HEALTH PROFESSIONALS RESEARCH EDUCATION PROGRAM –

Session 2: COMPLEX SERVICE INNOVATIONS – INTEGRATED CARE

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

NSW GOVERNMENT Health Hunter New England Local Health District

NSW GOVERNMENT Health Central Coast Local Health District

12.30 – 2.00pm Thursday 11 June 2020
Zoom: https://uonewcastle.zoom.us/j/660507254 **Meeting ID: 660 507 254**

RESEARCH ADVANTAGE
connecting and empowering

EXPERT FACILITATOR

NICK GOODWIN

Director - Central Coast Research Institute
Director of Research - Central Coast Local Health District

NSW GOVERNMENT Health Hunter New England Local Health District

RESEARCH ADVANTAGE connecting and empowering

NSW GOVERNMENT Health Central Coast Local Health District

Evaluating Complex Service Innovations - Integrated Care

The Need for Translational Research

Prof. Nicholas Goodwin

Paper to HPREP Seminar Series, 11 June, 2020

Leading the way in integrated care

It is an exciting time for CCLHD and the Central Coast community with the Clinical School and Research Institute for Integrated Care and Population Health, a joint initiative between our District and the University of Newcastle, recently commencing construction – you can read more about this milestone in the Redevelopment Staff Update.

This new facility will transform the ways in which we look at, develop and deliver healthcare, including integrated care which is a priority for our District and the focus of the Research Institute for Integrated Care and Population Health.

With the far-reaching impact and remit of the health system and increasing complexity of the community in which we work, ensuring an integrated care approach is becoming more important to overcoming service fragmentation, delivering value-based healthcare, and ensuring improved outcomes for Central Coast residents.

This was the focus of the paper recently published in the International Journal of Integrated Care entitled: Formative Evaluation of the Central Coast Integrated Care Program (CCICP), NSW Australia. CCLHD authors included Prof Nick Goodwin, Dr Peter Lewis, Michael Bishop, Rachael Sheather-Reid, Sarah Bradfield, Taryn Gazzard, Anthony Critchley and Sarah Wilcox.

You can read the full paper here: https://www.ijic.org/articles/10.5334/ijic.4633/

The article is an in-depth look at the first three years of the Central Coast Integrated Care Program (CCICP). The Program was a complex, multi-component intervention addressing three target populations and more than 40 sub-projects of different scale, priority and maturity. One of the projects, which continues today, is the Family Referral Service in Schools project which targets vulnerable youth and involves multiple partners.

The CCICP was developed in partnership with public and private primary care health agencies after CCLHD became one of three NSW demonstrator sites in 2014 tasked to develop and progress integrated care. The paper provides insights into implementation of the CCICP, key lessons from evaluations, and further supports the need for consistent collaboration and a more integrated approach to health.

As a result of this work, the strong relationship between CCLHD and the Hunter New England Central Coast Primary Health Network (HNECCPHN) has since been formalised under the Central Coast Alliance agreement.

New projects have also emerged, with a NSW Health-funded integrated care scaled initiative on the Central Coast to occur this financial year (2019/2020). It looks to provide additional support to Residential Aged Care Facilities (RACFs) and aims to demonstrate that with assistance, training and access to services, residents can receive care in RACFs where appropriate, leading to reduced unnecessary ambulance transfers and unplanned hospital admissions. Residents, in turn, will also have less risk of infection in hospital and reduced stress burden associated with relocation to a hospital setting.

This important integrated care work continues and will be expanded when the Research Institute for Integrated Care and Population Health opens.

Central Coast Research Institute

Prof. Nicholas Goodwin

Director

The CCRI is a joint venture between the University of Newcastle and the Central Coast Local Health District. It aims to build capacity for pioneering translational research in integrated care and population health relevant to improving the health and wellbeing of the Central Coast community, and to act as a trusted collaborative partner to promote world-class research and innovation across Australia and the Asia-Pacific.

Understanding Integrated Care

A Global Perspective

What is Integrated Care?

There are three distinct dimensions to what integrated care means in practice:

- Integrated care is necessary where fragmentations in care delivery mean that care has become so poorly co-ordinated around people's needs that there is an adverse, or sub-optimal, impact on care experiences and outcomes.
- Integrated care therefore seeks to improve the quality and cost-effectiveness of care for people and populations by ensuring that services are well coordinated around their needs. It is by definition, therefore, both 'people-centred' and 'population-oriented'.
- The people's perspective thus becomes the organising principle of service delivery, whether this be related to the individual patient, their carers/family, or the wider community to which they belong.

Integrated Care's Hypothesis

The hypothesis for integrated care is that it can contribute to meeting the **"Quadruple Aim"** goal in health systems

- Improving the user's care experience (e.g. satisfaction, confidence, trust)
- Improving the health of people and populations (e.g. morbidity, mortality, quality of life, reduced hospitalisations)
- Improving the cost-effectiveness of care systems (e.g. functional and technical efficiency)
- Improving the work-life balance of care providers and professionals

The Need for Integrated Care in Australia

A Compelling Case?

Do we have evidence for integrated care?

It depends …

The evidence: a summary

- Where integrated care better co-ordinates care around the needs of people at a personal, clinical and service-level it can improve quality of care, care outcomes and care experiences
- Uncertainty remains on the relative effectiveness of different system-level (organisational) approaches to integrated care as new structural solutions are often observed to be costly
- Getting the design and implementation of integrated care programmes right is important, and requires time to innovate and mature
- Research studies mostly look at integration, not integrated care!!!
  - The transformational impact of integrated care is at the micro-level of the patient, service user and professional teams, yet evaluation often fails to examine how care is actually delivered
- There is a lack of robust evidence overall on the economic impacts of integrated care approaches, but a significant amount of positive context-specific case experiences

Implementation science is weak

- Programme evaluations have shown limited ability to explain their results, so making it problematic to judge impact and costs
- Process evaluations provide explanation of key variables that influence the design and delivery of integrated care programmes, but don't give an understanding of what works, when and where?
- There is a need for a more intimate relationship between research and practice in order to understand its complexities and the strategies that result for effective implementation

Goodwin, N. Improving Integrated Care: Can Implementation Science Unlock the 'Black Box' of Complexities? *International Journal of Integrated Care*, 2019; 19(3): 12, 1–3. DOI: https://doi.org/10.5334/ijic.4724

EDITORIAL

Improving Integrated Care: Can Implementation Science Unlock the 'Black Box' of Complexities?

Nick Goodwin*,†

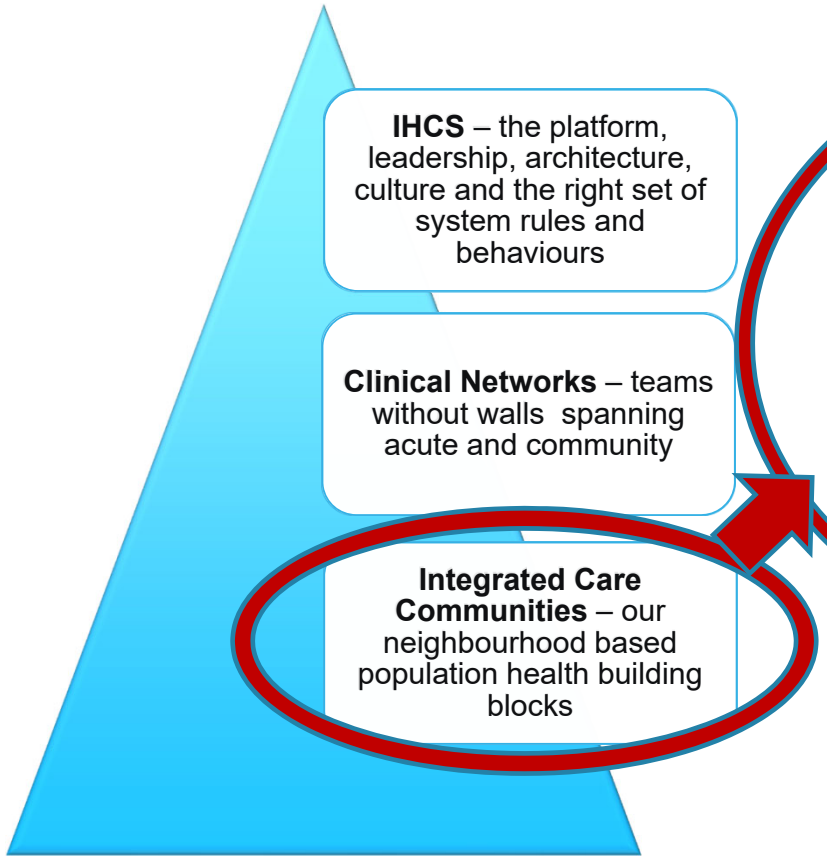
Keywords: complexity; evaluation; methodology; implementation science; improvement; integrated care; social science

