



Allied Health Framework for Value-Based Health Care

2022



Acknowledgements

The Queensland Health Allied Health Framework for Value-Based Health Care (the Framework) was prepared in collaboration with the Australian Healthcare and Hospitals Association (AHHA), under the guidance of a Stakeholder and Consumer Reference Group.



See Appendix 1 for a full list of those that contributed to the development of the Framework.

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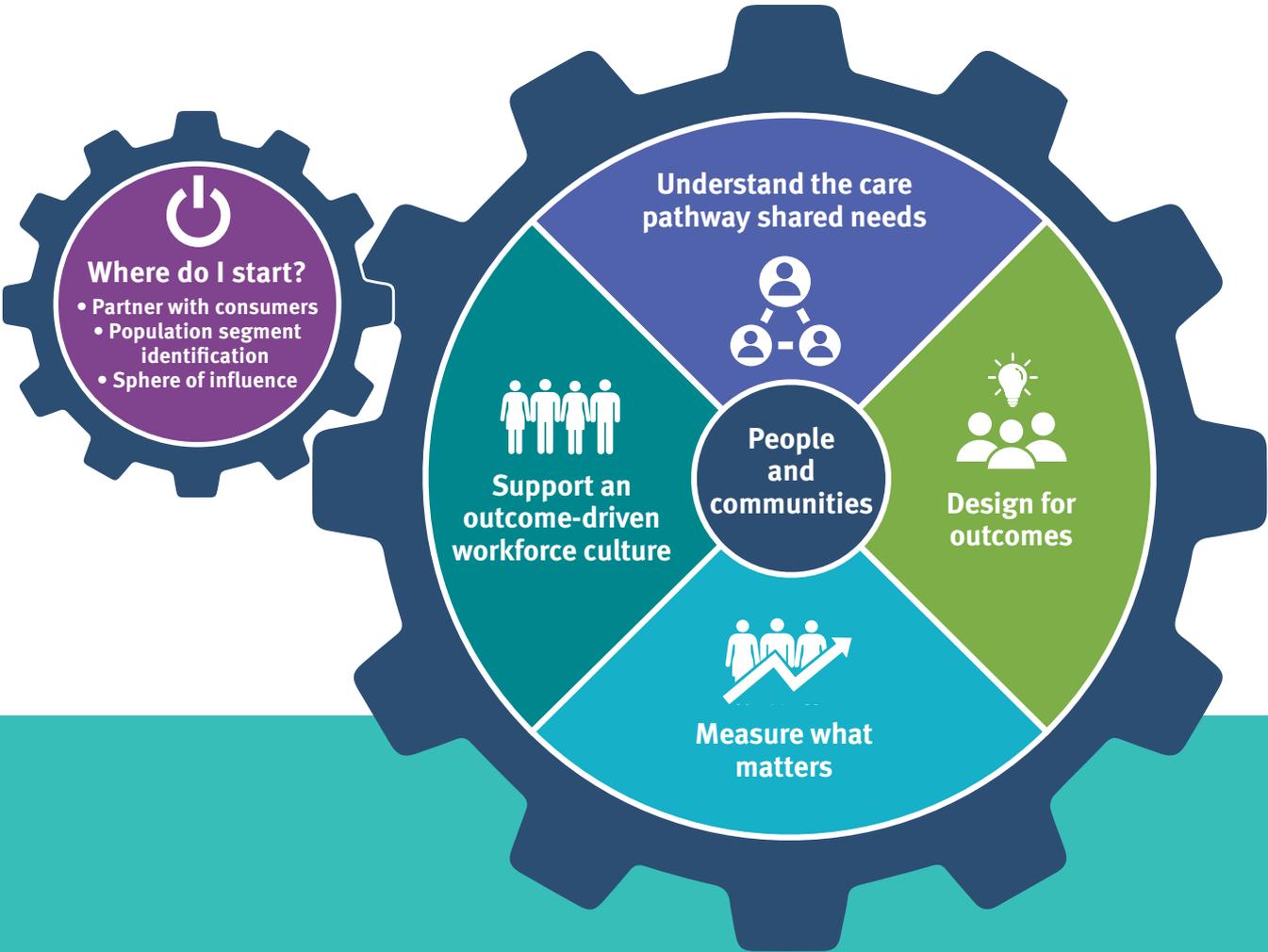
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Allied Health Framework for Value-Based Health Care

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Executive summary

The Queensland Health Allied Health Framework for Value-Based Health Care

Why is it important?

The Queensland Health Allied Health Framework for Value-Based Health Care (the Framework) has been developed to support the implementation and adoption of value-based health care (VBHC) in allied health services across Queensland.

VBHC is an evidence based, person-centred approach to support health care decision making and system transformation, with the aim of improving both health outcomes and the experience of care across a full care pathway for people, service providers, communities, health professionals and populations.¹ It has been defined as ‘the measured improvement in [a person’s] health outcomes for the cost of achieving that improvement.’²

What is it?

The Framework is designed as a tool to support health professionals as they explore VBHC implementation, providing a structure for working with consumers and communities to transform the way care is delivered.

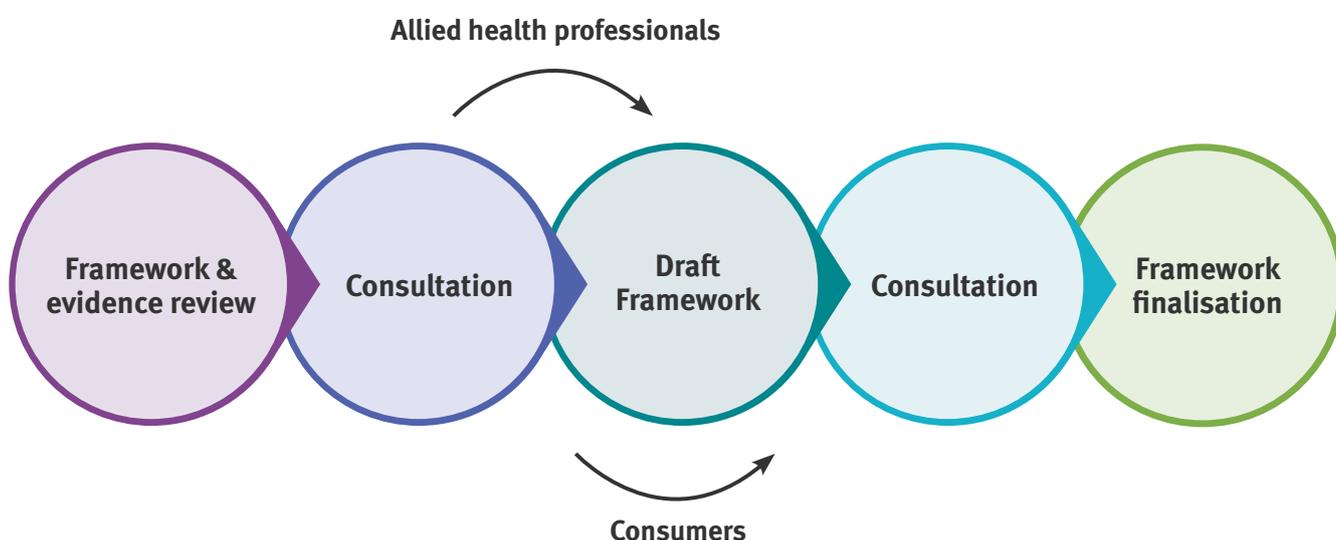
The Framework outlines five key domains that should be considered when shifting towards VBHC:

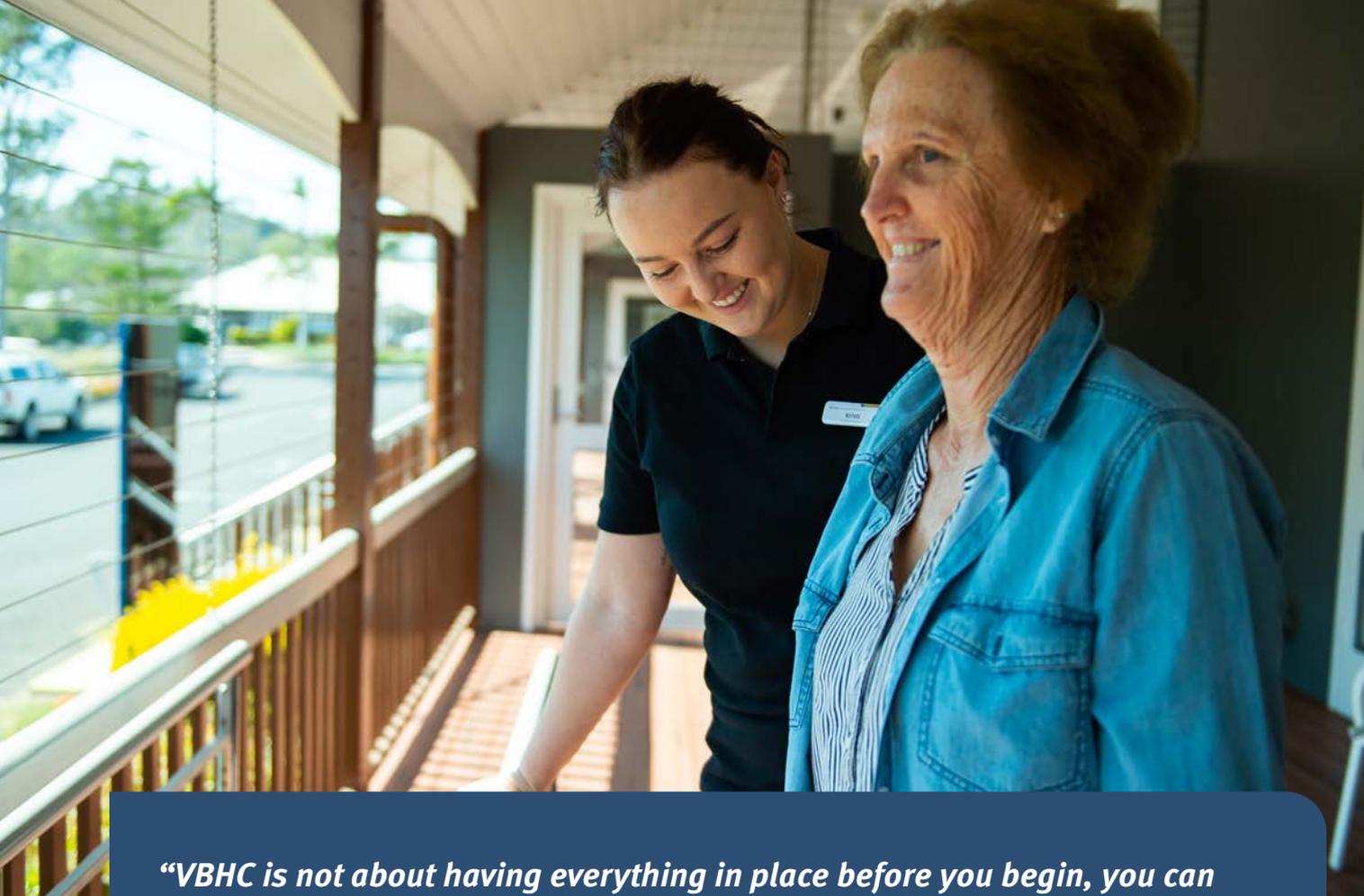
1. Where do I start?
2. Understand the care pathway and shared needs
3. Support an outcome-driven workforce culture
4. Measure what matters
5. Design for outcomes

How has it been developed?

The Framework has been developed in close collaboration with the Queensland Health allied health community and consumers to ensure it reflects the unique context and health system structures of Queensland.

The following phases of work were undertaken to inform the Framework’s development:





“VBHC is not about having everything in place before you begin, you can start anywhere. Just start!”

Dr. Deborah Cole – Former CEO of Dental Health Services Victoria

How is it used?

The Framework is designed to be used by health professionals, managers, project leads, administrators and supporting staff within Queensland Health as they work with consumers and communities to transition towards VBHC-driven service delivery.

The Framework recognises that there is no single pathway for VBHC implementation and that each service provider, team or individual will likely have unique strengths and scope to transition. These should be recognised and built upon to support the implementation of VBHC.

The Framework is designed to reflect the breadth of experiences, challenges and opportunities that encompass VBHC and provide support and guidance as teams, services and systems move towards the delivery of care built around the shared outcomes that matter to people and communities. The Framework is not designed to be an exhaustive information source. Useful resources, links, tips and case studies are highlighted throughout the document identifying key sources where readers can access additional information when and where they need it.

The Framework will be a living document, that, as circumstances change, technology evolves, new evidence emerges, and we learn, revisit and review the way we deliver VBHC, will be updated to reflect the needs and preferences of the health professionals and consumers it is designed to serve.

An overview of the Framework is provided in Appendix 2.

Introduction

Optimising the allied health workforce for the best care and best value: A 10-year Strategy 2019-2029, envisions a health system where all Queenslanders ‘have access to high value, client-centred allied health services with care provided by the right practitioner, in the right setting, at the right time’.³ This objective aligns with Queensland Health’s overarching vision, that by ‘2026 Queenslanders will be among the healthiest people in the world’.⁴

Value-based health care (VBHC) (detailed VBHC explanation available in Appendix 3) presents an evidence-based approach to support Queensland Health’s allied health workforce to achieve this vision.

A transition to VBHC across Queensland Health presents a significant opportunity for allied health to leverage its important role as system connectors and lead implementation of the VBHC strategic agenda across Queensland.

“While some descriptions conflate value-based health care and cost reduction, quality improvement, or patient satisfaction, those efforts – while important – are not the same as value, which focuses primarily on improving patient health outcomes.”

Teisberg, Wallace and O’Hara (2020) - Founders and researchers of VBHC

Allied Health Framework for Value-Based Health Care

Based on the research and evidence base, a literature review, and extensive consultations with the Queensland Health allied health professional and consumer community, the Framework has been developed to reflect Queensland’s unique context and provide a structured way for health professionals, teams, service providers, and organisations, together with the consumers and communities, to embark on a journey of VBHC transformation.

The Framework outlines five key domains that should be considered throughout this journey:

1. Where do I start?
2. Understand the care pathway and shared needs
3. Support an outcome-driven workplace culture
4. Measure what matters
5. Design for outcomes

The Framework is designed to support health professionals, project leaders, managers and administrators through the process of VBHC and recognises that there is no single pathway for VBHC implementation.

Many different people will have a role to play in the development and delivery of VBHC, such as project leads and managers, will be responsible for creating the strategy for change and leading VBHC project implementation, while others will be impacted by, and responsible for, delivering the change. For example an operational staff member working as part of a multidisciplinary team to support people and communities to achieve the outcomes that matter to them (e.g. a catering staff member working with health professionals to facilitate improved nutrition and enhanced energy for a person receiving care). Consumers must play a key role and be integrated and involved in decision making throughout the entire VBHC implementation journey.

This Framework is not designed to be all things to all people. It is designed to reflect the breadth of experiences that encompass VBHC. There will be elements of the framework that may be more or less relevant, depending on the scope and intended outcome of the program of work and this is ok. Each service provider, team or individual will likely be at a different starting point and have unique strengths that should be recognised and built upon to support the implementation of VBHC.

Building on unique strengths and targeting any inherent organisational weaknesses will mean that some elements of the VBHC journey may happen quickly, whilst others may take more time to implement. The pace, and specific 'pain points' of VBHC transformation will likely vary, therefore it is important to partner and learn from others, including health care consumers and their families, to avoid duplication and enhance value through collaborative thinking.

It is also important to recognise that what we design will evolve through time. This should be perceived positively, as any model of care should not be a 'set and forget' exercise. Circumstances change, technology evolves, and new evidence emerges, highlighting the need for continuous improvement. It is therefore important to continually revisit and review the way we deliver VBHC, adding or adapting processes, and removing or disinvesting in elements when they are no longer contributing to improved outcomes for the people and communities we serve.



Tip

It is important to recognise that the term 'value' can mean different things to different people and organisations, including:

- cost minimisation
- cost effectiveness
- embedding values in health care (e.g., equity or on 'health as a human right').
- triple, quadruple or quintuple aim
- patient experience or satisfaction
- an approach to quality improvement
- reducing low value care
- a focus on prevention
- team-based care.

VBHC encompasses all of these elements, and more. It is not about throwing out the processes and approaches that we already use, it is about shifting what we do to produce the best outcomes for people and communities with the resources we have available to us.

Using the Framework

Throughout the Framework you will find:



Key questions to consider

Featured at the beginning of each domain within the Framework are questions that are designed to get us thinking about the key elements that might need to be addressed within this domain.



Partnerships

Partnerships are a critical component of VBHC implementation and should be considered at every stage. Examples of the types of partnerships that we might want to consider are distributed throughout the Framework.

We encourage you to think broadly and creatively. No one has all the answers, and it is important to think outside the box and partner with the people, services, and communities (from a diversity of backgrounds both within and outside the health sector) that can most effectively help us to improve outcomes and enhance value for the people we service.



Tips

Highlights useful tips to consider as you progress through your VBHC journey.

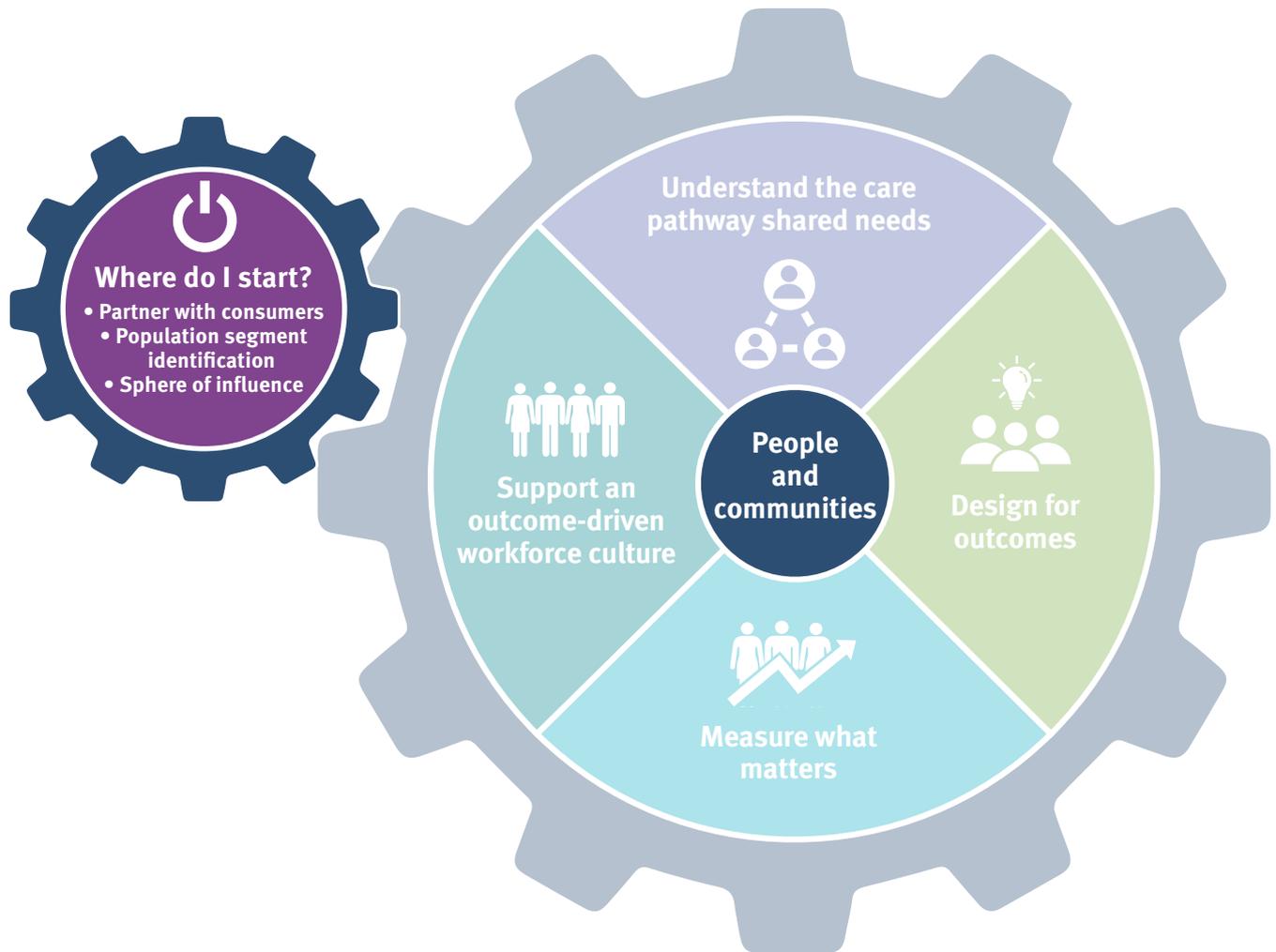


Case studies

There are many examples within Australia and around the world where health systems, services and teams of individuals are transitioning to VBHC. In many instances these examples are not specifically referred to as a VBHC initiative, demonstrating that VBHC is a way of thinking - not a strict process that must be followed.

