



# Overview:

## Allied Health Framework for Value-Based Health Care



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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](http://www.health.qld.gov.au/ahwac/html/VBHC)

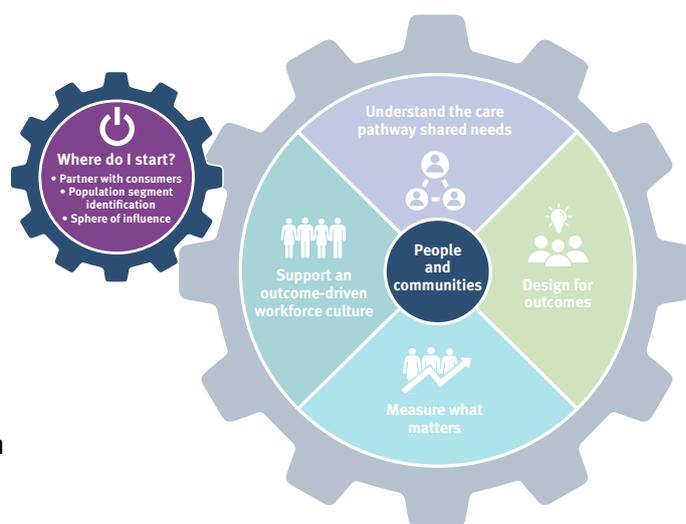
# Key considerations at each stage of implementation

## 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*

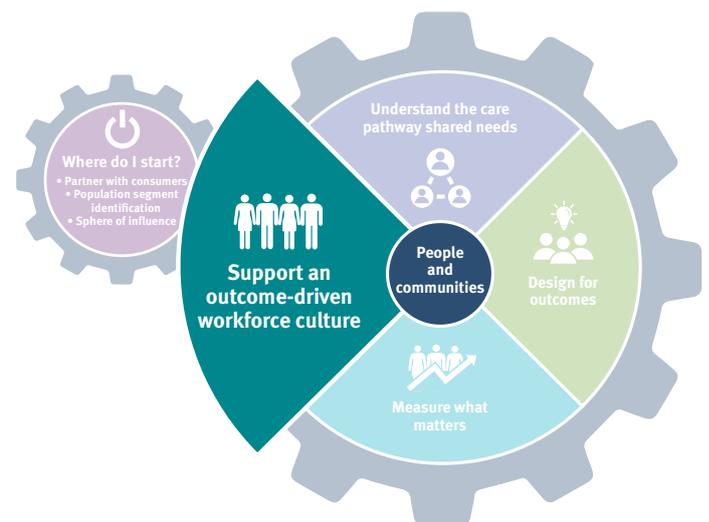
- How do we establish a culture within our organisation that is supportive of changing the status quo to better orientate care around what matters to people and communities?

*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?

