

Economic plan

This plan identifies the areas prioritised for economic modelling. The final analysis may differ from those described below. The rationale for any differences will be explained in the guideline.

1 Guideline

Older people with social care needs and multiple long-term conditions

2 List of modelling questions

Review questions by scope area	<p>Assessment and care planning: 2.1.1 What are the effects (benefits and harms) of different types of assessment and planning of personalised care on outcomes for older people with multiple long-term conditions and their carers?</p> <p>Service delivery frameworks: 2.1.2 What are the existing frameworks, models and components of care packages for managing multiple long-term conditions and what outcomes do they deliver?</p>
Population	Older adults over 65 years living in the community with lower socioeconomic status who have some limitations in basic and instrumental activities of daily living, high rates of hospitalisation and multiple chronic conditions. Excluded individuals with dementia unless there was a carer available to participate in the study.
Interventions and comparators considered for inclusion	<p>Intervention A: The 'GRACE' model (Geriatric Resources for Assessment and Care of Elders) is one example of an intervention that integrates health and social care professionals into the assessment, care planning and service delivery process.</p> <p>The GRACE model of care is an outpatient, multidisciplinary geriatric team (composed of a geriatrician, pharmacist, physical therapist, mental health social worker, community-based services liaison, practice manager and administrative assistant) plus case management (performed jointly by an advanced practice nurse and social worker).</p> <p>Comparator A: Individuals in the comparison group had access to usual primary and specialty care services. Both intervention and control groups had access to GP house calls and skilled nursing facilities. They also had access to the inpatient 'ACE' unit and consult services (inpatient acute care for elders model), which provide a 'geriatrics interdisciplinary team that integrates and enhances care delivered by the hospital attending physician' (Counsell et al 2007, p2624).</p>
Perspective	NHS and PSS perspective
Outcomes	Quality Adjusted Life Years as measured by the EQ-5D.
Type of analysis	Cost-utility analysis and cost-consequence analysis
Issues to note	<p>The cost-utility analysis on this particular intervention is based on one good quality US study (++/+) (Counsell et al 2007, 2009).</p> <p>This non-UK intervention might not yield the same results when</p>

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	<p>applied to the English context because of institutional differences, including:</p> <ul style="list-style-type: none">- Differences between countries in the patterns of service use. For instance, a service which yields cost savings because it leads to reductions in the use of acute care services is less likely to be cost-effective in settings with very low “standard’ use of acute care, other things being equal.- Differences in the unit costs of services.- Differences in the implementation of the intervention, because for instance of differences in skills and technologies. <p>Modelling analysis can be used to test the robustness of the published results to different assumptions about patterns of service use and service unit costs (as above), and in doing so to attempt to approximate the non-UK published results to the English service context.</p> <p>The sensitivity analyses incorporates uncertainties in:</p> <ul style="list-style-type: none">• English patterns of baseline service use, by reflecting<ul style="list-style-type: none">○ Existing variations in the patterns of service use in England○ Some of the limitations of the English data available (e.g. incomplete information on community healthcare resource use or the time horizon over which resource use was measured, in particular, resource use was extrapolated to a 24-month period using information on utilisation rates at 3 or 6 months).• The stochastic nature of the intervention’s effect on resources and QALYs gained<ul style="list-style-type: none">○ Replications of the study may lead to different results• The transferability of US results to the English context because of:<ul style="list-style-type: none">○ Differences between settings with respect to “usual care” (the comparator group)○ Differences in utilisation rates of similar services○ Differences in total resource use (differences in the types of care packages)○ Differences in the implementation of the intervention (the English context may require different levels of intensity or types of health and social care professionals)○ Differences in population demographics and health status (e.g. the US sample were of lower socioeconomic status than the UK samples used, majority are non-white, and low socioeconomic status)• The accuracy in measuring benefits (QALY gains), either because of:
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	<ul style="list-style-type: none">○ Mapping SF-36 measures to the EQ-5D○ The time duration over which the impact of the intervention on QALYs is considered- The Counsell et al (2007) study did not measure impact on community social care service use or admissions to nursing or care homes or impact on carer outcomes. However we address these limitations by drawing on evidence from additional studies.
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