Throughout the Framework we have highlighted several case studies designed to showcase VBHC work that is currently underway in various communities and population segments. These case studies demonstrate both small- and large-scale initiatives, presenting learnings and practical examples that can help inform our own VBHC journey.

1. Where do I start?



The implementation of VBHC should occur within the context of statewide health service planning and local planning by Hospital and Health Services (HHSs). Integrated planning is important, with all activities aligning with relevant Australian and Queensland Government policy and recognising the complex configuration of responsibility for policy, funding and service provision.⁵

As such, it is important to clearly define the scope of the VBHC initiative, and this will involve identifying a target population segment, (a distinct community or group of people with shared health needs); understanding our initial sphere of influence; and identifying the consumer partners who we will work with to provide a consumer lens across all elements of our VBHC initiative.

1.1 Partner with consumers



Key questions
to consider

- How are we going to make sure consumers are involved at all stages of our project's development?
- What mechanisms are we going to use to identify consumers and embed them in decision making processes at all stages of our project's development?

Why is it important?

When we begin thinking about VBHC and what implementation might look like within our service, it is important to consider who our consumer partners will be. Consumer partnerships are central to VBHC, and a VBHC reform, initiative or project cannot be considered value-based without it.

From project conceptualisation, we should be thinking through the processes and mechanisms we can leverage to ensure that consumer voices are at the centre of our project, initiative or reform. Embedding consumer voices in all stages enables us to design VBHC services that consider a fresh and empathetic perspective on others' needs and on the opportunities that arise from research and observation, and therefore understand what is important (valuable), to them.

What is it?

Consumer partnerships are 'about actively working with people who use the health care system to ensure that care is safe, high-quality and meets people's needs.'⁶ They recognise the value of the consumer voice and its impact on improving consumer experience and outcomes.⁷

How is it developed?

Partnering with consumers involves treating consumers with dignity and respect, sharing information and encouraging participation and collaboration.⁸

There are many different types of partnerships with consumers, carers and families that exist within the health care system.

The National Safety and Quality Health Service (NSQHS) standard identifies three levels at which consumer partnerships can be developed:⁹

- **At the individual level** – this encompasses interaction between people and health professionals at the point of care with the goal to improve the individual's health care. This includes providing care that is grounded in respect, sharing information in an ongoing way, ensuring people, carers, families and consumers are partners in decision making, and supporting and encouraging people to self-manage their own health. Engaging with people at this level throughout the project enables the consumer voice and needs to be considered.

- **At the service level** – consumers, carers and their families are involved in the overall design of a service, department or program including participating in the planning, design, development, implementation and evaluation stages of service improvements.
- **At the health service organisation level** – this involves the inclusion of consumers in the overall governance, policy and planning of health services and systems. This may also involve partnerships with community organisations and members of local communities.

Throughout our VBHC journey, we should continually consider how to leverage and foster these three types of consumer partnerships to maximise our understanding of the outcomes that matter to people and communities and to build services and systems that are value-based and outcomes-focused.

Useful resources

National Safety and Quality Health Service (NSQHS) – [Partnering with Consumers Standard](#)

[Consumers and Community Engagement Framework](#) – Developed by Health Consumers Queensland for Health Organisations and Consumers

1.2 Identify the population segment



Key questions
to consider

- Considering my sphere of influence, what is a population segment with a shared set of health needs that my service or skill set can contribute to addressing?
- How will we ensure equity informs our population segmentation decision?
- Are there segments of the population within our sphere of influence that would benefit from the care we provide but are currently not accessing it?
- What organisational or state government strategies and priorities are relevant to this population segment?

Why is it important?

Population segmentation allows us to separate populations into groups so that we can better assess each group's wants, needs and health priorities. It allows a deeper understanding of the challenges and opportunities faced by a distinct population group, better placing us to design integrated health care models to meet those needs in a way that is outcomes-focused and cost-effective.^{10, 11}

For any population segment, health care requirements may involve a wide range of health services, service providers and settings. Clearly defining the population segment will help to ensure activities prioritised are within the scope of Queensland Health's publicly-funded services and the role of the facility,¹² and that any activities beyond that scope are done in partnership with relevant service providers or coordinators such as with Primary Health Networks (PHNs).

VBHC can enable us to use the current funding mechanism available in new and innovative ways that are more focused on achieving the outcomes that are important to our population segment of interest.

What is it?

Population segmentation involves identifying communities or groups of people that share an interrelated set of needs or circumstances impacting their health that can be addressed in an integrated way.^{13,14}

This may include:

- an interrelated set of medical circumstances
- a shared medical condition inclusive of the most common associated conditions (e.g., for diabetics this could include hypertension, renal disease, retinal disease, and vascular disease)
- similar life stage (e.g., foetal life, infancy and childhood, adolescence, adult life, older age)
- a shared set of environmental conditions
- shared geographic location
- a shared risk profile for a condition or set of medical circumstances
- a shared diagnosis
- shared sociodemographic factors.

A practical example of what population segmentation can look like in practice and how it has been used to design population specific models of COVID-19 vaccination delivery is available on page 66.

How is it developed?

A good way to begin thinking about population segmentation is to link back to the core business of your profession and your organisation, its reason for being and core care principles. Mapping national, state, HHS, service and organisational priorities will also be useful to enable you to identify areas where the needs of your community align.

Using data is important, but limitations in the data should also be recognised. Increasing patient complexity and engrained system silos can create challenges to understanding the full spectrum of a population segment's needs. Multi-stakeholder collaboration, underpinned by partnerships with consumers, carers and their families, and engagement with interdisciplinary teams will therefore be important in helping to inform the development of a shared understanding of a population, their health needs, and their priorities.¹⁵

It is also important to identify and consider the risks and trade-offs associated with working with particular population segments, particularly when operating in fiscally constrained environments. VBHC is about delivering more with the resources we have so cost/benefit considerations can be important to inform segmentation decisions.

Equity should be a core consideration throughout this process. It is important to ensure that the design and benefits of new models of care are targeted and distributed equitably across all population groups you serve.¹⁶ Aside from considering the population groups and people you see and work with regularly, this also means considering those who do not access your services but who have health needs that would benefit from shared pathways of care (e.g., homeless populations, those who do not attend appointments) that are within your sphere to influence.

It is also important to ensure that the population segment identified is large enough to enable economies of scale. If the population segment we identify is too small, we will end up providing a series of boutique services. This can limit the provision of value by creating an imbalance between high service costs and minimal efficiencies throughout the care process. We need to be able to anticipate and plan for common needs of groups to maximise efficiencies and enhance value.

For example, it is possible that population groups that may appear to be distinct segments are accessing the same services, or pathways of care, so can be merged into one encompassing segment, for example people with different types of cancer may have a set of shared needs despite their various diagnoses. Assumptions regarding selection of the right population segment can be tested by interviewing a diversity of people believed to be part of that segment.

Useful resources

[The Queensland Health System Outlook to 2026](#) – Queensland priorities for sustainability of health services have been identified within this document.

Queensland Health. [Guide to Health Service Planning](#), version 3. 2015.

Queensland Health. [Publicly Funded Services Guideline](#), 2019.

[Allied Health Translating Research into Practice](#), Queensland Health.

[Six Sigma Methodology for Service Redesign principles and processes](#), Evans & Lindsay 2015 (Book preview).

[Local Area Needs Assessment](#) Queensland Government 2021.



Tip

Make sure your population segment is:

- identifiable — with attributes clearly defined
- meaningful — representing a meaningful portion of the population in which implementing VBHC change will create efficiencies and economies of scale
- responsive and actionable — able to benefit in response to health care service interventions.

Do not limit your thinking to people and communities who are already accessing your services. Be sure to consider the potential to address the unmet needs of people who are within the scope of Queensland Health publicly-funded services, and the role of the facility, but do not currently access your service.



Case study

DHSV Understanding unmet need in homeless populations

When seeking to understand the needs of the people and communities they served, Dental Health Services Victoria (DHSV) identified people experiencing homelessness as a segment of the population whose needs were unmet. They were not turning up for appointments and accessing the care they needed.

Using an appreciative inquiry technique (explored in greater detail in section 2.1) DHSV went into homeless communities to meet with them and found that many of their preconceptions about the experience and needs of homeless populations (e.g., that they have lots of spare time) were untrue.

Homeless populations in fact had very busy schedules. In order to survive they had to get to certain places at certain times i.e., to access food, to have a shower, to have their clothes washed or to access financial assistance. Homeless populations had to be very organised to maintain a functional life.

Based on this deeper understanding of need DHSV were then able to redesign their services to better meet the needs of this distinct population segment.

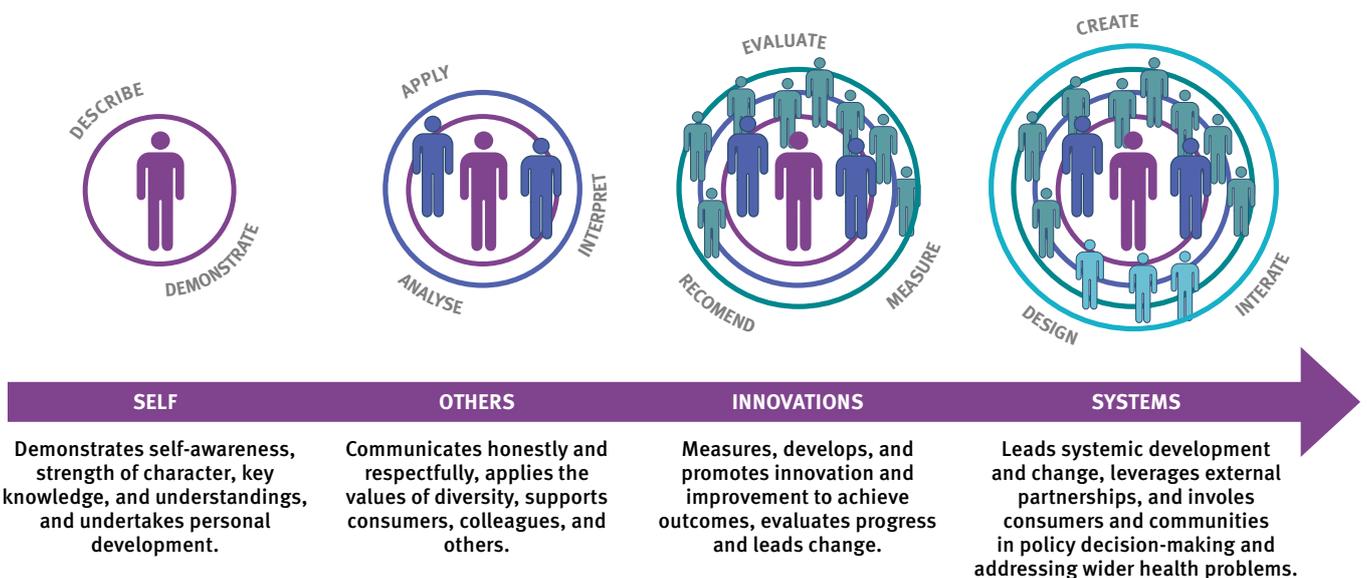


1.3 Sphere of influence

Consideration of our ‘sphere of influence’ is important to how we engage key stakeholders in creating successful change. Implementing VBHC can involve incremental changes as well as ‘big bang’ reforms. What you pursue along that continuum will be influenced by the network of people engaged in the process, their commitment to drive success and their capacity to implement and sustain changes. We refer to this network as our ‘sphere of influence’.

Spheres of influence may change over time, both for us as individuals as we develop professionally (see Figure 1) and through our teams and partnerships collectively, as we establish and build relationships that drive success. When assessing our sphere of influence, opportunities to implement VBHC can be supported by clinician leadership; executive buy-in; and the political landscape.

Figure 1 - Expanding spheres of influence as individuals develop professionally (adapted from PSA 2016)¹⁷





Key questions to consider

1.3.1 Clinician leadership

- Who are the (formal or informal) clinician leaders within our sphere of influence that can inspire, engage, and provide credibility with peers and stakeholders?
- How do we engage and support these key clinician leaders to champion VBHC and generate enthusiasm for its implementation?

1.3.2 Executive buy-in

- How does our work align with the objectives and key performance indicators (KPIs) of my organisation?
- How will we communicate with executives and bring them along on the journey of change?
- How can we demonstrate the unique benefits of allied health services?
- How does this align with Queensland Health and organisational objectives?

1.3.3 Political landscape

- Are there political factors that may impact VBHC reform that we need to be aware of?

1.3.1 Clinician leadership

Why is it important?

Mounting pressures on our health system is leading to inevitable system reform. Health professionals will be challenged to consider the wellbeing of the entire community they serve, not only the person sitting in front of them. Health professional workloads are increasing and with a proliferation of initiatives being proposed, clinician leadership is essential to ensure reform is safe, effective, practical, and sustainable.^{18, 19}

Change is challenging and clinician leaders can be important opinion leaders or champions, as they are able to influence others through their credibility, authority, and status. Effective clinician leaders can encourage and inspire change, creating an environment and culture in which people feel heard, valued, and able to contribute to a collective goal informed by ‘what works’ in practice.²⁰ Clinician leaders are able to recognise how to motivate those around them, communicating the message that change can help improve workforce wellbeing and enable health professionals to reconnect with their healing purpose.²¹

Nevertheless, before they can effectively advocate for change, clinician leaders need to understand why they are embarking on VBHC reform. VBHC requires working with the main players – health professionals, people, and communities – not directing activities to them.

Allied health professionals are an innovative and versatile group of professionals who support and connect care along the continuum, from emergency and acute care through to outpatient care, community health and primary prevention.^{22, 23} They are uniquely placed to provide effective clinician leadership in VBHC as demonstrated through the case studies on page 49 and 66.

What is it?

There is no single definition of clinician leadership. Instead, clinician leadership is often defined through a series of characteristics in which an individual begins taking responsibility for, and working on, the behalf of others (e.g., health workforce, people, and communities).

To be effective, clinician leaders must be seen to be credible, and recognised by colleagues as having clinical competence. They must have the skills to influence and communicate across interprofessional and sector boundaries,²⁴ and be able to negotiate the balance between clinical judgement and resource constraint with management and executive.

Clinician leaders are those who maintain a significant amount of clinical work to remain in touch with the realities of current practice and retain credibility with their clinical peers.

How is it developed?

Clinician leadership skills can be developed through courses and training materials. However, clinician leadership is often embedded in practice, learning from others, and testing leadership skills through practical experience. Mentoring opportunities also present an effective method to upskill health professionals and develop leaders.

How is it used?

They do not have to be the project lead, however securing the public support of clinician leaders is critical in raising the profile of VBHC and ensuring widespread acceptance of change.

Successful implementation is more likely when clinical leaders from multiple disciplines and professional groups are involved as supporters, and empowered to influence and persuade their respective services and professional groups.

1.3.2 Executive buy-in

Why is it important?

As health care becomes more integrated, responsibilities become intertwined, and decisions become interconnected. Engaging early with the executive of our service will build our own situational awareness, help us to develop balanced proposals, define scope and strategically frame our ideas for support.

Engagement with executives will help ensure that our program of work considers and adheres to the relevant governance and reporting structures, enhancing whole of service information sharing, quality improvement and process compliance.

Gaining executive buy-in can help us to link and leverage different organisational silos to work together towards agreed priorities and outcomes. It can also provide a mechanism for securing resourcing in the form of personnel, space, equipment, time, and money to support VBHC implementation. Engaging with executives, also presents the opportunity to highlight the benefits of allied health skills and leadership, demonstrating the value allied health can bring to our organisation through alignment with VBHC principles and organisational, HHSs or Queensland health priorities (See case studies throughout the Framework and further information about the role of allied health in VBHC at the end of the Framework).

What is it?

Executive buy-in can be described as the acceptance and willingness of executives to actively support or participate in something (e.g., VBHC).²⁵

This support may take the form of project approval, resource allocation (funding, personnel, space, time, equipment), public endorsement, partnership brokering, political management (internal and external), workplace culture development and more.

How is it developed?

Key strategies that can assist in successfully gaining executive and institutional support for a change initiative within a health care setting include:²⁶

1. **Priority** – align with broader organisational wide strategic priorities. Understand and clearly demonstrate why the work is important and how it aligns with the goals of executives. This will help secure access to resources already mobilised for institutional efforts in this space.
2. **Pragmatic** – present a plan that includes anticipated barriers and potential solutions.
3. **Proof of concept** – demonstrate that the idea is feasible and can produce results (e.g., through a pilot initiative).
4. **Politics** – perform a stakeholder analysis and find opportunities to work with peers and colleagues instead of against them. Building coalitions of support (as highlighted in the case study on page 49) will enhance our credibility and involving people whose networks do not overlap with ours will expand our sphere of influence. We should also recognise the value of critics and use their feedback to strengthen our arguments for change.
5. **Persistence** – just because we get a no at first does not mean that the project cannot succeed. It may mean that we have not appropriately articulated the ‘why’ and need to revisit how we align this with organisational priorities. It is important to keep trying in a respectful manner and recognise the importance of timing.
6. **People and power** – involving consumers in the development of the plans, and working with consumers to co-present to executives, helps demonstrate that you’ve taken a person-centred approach that is focused on creating improvements in consumer outcomes and experiences of care. Sharing power with consumers in this space is important to create transformational change.

The skill of ‘managing up’ can be useful here. It involves identifying and using similar skills and traits of executives or managers to help bring out the best in us as employees. This includes identifying the best way to communicate with our executives, understanding what is important to them and demonstrating that we care about them meeting their performance goals. ‘Managing up’ makes both our managers and our own job easier and enhances the value we provide.²⁷

Executive support is something that should be continually revisited, cultivated and maintained throughout the entire VBHC process. Considering and developing appropriate two-way communication and feedback mechanisms will be critical to facilitating ongoing dialogue.

How is it used?

Executives set the culture and behavioural tone of an organisation. Consequently, executive buy-in can be critical to the creation of an organisational environment that is supportive of VBHC reform. Executive buy-in should be used to help sell VBHC within organisations. Securing an executive champion who supports the vision and advocates on our behalf in senior forums can help garner support at the high level. Public executive endorsement of VBHC can instil a project with credibility and legitimacy, facilitating broader workforce support (see the case study on page 66 for an example of where this has occurred in practice).

Executive buy-in can also be critical to helping us understand macro level organisational and system issues, allowing us to better anticipate and plan for any potential roadblocks and leverage upcoming opportunities. It is important to establish regular channels of communication with executives keeping them informed and regularly updated on the progress of implementation. Doing this ensures they feel a part of the process and can share in and claim the successes.



Case study

Fostering an outcome-focused allied health workforce culture with the 'permission to lead'

The COVID-19 response within the Cairns and Hinterland HHS has had a strengthening impact on the allied health workforce within the organisation. The urgency of the situation created an environment in which allied health staff were given 'permission to lead', to step up and do what was needed to be done. Exemplifying this was the identification of the Executive Director of Allied Health as the person with the right balance of skills and expertise to lead the entire response.

As a result of their experience working as part of the COVID-19 response, many allied health professionals have gained skills and insights outside their usual scope of practice (e.g., allied health professionals managing the quarantine and isolation hotels or assisting on the virtual ward or to deliver vaccines). These new skills and expanded spheres of influence have created an allied health workforce within the HHS fuelled by an increased confidence in their abilities and an openness to new and innovative approaches of delivering care, creating a workforce culture responsive and adaptable to change.

Key enablers that were integral in the creation of this collaborative, change responsive workforce culture have been identified as:

- opportunities for allied health professionals to stretch their skills, supported by executive and enabled by growth and development mentoring
- providing a respectful and supportive environment into which staff could participate and provide input into strategic decision making
- opportunity to attend high level meetings and strategic discussions in which they could learn through observation
- providing exposure to the variety of services and professions across the health system, enabling staff to gain a more comprehensive understanding of how everything fits together and identify opportunities for innovation
- encouraging and supporting creative problem solving
- giving public credit to those who had done the work
- ensuring the flow of information to equip staff to make informed decisions.

1.3.3 Political landscape

Why is it important?

It is important to understand the political landscape of the people, communities, and services in which we intend to implement our initiative so that we are aware of, and can plan for, any potential barriers, mandates or enablers that may impact our initiative's design or implementation.

We may also need to consider issues broader than the specific health needs of people and communities. This may include considerations of how our work might positively or negatively influence, for example, local employment, regional development, and infrastructure.

What is it?

Understanding the background, interests and Parliamentary responsibilities of our elected representatives can help us build relationships and gain support for the work we want to do. This includes ensuring we are aware of and understand any key national or state-based reform agendas (e.g., the findings of a Royal Commission or a key health strategic reform agenda) that align with our case for change.

