

## Discussion outputs from DIGITAL HEALTH LEADERSHIP SUMMIT, March 2021

### Topic 6: Moving population health from outputs to outcomes: How do we change the conversation on the measurement for health?

This topic was discussed by groups in Auckland, Wellington and Christchurch.

#### Auckland delegates' responses

<b>Challenges/barriers</b>	<ul style="list-style-type: none"><li>• Who defines the outcome? It should be the patient</li><li>• Disconnect between MoH outcomes/outputs and the patient outcomes. Patient outcomes are not often measured</li><li>• For one surgery/condition, patients may have different desired outcomes. What outcome matters for that patient?</li><li>• What matters to the patient is important, but can we afford to tailor care to individual patient requirements?</li><li>• We have limited resources. We need to understand how best to use those resources</li><li>• Can't deliver a public health system without outputs</li><li>• Minimum service level, anything additional who pays?</li><li>• How do we move the goal of the system to improved wellbeing?</li><li>• The system is structurally disadvantaged to provide outcomes-based care. The system is fragmented – people must “jump through a million hoops”</li><li>• Budget will always be a constraint. “Do more with less”</li><li>• Currently, quantity vs. quality</li><li>• Do we have agreed acceptance criteria?</li><li>• Need to provide equitable access</li><li>• In mental health, difficult to measure outcomes</li><li>• Factor predictive of good child health outcomes is maternal literacy</li><li>• Importance of cohesion of supporting agencies, e.g., health, housing, education</li><li>• DHBs can meet MoH targets but still have ↑ levels of poor child health</li><li>• Outputs are based on funding models</li><li>• Need a lot of health education for the population</li><li>• What outcome do we want to achieve from all the outputs?</li></ul>
----------------------------	--

	<ul style="list-style-type: none"> <li>• Timeframes are often too short to achieve outcomes and programmes may be cut because they can't show positive results</li> <li>• Need to make health information easier for people with disabilities – how do we do this?</li> <li>• Lack of diversity amongst the decision makers → in terms of defining outcomes that matter</li> <li>• MoH require output-based data – throughputs, datapoints, easy to measure. Fits with the way the funding is modelled</li> <li>• Outcomes are often not able to be delivered by one agency, patient reported vs. provider reported, and are measurable, but often considered to be “nebulous”, less easy to equate to \$ spent. Paeds e.g., LOS for respiratory conditions related to immunisation rates, school attendance rates, often depend on, e.g., housing. Demoralising to focus on outcomes that you have no control over</li> <li>• Mental health subjective from a caregiver perspective, and Information is not being provided back to be used for insights</li> <li>• Outputs provide “fast” answers, outcomes are often longer to evaluate (3-year election cycle, 1-year budget cycle)</li> <li>• Barriers to measuring outcomes: Who gets to decide? Who gets to prioritise outcomes?</li> <li>• Outcome measures can be resource intensive</li> <li>• Outcome measures are more often related to wellbeing than health</li> <li>• How do we measure outcomes in a meaningful way over a long period of time?</li> <li>• No need to change the conversation, what is required is the doing</li> <li>• Outcomes may take five years to see improvement, doesn't match with funding cycle</li> <li>• Difficult to capture outcomes with mental health issues</li> <li>• Equity issues if patients cannot afford treatments, cannot access services</li> <li>• DHBs will lose funding if they, e.g., do not complete x number of THJRs. Funding model may drive output vs. outcome behaviour</li> <li>• For Allied Health, difficult to measure contribution to outcomes</li> <li>• Patient satisfaction surveys, ? validity, are the right questions being asked?</li> </ul>
<b>Ideas/solutions</b>	<ul style="list-style-type: none"> <li>• Surgery → rehab → vocation rehab. ACC model - ↓ LOS, ↑ return to work, pathway to support</li> <li>• Need to work harder to understand what patients really want, to understand how to support them to achieve those outcomes</li> <li>• Provide patients with the opportunity to meet with other patients who have experienced their journey, e.g., for a patient with cancer: <ul style="list-style-type: none"> <li>○ Should they have surgery/chemotherapy?</li> <li>○ What outcome do they want?</li> </ul> </li> </ul>

