SELFIE Workshop Presentations

International Conference on Integrated Care

Dublin

May 8th – 11th 2017

Introduction

Sustainable intEgrated care modeLs for multi-morbidity: delivery, FInancing and performancE

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on behalf of the SELFIE consortium

ICIC, Dublin, May 8th-11th, 2017

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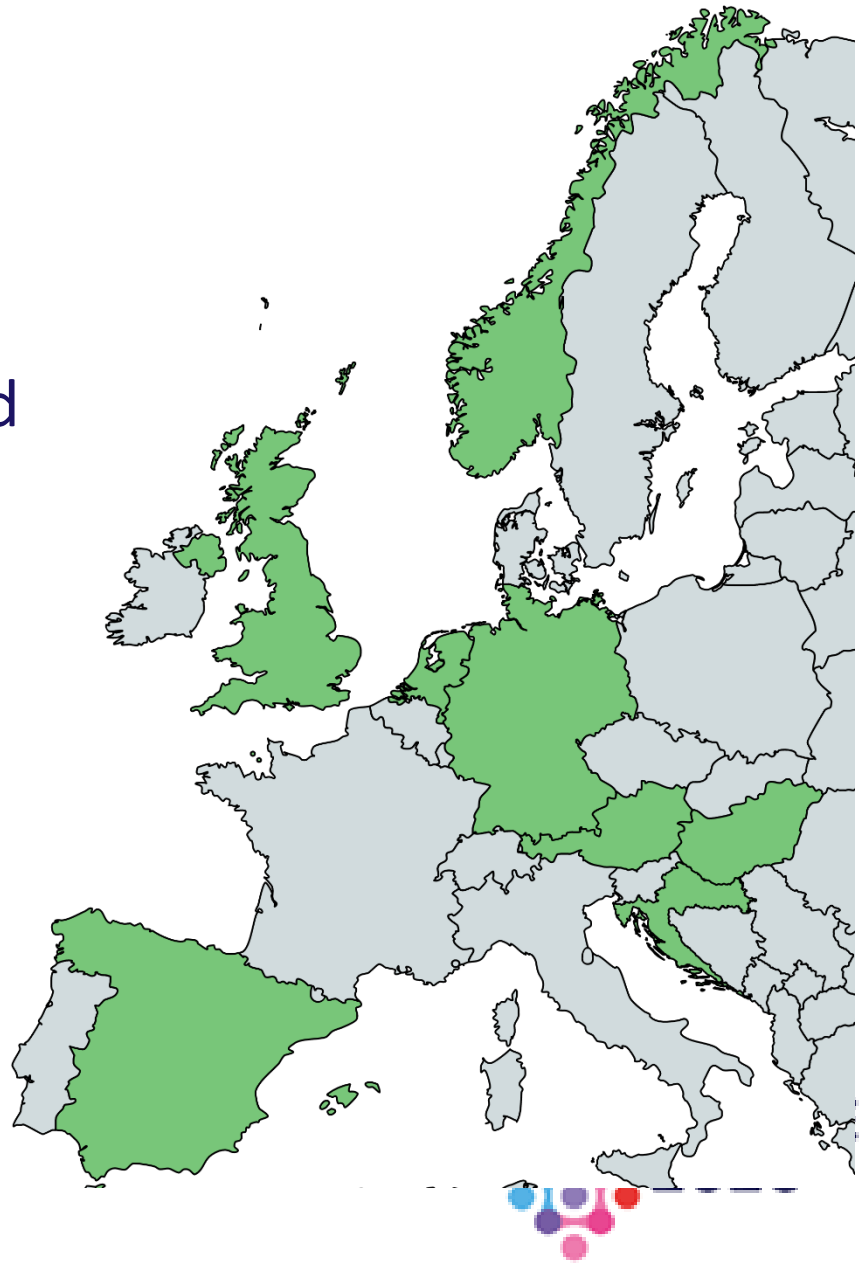
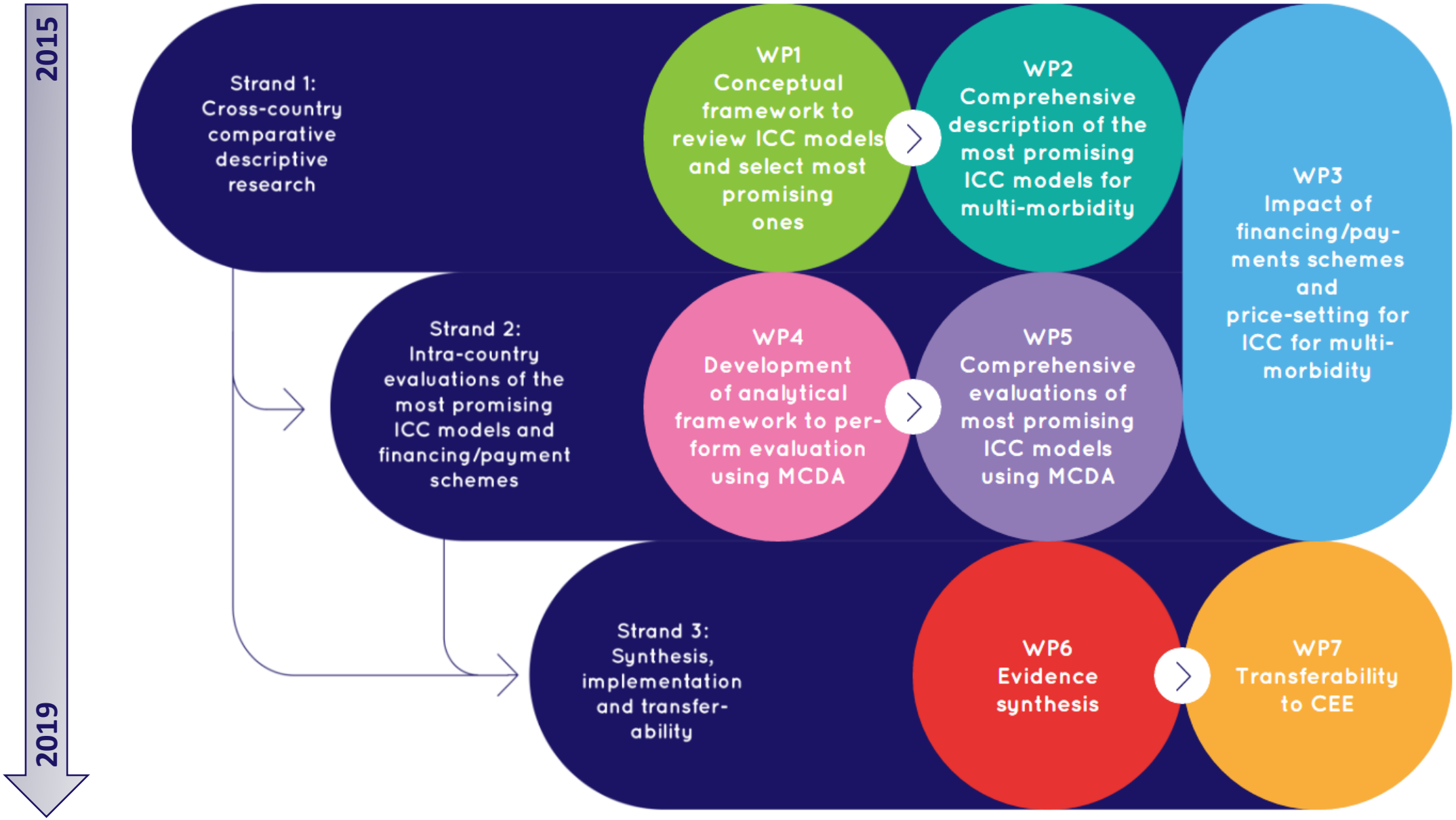
SELFIE consortium

1. Institute of Health Policy & Management, Erasmus University Rotterdam, the **Netherlands** (*coordinator*)
2. Institute for Advanced Studies, **Austria**
3. Agency for Quality & Accreditation in Health Care and Social Welfare, **Croatia**
4. Dept of Health Care Management, Berlin University of Technology, **Germany**
5. Syreon Research Institute, **Hungary**
6. Dept of Economics, University of Bergen, **Norway**
7. IDIBAPS Barcelona, **Spain**
8. Centre of Health Economics, University of Manchester, **UK**



SELFIE aims

1. Develop a **taxonomy of promising integrated care programmes** for persons with **multi-morbidity**
2. Describe **matching financing schemes** that provide incentives to implement such programmes
3. Provide **empirical evidence** about the impact of these programmes and financing schemes on outcomes using '**multi-criteria decision analyses**' (MCDA)
4. Develop novel **performance-monitoring tool**
5. Develop **implementation** and **transferability strategies**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2019
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WP1 Conceptual framework to review ICC models and select most promising ones
WP2 Comprehensive description of the most promising ICC models for multi-morbidity
WP3 Impact of financing/payments schemes and price-setting for ICC for multi-morbidity
Strand 2: Intra-country evaluations of the most promising ICC models and financing/payment schemes
WP4 Development of analytical framework to perform evaluation using MCDA
WP5 Comprehensive evaluations of most promising ICC models using MCDA
Strand 3: Synthesis, implementation and transferability
WP6 Evidence synthesis
WP7 Transferability to CEE

More info on SELFIE?