However, as public servants, employees of Queensland Health (including anyone who works for the Department, a HHS, the Queensland Ambulance Service, Board members or anyone contracted to perform a service for these entities), must be cognisant of existing Queensland Health guidelines for interactions with elected officials. Approval should be sought from senior officers.

How is it developed?

Mapping can be a useful way of examining the political landscape to understand how existing issues and structures might impact VBHC implementation. This can include mapping external structures such as the political system, party politics and policies, the regulatory environment, public opinion, other players in the VBHC space, partnership opportunities, funding structures and the global political context.²⁸

Consideration should be given to the inclusion of consumers in mapping process as they can provide useful insights into community opinion.

Understanding the political landscape enables us to tailor a project to capitalise on supportive internal or external structures (e.g., leveraging existing political mandates, relationships, or interest groups to advance our agenda). It will also enable us to better plan for and overcome any potential roadblocks or opposition.

While we are unlikely to address all issues and opportunities identified through the mapping process, having an awareness of what is occurring in the broader landscape can prove to be useful throughout our VBHC journey and will enable us to capitalise on opportunities when they arise.

How is it used?

Mapping and understanding the broad political landscape in which we operate can enable us to identify opportunities and areas of alignment that, where appropriate, we can capitalise on to explore partnerships and build support for our VBHC initiatives.

Useful resources

[Health Sector Advocacy Handbook](#)



Partnerships

Have you thought about how you can expand your sphere of influence through the development of partnerships?

Executive support can help facilitate the building of partnerships across disciplines, sectors and industries. They have access to arenas that clinicians and mid-level managers do not, and often have longstanding relationships with business, people and communities who they can access to cultivate support and connections for you and your initiative.



Case study

Health Justice Partnerships

Health Justice Partnerships can enable the expansion of a health professionals' sphere of influence through connecting with legal services. These partnerships help to address the complex problems in people's lives, such as a lack of housing or poor quality housing, fines and debt, violence, abuse and neglect, that impact an individual's health outcome, yet whose solutions sit outside of the health system.

Health Justice Partnerships²⁹ are designed as place-based models that evolve and vary over time with the aim of improving health and wellbeing:

- for individuals, through direct service provision (e.g., legal services) in places that they access (e.g., health care facilities)
- for people and communities vulnerable to complex need, by supporting integrated service responses and redesigning service systems around client needs and capability
- for vulnerable populations through advocacy for systemic change to policies which affect the social determinants of health.

Examples of Health Justice Partnerships across Australia are available [here](#).

2. Understand the care pathway and shared needs



Understanding pathways of care, the consumer care journey through the health care system, is a critical element of VBHC. It allows for the identification of shared needs and opportunities where the care pathway could be redesigned to improve outcomes, experiences, and efficiencies. When thinking about the care pathway we must be mindful of the elements of care that are within our sphere of influence to impact and create partnerships across sectors and services to facilitate smooth transitions, that enable people and communities to access more joined up care where people don't have to repeat their stories each time. Creating care pathways where people access the right care, at the right time, in the right place and from the right service providers.

Once we have identified the population segment to focus on, journey mapping and genuine and meaningful consumer engagement processes are key to empathising with them and enabling us to understand their experience of care.

2.1 Engaging with people to understand their needs

Why is it important?

‘Giving people an equal voice as active partners in health care improvement leads to better outcomes for all.’³⁰ Better health outcomes are achieved when health professionals, organisations and services partner with people and communities (e.g., consumers, patients, carers, families) to design and deliver care.

The insights and information gained from people who have a lived experience of a condition or care pathway enables health care professionals, services, and organisations to avoid mistakes, learn, innovate, and identify unmet needs and improvements.³¹ People with lived experience can provide a unique perspective on the ways services interact with each other and how this may impact daily life – elements often unseen by experts and health professionals but can have a big impact on health outcomes.³² It is also required as part of the National Safety and Quality Health Service (NSQHS) Standards (Standard 2 – Partnering with consumers).³³

What is it?

Engagement in health care refers to a wide range of strategies and approaches that involve people and communities in the design, planning, delivery, implementation and evaluation of health care services.³⁴

Engaging with people and communities can typically be described in two ways:

1. ensuring peoples voices and choices are central to the process of decision making around their own care
2. ensuring peoples voices and experience drive health services and systems improvements in performance and the experience of care.³⁵

A key consideration that should be at the forefront when developing and implementing methods of engagement is cultural safety. Cultural safety involves creating an environment that allows people to reflect and examine their own cultural identities and attitudes, seeking to improve the delivery of care though encouraging health professionals to be aware of, and reflect on differences, power dynamics, their own bias, attitudes, assumptions, and stereotypes, and how this all contributes to differences in the delivery of care.^{36, 37}

Cultural safety prioritises the experiences of the person receiving care and allows them, rather than the health professional, to determine if the encounter is safe.³⁸ The importance and benefits that can be achieved through listening to people and communities in a culturally safe environment are highlighted in the case study of the Aged Care Assessment Team (ACAT) implementation of a new model of care in the remote Aboriginal and Torres Strait Islander community of Yarrabah (see page 55).

How is it developed?

Co-design is described as a ‘way of bringing consumers, carers, families and health workers together to improve health services.’³⁹ Co-design goes beyond traditional partnering methods to involve consumers throughout the entire system, service planning or development process. It enables consumers to become equal partners in the improvement or design process, able to identify issues and reflect their needs and preferences throughout the entire pathway of care.⁴⁰

Experience Based Co-Design (EBCD) is a methodology that combines elements of design thinking and quality improvement to focus on improving the experience of care for health professionals, people, and communities. It goes beyond the usual approaches, bringing people together to understand the experience of care from multiple perspectives.^{41, 42}

Experience Group Sessions™ is a methodology developed by the founders of VBHC that bring small groups of people together with shared needs to identify health and lifestyle challenges that make it difficult to manage chronic medical conditions.⁴³ It allows people and their families to talk openly about how they understand their health, what they fear in relation to their health or diagnosis, and what they need to live a full life.^{44, 45}

Appreciative Inquiry is a strengths-based, positive approach to engagement and organisational change. It involves working with people in various forums to explore strengths and successes that already exist (internally and externally) and how they can be leveraged and built upon. This helps foster relationships and culture, create a common vision, and energise collective action.⁴⁶ The four distinct phases of appreciative inquiry include:⁴⁷

1. Discovery – exploring the best of what is
2. Dream – envisioning the future we really want
3. Design – leveraging the best of what is and visions for the future to design high impact strategies that move organisations forward
4. Destiny (Deploy) – putting strategies into action and revising when necessary.

Research can also be important to understanding the shared experiences and needs of people and communities (refer to the partnerships section below). Research can provide in-depth analysis of people and communities health and experiences through time, offering population level insights on health outcomes and experience, and providing a starting point for engagement. It also enables us to understand what initiatives have already been executed and any learnings we can adapt to.

Focus groups are a form of social research that bring small groups of people together who are generally demographically similar or who have common traits or experiences, to participate in facilitated discussions in which they share their perceptions, opinions, belief and attitudes towards a service, organisation, concept, idea, project or issue.⁴⁸

Kitchen table discussions are a consumer engagement methodology that can be used to hear community views on variety of subjects. They are unique in that they are facilitated and led by consumers, with a consumer host selecting the time and venue for a small group discussion on a topic or issue. This ensures the creation of a safe, friendly and supportive environment in which a diverse cross section of the community can express their views.⁴⁹

Yarning circles are a timeless way of learning which focuses on weaving stories together through facilitating people from different world views to come together to speak respectfully and contribute to a shared knowledge.⁵⁰

How is it used?

In the context of VBHC, engagement with people and communities is a critical first step to ensuring that we understand the needs and experiences of our population segment of interest, and to inform the process of journey mapping.

Engaging with people and communities enables us to accurately understand needs as well as how people access and move through our health care services.

It can also be used to support more comprehensive health strategies by ensuring that the health care needs of population groups in their entirety are considered (for example, the social, economic, health and environmental needs).⁵¹

Useful resources

[Experience Based Co-Design Tool Kit](#)

Video – [Importance of community engagement](#)

National Safety and Quality Health Service (NSQHS) – [Partnering with Consumers Standard](#)

Health Consumers Queensland (HCQ) offers free on-line training for all QH staff on how to partners with consumers effectively. Free on-line training is available [here](#).

[Patient Experience and Consumer Engagement: A Guide to Build Co-design Capability](#) – NSW Government Agency for Clinical Innovation



Partnerships

Have you thought about how you can better understand shared needs through partnerships?

Research institutions can be a useful partner to help us access and understand information about the shared needs of diverse population groups.

During the summer of 2019-2020 bushfires the Australian National University commenced longitudinal research to assess the impact of poor air quality related to bushfires in the Canberra, NSW South Coast and South East NSW regions, on the health and well-being of pregnant women, new mothers and their babies (Australian National University Medical School, 2020).

Aboriginal and Torres Strait Islander women and their babies were a particular focus due to the severe impact on this group within the region. With the COVID-19 pandemic following shortly after, research was expanded to take into consideration the impacts of this crisis as well.



Tip

Approaching evidence-based co-design ^{52 53}

While evidence-based co-design can be approached in a flexible manner, success will be dependent on:

1. Our **mind-set and way of thinking**. We must focus on deeply understanding the experiences and emotions of service users and staff, not attitudes or opinions.
2. The **methodology**. The methodology chosen must foster an environment where all people have an equal say. Traditional power arrangements must be disrupted to enable people with lived experience, and who may be vulnerable, to take part in the conversation. This requires dedicated time and resources for service users and staff.
3. The **tools** used. Different tools will be necessary to gather experiences. Avoid defaulting to traditional surveys. Instead, choose tools that will best meet the needs and preferences of the different groups. Examples have included yarning circles to understand the stories of Aboriginal and Torres Strait Islander people or engaging young people in local community settings.

Be prepared for evidence-based co-design projects to take 6-12 months.

2.2 Journey mapping



Key questions
to consider

- Do we understand the total care pathway of the people and communities we serve?
- What are the important touch points along the care journey? What changed as a result of that touch point? If that touch point had not occurred what would have happened? Could things be done differently?

Why is it important?

Care pathways evolve over time, often as a consequence of responses to local conditions such as variations within the service, the workforce or the broader environment. Work arounds are developed by different health professionals and groups, resulting in people having different experiences each time they interact with the health service. These pathways can be unnecessarily complex and difficult to navigate, inefficient or even ineffective. Furthermore, there are inefficiencies for the people receiving and providing care if there are multiple pathways being provided in one organisation.

By partnering with people, communities, consumers, their carers and their families, we can build a shared understanding of their experience of care for all service providers involved in that care pathway. Together we can make improvements that provide the best outcomes and experience of care for the resources available. This is fundamental to a value-based approach. (See case study on page 28 for an example of where this has occurred in practice.)

It is also important here to consider and map other services within the care environment. Are there other services that could be delivering elements of care within the pathway more efficiently and effectively? Are there partnership opportunities that could be explored with non-government organisations (NGOs) or private entities both within the health sector and more broadly that could enhance the value and outcomes delivered for the people and communities we serve? If so, this presents an opportunity to explore and develop partnerships to enhance integration and maximise system efficiencies.

What is it?

It is a visual tool that maps a consecutive series of 'touch points' between a person and service(s) that actively contribute to a person's experience of care.

How is it developed?

There are many methods that can be used for journey mapping. Importantly:

- Health care services are described from the perspective of the person receiving care and their carer or family.
- We engage with people to examine the reality of their care journey compared with the journey that the staff in the health service assume it to be.
- The voices of people and communities outside of the health service setting are included as they will often be more candid in their descriptions of the care pathway.
- Time is taken to consider those with the greatest health needs, who may not routinely be involved in this type of activity.
- The diversity of our community is considered, including First Nations Australians and their families, and those with complex care needs who need holistic and seamless care from a number of health professionals across a number of health services.
- The entire care pathway is considered (not just single episodes of care) and includes:
 - the pathway of the person receiving care from the start of contact with the health service until discharge from the service
 - the interactions by all the staff, volunteers, health professionals, and carers at different points along the pathway (it is important to record both a description of the interaction and the time taken to deliver it, as this will be important when designing the future service)
 - technology interactions recorded at the relevant points in the journey.
- The whole person experience is recognised, including:
 - social and emotional wellbeing
 - family, community and work commitments
 - personal, spiritual, and cultural considerations
 - physical and biological elements.
- Factors underlying access to, and quality of care are considered, including:
 - the geography and its impact on travel requirements and proximity to family and support networks
 - language and communication factors
 - financial resources
 - cultural safety.
- Assumptions about what is important to the person are avoided.
- Multiple perspectives are brought together, including the person, their family and carers, and the health and support workforce across services and sectors.
- In each HHS, National Safety and Quality Health Service (NSQHS) standard 2 requires that there is a person or team that leads consumer partnerships.⁵⁴ Seek their advice and support on how to find and support consumers through this activity.

How is it used?

The journey map can be used by all team members to:

- compare the current care pathway with standards of care and the evidence base for best practice care
- identify areas of risk, and ‘pain and gain points’ in the care pathway
- document cost and resources used along the entire care pathway.

Together, including with consumers, discuss the care pathway to identify opportunities to improve the experience of care, identify ineffective and unnecessary steps, and improve efficiencies.

Useful resources

Examples of additional analysis tools and approaches that may enhance the process of journey mapping include:

[Cause and effect analysis](#) – a diagram-based technique that combines brainstorming and mind mapping to help identify the likely cause of problems .

Postcode Analysis – analysing postcode patient data to understand where the people who are accessing your service live and the distances they travel to access care. This helps to deepen our understanding of the needs of the people we serve.

[Lowitja Institute Health Journey Mapping tools](#) – tools and resources designed to improve the quality and cultural safety of Aboriginal and Torres Strait Islander people’s health care journeys.



Case study

The Dental Health Services Victoria (DHSV) War Room

To facilitate the process of journey mapping DHSV established a ‘war room’. This dedicated room was always open to staff and contained the evolving journey map.

Staff could enter and add their thoughts to the pathway at any time, with a continual supply of post it notes and pens on hand. The result was a more detailed story of what the service did, and how it interacted with the people it served, than any one group of people could have achieved.

The finished map was so comprehensive it wrapped around the entire room.

Case study



Understanding the care pathway and shared needs in lymphoedema screening

Framework domain	Adopting a VBHC approach
Where do I start? Identifying the population and sphere of influence	<p>Six years ago, a Ministerial complaint was made regarding patient dissatisfaction of access to lymphoedema screening in the Metro North area.</p> <p>The complaint identified that services were primarily located close to inner city Brisbane hospitals and that a population segment of patients at risk or with lymphoedema who live outside of inner city Brisbane had to travel long distances to access services, creating a poor patient experience.</p>
Understand the care pathway and shared needs	<p>The care pathway was mapped from the evidence base with an acknowledgment that in a public health context there were constraints in what could be accessed.</p> <p>Surveys and focus groups were undertaken to get a deeper sense of the shared needs of people accessing lymphoedema services, with engagement and collaboration across a number of public hospitals, NGOs, general practices (GPs) and the PHN. Private providers were invited alongside key stakeholders to map out the pathway based on what was known of existing services. This was then presented back to the groups to confirm and talk through solutions. Once agreed, a number of multidisciplinary meetings led to the development of a draft pathway to identify where the entry points for consumers would be.</p> <p>Care pathways were developed within 12 months and designed to put the person at the centre of care. Stakeholder engagement focused on understanding, maximising, and connecting existing services to create a pathway that supported those impacted by lymphoedema to access services closer to home.</p>
Design for outcomes	<p>In response to the needs and available services identified in the mapping process, a new service was established with recurrent funding to run from Redcliffe hospital. Additional fixed term funding was also awarded to support an additional clinician to build the capability of community providers to provide quality care for these patients. Education resources and electronic decision-making tools were created and programmed into software to assist GPs and practice nurses to support people in the community.</p> <p>Electronic pathways were also created for patients accessing services via their NGO and private provider. These were broken up into different phases of the patient journey from referral documents and screening tools to ensure consistency relating to patient access to care.</p>

**Measure what matters**

The extensive breadth of this project required the consideration of several measures to determine if improvements were being made. Indicators that were considered within this project included:

- reporting of risk assessment (against the agreed risk definition), undertaken post-surgically at multidisciplinary team meetings
- communication of the level of risk to patients in a timely manner
- access of GPs to lymphoedema information
- GP attendance at training on the screening and monitoring of patients at risk of lymphoedema
- monitoring of patients within the pathway
- number of users of the electronic decision making tool developed to support clinicians
- increase in Lymphoedema service activity by participating NGOs
- reductions in unnecessary hospital admissions due to complications of poorly managed or late managed lymphoedema.

Patient outcomes were planned to be collected at the following time points postoperatively: 4 weeks, 3 months, 6 months, 9 months, 12 months. Patients were contacted by mail and telephone to determine responses to questions regarding:

- signs or symptoms of lymphoedema
- awareness of the Lymphoedema Clinical Pathway Project and what it meant for their care management
- whether their risk for lymphoedema had been reviewed since surgery, and if so, by whom
- access to monitoring services, including their preferred service provider, location, distance to travel
- satisfaction with their health care, via a standardised tool because satisfaction is difficult to measure.

Support an outcome driven workforce culture

The collaborative nature of the project and the establishment of a common goal from the very beginning, helped to create a problem-solving culture within the integrated team of consumers, NGOs, private providers, PHNs and the HHS.

Challenges and enablers

The overarching consensus was that having the consumer engaged early and throughout the entire process created a clear person-centred pathway to meet identified needs.

