The *Building Partnerships* Framework:

Proposed Evaluation Approach

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Author: Health Economics & Evaluation Team

Owner: Agency for Clinical Innovation

Street address:
Level 4, Sage Building
67 Albert Avenue
Chatswood NSW 2067

Postal address:
Agency for Clinical Innovation
PO Box 699
Chatswood NSW 2057

T +61 2 9464 4666
F +61 2 9464 4728
info@aci.health.nsw.gov.au
www.aci.health.nsw.gov.au

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ABBREVIATIONS USED IN THIS REPORT

ACI	NSW Agency for Clinical Innovation
ALBP	Acute Low Back Pain MoC
CDMP	NSW Chronic Disease Management Program
CHOPS	Confused Hospitalised Older Person project
EoI	Expression of Interest
GP	General Practitioner
HFS	Hip Fracture Standards project
LHD	Local Health District
ML	Medicare Local
MoC	Model of Care
MoH	NSW Ministry of Health
OACCP	Osteoarthritis Chronic Care Program
ORP	Osteoporotic Refracture Prevention MoC
RACF	Residential Aged Care Facility

1. Introduction

1.1 The Changing Health Needs of an Aging Population

In NSW, both life expectancy and the proportion of people living longer are increasing (1). A significant, and also growing, proportion of these older people are living with complex health needs, including chronic diseases such as dementia, which is estimated to affect 1 in 10 Australians aged 65 years and over (1) (2). Consequently, older people, their carers and families often experience multiple, disconnected and often duplicative interactions with the health system, as well as longer lengths of stay in hospitals (1). In addition, the demand for home care and community support services outweighs supply, often resulting in excessive stress on carers and unnecessary hospital admissions (1).

Therefore, it has become increasingly evident that an optimal provision of services for this population cannot be delivered by one provider or one sector – rather, services for older people with complex health needs, their carers and families must be coordinated across health and care sectors, with shared planning, management and accountability (1).

1.2 The *Building Partnerships* Vision

> *Older people, their carers and families in NSW, as partners in their care, are able to access appropriate, high quality, evidence-based health care that is provided in a timely, equitable and coordinated manner and delivered safely as close to home as is possible.*

1.3 About the *Building Partnerships* Framework

In a bid to address these changing needs, the NSW Agency for Clinical Innovation (ACI), under the auspices of the NSW Ministry of Health (MoH), has led the development of the *Building Partnerships* Framework (3) for older people with complex health needs, their carers and families to receive proactive, person-centred and evidence-based care, regardless of how or where they access it. The *Building Partnerships* Framework aligns with the MoH's Integrated Care Strategy (4) to implement innovative locally-led models of integrated care across the State to transform the NSW health care system.

Concurrently, the Commonwealth, State and Territory Governments have agreed to a national reform of the health and aged care systems. The *"My Aged Care"* (5) reforms aim to improve health outcomes and ensure the sustainability of the health system and the way in which sectors relate to each other. In addition, an important shift is that the consumer is at the centre of the aged care reform process.