- Website: www.selfie2020.eu
- Email: info@selfie2020.eu

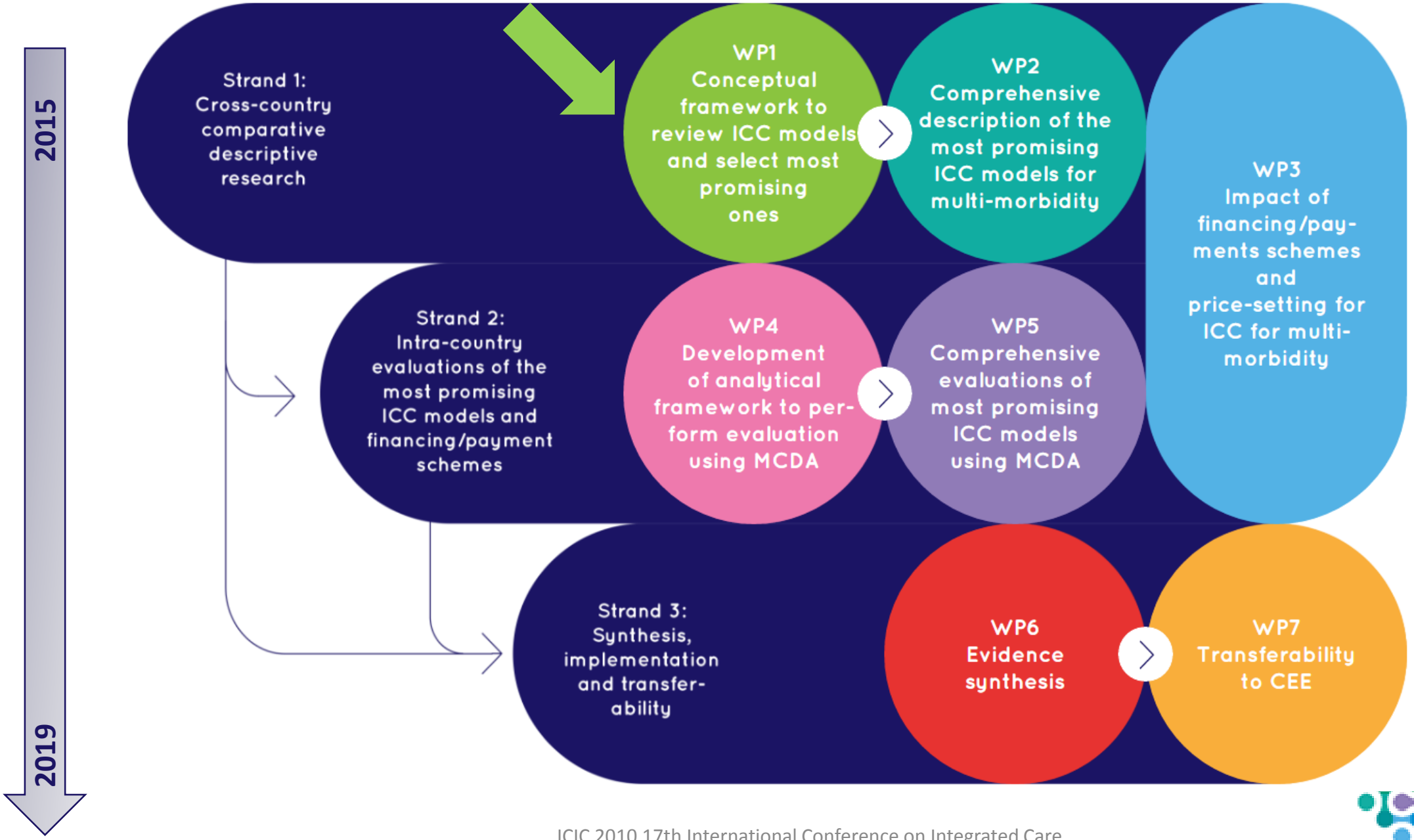
WP1

SELFIE Framework for Integrated Care for Multi-Morbidity

Verena Struckmann, Fenna Leijten, Ewout van Ginneken, Maureen Rutten-van Mölken

Outline

- SELFIE Framework development
- Introduction SELFIE framework
- Introduction of selected SELFIE framework components
- Selection of 17 integrated care programmes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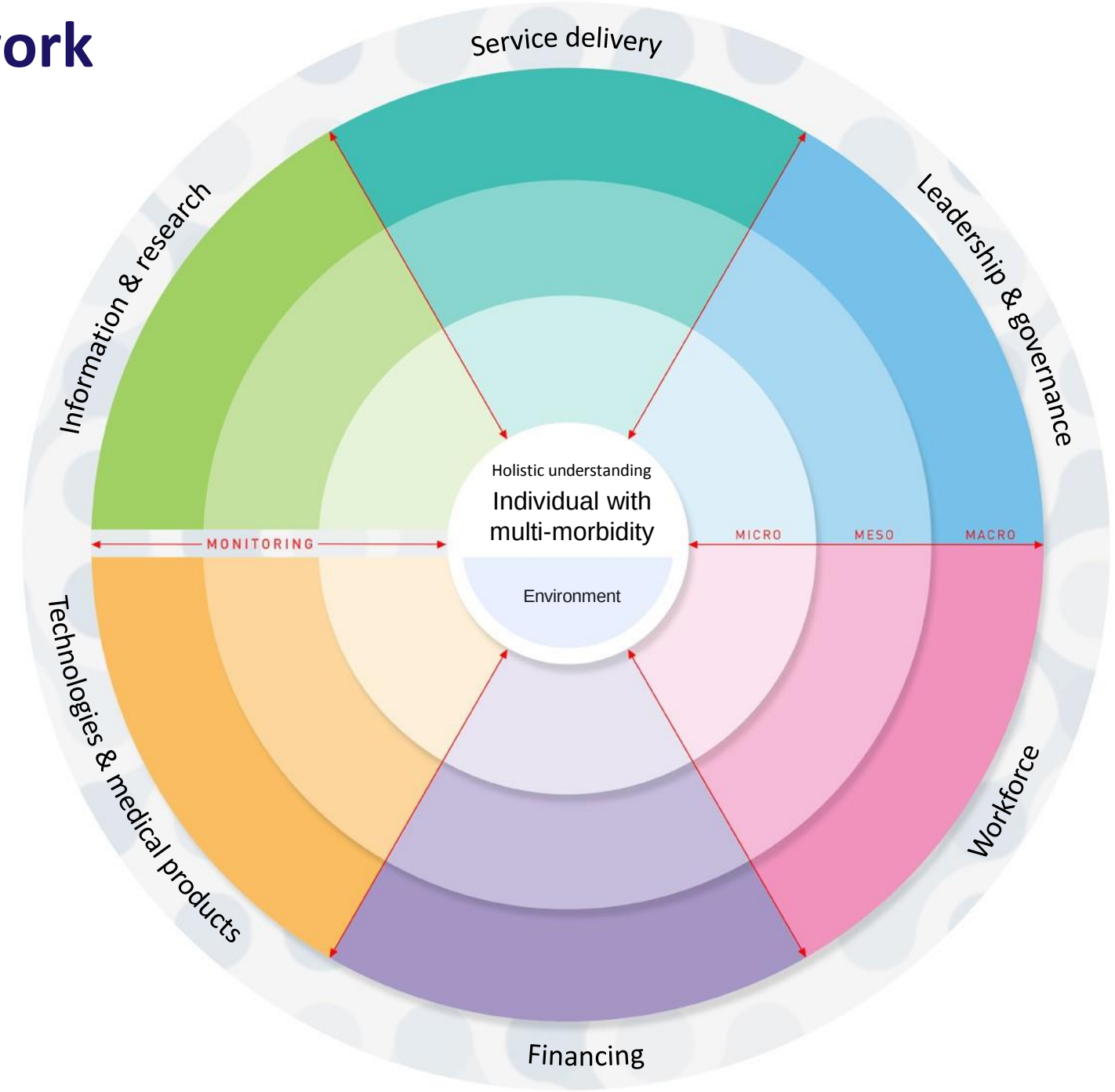
Developing a conceptual framework

- **Scoping review:** scientific & grey literature
- **International & national stakeholder advisory board meetings:**
  - Patients
  - Partners (i.e., informal caregivers)
  - Professionals
  - Payers
  - Policy makers

- **Iterative process**: scoping review and expert meetings

SELFIE Framework



Reference: Leijten FRM & Struckmann V, et al. The SELFIE Framework for Integrated Care for Multi-Morbidity: development and description. *Submitted to Health Policy*.

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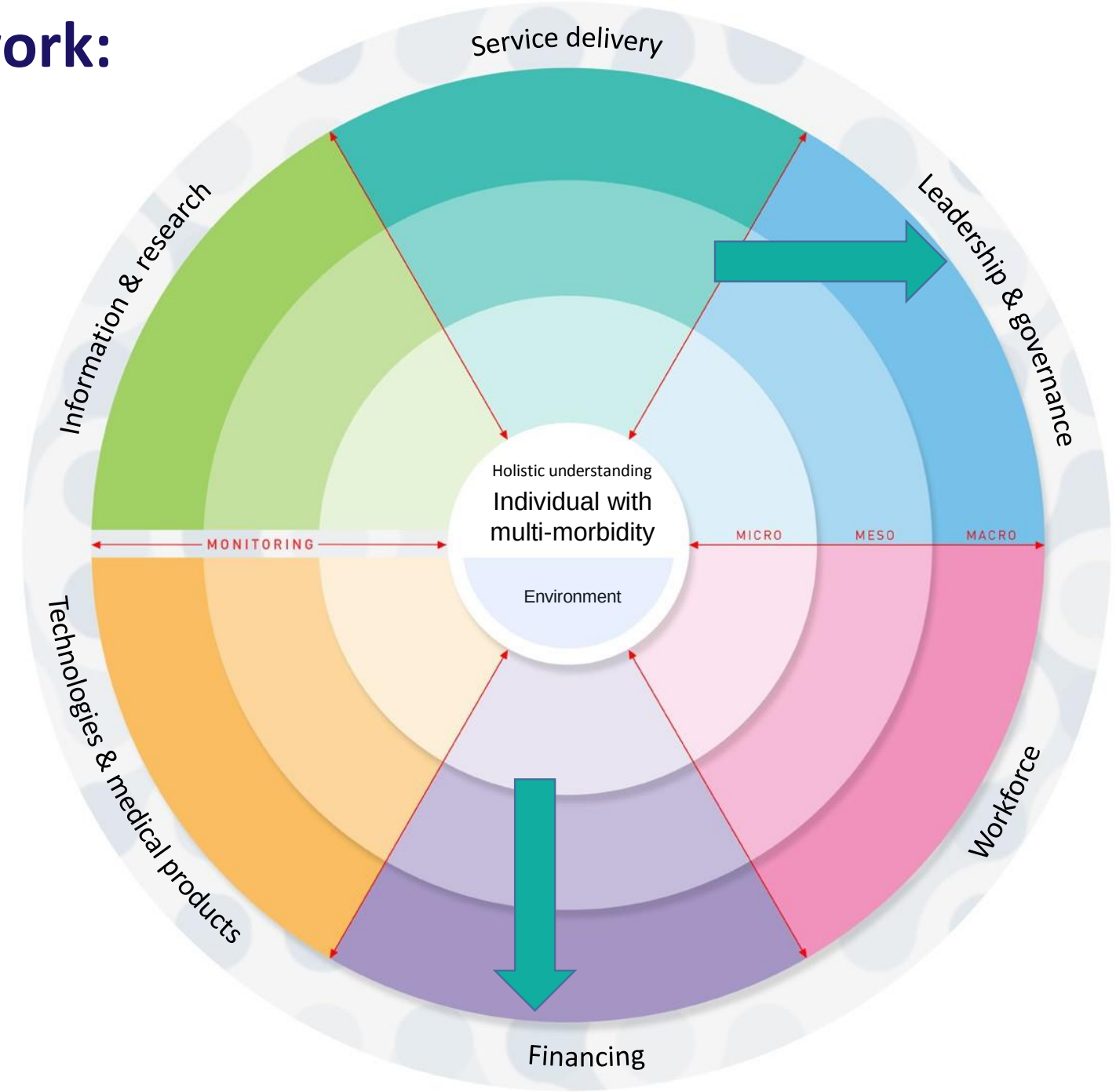
SELFIE Framework: Core

SELFIE Framework: components



Reference: Leijten FRM & Struckmann V, et al. The SELFIE Framework for Integrated Care for Multi-Morbidity: development and description. *Submitted to Health Policy*.