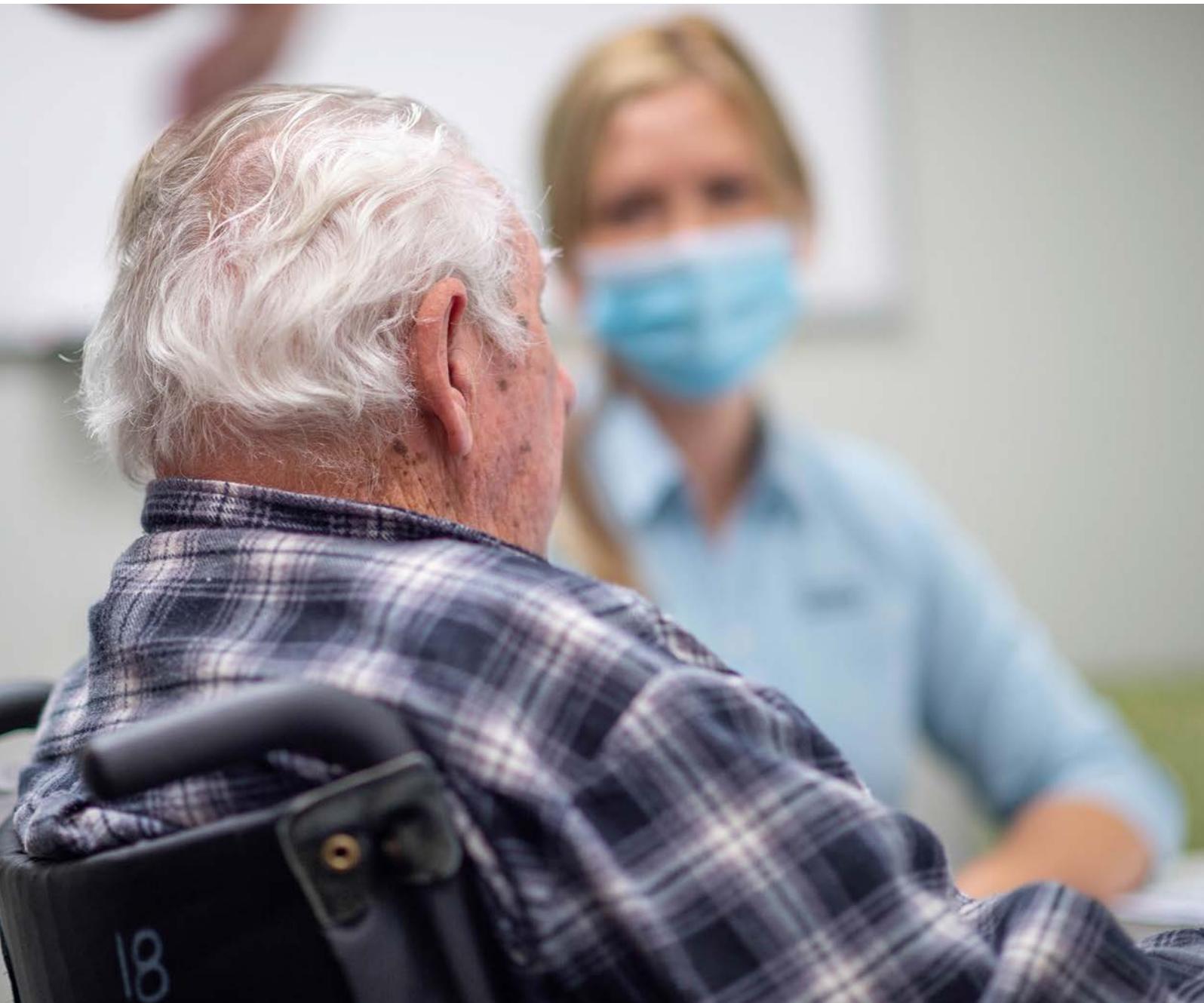


Lessons learned

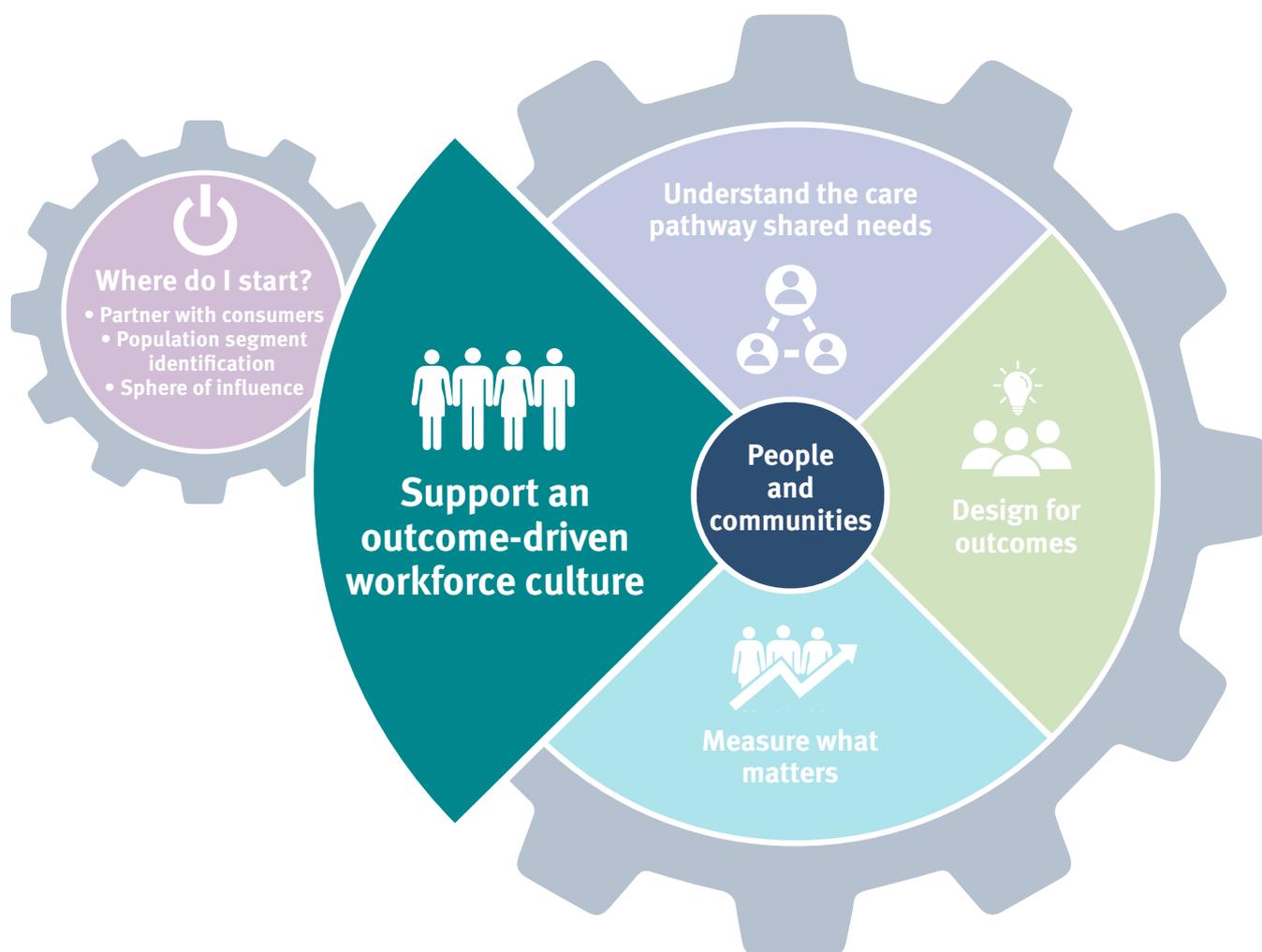
Consumers will help shape a project in ways you cannot anticipate. Don't have preconceived ideas about what the consumer will contribute and how they will participate. If we open ourselves to the possibility of being influenced by the consumer voice, we will end up with a better outcome.

Health provider mapping and engagement is critical from an early stage of the project.

Keep decision makers and funding bodies aware of the project throughout – this project was funded for recurrent service as a result of closely engaging these people throughout.



3. Support a person-centred outcome-driven workforce culture



A person-centred outcome-driven workforce culture involves pivoting the perspective of health services from the organisation of care around service providers, towards care structured around the identified shared needs of people and communities.⁵⁵ This not only has demonstrated benefits for people and communities but also enables health professionals to reconnect with their sense of purpose and intrinsic motivations for providing care, helping to reduce workforce disengagement and burnout.⁵⁶

This is a considerable cognitive and practical shift for any organisation, department, team or individual and will require not only top-down support but also bottom-up workforce engagement and buy-in to develop a culture supportive of changing the status quo to better orientate care around what matters to people and communities.

Opportunities to develop an outcome-driven workforce culture can be supported by change management and effective communication strategies that engage the workforce in the process of change.

3.1 Workforce culture



Key questions
to consider

- How do we establish a culture within our organisation that is supportive of changing the status quo to better orientate care around what matters to people and communities?

Why is it important?

Evidence demonstrates that a supportive workforce culture is vital to delivering the best outcomes for people and communities and ensuring the wellbeing of staff.^{57, 58} Workforce culture is not a static concept, it is dynamic and ever changing and as such can be cultivated and influenced.

Politics and self-interest often dictate how we feel about, and respond to, changes to the way we work. This can have both positive and negative impacts on the implementation of change initiatives such as VBHC.⁵⁹

It is important to understand the culture of the service or service provider in which we intend to implement change so we are aware of, and can plan for, any potential barriers, mandates or enablers that may impact the design or implementation of VBHC.

What is it?

While there are many definitions and descriptions of workforce culture, in its simplest form it is ‘how things are done around here’.⁶⁰ Workforce culture is reflective of a shared set of experiences, cognitive beliefs, assumptions, attitudes and practices that influence behaviour and professional relationships.⁶¹

Workforce culture exists at an institutional level (e.g., the culture of an entire hospital or health service), but also at the local level with the development of distinct subcultures at the ward, department and team levels, or within groups of professionals (e.g., doctors, nurses, individual allied health professions).⁶²

How is it developed?

To maximise the chance of successful VBHC implementation, we must consider how organisational values align with a person-centred, outcome-driven VBHC approach. In doing this, services and teams should focus on the development of a strengths-based workforce culture that is focused on encouraging and facilitating the workforce to build on what’s strong, rather than what’s wrong.^{63, 64}

Common elements that can assist to build and frame a positive workforce culture include:

- creating purpose
- communicating collaboratively
- embracing diversity
- inspiring loyalty
- celebrating teamwork
- engaging staff in the process of driving change.⁶⁵

There are numerous tools, techniques and strategies that can help support the development of a workforce culture aligned with the principles of VBHC that focuses on what matters to people and communities. Some examples include:⁶⁶

- organisational culture staff surveys and benchmarking
- identifying the behaviours required to support a person-centred, outcome-driven culture
- encouraging positive behaviours and not giving oxygen to negative ones
- creating a no blame environment
- calling out and addressing early, behaviour that is considerably below the line (see tip box page 34)
- storytelling sessions with teams and cultural groups to identify key themes to drive cultural improvements
- giving people permission to speak up
- modelling positive behaviours
- upskilling staff in emotional intelligence and resilience
- celebrating the wins
- establishing a culture that recognises each team, and team members, as equal contributors, despite playing different roles in service delivery
- transparency and honesty, including a willingness to admit when we get things wrong.⁶⁷

How is it used?

The creation of a supportive workforce culture can either make or break the success of a change initiative such as VBHC, as highlighted in the audiology workforce case study on page 39.

While at an individual level you may not have the power to mandate a top-down approach to culture, all individuals, teams, and leaders have the capacity to work within their unique sphere of influence to support the creation of a strengths-based workforce culture, in which people can unite around a shared objective that puts people and communities at the centre and supports change.

Useful resources

[BPA analytics](#)

[The Steps to Accountability](#) – Above the line and below the line behaviours ^{68, 69}

[Healthcare professionals' perspective on delivering personalised and holistic care: using the Theoretical Domains Framework](#), Wong, E et al. (2022)



The steps to accountability

Have you ever heard of the line of choice? It is an impactful tool that can help leaders and organisations measure where they sit in terms of accountability, ownership, and teamwork.^{68, 69}

Above the line thinking is usually prominent in teams who are happy to accept responsibility for the outcomes they produce (good and bad). This type of thinking is associated with enhanced collaboration and improved staff wellbeing:

- do it
- solve it
- own it
- see it.

Tip

Below the line thinking usually manifests in organisations with cultural issues where teams won't accept responsibility for outcomes. It is demonstrated by a culture of excuses such as:

- ignore/ deny
- it's not my job
- finger pointing
- confusion/ tell me what to do
- cover your tail
- wait and see.



Tip

It is important to provide the time and space for our workforce to stop and reflect on our workforce environment to identify improvements and acknowledge the things that are working well.



Case study

Have Your Say survey partnership

Metro North HHS partners with Best Practice Australia Analytics to run cultural surveys. Have Your Say is a 20-minute survey that allows staff to give feedback on their team, their facility, the organisation, things already done well and areas for improvement.

Insights from this survey are linked to strategic and operational plans to inform decision making and improvements at the operational level.

3.2 Change management



Key questions
to consider

- What structures and tools can we put in place and leverage to support our people through the process of change?

Why is it important?

A mantra of change management is ‘organisations do not change, people do’.⁷⁰ Change management provides a structure to help organisations influence people to change the way they do their jobs.⁷¹

If change is implemented sub-optimally it can have negative impacts on outcomes, staff wellbeing (e.g., hostility, high turnover, bullying, low morale, resistance to future change) and budgets,⁷² with initiatives likely to fail. Alternatively, if we create an environment that supports and encourages people to learn and embrace new ways of doing things, the implementation of successful change initiatives that improve person-centred health outcomes, are achievable.⁷³

What is it?

Change management is the application of a structured process utilising a set of tools to lead people through a process of change to achieve a desired outcome.⁷⁴

How is it developed?

There are many different change management frameworks and structures available to support change implementation. However, four key principles are common across the spectrum of processes:⁷⁵

1. **Understand change** – to be able to promote and sell the change we must understand why we are implementing a change and how it will affect the way people work. It is important here to recognise that ‘the why’ may be different for different stakeholders.
2. **Plan change** – effective change does not happen by chance. Organisations need to consider their unique circumstances, context, and experience to determine how best to implement successful change within their distinct sphere of influence (see section 1.3). Initially, building a coalition of willing supporters can assist us to engage with those who are less supportive.
3. **Implement change** – implementing change involves identifying a process or creating a customised plan to ensure those impacted by the change receive the awareness, leadership, support and training they need to change successfully.⁷⁶ There are many different approaches, frameworks, and tools available to support implementation. It is important for us to identify the approach that best suits our unique set of implementation circumstances.

4. **Communicate change** – This can be a ‘make-or-break’ component of change management. It is critical to clearly communicate why change is necessary so people understand what they need to do, and why they should do it. Tone is important to ensure that people react emotionally in a supportive manner, and it is important to acknowledge and validate those who may be experiencing loss as part of the change process. Developing a communication plan is critical, with targeted approaches identified for various segments of our organisation (see section 3.3).

How is it used?

Change management is used as a set of tools or structures to embed processes and communication techniques that facilitate the development of workforce culture that is supportive of, and responsive to, the implementation of VBHC.⁷⁷

Useful resources

[CES Guide to Implementation](#)

[Allied Health Translating Research into Practice](#), Queensland Health

[The behaviour change wheel: A new method for characterising and designing behaviour change interventions](#) – Michie van Stralen and West (2011)

[Application of the COM-B model to barriers and facilitators to chlamydia testing in general practice for young people and primary care practitioners: a systematic review](#), McDonagh et al. (2018)

[Diffusion of Innovation Theory](#)

[PARiHS framework for implementing research into practice](#)

[The Prosci ADKAR model](#) – an acronym for the five outcomes and individual needs to achieve for a change to be successful: Awareness, Desire, Knowledge, Ability and Reinforcement [The change adoption curve](#) – provides a framework for leaders to consider and sequence change by segmenting those experiencing change into 5 categories: innovators, early adopters, the early majority, the late majority and laggards.

[Start with ‘Why’](#) – TED Talk from Simon Sinek



Develop an elevator pitch

Developing an elevator pitch, a short 20-30 second, pre-prepared statement that explains, ‘the why’ of our VBHC change can be very useful, as it enables staff to explain what they are doing differently in a simple way.

This can help build support for change with people learning and receiving information from trusted peers.

Making sure your change champions can clearly and consistently articulate the following is also important:

Tip

1. our change is about...
2. the change is important and urgent because...
3. successful change will look like...
4. ...will be most affected by the changes.
5. our change plan is to...
6. what we need from you during the change is...
7. the benefits of the change to you, your team, and the organisation are...

3.3 Communication strategy



Key questions
to consider

- How are we going to communicate what is required to embed our change initiative to the people that need to implement it?

Why is it important?

A strategy for how we approach communication with those affected by a change is important to encourage understanding, acceptance and ultimately the behaviour change necessary for the change to be successful.

What is it?

A plan to achieve a communication objective.⁷⁸

How is it developed?

There are many frameworks and tools available that provide a structure to support the development of a communication strategy or plan. When designing an effective communication strategy to fit the needs of our unique circumstances we need to consider seven key principles:

1. **Be specific, early, and often** – let people know the change that will be occurring. Why is it occurring? Who will be affected? Who will be responsible? And when and where will it occur? It is important to keep people informed from the start and for the information to be tangible and easy to understand. Do not make people dig for details. You cannot over-communicate.
2. **Communicate through the right people** – evidence suggests that people need to trust and respect the person communicating the change, whether this be their direct supervisor, the project lead or a clinician leader they admire (see section 1.3.1 and section 1.3.2).
3. **Communicate through multiple channels** – everyone has different communication styles and different ways of receiving and understanding information, so it is best to use a variety of methods to get our message across (face to face meetings, presentations, email, newsletters, videos, social media and more). This will increase the coverage of the message contributing to better comprehension.
4. **Answer the question “What’s in it for me?”** – appeal to people’s individual interests. This can involve creating customised and tailored messaging to different stakeholder groups.
5. **Prepare for resistance** – a change initiative will always encounter resistance no matter how justified and necessary it is. We must be open and honest about elements of change that people may dislike, acknowledge and validate loss, and prepare for emotional reactions so that we can communicate with empathy. A good strategy to mitigate some of the effects of resistance is to map potential objections prior to announcing a change and preparing responses in advance. It can also be helpful to leverage off early adopters, using their enthusiasm and acceptance to help sell the change.⁷⁹

6. **Listen to feedback** – communication needs to flow both ways and people need to feel heard. Feedback can help us improve, with people identifying unforeseen issues. Even if the feedback is not likely to be taken on board, the act of allowing people to feel heard will likely increase acceptance of change. Allowing employees to influence the change process is a great way to increase enthusiasm for an initiative. It is also important to close the feedback loop by communicating our responses to feedback or questions received to all stakeholders (see case study on page 66 for a demonstration of the power of listening to feedback).
7. **Repetition is your friend** – people lead busy lives and will need to hear about the change many times, and in many ways, to fully comprehend it.

How is it used?

A communication plan is used to guide messaging around a change initiative. Through the structure of a communication plan, we can set communication goals, identify our target audiences, establish a timeline of communication, and identify effective messaging channels.⁸⁰



Case study



Creating an audiology workforce ready for change

Framework domain

Adopting a VBHC approach

Where do I start?

Identifying the population and sphere of influence

As part of the newborn hearing screening process, risk factors for post-natal hearing loss are recorded. Approximately 3% of the newborn population are born with risk factors. This population segment of children are referred on for a follow up audiology appointment at six months (children with a syndrome or craniofacial anomaly), 9 months, and 3.5 years. The program has been running for 17 years with approximately 1,800 referrals a year.

Data analysis has demonstrated that of the 22,000 children referred only 200 cases of hearing loss have been identified in the follow up appointments. The costs to identify these children are high and in many cases ongoing care does not improve outcomes, instead resulting in children being maintained within the system for ongoing appointments when care is clinically not necessary. This creates long waitlists and a high (33%) failure to attend rate.

Understand the care pathway and shared needs

The identification of this population segment of children led to an examination of the care pathway to identify points at which alternative processes might be implemented to streamline processes and improve outcomes.

Design for outcomes

In 2012, a more streamlined care pathway was presented to the audiology community. It proposed a change in practice to minimise post-assessment follow up and consider alternatives to diagnostic assessments at each time point, articulating the high cost for these diagnostic assessments and the impact to waitlists.

A proposal was made to transition away from the review and treatment model of care to a less intrusive and time-consuming screening model.

Measure what matters

A key element of the case for change was the recognition that the current model of care was not targeting improvement in the outcomes that mattered to the children and their families within the identified population segment.

One of the major areas that was being undervalued within the existing model was what VBHC pioneer Teisberg et al (2020) describes as outcomes of calm: the ability to live a normal life while getting care.⁸¹

High failure to attend rates highlighted that the model was not considering or measuring the impact (transport, cost, time) that these ongoing appointments were having on the everyday lives of this population segment of children and their families, who were maintained within the system despite no demonstrated hearing loss symptoms.



Support an outcome driven workforce culture

When the new model of audiology care was first proposed and discussed in 2012, there was resistance from the audiology workforce as it would require a change in the existing longstanding approach. Although audiology was supportive of reducing the number of appointments and assessments for the caseload, there was resistance to modifying the model to a screening model of care (as opposed to diagnostics). The proposal highlighted a broad cultural issue within audiology around medicolegal risk appetite.

Recognising the importance of ensuring workforce buy-in to the success of a screening model, the clinicians leading the work turned their attention to shifting longstanding ideas and care approaches within the audiology workforce.

Over the next decade these clinician leaders prioritised data capture to identify areas of opportunity and provide an evidence base for change. This was combined with ongoing education and awareness raising, highlighting areas for improvement and demonstrating an alternate pathway for children that would still provide safe and quality care.

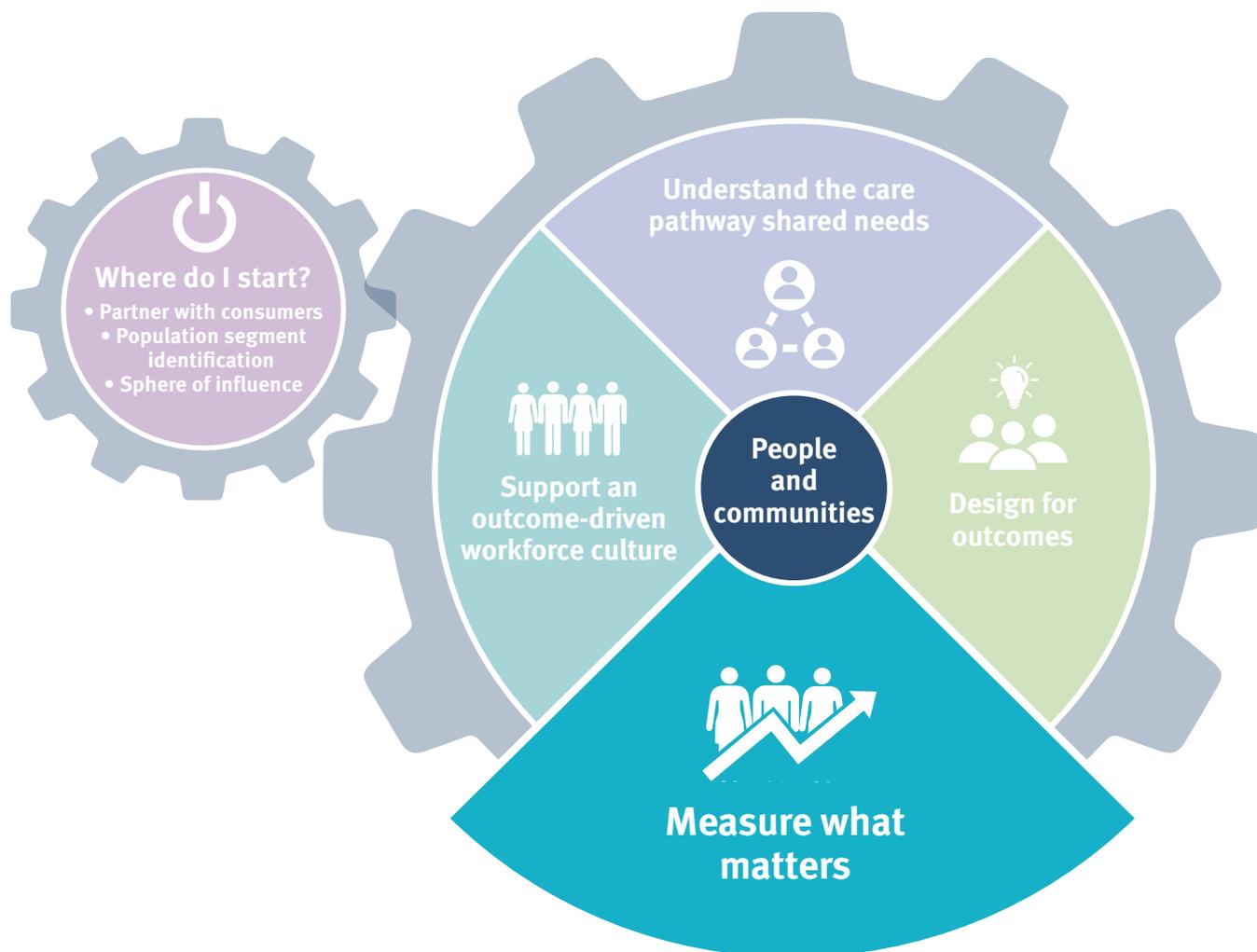
Through engaging and listening to the concerns of clinicians around scope of practice, risk and job satisfaction, running education briefings, and collecting and sharing data in regular audiology and leadership forums, the leaders of this work have led the audiology workforce on a journey of cultural change.

