Overview of the DHHS Outcomes Purchasing Framework

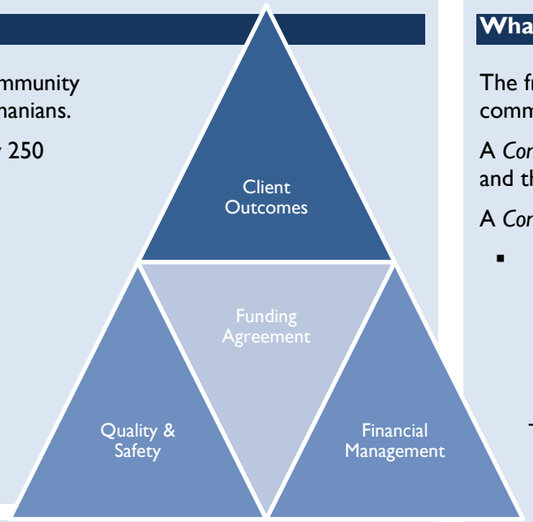
Why does DHHS need an Outcomes Purchasing Framework?

The Department of Health and Human Services (DHHS) funds a range of community organisations to deliver services to improve the health and wellbeing of Tasmanians.

In 2013-14 DHHS will provide over $220 million in funding to approximately 250 Community Sector Organisations, delivering over 600 services to Tasmanians in need. When spending this amount of tax payer's money, it is important that the Government makes sure that this money is achieving improved outcomes for the Tasmanian community.

DHHS has strong systems in place to monitor the financial management and the quality and safety of the services that it funds, but, until now, the Department has not had a structured way to describe and monitor the outcomes that those services are aiming to achieve for their clients.

Recognising this gap, the Department has worked with the community sector to develop the DHHS Outcomes Purchasing Framework.



What is the DHHS Outcomes Purchasing Framework?

The DHHS Outcomes Purchasing Framework describes how the Department will work with the community sector to agree what outcomes they want to achieve for clients and the broader Tasmanian community with government funding, and determine how they will make sure that those outcomes are being achieved.

The same approach to client outcomes will be used for all of the funding that DHHS provides to the community sector, including for housing and homelessness services, mental health services, drug and alcohol services, home and community care services, population health services, neighbourhood houses, gambling and community support services, disability services, and children and youth services.

The framework will help DHHS to work with the community sector to:

- think about the **outcomes** they want to achieve for clients
- think about the **indicators** that will show whether those outcomes are being progressed or achieved
- document agreed outcomes and indicators in a *Commissioning for Outcomes Statement* - to help tell the 'story' of what is sought to be achieved for clients with a particular program
- use the *Commissioning for Outcomes Statement* to monitor and improve outcomes for clients
- use the same approach and language as each other when thinking about client outcomes.

Why is outcomes measurement so important?

There is an increasing focus nationally and internationally on measuring client outcomes. This approach means there is less of an emphasis on inputs and activities, and more of an emphasis on the outcomes for the client (and the broader community) resulting from those inputs and activities.

Having a stronger focus on client outcomes will benefit government, service providers, clients and the broader community in a number of ways, including:

- supporting the service system to work in a more client-centred, integrated and efficient way, rather than having to work around bureaucratic and often siloed program funding structures
- strengthening the co-production and collaboration between DHHS and the community sector
- improving our understanding of where we should invest resources to get the best possible value and outcomes
- enabling service providers to adapt their practices in line with better outcomes
- enabling service providers more capacity to be innovative in how they will achieve a particular outcome
- concentrating on the important things, rather than counting inputs, activities and widgets
- attracting additional funding – by promoting value, telling success stories, maintaining a customer base and marketing achievements to investors (including government, the private sector and consumers themselves)
- improving public accountability and transparency about the value and outcomes of government funding.

What is a Commissioning for Outcomes Statement?

The framework requires that a *Commissioning for Outcomes Statement* be developed by DHHS, in collaboration with the community sector, for all programs that are funded by DHHS.

A *Commissioning for Outcomes Statement* is a written 'story' of the outcomes the program is trying to achieve for clients and the broader community, and it sets out how that will be monitored to improve outcomes for clients.

A *Commissioning for Outcomes Statement* is made up of the following things:

- **Program outcomes hierarchy** - While each program is unique, the outcomes hierarchy demonstrates that there is a similar logic about client outcomes that runs through all programs. The hierarchy is used as a starting point for the development of all DHHS funded program's outcomes hierarchies—to emphasise the core logic linking program outputs, to program outcomes, to population outcomes.

  The generic program outcomes hierarchy is made up of:

  – **Population outcomes** (sometimes called social outcomes) are the ultimate change in the community that the program contributes to. This might include things like, 'improved health and wellbeing for Tasmanians'. While the program contributes to the achievement of population outcomes, it is not solely responsible for them and it should not be held contractually accountable for their achievement (i.e. they should not be included as performance indicators in funding agreements). However they are still an important part of the broader program 'story' and purpose.

