Inner North West Care Planning Collaborative Project

Evaluation report

"The [INW] PCP has been a wonderful support just giving us a lot of tasters of things that we can bring back to our organisation"
– Project partner

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Executive Summary

Background

Since January 2014 Inner North West Primary Care Partnership (INW PCP) and its member agencies have been working on a *Care Planning Collaborative Project* (CPC Project) that aims to develop a consistent, integrated approach to client care to improve client health outcomes. In October 2016, INW PCP commenced a small scale monitoring evaluation to monitor progress on the CPC Pproject and inform future directions for the project in the next strategic planning phase.

Key Findings at a Glance

- INW PCP has engaged 25 participants from 12 different agencies throughout the project.
- The CPC Project has improved current practice both at a practitioner level and an organisational level. This includes clinician level improvements such as use of client centred language; collaborative goal setting and quality care plans, as well as organisational improvements such as policy development.
- The INW PCP held a number of training sessions to support agencies to make steps toward better service coordination in Goal Directed Care Planning (GDCP) and case conferencing. Over 140 people participated in the training.
- Three agencies booked further training independently of INW PCP, resulting in a further 27 staff attending follow up training sessions. These agencies have continued to engage with this consultant and have sustained this work independently after engaging in the project.
- Over 60% of respondents engaged in this project have been using the Goal Directed Care Planning Toolkit (GDCP Toolkit) as both an auditing tool at a clinician and organisational level. Additionally, approximately 50% of respondents reported organisational improvements such as policy development and ongoing evaluation and monitoring in GDCP that have been sustained after the original training sessions.
- These practitioner and organisational improvements translated into meaningful improvements in client outcomes. One interviewee reports below:

> *"One client was very much isolated apart from being a part of one of our programs once a week. So when we went through GDCP one of the things that came up was she said 'I would like to go and stroll in my street…' and she said that she 'used to like walking around her neighbourhood'. After a while she disclosed she was a recent arrival so she didn't feel safe in the area. Through the discussion it came out she was scared she would be lost and secondly she was not sure she was not confident she was able to lock the door of the house properly so she stayed at home all the time and never went out. She had never articulated this before even to her family. So the project coordinator came early to her house and showed her how to confidently lock the door and started with a walk of five houses and then worked her up to walking the whole block. She is now doing a daily half an hour walk and she is very happy. She is meeting other neighbours doing their gardening…"* – Project partner

Recommendations

- Consider issuing an expression of interest for a small shared care planning pilot project with passionate and engaged agencies consisting of one general practice, one community health service, one hospital and other additional agencies located in a small geographic region.
- INW PCP could advocate for agencies need for support in understanding the different requirements for care planning within My Aged Care and how that fits in with the GDCP Toolkit. This could be linked in with the work of The Northern and Western Community Care Alliance.
- Build Health Literacy principles into any future care planning projects and other related initiatives.
- Integrate core principles of client centred care and GDCP into any relevant future projects or initiatives.

About the Project

Since January 2014 INW PCP and its member agencies have been working on a *CPC Project* that aims to develop a consistent, integrated approach to client care to improve client health outcomes. Shared care planning is a key patient centred practice that facilitates communication between clients and health care professionals to support long term planned care. Evidence suggests that patients with long term conditions benefit from a care plan developed in partnership with their care team and with a person centred view of care (Burt et al, 2014). For the consumer this will improve coordination of care and communication with their care team, reduce the number of times information is repeated and reduce duplication of investigations and/or services.

The key objectives of *The CPC Project* are:

1. Develop a solid understanding of the key principles, systems and tools that support effective GDCP.
2. Review the existing systems for care planning within local member agencies and identify the strategies required to embed a best practice approach within the context of each agency.
3. Partner agencies will each implement system improvements for care planning, guided by best practice principles outlined in the Victorian Service Coordination Practice Manual 2012 and the GDCP Toolkit.
4. Collaboratively develop a local agreement with shared guiding principles for intra-agency care planning in Melbourne's Inner North West.
5. Strengthen partnerships between the different service providers and build a strong foundation for future collaborative work.

Currently the project is in Phase 1, as project partners expressed a desire to further embed GDCP internally in their organisations prior to commencing Phase 2 of the project, with intention to focus on inter-agency shared care planning.