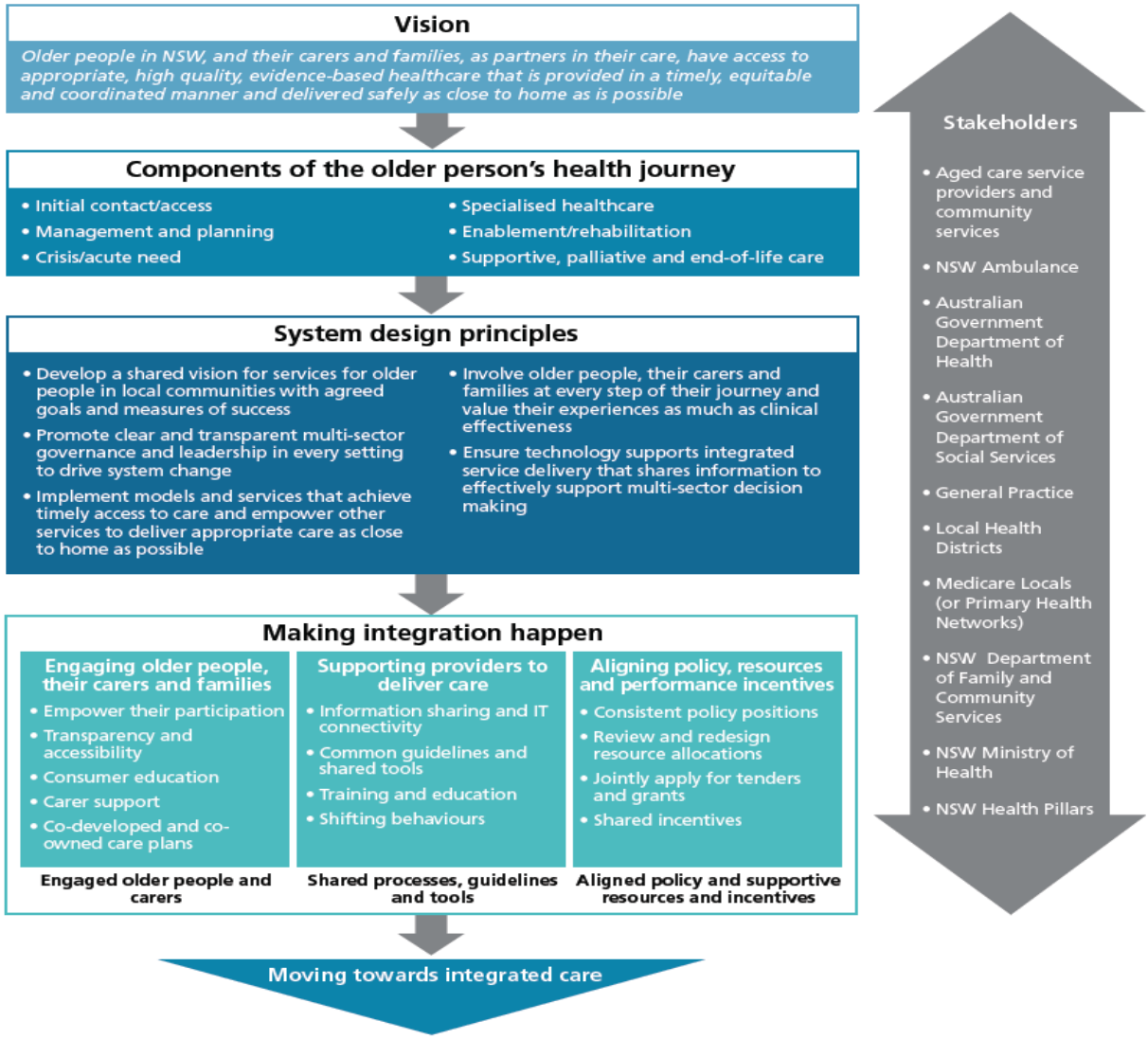
The *Building Partnerships* Framework forms part of a response to the NSW Government Ageing Strategy (1), which identifies the many other factors that influence an older person's health, including bio-psychosocial factors, housing, support services and transport. It acknowledges that the "*My Aged Care"* and future health reforms will impact on how services deliver care. However, the principles are universal and can be applied regardless of future policy and funding environments.

The purpose of the *Building Partnerships* Framework is to provide:

- A comprehensive overview of the key components, principles and next steps as services look to integrate care for older people with complex needs, their carers and families through collaborative service design and delivery across sectors.
- A platform to stimulate open discussion at the regional level and to promote collaborative actions towards integration among those who have a role to play in improving the health and wellbeing outcomes for older people with complex needs, their carers and families.
- Consistency and good practice guidance while allowing local services operational flexibility for innovation in work practices.

Figure 1: The Framework for Integrating Care for Older People with Complex Health Needs

Adapted from MacColl Institute for Healthcare Innovation (6)



Adapted from MacColl Institute for Healthcare Innovation 2012[1]

This *Building Partnerships* Framework is neither static nor siloed with all of the elements interacting. Also, the Framework alone will not lead to integrated models of service delivery. There is an intrinsic need for behaviour change at all levels by all stakeholders. This Framework provides a common and consistent conceptual model to align behaviours and understanding of service providers.

