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EDITORIAL	<i>Peter Thistlethwaite</i>	2
GUEST EDITORIAL	<i>Gerald Wistow</i>	3
KNOWLEDGE BASE	Using Project Evaluation to Build Capacity for Integrated Health Care at Local Levels <i>Shandell Elmer and Sue Kilpatrick</i>	6
FEATURE	Creation of a Care Trust: Managing the Project <i>Andrew Lavender</i>	14
COMMENTARY	Creation of a Care Trust: Managing the Project <i>Shane Hayward-Giles</i>	23
COMMENTARY	Creation of a Care Trust: Managing the Project <i>Edward Peck</i>	25
FEATURE	Mainstreaming Interprofessional Partnerships in a Metropolitan Borough <i>Dave Doyle and Michelle Cornes</i>	27
OVERVIEW	New Roles in Mental Health: The Creation of the Approved Mental Health Practitioner <i>Joan Rapaport</i>	37
CALL FOR PAPERS	Black and Minority Ethnic Communities and Individuals: Holistic Thinking and Integrated Care	47

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Using Project Evaluation to Build Capacity for Integrated Health Care at Local Levels

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ABSTRACT

Capacity-building evaluation featuring multi-disciplinary cross-agency workshops fostered continuous quality improvement, while focusing on skills required and systemic barriers to health care integration between GPs and a regional hospital.

KEYWORDS: INTEGRATION; EVALUATION; CAPACITY BUILDING; RURAL HEALTH

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Background

Rural regions in the developed world are experiencing pressures in delivering health care to the rising standard expected by those living there. These pressures reside in the challenges of workforce recruitment and retention, an ageing population, lack of critical population mass and increasing health care costs (Productivity Commission, 2005; Scottish Executive, 2005). Responses include expanded roles for health care professionals and service redesign, for example pre-admission clinics and patient care teams led by nurses and allied health professionals, and formal regional planning processes that work from the community hospital as a base for extended services, in Scotland (Scottish Executive, 2005). These

initiatives recognise that there are imperatives for rural regions to adopt an integrated approach that brings systems together to share knowledge and resources, over and above the advantages of an integrated approach to delivery of local health and social care – identified, for example, in Britain, as including organisational and cost efficiencies, greater capacity of patient advocacy and improved accountability (Integrated Care Network, 2004).

Integrated service delivery requires new ways of working that challenge traditional professional boundaries and existing organisational cultures. Cameron and Lart (2003), reporting a systematic review of research, found three recurring themes that caused problems in joint working: organisational, cultural and professional, and contextual. A shared approach to workforce and organisational development through capacity building can be expected to expand the resources available for health by improving communication and better integrated service/system development.

Bringing about sustained changes in people's behaviour and working environments requires engagement and commitment to the issue or goal. Structured learning opportunities that bring people from different disciplines and different services together are pivotal to achieving integration, especially through development of structures and processes to promote shared values and



understanding of other practitioners' skills (Cameron & Lart, 2003).

This paper reports the experience of using a project evaluation to build the capacity of health professionals to better integrate service delivery for patients transferring between hospital and community-based general practitioner care. The project was funded by the Australian Government's Department of Health and Ageing through the GP-Hospital Integration Demonstration Site programme and the Department of Health and Human Services (Tasmania). The evaluation provided an opportunity to involve the health professionals who participated in the project in a reflective, action learning cycle that extended the impact of the project, and better embedded joint working in the regional area.

The project

The project was a collaborative partnership of the hospital (located in a rural regional centre), a University Department of Rural Health and the local Division of General Practice (a federal government funded body for co-ordination of private GP services). The project was initiated by senior managers in the administrative section of the hospital and staff of the Division of General Practice, who approached the university to ascertain its interest in evaluating the project. This top-down initiative was planned to better integrate a variety of projects, new and existing, between the hospital and GPs, such as communication about hospital admission and discharge. A baseline assessment conducted at the commencement of the project revealed little evidence of joint planning, co-ordination or evaluation by those working on the ground in the sub-projects. Attempts to work in a multi-professional and cross-sectoral way were being thwarted by misunderstandings about professional cultures and lack of a systematic approach to patient care.