- Is living longer a good outcome?
- Martini Klinik study <https://www.all-can.org/efficiency-hub/martini-klinik-patient-centred-outcomes-data-collection-to-improve-prostate-cancer-care/>
- Value equals outcomes/outputs
- Need to analyse which outputs are most strongly correlated with positive outcomes
- Need to define outcomes with cohorts
- Need to measure \$
- Use of proxies, e.g., return to work – provides a sense of purpose
- Collective value seen in people living well
- If we could measure ROI, then we could make better decisions
- Don't be fixated on identifying the perfect outcome → can revisit and update, will be different for different populations
- We need to measure outcomes and then “tweak” services to improve outcomes
- Involving patients in co-design of solutions
- Need outcomes to be agreed by the patient, provider and funder
- Integrated pathway managed by one provider who then compensates all providers, e.g., GP, surgery, rehab
- Important to pay for the right intervention
- Moving to outcome measures supports equity
- ACC: Moving towards outcomes-based care, e.g., > 65 years, returning to pre-admission health
- Managing risk: Difference between performing 10 knee replacements AND having an outcome where the 10 patients can walk pain free
- Outcomes need to be framed from the individual's perspective
- We want the following outcomes: economic, medical, spiritual and community
- Wellbeing should be the indicator, e.g., ability to contribute to my community
- Improving population wellbeing is multi-faceted, improving access to fitness activities, healthy food, good housing, literacy
- Whānau Ora model seen as positive
- Tackling the “little” things, making tangible changes
- Need to join data from the “big agencies”, e.g., health, housing, education and justice
- Measure whanau contacts
- Outputs should be collected to assess outcomes

	<ul style="list-style-type: none"> <li>• Need to ensure there is consistency in what is being measured</li> <li>• Cardiology seen to be moving more towards patient outcomes, focus on rehab and functional outcomes</li> <li>• Focus on MDT approaches</li> <li>• Rehab: <ul style="list-style-type: none"> <li>○ Measuring “return to work”</li> <li>○ Many contributing social factors</li> <li>○ Impact on person and whanau</li> </ul> </li> <li>• Funding needs to be aligned with outcomes rather than outputs</li> <li>• Put the patient first, measure outcomes</li> <li>• Important to ensure that outcomes are important to the community</li> <li>• “Treat the patients, not the numbers”. As a system, we are working off the numbers</li> <li>• Need staff invested in prioritising the time for goal setting with patients</li> <li>• Have conversations with communities to identify what is important in terms of outcomes</li> <li>• Engage with patients in terms of desired outcomes</li> <li>• Multiple outcomes – short, medium and long term, with all stakeholders</li> <li>• Make sure outcomes are measurable and clear</li> <li>• PROMs: <ul style="list-style-type: none"> <li>○ Patient defined outcomes</li> <li>○ Need tools to document and follow up on</li> <li>○ Patient’s desired outcomes</li> </ul> </li> </ul>
--	---

### Christchurch delegates’ responses

<b>Challenges/barriers</b>	<ul style="list-style-type: none"> <li>• The system drives the behaviour, so what you ask for is what the system will deliver/measure</li> <li>• Preventative care needs to be funded; but it is difficult to measure patient outcomes</li> <li>• Tall Poppy” in NZ – DHBs competing with each other is not good</li> </ul>
<b>Ideas/solutions</b>	<ul style="list-style-type: none"> <li>• Change the deficit discourse towards strength-based approach</li> <li>• Unveil perverse incentives → funding and accountability ties us to outputs; and outputs are proxies to outcomes</li> <li>• What outcomes are important to patients (E.G. Q.O.L.; social determinants)?</li> </ul>

