# POLICY SUBMISION

Mental Health Australia

## NDIS outputs and outcomes measurement and data collection

### Key points

This is Mental Health Australia's second submission to the draft ILC Commissioning Framework. This submission focuses more broadly than mental-health specific issues within the draft ILC Commissioning Framework, and instead considers the issues around preparing the sector for the proposed outcomes-based commissioning being proposed by the NDIA.

### Preparing the sector

Many aspects of service providers' costs are fixed, or related to the number of clients, rather than the number of client-hours. This includes, for example, ICT infrastructure. As the NDIA's recent discussion paper on personal care and community participation notes that funders "have [not] supplied the tools and/or additional funding to" measure or improve efficiency, and "donors have often seen operation reviews as not 'core' to the mission of the NFP."[1] In practice, this has meant a significant under-investment in ICT (and related workforce skills) and other functions that are essential to the running of an organisation but not directly related to service provision. This was recognised through the introduction of the "establishment fee allowance" in 2015.

The Productivity Commission's report on the Contribution of the Not-for-Profit Sector noted that "[g]overnments could better tailor their support to promote development of relevant intermediary services and greater adoption of ICT to build sustainable capacity" and that "[g]overnments engaging in sector development activities should ensure that ICT issues are mainstreamed and that NFPs develop ICT strategies along with other business development planning." The importance of funding ICT for providers in human services has long been recognised in health, and is particularly warranted when the government is enforcing significant system changes on providers.

For at least the last 13 years, the Australian Government has continually provided financial support to the medical sector (in particular GPs) to adjust to new payment processes and ICT requirements on a 'per patient' basis. Currently, this is around $6.50 per patient per year.[2] Substantial one-off payments have been made to practices to improve ICT capacity and to implement electronic health records. There have also been additional incentives to encourage doctors to adopt electronic Medicare claiming[3] and support to software vendors to update their programmes to adjust to changes in payment procedures for Medicare.

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[1] http://www.ndis.gov.au/sites/default/files/NDIA%202016_17%20Price%20Review%20Discussion%20Paper%20final%2022%20March.docx

[2] The current PIP Digital Health incentive is $6.50 per patient per year. Previous incentives include the PIP Information Management/Information Technology incentive, which started prior to 2003 and the PIP eHealth incentive.

[3] Transition Support Package for Electronic Claiming for Medicare

These arguments and examples are especially relevant for the NDIS, given the focus on outcomes measurements, both in Individually Funded Packages, and in ILC. In order for providers to be able to generate the data needed to track a wide range outcomes within and across provider settings, a significant investment in ICT capability will be required.

The Commissioning Framework also says that the Agency wants to "focus on what might be done to help the sector successfully transition to an outcomes-based method of sourcing," which we welcome.

**Mental Health Australia recommends that:**

- **the Agency works with other parts of government (including IHPA) and non-government mental health stakeholders to ensure alignment and compatibility of data framework and systems; and**
- **funding be provided to service providers to upgrade IT and data collection capacity, in recognition of both the variability in current approaches to data** *collection and the likelihood that the NDIA's data requirements will change as* **the Scheme evolves.**
- **funding be provided to ICT companies to support the development and implementation of suitable software specifically tailored for NDIS providers.**

## Outputs and outcomes measurement

Mental Health Australia welcomes the commitment in the Commissioning Framework to establish a comprehensive outcomes framework to assess the impact of ILC.

However, some of the proposed outcomes, outputs and measures of outcomes may need further consideration, as many do not appear to meet standard monitoring and evaluation requirements. The purpose of any monitoring and evaluation framework is threefold:

1. Programme management
2. Accountability
3. Learning

For the purpose of programme management, a monitoring and evaluation framework should provide useful, timely evidence about how a programme is progressing towards agreed outcomes and objectives. As such the monitoring data should provide evidence not just that outputs are being produced, but also how they are supporting progress along the theorised pathways of change. The data needs to be sufficiently timely and valid that the programme manager can assess if the expected change is occurring, and if not to re-assess either the theory or the activities being implemented to catalyse change.