This ongoing engagement over the last decade, demonstrating and continually reinforcing the data and evidence, has initiated a shift in the sector. The audiology workforce across Queensland has now reached a point in which they are accepting of the implementation of a pilot screening model of care for children with risk factors for hearing loss. This has resulted in a VBHC grant being allocated for the pilot program to be implemented.

Challenges and enablers

The increase, and availability, of the allied health assistant workforce has demonstrated that screening models using a delegated workforce are successful.

4. Measure what matters



Measurement and feedback are integral to quality improvement in health care. The collection and analysis of data is critical to identifying areas of high-quality service delivery and areas in need of improvement.⁸²

Current health care measurement processes tend to focus on process and volume metrics. These metrics are designed to demonstrate if we are adhering to evidence-based guidelines, instead of determining whether people are meeting their care goals (e.g., pain relief, independent function).^{83, 84}

VBHC is built around the idea of systematically measuring the outcomes that matter to people and communities across the full care pathway, and then relating these outcomes to the cost that it takes to achieve them.⁸⁵ However, the concept of value is more complex than this simple equation. Within a universal health system such as Australia, considerations of outcomes based on social, environmental, and public value for defined groups or segments of the population, are also important to consider.^{86, 87, 88}

4.1 Measure outcomes



Key questions
to consider

- How will we know if we have been successful at improving the health outcomes of the people or communities we serve?
- Are we collecting the data to reflect what matters most to people and communities?
- Are our measures simple (3-5 questions) and do they answer the question ‘how are you doing?’ Instead of ‘how are we doing?’
- Have we involved people and communities in the design of our outcome measures?

Why is it important?

Although health care currently collects and reports a wealth of information, it does not always focus on, or prioritise, the outcomes that matter most to people and communities. This prevents value from aligning with how people experience care.⁸⁹ Outcome measurement seeks to refocus this approach to performance measurement, moving away from primarily measuring outputs to understanding if we are delivering care that meets the needs of the people and communities we serve.

Measuring outcomes during and after care delivery supports professionalism and clinical excellence by accelerating the learning of health professionals.⁹⁰ They enable us to understand if our intervention is achieving its objectives and to generate data from which we can learn and identify areas for improvement and efficiency.

Outcome measures also enable leaders to better align the organisation and delivery of services to support their organisation’s vision and purpose, improving the health and quality of life of the communities they serve.⁹¹

What is it?

Outcome measurement requires a pivot in thinking from traditional quality improvement metrics which focus on ‘how are we, as a service provider, doing?’ to asking people and communities ‘how are you doing?’ across a full care pathway.⁹²

The health outcomes that matter to people and communities are multi-dimensional, often encompassing levels of suffering, relief from suffering and disruption to life – not just satisfaction with service delivery.^{93,94} Patient-reported outcome measures (PROMs) and patient reported experience measures (PREMs) provide a structured way for people to report information about health outcomes.

PROMs capture a person’s perception of their own health through reporting on quality of life, daily functioning, symptoms and other elements of health and wellbeing.⁹⁵ PREMs illicit feedback on the experience of the service provided by a health care organisation. PREMs should not be about hospitality (e.g., did the physiotherapist respond promptly), but instead focus on comfort and dignity, measuring if a person was treated respectfully and felt their wishes were honoured by a health care service provider.⁹⁶ Both PROMs and PREMs are important to consider when thinking about how we will measure success and meeting the self-defined needs of the people and communities we serve.⁹⁷

How is it developed?

Measuring health outcomes does not have to be complex. In fact, the voluminous health outcome measurement sets commonly used in research are not practical in the clinical setting from the perspective of both a service provider and the people completing the measure.⁹⁸ Measurement instead needs to prioritise simplicity, aiming for no more than three to five measures.⁹⁹

Based on extensive research and evidence the creators of VBHC recommend that outcome measures should be expressed in terms of capability, comfort and calm (refer to Figure 2).^{100, 101, 102}

Figure 2 - Expressing outcomes in terms of the 3 Cs (Wallace & Teisberg 2016; Teisberg, Wallace & O'Hara 2020)



These three categories present a useful way to reframe the way we think about, and measure, health care performance. To ensure that our measures are truly representative of what matters to people and communities, the involvement of PROMs and PREMs in the design and development of outcome measures is also critical.^{103, 104}

Additionally, the International Consortium for Health Outcomes Measurement (ICHOM) works with health leaders and consumers internationally to develop sets of standardised outcomes for health conditions or population groups, together with measurement tools, and time points and risk adjustment factors. These 'standards sets' are developed through a multidisciplinary group of patient representatives, and clinical and registry leaders, considering the outcomes from different treatments and prioritising a core set of outcomes.^{105, 106} For example, the ICHOM standard set for Hip and Knee Osteoarthritis has been trialed in Australia, providing a standardised set of indicators for which data was collected across private and public clinical settings. This enabled system wide benchmarking and comparison which could then inform quality improvement.¹⁰⁷

While the ICHOM standards sets can be a useful starting point, depending on our identified population cohort, it may also be beneficial to think about how these sets can best be utilised to support our goals (e.g., simplified) instead of adopting them in their entirety.

How is it used?

Health outcomes should be used to facilitate learning and improvements at the system, clinical and individual level.¹⁰⁸

Outcome data is important from a system or organisational perspective to identify variations in services, highlight areas of high value care that could be replicated, and identify system or service inefficiencies where improvements could be made to enhance value.¹⁰⁹

Moreover, outcome measurement can be an effective tool to support the development of collaborative relationships between people and health professionals. Embedding PROMs and PREMs in conversations with people and communities enables them to see their progress over time, (e.g. revealing if the things that matter to them are getting better or worse) which can be an effective motivational tool and enhance trust between health professionals and the people they support.

Providing feedback on PREMs and PROMs is also important to incentivise engagement with the reporting process. If people (staff, people and communities) can see why we are collecting this information and how it is valuable, they will be more likely to continue to engage in the data collection process.

Useful resources

[PROMs](#) – Australian Commission on Safety and Quality in Health Care

[Value Based Healthcare: Person-centered Measurement: Focusing on the Three C's](#) – Tiffany Liu, Kevin Bozic and Elizabeth Teisberg

[International Consortium for Health Outcomes Measurement \(ICHOM\)](#)

[Australian Mental Health Outcomes and Classification Network](#)

[Patient-reported experience and outcome measures](#) – Australia's health 2018 – Australian Institute of Health and Welfare

[Measuring outcomes and costs](#) – Australian Centre for Value-Based Health Care

[Patient Safety and Quality Improvement Service](#) – Clinical Excellence Queensland

[What is value-based health care?](#) – A short introductory video to the concept of VBHC providing an overview of outcomes and costs



Partnerships

Have you considered partnering with other teams within Queensland Health to support the development of outcome measures within your organisation?

Queensland Health has a statewide approach to the collection of PROMs and PREMs. A branch within Clinical Excellence Queensland provides support for the implementation of PREMs and PROMs projects where there is demonstrated potential for statewide scalability.

4.2 Measure costs



Key questions
to consider

- How are we measuring the cost of our service delivery? Do we include both direct and indirect costs across a full care pathway?
- Who do we need to partner with to ensure we understand the actual costs (to the system, the service, and the individual) of a person's care pathway?

Why is it important?

Costing is important for identifying efficiencies, developing, and monitoring strategies to reduce costs, and encouraging innovation.¹¹⁰ To understand if an intervention is delivering value, the costs across a full care pathway must be considered.¹¹¹

What is it?

VBHC costing must reflect the actual costs of the care delivered to a person over a full care pathway. These costs are often distributed across many service providers (and divisional units within service providers) as well as the person and their family or carers.¹¹² Clinical fees are sometimes confused with the cost of delivering care, however they are an inaccurate estimate of the actual costs incurred.¹¹³

The actual cost of delivering care includes both direct costs (e.g., the costs associated directly with patient care such as consumables and equipment) and indirect costs (e.g., such as the distributed cost of running an administration department or the transport costs of a person travelling to and from care). Costs also include both costs incurred to the system as well as individual clinical costs.¹¹⁴

How is it developed?

Costs can be best understood by linking costing to the process of journey mapping (see 2.2). This involves calculating the cost of resources consumed at each stage of the journey, including understanding the resource capacity (the demands of the task, the level of clinical skill and workforce time allocation needed) as a person moves through a care pathway. Partnerships across sectors, disciplines, departments and with consumers are critical to understanding the actual costs of a person's journey, to the system, the service, and the individual. The lymphoedema screening case study on page 28 provides a practical example of how this might occur.

Time-driven activity-based costing (TDABC) has been proposed as a method to achieve this. It requires consideration of two key parameters: i) the capacity cost rate, and ii) the time required to perform activities in service delivery. It is applied in the health care setting through a seven-step process:

1. Select the health condition, treatment group or population segment.
2. Define the care delivery value chain (i.e., chart all key activities performed within the entire care cycle).
3. Map the process, including each activity in a person's care, incorporating all direct and indirect capacity-supplying resources.
4. Obtain time estimates for each process (i.e., for activities and resources used).
5. Estimate the cost of supplying resources for a person's care (i.e., cost of all direct and indirect resources involved in care delivery).
6. Estimate the capacity of each resource to calculate the capacity cost rate (which is the cost of capacity-supplying resources divided by the practical capacity of those resources).
7. Calculate the total cost of patient care.^{115, 116, 117}

How is it used?

Rather than replacing existing systems, consideration should be given to how methodologies that evaluate actual costs can be gradually incorporated into current systems. This enables us to better understand the full cost of delivering health care to the people and communities we serve and identify efficiencies.¹¹⁸

Once all the costs are identified, it is possible to see if there are opportunities to consolidate some activities and hence time, substitute different people to do some of the activities or introduce technologies. These are all important stages to design the future and improve value.

Useful resources

[Time-driven activity-based costing](#) (TDABC) – Robert Kaplan and Steven Anderson

[Activity Based Funding](#) – Independent Hospital Pricing Authority

[Tier 2 Non-Admitted Services Classification](#) – Independent Hospital Pricing Authority



Case study

Applying TDABC in the operating theatre

TDABC has been used by the Peter MacCallum Cancer Centre, Melbourne, to model anaesthetic personnel costs for a high-turnover operating list, comprising predominantly breast and melanoma surgery (Basto et al. 2019).

These costs were then used to assess the value of a process re-design, comparing serial design (with induction of anaesthesia within the operating room) with parallel design (with induction of anaesthesia within adjacent induction rooms).

Application of this model demonstrated that a significant increase in efficiency, at minimal expense for additional resources and without impacting patient safety, could be achieved.

4.3 Addressing variation



Key questions
to consider

- What do we know about unwarranted variation in the safety and quality of the care we provide?

Why is it important?

Understanding variation in health care is an important part of improving health outcomes for people and communities.¹¹⁹

What is it?

Clinical variation is ‘a difference in health care processes or outcomes, compared to peers or to a gold standard such as an evidence-based guideline recommendation’.¹²⁰

‘Variation in itself is not necessarily bad, and it can be good if it reflects health services responding to differences in patient preferences or underlying needs. When a difference in the use of health services does not reflect these factors, it is unwarranted variation and represents an opportunity for the health system to improve.’¹²¹

How is it developed?

Variation is typically derived from information routinely gathered by the health system, which is aggregated for a practice, hospital, or geographical region.¹²² It is important to accurately identify and quantify variation in health and health care provision so that it identifies true variation, and not variation due to chance.¹²³

The National Safety and Quality Health Service Standards, against which health service organisations are accredited, require health services to regularly review and compare data on performance from external sources and other similar health service organisations. Key tasks involved in this process include:¹²⁴

1. Identifying **key external data collections**, registries, audits, or reports that cover the specific areas of clinical practice relevant to patients, or procedures or services offered by the organisation. External sources of data to consider include the Australian Atlas of Healthcare Variation, and data provided by, or shared with, external organisations such as clinical quality registries, the Health Roundtable or peer organisations.
2. Supporting and encouraging health professionals’ s to **participate** in national and state or territory clinical quality registries.
3. In collaboration **with health professionals, reviewing clinical practice data** from the organisation, and comparing them with data from similar geographic areas or health service organisations.

4. Identifying any areas of practice that **vary from best practice**, that show widely differing practice within the organisation or that vary from practice in similar services. There is often a focus on the harms of not receiving evidence-based care. However, consideration should also be given to overdiagnosis and overtreatment.¹²⁵
5. Investigating the **reasons for any variation** and identifying whether it is **unwarranted variation** in the safety and quality of care.

How is it used?

There is no consensus on the criteria by which to value and prioritise health care interventions.¹²⁶ Very few are of absolutely no value in all clinical circumstances, nor are there many that are universally beneficial.¹²⁷ Addressing unwarranted variation requires developing a shared purpose, and building a culture of trust, innovation, and improvement.¹²⁸ Clinician leadership is important to support in this context, to achieve professional consensus in directing resources to those interventions which demonstrate higher value.¹²⁹ Additionally the workforce requires the skill and confidence to be able to critique available evidence and guidelines in order to decide what is the best care when there is the potential for variation.¹³⁰

Useful resources

[Choosing Wisely Australia. 2018 Report](#)

[Healthcare Variation](#) – Australian Commission on Safety and Quality in Health Care

[Australian atlas of Healthcare Variation Series](#) – Australian Commission on Safety and Quality in Health Care

[Allied Health Translating Research into Practice \(AH-TRIP\)](#), Queensland Health

[Queensland Clinical Networks](#) and [Clinical Senate](#)



Case study

Variation in medicines use in older people

Medicines use in older people was a clinical area of focus in the 2021 Australian Atlas of Healthcare Variation, including variation in polypharmacy (when people use five or more medicines at the same time).

In people aged 75 years and over, the rate of polypharmacy (when age and sex differences between populations was standardised) was six times as high in the area with the highest rate compared with the area with the lowest rate.

While polypharmacy can be appropriate for some people, it can increase their risk of medicines-related harm. Health professionals and consumers are encouraged to understand the risks and benefits of medicines and look at opportunities for deprescribing.

While prescribers and pharmacists are often prioritised in this process, the design of care pathways that support deprescribing, while maintaining the health outcomes that matter to people, may involve a broad range of allied health professions.

Case study



Adopting a VBHC approach in providing radiation therapy to adolescents and young adults (AYA)

Framework domain

Adopting a VBHC approach

Where do I start?

Identifying the population and sphere of influence

The construction of a new children's hospital resulted in the cessation of paediatric radiation therapy at a nearby Brisbane-based hospital. Previously, a specialised model of care was provided at this service to all children and adolescents under 18 years. A logical decision was made that any models or formal support structures offered to paediatrics were no longer needed and that an adult model of care was to be provided.

However, despite no longer receiving paediatric patients, the service still delivering care to AYA aged 15-25 years.

A small group of health professionals, who specialised in paediatric radiation therapy, soon identified that the adult model of care was not delivering the outcomes that mattered to the AYA patient cohort and their families.

Understand the care pathway and shared needs

These health professionals identified that the adult model did not allow sufficient time for radiation therapists to respond to the unique psychosocial, emotional, and physical needs of young people and their families.

Design for outcomes

The radiation therapists identified that through the delivery of an AYA model of care, including elements of the paediatric model, they could improve the outcomes that mattered for the person and the service. One example of this altered service delivery included allowing an additional 20 minutes of clinical time during pre-treatment for education with AYA accessing radiation therapy. This extra time led to increased compliance and reduced complications, improving the care experiences of young people and their families.

Measure what matters

The outcomes that mattered were observed as the experience of the young person and their family, in addition to adherence to treatment regimes. The additional 20 minutes allowed health professionals to deliver health care education that was developmentally appropriate for the young person, building rapport and answering questions, reducing the emotional distress experienced by AYA and their families. It increased the young persons and families' knowledge, which translated to better treatment adherence, improving an AYA's disease treatment experience.

Financial savings were also highlighted as a potential benefit, as decreasing anxiety meant that young people could comply with the requirements of radiation therapy without the need for medical sedation (a service provider cost).



Support an outcome driven workforce culture

A person-centred outcome-driven workforce culture involves pivoting the perspective of health services from the organisation of care around service providers, towards care structured around the identified shared needs of people and communities. This not only has demonstrated benefits for people and communities but helps to reduce workforce disengagement and burnout, enabling health professionals to reconnect to their sense of purpose and intrinsic motivations for providing care.

Despite some initial hesitation, the act of embedding the AYA model in standard practice demonstrates that this service listened and trusted the feedback of its workforce, a critical element in the creation of an outcome-driven workforce culture.

Challenges and enablers

Within Queensland Health, adult health services consider people aged 15 years and older as adults. This standard of care translates to adolescents being offered standardised adult treatment models, which have been proven to not deliver care that considers a young person's developmental capacity.

To ensure optimal outcomes for people and communities within radiation therapy, spending more time with patients who require care has been shown to lead to positive health and wellbeing outcomes. The management team supports this approach on a case-by-case patient basis but embedding this as standard for the AYA population could be viewed as an unnecessary, non-cost-effective use of the clinician's time.

However, strong support from management and clinicians championing quality health care outcomes for young people led to a coalition of support within the radiation therapy department backing and adopting this approach more consistently.