1.4 Proposed Implementation Strategy

As detailed further in the Framework's Implementation Plan (7), the proposed approach for implementing the *Building Partnerships* Framework includes:

- Seeking the endorsement of relevant professional and consumer peak body agencies;
- Developing and executing a communication plan to present the Framework to all key stakeholder groups;
- An EOI process offering all LHDs and MLs an opportunity to submit a joint proposal for implementing the Framework, with the support of the ACI; and
- The ACI supporting interested LHD/ML partnerships to refine, implement and evaluate their proposals.

The implementation may occur in a staged process, depending on the number and developmental-stage of proposals received.

1.5 Integration with Other Health Initiatives

One of the key system design principles of the *Building Partnerships* Framework promotes the adoption of existing ACI Models of Care (MoCs) and other programs relevant to older people, including:

- NSW Chronic Disease Management Program (CDMP);
- Confused Hospitalised Older Person Study (CHOPS);
- Osteoporotic Refracture Prevention (ORP);
- Osteoarthritis Chronic Care (OACCP);
- Acute Low Back Pain (ALBP);
- Musculoskeletal Primary Health Care Initiative (a primary health-based variation of the ORP, OACCP & ALBP projects);
- Hip Fracture Standards (HFS);
- NSW Pain Management Plan 2012-2016;
- Palliative and End-of-Life Care;
- Criteria-Lead Discharge project;
- Integrated Care Co-location Project; and
- Rehabilitation.

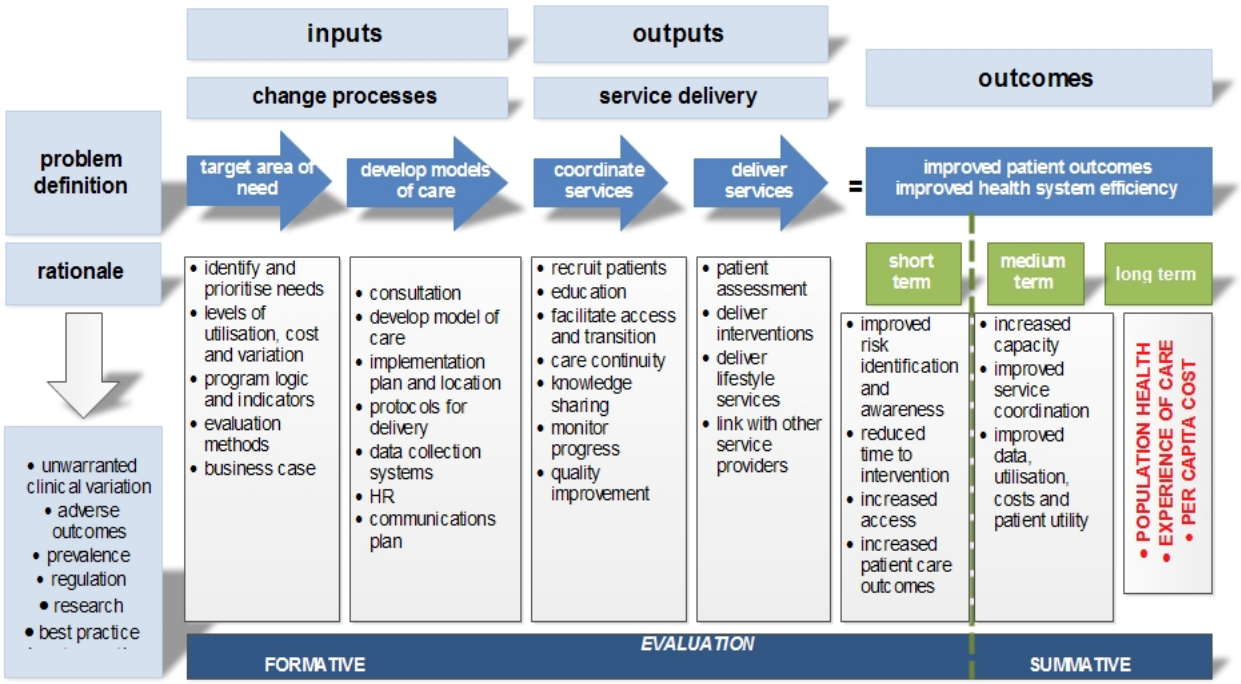
While usually focussing on more specific health issues, these initiatives each incorporate similar visions, principles, approaches, strategies and intended patient and system outcomes as the *Building Partnerships* Framework. Although most are applicable for people of all ages, it is likely that older people will constitute a majority of those to whom they are applied.