How Can We Explain It?
Cumbria & Morecambe Bay

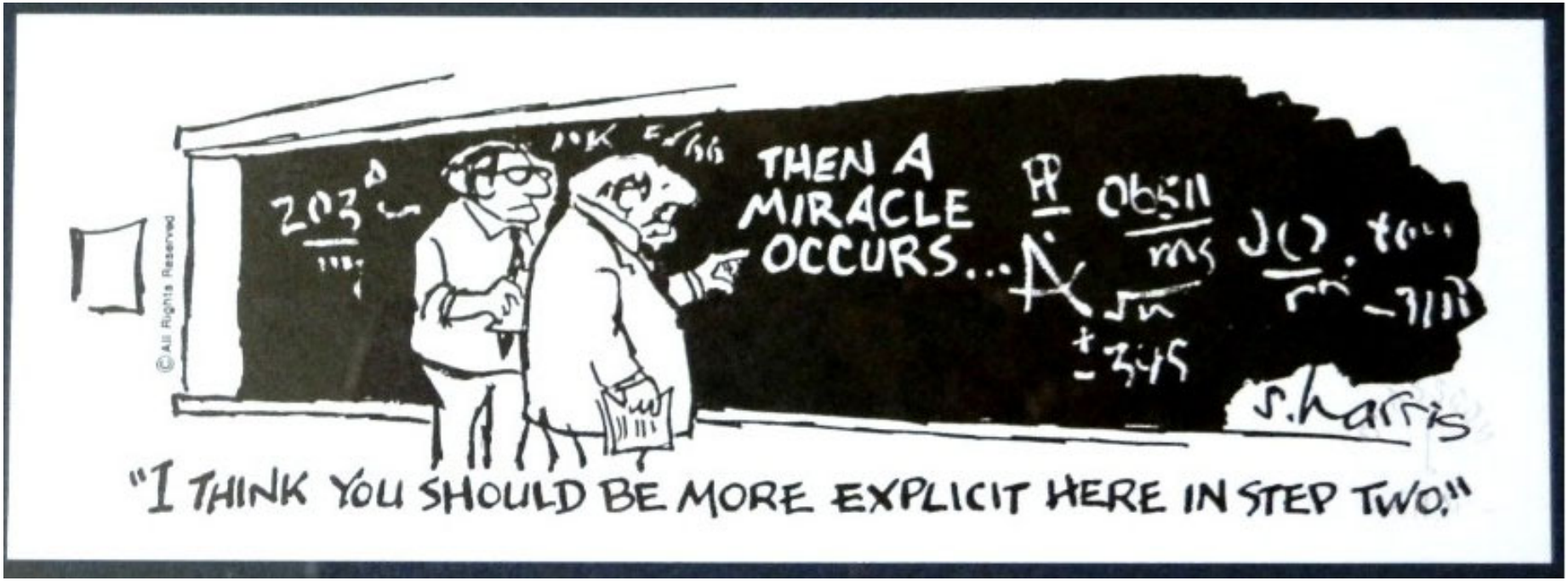
2014
Millom Alliance founded in rural community of 8500 people in response to closure of community hospital and crisis in GP recruitment – assets-based approach embraced

2018
Whole of Cumbria & Morecambe Bay (750k people) supported through 20 community-based alliances – fastest transforming integrated care system in the UK enabling 8-10% year on year financial savings & turnaround in population health outcomes

The Integrated Care Equation



Integrated health and social care teams
(building *real* teams around place and pathways)
+
Activated Individuals, carers and families
(activated individuals use services less and have better outcomes)
+
Communities mobilised at scale for health and well being
(the community as part of the local leadership *and* delivery team)
+
Changed drivers in the health system
(system leadership, system architecture, system culture, changed drivers, impacting on commissioning and provision)
=
A population health and wellbeing system


THEN A MIRACLE OCCURS...
S. Harris
"I THINK YOU SHOULD BE MORE EXPLICIT HERE IN STEP TWO."

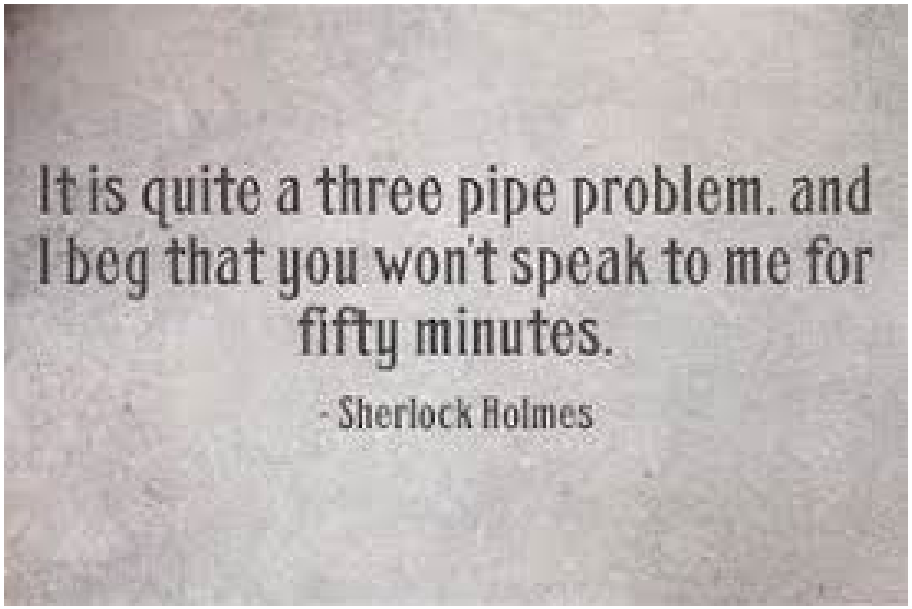
International Journal of Integrated Care

Goodwin, N 2016 Understanding and Evaluating the Implementation of Integrated Care: A 'Three Pipe' Problem. *International Journal of Integrated Care*, 16(4): 19, pp. 1–2, DOI: http://dx.doi.org/10.5334/ijic.2609

EDITORIAL

Understanding and Evaluating the Implementation of Integrated Care: A 'Three Pipe' Problem

Nick Goodwin



- In the diffusion of innovations there is a lack of any robust understanding in how complex service innovations can be implemented and sustained across contexts and settings (Greenhalgh et al, 2004)
- There is a need to unpick how outcomes result from intricate interplay between multi-component interventions in different contexts and settings
- A blend of realistic evaluation methods (e.g. COMIC), behavioural theory and use of mixed-methods may help us understand how, when and why integrated care *interventions* influenced outcomes in specific cases
- Simple implementation models are elusive

So, what is integrated care again?

- Integrate is the combination of two sets of implementation activities:
  - ❖ the ‘integration of things’ to bring together that which is fragmented or misaligned
  - ❖ the process of caring for people and populations
- Integrated care, then, is not a defined intervention – it represents a suite of values, principles, methods and tools that seek to come together in different ways to overcome care fragmentations and improve care quality
- Therefore, integrated care as an activity is about implementation – about how we do things differently
- This means that research and evaluation must recognise there is no discernible difference between the intended intervention (design) and its implementation
- This helps to explain a lot of things … !
- So, if we are seeking to promote a translational research agenda, implementation science needs to move away from generalised explanations of variance to examine and test the implementation processes themselves

Integrated Care: Frameworks for Evaluation

Getting to Grips with Complexity?