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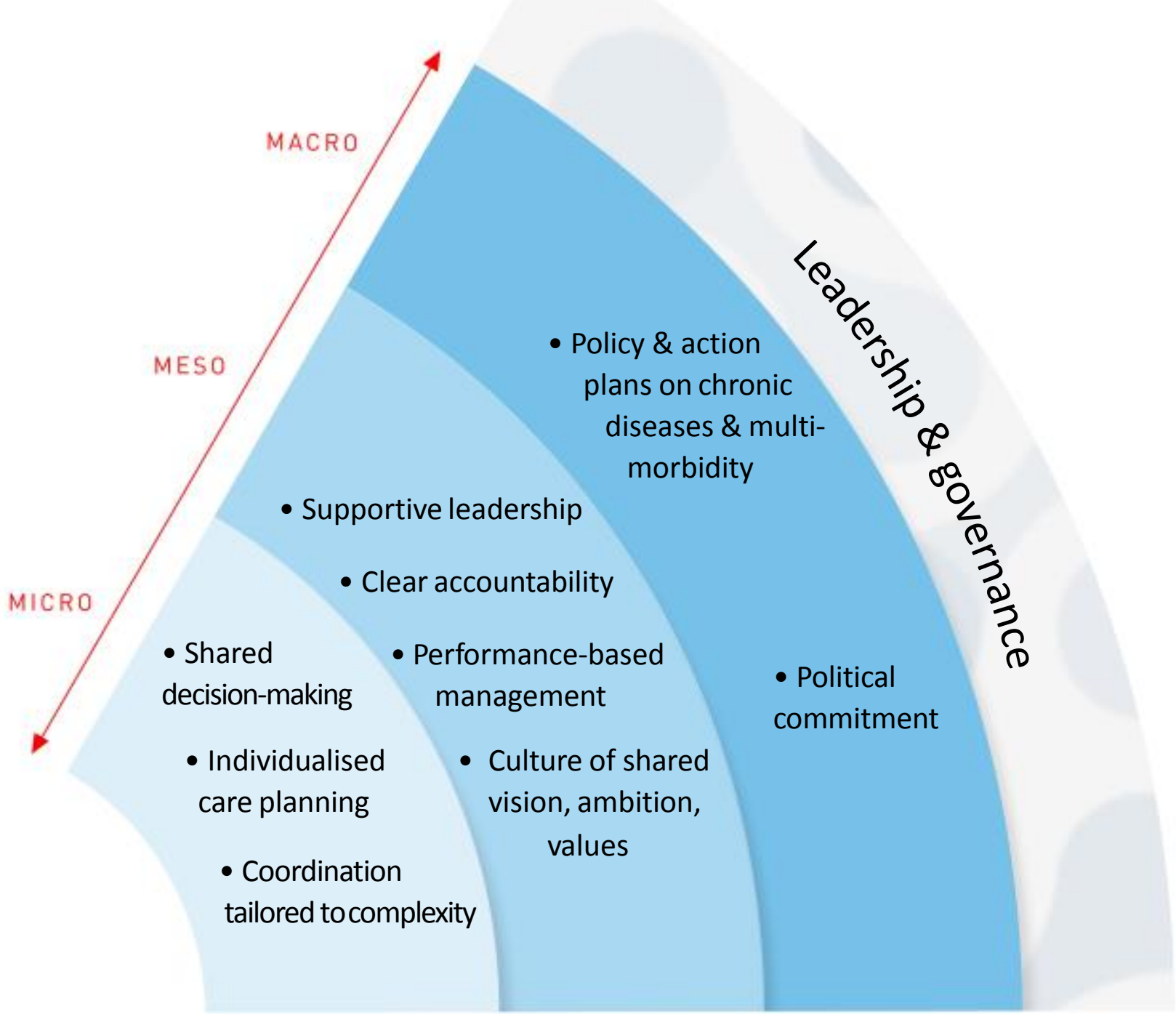
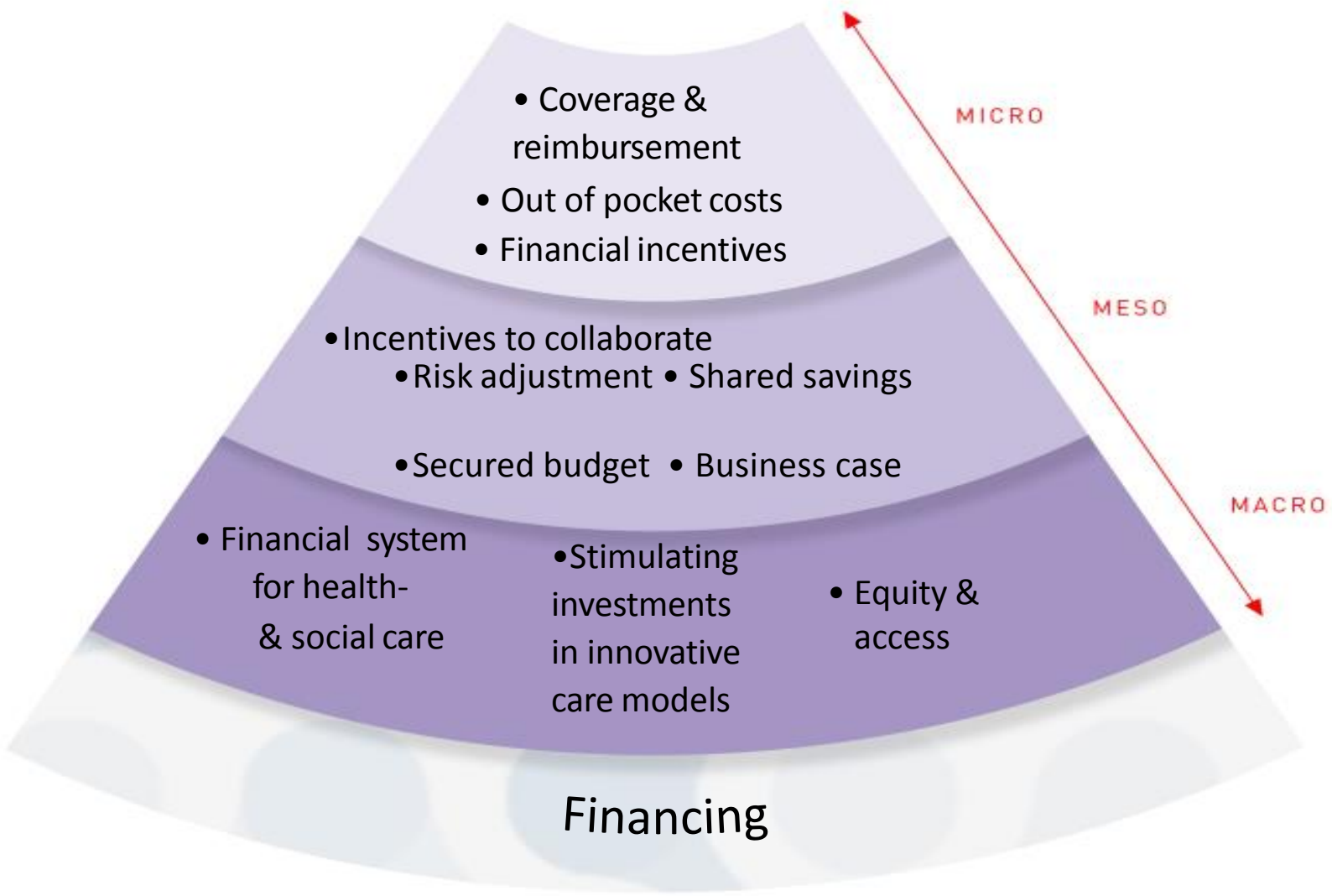
SELFIE Framework:
Leadership & Governance

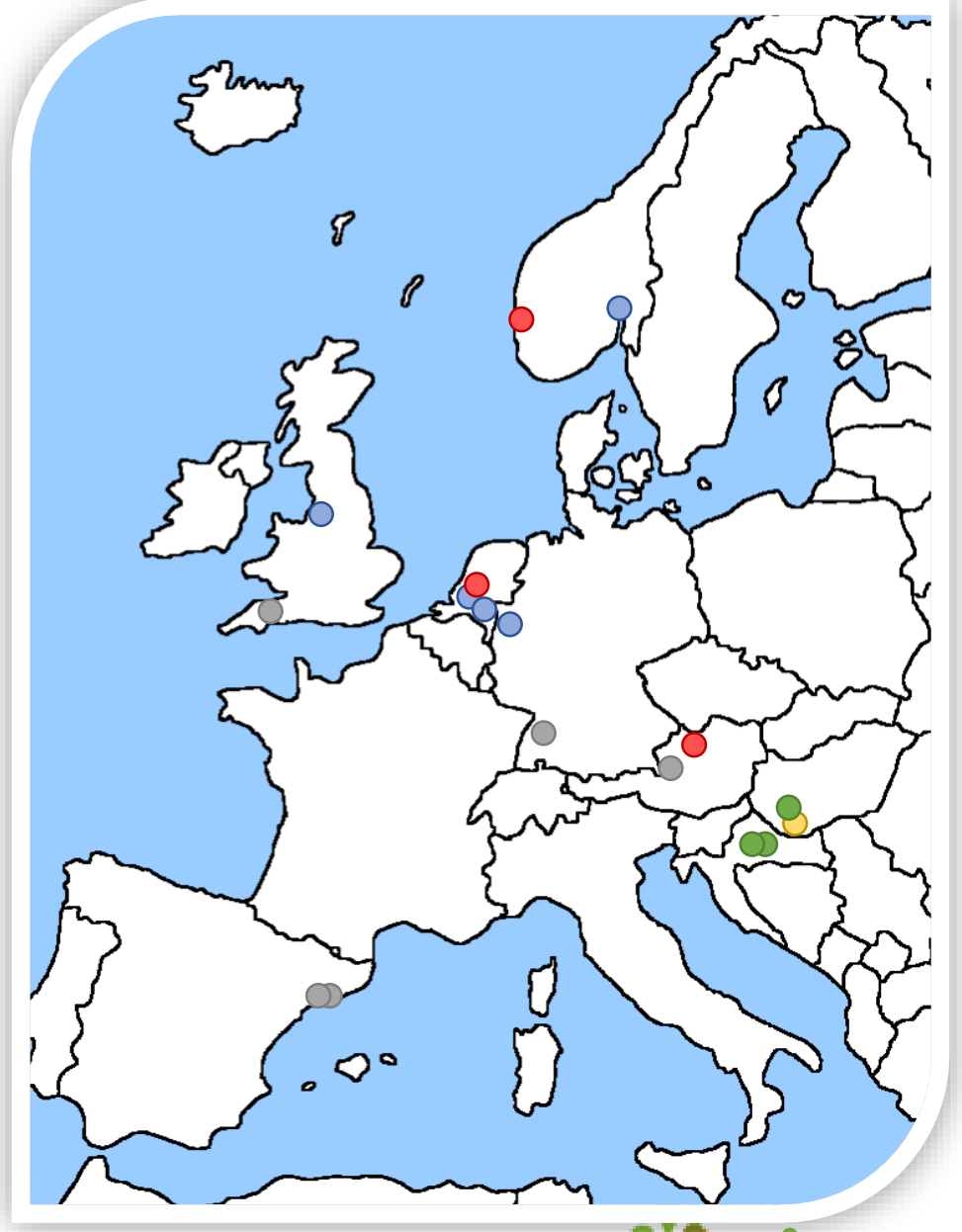


SELFIE Framework: Financing



Selection of 17 programmes

- Variability across selected programmes:
  - ***Target group***: **frail elderly**, **palliative patients/ oncology patients**, **persons with problems in multiple life domains**, **whole populations**
  - ***Scope*****:** small-scale case finding, screening, regional approaches, population health management
  - ***Focus:*** prevention, crossing health- and social care, palliative care, transfer care
- 17 programmes were **described** and will be **evaluated**