For the purpose of accountability, a monitoring and evaluation framework must demonstrate to the intended beneficiaries and the programme funder that the programme is achieving its intended outcomes, and is an effective and efficient investment of resources. For beneficiaries – in this instance people living with disabilities and their carers – this means findings should demonstrate that changes in their circumstances can be attributed to the new programme and not to factors external to the intervention. For programme funders, this means data should demonstrate the effective and efficient use of public resources in the achievement of policy objectives.

For the purpose of learning, data collected should assist future programme designers and implementers to better understand what activities achieve the best outcomes for which beneficiaries under what circumstances. It should also assist in identifying and understanding unintended consequences and outcomes, especially negative ones. Such learning should result in more effective and efficient programmes in the future.

Mental Health Australia, in consultation with monitoring and evaluation experts, has undertaken some initial analysis of the proposed measures, and this analysis is **attached.** Our analysis indicates that the proposed indicators need significant further consideration. Issues include:

- It may be difficult to attribute the desired outcomes to the outputs provided through ILC funding.
- The data is unlikely to be collected in a timely enough manner to improve programme management and is unlikely to contribute to learning around appropriate programme design.
- The indicators are often too highly aggregated.
- The indicators are often imprecise or not well defined.

In addition, the measures mainly relate to people who "turn up" and seek assistance, with relatively few measures that would incentivise ILC providers to engage in assertive outreach with marginalised people who have the greatest need for support.

The establishment of an outcomes framework aligns with work recently undertaken by the Independent Hospitals Pricing Authority (IHPA) and Mental Health Australia on how community managed mental health providers (many of which will in the future deliver NDIS-funded services) can adopt the new Australian Mental Health Care Classification (AHMCC).[4] For NDIS data collection to be successful and efficient, it will be essential that it is harmonised with data and data systems that are already being used by organisations and other tiers of government for other purposes.

Consultations undertaken for that project suggest that, with adequate funding for data collection systems, community managed organisations could collect appropriate outcome measures and data at the level required to contribute to the AMHCC. Feedback received through the consultation process showed that community managed organisations would welcome an opportunity to increase their data collection capacity by collecting data that meaningfully describes their service models and provides evidence regarding the quality and cost-effectiveness of these services.

**Mental Health Australia recommends the proposed outcomes, outputs and indicators be reviewed to ensure they meet best practice in monitoring and evaluation and align with work being undertaken elsewhere within government.**

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[4] https://mhaustralia.org/general/independent-hospital-pricing-authority-needs-assessment-report

## Attachment: Analysis of ILC Commissioning Framework outcome measurements

| Outcome statement | Proposed focus of measurement | Potential indicators | Comment |
|---|---|---|---|
| **People with a disability have the capacity to exercise choice and control in pursuit of their goals.** | | | This will be difficult to attribute to the ILC. Perhaps reword the outcome statement as: "*People with a disability report they have an increased capacity to exercise choice and control in pursuit of their goals as a result of support under the ILC* or "*People with a disability report an increased capacity … compared to 12 months prior*" |
| | Outputs | The percentage of ILC assisted individuals and families [who] report that they are informed about the range of services and supports that are available to them to meet their individual needs and goals.<br>The percentage of ILC supported families who understand what supports the NDIS offers and for whom. | It is very difficult to quantify the verbs 'are informed' or 'understand'. Likewise, it will be hard to ascertain whether people are informed with the information that is most useful for their particular circumstances, rather than being generally informed. That is, it will be hard to identify what people don't know that they don't know. |
| | Outcomes | The percentage of assisted individuals and families who are satisfied with the level of decision making they have in their lives.<br>The percentage of supported families who report they are able to advocate effectively for their family member with disability. | Again, attribution will be difficult. Interpretation will also be problematic: if someone is dissatisfied with the level of decision making they have, does that mean the ILC support has failed? If someone is satisfied, does that mean the ILC support has helped, or has the person come to terms with an expected (low or high) level of self-efficacy? Two more specific indicators could measure the change in |