The Need for Assessment Frameworks to Support Integrated Care

- There is a lack of evidence supporting ‘how’ to design, pilot, implement, assess, and scale-up innovations that support integrated care;
- Most existing diagnostic frameworks set out the key building blocks of an integrated care system, but are unable to articulate or untangle the highly complex dynamics and interrelationships between key factors;
- There is some understanding of this complexity, but approaches lack the ability to untangle complex relationships;
- There are many existing tools to support measurement of processes and outcomes, but very few are specifically tailored to integrated care;
- There are few effective tools to understand support implementation in practice. Our understanding of what it takes to implement integrated care effectively is at an early stage of development;

Assessment Frameworks May Help Overcome Avoidable System Failures

- Integrated care programmes are fragile for many reasons:
  - Politics
  - Finance and incentives
  - Governance and accountability
  - Professional tribalism
  - Social norms and values
  - Evidence and belief
  - Time
- They require constant effort to nurture
  - Building social capital is a necessity
  - Culture and values are important

- Integrated care projects are often established in isolation
  - Projects often start and remain as time-limited pilots and fail to be sustained, to be replicated, or to grow to the necessary scale and maturity to have impact
- Organisations and systems usually have limited knowledge of, or access to, grounded implementation practice
- There is often a lack of investment in research and evaluation to assess the ability of care systems to adopt integrated care successfully

Assessment Frameworks Can Help Guide Research and Evaluation

International Journal of Integrated Care

Suter, E, et al. Indicators and Measurement Tools for Health Systems Integration: A Knowledge Synthesis. *International Journal of Integrated Care*, 2017; 17(6): 4, 1–17. DOI: https://doi.org/10.5334/ijic.3931

RESEARCH AND THEORY

Indicators and Measurement Tools for Health Systems Integration: A Knowledge Synthesis

Esther Suter*†, Nelly D. Oelke‡, Maria Alice Dias da Silva Lima§, Michelle Stiphout†, Robert Janke‖, Regina Rigatto Witt§, Cheryl Van Vliet-Brown‡, Kaela Schill‡, Mahnoush Rostami†, Shelanne Hepp†, Arden Birney†, Fatima Al-Roubaiai¶ and Giselda Quintana Marques§

"Our findings highlight a continued gap in tools to measure foundational components that support integrated care … Continued progress towards integrated care depends on our ability to evaluate the success of strategies across different levels and context"

Key Points:

- Despite far reaching support for integrated care, conceptualizing and measuring integrated care remains challenging
- From 114 unique tools reviewed, most sought to measure care coordination, patient engagement and team effectiveness/performance.
- Few tools examined performance measures and information systems, alignment of organizational goals and resource allocation.
- The search yielded 12 tools that measure overall integration ('multiple domains')

There are a lot of frameworks emerging …

Some examples:

Disease perspective:
- e.g. Chronic care model & variants (US)

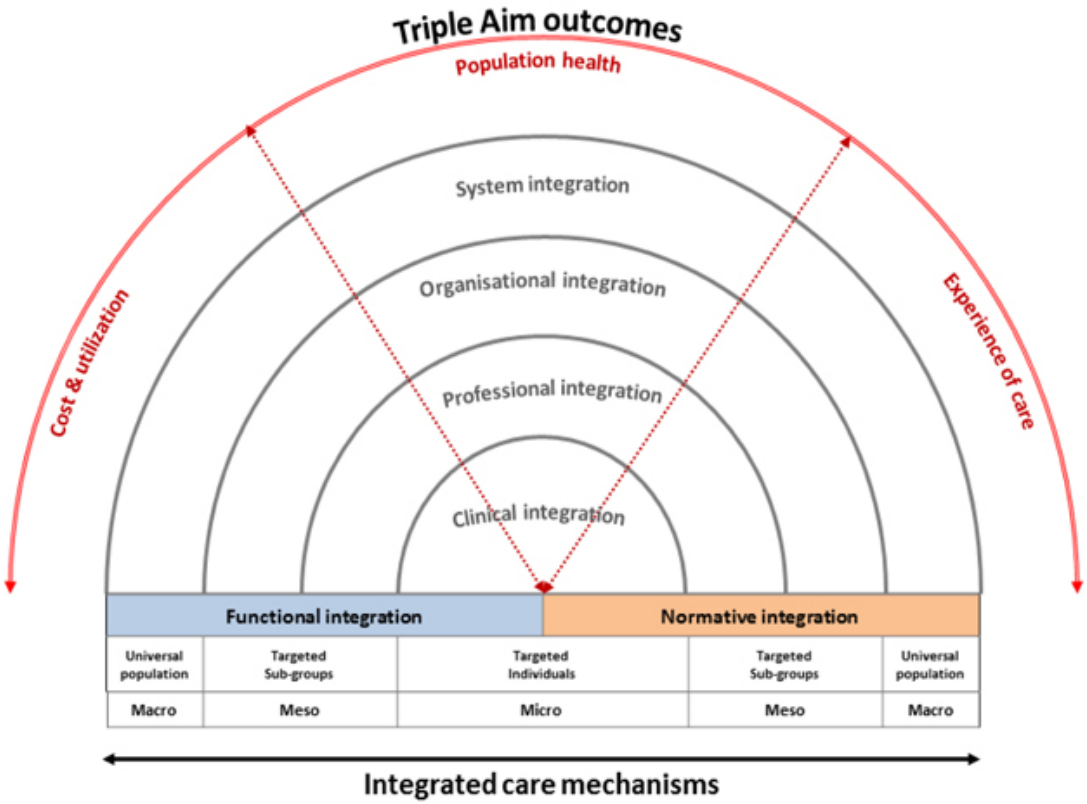
Systems perspective:
- e.g. WHO Global Framework; SCIROCCO (Europe)

Project or programme perspective:
- e.g. Fulop Model, Rainbow Model; Project INTEGRATE (Europe). Readiness Domains (Optimity)

Governance perspective:
- e.g. Ten Key Principles – HSO76000 Standards (Canada); Health Governance for Integrated Care (Nicholson, Australia)

Developmental perspective:
- e.g. COMIC; Development Model for Integrated Care (Netherlands)