This Framework will operate within the broader context of the NSW Integrated Care Strategy, which aims: "*to build strong partnerships within the health system, including primary, community & acute care, as well as public, private & not-for-profit providers … to provide seamless, effective & efficient care that responds to all of a person's health needs, across physical & mental health, in partnership with the individual, their carers & family … based around the needs of the individual, to provide the right care in the right place at the right time and make sure dollars go to the most effective way of delivering healthcare*". The Strategy includes developing a number of statewide infrastructure projects to support integrated care which will be instrumental in implementing and evaluating the *Building Partnerships* Framework.

1.6 Commitment to Evaluation

Both the ACI and the NSW Government are committed to research and evaluation to provide an evidence base for the development of effective models of care across NSW and to inform future policies and program development (8) (9).

To this end, the ACI encourages the use of program logic models (as below) for illustrating a program and defining what should be measured and when this should occur in an evaluation (9):



1.7 Purpose of this Document

This document presents:

- An overview of the evaluation priorities for the *Building Partnerships* Framework;
- An overview of the evaluative challenges posed by the *Building Partnerships* Framework; and
- A proposed multi-level approach for evaluating the implementation and impact of the *Building Partnerships* Framework.

It has been developed in accordance with ACI and NSW Government evaluation guidelines (8) (9).

Further discussions will be required to refine and finalise all components and to define responsibilities at service provision sites, LHDs and the Aged Health Network.

2. Evaluating the *Building Partnerships* Framework

2.1 Evaluation Priorities

Consultations with the ACI Implementation team and the ACI Aged Health Network have identified the following broad evaluation priorities for the *Building Partnerships* Framework:

- Improving **older people, their carers and families' experiences** within the health system;
- Improving **health system efficiency** (with emphasis on the NSW Health perspective); and
- Optimising **older people's health outcomes**.

More specifically, these consultations and a review of the Framework and NSW Integrated Care model have identified the following wide array of potential outcomes to be evaluated:

2.1.1 Patient-oriented outcomes

- Improved experience
- Improved continuity/ streamlining of care/ easier navigation through the various parts of the health system
- Reduced waiting times
- Reduced deterioration
- Fewer complications
- Improved return to optimal functioning
- Quicker access rehabilitation
- Quicker return home
- Better understanding of the services available
- Less unsupported morbidity
- Increased capacity/capability to confidently manage at home
- More optimal health outcomes

2.1.2 System-oriented outcomes

- Reduced cost per care episode
- Reduced diagnostics and assessments
- Reduced length of stay
- Reduced need & use of behavioural restraints
- Less unnecessary residential aged care facility admissions
- Fewer unplanned and avoidable admissions, readmissions & Emergency Department attendances
- Reduced frequency of planned hospital admissions & Emergency Department attendance
- Improved communication between care providers
- Improved communication to older person, carer and family
- Cost-effectiveness
- Improved uptake of relevant primary care services/ more patients being cared for in the community
- Better sharing of clinical information/ reduced duplication of pathology & radiology tests

2.1.3 Carer-oriented outcomes

- Improved experience
- Reduced anxiety
- Increased knowledge and skills to support older person

2.1.4 Staff-oriented outcomes

- Increased knowledge, capacity & capability regarding the management of older people with complex health needs
- Improved experience

2.1.5 Quality-related outcomes – ability to access care that is:

- Appropriate
- High quality
- Evidence-based
- Timely
- Equitable
- Coordinated manner
- Delivered safely
- As close to home as is possible

2.1.6 Process Evaluation

In addition, a comprehensive process evaluation will be required in order to monitor:

- Awareness & uptake of the *Building Partnerships* Framework;
- The nature, extent & quality of care integration before and during this project;
- The extent to which the other health initiatives are implemented; and
- Patient, carer & staff feedback about the Integrated Care approach.