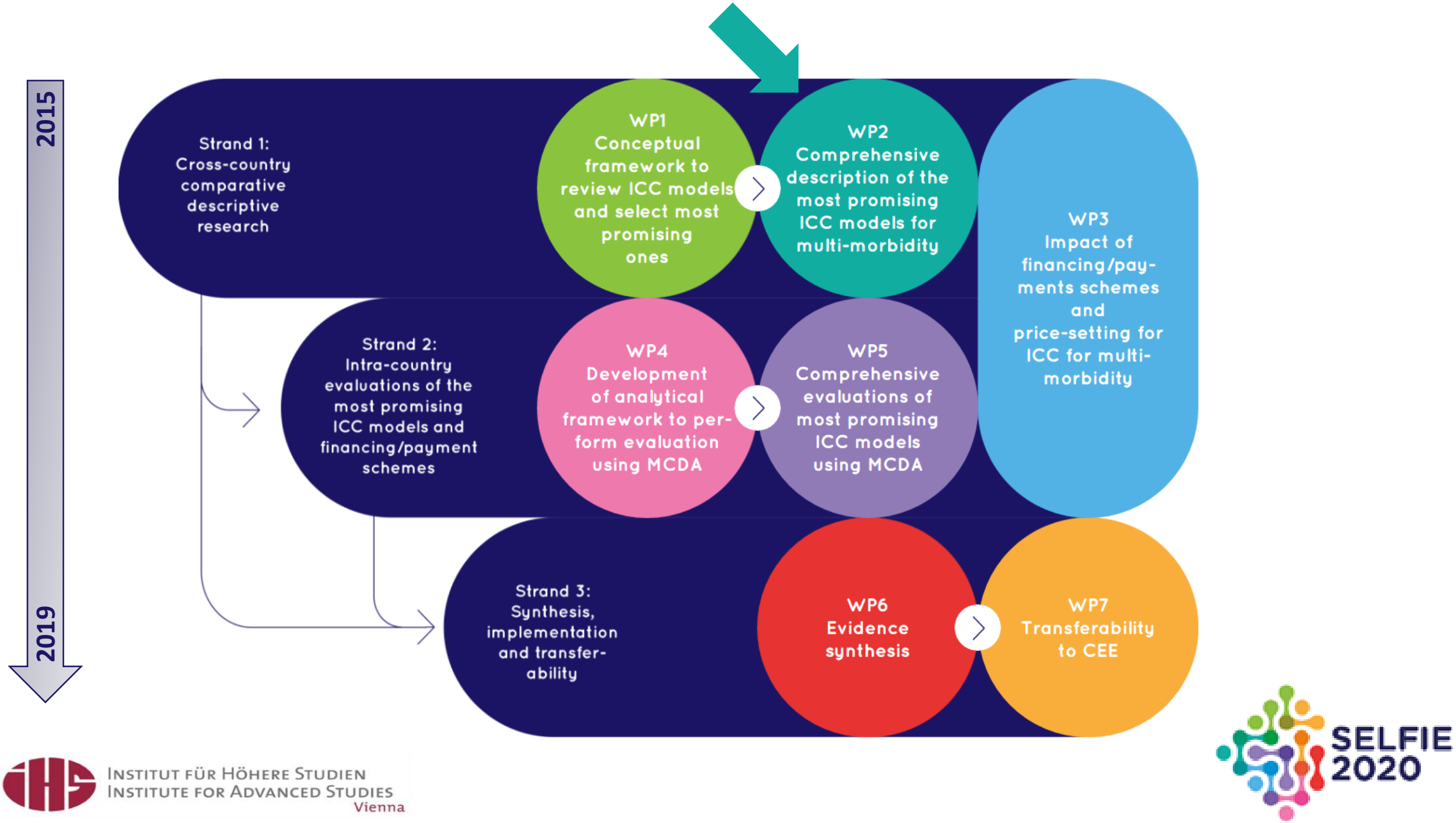


WP2

SELFIE Workshop: Barriers and facilitators to the implementation of promising integrated care programmes for multi-morbidity – An overarching analysis

Miriam Reiss
Thomas Czypionka, Markus Kraus

International Conference on Integrated Care (ICIC), Dublin, May 8th-11th, 2017



Institut für Höhere Studien
Institute for Advanced Studies
Vienna

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Contents

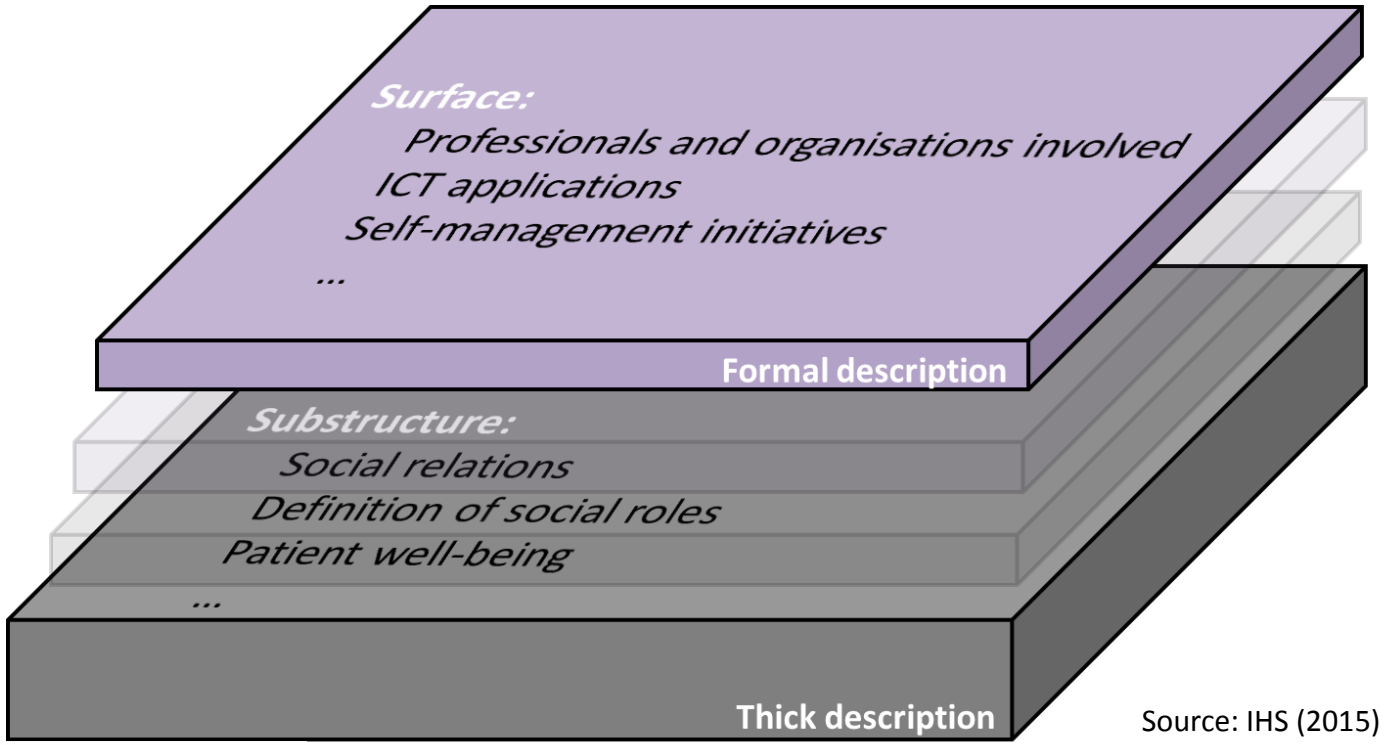
- Introduction
- Method
- Results
- Conclusions

WP2: Introduction

- Aim of WP2 of SELFIE: **comprehensively describe** 17 programmes selected in WP1, guided by conceptual framework
- Methodological approach: **thick description**
- Individual reports on the 17 programmes prepared by SELFIE partners
- Current status: IHS and IDIBAPS perform **overarching analyses**
- Focus of today's presentation on the **core and micro level** of the framework, mainly in the area **service delivery**

WP2: Method – Thick description in general

- Qualitative approach to investigate **implicit social practices**
- Origins in philosophy (Ryle, 1949) and anthropology (Geertz, 1973)
- Covers **several levels of depth of analysis**:



Source: IHS (2015)

WP2: Method – Thick description in the context of SELFIE

- Information gathered by means of **two complementing approaches**:
  1. Document analysis
  2. Qualitative interviews
- Document analysis of programme documents
- Qualitative interviews with 10-20 relevant stakeholders

Programme manager(s)	Informal caregivers
Programme initiator(s)	Clients
Representatives of sponsor/payer organisations	Other stakeholders
Medical and social staff	

WP2: Method – Overarching analysis

- Thick description reports **screened**
- **Common central aspects** identified
- Currently focused on **selected programmes**
- Still **work in progress**…

WP2: Results – Overarching analysis

Themes that emerged in overarching analysis:

- Holistic approach
- Continuity of care
- Client involvement
- Informal caregiver involvement
- Self management
- Relationship between professionals

WP2: Results – Holistic approach

- **Social aspects**
  - **SMC Liebenau** (AT): SMC team follows a social medicine approach and stresses significance of social aspects for health
  - **South Somerset** (UK): Multi-morbidity not only considered in terms of complex health conditions, but also complex social needs
  - **BSiN** (NL): Multiple life domains taken into account – needs assessment and support based on self-sufficiency matrix
- **Mental health**
  - **South Somerset** (UK): Presence of mental health problems increases complexity and requires specific management

"I think anxiety and depression are huge and I certainly didn't realise how much that impacts on a person's health and wellbeing and, you know, some people can have three, four long term conditions and can manage quite well, somebody that could have anxiety and depression could have one long term condition and it's, you know, they don't manage at all."

[care coordinator]

"If someone doesn't know how he is going to finance his everyday needs, then coping, for instance, with his diabetes or his multiple illnesses is probably the least of his worries, because he'll say: 'Okay, that's an organic illness that I have, but I don't know if I can keep the apartment or I don't know if the youth welfare office is going to take my children away or something. As a doctor, I then have the responsibility to also help resolve these problems, because only then will the medicine prescribed work."

[physician]

WP2: Results – Continuity of care

- **Importance of single contact point**
  - **South Somerset** (UK): Programme helps clients manoeuvre through the system
  - **SMC Liebenau** (AT): Presence of social worker at SMC allows for low-threshold access
  - **U-PROFIT** (NL): Clients and informal caregivers value that elderly care nurse is a consistent factor in their lives

"It doesn't matter what is wrong with me, I can discuss it with them. If I need a doctor's appointment, they can make one at the surgery for me and they can…if it's something to do with, say, the diabetes and they think I need a review, they will arrange all of that for me. So it is, as they have said, one body of people I can go to that has access to everything I need."

[client]

WP2: Results – Client involvement

- **Shared decision making**
  - **Gesundes Kinzigtal** (DE): Clients value opportunity to be involved in care planning
  - **BSiN** (NL): During case management trajectory, client is in charge of the individual care plan
  - **CCFE** (NL): Clients and/or informal caregivers participate in multi-disciplinary team meetings – sometimes seen as problematic by professionals

"I always have the right to have a say. It concerns my health. A physician can tell me what he wants, but if I say 'no', I mean 'no' and consequently the care is adapted. The physicians here always ask me what I want to do to change something or how I prefer to start"

[client]

WP2: Results – Client involvement

- **Joint goal setting/prioritisation**
  - **Gesundes Kinzigtal** (DE): Individual treatment plan based on realistic goals set by client
  - **U-PROFIT** (NL): Goals, e.g. living at home for longer, can only be achieved if prioritised by client, and not only by professionals
  - **CCFE** (NL): Personal goals in individualised care plan vary considerably

"If I have a patient with for example overweight and Diabetes, I try to actively involve him. I ask the patient: What can you contribute to the improvement of your health status? What are you willing to contribute? What is your aim for your personal health? It does not matter whether the patient expresses the wish to be physically active, to reduce weight or to change the diet. Usually I try to include the patient's wish and adapt the treatment options accordingly in order to achieve the highest compliance and motivation."

[physician]

WP2: Results – Informal caregiver involvement

- **Different ways of involving informal caregivers**
  - **Casaplus** (DE): Case managers offer consultations for informal caregivers
  - **CCFE** (NL): Informal caregiver support through e.g. direct support from case manager, referral to point of (peer) support, daytime activities for frail elderly at nursing home
  - **U-PROFIT** (NL): Elderly care nurse can involve informal caregiver in different ways, e.g. involvement in individualised care planning/holistic assessment, monitoring of informal caregiver's health and mental well-being, information on available support services

"[…] as they are burdened too, especially when their relative is seriously ill or needs admission to a nursing home or wants to inform himself or just need someone to talk to. All of this can be very important for informal carers"

[programme manager]

WP2: Results – Self management

- **Self management as means of empowerment**
  - **Gesundes Kinzigtal** (DE): Self management support as essential element of programme aimed at empowering clients
  - **SMC Liebenau** (AT): SMC team believes in an emancipatory medicine approach – services aimed at encouraging clients to promote their own physical and mental health (e.g. health promotion, education and information services)
  - **South Somerset** (UK): Minimising dependency by self management support

"We do not want to be the clucking hen, who asks every week did you do this, did you do that. Like this the patient is never going to do something independently. So the idea and our philosophy is in the end to support self-empowerment, so that the physician is not the coach for a patient's entire life, but simply the companion, a 'supervisor' for a certain time."

