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**Measuring outcomes in health settings – concepts to apply to community care**

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## Measuring outcomes in health settings –concepts to apply to community care

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Measuring outcomes in health  
settings – concepts to apply to  
community care

Professor Kathy Eagar, Cathy Duncan and Peter Samsa  
Australian Health Services Research Institute  
Measuring Outcomes in Community Care Workshop  
Sydney, 3<sup>rd</sup> March, 2015

# Overview

- ◆ What we mean by an outcome
- ◆ Why measure outcomes
- ◆ A brief introduction to our outcome centres
- ◆ How we measure outcomes in our outcome centres
- ◆ Benchmarking cycle
- ◆ What we have learned and how this applies to community care

# Outcome

A change in an individual or group of individuals that can be attributed (at least in part) to an intervention or series of interventions

3 key ideas:

- ◆ change
- ◆ attribution
- ◆ intervention

*Outcome*  
 $\neq$   
*Health status*

# Why measure outcomes?

- ◆ Fit with policy environment of personalised care
- ◆ Leads to improved quality

# Outcomes, Needs and Goals

- ◆ individualised measure
- ◆ linked to a person's needs and goals

# Types of Need

- ◆ Normative need
- ◆ Expressed need
- ◆ Comparative need
- ◆ Felt need

(Bradshaw 1972 )



# Goals

- ◆ A simple statement /s
- ◆ The purpose of care
- ◆ People can have many goals
- ◆ A set of goals needs to be individualised and cannot be assumed

# Types of Outcomes

- ◆ Maintenance outcomes
- ◆ Change outcomes
- ◆ Process outcomes

# Level of Outcomes

- ◆ Consumer
- ◆ Carer
- ◆ Service provider
- ◆ System / program

# Outputs and Need

- ◆ Measured outputs do not equate to meeting people's needs

# Outputs vs Outcomes, Miller, 2008

| <b>Service Led Output Focused</b>  | <b>Outcomes focused</b>   |
|--|---|
| Current tools encourage information gathering through standardised question and answer approaches to assessment, support planning and review | Decision making informed by semi-structured conversations with individuals in assessment, support planning and review |
| Tick box approach to assessment  | Analytical skills involved in assessment  |
| The person's views may be included in decision-making  | The person's views/preferences are central to decision making   |
| The person is viewed as a client, service user or patient  | The person is a citizen with rights and responsibilities  |

# Outputs vs Outcomes (cont)

| Service Led Output Focused   | Outcomes focused   |
|--|--|
| Where needs link to strict eligibility criteria, the assessor is required to maximise individual difficulties to access services                     | Outcomes allow preventive work to take place while services and resources are prioritised for those most in need   |
| If the person is deemed eligible, identified needs are matched to a limited range of block provided services, resulting in service driven approaches | Identifying outcomes involve considering a range of solutions/strategies including the role of the person, family supports and community based resources |

# Outputs vs Outcomes (cont)

| Service Led Output Focused  | Outcomes focused  |
|---|---|
| Where needs are tied to eligibility criteria, preventive work with people with low level needs may be excluded  | Outcomes allow preventive work to take place while services and resources are prioritised for those most in need                                  |
| Focusing exclusively on deficits and difficulties, and how needs are to be met, results in a focus on tasks and in services which do things to people | By focusing on strengths, capacities and goals, while mindful of limitations, the role of the person is maximised. Services do things with people |

# Outputs vs Outcomes (cont)

| Service Led Output Focused  | Outcomes focused  |
|---|---|
| Matching needs/deficits to services tends to result in static service delivery  | Outcomes may change in the person's life journey and so should be revisited   |
| Where outcomes are identified, these tend to be professional or organisational outcomes e.g. improved nutrition, or avoid delayed discharge | Outcomes are what matter to the person, though often consistent with professional and organisational outcomes e.g. being able to get out and about. |
| Starting from what services are currently available restricts communication and limits options  | Starting from the person's priorities supports enabling relationships, creates clarity and identifies goals at an early stage.                      |



# How do you assess an 'outcome'?

## Whose assessment counts?

### *The Person*

- ◆ Stay at home as long as possible
- ◆ Function as independently as possible
- ◆ Have maximum confidence, choice and control
- ◆ Have friends
- ◆ Have things to do
- ◆ Come to terms with loss
- ◆ Be happy

# How do you assess an 'outcome'?

## Whose assessment counts? (cont)

### ***The Carer***

- ◆ Maximum wellbeing of person and carer
- ◆ Minimum carer burden
- ◆ Choice and control in determining services

### ***The Provider***

- ◆ Maximum improvement
- ◆ Minimum burden on the service system

### ***The Payer***

- ◆ Maximum improvement at minimum cost?
- ◆ Minimum burden on society?