| Outcome statement | Proposed focus of measurement | Potential indicators | Comment |
|---|---|---|---|
| | | | levels of decision making as a result of ILC support, and levels of satisfaction with those changes in decision making over time.<br>Also, the alignment of the 2nd measure is not clear to the outcome statement, which is specifically about people with disability. If measuring impact on families, there should be a specific outcome statement on the impact of ILC support for families in terms of increased capacity to advocate on their family member's behalf. |
| **Independence and social/economic participation of all people with disability is promoted.** | | | What does it mean to promote? How can this be measured? What data would be collected to monitor quality and levels of promotion?<br>Perhaps reword as three statements, as people may have one but not the other: *1) People with disability experience an improved level of independence as a result of ILC support. 2) People with disability experience improved social participation as a result of ILC support. 3) People with disability experience improved economic participation as a result of ILC support.*<br>It may be perfectly appropriate for someone's circumstances that they need to improve economic but not social participation, or vice versa; these could be important measurements of the effectiveness of ILC support but will require careful interpretation. |

| Outcome statement | Proposed focus of measurement | Potential indicators | Comment |
|---|---|---|---|
|  | Quality and effectiveness | The percentage of assisted non-participants who report unmet support needs after intervention by ILC. | How will non-participants be contacted to report on this? How will the denominator be determined?<br>The reporting of unmet support needs might not suggest that ILC intervention had failed. Likewise, this measure doesn't necessarily reflect anything about the extent to which independence and social/economic participation is promoted.<br>Alternative indicators (for the reworded outcome statements above) might be: *The percentage of people with disability who have had contact with the ILC and who report that 1) ILC intervention did not improve levels of independence. 2) ILC intervention did not improve social participation. 3) ILC intervention did not improve economic participation.* |
|  | Outcomes | The percentage of assisted individuals who:<br>• feel like they belong to a community group<br>• have friends outside of family<br>• are more independent than they were two years ago<br>• are involved in a community group in the last 12 months<br>• volunteer<br>• are in open employment | It would be useful to incorporate validated social inclusion and economic participation outcome measures, of which there are a number, somewhere within this measurement framework. However, attribution is again difficult for these measures, and they don't necessarily readily relate back to the outcome statement.<br>It might be preferable to frame the outcome indicators to relate more closely to the outcome statement, and to measure participants' satisfaction with their levels of independence (and change over time), |

| Outcome statement | Proposed focus of measurement | Potential indicators | Comment |
|---|---|---|---|
| | | • are not in open employment and can see a pathway to open employment<br>• would like more work<br>• take part in mainstream play groups.<br>The percentage of assisted parents whose children:<br>• attend age appropriate, community, cultural and religious activities whose families feel they are welcomed and actively included<br>• perceive their child shows evidence of self-determination in his/her life. | social participation, and economic participation. |
| **Informal support and care arrangements are upheld and nurtured** | | | It's not clear what this is seeking to measure.  Level of support to a person's informal social and care network? Ensuring that a person has such a network? What does nurturing entail in this context? Perhaps reword as: *People with disability and their carers are supported to maintain or strengthen their informal social and care networks.*<br>Alternatively, if this outcome statement is specifically about supporting carers (as is |

