY23 spend, followed by Mid severity (20%) and Low severity (9%)

Low severity Medical Treatment accounts for the majority of claims count: c.1.9Mn in total

High severity clients/kiritaki account for a considerably larger lifetime spend than mid-severity: c.5x for Medical, c.6x for Rehab and c.10x for Compensation

Source: ACC data; Note: bulk-funded spend is excluded, figures are rounded. Internal adjustments can lead to minor differences in data representation

The current service delivery model shows similar severity claims do not receive a consistent response and leads to differing spend per claim

Initial Channel Allocation	Unit	High severity <i>(serious injury claims + claims with >=\$20,000)</i>	Mid severity <i>(total expenditure >\$1,500 and <\$20,000)</i>	Low severity <i>(claims with total expenditure <=\$1,500)</i>	Total
Enabled	Spend in-year (\$Mn)	\$20Mn	\$90Mn	\$20Mn	\$130 Mn
	Count of claims (in-year)	1,690	29,687	39,001	
	Spend per claim	\$11,834	\$3,032	\$513	
Assisted	Spend in-year (\$Mn)	\$1,350Mn	\$65Mn	\$20Mn	\$1,850 Mn
	Count of claims (in-year)	63,229	107,219	51,833	
	Spend per claim	\$21,351	\$4,337	\$386	
Supported	Spend in-year (\$Mn)	\$870Mn	\$60Mn	\$3Mn	\$940 Mn
	Count of claims (in-year)	25,031	15,509	9,677	
	Spend per claim	\$34,757	\$3,869	\$310	
Partnered	Spend in-year (\$Mn)	\$920Mn	\$35Mn	\$2Mn	\$950 Mn
	Count of claims (in-year)	10,763	11,977	3,652	
	Spend per claim	\$85,478	\$2,922	\$548	
Other	Spend in-year (\$Mn)	\$530Mn	\$420Mn	\$420Mn	\$1,370 Bn
	Count of claims (in-year)	43,886	217,248	1,827,670	
	Spend per claim	\$12,077	\$1,933	\$230	
		\$3,700Mn (71%)	\$1,050Mn (20%)	\$465Mn (9%)	\$5.2Bn (100%)

High severity claims are dealt with multiple case management solutions: Assisted (63k), Supported (25k), Partnered (10k), Other (43k)

Severe claims with high-touch support are linked to higher spending, and for mid severity claims spend decreases

Assisted claims account for the majority of FY23 spend (\$1.85Bn), followed by Other (\$1.37Bn)

Enabled claims account for only a small portion of total claims and spend (\$130Mn)

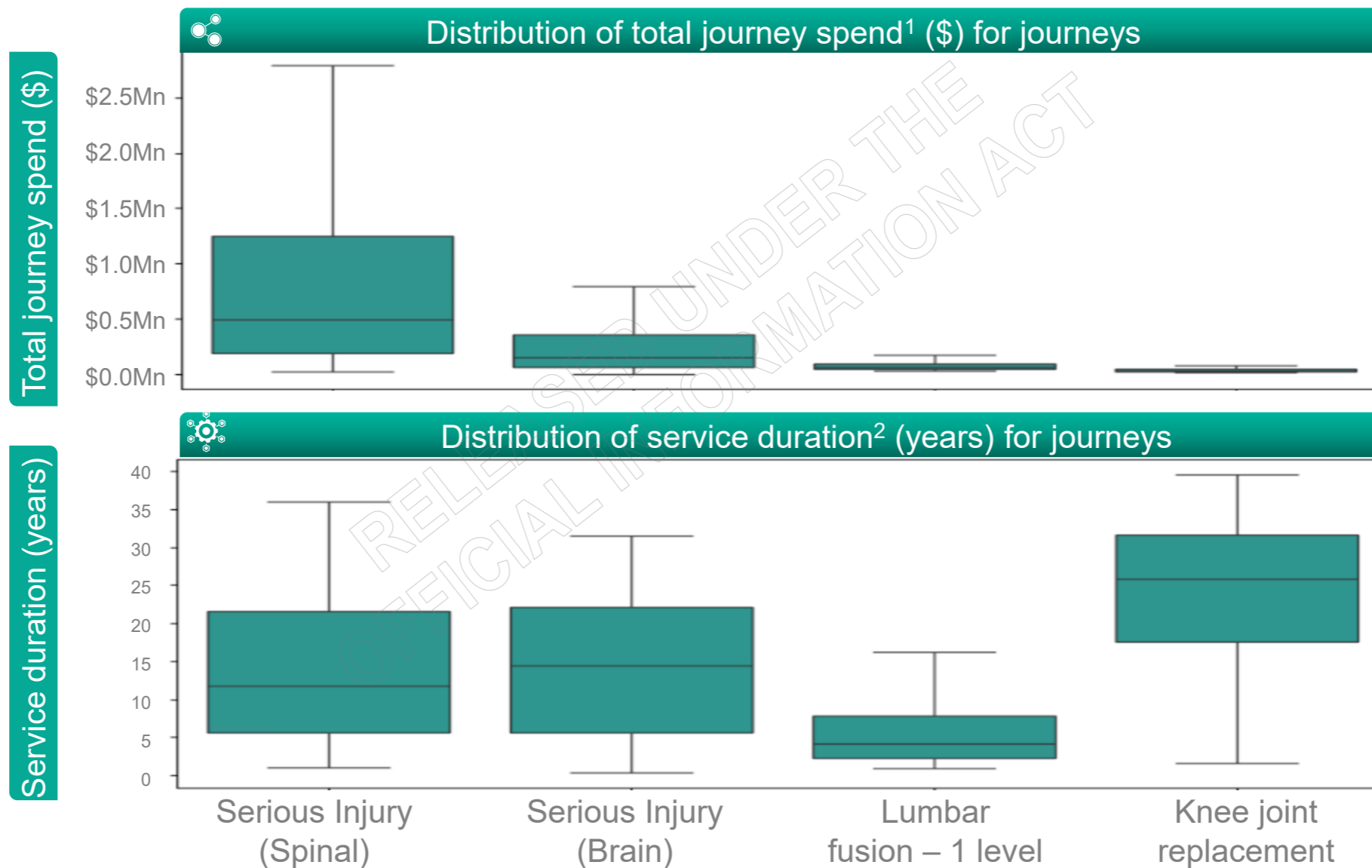
Source: ACC data; Note: bulk-funded spend is excluded, figures are rounded. Internal adjustments can lead to minor differences in data representation. Claims divided as per the initial channel allocation

