Outcomes-based payment:

How the model works

Gold arrows represent flows of money:

either funding for providers, spending on care for service users, or sharing of gains/losses.

Commissioners

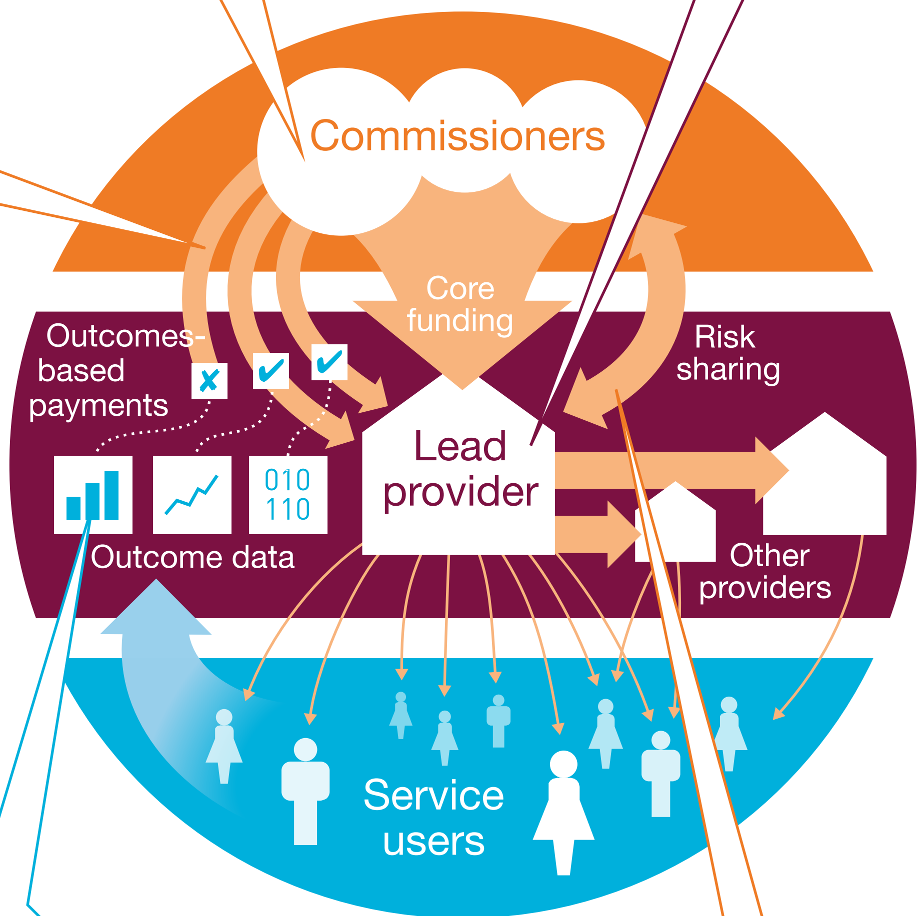
In this model, commissioners contract one 'lead provider' to meet the care needs of a defined population. Commissioners (such as CCGs or local government) may pool budgets to broaden the range of care covered by the contract.

Lead provider

The lead provider is responsible for quality care being delivered. They can provide care directly, but can also subcontract to other providers of physical, mental and community health care if needed.

Outcomes-based payments

Data on outcomes are collected and assessed. When pre-agreed targets are achieved, specified additional funding is released to the lead provider, and can be shared with sub-contracted providers.



Outcome data

Examples of relevant data that can be used to set these targets are:

- Patient experiences
- Clinical outcomes
- Population outcomes
- Access to services
- Governance quality
- Financial targets

Outcomes measures should be co-produced as a collaboration between parties such as patients, clinicians, provider management, commissioners and local government.

Risk sharing

Gains and losses are shared between commissioners and providers, reducing individual risks for all parties (eg risk of higher than expected demand for providers and risk of lower than expected demand for commissioners).