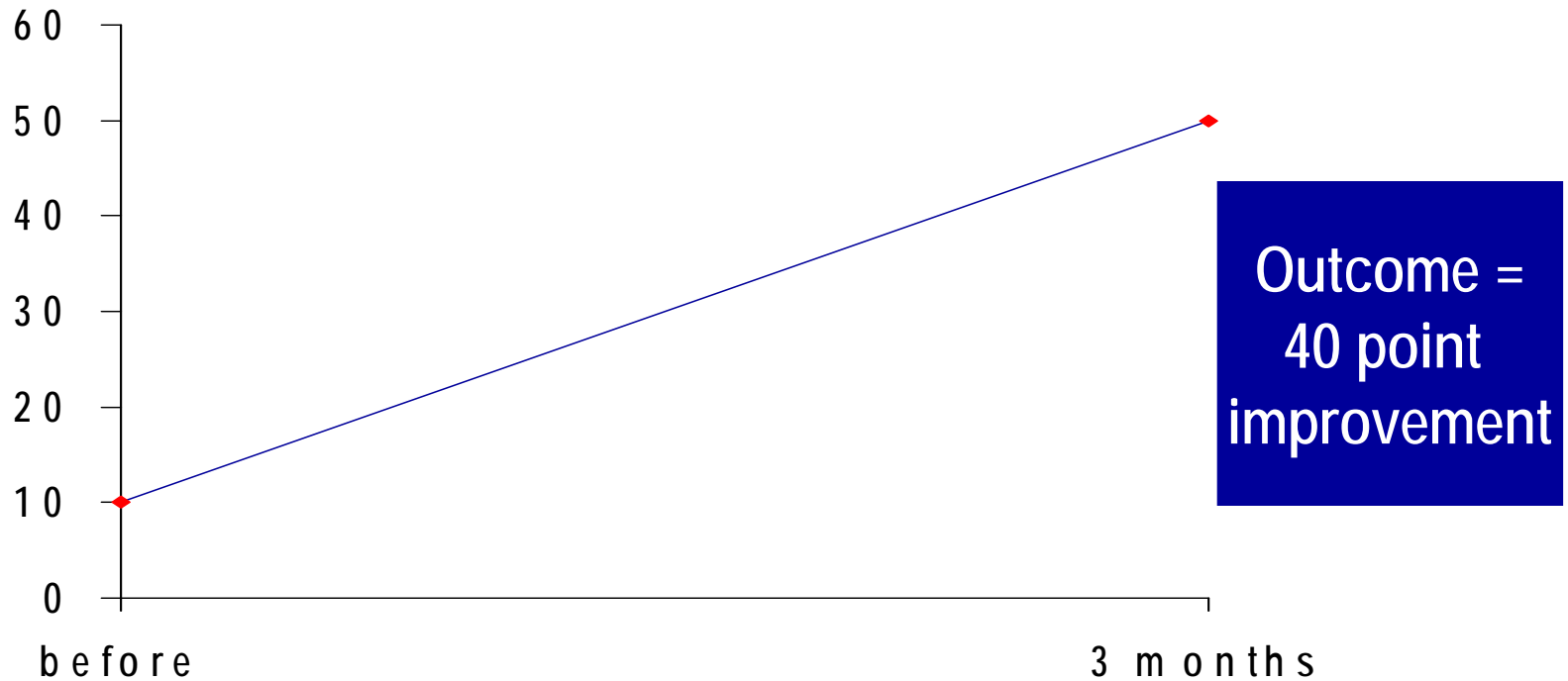
# Outcomes assessment can't be a one-off event

- ◆ Need reassessment, based on a protocol:
  - Significant event (e.g., fall, carer crisis, hospital admission)
  - pre-agreed time periods (e.g., 6 or 12 monthly)
- ◆ Types of outcomes at these points:
  - alive or dead (level 1)
  - better or worse (level 2)
  - better or worse than expected (level 3)
  - value for money (level 4)

# Before and after

- ◆ Health outcome = difference in health status 'before and after' intervention.
  - grounded in an acute care paradigm in which sick patients receive treatment and, as a result, get better.
  - the way that clinicians (and consumers) typically judge the success of most health care interventions.
- ◆ Of limited value in measuring the outcomes for people with protracted and chronic illnesses.
  - Some people have conditions that last a life time.