[non-physician programme management staff]

WP2: Results – Self management

- **Challenges of self management**
  - **HNT** (AT): Treatment needs to be adapted to client's compliance – self management abilities not solely depending on age
  - **South Somerset** (UK): Self management interventions dependent on individual client
  - **SMC Liebenau** (AT): Ambivalent view on self management – client needs support from outside

"So, I would describe self-management more as a problematic approach. […] You need contact persons. You need a person on the outside to communicate with about it. […] You need someone, an outsider, who helps you to manage it. So one of our most important tasks is to help patients manage their health, because they can't do it on their own."

[physician]

"It depends on the person. I see 86-year-olds who are top fit, have all their faculties, are communicative, receptive and can see well and I also see people where I look at their date of birth and think, that can't be – he's only 68, but already biologically so old and tired. So it depends on the person. There are definitely clients who are willing and able, and others who you definitely wouldn't get through to in such training courses. So there are both. It differs from case to case. Compliance is the issue. Who has compliance, who doesn't."

[case manager]

WP2: Results – Relationship between professionals

- **Importance of communication**
  - **HNT** (AT): Low thresholds in communication between involved professionals
  - **South Somerset** (UK): „Huddles“ as key instrument for communication within care team
  - **SMC Liebenau** (AT): Regular joint case conferences for quality assurance purposes – valued by all involved professionals

“I think a certain culture has since developed over the years in the Tennengau region. Nowadays, there are no borders between the different participants. If I contact someone, that contact is basically friendly and positive from the start, even if I were perhaps on occasion to voice criticism. […] I’ve heard that in other areas that can often cause tensions, that people are in competition with each other. […] We support and encourage each other and that’s what I find good and is what, I think, has established itself over the course of time.”

[care manager/initiator]

WP2: Conclusions

- Barriers and facilitators for functioning of programmes **similar across different programmes**
- Aspects of **personal relationships** between clients and professionals/among professionals central
- **Person-centeredness** emphasised in all programmes – manifests itself in various ways
- Identified aspects and experiences can be **valuable for future implementation efforts**

- **Next step**: further overarching analyses with focus on governance and implementation process (IHS)/technologies and information (IDIBAPS)

Thank you!

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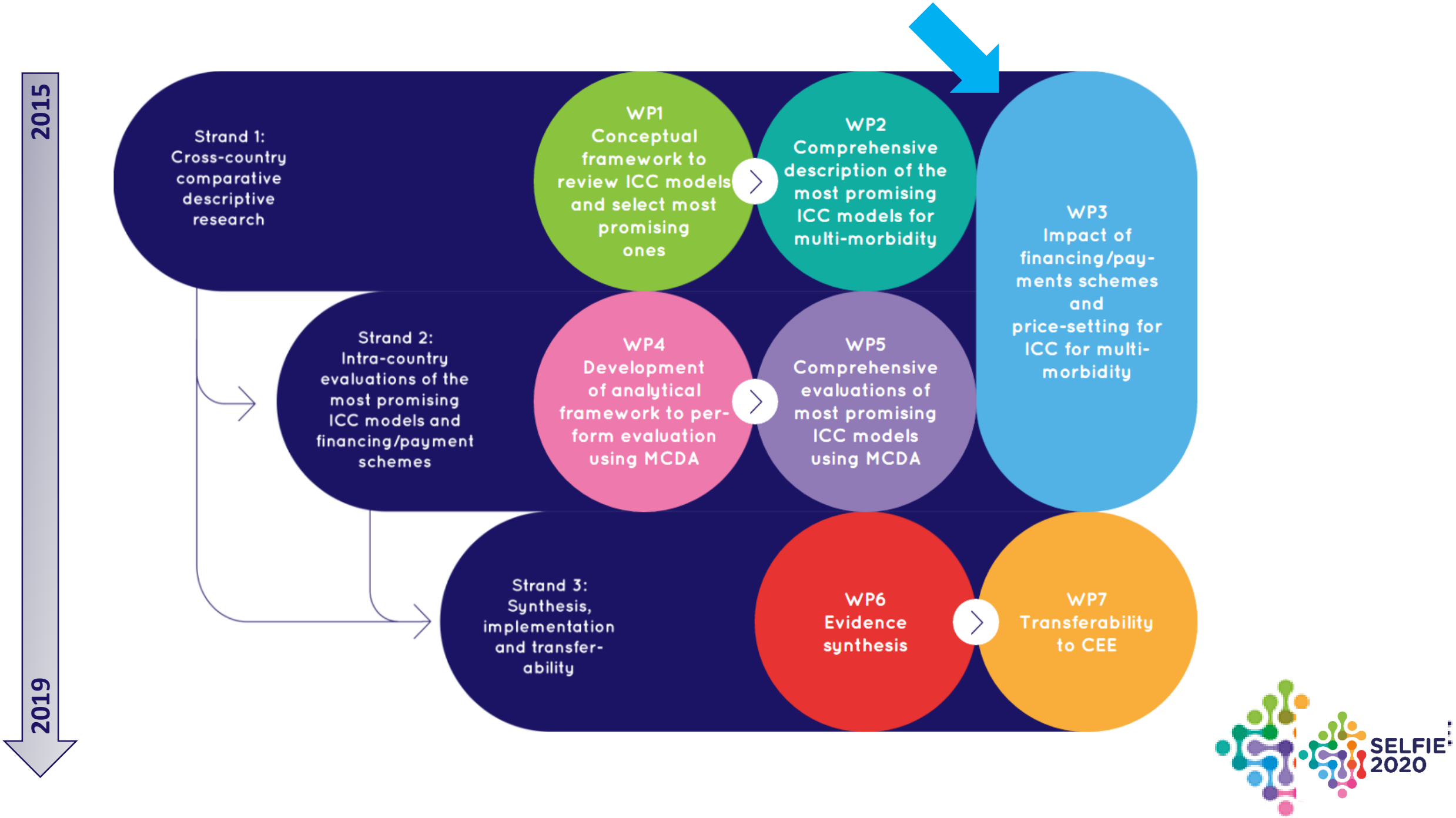
WP3

SELFIE Workshop: Exploring different financial and payment schemes applied across integrated care programmes for multi-morbidity

Jonathan Stokes, Søren Rud Kristensen, Matt Sutton

ICIC, Dublin, May 8th-11th, 2017

MANCHESTER 1824
The University of Manchester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Content

- Motivation
- Research Questions
- Methods
- Results
  - Existing base-payment systems
  - Macro-level incentives for integration
  - Programme-level incentives for integration
- Discussion

WP3: Motivation

- Ageing populations and increasing multi-morbidity puts health systems under pressure
- Payment mechanisms influence provider behaviour
- Perception that existing payment models may contribute to costly and fragmented care for multi-morbid patients
- New integrated care models may address these problems
- (Funding integration NOT a choice criteria for SELFIE programmes)

WP3: Research Questions

- Which incentives do the “base-payment systems” provide for integration of care (17 SELFIE programmes)?

- To what extent do macro level incentives in the 8 SELFIE countries exist to support integration of care?

- To what extent do any payment mechanisms introduced in the 17 SELFIE integrated care models support integration?

WP3: Methods

- Map base-payment systems for primary, secondary and social care in the 8 countries/17 programmes
  - Classify following Quinn typology

- Identify macro-level payment incentives to stimulate integration of care

- Map specific financial incentives to stimulate integration of care in the 17 programmes
  - Classify using Tsiachristas et al. typology

WP3: Methods (Typologies)

General (base) payment models (Quinn 2015, AIM)

- Global budgets
- Capitation
- Activity-based funding (e.g. DRG)
- Per diem
- Fee-for-service
- Cost reimbursement

Payments designed to stimulate integration (Tsiachristas et al. 2013, HP)

- Pay-for-coordination
- Pay-for-performance
- Bundled payment (related to single condition)
- Global payment (covering all health and care)

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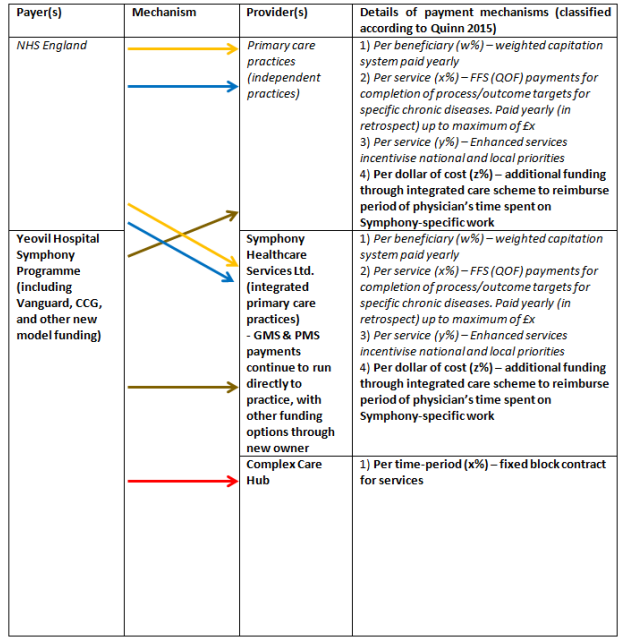
WP3: Methods (Data)

- Qualitative data on financing from SELFIE 'thick descriptions' (WP2)

- Questionnaire survey on financial incentives in each programme to national partners with interview follow-ups as necessary
  - List all payers
  - List all providers
  - Insert payment mechanism(s) for each payer to provider
  - Detail all payment mechanisms
  - Take diagram to relevant interviews



Payer(s)	Mechanism	Provider(s)	Details of payment mechanisms (classified according to Quinn 2015)
NHS England		*Primary care practices (independent practices)*	1) *Per beneficiary (w%) – weighted capitation system paid yearly* 2) *Per service (x%) – FFS (QOF) payments for completion of process/outcome targets for specific chronic diseases. Paid yearly (in retrospect) up to maximum of £x* 3) *Per service (y%) – Enhanced services incentivise national and local priorities* 4) **Per dollar of cost (z%) – additional funding through integrated care scheme to reimburse period of physician's time spent on Symphony-specific work**
Yeovil Hospital Symphony Programme (including Vanguard, CCG, and other new model funding)		**Symphony Healthcare Services Ltd. (integrated primary care practices) - GMS & PMS payments continue to run directly to practice, with other funding options through new owner**	1) *Per beneficiary (w%) – weighted capitation system paid yearly* 2) *Per service (x%) – FFS (QOF) payments for completion of process/outcome targets for specific chronic diseases. Paid yearly (in retrospect) up to maximum of £x* 3) *Per service (y%) – Enhanced services incentivise national and local priorities* 4) **Per dollar of cost (z%) – additional funding through integrated care scheme to reimburse period of physician's time spent on Symphony-specific work**
		Complex Care Hub	1) **Per time-period (x%) – fixed block contract for services**

Bold = new as part of integrated care programme
Italics = existing regular services

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WP3: Results (Existing base-payment systems)