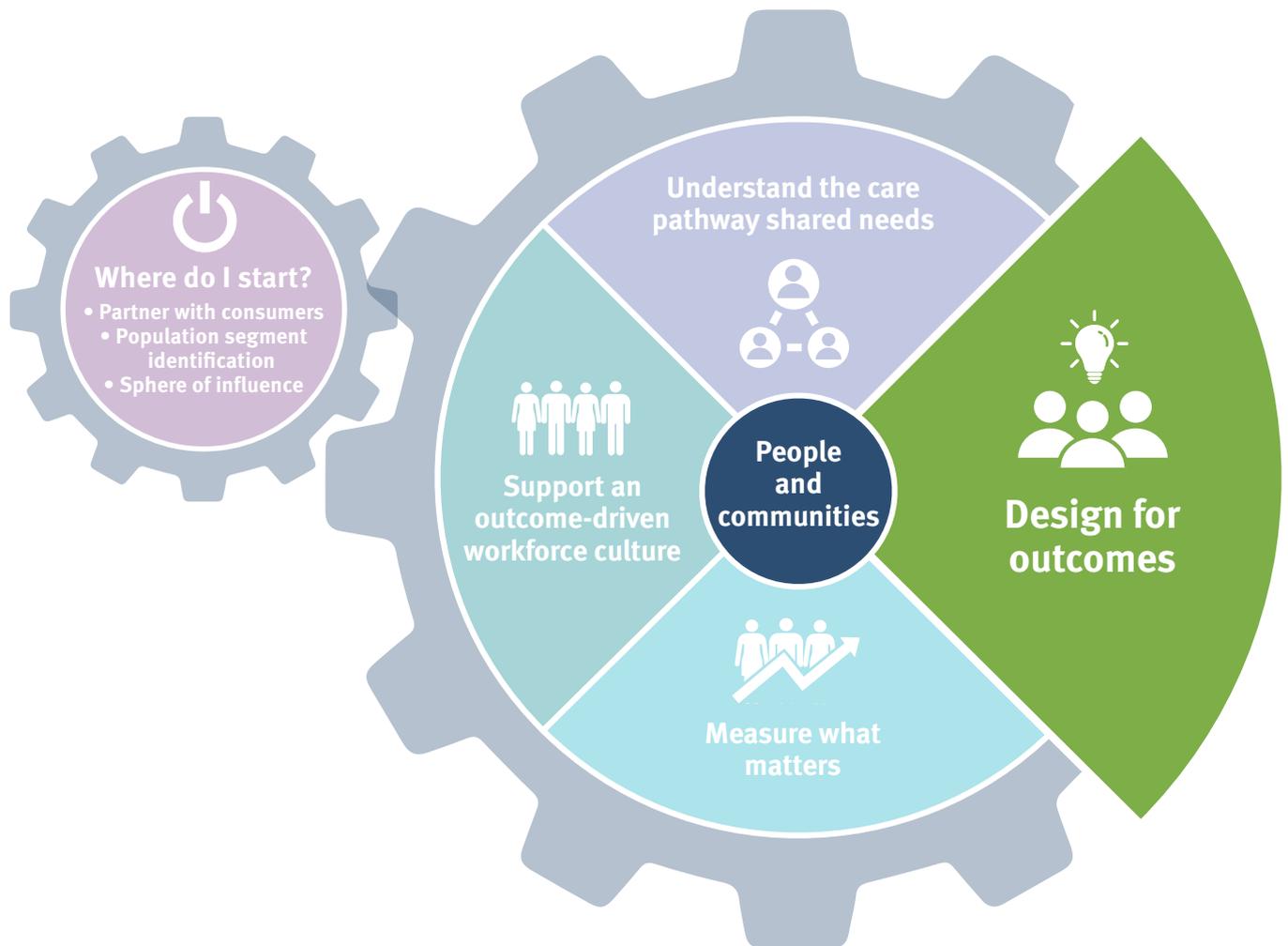
The achievement of executive buy-in was a critical enabler in the delivery of the AYA model of care, which was achieved through aligning the goals of the approach with the desires of executives to deliver person-centred value-based health care. Securing executive support for models of care that incorporate 'soft' approaches can be difficult, as they can come at a cost due to funding structures that support activity over the quality that is of value to the person.

Ongoing management and executive support allows this model to be scaled and become embedded into care for AYA as a standard.

Lessons learned

The importance of stakeholder engagement and feedback. Often it is not just about adopting a process; you need to consider all the moving parts that accompany it, including billing and administrative tasks that will benefit from adopting a new standard of care delivery.

5. Design for outcomes



Designing for outcomes is the stage where we begin to bring all the elements of thinking and planning together to practically design and implement VBHC with our identified population segment.

The process of designing should be strongly linked to journey mapping (see section 2.2): the process through which we develop an understanding of the ‘pain and gain’ points within the care pathways of our population segment of interest, with consumer partners involved and embedded throughout the design process. Understanding the experience of a person as they move through the health care system allows us to identify the areas we can create efficiencies and improve experience, enabling us to define the scope of our intervention and design for outcome improvements.

Consumers must therefore be key partners in the design of VBHC models of care. However, it is important here to recognise the power imbalance that can exist between health professionals and health care consumers. The design of spaces, processes and VBHC care models must be cognisant of this issue and seek to overcome any imbalance of power through creating a caring environment that supports equal partnerships.

Within the design process we must also consider what is happening outside of our direct sphere of influence or area of service delivery, and how we might be able to collaborate or partner with others to leverage existing work or evidence. We must be mindful of the possibility of unintended consequences and work with others to identify, avoid and/or mitigate them. We should consider population health and prevention interventions that improve health outcomes by keeping people out of care, as well as how we might provide value through strengthening our contribution to these types of initiatives.

When designing solutions, we should also consider the carbon footprint of the health care we provide. Many wellbeing and outcome benefits are possible through understanding the emission intensity of care pathways and making small changes to the way we deliver care. This can result in improved health outcomes from cleaner air, increased physical activity, improved diets, and reduced health impacts of climate change, as well as reducing financial health care costs through creating efficiencies and reducing unnecessary waste.^{131, 132}

Understanding the research and evidence base is also important when designing. Ensuring we have considered relevant, timely, best practice data and evidence enables us to learn and leverage ideas to enhance the intervention and bolster credibility within the health professional community, as highlighted in the audiology workforce case study on page 39.¹³³

The development of integrated learning teams, that include consumers, carers and family members as equal partners, is integral to the design of VBHC. Designing and implementing multifaceted solutions that address the shared needs of identified population segments requires a dedicated team made up of consumers and a mix of disciplines, that may involve people from within and outside the health sector. It is important within the design phase to consider how existing organisational structures, such as funding, governance, digital interoperability and data, can be leveraged or enhanced to support teams to improve the outcomes that matter.

A logical way to think about designing a service to implement, involves starting with the desired future state experiences and interactions along the journey, then considering what ‘front stage’ and ‘backstage’ actions are required to bring that to life. The ‘front stage’ actions are those that occur direct with the consumer and health professional, employees and or technology. The ‘backstage’ actions are all the processes, procedures, systems and technology that enable the front stage actions to occur. Finally enabling factors such as marketing, communications, change, systems, governance and measurement factors can be considered.¹³⁴



5.1 Integrate learning teams

Key questions to consider

- Who will be part of our care team? People, communities and carers? How will we involve them in the design of our solution?
- How will shared goals be developed? What processes will be put in place to facilitate communication and collaboration across disciplines? Services? Sectors? With consumers and their carers and families?
- How do we maximise efficiency within the team? How do we ensure all members of our team work to top of licence? How do we minimise the cost of the care through design?
- How do we include and involve consumers, their carers, and their families in the care team?

Why is it important?

‘When the goal of care shifts from treating care to solving [people’s] needs, care teams can both address the clinical needs of patients and begin to address the nonclinical needs that, when left unmet, undermine [people’s] health’.¹³⁵

Effective team-based care has been shown to improve health professional wellbeing and satisfaction and reduce burnout.^{136,137} Ensuring that team members are each working to the top of their licence of practice can bring benefits such as improved timeliness and access to care, reduced costs of service delivery and greater operational efficiencies.¹³⁸

Team-based models of care can also build capacity for a region or community, providing a workforce model that addresses population needs and goals.¹³⁹ At the same time, it is important that the team is cost effective. Therefore, during the design process we should focus on mechanisms that bring the right people in at the right time (not having everybody on hand ‘just in case’) (see case study on page 33).

Inclusion of consumers, carers and family members as members of the team is also a critical element of VBHC as it enables the inclusion of valuable insights, beyond narrow clinical perspectives, and can enhance consumer knowledge and treatment adherence to improve outcomes (see case study page 55 and 66).

What is it?

Integrated learning teams are made up of care service providers from a diversity of disciplines, consumers, carers and their families, who work together with a shared focus centred on a person’s needs and with collective ownership of the goals to be achieved.¹⁴⁰

Integrated learning teams deliver care that is respectful of, and responsive, to the preference and needs of people and communities.¹⁴¹ Teams may encompass members from both clinical and nonclinical disciplines, across various settings, including acute and primary care, as well as settings broader than just health care. They should also include the person receiving care, their families and carers. A key feature that binds integrated teams together is that they see themselves as intact social entities (not just groups of people thrown together or formed ad-hoc).¹⁴²

Integrated learning teams should also be dynamic, changing over time in line with shifting needs of the person or population group receiving care.¹⁴³ The Yarrabah community case study on page 55 provides a clear example of the benefits that can be achieved through bringing all the parties involved in the care pathway together to create an integrated team centred around the shared goal of improving community outcomes.

How is it developed?

When seeking to develop integrated learning teams that support the design and delivery of VBHC, factors to be considered include:¹⁴⁴

- **Clinical governance** – regardless of the structure of the team, or the role or disciplines of the members, it is important to establish collaborative governance structures to systemise how the team will practically work together and respond to any conflict. Part of the clinical governance is to ensure that there is a constant scan of the current evidence and best practice and opportunities to change when more information becomes available.
- **Data** – mechanisms to link and share clinical data in real time enable teams to integrate across different sectors to improve care. A consistent approach to data collection and the use of indicators and measures is important to ensure that all members of the team are working with the same information to improve outcomes. Establishing mechanisms (e.g. Apps) that allow consumers the ability to access and contribute to their own health data in their own time is also important to facilitate shared understanding and improved outcomes.
- **Interoperable technology and infrastructure** – it is important to consider how technology can enable team members to communicate and learn from each other, develop shared care plans, and share vital data and electronic medical records to inform person-centred care. Digital technology could support both formal and informal mechanisms for communication and learning and create efficiencies through reducing the need for co-location or travel.
- **Funding flows** – we must understand and consider how the funding flows within our organisation to identify the funding mechanisms that can be leveraged to support our integrated team to deliver VBHC.
- **Create space for knowledge sharing** – prioritise the creation of a shared space (this can be virtual) and processes for knowledge sharing and communication. This will enable each team member to better understand what the others bring to the team and provide a touch point to ensure the team is on the same page when delivering care. The inclusion of consumers within the shared space can be beneficial in helping to focus the various health professionals involved in the care, on the outcomes that matter to the consumers.

How is it used?

When designing for outcomes the knowledge and insights of integrated learning teams are critical to understanding the realities of delivering care on the ground. This is necessary to identify areas where efficiencies can be created.

Integrating teams enable health professionals to work to their top of licence and facilitate smooth transitions within a care journey, improving the care experience for the person, the health professional, the service provider, and the system.

Integrated learning teams demonstrate collaborative thinking and learning to design care and improve outcomes based on learning from experience.¹⁴⁵

Useful resources

[Enabling person-centred, team-based care](#)

Health Justice Australia – [Service models of the health justice landscape: A closer look at partnership](#)

[Shared or brokered care: A paradigm shift for clinical governance frameworks](#) – Deeble Institute for Health Policy Research



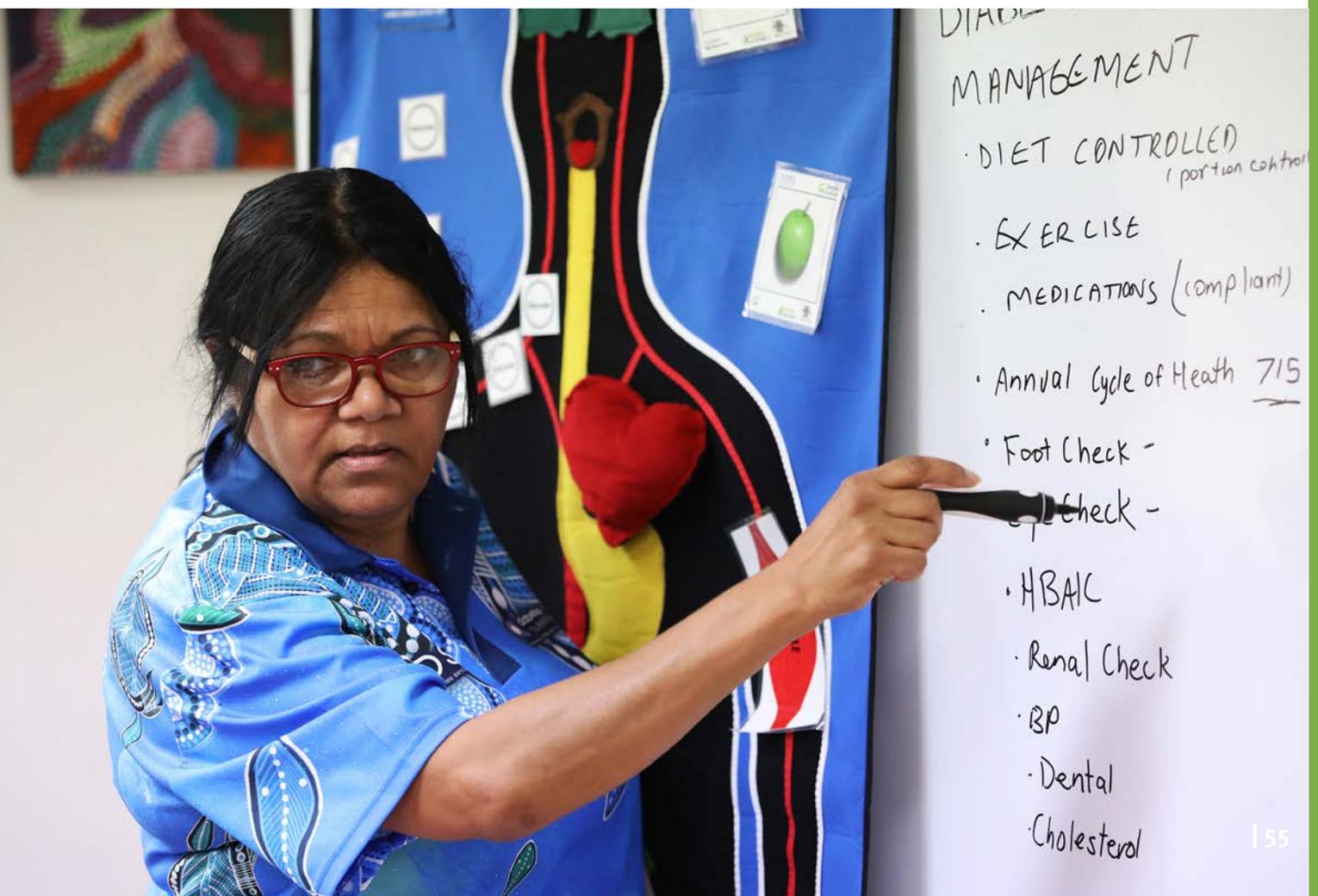
Should the model of care we have designed be part of a trial for funding reform? ⁴⁶

Shifting the way we provide care can be challenging when funding mechanisms create disincentives for change.

Activity-based funding (ABF) was introduced to Australian public hospitals in 2012. While it has contributed to a more equitable and transparent system of hospital funding, it works best for funding predictable one-off episodes of care. As such, the Independent Health and Aged Care Pricing Authority (IHACPA) is exploring alternate funding models that have the potential to create 'better incentives for improved continuity of care, use of evidence-based care pathways and substitution of the most effective service response'.

IHACPA has identified that around 30% of people currently funded under ABF could potentially benefit from alternate funding approaches. They are looking to partner to develop and trial innovative models of care and funding reform, at both the program level (e.g., bundled payments or capitation payments, refinements to ABF or outcomes-based payments) and the system level (e.g., blended funding models and pooling payment streams).

IHACPA is developing project parameters and business rules to facilitate piloting state and territory nominated innovative models of care and services for 2022-23, to inform the national pricing model. It would be worthwhile to consider how our VBHC transformation relates to these pilots.



Case study



Co-designing a community-centred, outcome-focused and culturally responsive model of care with a discrete Aboriginal community

Critical enabler

Adopting a VBHC approach

Where do I start?

Identifying the population and sphere of influence

It was identified by the Aged Care Assessment Team (ACAT) within the Cairns and Hinterland HHS that despite having a high proportion of ageing community members with complex needs, there was a very small number of referrals to ACAT from the Aboriginal community of Yarrabah.

Thus, ACAT identified this community (the aged community of Yarrabah) as a defined population segment that was within their jurisdictional sphere of influence to improve health outcomes.

To work more effectively with this defined population ACAT needed to build community trust. Critical to this would be developing partnerships with existing trusted community-controlled services and providers. This led to the development of a formal partnership with the local Aboriginal Medical Service (AMS) Gurriny Yealamucka and the development of a close working relationship with the community service provider Mutkin Aged and Community Care in Yarrabah.





Understand the care pathway and shared needs

ACAT and Gurriny began by reviewing the current process to identify and analyse what wasn't working well. Both formal and informal community consultation was undertaken to better understand the care pathway and shared needs, this involved informal conversations with community members and staff at Gurriny and Mutkin (community care organisation), and inter-agency case conferencing and stakeholder meetings.

Through this process several areas of shared needs were identified including:

- the aged care system wasn't well known or understood by community members or the health services in Yarrabah
- the ACAT referral process was not well known, difficult to access and confusing for community members
- ACAT referrals were regularly cancelled, and referral numbers were low
- there was limited contact and no established working relationships between ACAT and the health and community services within Yarrabah
- clients often couldn't access the care they had been approved for following assessment
- clients were notified of allocation of home care packages via mail, which were often not received.

Building genuine and respectful relationships with community-controlled services and community members was, and continues to be, an essential component of providing culturally responsive care and understanding the needs and outcomes that are important to these communities. Clients need to feel safe with the ACAT assessor to build the trust required to share their own information and needs, and to take on board information provided. It was identified though speaking with people that for a lot of clients this could not be achieved through a single visit.

Working relationships and collaboration with Indigenous health worker was fundamental to facilitating a better understanding of need and ultimately to the success of the new model of care. Indigenous health workers act as leaders both within the community and within health service, providing cultural brokage between visiting community services and Yarrabah community members, enabling ACAT to better communicate with and understand the people they were there to care for. The Indigenous health worker partnered with the ACAT assessor at all points of the client journey and often took a lead role in the process.



Design for outcomes

In response to the identified needs and in collaboration with community, ACAT and Gurriny co-designed a more flexible model of care that addressed the unmet needs and barriers to clients accessing an assessment and services after assessment.

The new model established an introductory home visit led by the Indigenous health worker, where the client was introduced to the assessor, the purpose of assessment was explained and consent for assessment was obtained. This process allowed for important family members to be identified and present for the assessment visit. A follow up home visit would then occur to explain the outcome of assessment and deliver client documents. Six months post-assessment a client follow up would again be completed to ensure clients, families and service providers were supported to take up offered home care packages and to provide information on next steps.

Issues with receiving correspondence were addressed by having My Aged Care correspondence sent to the AMS who would deliver documents to the client and provide the support and education as needed.

To improve communication between the three key stakeholders (ACAT, Gurriny and Mutkin), a fortnightly case conference was established. The purpose of this was to discuss clients in need of support, to refer to each other's services, and to follow up on referrals made. It also included an educational element allowing services to learn from each other.

A third initiative from this new model of care was to have a single, dedicated ACAT assessor embedded within the Gurriny service on a regular basis, depending on community need. The assessor became the primary email and phone contact for enquiries and was able to provide education around the aged care system both formally and informally to providers and community members. This regular physical presence allowed ACAT to build community trust and engage with health services and the community in a more meaningful way.



Measure what matters

The aged care assessment team have KPIs centred around timeliness of assessment, set by the Commonwealth, which are regularly audited and monitored. Data was also readily available on the numbers of referrals by location. An additional measure examined through this model of care was access to support following assessment, which is not a measure routinely reviewed by ACAT or the Commonwealth.

A retrospective data analysis demonstrated that referral numbers increased from 13 in 2019 to 44 in 2021. Referrals were made from a greater variety of sources. In 2019 referrals were mostly made by the service provider, Mutkin, whereas in 2021 referrals were also received from Gurriny doctors, nurses and health workers.

The data revealed that in 2019, 8 people were approved for a home care package and none of these clients had accessed their package. In 2021, 20 clients were approved for a home care package, 5 were receiving their home care package, 4 had been allocated a package and were awaiting services to commence, 6 were still on the National Queue for their package, 3 had withdrawn due to accessing residential care, 1 person had passed away and 1 had not taken up their offered package.

This data demonstrates that the new model of care has resulted in more community members being able to access assessment and, most importantly, aged care supports following assessment.

The scope of this initiative did not allow for the formal co-design and measurement of outcome indicators, beyond access, that were identified as important to the community. However informal reports from the community and health services within Yarrabah have highlighted that people feel that their outcomes have improved as a result of the increased access to aged care information and care supports.

VBHC outcomes measurement requires a shift to measuring 'how are you doing' rather than 'how are we doing?' This is a significant shift in the context of health care measurement and one that it is still in its infancy within the Australian health system.



Support an outcome driven workplace culture

Prior to the implementation of the new model of care, ACAT, Gurriny and Mutkin were working mostly in isolation. There were no robust means to facilitate ongoing communication between the three services, particularly in relation to shared clients.

All three stakeholders identified the need to strengthen relationships and communication between services. This was achieved through participation in the newly established case conferences and the consistent presence of an ACAT assessor within the community.

Structures to promote ongoing communication and collaboration, ensured the three stakeholders were working towards shared goals and supported an outcome-focused culture in relation to aged care services. A strong element of the culture fostered through collaboration was an openness to learning from each other, through both informal and formal learning opportunities.

Leadership in driving an outcome-focused workplace culture was provided by all three stakeholders who have been equally invested in ensuring the success of the new model of care.

Challenges and enablers

Key to the success of model of the care was the previous experience the ACAT assessor, working with the Yarrabah community, had working with discrete Aboriginal communities. The assessor was motivated to learn about the unique, shared history of Yarrabah, to learn from community members and providers within the community and to take a collaborative approach to service design and delivery. The ACAT assessor was both the provider and receiver of education within the model.

