The care planning sub-program: lessons from the national evaluation

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Abstract
Today’s session

- Care Planning Sub-Program overview
- Evaluation overview
- Key activities from the sub-program & their impacts
- Key findings

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The Care Planning Sub-Program: lessons from the national evaluation

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Centre for Health Service Development

Funded by the Australian Government Department of Health and Ageing through the Local Palliative Care Grants Program
Today’s session

- Care Planning Sub-Program overview
- Evaluation overview
- Key activities from the sub-program & their impacts
- Key findings
Care Planning Sub-Program overview

- **Projects:** 33 projects across Australia
- **Funder:** Australian Government Department of Health and Ageing through the Local Palliative Care Grants Program
- **Total budget:** $7.5 million over 3 years
- **Project duration:** 1 – 3 years from 2006 - 09
- **Project funding:** from $100,000 to $250,000
- **Project settings:** 17 of the 33 Care Planning projects were based in regional or remote areas
Location of projects
Care Planning Sub-Program objectives

Improve the use of care planning to:

1. develop and implement **flexible models of service** delivery that meet the needs of each palliative patient in their local community

2. improve **collaboration between services** involved in providing care

3. support the smooth and appropriate **transition between settings of care**

**NB:** just over half of the projects addressed all 3 objectives
Evaluation overview

- Centre for Health Service Development (CHSD)
  - national evaluator for the sub-program

- Projects conducted their own project evaluation
  - some with external evaluators
  - most evaluating themselves
  - plus contributed to the national evaluation

- National evaluation
  - data from the projects
  - plus other sources
Evaluation framework

Level 1: Impact on, and outcomes for, consumers (patients, families, carers, friends, communities)

Level 2: Impact on, and outcomes for, providers (professionals, volunteers, organisations)

Level 3: Impact on, and outcomes for, the system (structures and processes, networks, relationships)

<table>
<thead>
<tr>
<th>‘Plain language’ questions</th>
<th>Corresponding evaluation issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>What did you do?</td>
<td>DELIVERY</td>
</tr>
<tr>
<td>How did it go?</td>
<td>IMPACT</td>
</tr>
<tr>
<td>Can you keep it going?</td>
<td>SUSTAINABILITY</td>
</tr>
<tr>
<td>What has been learned?</td>
<td>CAPACITY BUILDING</td>
</tr>
<tr>
<td>Are your lessons useful for someone else?</td>
<td>GENERALISABILITY</td>
</tr>
<tr>
<td>Who did you tell?</td>
<td>DISSEMINATION</td>
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</tbody>
</table>
Key project activities – what did they do?

- Project level activities (100s)

- We classified the activities by:
  - 3 levels (consumers, providers, system)
  - taxonomy of interventions

- 3 Tables: listing intervention category; projects, examples of activities (examples following)
# Activities targeting consumers

## Intervention category

<table>
<thead>
<tr>
<th>Examples of activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personalised information &amp; communication mechanisms</strong></td>
</tr>
<tr>
<td>- Patient card</td>
</tr>
<tr>
<td>- My Health Diary</td>
</tr>
<tr>
<td>- Patient-held record folder</td>
</tr>
<tr>
<td><strong>Client &amp; carer involvement in care planning</strong></td>
</tr>
<tr>
<td>- Advance Care Plans</td>
</tr>
<tr>
<td>- Case conference participation</td>
</tr>
<tr>
<td><strong>General information (produced by 1/3 of the projects)</strong></td>
</tr>
<tr>
<td>- Brochures</td>
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<tr>
<td>- Leaflets</td>
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<tr>
<td>- DVDs</td>
</tr>
<tr>
<td><strong>Access to care based on need</strong></td>
</tr>
<tr>
<td>- Improved assessment tools</td>
</tr>
<tr>
<td>- Referral procedures</td>
</tr>
</tbody>
</table>
Activities targeting providers

<table>
<thead>
<tr>
<th>Intervention category</th>
<th>Examples of activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education &amp; decision support materials</td>
<td>▪ MAPCare website</td>
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<tr>
<td></td>
<td>▪ EoL care pathways</td>
</tr>
<tr>
<td></td>
<td>▪ PaedPallCarePlan</td>
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<tr>
<td>Educational meetings (incl training)</td>
<td>▪ Education sessions</td>
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<tr>
<td></td>
<td>▪ Workshops</td>
</tr>
<tr>
<td>Local opinion leaders</td>
<td>▪ Steering committees or advisory groups</td>
</tr>
<tr>
<td>Audit &amp; feedback (&gt; 1/3 of projects)</td>
<td>▪ Audits of care plans</td>
</tr>
<tr>
<td></td>
<td>▪ Review of charts</td>
</tr>
<tr>
<td>Encourage closer collaboration among providers &amp; enhance continuity of care for clients</td>
<td>▪ Care plan, after case discussion or case conferences</td>
</tr>
</tbody>
</table>
# Activities targeting organisations & the health / care system

<table>
<thead>
<tr>
<th>Intervention category</th>
<th>Examples of activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal integration of services</td>
<td>▪ MOU</td>
</tr>
<tr>
<td></td>
<td>▪ Partnership model of palliative care</td>
</tr>
<tr>
<td>Presence &amp; organisation of quality monitoring mechanisms</td>
<td>▪ Plan-Do-Study-Act cycles</td>
</tr>
<tr>
<td>Physical changes to the health care site, facilities or equipment</td>
<td>▪ Introduction of a medication imprest system</td>
</tr>
<tr>
<td></td>
<td>▪ Loan of equipment</td>
</tr>
</tbody>
</table>
Evaluation findings of impacts & outcomes – how did they go?

- What activities & / or interventions worked?
- What was their impact?
- What was the evidence?
Impacts and outcomes on palliative care clients & their carers

- Improved co-ordination and communication
- **Improved end of life care**
- Improved assessment and management
- Access to information
- Involvement in decision-making
- Reduced burden of care
- Community capacity
Impacts & outcomes on health professionals & care providers

- Increase capacity of staff resulting from education
- New approaches to care planning
- Improved access to specialist services & resources
- Improved relations btn services
- Improved competence, confidence & self awareness
Impacts & outcomes on the health / care system

- Integration of new processes and models of care
- Establishment of new services
- Development of resources
- Impacts on hospitals
- Access to financial resources
- A change on attitude towards palliative care
- Improved partnerships
- Building the evidence base
Key findings

◆ Provision of primary palliative care in people’s home is possible but need resources e.g. training, guidelines, equipment etc

◆ Partnerships are fundamental to the provision of holistic, planned and coordinated care for people with palliative care needs.

Partnerships outcomes: multidisciplinary case conferences; care planning for end of life; competence and confidence of staff; targeting specific population groups

◆ Palliative care is core business for residential aged care
Access to sub-program information

- Project final reports
  - will be on Caresearch

- Care Planning projects
  - presenting at the conference (+ posters)

**Saturday**
*System & Service Development session:*
- After hours – Heather Tan
- Community-based – Sally Brown

**Sunday**
*Aged Care Workforce session:*
- Assessment of Pain – Angela Stones
- Care Planning tools – Penny Abbington
- Nurse consultancy – Naomi Winter
- Decision-making frameworks – Christine Ryan
- Linking providers to palliative approach – Penny West
Acknowledgements

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◆ DoHA Project Officers

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