Stakeholders:

The following stakeholders have been involved in the:

1. City of Melbourne
2. cohealth (CoH)
3. Melbourne Health (HARP)
4. Merri Health (MH)
5. Migrant Resource Centre
6. Moonee Valley City Council
7. Moreland City Council
8. North Richmond CHS
9. North Western Melbourne Primary Health Network (NWM PHN)
10. Royal District Nursing Service (RDNS)
11. St Vincent's Hospital HARP program
12. Youth Projects Ltd

The Evaluation

Aim

INW PCP has been undertaking a monitoring evaluation to summarise the key outcomes to date and lessons learned from the *CPC Project*. The evaluation will highlight the key benefits from this project and inform future directions that the project could take. The evaluation will also consider agency capacity and readiness for project continuation as there has been a number of Commonwealth reforms that have altered the health care context for many agencies in the space of shared care planning.

Evaluation Approach

This evaluation is informed by the following approaches:

1. **Monitoring evaluation approach** which involves aspects of outcome, process and orientation. This type of approach gathers data available to date, reflects on lessons learned and orients and aligns future goals for the project (Owen, 2007).
2. **Ripple effect mapping** is an evaluation method used to conduct impact evaluation that engages stakeholders to retrospectively and visually map project impact. It is ideally suited for projects involving complex interventions or collaborations (Kollock, 2011).

Evaluation Criteria

The report follows the outline of the evaluation criteria outlined in Appendix 1. This report outlines each section and evaluation question as a subheading.

Evaluation Resources

Methods and data sources used in the evaluation are listed below:

- INW PCP documents
- Partner agency documents
- Qualitative interviews

Evaluation Report

Monitoring

Some of the questions used to guide this part of the evaluation included:

- *To what extent is the delivery of the CPC Project consistent with the project plan?*
- *To what extent is the delivery of the project reaching target stakeholders?*
- *To what extent are contextual factors affecting project delivery?*

All agencies were invited to participate in the CPC Project evaluation. Seven people responded to email requests for interviews and five (42%) project partners engaged in qualitative interviews about the project. The project partners that participated in the interviews represented a range of sectors including hospital, community health, local government and community based agencies. All respondents reported an appreciation of the work of INW PCP project coordinators and acknowledged that, without the support of this project, progress in GDCP and shared care planning would not have improved as it did.

> *"The project workers are really good at what they do and it is really hard pulling people together... I think the frequency of the meetings, the content of the meetings, the fact that there was always homework to take away, was great..."*– Project Partner

Consistency with Original Project Plan:

The original *CPC Project* plan began with a phased approach to implementation. The first phase involved intra-agency shared care planning and the second phase involved moving towards inter-agency care planning collaboration. These phases are outlined in Table 1.

Table 1: Phases and timeframes of the CPC Project

The INW PCP Care Planning Collaborative Initiative		
	Focus	**Aim**
Phase One 2014 - 2015	*Intra-Agency Care Planning* **Implementation of Goal Directed Care Planning**	a) To formalise and improve existing care planning practices and processes within member agencies in preparation for shared care planning
Phase Two 2016 - 2017	*Inter-Agency Care Planning* **Development of an Inner North West Melbourne Framework for Care Planning Practice**	a) To formalise and improve existing care planning practices and processes between agencies b) To improve the experience and outcomes for consumers and carers who require inter-agency care planning

Phase 1: Intra-Agency Care Planning

The delivery of Phase 1 has been consistent with the project plan. Agencies highly value the core principles of GDCP and shared care planning, are very passionate about client centred care and have worked hard in championing intra-agency care planning internally within their organisations. While organisations have been at different levels in implementing and embedding GDCP and shared care planning, most agencies have used the resources and tools that INW PCP have provided and responded well to small incremental changes introduced to the member agencies through Plan Do Study Act (PDSA) cycles.