Executive buy-in and 'permission to lead' were also important with the ACAT assessor on the ground in Yarrabah trusted to use their judgement and make changes in response to need.

The openness of Gurriny and Mutkin around embracing and seeing value in the change to service delivery was another key enabler.

Succession planning for the ACAT assessor role has been a challenge, impacting the ability of ACAT to ensure the continued implementation of the model of care with a suitably experienced assessor.

COVID-19 has also posed challenges with community access restrictions impacting the ability of ACAT to maintain regular visits to the Yarrabah community. Competing COVID-19 related priorities within Gurriny (vaccination and outbreak management) have also impacted ACAT access to Gurriny staff, a critical partner in the delivery of the new service model.

Lessons learned

The importance of co-design and inter-agency collaboration from the outset when designing and implementing a new service model.

Allowing the model of care to evolve based on feedback received and ongoing evaluation.

5.2 Clinical risk management



Key questions
to consider

- Do we understand the clinical risks for our current pathways of care and our proposed pathways of care? What are the risks of not changing?
- Do we have transparent responsibility and accountability for identifying and controlling risks throughout the pathway?

Why is it important?

Clinical risk management has traditionally focused on patient safety and reducing medical errors. However, with the rapid pace of evidence published, the expanding role of technologies and increasing cybersecurity concerns, and ever-changing regulatory, legal, political and funding contexts, clinical risk management is becoming increasingly complex.

Additionally in a health care environment increasingly constrained by resource scarcity and rising service demand, disinvesting in low value services in order to reinvest in high value ones, is another area of clinical risk management that should be considered when designing for outcomes.¹⁴⁷ When designing our service, it is important to ensure that the choices we make about how we spend our health care dollars promotes the creation of a system that can remain sustainable in the future and guarantees the best possible outcomes for people and communities. We do not want to spend our limited resources on providing outdated, ineffective services where new and innovative solutions have been developed that deliver better value. Consumers should be a partner in decisions around health care investment and disinvestment.

Clinical risks are inevitable. What is important is that risks are proactively considered through a broad lens of the entire ecosystem,¹⁴⁸ with a workforce culture that enables transparent identification and introduction of actions for mitigation.

What is it?

Clinical risk management is concerned with ‘improving the quality and safety of health care services by identifying circumstances and opportunities that put patients at risk of harm and then acting to prevent or control those risks’.¹⁴⁹ It is part of a good clinical governance system, where effective risk management involves every level of the health service. All staff have a responsibility to understand and employ risk management in their day-to-day work. Health professionals also need to take a step back and consider not only the clinical care they provide, but also the processes, structures and environment within which they provide this care.¹⁵⁰



How is it developed?

The *Australian/New Zealand Standard AS/NZS ISO 31000:2018 Risk Management* outlines a systematic risk management process that can be used for clinical risk management. Having established the context, risk assessment involves:

- identifying the risks
- analysing the risks
- evaluating the risks
- treating the risks
- continual monitoring and review, including communication and consultation.

It is not a process of risk avoidance. Rather, it is about understanding the range of ways that clinical risks can be treated to reduce the risk to a level considered acceptable to a health service, and the people and communities it serves. It requires all staff to be trusted and empowered to identify, analyse, report, and manage risks within their practice. There should also be transparent responsibility and accountability across the entire pathway of care.

Managing the risk of disinvestment can be particularly complex as there are often numerous vested interests involved in maintaining the status quo, combined with the difficulties of initiating health professional behaviour change.¹⁵¹ However, as demonstrated within the case study creating an audiology workforce ready for change on page 39, with time, evidence and education, it can be done. Continually demonstrating and reinforcing our case for disinvestment through data and evidence is essential along with, fostering open communication that allows those impacted by the disinvestment to feel valued and heard.

Useful resources

[Active disinvestment in low value care in Australia will improve outcomes and reduce waste](#) – Deeble institute for Health Policy Research issues brief

[Medico-legal risks and low-value care](#) – NPS Medicine free online self-directed training module designed for health professionals highlighting how medico-legal risks and low value care are connected in several ways

[Choosing Wisely Australia](#)

5.3 Evaluation



Key questions
to consider

- How do we embed evaluation and continuous improvement processes in the design of our VBHC intervention?

Why is it important?

Evaluation supports an evidence-based approach to health care delivery and service improvement, helping us understand if we are making beneficial change in the most effective way.¹⁵² It enables us to identify what is working well and areas for improvement.¹⁵³ Evaluation is also important for enabling findings and experience to be shared, allowing people to learn from each other.¹⁵⁴

What is it?

Evaluation provides a systematic method to study a program, practice, intervention, or initiative to understand how well it achieves its aims and objectives.^{155, 156} It not only tells us if something worked, but it also considers why and how it worked.¹⁵⁷ Evidence-based evaluation provides a method to determine the effectiveness or efficiency of a program or service, enabling us to understand if it is delivering value.¹⁵⁸

How is it developed?

It is important to consider and plan your evaluation within the design phase of VBHC implementation with consumers included as a partner in the evaluation design. This process helps us to clarify what we hope to achieve and ensures that we are collecting and measuring the right data from the outset.

In VBHC it is important to evaluate how well we are improving outcomes, as well as the economic impacts of care. Provision for evaluation, including data collection, feedback and measurement mechanisms, should be built in at the design phase of VBHC to ensure that evaluation processes are embedded as an integral part of the delivery process (rather than as an 'add on' competing for resources).¹⁵⁹ It is also important to consider how we will collect and reflect a variety of perspectives within the evaluation (e.g., health professionals, consumers, carers, families, executives, people and communities).¹⁶⁰

There are a range of different formal research and study designs that can be used to inform evaluation and, in many instances, routinely collected health care data sources are available to support the evaluation process. However, when designing and deciding which measures and data sources to use, it is also important to consider construct validity and ensure that the measures are reflective of the outcomes we are seeking to understand.¹⁶¹

How is it used?

Evaluation is critical to identify and inform improvements, and to demonstrate our program's impact. When done well, it helps solve problems, inform future decision making and build knowledge to inform continuous improvement.^{162, 163}

Evaluation is critical to provide the evidence necessary to support reinvestment and/or the scaling up of our program of work and can be a critical factor to help us consolidate executive buy-in (section 1.3.1).

Dissemination of evaluation findings is also important, particularly in the context of VBHC where there is limited evidence in the Australian landscape. Sharing evaluation findings enables people to learn and improve as well as avoid possible pitfalls and the inefficiencies of duplicated effort. It can also inform government policies that will enable further developments in VBHC.

The process of undertaking and communicating evaluation can also help foster trust and strengthen workforce culture (section 3.1), providing an opportunity to demonstrate and celebrate wins and for stakeholders with issues to be heard. Closing feedback loops (e.g., reporting findings back to the people who participated in the program and evaluation process) is also critical.¹⁶⁴

Useful Resources

[Evaluation: What to consider](#) – The Health Foundation

[Planning and Evaluation step by step guide](#) – Australian Institute of Family Studies

[National Safety and Quality Health Service \(NSQHS\) Standards](#)

[The Quadruple Aim: care, health, cost and meaning in work](#) – Sikka, R., Morath, J., & Leape, L (2015)





The quadruple aim ¹⁶⁵

The quadruple aim has been used by services and providers throughout Australia as a template to both design for outcomes and evaluate health interventions and service design, that supports the delivery of VBHC. It ensures the consideration of four elements; improving the individual experience of care, improving the health of populations, reducing the per capita cost of health care and improving the experience of providing care.

The Western Queensland (2019) Health Care Home Model of Care has developed the following evaluation framework to reflect the quadruple aim:



Enhancing patient experience of care

- care tailored to the needs of an individual
- coordinated and comprehensive care
- safe and effective care
- timely and equitable access
- increased skills and confidence to manage one's own care.



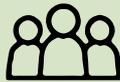
Maximising population health outcomes

- reduced disease burden
- increased focus on prevention
- improved quality of care
- improvement in individual behavioural and physical health.



Improved efficiency and sustainability in health care

- more efficient and effective service delivery
- increased resourcing to primary care
- improved access to primary care, reducing demand on hospitals.



Optimising health provider experience

- increased clinician and staff satisfaction
- increased flexibility and scope for innovation
- evidence of leadership and team based approach
- quality improvement culture in practice.

Case study



Applying a VBHC lens to an allied health-led COVID-19 vaccination roll out in Queensland

Framework domain

Adopting a VBHC approach

Where do I start?

In response to the COVID-19 pandemic and the need to coordinate a vaccine rollout across the North West of Queensland, the executive team at North West HHS was asked to consider how this would be coordinated.

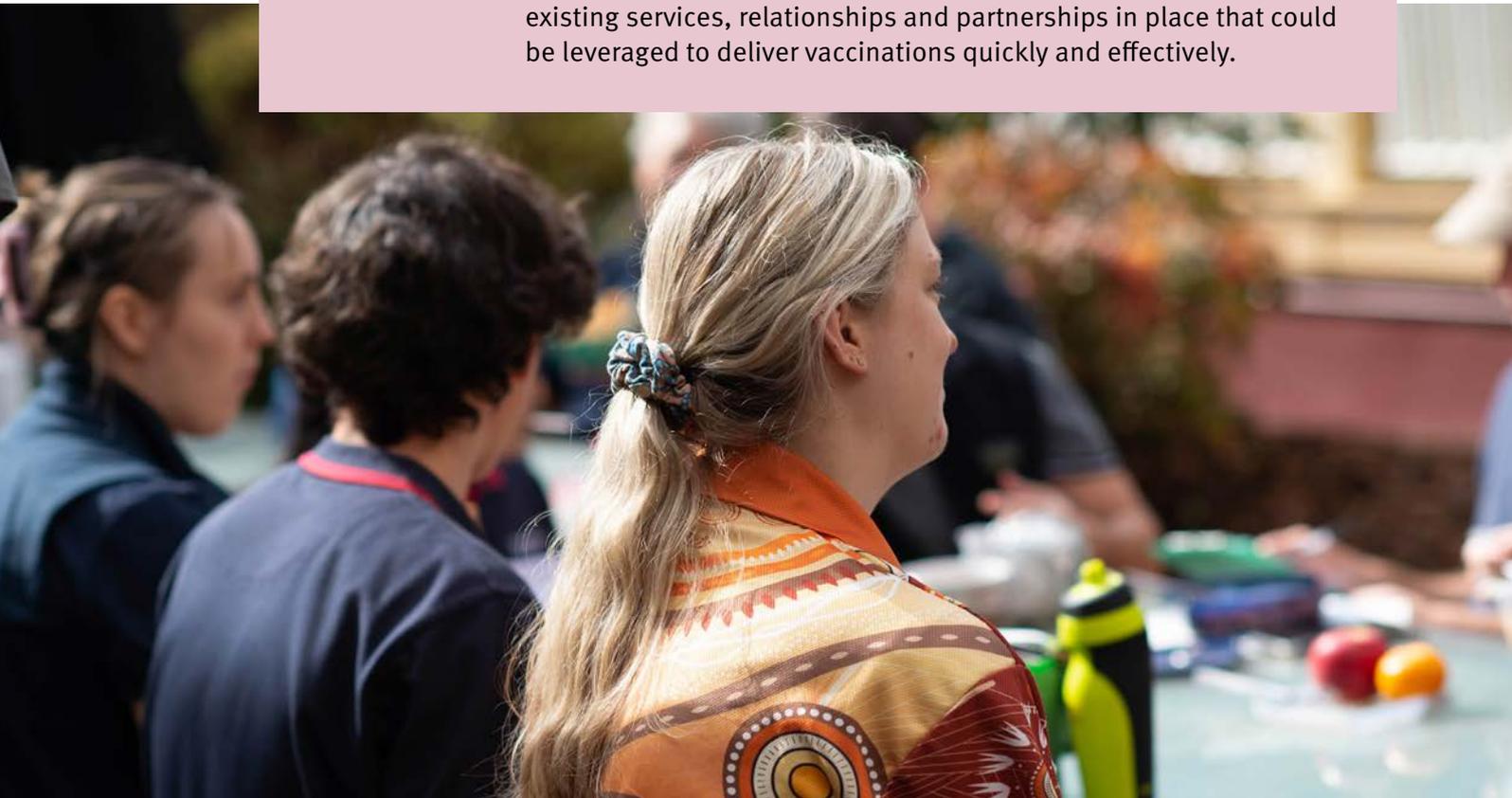
Identifying the population and sphere of influence

As a result of their unique sphere of influence, which encompassed extensive system knowledge, relationships across services and sectors, familiarity with governance and compliance structures and understanding of a number of the technical issues around vaccine supply logistics, the Director of Pharmacy at North West HHS was asked to lead the North West vaccination response.

Understand the care pathway and shared needs

The coordination effort for the North West vaccination rollout was massive, and involved understanding and leveraging the skills and expertise of numerous stakeholders across a number of sectors, including IT, communications, logistics, health promotion, Aboriginal and Torres Strait Islander communities, PHNs, State Government, Federal Government, disaster management organisations, private industry and more.

This involved mapping out and understanding the needs of different population segments within the community, and understanding the existing services, relationships and partnerships in place that could be leveraged to deliver vaccinations quickly and effectively.





Design for outcomes

As a result of identifying and understanding the unique needs of the different population segments within the North West Queensland region a number of different vaccination models were designed. These targeted the following distinct population segments:

First Nations Australians – strong existing relationships with Aboriginal and Community Controlled Health Organisations (ACCHOs) and First Nations Australian community leaders enabled First Nations Australian representatives to be embedded in the vaccine response planning and roll out early and often. This facilitated support from clinics and services in community, fostering a culture of acceptance and participation in the vaccine rollout.

Collaboration with state policy makers was also important in facilitating First Nations Australian vaccination uptake. Building on the extensive efforts of community leaders to facilitate widespread acceptance of the vaccine within First Nations Australian communities, policy makers were able to implement incentive policies that activated First Nations Australian communities to get vaccinated.

In a single fortnight after one such announcement there was a 12% increase in the number of First Nations Australians vaccinated within the North West region. Vaccine services were coordinated and positioned to facilitate rapid widespread access across health care providers, capitalising on the significant surge in demand.

The strength of designing these solutions to reflect the needs of this unique population segment is demonstrated by the fact that the First Nations Australians population segment within Mt Isa were the highest vaccinated population within North West Queensland.

Homeless populations – were targeted through outreach to homeless shelters in the first instance, and then through health workers going out into the community to meet homeless people where they were. These efforts aimed to provide culturally appropriate and convenient access to health information and vaccination services.

Remote communities – integrated cross-sector, multidisciplinary teams were essential to enable vaccination in remote communities. Through collaborating and partnering with First Nations Australian community leaders, local councils and services on the ground, the vaccination team were able to set up vaccination clinics in local hubs. Access to council buildings or local charities (e.g., PCYC) enabled the vaccination team to put on community events such as BBQs to encourage people to get vaccinated. In some communities these events included the attendance of ex-Cowboys rugby league players as a result of a partnership established with the Cowboys Football Club and Rex flights. Smaller, very remote communities were provided access to vaccination through a joint Royal Flying Doctors Service and North West HHS initiative.

Metro communities – under the strategic direction of the Mount Isa District Disaster Management Group a vaccination clinic was set up at the Mt Isa Civic Centre, a centralised and easily accessible location within the central shopping district of Mt Isa.

**Measure what matters**

The primary outcomes that were tracked in this project were vaccination rates. The urgency of the rollout did not allow time for more in-depth consideration of the outcomes that mattered to people and communities. VBHC outcomes measurement requires a shift to measuring ‘how are you doing’ rather than ‘how are we doing?’ This is a significant shift in the context of health care measurement and one that it is still in its infancy within the Australian health system.

Support an outcome driven workplace culture

Initially, the small team leading the response, which included the Director of Pharmacy, the Public Health clinical nurse consultant (CNC) and the infection control nurse, found it very difficult to get buy-in.

A framework was developed and released for consultation to define the scope of the work. This was accepted and endorsed by the executive committee, which provided the necessary ‘permission to lead’ to the Director of Pharmacy and the vaccination team. Yet, engagement from the wider workforce was still lacking, with staff dismissing the vaccine rollout as not important to them in their daily roles. It was only when the executive team went the extra step and made their support highly visible that this changed.

After reporting the difficulties to the executive leadership team, the executives responded immediately. Within an hour they had every senior leader within the HHS in a room, to be briefed by the team coordinating the vaccine rollout. Support was then very forthcoming, with senior leaders communicating across the service the importance of all staff assisting to support the vaccine rollout.

Challenges and enablers

One of the biggest enablers of the North West HHS vaccination response was its focus on communication and building partnerships early in the process. This enabled the development of a large integrated team in which everyone was working towards a common goal.

Another enabler was the fact that North West HHS had longstanding existing partnerships with trusted community services, which could be activated to support the COVID-19 response and facilitate the delivery of vaccinations quickly and effectively.

As a result of these existing partnerships, 75% of vaccinations within the North West region were delivered by the HHS.

Lessons learned

Don’t get overwhelmed with perfection, starting is more important.

The role of allied health in value-based health care

VBHC is not a new phenomenon within allied health service delivery as highlighted in table 1 below. The Framework has been developed to address the need for a structured approach to allied health VBHC implementation based on what health professionals and consumers need and expect.

Allied health professionals provide a broad range of services across the aged care, mental health, disability, and health sectors to improve the health and wellbeing of people and communities. They are an essential element of the Australian health system and an important partner in the development of an integrated health system that improves health outcomes and promotes value.

Scott (2014) proposed 10 clinician driven strategies to maximise value in the Australian health care system. Against these categories, Lizarondo et al. (2014) have identified examples of how allied health can contribute to strategies that not only improve the quality of outcomes, but offer innovative solutions for sustainable health care in maximising value (see table 1).

Table 1. Allied health examples of maximising value

Clinician driven strategies for maximising value (Scott 2014)	Allied health examples (adapted from Lizarondo, et al. 2015)
Minimise errors in diagnosis	<ul style="list-style-type: none"> • dietitians undertaking accurate evaluation of gastrointestinal disturbances to minimise expensive investigations such as CT, endoscopy, colonoscopy • physiotherapists and occupational therapists conducting assessment (e.g. muscle tone) to ensure treatment is accurately targeted to the affected site; hence avoiding unnecessary damage to non-affected sites • social workers undertaking comprehensive psychosocial assessment to identify at risk patients and refer appropriately; timely referral can reduce unnecessary hospitalisation.
Discontinue low or no value practices that provide little value or cause harm	<p>These strategies have been associated with delivering evidence-based techniques, and therefore discontinuing the use of the following interventions or strategies:</p> <ul style="list-style-type: none"> • electrophysical agents in conditions where there are no supporting evidence of effectiveness • low-bacteria diet in immunocompromised patients • inappropriate debridement of ischaemic wounds • inappropriate referrals.
Defer the use of unproven interventions	

<p>Select care option according to comparative cost-effectiveness</p>	<ul style="list-style-type: none"> • promoting self-management (to decrease dependence on the health system) to replace active management from practitioners • supporting allied health extended scope of practice (to decrease use of medical consultancy time) • providing rehabilitation care on an ambulatory basis, which can replace in-patient care • pre-rehabilitating patients with osteoarthritis (who may not then need surgical intervention or, if requiring surgery, outcomes may be more positive).
<p>Target clinical interventions to those which have the greatest benefit</p>	<ul style="list-style-type: none"> • specialised roles within individual disciplines; for example, comorbidity specialist or enhanced roles in neuropsychology for mental health (e.g., substance misuse and dementia) • screening and early intervention; for example, timely access to audiology services, or screening and early intervention for children with speech and language disorders during early childhood.
<p>Adopt a more conservative approach nearing end of life</p>	<ul style="list-style-type: none"> • counselling support offered by social workers and psychologists can assist patients and their carers make informed decisions about commencing or continuing active treatments • physiotherapists and occupational therapists working collaboratively to assist with rehabilitation needs (e.g., pain management, graded exercise plan, home needs assessment) of patients, thereby optimising function, quality of life and achieving safe home and/or community care • providing support to patients and their families nearing end of life.
<p>Actively involve patients in shared decision making and self-management</p>	<ul style="list-style-type: none"> • discussing goals with patients and actively supporting them in their decision making; setting client-centred goals; family meetings • ensuring capacity assessments have been conducted thoroughly (assessing people's right to choose) • social workers providing psychosocial support and advocacy regarding patients right to decision making.
<p>Minimise day to day operational waste</p>	<ul style="list-style-type: none"> • considering alternative workforce models that incorporate the use of allied health assistants • facilitating early allied health input (e.g., timely swallowing assessment; early screening and assessment of nutritional issues) • improving coordination of care and communication between professionals to minimise overlap in services • use of group interventions (e.g., group weight loss program).