- Create a platform to collate outputs around an individual; to then evaluate outcomes – data points beyond outputs, e.g., touchpoints with the healthcare system, experiences
- We should talk about a journey towards measuring outcomes
- Funding drives behaviour and should fund outcomes
- We need to engage (the right patient/consumer) patients, they speak about outcomes. You must ask questions the right way, create dialogue
- Leadership: To drive for/challenge change in how we operate and measure performance, to enable cross-organisation collaboration
- It is okay to measure outputs if they are linked to an outcome – outcomes are dependent on many components/outputs
- Nationally mandated standards using SNOMED CT will help make DHBs; and make it easier to measure outcomes
- You need to measure outputs and outcomes to deliver an efficient system
- Leadership to enable cross-organisation collaboration
- Emerging technology can help us to gather detailed, personalised data to move population health to precision medicine
- Social work is an outcome-based model; but social work is measured by outputs
- Create tools for engaging with patients to measure health outcomes
- Use data from overseas; where people have moved from outputs to outcomes; that may be applicable to NZ
- Give patients individual health budgets to determine where they spend/allocate resources
- Preventative care needs to be offered to whole population and not to the worst 1%, e.g., youth access to mental health services
- We need joined up datasets; outputs are quite siloed, and pieced together we may measure outcomes
- Data standardisation is required → HPI and SNOMED
- Outputs are point in time, but not necessarily the start of a patient's journey. Outcomes can take time to measure; and can help improve outputs
- Where there is evidence of benefits; output measurement is okay
- Start talking about the effect of social determinants of health
- Measure outcomes in a different way – Statistics NZ international/national view
- To measure outcomes, you need access to quality data, aggregated across primary and secondary care, e.g., planning for podiatry services need access to diabetes data

## Wellington delegates' responses

<b>Challenges/barriers</b>	<ul style="list-style-type: none"> <li>• With palliative care, we don't know what a good death is and who has one</li> <li>• Data is needed to drive change</li> <li>• Government needs to move to a wellness agenda</li> <li>• ↓ body of knowledge around mental health and outcomes, lack of knowledge</li> <li>• Tension between health cost and supporting "positive outcomes" and wellness, e.g., body positive, support for more relevant BMI measures</li> <li>• Resourcing – data is often available but needs resource to analyse and assist with planning interventions</li> <li>• The focus is currently on mortality and morbidity</li> <li>• Cardiovascular data → don't have local information and haven't identified what are positive outcomes</li> <li>• Outcomes are hard to measure, which is why we measure outputs</li> <li>• Not sure that current systems are designed to measure outcomes</li> <li>• If you want to measure outcomes, where do you start?</li> </ul>
<b>Ideas/solutions</b>	<ul style="list-style-type: none"> <li>• Need standard measures</li> <li>• IT systems need to be integrated, part of the clinical process</li> <li>• Identify what outcomes are important to measure</li> <li>• Make the measurement process efficient and scalable</li> <li>• How do we ask questions to get the right information, e.g., ethnicity</li> <li>• Identify what already exists, e.g., Advanced Care Plans</li> <li>• Question the use of anonymised data to analyse the effects of healthcare interventions. IDI can be used, but not for longitudinal analysis. Identify a population at risk and track over time.</li> <li>• Use a cohort, e.g., a school, an iwi, hapu and observe health outcomes – sub populations, specific outcomes</li> <li>• Focus on addressing the enablers of wellbeing</li> <li>• In terms of outcomes, identify what is important to the person</li> <li>• PROMs → Patient Reported Outcome Measures → could we have a national programme</li> <li>• Importance of a well-informed population – health literacy</li> <li>• Importance of measuring qualitative data</li> </ul>

- Use data to identify where best to perform interventions, e.g., smoking cessation
  - Ban advertising
  - Health promotion
- COVID – vaccination:
  - Use of Te Puni Kokiri geospatial data
  - Potential to provide outcomes information
- Measure at the service level:
  - Numbers in and out
  - Should the person be in this service, could we have intervened 6/12 earlier?
- Advance Care Plans – an opportunity to influence a positive outcome
- Example of outpatient DNA rates, seen as negative if patient DNAs but need enablers so that patients can be engaged re best options for consult, e.g., Telehealth
- Diabetes amputation rates, poorly measured – opportunity to ↓ rates
- PHO Quality Plans based on analysis of available data. Form a plan to work on for the year
- Resourcing: Need people with the skills to analyse the data
- Make the data available to individual clinicians so that they can turn the data into insights
- Dream tech – patients with activity trackers, so physios can be directed to patients not mobilising
- Home monitoring – support patients to be independent at home
- Need to identify what the patient experience is/level of satisfaction, e.g., elderly have bowel surgery. Risk of patients having poor outcomes, no longer able to live independently. Patients require more information on prediction of risk to assist with their decision making
- Need benchmarks to measure cause and effect
- Use of wearables to measure patient data, e.g., measure HR for a month pre and two months post-surgery (cardiac surgery)
- Need to be transparent