2.2 Evaluative Challenges

2.2.1 Clearly Defining the Target Group

While aiming to benefit all older people, the *Building Partnerships* Framework defines its **priority target group** as: *Older people whose underlying co-morbidities and individual circumstances have a direct impact on their ability to function and maintain independence on a daily basis*. This definition has been purposely designed to maximise the Framework's relevance to a broad and inclusive array of patients. While practical for implementation purposes, this raises a number of questions when trying to evaluate whether the Framework has improved anything for those it aimed to help. These questions include:

- Who is 'older'? … according to the Framework, this "*is not age dependent but does most often pertain to those over 75 years of age*". However, some of the other initiatives to be implemented as part of the Framework are aimed at people aged 65 years and over. In addition, it is Australian government convention to acknowledge Indigenous Australians aged 50+ years as 'older' (10)?
- How many co-morbidities / individual circumstances are required to constitute 'complex'?
- What is meant by 'individual circumstances'? … are they a necessary requirement for inclusion (as implied by the 'and')?
- Is some degree of restricted daily functioning essential for inclusion? … or, in other words, does the target group exclude fully functional older people even if they have multiple co-morbidities / individual circumstances?

2.2.2 Big Picture Nature of the Framework

As discussed earlier, the *Building Partnerships* Framework aims to provide an evidence-based overview and platform to promote regional level discussions and collaborations towards integrating care among all professionals with a role to play in improving the health and wellbeing of older Australians. By design, it "*is not prescriptive but provides overarching principles to guide local service planning*". While facilitating regional flexibility and innovation, this means that the components of the Framework to be implemented within each participating region, how those components will be implemented or the specific outcomes to be addressed will become clear only through the EoI process. Consequently, the evaluation approach needs to remain flexible with evaluation strategies being developed in close consultation with LHDs and MLs to ensure relevance to each region's implementation.

2.2.3 Ability to Attribute Any Changes to the Framework

The way the *Building Partnerships* Framework fits within the NSW Integrated Care Strategy and incorporates and/or overlaps the implementation of numerous ACI MoCs and other health initiatives will limit the ability for any changes in the outcomes of interest to be attributed directly to the Framework itself, particularly at the statewide level. Localised evaluation plans will need to reflect this potential limitation.

2.2.4 Streamlining with the NSW Integrated Care Strategy Evaluation Activities

Given their high degree of alignment, it is important that the evaluation of the *Building Partnerships* Framework streamlines with that of the NSW Integrated Care Strategy, drawing from the Strategy's proposed statewide infrastructure wherever possible. Although the Strategy's evaluation is also still in the planning stage, the ACI is an active partner in this process, which may provide the opportunity to ensure a streamlined evaluation across both the Framework and the Strategy.

2.3 Proposed Approach

Given the evaluation priorities and challenges outlined in the previous sections, the following multi-level approach is proposed for evaluating the implementation of the *Building Partnerships* Framework:

- Locally-tailored pre-post outcome evaluations to explore the impact of each pilot site's chosen activities on their chosen target group, in relation to their chosen outcomes (which should encompass all three evaluation priority areas).

- A standardised, overarching process evaluation to explore:
  - the overall impact of the Framework on care integration;
  - the extent to which the various MoCs and other health initiatives are implemented; and
  - patient, carer & staff feedback about the integrated care approach.

2.3.1 Locally-Tailored Pre-Post Outcome Evaluations

As part of the EOI process, sites interested in piloting the *Building Partnerships* Framework will be asked to indicate their commitment to evaluating their integration project, including allocating a proportion of their funding to resource the collection, collation and reporting of relevant evaluation data.

Following their diagnostic phase, the ACI will assist each participating LHD/ML partnership to develop an evaluation plan, tools and processes relevant to their individual projects and support the sites with conducting their evaluations. This will involve completing a template (such as the draft included in the Appendix), which will be refined in conjunction with the broader NSW Integrated Care Strategy.