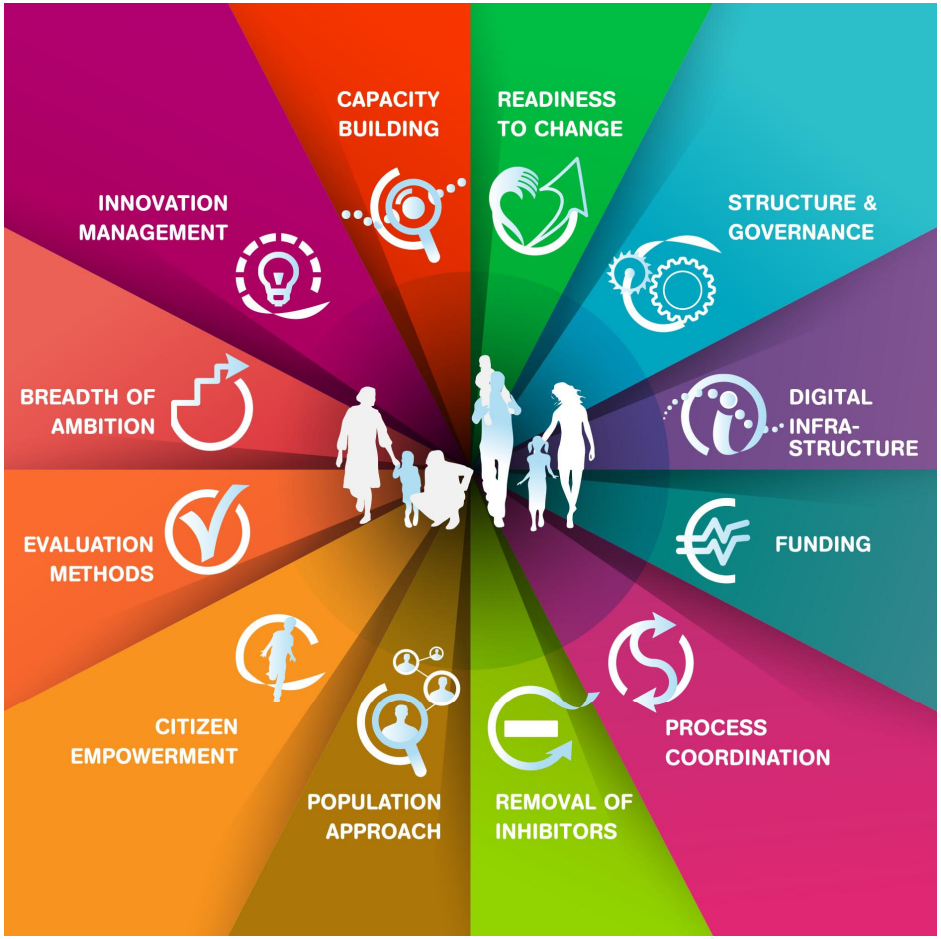
NOTE three key things:
1) People-centred care usually missing;
2) Workforce capabilities usually missing;
3) No/little understanding of how these building blocks operate as a system



Valentijn P et al (2015) Towards an international taxonomy of integrated primary care: a Delphi consensus approach. BMC Fam Pract, 16(1):64-015-0278-x

Integrated Care: System Maturity Indicators

Scirocco Exchange



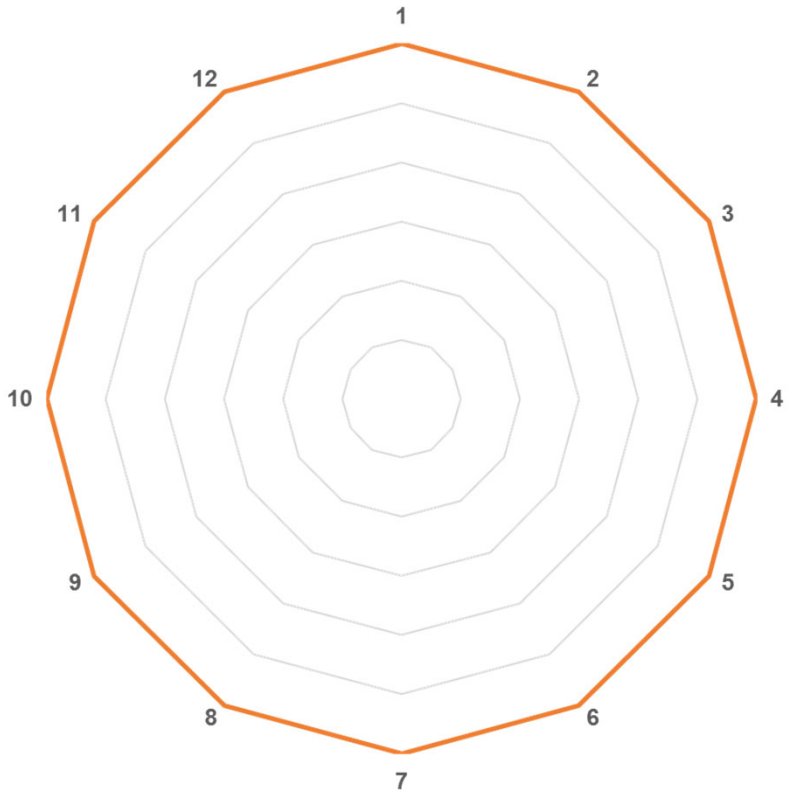
Self-assessment of maturity in care systems to support integrated care

Stakeholder perceptions and multi-disciplinary discussions

Identify strengths and weaknesses of regions to adopt integrated care

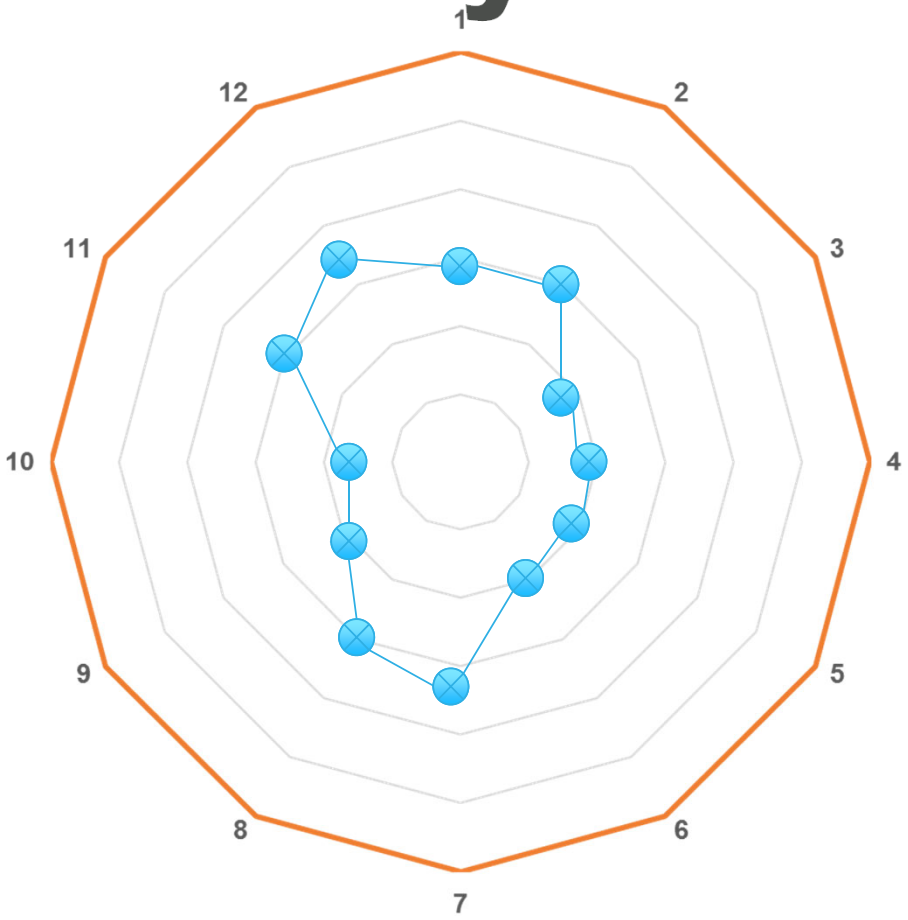
Facilitate improvements through transfer of knowledge, implementation support and ‘twinning’

Australia: A System with Low Maturity for Integrated Care



1. Readiness to Change
2. Structure & Governance
3. ICT & eHealth services
4. Standardisation & simplification
5. Funding
6. Removal of inhibitors
7. Population approach
8. Citizen empowerment
9. Evaluation methods
10. Breadth of ambition
11. Innovation management
12. Capacity building

Australia: A System with Low Maturity for Integrated Care



1. Readiness to Change
2. Structure & Governance
3. ICT & eHealth services
4. Standardisation & simplification
5. Funding
6. Removal of inhibitors
7. Population approach
8. Citizen empowerment
9. Evaluation methods
10. Breadth of ambition
11. Innovation management
12. Capacity building

Basque Country Spain, 2018

Scotland, 2018

https://www.scirocco-project.eu/

The Integrated Care Initiative Tool

International Journal of Integrated Care

Read, DMY, et al. Using the Project INTEGRATE Framework in Practice in Central Coast, Australia. *International Journal of Integrated Care*, 2019; 19(2): 10, 1–12. DOI: https://doi.org/10.5334/ijic.4624