While health care integration is a widely used turn of phrase, there are various interpretations of integration in different health professions and

organisations (Alexander, 2001). Integration in this project was promoted as existing on a spectrum ranging from:

- linkage (informal relationship between service providers that is enacted as needed)
- collaboration (two or more services work together usually in relation to shared patient care for which there is usually formal or standardised information sharing)
- co-ordination (relationships between services are more formalised and there is evidence of shared planning, delivery and evaluation of care in relation to mutually agreed goals)
- integrated (characterised by pooled funding, sharing of resources and joint programmes) (Alexander, 2001; Leutz, 1999; Leutz, 2005; Reynolds *et al*, 2001).

These states of integration could be viewed as transitional stages, however; some health care activities may never achieve full integration, nor do they need to.

Capacity-building evaluation

The requirement for evaluation of this project stemmed from the contractual obligations with the Australian Department of Health and Ageing that required an evaluation for accountability purposes. As this project was part of a national demonstration programme, the Australian Department of Health and Ageing was also interested in the cumulative lessons learnt that would be generated from each of the GP-hospital integration demonstration sites. In addition to meeting these evaluation requirements, the evaluators from the University Department of Rural Health believed that a capacity-building approach to the evaluation would enhance the utility of the evaluation and the effectiveness of the project. After negotiation, the funding agency agreed to a capacity-building evaluation and, in this way, a 'top-down' evaluation imperative was combined with a focus on the learning needs of the 'on-the-ground' practitioners, a 'bottom-up' approach.



Capacity-building evaluation integrates evaluation with the activities of the project being evaluated. The approach is consistent with participatory action research facilitated by external agents (Selener, 1997), which can build the capacity of participants to identify and make changes, in this case changes that improve health care integration at local levels. A participatory evaluation is a collaborative approach that builds on the strengths and values contribution of all involved, focusing on learning, success and action. Incorporating evaluation with the development of new ways of working in a clinical environment has been found to be complex, and adds extra burdens for practitioners (Finch *et al*, 2003). Finch and colleagues note also that workability issues mean that such evaluations do not conform to the randomised control/gold standard designs which clinicians hold in high regard, which has been found to reduce the implementation of findings from these evaluations. However, inclusion of capacity building with project evaluation has a long and successful history in other fields (Lusthaus *et al*, 2000), including health promotion (Judd *et al*, 2001).

A feature of the capacity-building approach is that the evaluation process is ongoing, and includes ways to enable participants to learn from what is occurring and to incorporate these learnings into their integration initiatives. In this way, the evaluation occurs prospectively, not just at the end (Redfern *et al*, 2003). It recognises the progression of change, that is, change to knowledge, attitudes, skills and then behaviour (Public Health Agency of Canada, 1996). Thus, the evaluators were using a formative approach to evaluation:

to give information and assistance to people who are able to make changes to an intervention so that they can make improvements
(Øvretveit, 1998 p43).

Formative evaluations aim to contribute to knowledge and solve practical problems, and as

such they are one form of action research. The formative approach to evaluation was augmented by providing opportunity to increase knowledge and skills, thereby adding a capacity-building dimension.

A capacity-building evaluation approach is not only akin to participatory action research, it is also congruent with continuous quality improvement because of its collaborative approach and the achievement of improvement through incremental steps. The capacity-building approach to evaluation goes further, to include a focus on the skills required and the 'systemic' barriers to change (Senge *et al*, 2000). Capacity building assists through development of structures and processes to develop shared values and practitioners' skills. It requires a broader, systems-based view of research and evaluation. The aim of capacity-building evaluation is to assess and report a project's merit, worth, significance and present lessons learnt. The purpose is not to prove, but to improve.

Design

The objectives of the evaluation were two-fold: to evaluate the consolidated outcomes of the various GP-Hospital Integration initiatives (the top-down imperative) and to foster attitudes and behaviours of reflection, critical inquiry and collaborative action among participants responsible for health care integration activities (a bottom-up focus). The development of the evaluation plan occurred with reference to the reports resulting from the National Demonstration Hospitals Program (NDHP), with particular reference to Phase 3 which focused on integration, and other literature about the evaluation of integration programmes (Jackson & de Jonge, 2000; Alexander, 2001). The evaluators were also mindful that best practice evaluations should conform to four standards, according to the American Evaluation Association: utility, feasibility, propriety and accuracy (American Evaluation Association, n.d.).