2.3.2 Standardised Process Evaluation

As part of the EOI process, sites interested sites will also be asked to incorporate a standardised process evaluation as part of their overall site-specific evaluation approach.

While the process evaluation tools and process will need to be developed in partnership with the broader NSW Integrated Care Strategy, they will likely include:

- Some baseline assessment of the nature, extent & quality of care integration and the various MoCs and other health initiatives in the region;
- Ongoing monitoring of these aspects throughout the project implementation phase (eg: number of cross-sectoral meetings and nature of participants, numbers and nature of patients recruited to the various health initiatives); and
- Some post assessment of the nature, extent & quality of care integration and the various MoCs and other health initiatives in the region.

3. References

1. **NSW Department of Family & Community Services.** *NSW Ageing Strategy.* Sydney : NSW Government, 2012.

2. **Fight Alzheimer's, Save Australia.** Dementia Statistics. *https://fightdementia.org.au/about-dementia-and-memory-loss/statistics.* [Online] 2013. [Cited:]

3. **NSW Agency for Clinical Innovation.** *Building Partnerships: A Framework for Integrating Care for Older People with Complex Health Needs.* Sydney : NSW Agency for Clinical Innovation, 2014.

4. **NSW Health.** NSW Integrated Care Strategy. *http://www.health.nsw.gov.au/integratedcare/Pages/default.aspx.* [Online] 2014. [Cited:]

5. **Australian Government Department of Social Services.** MyAgedCare. *http://www.myagedcare.gov.au/.* [Online] 2014. [Cited:]

6. **MacColl Institute for Healthcare Innovation .** It Takes a Region: Creating a Framework to Improve Chronic Disease Care. *http://www.improvingchroniccare.org/downloads/chcfreport.pdf.* [Online] 2006. [Cited:]

7. **Aged Health Network.** *Building Partnerships Framework: Implementation Plan.* Sydney : NSW Agency for Clinical Innovation, 2014.

8. **NSW Government.** *NSW Government Evaluation Framework August 2013.* Sydney : NSW Government, 2013.

9. **NSW Agency for Clinical Innovation.** *Understanding Program Evaluation: An ACI Framework.* Sydney : NSW Agency for Clinical Innovation, 2013.

10. **Australian Government Department of Health.** Commonwealth HACC Program. *http://www.health.gov.au/internet/main/publishing.nsf/Content/hacc-index.htm.* [Online] 2014. [Cited:]

4. APPENDIX: Evaluation Plan Template (Draft)

Title

Provide a succinct working title for the project

Background

Provide a brief background to the project including the nature of the issue(s) to be addressed and evidence of a need for improvement – this will likely summarise the literature and data reviewed during the diagnostic phase of the project

Goals and Objectives

Document the overall goals and objectives of the program – these should be consistent with the project's short, intermediate and long term outcomes (see Program Logic section) and cover the three broad evaluation priorities of the Building Partnerships Framework (ie: patient and carer experiences, health system efficiency and older people's health outcomes)

Some Potential Outcomes of Interest

Patient-oriented outcomes

- Improved experience
- Improved continuity/ streamlining of care/ easier navigation through the various parts of the health system
- Reduced waiting times
- Reduced deterioration
- Fewer complications
- Improved return to optimal functioning
- Quicker access rehabilitation
- Quicker return home
- Better understanding of the services available
- Less unsupported morbidity
- Increased capacity/capability to confidently manage at home
- More optimal health outcomes

System-oriented outcomes

- Reduced cost per care episode
- Reduced diagnostics and assessments
- Reduced length of stay
- Reduced need and use of behavioural restraints
- Less unnecessary residential aged care facility (RACF) admissions
- Fewer unplanned and avoidable admissions, readmissions & Emergency Department attendances
- Reduced frequency of planned hospital admissions & Emergency Department attendance
- Improved communication between care providers
- Improved communication to older person, their carer and family
- Cost-effectiveness
- Improved uptake of relevant primary care services/ more patients being cared for in the community
- Better sharing of clinical information/ reduced duplication of pathology & radiology tests