# Outcomes: Before and After



*The difference before and after the intervention*

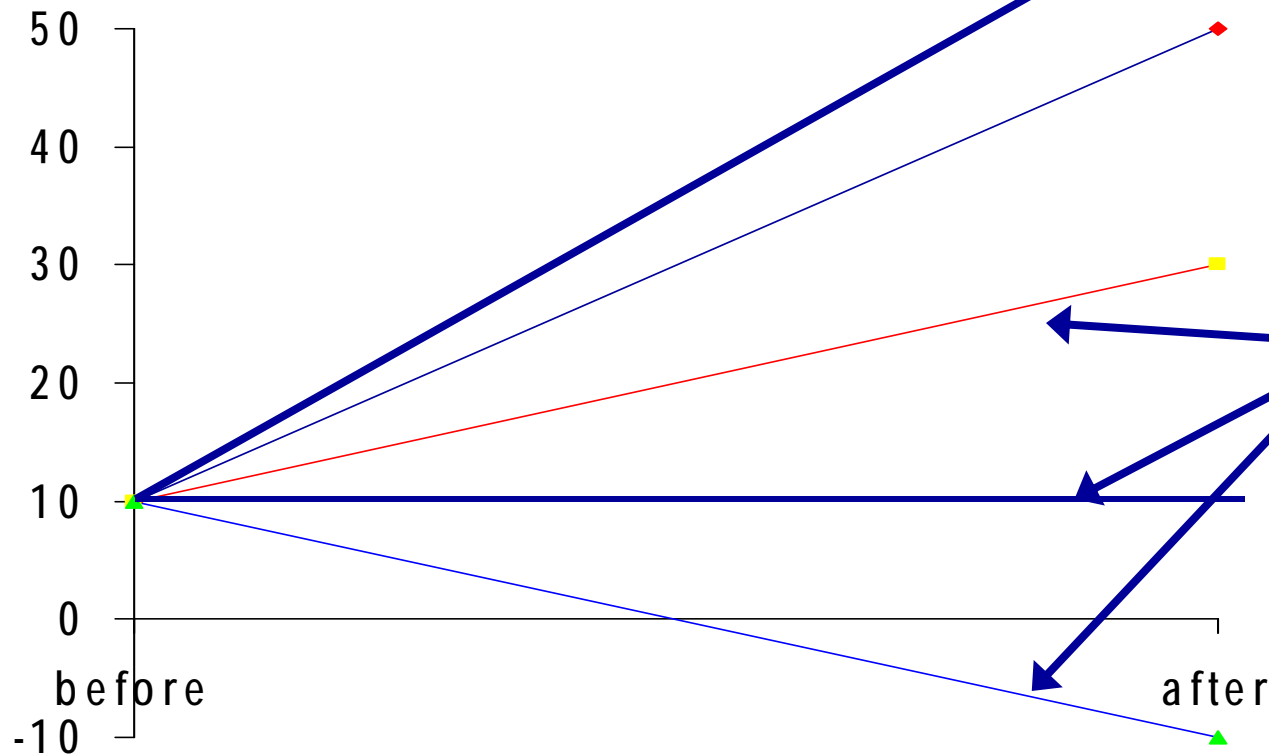
# Measuring outcomes - before and after

- ◆ 2 or more points of time
- ◆ 'Outcome' is the difference between the two
- ◆ Two possible outcomes at these points:
  - alive or dead (level 1)
  - better or worse (level 2)

# With and without

- ◆ Health outcome = the difference between the person's quality of life and health status if they had received no intervention (or another type of intervention) and that person's expected quality of life and health status with the intervention.
- ◆ Includes outcomes for both consumers and carers.