A series of multi-disciplinary workshops were chosen as the most effective and efficient means



of conducting a capacity-building evaluation. The workshops were multi-disciplinary and cross-sectoral, in order to promote discussion about shared patient care. Each workshop offered skill development in research and evaluation methods as well as being relevant to participants' clinical practice. The workshop facilitators were members of the project team who had considerable experience in health and extensive networks at the demonstration site. Expert knowledge was also sought from representatives from centres with expertise in health care integration.

The workshops were designed to provide those involved in each of the sub-projects with knowledge and skills to support their implementation of good practice evaluation of integrated health programmes. The topics of the workshops included specific evaluation design features (Jackson & de Jong, 2000; Alexander, 2001) such as:

- inviting the collaboration of all stakeholders
- clearly specifying the purpose of the evaluation and ensuring it is understood by those involved
- designing the evaluation to reflect both the objectives of the national programme and the objectives for the demonstration site

- using a mix of qualitative and quantitative data relevant and useful to the stakeholders, and developing strategies to provide these data to those who require such information for decision-making at management and practitioner level
- devising the evaluation to cover multiple aspects of the integration initiatives, including evaluation of processes and outcomes of care from the perspectives of the hospital, GPs and patients
- developing clear links between the evaluation and quality improvement processes
- considering the ethical implications of the evaluation to ensure that the rights of participants (patients and practitioners) are respected and protected.

The capacity-building approach enabled participants to carry out change at a local level as a result of their evaluations, thus contributing to the continuous improvement of the integration processes. *Box 1*, below, provides an example. *Figure 1*, overleaf, shows how the shared reflective cycle that features joint evaluation and facilitates continuous improvement was overlaid on the more practical aspects of the shared learning process engaged in by members of the working party.

Box 1: EXAMPLE: PRE-OPERATIVE ASSESSMENT COMMUNICATION

We illustrate the impacts of capacity-building evaluation with the example of strategies used to assist GPs and hospital practitioners involved in the pre-operative assessment of patients. The pre-operative assessment clinic (POA clinic) identified the need for the hospital to receive information from GPs as part of pre-operative assessment. A working party was formed, consisting of the GP liaison officer, the project officer from the Division of General Practice, and representatives of the hospital patient information management systems, pharmacy and POA clinic.