Carer-oriented outcomes

- Improved experience
- Reduced anxiety
- Increased knowledge/ skills to support older person

Staff-oriented outcomes

- Increased knowledge, capacity & capability regarding the management of older people with complex health needs
- Improved experience

Quality-related outcomes – ability to access care that is:

- Appropriate
- High quality
- Evidence-based
- Timely
- Equitable
- Coordinated manner
- Delivered safely
- As close to home as is possible

Patient Cohort

Specify the characteristics of the patients to be targeted by this project – within the Framework's broad target group (ie: older people whose underlying co-morbidities and individual circumstances have a direct impact on their ability to function and maintain independence on a daily basis)

***Example**: People aged 65+ years attending for a 2nd, or greater, unplanned ED visit or hospital admission within an X-month period AND with DRG/ NWAU/ URG indicating moderate-high complexity (with N visits & timeframe triggers to be determined based on data – say, top quintile … and could consider limiting to top 5 DRGs associated with "frequent flyers")*

Program Logic

Complete the following details, which will be worked into a program logic for this project

Inputs Resources used to implement a project – eg: staff, funding, in- kind support, equipment		
Activities Actions undertaken by the project to achieve the desired goals – eg: staff training, developing new systems to support new models of care		
Outputs Immediate results/products from an action (usually measured in numbers) – eg: number of staff trained, number of procedures, implementation of model of care across a specified number of sites		
Outcomes Desired changes to show movement towards the project's goals and objectives	**Short-term**	
	Intermediate	
	Long-term	

Timeframe

Provide a timeframe including project development, baseline data collection period, key project implementation phases and post data collection period

Evaluation Questions & Data Sources

Detail the evaluation questions to be answered (which should evolve from the project goals, objectives and program logic) and indicate the corresponding data source(s) for each question – these could include existing health datasets, new project-specific evaluation tools and/or the infrastructure tools being developed as part of the NSW Integrated Care Strategy (ie: HealtheNet patient info system, risk stratification tools, patient-reported outcome measures and real-time patient feedback)

Evaluation Questions	Data Source(s)

Some Potential Data Sources

Admitted patient data	**Sources:** NSW Admitted Patient Data Collection, Activity Based Funding collections, Clinical Registries, Australian Institute of Health and Welfare (AIHW) datasets, hospital records, previous research on utilisation. **Examples of indicators that can be derived**: Unplanned hospital readmissions, average length of stay, bed-days, primary and secondary conditions, potentially preventable hospitalisations and complexity of care, health service costs can be compared for specific conditions using National Weighted Activity Units (NWAUs) and payment data (public/private)
Non-admitted data	**Sources:** Emergency Department data, Outpatient Clinics, and some ambulatory forms of care **Examples of indicators that can be derived:** Waiting times for emergency department care, outpatient clinic utilisation, some hospital in the home data
Sub-acute data	**Examples:** Sub acute care collections relating to Rehabilitation, Palliative Care, Geriatric Evaluation and Management and Psycho-geriatric data sets. **Examples of indicators that can be derived:** Occasions of service, care setting, care following acute care (if data are linked)
Community data	**Examples**: Specific service records, MBS data. **Examples of indicators that can be derived**: Access to GP type services, care plan utilisation
Population health	**Sources:** Centre for Epidemiology and Evidence (MoH), Australian Bureau of Statistics (ABS) Community Profiles, Remoteness, Socio Economic Indicators for Area (SEIFA), Mortality tables, Cancer Registry, NSW Health Hospital Statistics Reports, NSW Planning Population Projections. **Examples of indicators to be derived:** This can be used to examine incidence and prevalence rates and compare effectiveness of targeted programs
Waiting times	**Sources:** Elective Surgery Waiting Times National Minimum Data Set, specific hospital service records. **Examples of indicators to be derived:** Waiting times for specific procedures, waiting list movements/delays

Evaluation Resourcing

Provide an overview of how the evaluation activities will be resourced (with personnel and/or dollars)