> *"…the fact that there was always homework to take away was great. We did some PDSA cycles so that keeps you accountable to look at small improvements we can make in our organisation."* – Project Partner

Phase 2: Inter-Agency Care Planning

When the discussion came to do inter-agency care planning, agencies expressed hesitation and felt they needed to embed practices further before moving into Phase 2. A number of factors affected the shift to Phase 2 and these are *listed in order of the frequency* in which they were reported by stakeholders:

1. **Uncertainty and anticipation about future direction for agencies and the project due to the transition to My Aged Care and NDIS**

Most agencies reported that it has been an uncertain care planning environment with the My Aged Care and National Disability Insurance Scheme (NDIS) reforms occurring in the healthcare sector. Anticipation of these changes affected the Care Planning project progressing.

> *"For a long period there from April last year up until about August this year we have been anticipating change but not knowing what it was so we still continued business but we never knew how it would impact us going forward so it takes the wind out of your sails a bit because you are not quite sure what kind of longevity it has – the work you are doing, but we do understand how it is good practice and we don't want to lose it…"*
> – Project Partner

Additionally, with the My Aged Care reform, agencies have had to re-examine and rework care planning and auditing systems in order not to duplicate these processes.

> *"What it has meant for us though is that initially the expectations and auditing requirements that we had set up previous to the My Aged Care reforms taking effect have now had to be re-examined because part of what is important around care planning is that you don't duplicate, you don't go and ask the client the same questions and reproduce what they already have. It's actually the care plan from My Aged Care."*–
> Project Partner

2. Ongoing structural and system barriers to inter-agency shared care planning

Structural barriers such as lack of IT systems that interfaced well, issues with client confidentiality and consent, as well as struggles implementing and tracking shared care planning across one single agency impacted on the shift to Phase 2 of the project.

> *"I think that the discussion around inter-agency care plan was well and truly over ambitious for the PCP to look at because there are so many structural barriers to – it is impractical at this stage because we just don't have anything to support it."* – Project Partner

3. A large number of diverse agencies with varying levels of capacity and engagement

One of the lessons learned from this project is that embedding a framework such as GDCP has taken longer than expected and while there has been good work done there has been various levels of buy in and progress across different organisations. Some agencies have lacked managerial support while others have experienced resistance from frontline workers due to competing work pressures, issues with health literacy and other related issues.

> *"I think for us the other thing was getting consent across the department that this was an important tool for us to use. The working group could only get so far and then it really needed to be taken up by the broader management team and implemented more widely and that was difficult to do."* – Project Partner

4. Some agencies have embedded GDCP and are doing continuous improvement

Some agencies were at the stage of embedding GDCP and were doing continuous improvement work in this area. Most of the agencies that have progressed have passionate champions at higher management levels. Other agencies have struggled to implement changes at an organisational level and have found it challenging to embed GDCP and intra-agency shared care planning. This diversity in stakeholders and their progress in implementing and embedding GDCP meant that it was hard to provide support equally for all project participants.

> *"We sort of feel that we have had our establishment phase, our developmental phase our codesign and now we are moving into our embedding phase and this is just about getting the basic principles right about how we have a conversation with clients…"*
> - Project Partner

5. Differing agency requirements for care planning

Some agencies have adapted the core principles of GDCP and shared care planning to their own organisational setting. As each agency operates slightly differently this is to be expected, however, this adaption of GDCP Toolkit may lead to some agencies having consistent scoring on the GDCP Toolkit where certain items may not apply to their agency.

"That actual program [GDCP] is a very specific way of doing care planning or goal setting. It did not meet the needs of how we do things in house and potentially raised more questions and disparity at a clinician level …" - Project Partner

Despite these challenges, 8 agencies out of 12 have been actively engaged in the project (i.e. attended more meetings than the average meeting attendance rate of 4.77) and have continued to embed GDCP.