| Outcome statement | Proposed focus of measurement | Potential indicators | Comment |
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| | | | implied by the output statement below) then it should be framed as such: *Informal carers of a person with disability are supported to maintain or strengthen their informal social and care networks.* |
| | Outputs | The number and percentage of assisted carers who identified as having low level support needs who receive referral or assistance. | These should be two indicators (or perhaps four, depending on who the target group is – the people with disability or their carers):<br>*The number and percentage of people with disability who receive referrals, stratified by identified level of need.*<br>*The number and percentage of carers of a person with disability who receives assistance, stratified by identified level of need.* |
| | Quality and effectiveness | The percentage of assisted people with disability who report that they are supported to maintain the connections they want with family and friends.<br><br>The percentage of Aboriginal and Torres Strait Islander peoples, or people from culturally and linguistically diverse backgrounds, who are assisted to maintain and strengthen their cultural, spiritual and language connections. | Separate out Aboriginal and Torres Stait Islander peoples from people from culturally and linguistically diverse backgrounds.<br>Need to clarify what it means to maintain and strengthen cultural, spiritual and language connections as this will mean different things to everyone. As above, attribution will be difficult, and a negative response may not reflect on ILC intervention.<br>Perhaps reword as: *The percentage of Aboriginal and Torres Strait Islander peoples who report satisfaction with the impact of ILC support in assisting them to maintain or strengthen…* |
| | Outcomes | The percentage of individuals who: | As noted above, there are validated social inclusion measurements that could be |

| Outcome statement | Proposed focus of measurement | Potential indicators | Comment |
|---|---|---|---|
| | | • have someone outside their home to call on for emotional assistance<br>• have someone outside their home to call on for practical assistance<br>• often feel lonely<br>• feel socially isolated. | included within this outcomes framework. The language here needs to relate directly back to the outcome statement it is supposed to be measuring. |
| **People with disability have appropriate support during their lifetime, including early intervention** | | | How is appropriate support defined? How can this be measured over one's lifetime? It might be more useful to change the words 'during their lifetime' to '*across the lifespan*' as a statement to ensure that people with disability may enter the ILC system at any point in their lives.<br>Suggest adding *as required* following the word 'support'. |
| | Outputs | The number and percentage of referrals received by the ILC provider of individuals or families with a recent diagnosis of a disability.<br>The percentage of people with disability who are supported or linked to support without making an access request. | It is not clear how this will relate to the outcome statement. It might be more useful to collect data on demographics of people who are referred and those who are assisted, to monitor whether the system is being accessed by those who are expected to do so.<br>The second indicator is not clear – if an access request is not made is this an official ILC link? How is this recorded and what data might be available to measure this? This could create a disincentive to help people applying for the NDIS, which |

| Outcome statement | Proposed focus of measurement | Potential indicators | Comment |
|---|---|---|---|
| | | | may have negative outcomes in the longer term. |
| | Quality and effectiveness | Percentage of individuals and families who have a better understanding about their diagnosis/condition after ILC assistance. | How is better understanding measured? Measured against what denominator? Perhaps reword as: *Percentage of people with disability and families who report improved knowledge regarding their diagnosis as a result of ILC assistance.* |
| **Participants can access unfunded supports and individual funding is provided at the optimal time** | | | There are two units of measurement here – access and funding provision.<br>Who defines what is optimal?<br>Should be clarified as two statements. |
| | Outputs | The percentage of access requests from referred individuals or families that are accepted. | Unclear why "families" is included here, as access request only come from an individual. |
| | Outcomes | The relative percentage of individuals who make access requests in the early stages of their condition.<br>The relative cost of plan management support in ILC assisted participant plans. | Is this assuming that the early stage is the optimal time? Is it better to measure whether recipients report that access was provided at the optimal time? Is there a definition of "early stages"?<br>It is not clear what comparator will be used and what is being assessed. |
| **High quality, efficient and effective disability support is available, including ILC activities.** | | | This is measuring many things at once. If measuring support other than the ILC, how will this data be collected? Who will be responsible for it, and for aggregating across the ILC and other providers? |
| | Quality and effectiveness | ILC providers have a clear and accessible point of contact. | Point of contact for what? How will this be recorded? |