			Austria		Croatia		Germany		Hungary		Netherlands			Norway		Spain		UK	
		Common term	Tennengau	Liebenau	GeroS	Palliative	Kinzigtal	Casaplus	PCCS	Onco-Network	KOMPLEET	U-PROFIT	BSiN	Learning Networks	MAR	Ais-Be	BSA	Salford	South Somerset
Unit of payment	**Time period**	*Budget/Salary*	X	X	X	X			X		X	X	X	X				X	X
	Beneficiary	*Capitation*	X	X	X	X		X							X	X	X	X	X
	Recipient	*Contact Capitation*																	
	Episode	*DRG/Bundled payment*	X	X	X	X	X		X	X	X							X	
	Day	*Per diem*	X	X	X	X	X			X									
	Service	*Fee for service*	X	X	X	X	X		X	X				X	X	X	X	X	X
	Cost	*Cost reimbursement*	X	X				X		X								X	X
	Charges	*% of charges*					X											X	
	Number of payers		5	6	3	3	3	1	4	1	3	3	2	3	2	1	1	2	2
	Number of provider types		6	7	4	6	5	1	4	4	3	1	1	1	1	3	3	3	3
	All participating providers paid by same mechanisms		No	No	No	No	No	n/a	No	No	No	n/a	n/a	n/a	n/a	No	No	No	No

- Primary care: Capitation / Fee-for-service

	Unit of payment	**Time period**	**Benefi-ciary**	**Recipient**	**Episode**	**Day**	**Service**	**Cost**	**Charges**
	Common term	*Budget/ Salary*	*Capita-tion*	*Contact Capita-tion*	*DRG/ Bundled payment*	*Per diem*	*Fee-for-service*	*Cost reimbur-sement*	*% of charges*
Country	**Programme**								
Austria	Tennengau		X				X		
	Liebenau		X				X		
Croatia	GeroS		X				X		
	Palliative		X				X		
Germany[a]	Kinzigtal						X	X	
	Casaplus		X					X	
Hungary[b]	PCCS								
	Onco-Network								
Netherlands	KOMPLEET	X			X				
	U-PROFIT	X							
	BSiN	X			X				
Norway	Learning Networks	X					X		
	MAR		X				X		
Spain	Ais-Be		X				X		
	BSA		X				X		
UK	Salford		X				X	X	
	South Somerset		X				X	X	

Notes: Blue indicates programme specific incentives, all other are base payment mechanisms. a) Per cost in this case refers to the shared savings programme b) n/a

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WP3: Results (Existing base-payment systems)

- Secondary care: Global budget / DRG / Fee-for-service
- Social care: Per diem

	Unit of payment	Time period	Beneficiary	Recipient	Episode	Day	Service	Cost	Charges
	Common term	*Budget/ Salary*	*Capitation*	*Contact Capitation*	*DRG/ Bundled payment*	*Per diem*	*Fee-for-service*	*Cost reimbursement*	*% of charges*
Country	**Programme**								
Austria	Tennengau	X			X	X			
	Liebenau	X			X	X			
Croatia	GeroS		X			X	X		
	Palliative		X			X	X		
Germany	Kinzigtal					X			
	Casaplus[a]								
Hungary	PCCS[a]								
	Onco-Network[a]								
Netherlands	KOMPLEET[a]								
	U-PROFIT[a]								
	BSiN	X			X				
Norway	Learning Networks	X					X		
	MAR		X				X		
Spain	Ais-Be[b]								
	BSA		X						
UK	Salford							X	X
	South Somerset[a]								

Notes: a) N/A b) TBD - Integration between healthcare and social support systems will be deployed between 2017-2019

	Unit of payment	Time period	Beneficiary	Recipient	Episode	Day	Service	Cost	Charges
	Common term	*Budget/ Salary*	*Capitation*	*Contact Capitation*	*DRG/ Bundled payment*	*Per diem*	*Fee-for-service*	*Cost reimbursement*	*% of charges*
Country	**Programme**								
Austria	Tennengau	X			X	X		X	X
	Liebenau	X			X	X		X	X
Croatia	GeroS	X			X	X		X	
	Palliative	X			X	X		X	
Germany	Kinzigtal				X				
	Casaplus*								
Hungary	PCCS	X			X			X	
	Onco-Network	X			X	X		X	
Netherlands	KOMPLEET*								
	U-PROFIT*								
	BSiN*								
Norway	Learning Networks*								
	MAR		X					X	
Spain	Ais-Be		X					X	
	BSA		X					X	
UK	Salford	X			X			X	X
	South Somerset	X							

Notes: Blue indicates programme specific incentives, all other are base payment mechanisms a) N/A

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WP3: Results (Existing base-payment systems)

- **Fee-for-service (FFS) / DRG**
  - Strong incentives for activity i.e. Treating acute illness > long-term preventative
  - Risk of overtreatment (burden of care)
  - No incentive to work with other providers

- **Capitation / Global budgets**
  - Incentives to minimise care (if unsupported by other incentives or performance monitoring)
  - Risk of avoiding complex multi-morbid patients (risk-adjustment)

- **Per diem**
  - Typically not risk-adjusted, incentive to avoid complex care/extend days charged
- **Do not provide optimal incentives for multi-morbid patients**

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WP3: Results (Macro-level)

Country	Macro level incentives for integration
Austria	Reformpool (2005-2013)
Croatia	No financial incentives for integration
Germany	Pilots of Disease Management Programmes (1993-), Integrated care programmes (2000-) , Federal Joint Committee (2016) , Innovation Fund
Hungary	No long term incentives for cross sector integration*
The Netherlands	Bundled payments (2010), Population based payment pilots (ongoing)
Norway	Coordination reform (2012)
Spain (Catalonia)	GMA: Adjusted multimorbidity groups, P4P
England	Integrated Care Pilots (2009-12), Integrated Care and Support Pioneers (2013), Devolution (2016)

* Primary care incentives exist, but this is also true in UK & Netherlands

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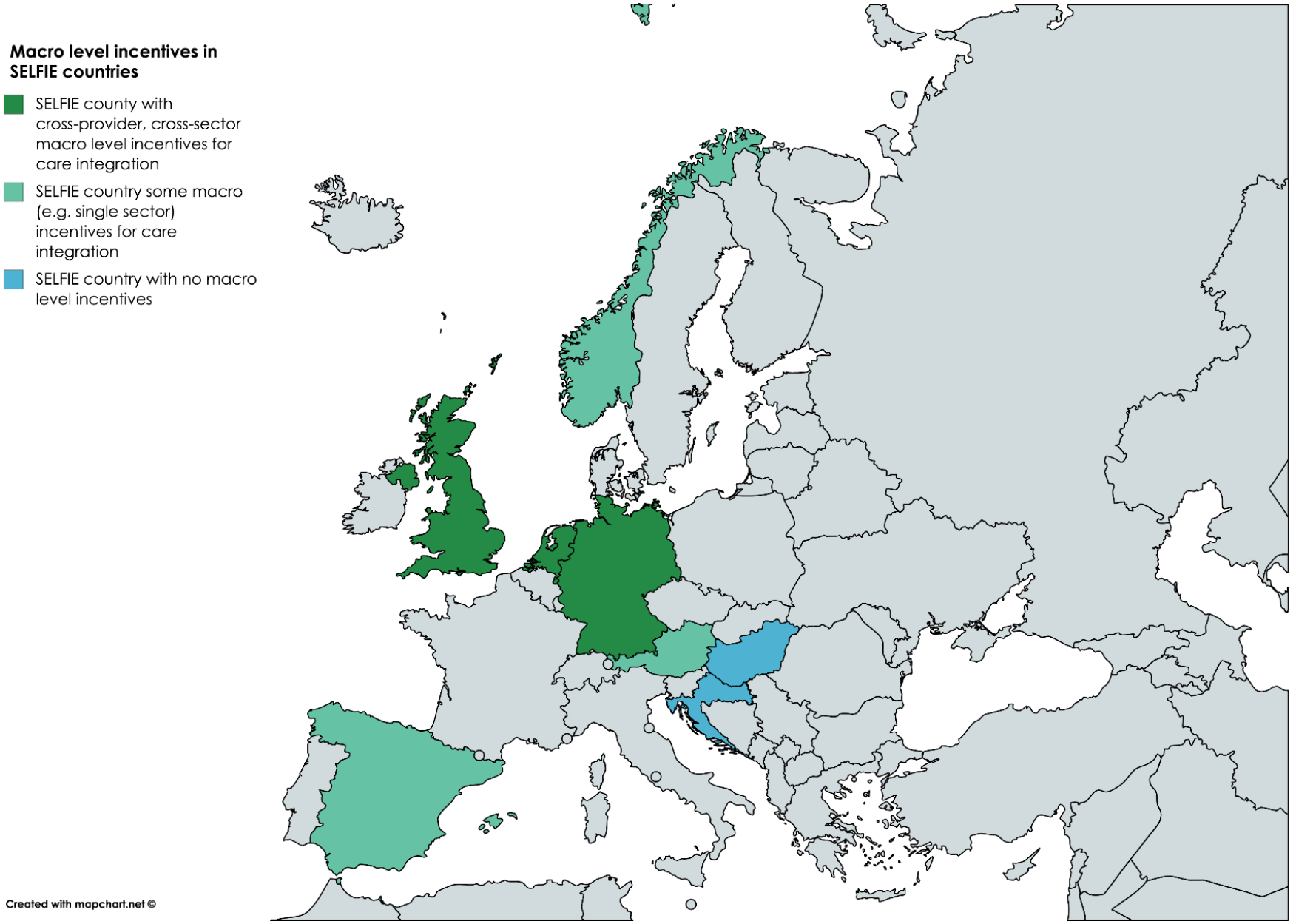
WP3: Results (Macro-level)



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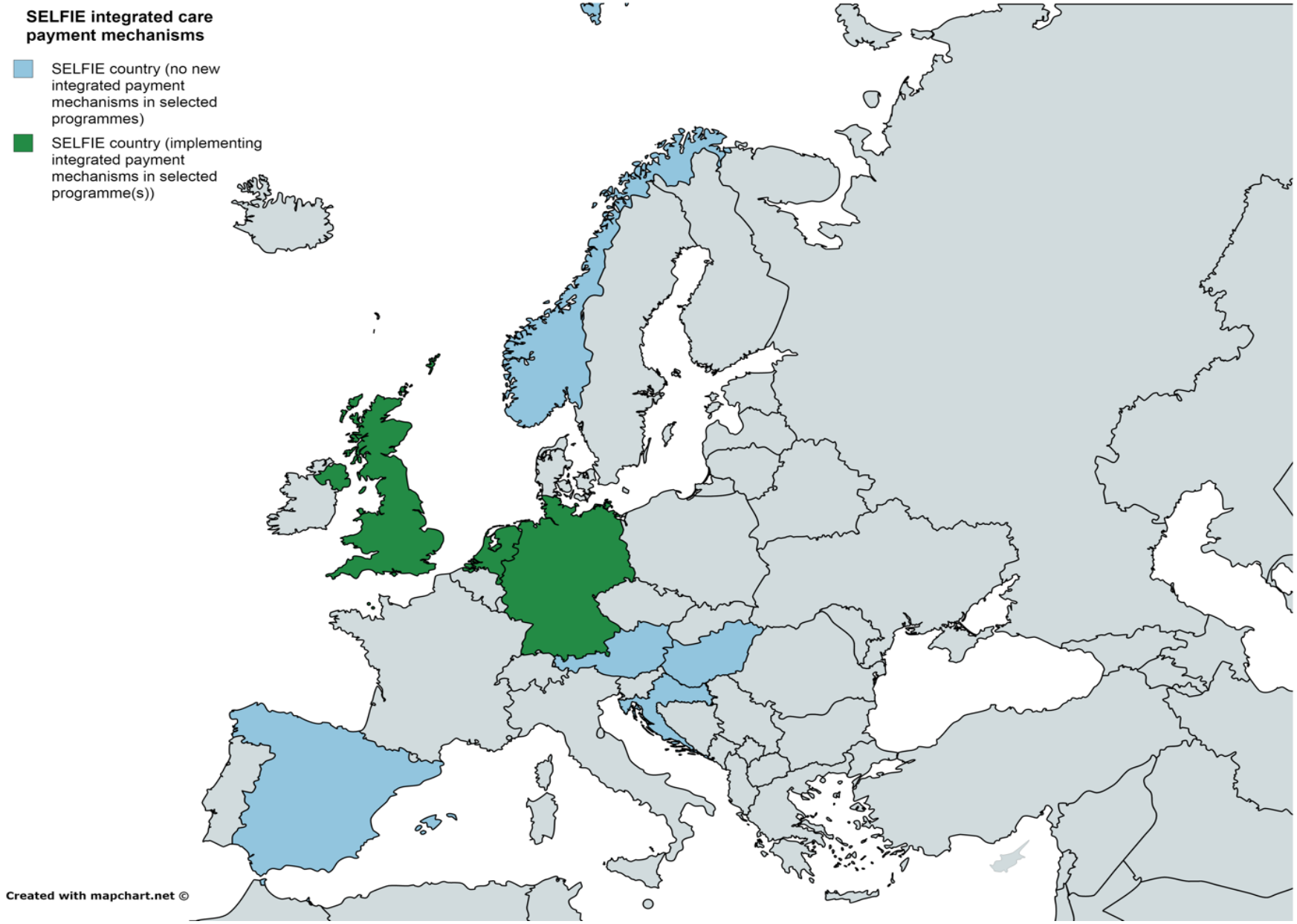
WP3: Results (Programme-level)