Chapter 2 | Benchmarking Supporting materials

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

Variation in duration and spend within four longest journey types

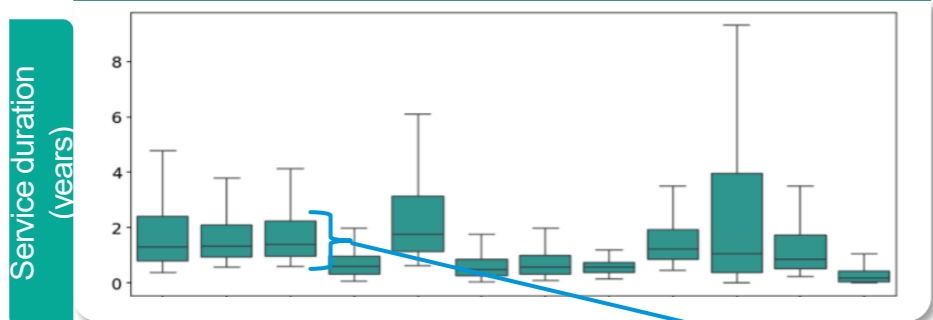
These journeys lasting over 10 years are excluded in our analysis, as they are not fully captured in the data



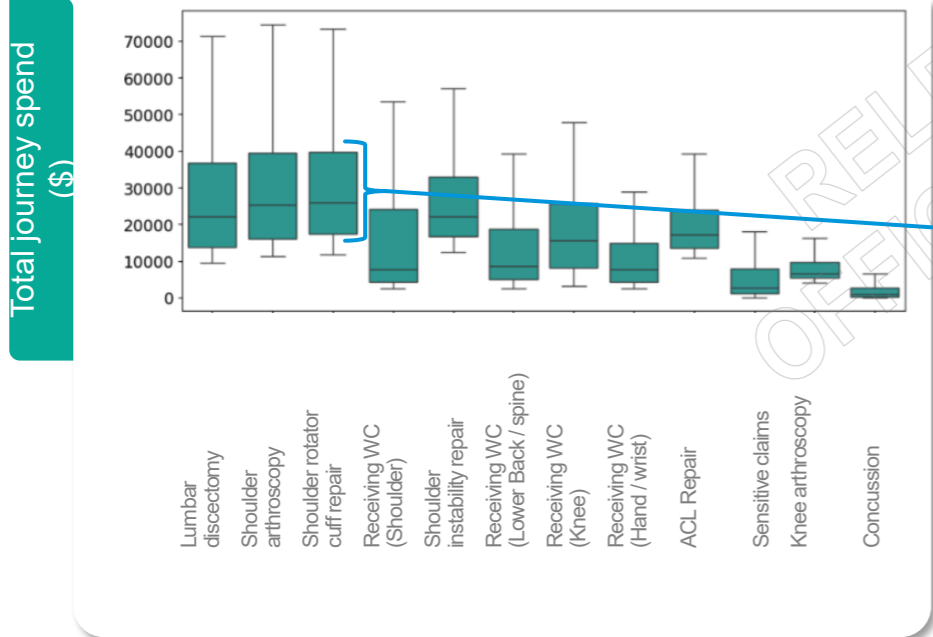
1. Total journey spend sums the payments for all services in the journey, excluding GST. 2. Service duration is calculated as the number of years from the lodgement date to the date of the last medical or rehabilitation service; Source: 'Completed' journeys with last medical or rehabilitation service provided between 2011 to 2023. They are considered to be 'completed' as no new services have been provided in the past 3 months before Oct 2023. These journeys often last over 10 years, unlikely to be fully captured from 2011 to 2023, hence are deprioritised in our analysis

Deep dive | Deep dive on shoulder rotator cuff journeys shows very different paths with very different cost and duration profiles