RESEARCH AND THEORY

Using the Project INTEGRATE Framework in Practice in Central Coast, Australia

Donna M.Y. Read*, Hazel Dalton*, Angela Booth*, Nick Goodwin†, Anne Hendry‡ and David Perkins*

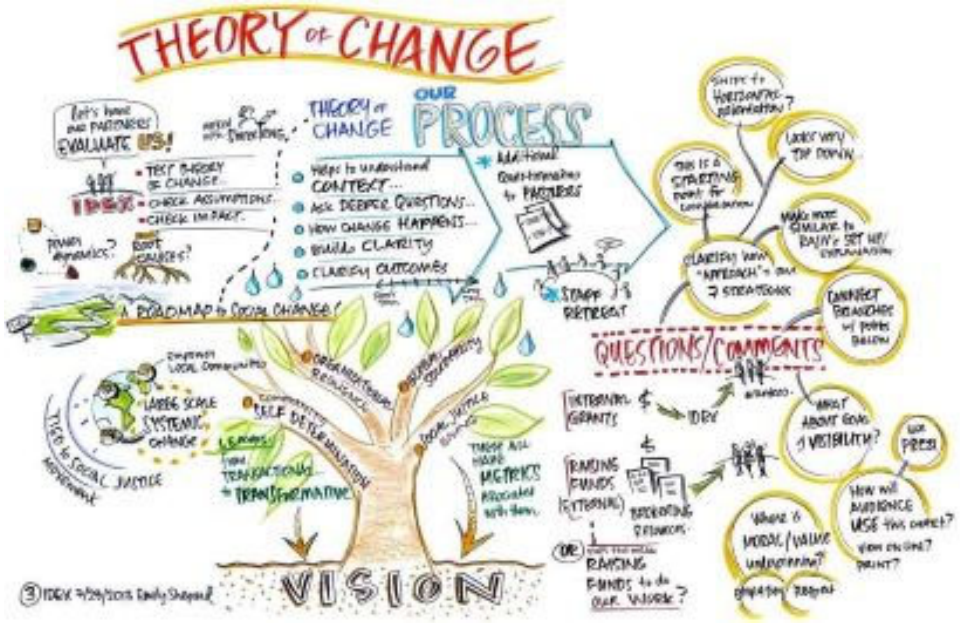
Introduction: Integrated care implies sustained change in complex systems and progress is not always linear or easy to assess. The Central Coast integrated Care Program (CCICP) was planned as a ten-year place-based system change. This paper reports the first formative evaluation to provide a detailed description of the implementation of the CCICP, after two years of activity, and the current progress towards integrated care.

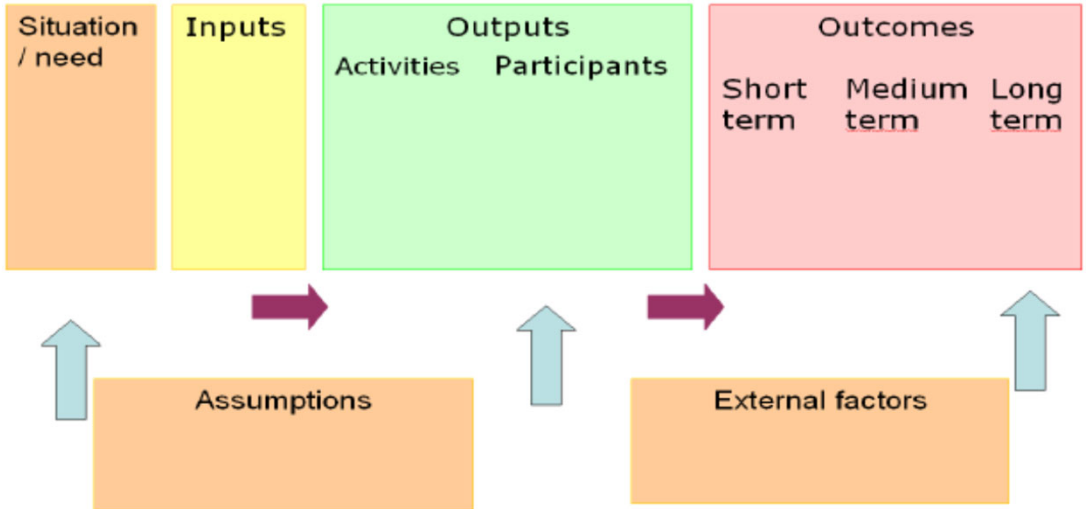
Theory and Methods: Progress towards integrated care achieved by the CCICP was evaluated using the Project INTEGRATE Framework data in a mixed methods approach included semi-structured interviews (n = 23) and Project INTEGRATE Framework based surveys (n = 27). All data collected involved key stakeholders, with close involvement in the program, self-reporting.

Seven domains:

1. Person-centred care: the people's perspective of health & wellbeing and their role as partners in care
2. **Clinical integration: care services that are coordinated with and around consumers**
3. Professional integration: professionals that work together in teams and/or networks
4. Organisational integration: how partners in care work together
5. Systemic integration: an enabling platform for integrated care – governance, accountability, finances, assessment etc
6. **Functional integration – how data and information is effectively communicated across the system**
7. Normative integration – shared vision, norms and value

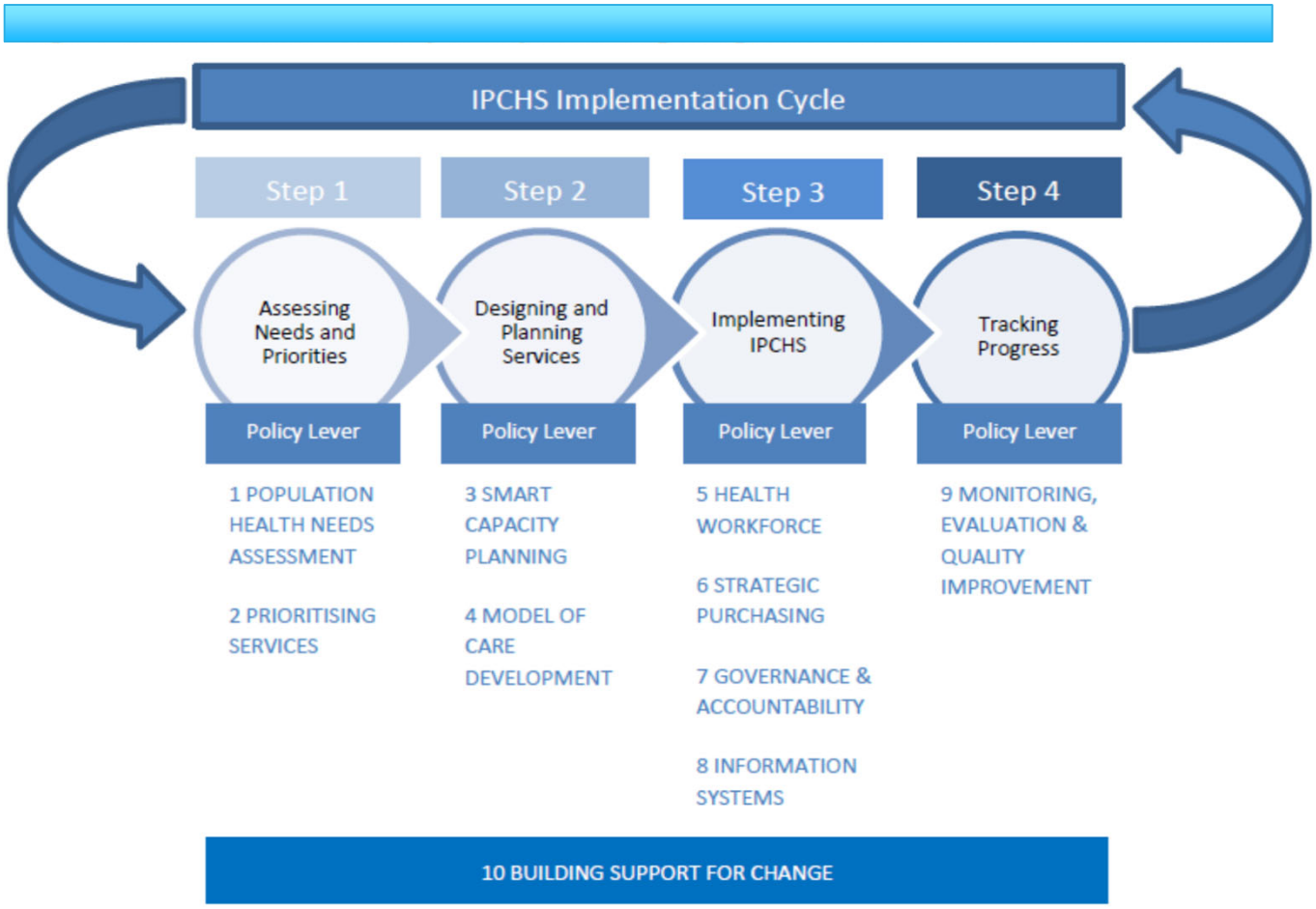
Implementation science requires a theory of change





