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SIRA NSW

Health outcomes framework for the NSW workers compensation and motor accident injury schemes

Response to the Consultation Paper, 21 July 2020

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Q1. How can the health outcomes framework be most effectively used to improve health outcomes and the value of healthcare expenditure?

The effectiveness of the Health Outcomes Framework (HOF) will depend largely on:

- the implementation of robust systems of governance and service delivery by health service organisations (HSOs) - from providers of acute and primary care to providers of workplace rehabilitation services and community-based care; AND
- how insurers/agents and employers support HSOs in the provision of person-centred , valued-based care.

The HOF has the potential to help insurers/agent and employers align their values, policies and practices of with those of HSOs. Alignment in this regard will:

- create a common understanding of person-centred, values-based care;
- coalesce efforts on expediting access to quality healthcare services; and
- 'weed-out' the inefficiencies and costs associated with long-standing values mismatch between healthcare providers and insurers/agents.[1]

Q4. What can WC and CTP scheme participants (insurers, health practitioners, claimants, employers) do to help advance the vision of value-based care in the schemes?

Advancement of values-based care will require insurers/agents in particular to adopt the vision and its principles into their programs and practices. At a minimum, this requires adjusting decision-making processes so that:

- the needs, goals and priorities of injured persons are placed at the centre; and
- they enable efficient access to services that produce health outcomes that matter to injured persons.

HSOs can help advance the vision by (a) establishing and implementing robust systems clinical governance and service delivery, and (b) evaluating those systems against the measures communicated in the HOF. In doing so, HSOs (whether approved by SIRA or otherwise) should be required to reference existing frameworks and standards for clinical governance and service delivery in healthcare.

[1] Inefficiencies and undue costs can arise when insurers/agents view health needs and healthcare through a narrow prism concerned with claims management objectives of (work) capacity, liability and cost-reduction. This, for example, can result in (i) protracted approval processes and delayed access to necessary care, (ii) fragmentation of health needs and discontinuity of healthcare, and (iii) use of healthcare providers as proxies for claims management activities, such as compliance monitoring.

For example: see the National Safety and Quality Health Service (NSQHS) Standards https://www.safetyandquality.gov.au/standards/nsqhs-standards

Q5. Are there areas where you believe SIRA should focus its implementation efforts to best promote achievement of value-based care?

When establishing/reviewing its approval frameworks for healthcare providers, including but not limited to those for workplace rehabilitation providers, SIRA should consider adopting/adapting the NSQHS Standards as published by the Australian Commission on Safety and Quality in Health Care. The NSQHS Standards provide a well-researched, established and relevant platform. https://www.safetyandquality.gov.au/standards/nsqhs-standards

Importantly, the domains, outcomes and implementation plan described in the HOF synergise well with the NSQHS Standards. For instance, compliance with the NSQHS Standards requires HSOs to

- establish clinical governance mechanisms for evaluating systems and services;
- identify specific measures spanning service efficacy, health and quality of life, consumer experience, and safety and quality;
- monitor and report on performance against those measures; and
- engage consumers in healthcare evaluation;

The table below outlines the synergies between the NSQHS Standards and the six domains of the HOF.

The six domains of the HOF	Synergies with the NSQHS standards
1. Physical and mental health, including 'toward zero harmful dependence on treatment and care'.	The standards spanning (i) clinical governance, (ii) comprehensive care, (iii) medication safety, and (iv) communication for safety require HSOs to evaluate the reliability, safety and quality of their services, including their effectiveness in preventing and managing specific risks of harm.

2. Injured person experience and accessibility **3. Wellbeing – return to work/activities, social engagement, etc.**	The standard for clinical governance combined with the standard for partnering with consumers provides a person-centred, values-based framework for evaluating systems and services. The framework requires HSOs to engage consumers as partners in the planning and provisions of their own care as well as the evaluation of the care received having regard to measures of: • Consumer experience and satisfaction; • Health and quality of life; and • Service effectiveness.
4. Cost of healthcare	Measurement of healthcare costs, including efficient resource allocation and appropriate levels of care, falls within the standard for clinical governance. It requires HSOs to evaluate service efficacy against relevant safety and quality measures.
5. Safety and quality of healthcare	The standard for clinical governance requires HSOs to identify safety and quality measures, and monitor and report performance and outcomes against those measures.
6. Healthcare provider capability, delivery and experience	The standard for clinical governance requires HSOs to monitor and measure clinical performance and effectiveness and their relationship to: • credentialing; • training, supervision and professional development; • evidence-based care; • variations in practice and health outcomes.

Q6. Do you have any comments on the implementation plan?

Understandably, the implementation plan, at present, is centred on the activities to be undertaken by SIRA.

As 'horizon 1' takes shape and relevant metrics are identified, it would be prudent for SIRA to communicate the priority actions involving the key actors upon whom the implementation and effectiveness of the HOF depends.