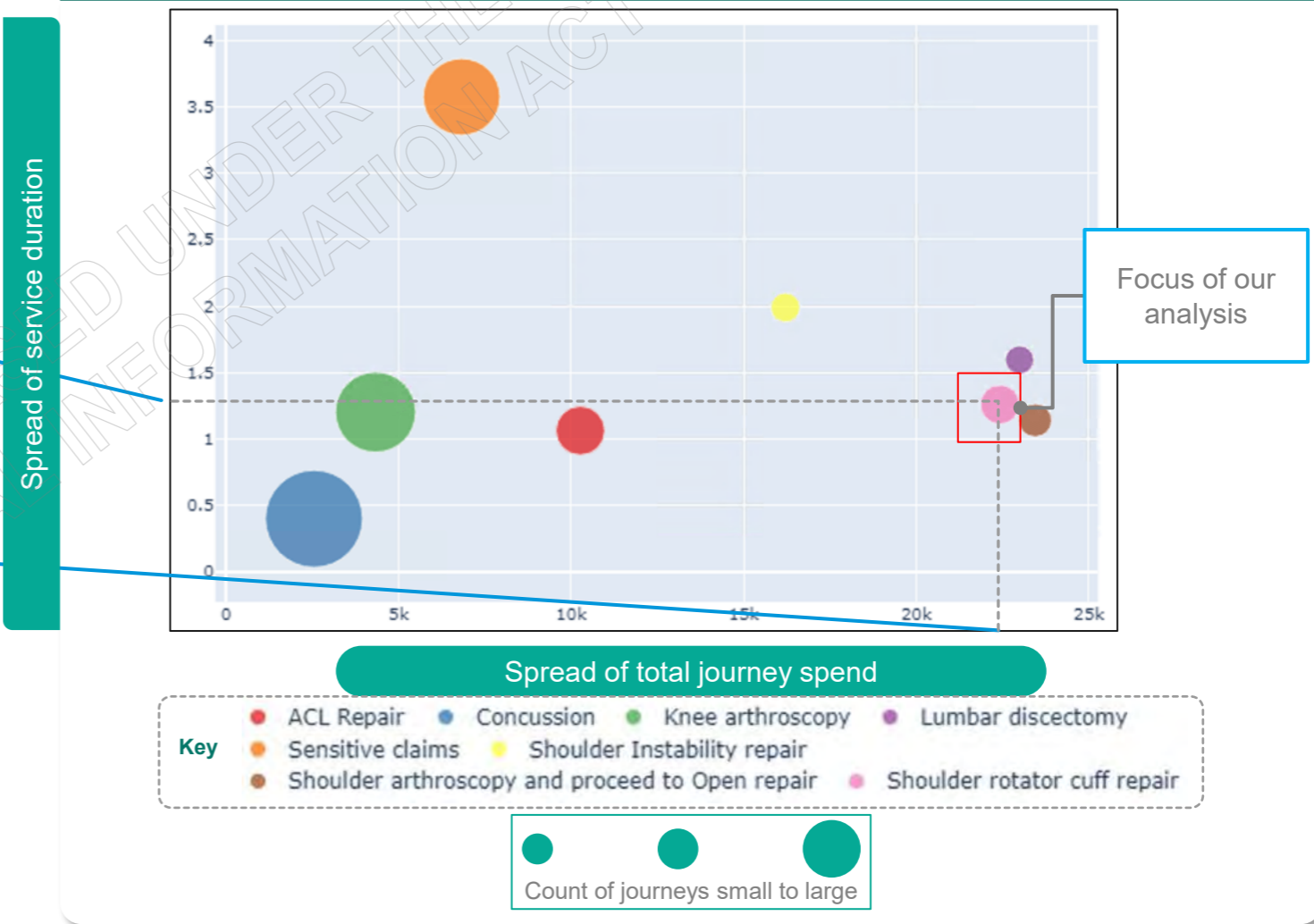
Distribution of service duration² (years) for journeys



Distribution of total journey spend¹ (\$) for journeys



Spread of total journey spend and service duration for journey types

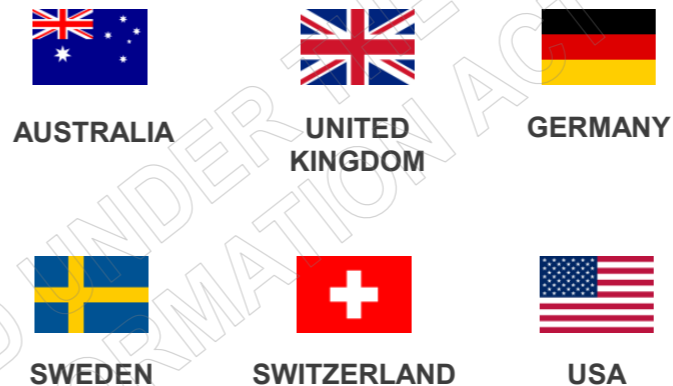


Source: 'Completed ' journeys with last medical or rehabilitation service provided between 2011 to 2023. They are considered to be 'completed' as no new services have been provided in the past 3 months before Oct 2023 148

Benchmarks focused on top spend services **within...**

- 1 Elective surgery
- 2 High-tech imaging
- 3 Non-Acute Inpatient Rehabilitation
- 4 Home & Community Support Services
- 5 Allied Health Services
- 6 Integrated Services for Sensitive Claims
- 7 Home-Based Rehabilitation

... looking at a selected set of countries



- Comparability of health systems: Public and private, high quality
- Adequate data availability
 - Recency
 - Level of granularity
 - Comprehensiveness