Wisconsin Model: Planning a Programme Evaluation

Design Thinking & Implementation Pathways (WHO, forthcoming)



Lessons for Australia?

Is there a narrative for integrated care?

Eleven priorities for action

1. Provide a compelling narrative for integrated care
2. Population health focus – integrated thinking on key strategies such as public health, mental health, ageing, children and families – this has the biggest potential for transformational change
3. Engage with the community through co-productive partnerships that empower and promote person-centred care
4. Devolution - take a place-based approach that centres activities on a regional and local basis (key role for LHNs, PHNs, Councils etc)
5. Align financial incentives & move towards pooled budgets and capitation-style contracts - providers to take on financial risks / gain financial rewards
6. Allow innovations in integrated care to embed

Eleven priorities for action

7. Move from micro-purchasing with a short-term competitive tendering mindset to strategic commissioning that develops new types of alliances and contracts for long-term gain
8. Develop new systems of governance and accountability that support integrated care – towards alliances and integrated care systems
9. Support programmes for leadership, organisational development, quality improvement, and coaching to support implementation
10. Invest in workforce skills and capacity – especially in primary and community care settings, and across physical/mental health care
11. **Evaluate the impact of integrated care – focus on value created rather than efficiencies gained – avoid trials mentality - share innovation and learning – focus on implementation science and quality improvement**

Leading the way in integrated care

It is an exciting time for CCLHD and the Central Coast community with the Clinical School and Research Institute for Integrated Care and Population Health, a joint initiative between our District and the University of Newcastle, recently commencing construction – you can read more about this milestone in the Redevelopment Staff Update.

This new facility will transform the ways in which we look at, develop and deliver healthcare, including integrated care which is a priority for our District and the focus of the Research Institute for Integrated Care and Population Health.

With the far-reaching impact and remit of the health system and increasing complexity of the community in which we work, ensuring an integrated care approach is becoming more important to overcoming service fragmentation, delivering value-based healthcare, and ensuring improved outcomes for Central Coast residents.

This was the focus of the paper recently published in the International Journal of Integrated Care entitled: Formative Evaluation of the Central Coast Integrated Care Program (CCICP), NSW Australia. CCLHD authors included Prof Nick Goodwin, Dr Peter Lewis, Michael Bishop, Rachael Sheather-Reid, Sarah Bradfield, Taryn Gazzard, Anthony Critchley and Sarah Wilcox.

You can read the full paper here: https://www.ijic.org/articles/10.5334/ijic.4633/

The article is an in-depth look at the first three years of the Central Coast Integrated Care Program (CCICP). The Program was a complex, multi-component intervention addressing three target populations and more than 40 sub-projects of different scale, priority and maturity. One of the projects, which continues today, is the Family Referral Service in Schools project which targets vulnerable youth and involves multiple partners.

The CCICP was developed in partnership with public and private primary care health agencies after CCLHD became one of three NSW demonstrator sites in 2014 tasked to develop and progress integrated care. The paper provides insights into implementation of the CCICP, key lessons from evaluations, and further supports the need for consistent collaboration and a more integrated approach to health.

As a result of this work, the strong relationship between CCLHD and the Hunter New England Central Coast Primary Health Network (HNECCPHN) has since been formalised under the Central Coast Alliance agreement.

New projects have also emerged, with a NSW Health-funded integrated care scaled initiative on the Central Coast to occur this financial year (2019/2020). It looks to provide additional support to Residential Aged Care Facilities (RACFs) and aims to demonstrate that with assistance, training and access to services, residents can receive care in RACFs where appropriate, leading to reduced unnecessary ambulance transfers and unplanned hospital admissions. Residents, in turn, will also have less risk of infection in hospital and reduced stress burden associated with relocation to a hospital setting.

This important integrated care work continues and will be expanded when the Research Institute for Integrated Care and Population Health opens.

Central Coast Research Institute

Prof. Nicholas Goodwin

Director

Contact: Nicholas.Goodwin@newcastle.edu.au

Faculty of Health & Medicine
PO Box 127, Ourimbah, NSW 2258, Australia

GUEST SPEAKER

DOCTOR JOANNE EPP

Senior Research Fellow
Macquarie Business School
Macquarie University
Centre for Health Economy (MUCHE)

T: +612 9850 1871
E: joanne.epp@mq.edu.au

NSW GOVERNMENT Health Hunter New England Local Health District

RESEARCH ADVANTAGE

NSW GOVERNMENT Health Central Coast Local Health District

Economic Evaluation

Introduction

- Integrated care often assumed to increased effectiveness and quality of care, while being cost-effective or cost saving at the same time
- Evidence of the relative costs and benefits is inconclusive
- Economic evaluation of integrated care is difficult due to complex interventions
- Economic evaluation suited to simple interventions (e.g., health technology assessment)
- Integrated care often involve complex interventions requiring different cost and benefit methods for non-health benefits, such as satisfaction and experience

Economic Evaluation

Challenges

- Economic evaluation involves comparative analysis (e.g., usual practice is often equally complex)
- Study design for integrated care relies on observational design - introduces potential sources of bias and confounding factors
- Often lack of appropriate control group
- Difficult to establish causality – often interaction between control and treatment groups
- Data availability and quality – lack of validated surveys and collection problems
- Evaluation period often too short to capture full effect of integrated care intervention