  – **Program outcomes** are the outcomes that a program does have some level of direct control over and can be held accountable for in funding agreements. Program outcomes can be presented in three levels—linking

    - outputs (*how much did we do?*),
    - to quality (*how well did we do it?*),
    - to changes for assisted clients (*did we achieve what we expected for assisted clients?).*

- **Theory of change -** While the development of a generic program outcomes hierarchy emphasises the common parts of all programs, the program's 'theory of change' is intended to emphasise the unique assumptions, pre-conditions and contextual factors underpinning the outcomes hierarchy.
- **Population outcome indicators** are quantifiable data items that provide a valid and reliable indication of the status or trend for a population outcome—referenced against a baseline.
- **Program performance indicators** are quantifiable data items that provide a valid and reliable indication of the achievement of the program outcomes presented in the outcomes hierarchy — referenced against a standard or target that is set to define the expected level of performance.

Some **examples** of generic outcomes and indicators against the generic program outcomes hierarchy are included on the next page of this overview document. The framework document also includes some examples of *Commissioning for Outcomes Statements* for a number of DHHS funded programs that were developed during workshops to test the framework. These examples can be used as a starting point for other similar programs.

How can the Outcomes Purchasing Framework be used to improve outcomes?

While the focus of the framework is on co-production and development of the *Commissioning for Outcomes Statement*, it also talks broadly about how these written statements can be used for a number of other purposes-from contracting, to ongoing monitoring and reporting, to evaluation.

The framework provides broad guidance about how to:

- use information from the program-level *Commissioning for Outcomes Statement* to negotiate the performance indicators and targets in individual funding agreements with service providers
- monitor and measure client outcomes against the *Commissioning for Outcomes Statement*
- report and review progress, achievements and issues against the *Commissioning for Outcomes Statement*
- use that information to plan appropriate actions to respond to poor performance and improve outcomes
- use that information to inform outcome evaluations, future planning and funding decisions.

Examples of Generic Outcomes and Indicators against the Program Outcomes Hierarchy

	Generic outcomes hierarchy	Generic outcomes	Generic outcome indicators
Population outcomes	Changes contribute to improvements in the target population / community	▪ Improved health and well-being	▪ % <target population> achieving <standardised health / well-being status>
		▪ Improved child safety and well-being	▪ % of children in their first year of full-time school who are developmentally on track ▪ % of children and young people reported as at risk of significant harm ▪ % of children and young people in statutory out of home care
		▪ Safe, affordable housing	▪ % <target population> who are homeless ▪ % <target population> exiting homelessness who sustain their housing
		▪ Participation in education, training and employment	▪ % <target population> participating in <standardised definition of employment, training and education >
		▪ Participation in the community	▪ % <target population> participating in <agreed community participation activities>
		▪ Improved economic independence	▪ % <target population> who rely on welfare as their main source of income
	⬆	▪ Improved family functioning / relationships	▪ % <target population> achieving <standardised family functioning measure>
	Changes are achieved for assisted clients / target groups *(did we achieve what we expected?)*	▪ Improved life circumstances – in relevant outcome domains	▪ % clients with improvement in life circumstances—across relevant outcome domains: – Physical health – Mental health and well-being – Personal and family safety – Self-care and independent living skills – Age-appropriate development – Social networks and relationships – Family functioning – Managing money – Employment, education, training – Housing
Program outcomes	⬆	▪ Attainment of individual client goals – in relevant goal domains	▪ % clients achieving their individual goals – in relevant goal domains – Changed knowledge and skills – Changed self-confidence to make own decisions – Changed behaviours (reduced harmful behaviours; increased positive behaviours) – Changed engagement with relevant support services – Changed impact of immediate crisis (e.g. impacts ameliorated)
	Services are responsive to the target group and conducive to the achievement of the intended outcomes *(how well did we do it?)*	▪ Clients are satisfied with the service (against agreed attributes) ▪ Partner agencies are satisfied with the service (against agreed attributes) ▪ Agreed geographic and target group coverage is met ▪ Agreed service / practice standards are met	▪ % assisted clients reporting they are satisfied with <service attributes> e.g. responsiveness of the service to individual needs ▪ % partner agencies reporting they are satisfied with <service attributes> e.g. responsiveness of the service to client referrals ▪ % of assisted clients from priority cohorts / locations ▪ Extent to which service meets agreed <program-specific service / practice standards> e.g. % of clients with individual case plans
	⬆ Services are available to targeted clients and communities *(how much did we do?)*	▪ Pattern of clients assisted meets agreed specifications ▪ Pattern of services / assistance provided meets agreed specifications	▪ Number and profile of assisted clients ▪ Number and profile of service episodes <by program-specific service types>

Tasmanian Government