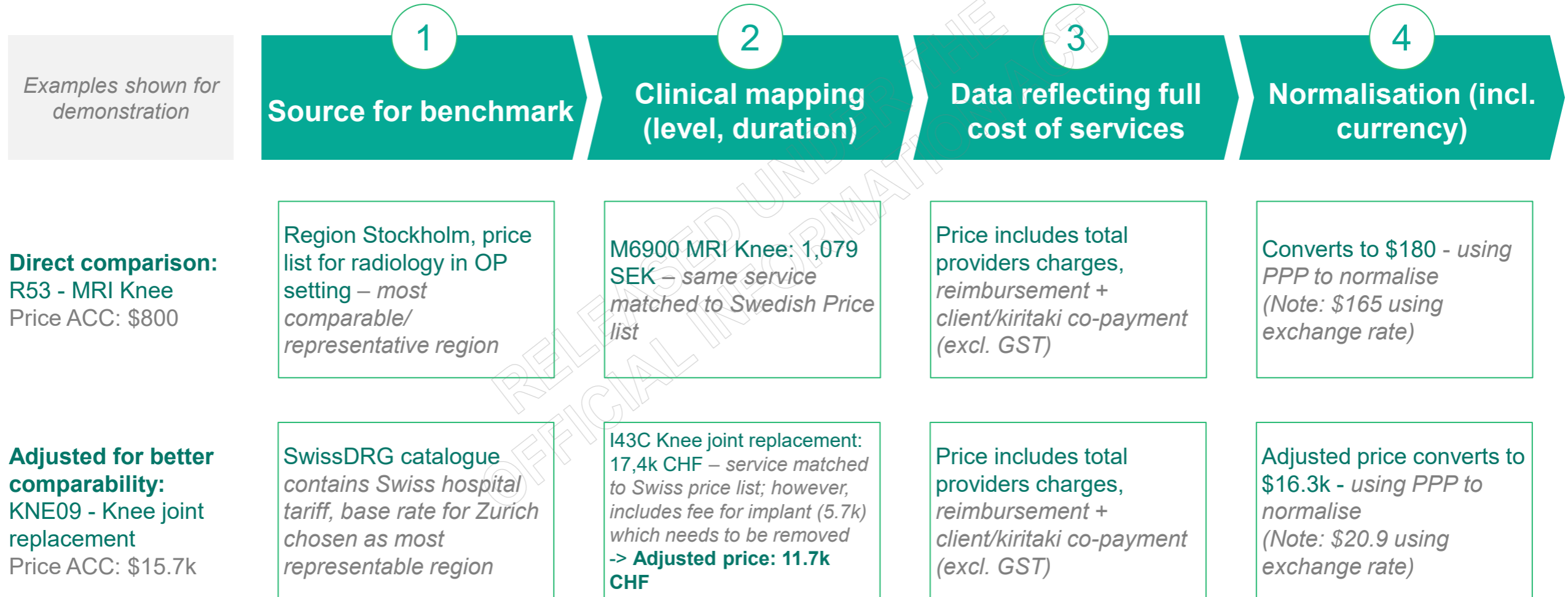
... and moderating for differences between systems

- GST excluded and exchange rates applied
- Adjusted for Purchasing Power Parity
- Specifically examined inclusions within price and normalised for these
- Levels of procedure complexity considered

Backup | Benchmarking matching and normalisation methodology summary

- 1 For each country drew from **several data sources** to compile information for each of the categories. Within some countries different prices available for many geographic areas: therefore, chose **areas most representative for that country** (e.g., Zurich for Switzerland)
- 2 **Performed clinical mapping** to ensure codes are like for like and encompass **comparable levels and duration of care**, i.e., assessed whether ward costs, HCP time, costs for implants and reporting etc. were included or not, and adjusted if needed for best possible comparability with client/kiritaki codes
- 3 Ensured prices collected are based on **total provider reimbursement** (GST exclusive) – not only payer costs;
i.e., data reflecting full costs of services
- 4 Normalised prices using **Purchasing Power Parity (PPP)** calculation


Two worked examples | MRI Knee & Knee joint replacement (i)



Sources | Price benchmarks are based on publicly available price lists (i)

Category	 Australia	 Germany	 Sweden
HTI	<ul style="list-style-type: none"> • DoH Medical Cost Finder: Typical cost for private services • WorkSafe Queensland: Typical cost for specialist scans • MPSports Physicians: Provider website 	<ul style="list-style-type: none"> • Uniform Assessment Standard (EBM): SHI tariff for medical and radiology services in OP setting 	<ul style="list-style-type: none"> • Region Stockholm: Contract price lists for radiology & orthopaedics in OP setting
Elective surgery	<ul style="list-style-type: none"> • DoH Medical Cost Finder: Typical cost for private services • Medibank Private: Approx. private costs 	<ul style="list-style-type: none"> • German DRG catalogue: General hospital pricing system 	<ul style="list-style-type: none"> • National Board of Health and Welfare DRG catalogue: Pricing system for spec. services • Region Stockholm: Contract price lists for orthop. surg. in daycare and IP settings
IHCS	<ul style="list-style-type: none"> • Homage, Care provider website 	<ul style="list-style-type: none"> • AOK Bayern: Rates for care services • Pflege.dk: Portal with info on standard prices for home care services 	<ul style="list-style-type: none"> • Swedish Association of Local Authorities and Communities: Avg. rates for care services
ISSC	<ul style="list-style-type: none"> • DoH Medical Cost Finder: Typical cost for mental health services • Hardwick Psych. Services, Provider website 	<ul style="list-style-type: none"> • Uniform Assessment Standard (EBM): SHI tariff for medical services 	<ul style="list-style-type: none"> • Region Skåne: Tariff for mental health services
Allied Health	<ul style="list-style-type: none"> • NSW Ins. Reg. Authority: Physiotherapy fees 	<ul style="list-style-type: none"> • National Physiotherapy Fee Agreement 	<ul style="list-style-type: none"> • Region Stockholm: Contract price list for physiotherapy
Home-based rehab	<ul style="list-style-type: none"> • Homage, Care provider website 	<ul style="list-style-type: none"> • Independent Consumer Advice Centres: Info about SHI rates to home-based care • AOK Bayern: Rates for care service 	<ul style="list-style-type: none"> • N/A
Non-acute inpat. rehab	<ul style="list-style-type: none"> • NSW Ins. Reg. Authority: private hosp. fees 	<ul style="list-style-type: none"> • National Association of Statutory Health Insurance Funds: Avg. price for inpat. rehab 	<ul style="list-style-type: none"> • Region Stockholm: Contract price list for inpatient rehabilitation