Economic Evaluation

Challenges

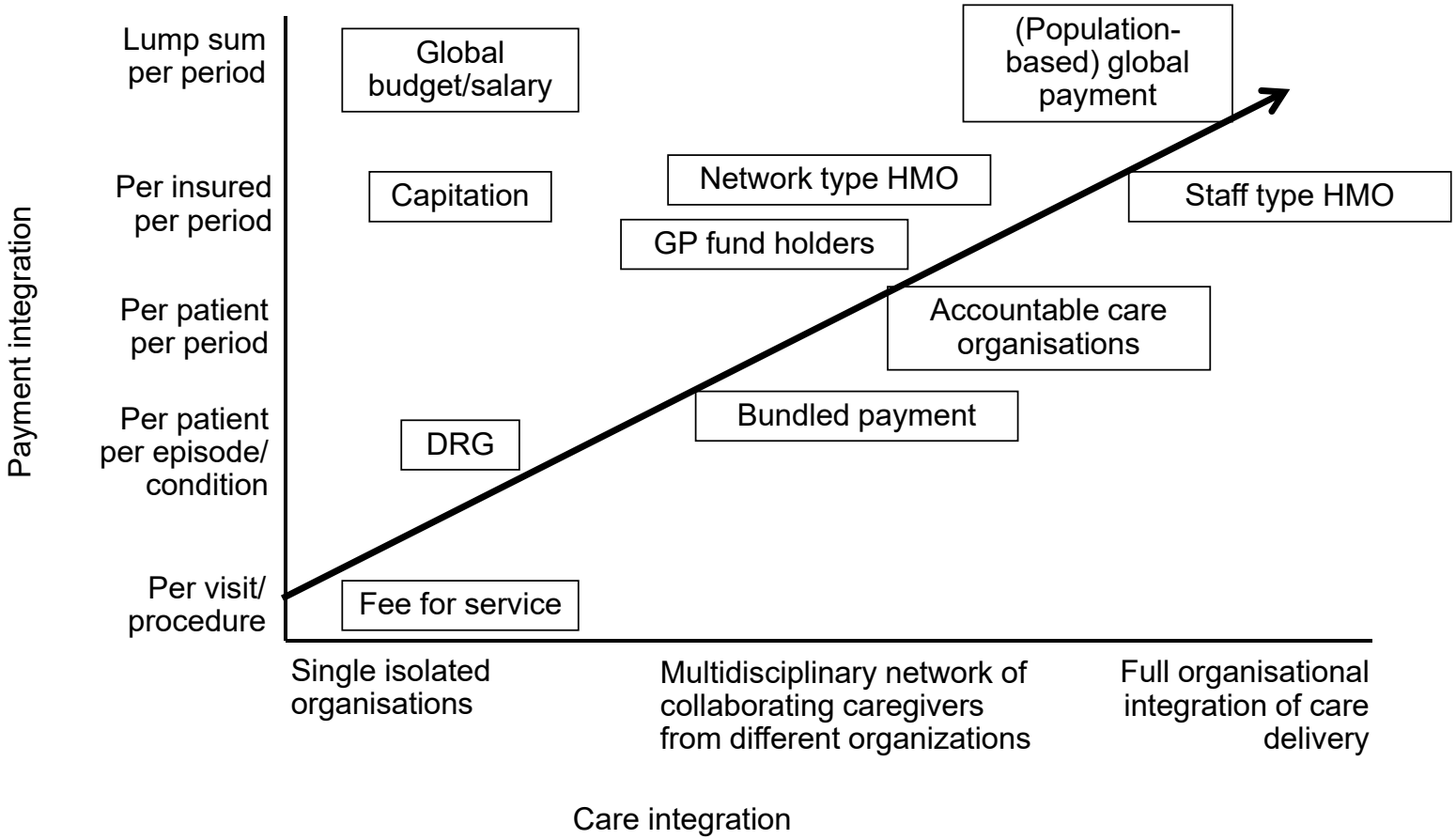
- Integrated care impacts many outcomes at different levels:
  - organisational level and delivery of care
  - patient satisfaction with care
  - access to care
  - informal care-giver satisfaction and quality of life
  - patient's lifestyle and risk factors
  - patient's ability to self-manage and cope with disease
  - clinical outcomes
  - functional status
  - quality of life, well-being and mortality

Economic Evaluation

Challenges

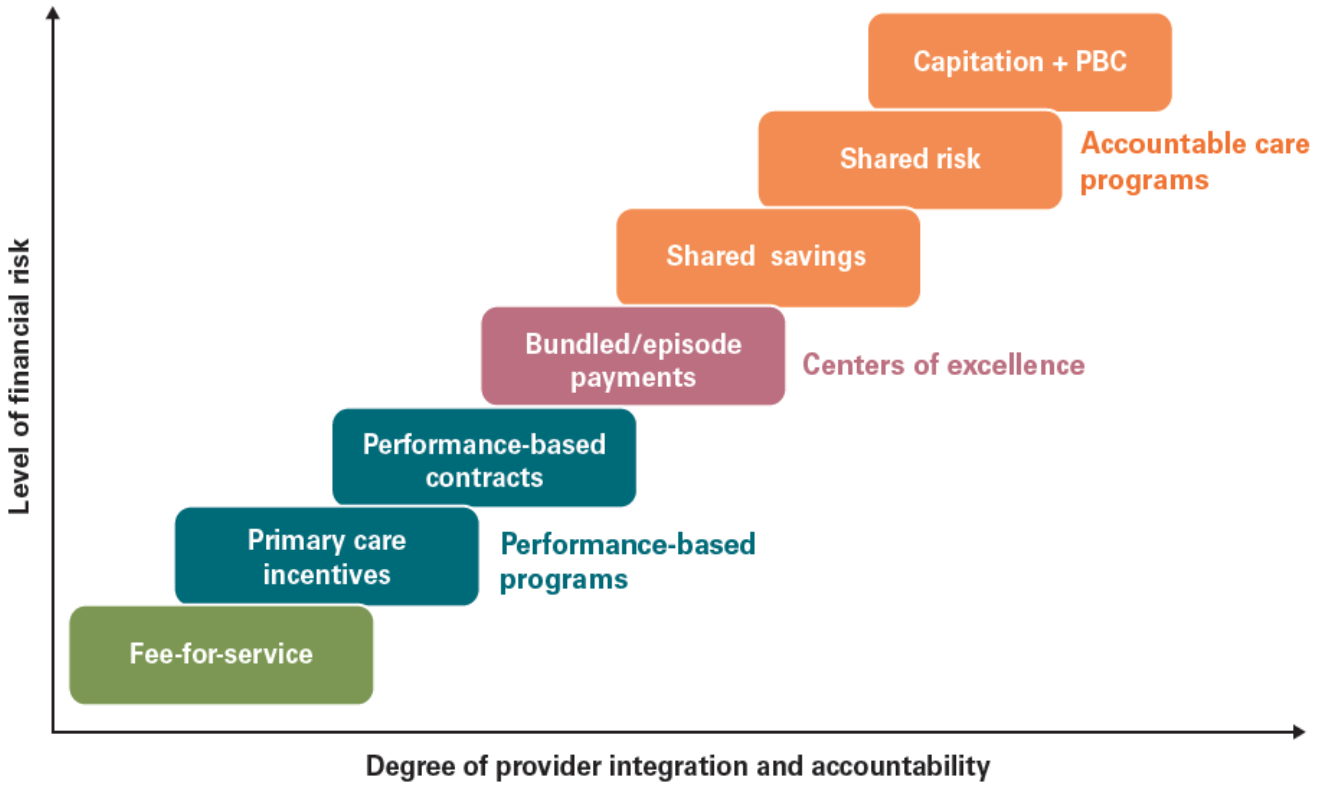
- Integrated care outcomes not captured in current metrics (QALYs), need PREMS, PROMS and other survey results
- Need to consider perspectives at multiple levels (e.g., patient, primary care, community, hospital, funders)
- The role of financial incentives often included in integrated care interventions

Integrated care requires integrated payment, comprehensiveness and scope



Tsiachristas, 2016, IJIC

Financial risk to care providers



Economic Evaluation

Recommendations (Tsiachristas, 2016, IJIC)

- Cost-Benefit Analysis and Cost-Effectiveness Analysis have limitations due to difficulties of quantifying all the benefits
- Cost Consequence Analysis (CCA) considered adequate alternative in combination with Multi-Criteria Decision Analysis (MCDA)
- In MCDA different criteria are weighted according to their relative importance to the decision by different stakeholders, including patients
- Include a process evaluation to provide insights on implementation fidelity

Outcomes Based Commissioning for Vulnerable People Evaluation

- Central Coast Local Health District introduced the Outcomes Based Commissioning (OBC) pilot program
- Aimed to keep vulnerable older people healthy and at home, through care coordination
- Targeted low socioeconomic area in north Wyong with limited access to public transport and coordination of health care services
- CCLHD commissioned two private providers to deliver a care coordination model for one year (2017-2018)
- Provider payments were based on saved unplanned bed days

Outcomes Based Commissioning Background

- The target population was:
  - People aged 65 years and over
  - Two or more chronic conditions
  - One or more unplanned hospitalisations in the 12 months prior
- Four patient groups were identified:
  - Intervention group, consisting of enrolled and not enrolled groups
  - Control group
- 207 patients enrolled and 332 control patients