Meeting Attendance

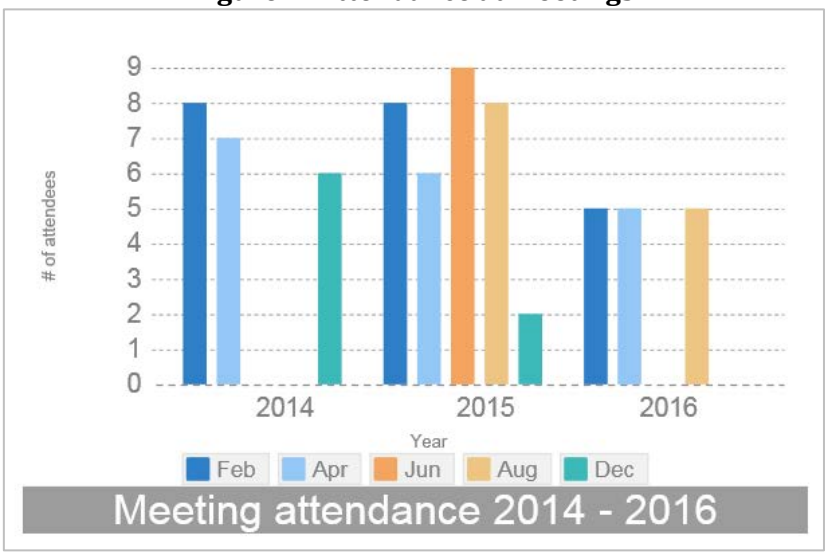
Attendance of individual organisations at planning meetings was used as an indicator for active participation and project monitoring. The average meeting attendance for an organisation at CPC Project meetings over the entire project was 4.76 (out of a total of 12 agencies) and meeting members changed over the course of the project due to staff change over and proxy attendees. Changes in overall attendance per year were charted over the 3 year cycle of the project (see Table 2 for more detail). The results indicate a gradual reduction in meeting attendance over the time.

Table 2: Average attendance per year

Year	# of meetings held	Average attendance/ yr. (%)
2014	3	70%
2015	5	46%
2016	3	43.3%

Similarly, this decrease was reflected in the number of individuals attending each meeting over the 3 year period (refer to Figure 1).

Figure 1: Attendance at meetings



The main reason for decreasing attendance rates were reported by interviewees as:

- decreased capacity to engage in meetings due to increased administrative load
- fluctuation in attendance affecting meetings progressing
- diverse group of stakeholders at varying levels of progress.

Some illustrative quotes are outlined below:

> *"Like for example I hardly attended any meetings this year because we have been so overwhelmed with all the changes that are happening … you know … because they were doing the split of our clients… so they were saying identify this client and 'check if this data is correct.. the data that we have … so lots of checking. Then there were the programs – so they needed to map the HACC programs to the Commonwealth…it's been a lot of extra work. And now again with NDIS…"* - Project Partner

> *"I guess for me what I found a bit frustrating about it [the project] is that … you'd turn up to meetings and there wouldn't be the same people there that there were last time or there might only be three people … it was difficult to share information equally when others didn't come prepared or were not at the same stage"* – Project Partner

Other Barriers for Project Delivery

The complexities of care planning processes meant that there were a number of individual, organisational and system barriers to project delivery. The following issues were mentioned as being on the ground challenges for GDCP.

At a clinician level:

- Inconsistency in content of care plans
- Clients are often not given a copy of their care plan
- Health literacy is an issue for some clients
- Care plan not goal orientated
- Multiple versions of care plans are being developed- client repeating their story; no awareness of care plans that are in existence.

At an organisational level:

- Agencies needing to adhere to different guidelines such as the Health Independence Program (HIP) guidelines
- Reviewing of care plans has been inconsistent
- Organisations at different levels for implementing policy documents and frameworks for GDCP
- Lack of meaningful engagement with general practices
- The need to determine who holds primary responsibility for the care plan.

"No one is taking responsibility for leading on that care plan – we have care coordinators that are community ICD funded. They do have the time to pull everything together. So I think a barrier around that is who is going to take responsibility for working with the client and pull everything together." – Project Partner

At a systems level:

- My Aged Care and NDIS reforms
- Lack of IT systems that interface well (for shared care planning).

Splashes (outputs) and Ripples (outcomes)

Some of the questions considered in this part of the evaluation included:

- *To what extent have the training sessions (GDCP and Case Conferencing) improved understanding of the key principles and building blocks of shared care planning?*
- *To what extent has the GDCP Toolkit been promoted to partner agencies?*
- *To what extent have agencies used the GDCP Toolkit checklist to audit care planning practice and organisational systems?*
- *To what extent has the project improved current practice at a practitioner level?*
- *To what extent has the project improved current practice at an organisational level?*
- *What additional outcomes have come from the project?*

The GDCP and Case Conferencing Training Sessions

The INW PCP held a number of training sessions to support agencies to make steps toward better service coordination in GDCP and case conferencing. Overall INW PCP has delivered 8 training sessions – 6 on GDCP and 2 on case conferencing. These training sessions were reported to enhance participants' confidence and improved their self-rated knowledge of GDCP.