Sources | Price benchmarks are based on publicly available price lists (ii)

Category	 Switzerland	 UK	 USA
HTI	<ul style="list-style-type: none"> • TarMed Suisse: Tariff for radiology in OP setting, (chose Zurich area rates) 	<ul style="list-style-type: none"> • NHS National Tariff Payment System: Prices for unbundled diagnostic imaging services 	<ul style="list-style-type: none"> • Medicare Procedure Price Lookup: national average total cost in hosp. OP departments
Elective surgery	<ul style="list-style-type: none"> • Swiss DRG catalogue: Hospital financing tariff (chose Zurich area rates) 	<ul style="list-style-type: none"> • NHS National Tariff Payment System: Day case & ordinary elective spell tariff 	<ul style="list-style-type: none"> • Medicare Procedure Price Lookup national average total fees for procedures in OP setting • Medicare Inpatient Prospective Payment System (IPPS): Payment rates for inpatient hospital facility costs for the procedures¹
IHCS	<ul style="list-style-type: none"> • Swiss Federal Office for Public Health: Description of financing of home care services 	<ul style="list-style-type: none"> • NHS Digital: Adult social care activity and finance report: Average standard rates 	<ul style="list-style-type: none"> • CareScout: Median hourly charges by surveyed home care agencies (n=4195) • SeniorList: Portal with info on standard prices for home care services
ISSC	<ul style="list-style-type: none"> • TarMed Suisse: Tariff for mental health services 	<ul style="list-style-type: none"> • National Schedule of NHS Costs: Average unit cost to NHS of providing defined services 	<ul style="list-style-type: none"> • Medicare Physician Fee Schedule: Avg. payment rates for mental health providers in OP setting
Allied Health	<ul style="list-style-type: none"> • Swiss Physiotherapy Association: Tariff for physical therapy services 	<ul style="list-style-type: none"> • National Schedule of NHS Costs: Average unit cost to NHS of providing defined services 	<ul style="list-style-type: none"> • Medicare Physician Fee Schedule: Avg. payment rates for physical therapy in OP setting
Home-based rehab	<ul style="list-style-type: none"> • Visana Health Insurance Company: Tariff for care services • Sanitas Health Insurance Company: Tariff for care services 	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • CareScout: Median hourly charges by surveyed home care agencies (n=4195)
Non-acute inpat. rehab	<ul style="list-style-type: none"> • Swiss Federal Office for Statistics: Average prices for rehabilitation services 	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • CMS: Inpatient Rehabilitation Facility Prospective Payment System

Note: For US, Medicare rates were used because they are the only widely-available prices. Medicare rates are lower than commercial rates (e.g., Congressional Budget Office found commercial physician rates were 30% higher than Medicare rates); 1. Inpatient ward fees for US included for codes matched to knee joint replacement, lumbar discectomy, lumbar fusion and metalware removal

[s 9(2)(j)]

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

Client/kiritaki journey best practice learnings suggest ACC should prioritise designing end-to-end rehabilitation journeys that monitor value and variation

Organisation

Key insights and learnings



Helsana



LUZ SAÚDE



Cancer Institute NSW



suva

- Use pathways for all condition and injury types
- Ensuring that only high-value treatments are used
- Using risk stratification to measure with evidence the balance and variation around cost on a client/kiritaki level
- Allocation of clinical navigator to maintain client/kiritaki journeys and pathways
- Using 'hub and spoke' model to improve quality and client/kiritaki outcomes
- Working in conjunction with payers and providers to provide independent insights around trauma outcomes
- Feeding back to providers to manage and improve care
- Tracking episode costs amongst providers to identify best practice and outliers

Backup | We have looked at overseas organisations to inspire best practice for embedding client/kiritaki journey approaches



Country		
Description	<p><u>KP 'on-the-job' program:</u></p> <p>Developed evidence-based pathways, incl. best practice outcomes for each injury type/client journey</p> <p>Specific tools and software in place to support established client/kiritaki pathways</p> <p>Individuals get accompanied by care team including case managing nurse for entire journey until return to work – including follow-ups and preventive collaboration with employers</p>	<p>Cooperative of seven top-performing Dutch hospitals</p> <p>Following a client-centric and structured 'VBHC implementation' approach by client/kiritaki journey type</p> <p>Have 'lumpsum' contracts with payers in place for all journeys and client/kiritaki types – bonus/malus payments based on KPI achievements</p>
Impact	<ul style="list-style-type: none"> • Real-time management of best practice pathways brings individuals back to work three times as fast • Financial efficiencies due to targeted treatment, less time off work 	<ul style="list-style-type: none"> • Continuous revenue growth for hospitals • Cost savings based on less superfluous procedures/services • Reduced re-operation rates

Payments, and delivery organisation & structures best practices suggest ACC should shape market to drive integrated practice along journeys & align incentives for value