<p>Convert health care institutions into rapidly learning organisations</p>	<ul style="list-style-type: none"> • implementing educational interventions (e.g., journal clubs, in-service education, grand rounds, conference attendance, continuing professional development); interprofessional education • improving resources to support educational activities for staff (e.g., grants).
<p>Advocate for integrated patient care across all clinical settings</p>	<ul style="list-style-type: none"> • earlier access to allied health services • improving structures (policies, procedures, support) for integrated care (e.g., comprehensive care plans) • improving process for discharge planning • improving communication in the team • providing multidisciplinary interventions for a holistic approach • case coordination.

Appendix 1 – Acknowledgements

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Gavin Brealey	Director of Occupational Therapy Community and Oral Health, Metro North HHS
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Leigh Burton	Director of Allied Health, Cairns HHS
Shaun Hamwood	Director of Pharmacy, South West HHS
Geoff Grima	Director of Allied Health, Metro North HHS
Mark Nelson	Director of Physiotherapy, Metro South Health
Merrilyn Banks	Director of Dietetics, Metro North Health
Trent Johnston	Podiatrist, Townsville HHS
Toni Salmond	Director, Darling Downs HHS
Tina Chen	Consumer Representative
Peter Button	Consumer Representative
Anja Christoffersen	Consumer Representative
Dan Kent	Consumer Representative
Kim Coulter	Consumer Representative
Janelle Colquhoun	Consumer Representative
Donna Allen	Consumer Representative
Deborah Cole	Chair, Australian Centre for Value-Based Health Care Advisory Group
Kylie Woolcock	Project lead, Australian Healthcare and Hospitals Association
Emma Hoban	Project consultant, Australian Healthcare and Hospital Association

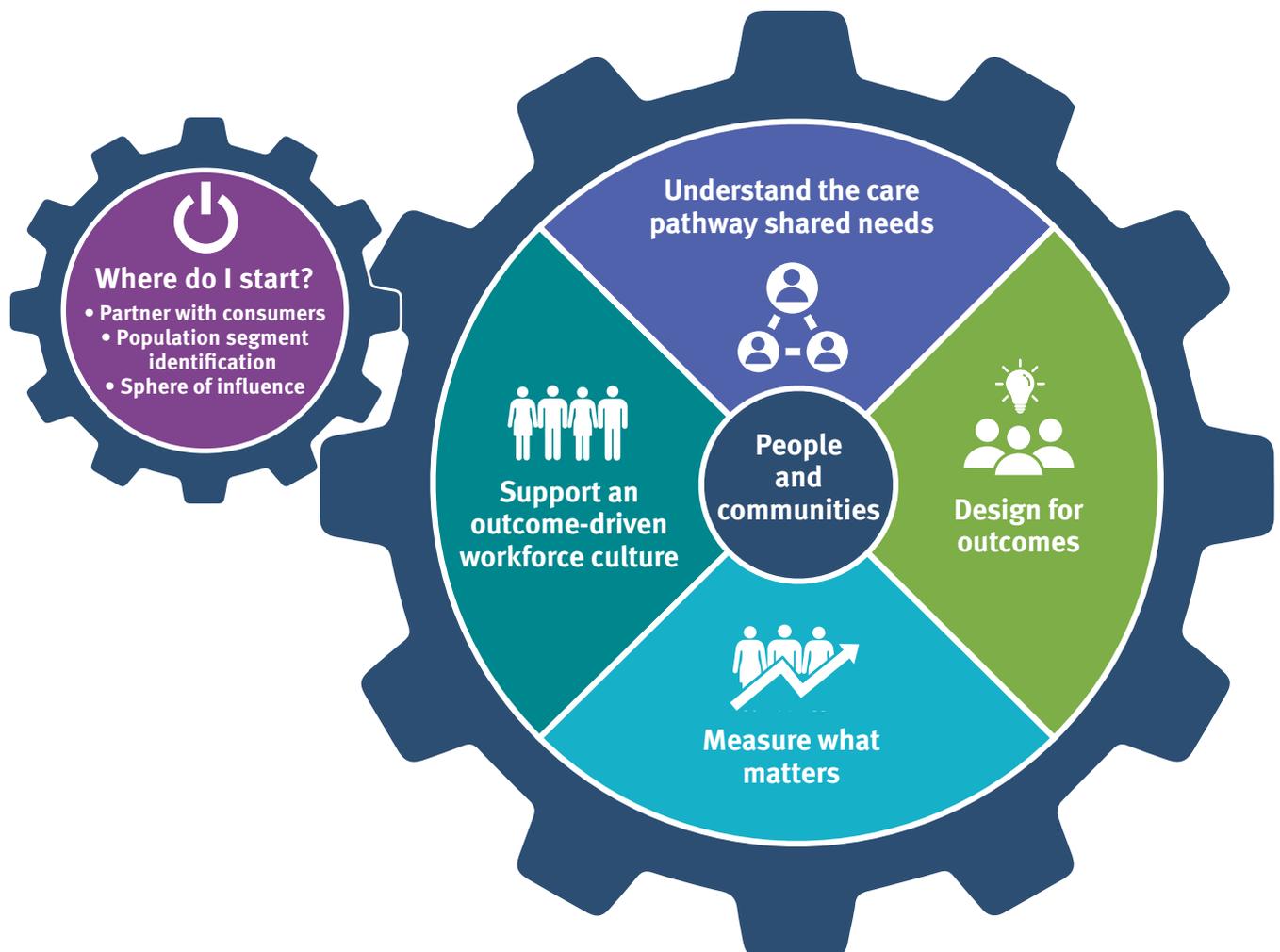
Appendix 2 – Overview and key questions to consider

This document provides an overview of the main elements of the Queensland Health Allied Health Framework for Value-Based Health Care (the Framework).

The Framework is designed as a tool to support health professionals as they explore value-based health care (VBHC) implementation, providing a structure for working with consumers and communities to change the way care is delivered to focus on the outcomes that matter to people and communities.

This document identifies key questions to be considered at each stage of implementation.

The Framework recognises that there is no single pathway for VBHC implementation and that each service, provider or individual will have unique strengths and scope to transition. These should be recognised and built upon to support the implementation of VBHC.



The complete Framework can be accessed at: www.health.qld.gov.au/ahwac/html/VBHC

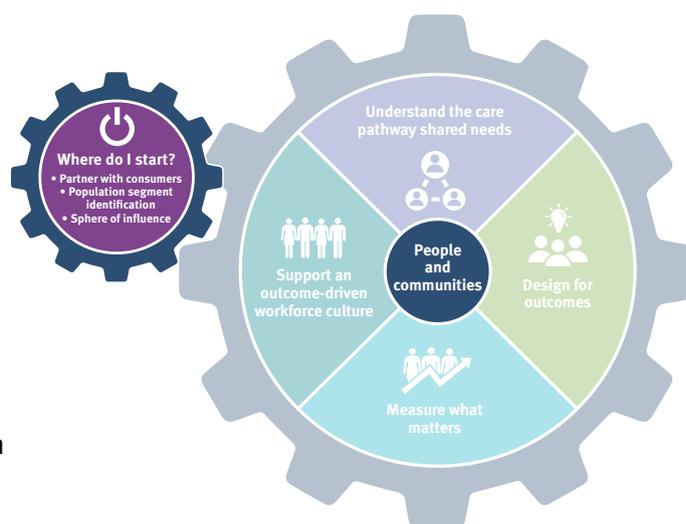
Key considerations at each stage of implementation

Where do I start?

Partner with consumers

From the outset, consumer voices need to be at the centre of reform. True partnership will involve treating consumers with dignity and respect, sharing information, and encouraging participation and collaboration.

- How are we going to make sure consumers are involved at all stages of our project's development?
- What mechanisms are we going to use to identify consumers and embed them in decision making processes at all stages of our project's development and implementation?



Identify population segment

Population segmentation allows us to distinguish and better understand a distinct community or group of people cared for by our health service. Clearly defining the population segment will help to ensure activities prioritised are within the scope of Queensland Health's publicly funded services and the role of the facility, and that any activities beyond that scope are done in partnership with relevant service providers or coordinators such as with Change to Primary Health Networks (PHNs).

This population will be the target beneficiaries of your reform project.

- What is a population segment within my sphere of influence that has a shared set of needs that my service or skill set can contribute to addressing?
- How will we ensure equity informs our population segmentation decision?
- Are there segments of the population within our sphere of influence that would benefit from the care we provide but are currently not accessing it?
- What organisational or state government strategies and priorities are relevant to this population segment?

Consider your sphere of influence

A sphere of influence refers to the network of people, resources, and systems that make up the person's professional environment. As allied health professionals develop expertise, experience, and capacity to contribute to health care, their spheres of influence and leadership capacity will expand. This has implications for any reform project and should be an early consideration.

Clinician leadership

- Who are the (formal or informal) clinician leaders within our sphere of influence that can inspire, engage, and provide credibility with peers and stakeholders?
- How do we engage and support these key clinician leaders to champion VBHC and generate enthusiasm for its implementation?

Executive buy-in

- How does our work align with the objectives and key performance indicators (KPIs) of my organisation?
- How will we maintain executive buy-in throughout the process?

- How will we communicate with executives and bring them along on the journey of change?
- How can we demonstrate the unique benefits of allied health leadership?
- How can we demonstrate alignment with organisational and Queensland Health objectives?

Political landscape

- Are their political factors that may impact VBHC reform that we need to be aware of?

Implementation domains

Understand the care pathway and shared needs

Your population segment will access and move through health care services via certain pathways. They will have shared wants, needs and health priorities. Identifying and understanding these contexts will reveal opportunities for reform, and will require:

Engaging with people to understand their needs

- How do we ensure that people and communities are partners in the processes of designing, delivering, implementing and evaluating the services we provide?

Journey mapping

- Do we understand the total care pathway of the people and communities we serve?
- What are the important touch points along the care journey? What changed as a result of that touch point? If that touch point had not occurred what would have happened? Could things be done differently?

Support a person-centred outcome-driven workforce culture

Instead of care organised around service providers, care will pivot to be structured around the identified care pathways and shared needs of people and communities, requiring consideration of:

Workforce culture

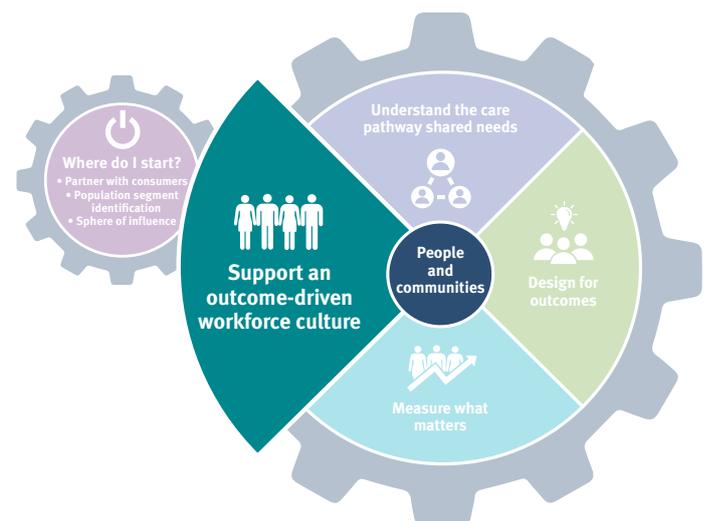
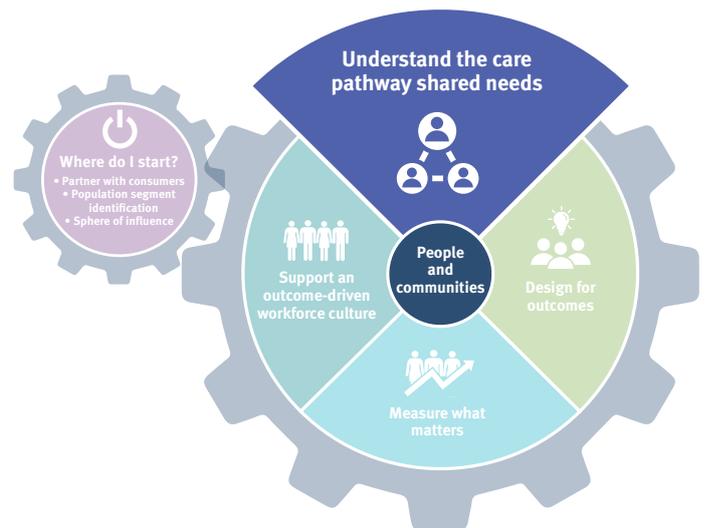
- How do we establish a culture within our organisation that is supportive of changing the status quo to better orientate care around what matters to people and communities?

Change management

- What structures and tools can we put in place and leverage to support our people through the process of change?

Communication strategy

- How are we going to communicate what is required to embed our change initiative to the people that need to implement it?



Measure what matters

The collection and analysis of data is critical to identifying areas of high-quality service delivery and areas in need of improvement. Involving consumers in the design, collection, analysis and reporting process can ensure we measure what matters.

Measure outcomes

- How will we know if we have been successful at improving the health outcomes of the people or communities we serve?
- Are we collecting the data to reflect what matters most to people and communities?
- Are our measures simple (3-5 questions) and do they answer the question ‘how are you doing?’ instead of ‘how are we doing?’
- Have we involved people and communities in the design of our outcome measures?

Measure costs

- How are we measuring the cost of our service delivery? Do we include both direct and indirect costs across a full care pathway?
- Who do we need to partner with to ensure we understand the actual costs (to the system, the service, and the individual) of a person’s care pathway?

Addressing variation

- What do we know about unwarranted variation in the safety and quality of the care we provide?

Design for outcomes

Where we bring all the above elements of thinking and planning together to practically design and implement reforms with our identified population segment.

Integrate learning teams

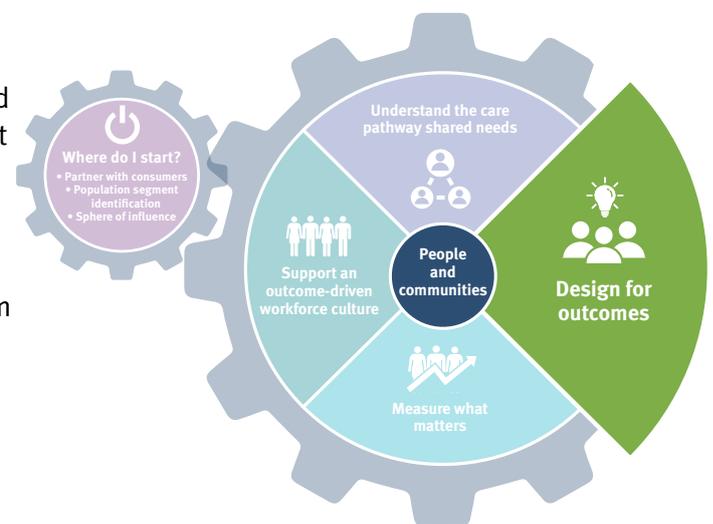
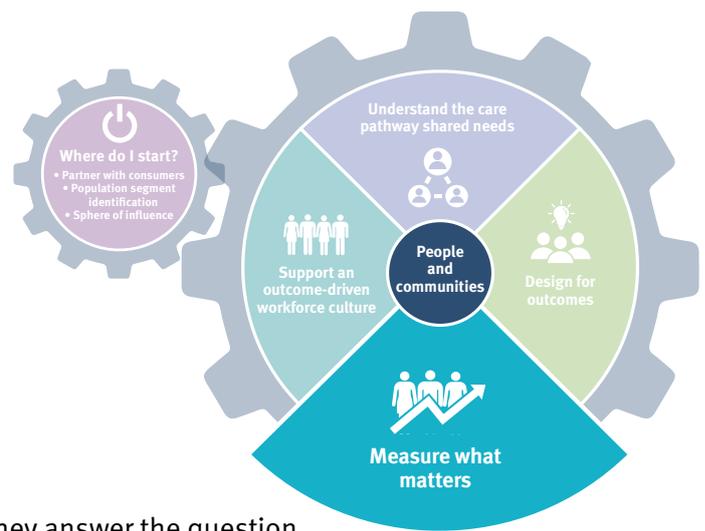
- Who will be part of our care team? People, communities and carers? How will we involve them in the design of our solution?
- How will shared goals be developed? What processes will be put in place to facilitate communication and collaboration across disciplines? Services? Sectors? With consumers and their carers and families?
- How do we maximise efficiency within the team? How do we ensure all members of our team work to top of scope? How to we minimise the cost of the care through design?
- How do we include and involve consumers, their carers, and their families in the care team?

Clinical risk management

- Do we understand the clinical risks for our current pathways of care and our proposed pathways of care? What are the risks of not changing?
- Do we have transparent responsibility and accountability for identifying and controlling risks throughout the pathway?

Evaluation

- How do we embed evaluation and continuous improvement processes in the design of our VBHC intervention?

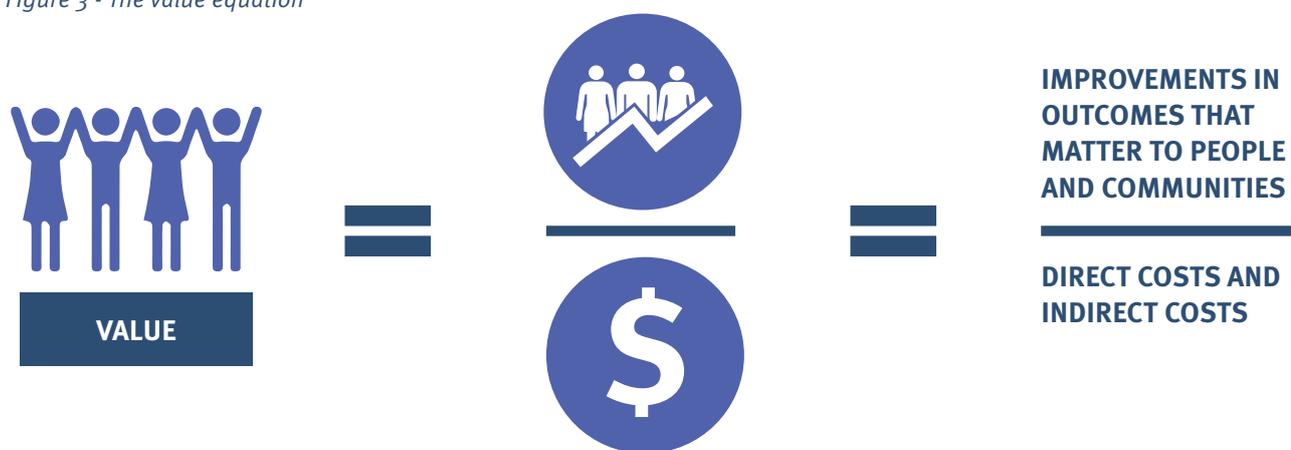


Appendix 3 - Value-based health care (VBHC)

VBHC is a global movement that offers an approach to the organisation of health care systems that provides value for people and communities. VBHC is a person-centred way to support health care decision making and system transformation, with the aim to improve both health outcomes and the experience of care across a full care pathway for people, service providers, communities, health professionals and populations.¹⁶⁶

The classic definition of VBHC is based on work initially led by Professors Michael Porter and Elizabeth Teisberg at the Harvard Business School. Porter and Teisberg (2006) conceptualised value in health care as ‘the measured improvement in a patient’s health outcomes for the cost of achieving that improvement’¹⁶⁷ that may be reflected in terms of the value equation (Figure 3).

Figure 3 - The value equation



In the Australian universal health care system, embedded principles of equity and public value highlight the need to consider community and population health as well as social, environmental, and cultural outcomes in the conceptualisation of VBHC.^{168,169}

Teisberg et al.¹⁷⁰ in 2020 published a *Strategic framework for Value-based Health Care Implementation* which outlined five stages of implementation: understanding shared health needs of patients; design solution to improve health outcomes; integrate learning teams; measure health outcomes and costs; and expand partnerships.

This research has informed the development of the *Queensland Health Allied Health Framework for Value-Based Health Care* (the Framework), providing a scaffolding upon which elements have been added and adapted to reflect the context and experiences of allied health in Queensland.

Useful resources

Redefining health care: Creating value-based competition on results. – Porter, M and Teisberg, E. (2006). Boston, Mass: Harvard Business School Press.

[Defining and Implementing Value-Based Health Care: A Strategic Framework.](#) – Teisberg E, Wallace S and O’Hara S. (2020).

[The Roadmap for Implementing Value-Based Healthcare in European University Hospitals](#) – Consensus Report and Recommendations – Cossio-Gil et al. (2021)

[The Quadruple Aim: care, health, cost and meaning in work](#) – Sikka, R., Morath, J., & Leape, L (2015)

[What is value-based health care?](#) – A short introductory video to the concept of VBHC

[Value in Healthcare: A case for change](#) – short explainer video developed by the World Economic Forum

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