A total of six workshops (a series of three workshops run twice) were rolled out. Overall 122 people participated in the training. Attendance at the workshops is outlined below:

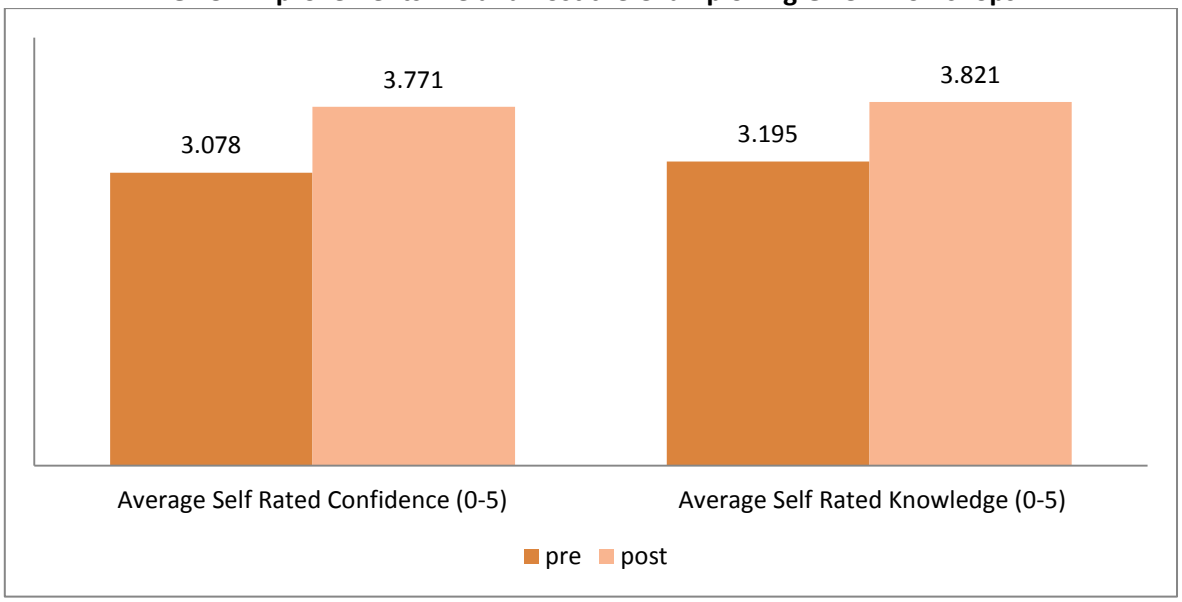
- Workshop 1: 58 individuals
- Workshop 2: 35 individuals
- Workshop 3: 29 individuals.

93% of participants reported that the training was valuable, particularly for the following elements:

- understanding the practical strategies to support identification and documentation of goals
- use of practical activities, examples and group discussion
- the tools and templates.

Self-rated knowledge was also used as an indicator for workshop outcome with average self-rated knowledge notably improved (see Figure 2).

Figure 2: Participant Self-Rated Knowledge and Confidence in Facilitating GDCP Improvements Pre and Post the Championing GDCP Workshops



In order to support agencies in shared care planning two case conferencing training sessions were held in 2016. Overall 26 people from 10 agencies participated in case conferencing over the two sessions. Attendance at the sessions was outlined as:

- Workshop 1: 12 participants
- Workshop 2: 13 participants.

Most participants responded positively to the training sessions on case conferencing with most respondents responding positively to both the content and delivery of the training.

Promotion of the GDCP Toolkit

The INW PCP networks have been a valuable platform for promotion of the GDCP Toolkit. From the GDCP sessions run through INW PCP – three agencies booked further training independently of INW PCP, resulting in a further 27 staff attending follow up training sessions. These agencies have continued to engage with this consultant and sustain their work independently of INW PCP.