Q7. Do you have any other comments?

The table below provides a brief critique of the outcomes for each domain comprising the Health Outcomes Framework (HOF). Observations / comments primarily identify what is required to ensure clear communication and/or attainment of the outcomes.

HOF Domain	Outcome	Observation /Comment
1. Physical and mental health	1.1-1.2. Physical and mental health is improved or maintained - supports return to work/activities and is tailored to the nature and extent of injury.	
	1.3. Towards zero harmful dependence on treatment and care (avoidance / minimisation) - including harmful substances and unnecessary treatment and care.	Attainment of this outcome depends on the establishment and implementation of robust systems of clinical governance and service delivery, including systems for medication management, by health service organisations.
2. Injured person experience and accessibility	2.1. Injured persons and their families/carers are satisfied with treatment and care processes, including dispute resolution, and experience – end-to-end health care services and dispute resolution.	Measures should include relevant 'quality of life' measures that can (at a minimum) be administered at the commencement and finalisation of care. Measures should focus primarily on the subject's self-assessment of gains made and goals attained rather than generalised 'satisfaction' with services and processes.
	2.2. Cost of healthcare services is aligned with market rates for industry peers Access to timely evidence-based treatment; can navigate appropriate services across	The stated outcome concerns healthcare costs and market rates. It does not concern access to and navigation of health services as otherwise described. It duplicates the outcome 4.2

	the continuum of integrated health services .	of the framework This appears to be an error.
	2.3. Level of healthcare services provided is appropriate - inclusive and responsive to choice, culture, identity, circumstances and goals of the individual.	This outcome requires cultural literacy and competency providing services for people with unique needs. This should be integrated into a healthcare provider's systems of clinical governance comprehensive care.
	2.4. Healthcare is integrated and transitions of care are facilitated effectively - integrated across the continuum of need. Transitions between care; disciplines are effectively facilitated to enable continuity of care.	This outcome requires systems/processes for collaborative planning and care, including (clinical) handover i.e. inter/trans-disciplinary processes.
3. Wellbeing	3.1. Injured persons return to work/activities in a timely manner - achieve recovery milestones.	Application of this outcome needs to ensure that employment participation (RTW) is enabled or, in the least, supported by goal/milestone attainment in other life roles/activities.
	3.2. Injured persons are empowered to return to work/activities - personally empowered, actively engaged and are effectively supported by insurers/claim agents and employers in pursuing return to work/activities. Includes influencing behaviours that may impact effective engagement in the return to work/activities process.	This outcome would require measures of: • self-efficacy concerning work and other relevant roles; and • value perceptions of the support provided by agents and employers (i.e. the degree to which an agent or employer has contributed to the attainment of the injured person's goals/milestones.

	3.3. Social engagement, resilience and connectedness are maintained (i.e. participation in social activities and community). Injured persons demonstrate resilience - meaning they are able to adapt effectively to changing circumstances.	Resilience is not an outcome; nor is it a trait, skill, process, or outcome that can be directly observed or measured. Rather, it is a dynamic concept with multiple interacting biological, psychological, social and cultural determinants and competing definitions. For any one person, levels of 'resilience' can differ across contexts or life domains. For this reason, 'resilience' should be removed as a wellbeing-related outcome. For a general discussion of resilience theory and the challenges with definitions and measurement, begin with Steven M. Southwick et al. Resilience definitions, theory, and challenges: interdisciplinary perspectives, *European Journal of Psychotraumatology (5)*, 2014. Re: social engagement and connectedness - this outcome requires health service organisations and practitioners to administer measures of social and community participation and to ensure that goal-setting and planning are specific to needs and salient risks, and priorities that support/enable/optimise participation.
4. Cost of healthcare	4.1. Healthcare is cost efficient - delivered for maximum impact, enabling efficiencies in resource	This outcome suggests that a macro-level aggregate analysis of healthcare services is proposed.

	allocation. Efficiency is enabled by the level of healthcare resources utilised and the mix of health services provided, and changes in the costs of healthcare support and desired health outcomes.	Whilst this obviates the need to identify the entities providing services and producing outcomes, an aggregate analysis makes it difficult to identify the causes or factors contributing to inefficient healthcare.
	4.2. Cost of healthcare services is aligned with market rates for industry peers – relative to the level of quality and health outcomes being sought.	Measurement of this outcome will require both meso-level and micro level analyses of costs relative to inputs and expected benefits. • Meso – activities of health service organisations, groups of practitioners, or individual practitioners in the system. • Micro - specific treatments or intervention
	4.3. Level of healthcare services provided is appropriate - supports recovery and health outcomes; no over-servicing, <u>in line with relevant benchmarks, guidelines and/or frameworks.</u> Reduced leakage in the system.	This outcome is (indirectly) concerned with the identification of low value and potentially harmful care, which is synonymous with outcomes 5.1-5.3 under domain 5 'Safety and quality of healthcare'. Measures of service appropriateness are core to service safety and quality. Therefore, this outcome should either be (a) reframed so that it is specific to the control of 'leakage' and/or 'over-servicing', or (b) removed. It must not be assumed that the elimination of low value care will result in lower healthcare costs. Conversely, it could result in higher unit costs over time as resources are allocated and mobilised