Outcomes Based Commissioning Evaluation objectives

- The primary outcome measures of Outcomes Based Commissioning were:
  - Reduced unplanned hospital bed days (LOS) and ED presentations
  - Improved health outcomes
- Included an economic evaluation
  - Cost effectiveness
  - Return on investment
- Included a process evaluation

Outcomes Based Commissioning
Additional evaluation objectives

Whether implementation of the provider's model of care (MoC) was undertaken as intended

Whether the design of each provider's MoC led to successes or failures in delivering intended outcomes

How incentives have driven the behaviour of providers

How providers changed their usual care to deliver coordinated care activities, outputs and outcomes

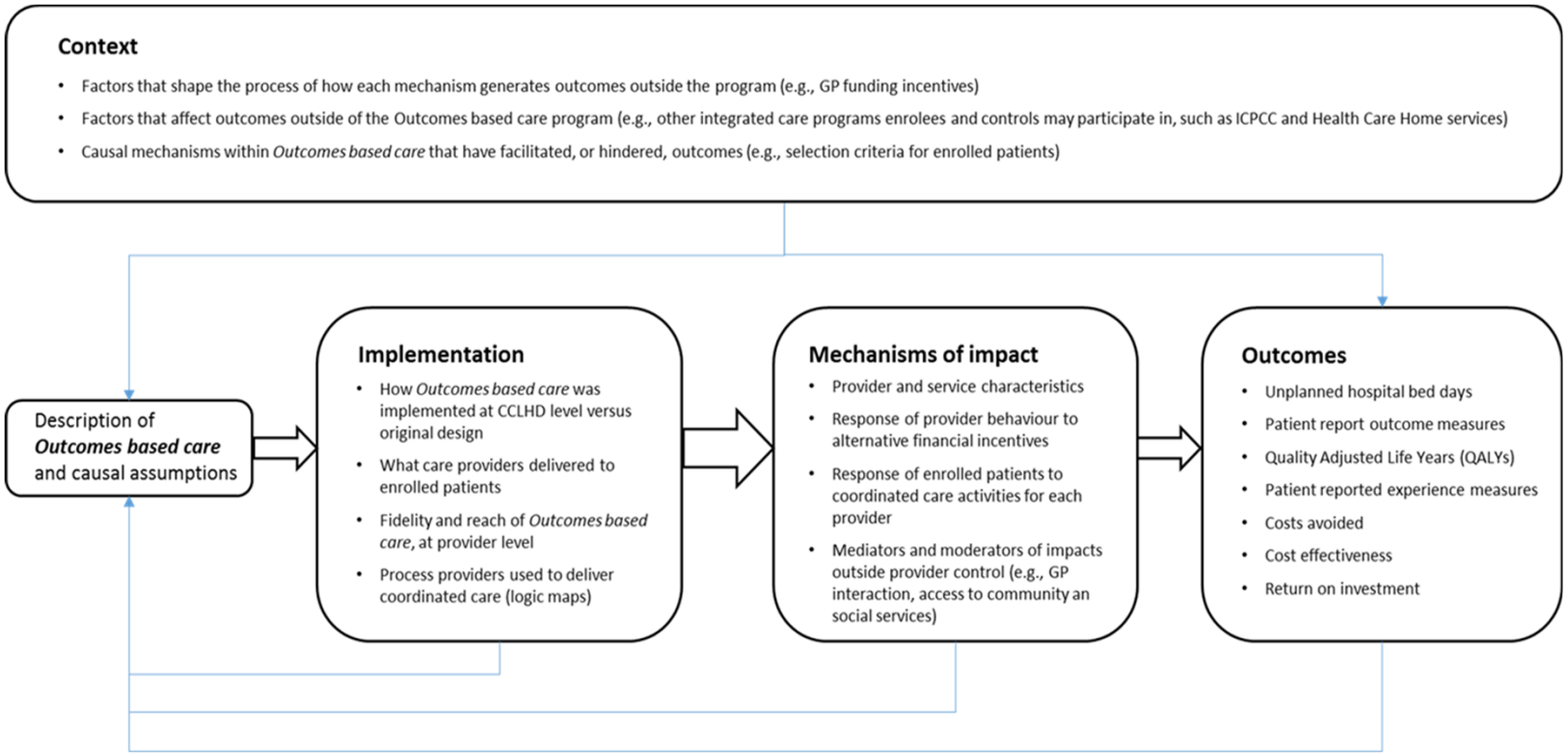
The extent to which providers relied on other healthcare system stakeholders to deliver outcomes (e.g. GPs)

How each providers MoC could be adapted to fit other healthcare and social contexts within Australia and internationally

Outcomes Based Commissioning
Process evaluation methodology

MACQUARIE University

Key functions of process evaluation to assess Outcomes Based Commissioning



Source: Adapted from Moore et al (2015)

Outcomes Based Commissioning Findings

Hospital utilisation

- Increased ED presentations for intervention group, enrolled group and non enrolled group, but not statistically significant
- For unplanned hospitalisations, *Outcomes Based Commissioning*:
    - Increased LOS for intervention group but not statistically significant
    - Increased LOS for enrolled group, and statistically significant
    - Reduced LOS for non enrolled group, but not statistically significant

Health outcomes

- Some evidence of improved health outcomes for the enrolled group from PROMIS

Outcomes Based Commissioning Findings - Implementation

- **Enrolment delays** – resulted in some patients receiving the intervention for 9 months
- **Patient reach** – was lower than expected and patients could not change their mind
- **Patient composition** – the risk stratification process resulted in a cohort of patients older and more complex than expected
- **Timeframe –** enrolment and service delays (Home Care Packages) meant a shorter implementation than planned one year

Outcomes Based Commissioning Findings - Mechanisms of Impact

- **Patient monitoring** – was variable across patients and over time
- **Patient behaviour** – lack of patient engagement reported due to mental illness
- **Access to services** – was delayed (e.g., Home Care Packages)

Outcomes Based Commissioning Findings - Mechanisms of Impact

- **Outcome measurement** – funding model based on predicted bed use; many patients required more healthcare than average
- **Financial Incentives** – providers took on highest level of risk to get largest payment; higher hospital use than predicted resulted in contracts needing to be renegotiated

Outcomes Based Commissioning Findings - Context

- **Communication** – hospital system not able to inform service providers of patient hospitalisations
- **GP Involvement** – fee-for-service model made it difficult for providers to involve GPs in patient care plans

Outcomes Based Commissioning Challenges and Discussion

MACQUARIE University

Complex program literature confirms possible issues relevant to evaluating Outcomes Based Commissioning (Craig P, 2008, BMJ)

- Number of interacting components within the treatment and control interventions
- Number and difficulty of behaviours required by those delivering or receiving the intervention
- Number of groups or organisational levels targeted by the intervention
- Number and variability of outcomes
- Degree of flexibility or tailoring of the intervention permitted

Outcomes Based Commissioning Limitations

MACQUARIE University

Survey data to be collected at enrolment and again when Outcomes Based Commissioning finished

- Surveys not administered as planned and the timings varied for each survey and between the enrolled and control groups.
- Response rates also varied by survey type and mode of administration.
- One provider, in particular did not capture adequate evaluation data.

Outcomes Based Commissioning Lessons Learned

14 evaluation recommendations

- Enrolment process
- Patient reach and composition
- Timeframe
- Measuring outcomes
- Use of financial incentives
- GP involvement and communication

Outcomes Based Commissioning Recommendations

MACQUARIE University

Full report available on MUCHE website

- It is difficult for providers to improve outcomes within one year.
- An upfront data collection and evaluation plan is essential.
- The use of a control group will avoid misleading conclusions.
- Process evaluation should accompany economic evaluation.

https://www.mq.edu.au/research/research-centres-groups-and-facilities/prosperous-economies/centres/centre-for-the-health-economy

Thank you

For more information on this presentation, or the Macquarie University Centre for the Health Economy (MUCHE), please contact:

Dr Joanne Epp
Senior Research Fellow
Joanne.epp@mq.edu.au