Organisation

Key insights and learnings



Helsana



LUZ SAÚDE



Cancer Institute NSW






suva

- *Moving away from incentivising volume, towards incentivising value*
- *Using strategic procurement to replicate end-to-end client/kiritaki journey amongst numerous providers*
- *Contracting for outcomes-based bundles*
- *Widespread use of benchmarks and structured price discovery techniques to improve value*
- *Leveraging scale volume to achieve better commercial outcomes*
- *Building trust based on evidence to enable change, with multi-year contracting to support long-term the change*
- *Adopting a collaborative/collegial approach as a key success factor to implementation*
- *Moderating funding to ensure more equitable outcomes across system*

Backup | We have looked at overseas organisations to inspire best practice for payments, and delivery organisation and structures



Country			
Description	<p>14-year tender issued for imaging services, incl. maintenance, upgrades and full service</p> <p>R&D and innovation scores also built into tender, beyond pricing parameters</p> <p>Contract awarded based on combination of attractive pricing and high quality</p>	<p>Payment program along client/kiritaki journey bundles including hip and knee replacements (HKR), with 3.2% of payment paid retroactively if outcome goals are met</p> <p>Bundled payment program for client/kiritaki journeys incurring spine surgery, with even higher outcomes-based payment of 10%</p>	<p>Washington: Result-based close clinical partnerships with large number of hospitals and supporting medical groups for newly establishing KP on-the-job program</p> <p>Capitated funding issued to specialist physicians, with set \$ amount paid for each enrolled member, supplemented by small quality incentives</p> <p>Block funding issued to hospitals with allocation of funds determined by managers/providers, and incentives provided for high-value care</p>
Impact	<ul style="list-style-type: none"> • Prices driven down by competition and transparency – helping to manage costs over the long term • Established a local innovation hub for research and education focused on improving outcomes in ten high-priority therapy areas 	<ul style="list-style-type: none"> • Hip and knee replacements: 18% reduction in 2yr complications, 20% reduction in cost per client/kiritaki • Spine surgery: 28% reduction in length of stay, 28% reduction in 1yr reoperation rate 	<ul style="list-style-type: none"> • 25% higher cost efficiency, less overservicing • Clients/kiritaki returning to work 3x faster • General improvements in health outcomes e.g., reduced co-morbidities

Informatics/data, benchmarking, research & tools best practices suggest ACC should prioritise collecting & integrating outcome metrics into workflows & decision making

Organisation

Key insights and learnings



Helsana



LUZ SAÚDE






Cancer Institute NSW



- *Developing advanced statistics and reporting to better measure KPIs and manage providers*
- *Use of data analytics and machine learning to stratify clients/kiritaki*
- *Working closely with trauma registries to collect and track outcome data*
- *Using off the shelf products to measure PROMs and PREMs (e.g., The Clinician)*
- *Using international benchmarks and standards to develop outcome measures (e.g., ICHOM)*
- *Using widespread implementation of PREMs/PROMs and outcomes data to inform treatment*
- *Integrating data collection into clinical workflow to support widespread roll-out and adoption*
- *Persisting with sharing of data to providers to build trust and deliver better outcomes*

Backup | We have looked at overseas organisations to inspire best practice for leveraging Informatics/data, benchmarking, research and tools



Country			
Description	<p>Health Outcomes & Patient Exp. (HOPE) platform developed using ServiceNow – incl. custom-built client, carer & clinician portals, integrated into clinical workflow and leading EHR/PMS solutions</p> <p>Direct feedback about PRMs and PREMs (patient-reported outcome and experience measures) collected from clients/kiritaki and real-time used by clinicians to inform care and treatment</p>	<p>Enhanced Recovery Program co-designed with TAC clients/kiritaki and providers, using The Clinician’s ZEDOC platform</p> <p>Questionnaire on health outcomes and experiences filled out by clients/kiritaki four times throughout treatment; PRMs and PREMs used to inform physiotherapists’ clinical decisions and assist them to deliver relevant communication and educational materials to client/kiritaki</p>	<p>Dutch Institute for Clinical Auditing aiming at giving doctors and prof. associations insight into their quality of care and providing improvement potential</p> <p>Developed robust benchmark platform showing performance of health care institutes relative to peers, based on standard KPIs (100 participating hospitals, c.500 quality & outcome indicators, 40 disease groups)</p>
Impact	<ul style="list-style-type: none"> Provides routine and systematic direct feedback to clinicians and care teams about client/kiritaki outcomes and experiences Helps deliver better client/kiritaki outcomes and improve overall wellbeing 	<ul style="list-style-type: none"> Client/kiritaki responses help physiotherapist and TAC understand how injury is affecting client/kiritaki over course of treatment Supports delivery of treatment tailored to client’s/kiritaki individual needs 	<ul style="list-style-type: none"> Med. survival of melanoma clients/kiritaki after syst. therapy increased from 12 to 22 months 32-minute reduction in time b/w diagnosis and treatment for cerebral infarction 52% lower mortality and 29% fewer severe complications after colorectal cancer surgery

Backup | Provider interviews have highlighted additional challenges and appetite for significant change in the sector

	1 Evidence based pathways	2 Strategic Procurement	3 Data and analytics
Challenges	<p>Benefits seen in allowing more flexibility in the way services are delivered, and more trust placed in providers</p> <p>Large amount of waste generated by slow approvals process</p>	<p>The current provider market structure has been largely precipitated by the ACC contracting environment</p> <p>Contracting solutions risk cutting out smaller operators (who depend more heavily on Cost of Treatment Regulations)</p>	<p>Current data architecture is fragmented between providers, PHOs, Health New Zealand/Te Whatu Ora and ACC without being joined up</p>
Opportunities/solutions	<p>Some success in the use of primary care led pathways (as the holder of most client/kiritaki information)</p> <p>Supportive of moving towards an end-to-end view of client/kiritaki and measuring outcomes</p> <p>Enhanced navigation is seen as attractive to clients/Kiritaki and beneficial to providers</p>	<p>Support local decisioning and market-based approaches</p> <p>Commission or invest for more primary and secondary prevention, including proactive care for high-risk clients</p> <p>Any solution must improve administrative burden, particularly for primary care</p>	<p>Data and analytics are not used to risk weight/stratify claim approval, delaying simple claims</p> <p>Providers would be open to benchmarking but requires transparency on use of data and normalisation of client/kiritaki factors</p> <p>Health pathways decision support tool is in widespread use across Primary Care</p> <p>Client experience is intermittently measured (surveys etc.) but not acted on routinely to improve care</p>