| Outcome statement | Proposed focus of measurement | Potential indicators | Comment |
|---|---|---|---|
| | | ILC provider staff have an appropriate professional qualification and/or experience.<br>The percentage of ILC-assisted individuals and families who express that they receive quality supports. | |
| | Outcomes | The percentage of ILC-assisted participants who achieve their goals. | This is dependent upon the recording of goals for independent audit, or upon surveying participants, in which case it might be reworded as: *The percentage of ILC-assisted participants who report that they have achieved their goals as a result of ILC assistance.*<br>This would also need to be compared with non-ILC-assisted participants. |
| **People with disability, their families and carers can shape supports and services** | | | Perhaps reword as: *People with disability, their families and carers are able to provide input into the development and delivery of supports and services.* |
| | Outputs | The number of people with disability, their families and carers who have increased their capacity to advocate for themselves. | The output of the outcome statement might better be framed as: *The number of people with disability, their families and carers who report they have had an opportunity to provide input into the development and delivery of services.*<br>Alternatively, reframe the outcome statement to reflect the aim of increasing people's ability to advocate. |
| | Outcomes | The percentage of assisted families who report they are able to gain access to desired services, | This is about access and is better placed with the outcome statement above regarding access to services. |

| Outcome statement | Proposed focus of measurement | Potential indicators | Comment |
|---|---|---|---|
| | | programs and activities in their community. | |
| **Interests of people with disability are faithfully represented in policy/infrastructure design** | | | Whose interests and how are these captured?<br>How does one measure 'faithfully'?<br>Policy and infrastructure design are two separate things and should be treated as such.<br>It would be more useful to include an element of co-design in seeking the contribution of people with disability into the design of policy and infrastructure. |
| | Outcomes | The percentage of assisted individuals who:<br>• feel able to have a say on community issues that are important to them<br>• were prevented from doing a course they wanted to do. | These will require amendment once the outcome statement is amended to two statements reflecting the use of co-design. |
| **Increased community/mainstream awareness and knowledge of how to support people with disability** | | | Awareness and knowledge of how to do something are two different measurements.<br>Community/mainstream should be clarified – what is assumed to be the difference here?<br>From the statements below, it seems that the intention here is more about equipping community and universal services to support people with disability. If so, this should be stated specifically rather than 'awareness and knowledge'. |

| Outcome statement | Proposed focus of measurement | Potential indicators | Comment |
|---|---|---|---|
|  | Outputs | The percentage of referrals by ILC to mainstream services that are accepted by the mainstream agency.<br>The number of referrals to other ILC services.<br>The percentage of mainstream or community organisation staff who report awareness of Aboriginal/CALD interpretations of disability. | These statements are referring to services or agencies, which is not clear in the outcome statement.<br>It is not clear how the number of referrals relates to the outcome statement.<br>There should be separate statements for Aboriginal and Torres Strait Islander and culturally and linguistically diverse populations. |
|  | Quality and effectiveness | The contracted organisation has partnerships and collaborates to enable it to effectively work with community support networks, other organisations and government agencies as relevant and appropriate.<br>The percentage of mainstream or community organisation staff that report increased confidence to interact with people with disability, carers and family following work with ILC provider.<br>The percentage of local employers that report appreciation of the potential benefit from employing a person with disability. | As above, the outcome statement needs clarification and then these statements require amendments to reflect the intended outcome.<br>Employment is rather a separate issue from service provision and an indicator reflecting the perspectives of employers may be better placed elsewhere, or reworded when this outcome statement is clarified. |
|  | Outcomes | The percentage of assisted individuals who:<br>• are involved in a community group in the last 12 months | As above, regarding clear reflection of the intention of the outcome statement.<br>These are similar to some of the outcome indicators regarding social inclusion factors |

| Outcome statement | Proposed focus of measurement | Potential indicators | Comment |
|---|---|---|---|
|  |  | • attend mainstream childcare programs<br>• take part in mainstream co-curricular activities<br>• take part in mainstream extra-curricular activities<br>• attend mainstream holiday programs<br>• take part in mainstream education and training<br>• feel increased confidence to interact with mainstream services and activities. | above, and should be reconsidered once the outcome statement is clarified. |