Country	Austria		Croatia		Germany		Hungary		Netherlands			Norway		Spain		UK	
Programme	Health Network Tennengau (HNT)	Social Medical Centre (SMC) Liebenau	GeroS	Palliative Care System	Casaplus	Gesundes Kinzigtal	Onconetwork	Palliative Care Consulting Service (Mobile team)	Proactive Primary Care Approach for Frail Elderly (U-PROFIT)	Care Chain Frail Elderly (KOMPLEET)	Better Together in Amsterdam North (BSiN)	Medically Assisted Rehab (MAR) Opioid Addiction	Health Network Tennengau	Badalona Serveis Assitencials (BSA)	Area Integral de Salut – Esquerra Eixample (AIS-BE)	Salford	South Somerset Symphony Programme
New provider payment mechanisms?	No	No	No	No	No	Yes	No	No	Yes	Yes	Yes	No	No	No	No	Yes	Yes

WP3: Results (Programme-level)

- Germany
  - Gesundes Kinzigtal
    - Pay-for-coordination, Shared savings
- The Netherlands
  - Proactive Primary Care Approach for Frail Elderly (U-PROFIT)
    - Pay-for-coordination
  - Care Chain Frail Elderly (KOMPLEET)
    - Bundled payments (in development, piloting)
  - Better Together in Amsterdam North (BSiN)
    - Bundled payment via pooled budget
- England
  - Salford
    - Pump-prime funding (Vanguard – pay-for-coordination), Pooled health and care budget
  - South Somerset Symphony programme
    - Pump-prime funding (Vanguard – pay-for-coordination), Integrated primary care practices

WP3: Results (Programme-level)



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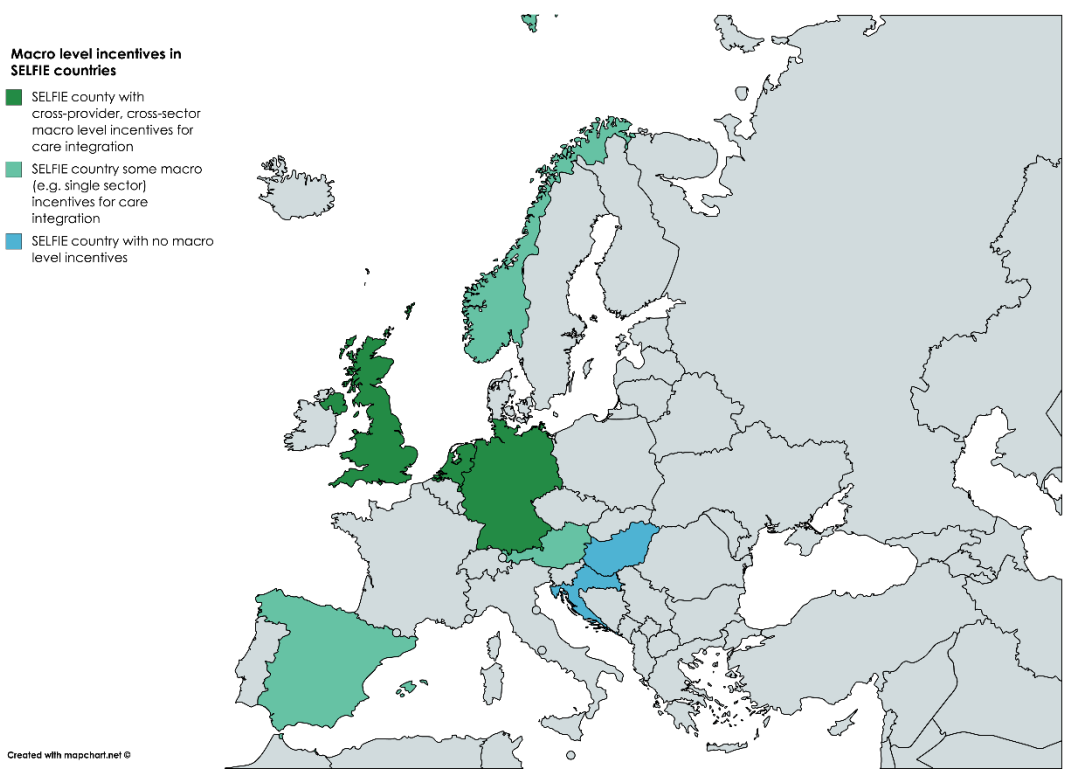
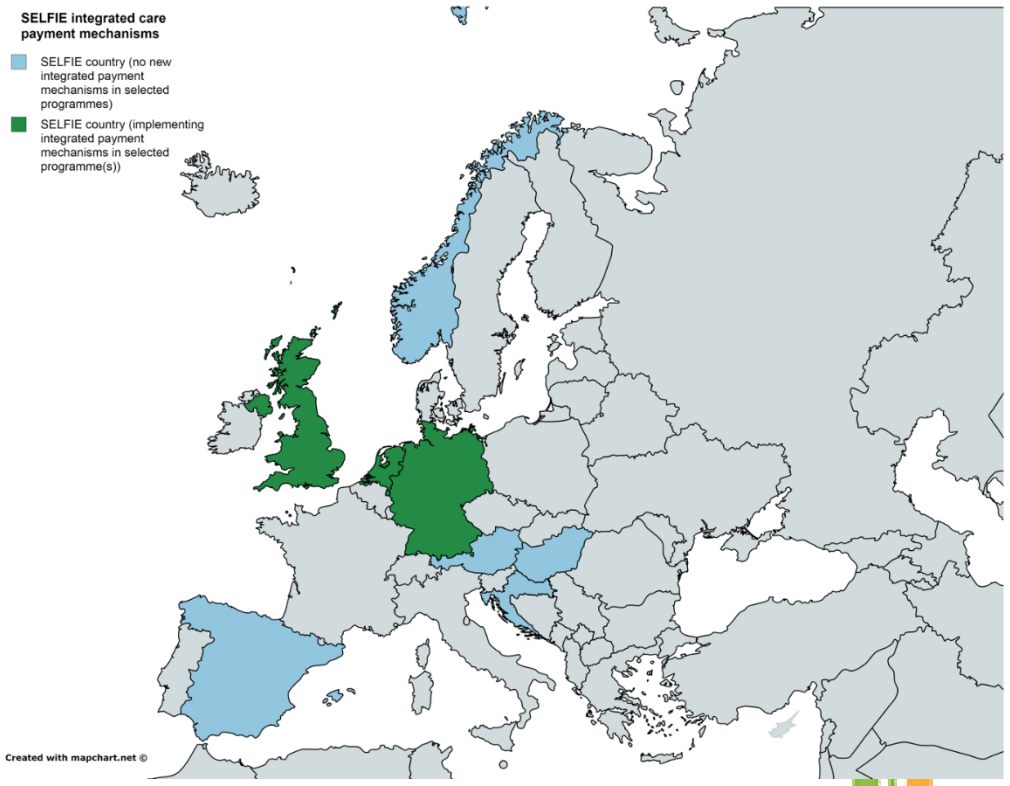
WP3: Results (Macro- vs. Programme-level)

Macro-level incentives



Programme-level incentives



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WP3: Discussion

Conclusion

- Macro-level financial policies for integration ‘necessary but not sufficient’ for programme-level incentives

Future work

- Interaction effects are important:
  - Do programme incentives replace or top up existing payments?
  - How do macro and programme incentives interact?
  - Effects of mixed payment systems?
- Do existing typologies describe incentives adequately?
- Effects of payment mechanisms on multimorbid patients?

Thanks for your attention!

Questions?

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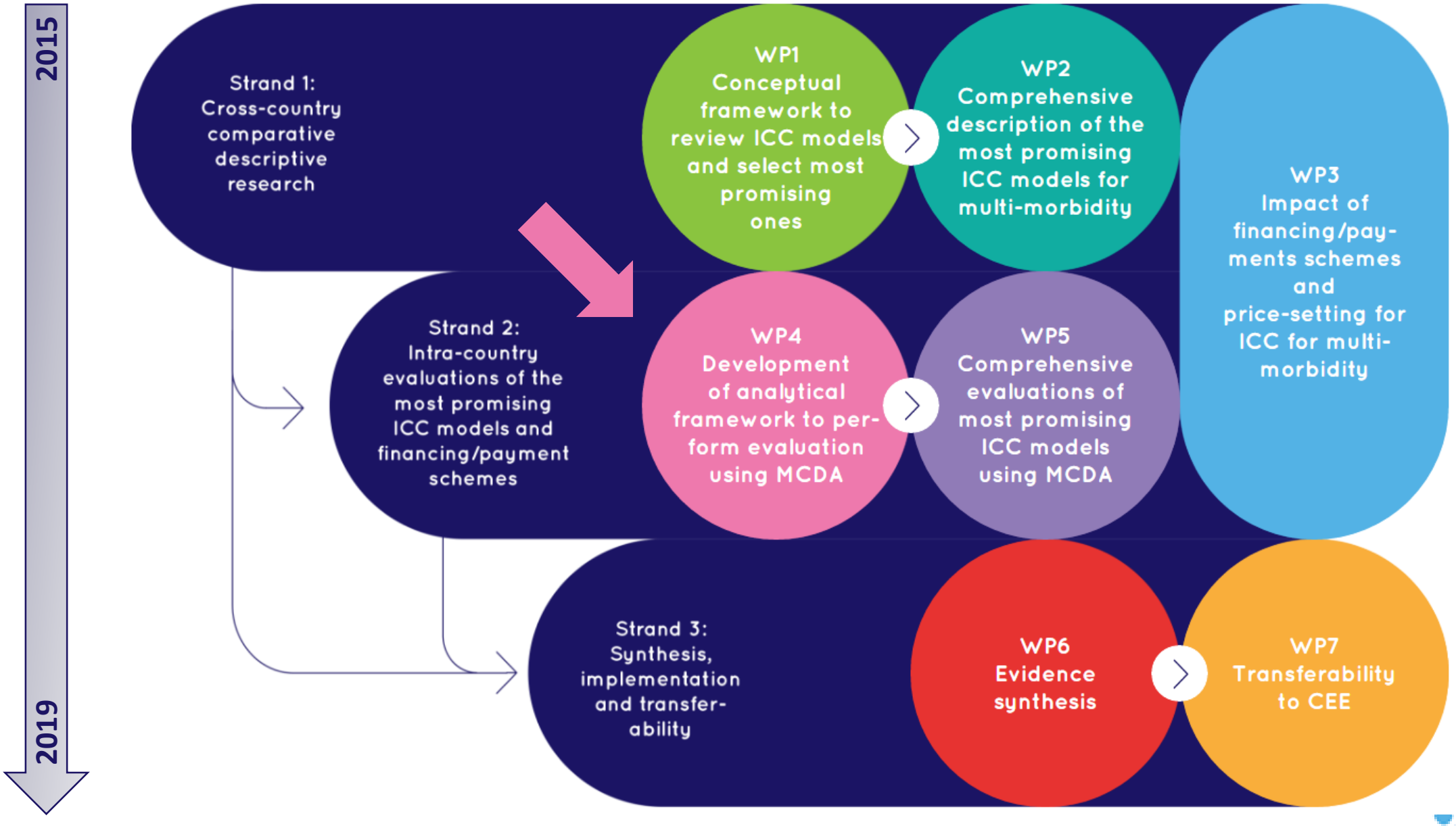
WP4