Several key **provider/provider representative and clinical groups** engaged with:

- NZ Private Surgical Hospitals Associate
- General Practice New Zealand

- Royal NZ College of General Practice
- NZ Orthopaedics Association

- Physiotherapy NZ
- NZ College of Clinical Psychologists

Chapter 3 | Recommendations



Supporting materials

The identified priority areas will drive significant benefits for ACC

Priority area	4.1 Enable Primary & Community Care to manage client/kiritaki pathways	4.2 Enable clients/kiritaki & clinicians to use PRMs to inform treatment decisions	4.3 Create analytics to manage outliers, support continuous improvement	4.4 Assess implications for current core systems & define technology roadmap
Description	<ul style="list-style-type: none"> ACC to develop decision support & screening tools to enable Primary & Community Care to direct clients across pathways, manage lines of treatment 	<ul style="list-style-type: none"> ACC to co-design and embed PRMs, clinical outcome measures & client/kiritaki defined targets in clinical processes to inform treatment decisions 	<ul style="list-style-type: none"> ACC to measure variations in outcomes, intervene in case of significant variation and support continuous improvement by benchmarking providers 	<ul style="list-style-type: none"> ACC to assess implications of the TCM for current core systems and investment roadmap, update roadmap to ensure development of priority data, analytics & tools
Benefits	<ul style="list-style-type: none"> Clients/kiritaki would be directed on pathways which best fit their needs – improving outcomes and reducing low-value care 	<ul style="list-style-type: none"> Clinical treatments which best fit clients'/kiritaki needs and transparency on client/kiritaki priorities: improving outcomes and reducing low-value care 	<ul style="list-style-type: none"> ACC would focus interventions on high complexity clients/kiritaki and ensure continuous improvement (incl. provider benchmarks) 	<ul style="list-style-type: none"> Technology roadmap focusing on data, analytics and tools which are aligned with ACC'S strategic direction and translating to clear business outcomes

Data | ACC can leverage best practices from global organisations to develop a new technology roadmap supporting the TCM



Country		
Description	<p>Developed Health Outcomes & Patient Exp. (HOPE) platform with custom-built client/kiritaki, carer & clinician portals to collect PRMs and include them in clinical workflows</p>	<p>Enhanced Recovery Program co-designed with TAC clients/kiritaki and providers using The Clinician's ZEDOC platform to improve quality of care and client/kiritaki outcomes</p>
Key success factors (data)	<ul style="list-style-type: none"> • Program defined in strong collaboration with clients/kiritaki and providers • Data collection and reporting integrated into clinical workflows and multiple leading HER/PMS solutions • Feedback collected and used real-time from clients/kiritaki and clinicians • Data used both at population level (e.g., trends analyses, definition of client/kiritaki pathways) and to inform individual treatment • Focus on inclusivity: included multiple languages, voice-to-text and text-to-voice tools • Used PRMs to improve value-based commissioning 	<ul style="list-style-type: none"> • Co-designed program with both clients/kiritaki and providers • Co-designed replicable process to ensure data collection & analysis, including a questionnaire on health outcomes and experiences to be filled four times throughout the treatment (start, middle, end, after completion) • Leveraged ZEDOC platform from the Clinician to leverage pre-existing data collection and reporting solutions (e.g., SMS prompts before questionnaires, set of pre-existing PROMs, PREMs, ...), send educational materials to clients/kiritaki • Prioritised adoption for medium to high severity clients/kiritaki

Analytical Capabilities | ACC can leverage best practices from global organisations to develop a new technology roadmap supporting the TCM

German health insurer



Country		
Description	<p>Used Machine Learning to analyse client/kiritaki pathways, risk-stratify clients/kiritaki, identify key intervention points and appropriate interventions along these to deliver high value personalised care</p>	<p>Use real-time data and analytics from a small, centralised team to enable early risk/response stratification and pathways management according to client/kiritaki outcomes</p>
Key success factors (analytical capabilities)	<ul style="list-style-type: none"> • Used Machine Learning prediction models to inform clearly defined use cases (e.g., early diagnosis, identification of clients/kiritaki at risk) in specific pathways (e.g., knee arthroplasty) • Defined clear processes to act on the identified clients/kiritaki at risk • Paired advanced analytics teams with medical experts, ensured regular discussions and progress between the groups (e.g., narrowing down population, evaluating features) • Defined clear measures of success along the pathway and tracked providers performance along those 	<ul style="list-style-type: none"> • Identified early risk predictors to developed an early warning system - Advance Alert Monitor (AAM) - helping care teams predict when clients/kiritaki are at risk for clinical deterioration based on comorbidity scores and outcome data • Measures treatment and outcome measures real time to quickly inform management of lines of treatment • Works with a small centralised team of analysts which also support primary care teams. Automated reporting at individual and population levels, so that analysts could create the insights which management teams leveraged to create action plans