> *"Yes I have recommended [consultant] and it has been really good having that taster through the PCP and has had a flow on effect"* – Project Partner

Agencies using the GDCP Evaluation Tool

The CPC Project has improved current practice both at a practitioner level and an organisational level. Over 60% of the agencies engaged in this project have been using the GDCP Toolkit as an auditing tool at both a clinician and organisational level. Others have created local interpretations of the guidelines and GDCP Toolkit to better suit their needs. The agencies that have been most engaged in the project have sustained their improvement work and seen definite progress during the project.

"I think with all change people expect that it goes up in this kind of trajectory but actually performance dips before you get the benefits and a lot of people kind of give up when performance dips... but the ones who have stuck at it have seen the tangible benefits now … The clincher has been really good – because we surveyed over 500 clients – and while only 38% (190) had a care plan - of those 38% - ***97%*** *found them really useful…"* – Project Partner

In previous meetings the agencies identified areas for clinician level improvements such as using client centred language, collaborative goal setting and quality care plans. These were reported by interviewees to have improved meaningfully over the duration of the project. Care plans were evaluated and submitted to consultants for feedback as part of continuous improvement work.

"We have set up an evaluation framework that looked at from a staff point of view, a client point of view and from an organisational point of view. And we have been doing bits and pieces so from a staff point of view we've been doing audits of completed care plans and also audited the templates themselves to make sure they all meet standards and that again came from the PCP where [name] had introduced us to the auditing tools. So every team was asked to submit tools and audit and then [name] also went through those and gave everyone good constructive feedback about how they could improve…" – Project Partner

Additionally, approximately 50% of agencies reported organisational improvements such as policy development and ongoing evaluation and monitoring.

"We have developed some policies according to the GDCP guidelines. I showed some to [consultant]. some drafted guidelines – so yes we have the care planning policy and we have the trainings and our own internal workshop with staff coming together and trying to discuss scenarios around care plans and so the process is fairly much embedded now in our clients. We have a care plan for all the clients that we have."– Project Partner

Additional outcomes from the project included some agencies valuing the GDCP tool kit as a beacon and something to hold on to during times of reform and to give them a selling point over other providers.

"GDCP has been seen as a kind of a beacon through all the changes… Our messaging has been more than ever that we want to continue with GDCP because in a competitive environment we think that might give us the edge if you do it well. At the end of the day it is still about the discussion that you have with the client about how you are going to work together and let's write that down." - Project Partner

Client/Consumer Stories

These practitioner and organisational improvements translated into meaningful improvements in client outcomes. One interviewee reports below.

> *"One client was very much isolated apart from being a part of one of our programs once a week. So when we went through GDCP one of the things that came up was she said 'I would like to go and stroll in my street… 'And she said that she 'used to like walking around her neighbourhood'. After a while she disclosed she was a recent arrival so she didn't feel safe in the area. Through the discussion it came out she was scared she would be lost and secondly she was not sure she was not confident she was able to lock the door of the house properly so she stayed at home all the time and never went out. She had never articulated this before even to her family so the project coordinator came early to her house and showed her how to confidently lock the door and started with a walk of five houses and then worked her up to walking the whole block. She is now doing a daily half an hour walk and she is very happy. She is meeting other neighbours doing their gardening…"* – Project Partner

Sustainability, Transferability and Next Steps

Questions used to guide this part of the evaluation included:

- *Agency capacity and readiness for project continuation*
- *Are there recommended changes for the project?*

Some agencies commented that the transition of HACC to the Commonwealth has limited their ability to be involved in the CPC Project and has also influenced the relevance of the CPC Project to new care planning requirements. Others have commented that the My Aged Care plans are more like a referral plan as opposed to a care plan. Most agencies reported needing more time to become familiar with My Aged Care before they moved forward with shared care planning. Organisations put forward a number of suggestions for future directions. These comments are displayed below:

Agency Feedback and Suggestions

1. **A pilot project involving one general practice, one community health service, one hospital and other interested organisations.**

> *"Would it be worth getting an agreement and actually setting up a pilot within the PCP where we've got some GPs involved, community health, RDNS whoever else wants to be – like an expression of interest – there's a group of us that are going to pilot in a small area. This is the way we are going to share, and have some local business rules around how we are going to do this with our shared clients. And if Melbourne Health were involved as well at a very local level. That would be wonderful to do a small pilot around shared care planning."* – Project Partner

2. Identify member agencies that need additional support with GDCP

> *"I think in terms of the care planning project the PCP is probably best off actually identifying agencies that actually want support with implementing GDCP and guiding them through the process of this is how it could work in their system. Working at agencies on an individual basis…"* – Project Partner

3. Engagement with other stakeholders

Stakeholders in community health settings expressed the desire for meaningful engagement with general practices and the hospitals.