Benefits

Monitor
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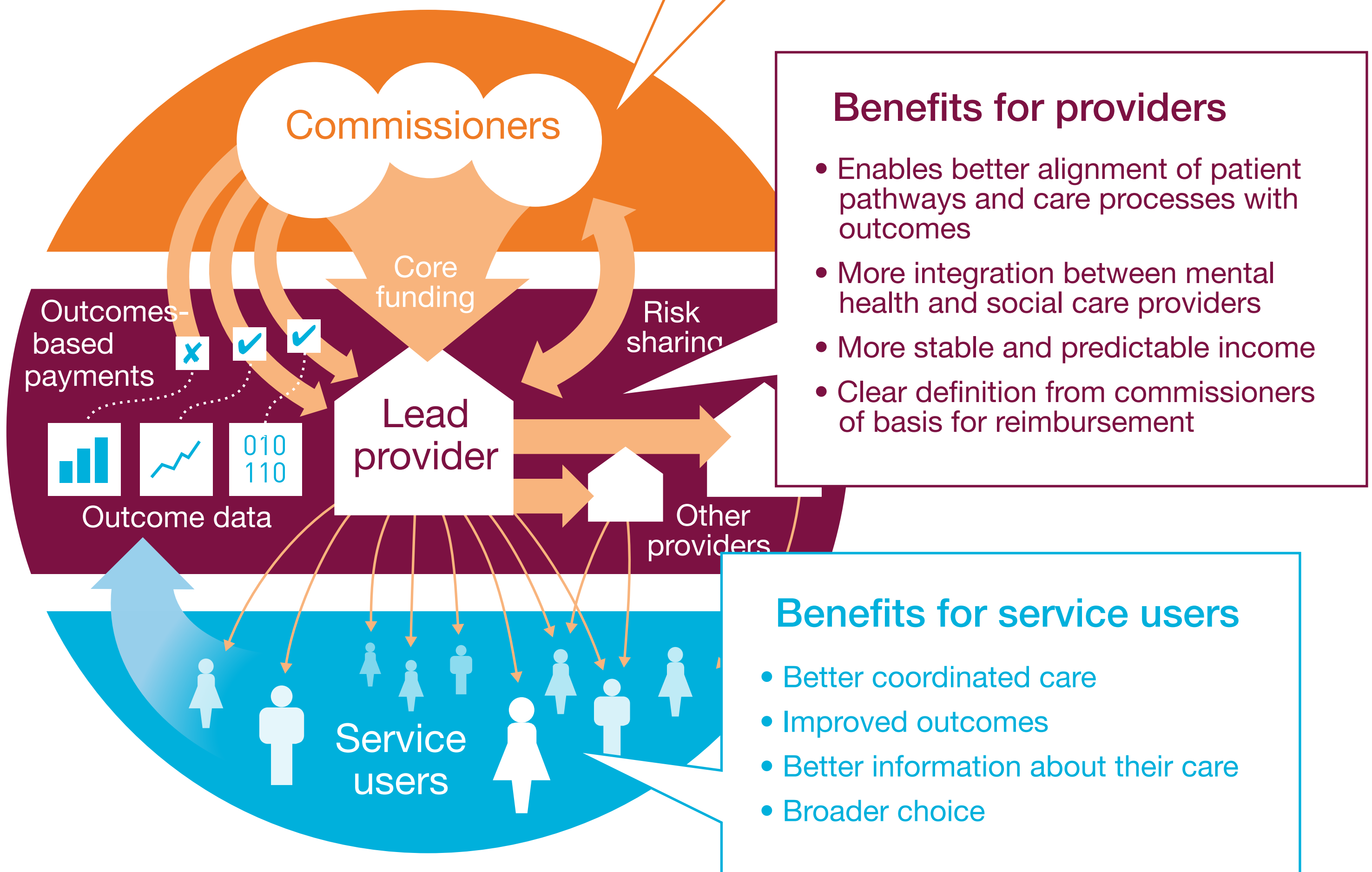
System-wide benefits

- Enables increased focus on coordinated patient-centred care
- Can reduce duplication and transaction costs across organisations
- Outcome measures increase accountability to ensure the best value care for patients

Benefits for commissioners

- Allows commissioners to define outcomes clearly and contract for those they want achieved
- Improved provider accountability to ensure value for taxpayers' money
- Streamlined administration, because of much smaller number of providers and contracts to manage



Benefits for providers

- Enables better alignment of patient pathways and care processes with outcomes
- More integration between mental health and social care providers
- More stable and predictable income
- Clear definition from commissioners of basis for reimbursement

Benefits for service users

- Better coordinated care
- Improved outcomes
- Better information about their care
- Broader choice

Implementation

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1 Identify population

The first steps are to identify the people covered and their health care needs. These determine the initial core funding.

2 Define quality and outcomes

Outcome data to be collected could include:

- Patient reported
- Clinical
- Population
- Governance data
- Access/Productivity

Outcomes to measure should be defined and agreed with local:

- Patients
- Clinicians
- Commissioners
- Providers

3 Attach payments

Payment values are linked to outcomes by specifying:

- Weightings for outcome measures
- Thresholds/bands that trigger payments
- Risk sharing between providers and commissioners
- Outcomes-based payment for sub-contracts

4 Manage implementation

Consider the pace of transition:
Timing of first move to outcomes-based payment depends on quality of local outcomes data.

Further refinement and development of outcomes-based payment can continue indefinitely.

Example timeline

- Year 1 – Establish needed data flows and a baseline
- Year 2 – Partial move to outcomes-based payment in year 2, where data allows
- Year 3, Year 4 – Full move to outcomes-based payment from year 3
- Year 5 – Further refinement