Tools | ACC can leverage best practices from global organisations to develop a new technology roadmap supporting the TCM

DICA

Humana

Country		
Description	<p>Developed benchmarking platform showing performance of health care institutes relative to peers to give doctors insight into their quality of care and providing improvement potential</p>	<p>Supports primary care physicians to manage clients/kiritaki along pathways by providing tools with a focus on disease prevention and holistic management of chronic diseases</p>
Key success factors (tools)	<ul style="list-style-type: none"> • Partnered with ICHOM to identify disease-specific standard registries to ensure accurate comparison • Indicators used in the benchmarking are agreed with the sector during 'Indicator Days' twice a year and evaluated by a clinical team. Then, DICA publishes a guidebook for the year and providers publish the agreed indicators on the DICA platform • Interim feedback is provided during the year to lower-performing providers • Benchmarking includes both clinical outcomes and PROMs, PREMs; dashboards are available to providers and clients 	<ul style="list-style-type: none"> • Initially focused on identifying drivers and locations of high spend, computed value at stake & current failure points for those • Defined target use cases: expand physicians' view of clients' health, manage overall population, enhance care prevention • Focused on informing physicians with clear & actionable data • Started tracking outcomes such as clinical measures and Healthcare Effectiveness Data and Information Set (HEDIS), then included more complex measures on care coordination (e.g., follow-ups after ER visit for high-risk clients/kiritaki, transition of care measures across different providers)

Chapter 3 | Equity Considerations

Supporting materials

He Tauira | Example: Equity Profiles



James (Samoan) is a foundation layer and general contractor who has recurring back injury that prevents him from lifting large loads. James needs to be on ACC but is reluctant to engage with mainstream providers due to cultural mismatch and dismissive attitudes. Finding the right doctor is important to him, one that empathises with his cultural values and understands his family pressures



Wena (Māori) works as a shellfish team manager. She has recurring issues with her hands due to years of high-speed shellfish preparation; she can barely touch thumb and finger and has taken a team manager role to oversee recruits but is still required to help on high loads. Wena is not currently on ACC. Her pressure comes from employer taking advantage of her and threatening Wena with losing her promotion. Wena is afraid of stopping work and is seeking private help after-hours, so she can keep her shifts

Equity Insights:

Pre-journey nurturing is critical to referral onto and completion of a pathway

Income insecurity is distressing

May have exploitative employers

Seek Kaupapa Māori/Pasifika-first solutions

Navigator would describe potential pathways and supports available



Several considerations for advancing equity through market-shaping capabilities

A key integrated goal of this strategy is raising the equity and Kaupapa Māori foundation of our core service delivery via these markets. We also acknowledge Māori, Pasifika, women, immigrants, disabled and equity groups need diverse services and options. We are setting positive expectations for Māori and our equity groups to have improved access to these services

Key equity considerations

3.1 Incorporate alternative procurement strategies for clinical services¹

- For Māori, Pasifika and rural communities, access to clinical services and experiences of clinical services are monitored to improve outcomes
- We acknowledge that rural/Māori areas are disproportionately serviced, so procurement strategies will encourage larger providers to create service management plans for these areas

3.2 Establish marketplaces for non-clinical products and services

- Supporting more regional market competition means better engagement by Māori services and clients/kiritaki
- Provide for whānau innovation around services e.g., travel
- Streamline onboarding process to marketplace – many providers require an extra FTE for paperwork, but this should not be a barrier
- Focus on equity means many Māori are active on the marketplaces as equity performance requires a proportional shift in Māori participation and inclusion

3.3 Build a strategic procurement centre of excellence

- Reporting on access gaps, price inequity and other experience challenges are important to the centre of excellence

3.4 Focus efforts by prioritising highest value opportunities

- Addressing high levels of inequity in rural, Māori and Pasifika areas and communities are high priority
- Identifying real problems that can be immediately fixed with minimal cost and maximum reach are of high value

1. Referring to all medical treatment and rehabilitation services

Enhancing data, analytical capabilities and tools can significantly advance ACC's equity agenda

Key equity considerations

- 4.1** Enable Primary & Community Care to manage client/kiritaki pathways

 - Enabling P&CC to better understand Māori and priority populations with quantitative & actionable data can support equitable treatment without creating 'separate pathways' which limit access
 - Screening tools can enable P&CC to ensure priority populations receive appropriate care throughout their journey, and adequate support in case of access barriers
- 4.2** Enable clients/kiritaki & clinicians to use PRMs to inform treatment decisions

 - Key to define culturally appropriate PRMs (e.g., aligned with the 4 aspects of wellbeing¹ for Māori)
 - Measures to be defined with sector bodies to support a national impact narrative
 - ACC should define a balanced portfolio of measures, which allows comparison across client/kiritaki cohorts while also being specific enough to offer personalised care
- 4.3** Create analytics to manage outliers, support continuous improvement

 - Ensuring equity in the system might include allowing variation in treatment to receive the same outcome
 - Defining 'what good looks like' when measuring variation and benchmarking providers should include measures which ensure comparison of a diverse population (e.g., meeting client/kiritaki defined targets)
- 4.4** Assess implications for current core systems & define technology roadmap

 - When defining the updated tech roadmap, ACC should include considerations from the Data Equity Roadmap (e.g., Māori data sovereignty, culturally appropriate measures)
 - To support ACC's impact narrative, it will be key to define standard measures throughout departments which are influenceable by ACC and advance Huakina Te Rā



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

Thank you



RELEASED UNDER THE OFFICIAL INFORMATION ACT