		for evidence-based and evidence-informed care.
5. Safety and quality of healthcare	5.1. Healthcare delivered is of high quality - achieves the desired health outcomes for injured persons (e.g. is effective and evidence-based) and is at least comparable to that of other health systems.	Attainment of outcomes 5.1-5.6 depends largely on the implementation of robust systems of clinical governance by health service organisations. This gives weight to requiring all SIRA-approved service providers to comply with an appropriate set of clinical governance and healthcare service standards. For example: National Safety and Quality Health Service (NSQHS) Standards.
	5.2. Low value treatment and care is minimised - reflect evidence-based practice - healthcare services considered to offer little to no benefit are discouraged and/or avoided.	
	5.3. Treatment and care match the needs of injured persons - so that underservicing is minimised or avoided.	
	5.4. Timely adoption of new evidence-based treatment and care options - where they enable effective and safe achievement of desired health outcomes.	
	5.5. Towards zero serious incidents/adverse events.	
	5.6. Information is collected (reported) and used to drive healthcare activities - efficiently and effectively to drive and support healthcare activities (in accordance with applicable legislation).	
6. Healthcare provider capability, delivery and experience	6.1. High quality healthcare providers are attracted and retained - that best support the provision of	Attainment of this outcome depends on the implementation of robust systems of clinical

	value-based health services for all injured persons, including in regional areas and other markets with low numbers of providers.	governance by health service organisations, including workforce planning and credentialing processes. Again, this gives weight to requiring all SIRA-approved service providers to comply with an appropriate set of clinical governance and healthcare service standards. For example: National Safety and Quality Health Service (NSQHS) Standards. SIRA should introduce mechanisms for incentivising entry of health service providers who specialise in certain sectors/client cohorts and who bring innovative approaches for improving access to care in regional and remote locations.
	6.2 Clinician and staff wellbeing, development, and engagement are improved or maintained - managed by insurers/claim agents and employers and influenced by SIRA, empowering and enabling them to deliver optimal health outcomes for injured persons.	This outcome suggests that clinician wellbeing, development, etc, are the domain of agents and employers. They are not. Accountabilities and responsibilities for this outcome are the domain of health service organisations and practitioners in accordance with their systems of clinical governance. Agents and employers should play a supporting role NOT a managing role. In its current form, the outcome could invite agents in particular to engage in unhelpful 'management' practices (e.g. prescribing and directing healthcare

		activities; deterring or constraining access to necessary care; rationalising care on the grounds of service cost reduction; administration of onerous service deeds and contracts that produce no benefit or value to injured persons or employers). The outcome should be reframed so that is focused on supporting healthcare providers with establishing partnerships with consumers (injured persons, employers, agents and others) for the purposes of service planning, design, delivery, measurement and evaluation. Doing so is central to clinical governance e.g. refer to Standard 2 of the NSQHS Standards – Partnering with Consumers Standard.
	6.3. Providers integrate and collaborate - to achieve value-based healthcare outcomes for injured persons e.g. shared care plans.	This is a clinical governance matter - one that requires healthcare providers to establish and implement relevant policies and processes. It supports outcome 2.4 re: the effective integration and transitions of care.
	6.4. Healthcare providers are capable and exhibit desirable behaviours - consistent with the objectives of the schemes by approving suitable providers (WC scheme) and referring undesirable provider behaviour (CTP scheme) to healthcare regulators.	This outcome requires SIRA to establish suitable approval mechanisms that require healthcare providers to establish, implement, evaluate, review and improve systems of governance and service that support the aims, purposes, domains and outcomes described in the Health Outcome Framework.

		As indicated above, the National Safety and Quality Health Service (NSQHS) Standards provide a well-researched, established and relevant platform for building a robust approval framework for healthcare providers.

About the Author

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Jamie has worked in the occupational health and injury management field since 1990 – first as an occupational rehabilitation practitioner and now as consultant in health policy, systems evaluation and professional development.

From 1999 to 2002, he was a senior officer with WorkCover NSW where he was engaged in the workers compensation scheme reform agenda.

In 2002, Jamie established *Nth°Degree,* through which he works with organisations in various healthcare and industrial settings to improve systems of clinical governance, quality and service provision.

Disclosures

- Registered occupational therapist
- Former Senior Policy Officer, WorkCover NSW
- Former Director and Vice President, Occupational Therapy Australia NSW
- Member of Occupational Therapy Australia
- Member of the World Federation of Occupational Therapists
- Member of the International Association for the Study of Pain