SELFIE Workshop: Multi-Criteria Decision Analyses to evaluate integrated care programmes for multi-morbidity

Fenna Leijten, Melinde Boland, Maaike Hoedemakers,

Milad Karimi, Apostolos Tsiachristas, Maureen Rutten-van Mölken

ICIC, Dublin, May 8th-11th, 2017


2015
2019
Strand 1: Cross-country comparative descriptive research
WP1 Conceptual framework to review ICC models and select most promising ones
WP2 Comprehensive description of the most promising ICC models for multi-morbidity
WP3 Impact of financing/payments schemes and price-setting for ICC for multi-morbidity
Strand 2: Intra-country evaluations of the most promising ICC models and financing/payment schemes
WP4 Development of analytical framework to perform evaluation using MCDA
WP5 Comprehensive evaluations of most promising ICC models using MCDA
Strand 3: Synthesis, implementation and transferability
WP6 Evidence synthesis
WP7 Transferability to CEE

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Content

- Why MCDA?
- MCDA in SELFIE
- Outcomes included in the evaluations
- Weight-elicitation study
- Conclusion

WP4: Why MCDA?

- **Multi-criteria decision analysis (MCDA)**

- Method to aid decision-making that makes the impact that multiple criteria have on a decision, and their relative importance, explicit.

- Suited for complex interventions where multiple criteria play a role, such as integrated care:
  - consists of various interacting components
  - changes on patient-, professional-, organisational-, and financial level;
  - multiple aims and outcomes (i.e., to improve the triple aim);
  - evaluation needs to go beyond traditional cost/QALY.

- **Goal**: to improve transparency, credibility, acceptability, and accountability of the decision-making process.

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WP4: MCDA in SELFIE

- Evaluation of the 17 promising integrated care programmes for multi-morbidity [as compared to usual care]
- What is the decision context?
  - reimbursement,
  - continuation, and/or
  - wider implementation

- Stakeholders involved in making these decisions: 5Ps

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WP4: MCDA in SELFIE

- Include multiple relevant **outcomes**
- Weights (i.e., relative importance) of these outcomes from the 5P perspectives

WP4: Outcomes – developing a core set (1)

Four sources

1. Literature review:
   - WP1, what are outcomes in past/current evaluations?
2. National stakeholder advisory board meetings (5Ps, 8 countries):
   - When would you implement, reimburse, scale-up, or participate in an integrated care programme for multi-morbidity?
3. 17 selected programmes:
   - What are their goals, what outcomes are they already measuring?
4. Focus groups with persons with multi-morbidity (8 countries)
   - How would you define ‘good health’ and a ‘good care process’?

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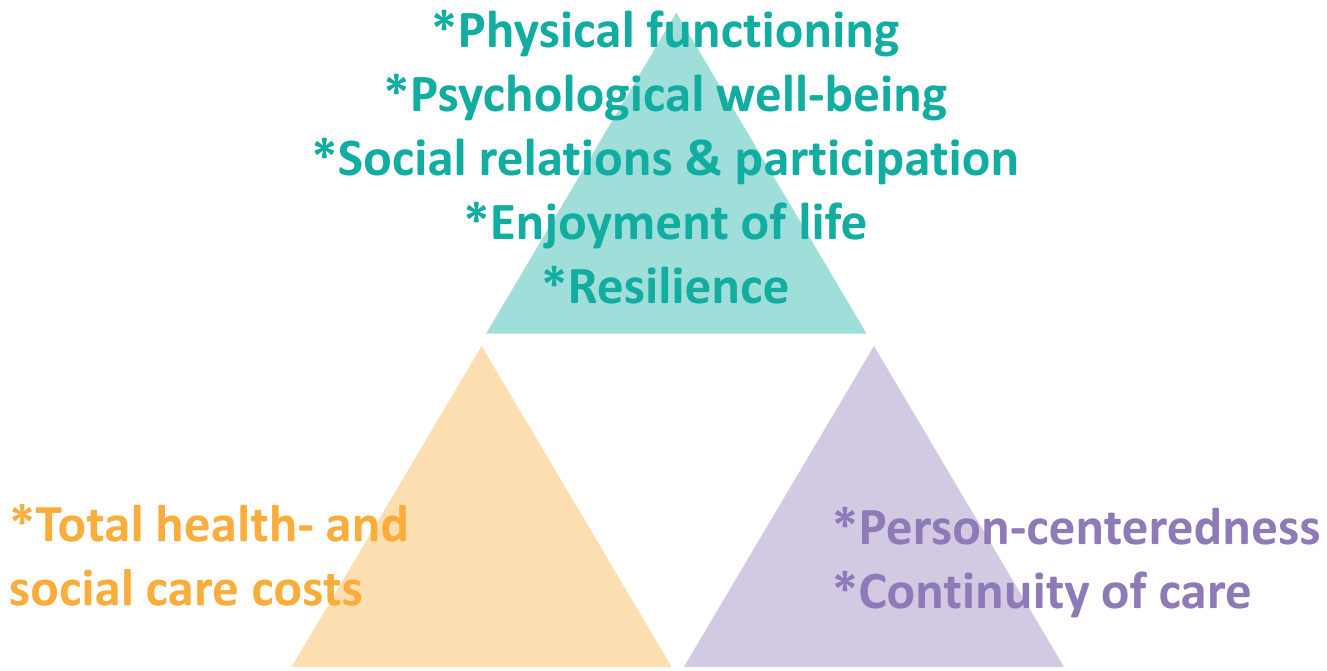
WP4: Outcomes – developing a core set (2)

- Core set of outcomes:



- Measured in all 17 programme-evaluations

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WP4: Outcomes – programme-type specific

	Programme-type specific outcomes
	Population health management
Health & well-being	Activation & engagement
Experience	
Costs	Ambulatory care sensitive hospital admission
	Hospital re-admissions

WP4: Outcomes – programme-type specific

	Programme-type specific outcomes	
	Population health management	**Frail elderly**
Health & well-being	Activation & engagement	Autonomy
Experience		Burden of medication
		Burden of informal caregiving
Costs	Ambulatory care sensitive hospital admission	Long-term institution admissions
	Hospital re-admissions	Falls leading to hospital admissions

WP4: Outcomes – programme-type specific

	Programme-type specific outcomes		
	Population health management	**Frail elderly**	**Palliative and oncology**
Health & well-being	Activation & engagement	Autonomy	Mortality
			Pain and other symptoms
Experience		Burden of medication	Compassionate care
		Burden of informal caregiving	Timely access to care
			Preferred place of death
			Burden of informal caregiving
Costs	Ambulatory care sensitive hospital admission	Long-term institution admissions	
	Hospital re-admissions	Falls leading to hospital admissions	

WP4: Outcomes – programme-type specific

	Programme-type specific outcomes			
	Population health management	**Frail elderly**	**Palliative and oncology**	**Problems in multiple life domains**
Health & well-being	Activation & engagement	Autonomy	Mortality	Financial independence
			Pain and other symptoms	
Experience		Burden of medication	Compassionate care	
		Burden of informal caregiving	Timely access to care	
			Preferred place of death	
			Burden of informal caregiving	
Costs	Ambulatory care sensitive hospital admission	Long-term institution admissions		Contacts with the justice system
	Hospital re-admissions	Falls leading to hospital admissions		

WP4: Outcomes – indicators

- Outcomes measured mostly by self-report
- Use of existing, validated, instruments where possible
- Bundled 'SELFIE questionnaire'
- Variation when programmes were already assessing the outcome with a different instrument

- Performance on the **core set** and **programme-type specific outcomes** of all 17 integrated care programmes and a control/comparator will be repeatedly assessed (≥2 measurements)

WP4: MCDA in SELFIE

- Include multiple relevant outcomes
- **Weights** (i.e., relative importance) of these outcomes from the 5P perspectives

WP4: Weighing outcomes – the core set

- Discrete choice experiments (DCE)
- Same in:
  - 5P respondent groups
  - 8 countries
- Cross-country and -stakeholder comparisons possible

	Care programme A	Care programme B
Physical functioning	**Severely** limited in physical functioning and activities of daily living	**Severely** limited in physical functioning and activities of daily living
Psychological well-being	**Seldom or never** being stressed, worried, listless, anxious, and down	**Always or mostly** being stressed, worried, listless, anxious, and down
Social relationships & participation	Having **a lot** of meaningful connections with others	Having **some** meaningful connections with others
Enjoyment of life	Having **some** pleasure and happiness in life	Having **some** pleasure and happiness in life
Resilience	**Fair** ability to recover, adjust, and restore equilibrium	**Fair** ability to recover, adjust, and restore equilibrium
Person-centeredness	**Not or barely** person-centred	**Somewhat** person-centred
Continuity of care	**Fair** collaboration, transitions, and timeliness	**Fair** collaboration, transitions, and timeliness
Total health- and social care costs	**8500 euros** per participant per year	**5000 euros** per participant per year

Which care programme do you prefer?

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WP4: Weighing outcomes – programme-type specific

- Swing weighting (SMARTER)
- "If you could change one outcome from **worst** to **best**, which would that be?"

- Continue doing so for all outcomes, until none are left
- In essence a ranking that takes range into account

WP4: Weighting outcomes

- Sets of weights for the core set, amongst:
  - Each 5P stakeholder group (patients, partners, professionals, payers, policy makers)
  - Each of the 8 SELFIE countries
- Weight-sets can be compared between stakeholder types and countries/regions.
- Programme-type specific weights for 5Ps within a country and across similar programmes

- **Weights will be included in an online MCDA-tool → can be used in future evaluations!**

WP4: Aggregating performance and weights

- Standardised **performance** scores are aggregated with **weights**
- This allows for nuanced programme evaluations that explicitly incorporate different stakeholders' preferences

- The *process* of the MCDA is also part of the result

WP4: Conclusion

- Interpretation of findings with international and national stakeholder advisory boards

- When can you expect results?
  - **Performance** being assessed now through July 2018
  - **Weights** available in the fall of 2017
  - Online MCDA tool – spring/summer 2018
- Publications on:
  - Focus group results underway
  - SELFIE-MCDA approach underway
- Sign up for the SELFIE newsletter via the website: www.selfie2020.eu (bottom of webpage)

Thanks for your attention!

Questions?

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