> *"I think one of the important things for us is actually GP engagement and actually linking really effectively with GPs because we don't, we haven't to date really been effective at linking in with the local GPs…"* – Project Partner

Apart from engagement with GPs, agencies expressed the need to connect with organisations more broadly that exert influence on the social determinants of health. 'Non-health' organisations were specifically mentioned.

4. Moving to a focus on health literacy

Some agencies suggested that a focus on aspects of health literacy would be relevant to the CPC Project as it affects client's ability to engage in self-care and chronic disease management.

> *"Demystifying health literacy is the next thing for us. Clinicians are scared of what health literacy means … Demystifying that at a clinician level."* – Project Partner

5. Understanding how My Aged Care affects GDCP

Another resource that was suggested was additional training as to how GDCP relates to My Aged Care and how it affects care planning and how it will affect shared care planning long term.

> *"By the time they come to your organisation they already come with some sort of plan. I would like to see more of what is the impact of MAC on shared care planning."* – Project Partner

Recommendations

- Consider issuing an expression of interest for a small shared care planning pilot project with passionate and engaged agencies consisting of one general practice, one community health service, one hospital and other additional agencies located in a small geographic region.
- INW PCP could advocate for agencies need for support in understanding the different requirements for care planning within My Aged Care and how that fits in with the GDCP Toolkit. This could be linked in with the work of The Northern and Western Community Care Alliance.

- Build Health Literacy principles into any future care planning projects and other related initiatives.
- Integrate core principles of client centred care and GDCP into any relevant future projects or initiatives.

Appendix 1: Key Evaluation Criteria

Performance Criterion	Evaluation Questions	Indicators	Data Collection Methods
Monitoring	• To what extent is the delivery of the CPC Project consistent with the project plan? • To what extent is the delivery of the project reaching target stakeholders? - Are there stakeholders that could be engaged in this project that are not represented? - What other resources and/or skills would be helpful for this initiative? • To what extent are contextual factors affecting project delivery?	• # of meetings • Training session raw data • Meeting attendance - Meeting themes and decisions - PDSA cycles • Stakeholder feedback	• INW PCP planning and evaluation document analysis • Training evaluation documents - GDCP training - Case conferencing training • Meeting minutes textual analysis • Survey and/or qualitative interviews with stakeholders
Splash (outputs)	• To what extent have the training sessions (GDCP and Case Conferencing) improved understanding of the key principles and building blocks of shared care planning? • To what extent has the GDCP Toolkit been promoted to partner agencies? • To what extent have agencies used the GDCP Toolkit checklist to audit care planning practice and organisational systems?	• # of training sessions • # of attendees at training sessions • Data collected from surveys • Agency audits and reports of GDCP	• INW PCP internal data and evaluation documents • Repeat audit of the GDCP Toolkit to update progress from the 2015 data • Qualitative interviews or surveys
Impact (ripples)	• To what extent has the project improved current practice at a practitioner level? Key improvement areas identified by agencies were: - Use of client centred language - Collaborative goal setting - Quality of care plans	• Practitioner level audits • Organisational audits or improvements • Consumer stories/ case studies provided by agencies	• Focus group mapping sessions • Qualitative interviews with stakeholders • Consumer stories/ case studies

	• To what extent has the project improved current practice at an organisational level? Key improvement areas identified by agencies were: - Staff orientation and education - GDCP evaluation and monitoring - Policy development • What additional outcomes have come from the project?		
Sustainability & Transferability	• Agency capacity and readiness for project continuation - What further resources or structural supports are required? - Barriers and enablers for project continuation - Which agencies have capacity and are interested in continuing? • Are there recommended changes for the project? - What should be the focus of the next phase of the project? - How can INW PCP best support agencies moving forward?	• Stakeholder feedback	• Qualitative interviews with stakeholders

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