# Outcomes: With and Without



Outcome with this intervention is now either -20, 20, 40 or 50 points improvement, depending on what might have happened with no intervention or another type of intervention

*The expected difference with and without an intervention*



# Measuring outcomes - with and without

- ◆ 2 or more points of time
- ◆ ‘Outcome’ is the difference between the two points in time, taking into account what might have happened without the intervention
- ◆ Four possible outcomes at these points:
  - alive or dead (level 1)
  - better or worse (level 2)
  - better or worse than expected (level 3)
  - value for money (level 4)

# Why measure consumer outcomes?

## ◆ For research and clinical learning

- What works for which consumers

## ◆ To support communication

- Between service providers and across sector (common language)
- Between service providers and consumers

## ◆ For use in service delivery

- To assess and monitor consumer progress and outcomes
- To demonstrate to purchasers that service provision is effective and value for money

# AHSRI clinical repository & benchmarking initiatives

- ◆ Australasian Rehabilitation Outcome Centre (AROC) Started in 2002. Participating services: 372
- ◆ Palliative Care Outcomes Collaboration (PCOC) Started in 2005. Participating services: 130
- ◆ electronic Persistent Pain Outcomes Collaboration (ePPOC) Started in 2013. Participating services: 33

# How PCOC and ePPOC work

- ◆ Work with services to incorporate patient outcome measures **into routine practice**
- ◆ Provide ongoing support through training and assistance with IT
- ◆ Analyse the data and provide feedback on the results to individual services - reports every 6 months
- ◆ Facilitate benchmarking with other services
- ◆ Assist services with practice quality changes
  - Quality Improvement Facilitators (QIFs)

# Approach to pain management

Pain management is core business in both palliative care and chronic pain management, however strategies and approaches differ

## PCOC

- ◆ Aim is for patient to be pain-free
- ◆ Opioids are used routinely in clinical practice

vs

## ePPOC

vs

- ◆ Aim is often to help patient live with the pain
- ◆ Goal is to minimise use of opioids

# Benchmarking

- ◆ Service providers want to know how they are going compared to other service providers
- ◆ Need to compare similar service delivery to similar consumers (apples to apples, not oranges)
- ◆ Need for a classification system for consumers, more sophisticated than level of Home Care Package (e.g., low function, no carer, no cognitive impairment)

# Benchmarking (Cont)

- ◆ Need to provide opportunities for service providers to learn ‘best practice’ from each other, e.g.,
  - \* confidential reports comparing one service’s results to similar services,
  - \* benchmarking workshops, where service providers can meet with others to discuss improvements
- ◆ Challenge of improving outcomes in a competitive tender culture

# Benchmarking (Cont)

- ◆ Has led to significant improvements in performance in AROC and PCOC, ePPOC still in early stages



# What we have learned

- ◆ More focus on consumer reported measures as the three centres have developed
- ◆ Sustainability depends on having clinically useful measures capable of routine collection
- ◆ Importance of measuring and reporting clinically significant change
- ◆ Importance of national approach and Quality Improvement Facilitators for quality improvement, not just for training

# Outcomes in community care

- ◆ More complex environment
- ◆ More variability
- ◆ Availability and sustainability of carer is a critical factor
- ◆ Process of measuring outcomes in community care can build on the logic of health based outcome measurement systems

# What to measure / when to measure?

- ◆ Information for outcome measurement should be a by-product of the information collected for care planning, not an additional piece of work.
- ◆ What is best practice care planning? i.e.: process, cycle, 'phases of care', what triggers a change in care plan, when to review etc.

# What to measure / when to measure? (cont)

- ◆ What information is needed for ‘best practice’ care planning?
- ◆ Are we measuring outcomes for the care recipient, carer or the ‘carer dyad’ or a combination of all of these?

# Conclusion

- ◆ The jury is in - measuring patient outcomes and benchmarking has been demonstrated to drive improvements in patient care
- ◆ There is much more to do in community care
  - Improving the evidence base
  - Implementing the evidence
  - Learning from each other

# Further information

AHSRI - <http://ahsri.uow.edu.au>

PCOC - <http://ahsri.uow.edu.au/pcoc/>

ePPOC - <http://ahsri.uow.edu.au/eppoc/>

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