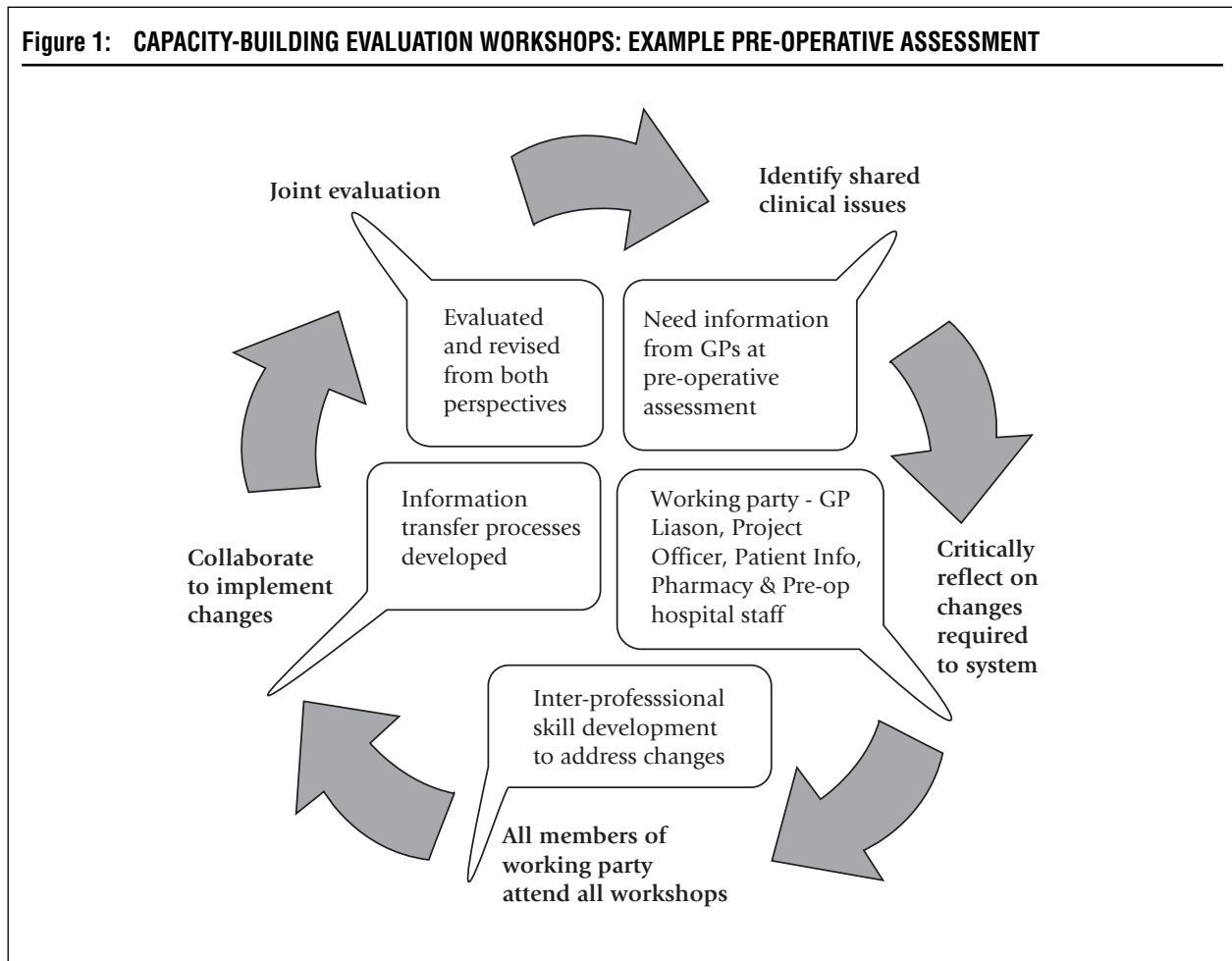
All members of the working party attended all workshops conducted as part of the GP-Hospital Integration project. Together they developed an information transfer process which took the form of a GP information transfer summary form that was made available to GPs as an electronic template. The working party conducted an audit of the use of the transfer summary forms by GPs to evaluate the initiative. In addition to the audit, GPs were surveyed in relation to their perceptions of the functionality of the process and the usefulness of the form. Since the evaluation was conducted jointly, the working party was able to use the findings to improve the information transfer process from the perspectives of both the hospital and general practice.



The joint evaluation strategies yielded mixed results and demonstrated the importance of evaluating the initiative from both perspectives. An audit of 50 GP information transfer summary forms found that 94% of the forms, designed to be used electronically, were hand-written. This finding was consistent with a survey of 40 GPs that showed only 30% found the electronic template easy to use (Figure 2, opposite). Low rates of use by GPs of electronic means for retrieval and transfer of patient information were also demonstrated by the audit finding that only 20% of GPs had added the GP electronic health summary, recommended by the working party as a key means of communicating information from the patient's medical record to the hospital.

Different perspectives and viewpoints gained from the audit and the survey are clearly

demonstrated in the following examples. The results of the survey of GPs shown in Figure 2 suggest that they viewed the information transfer process as an opportunity to focus primarily on the clinical needs of the patients prior to admission, with less emphasis on social needs or future needs, such as the home medicine review (HMR) post-discharge. This differed from the viewpoint of the POA clinic staff, who had hoped that the information gained would assist in the discharge planning process. From the audit it was unclear whether patients made an appointment with their GP before attending the POA Clinic (as was the intention), or left the form at the GP practice for completion. A much clearer picture was gained from the survey, which revealed that approximately 60% of those GPs surveyed reported that their patients had made an appointment.



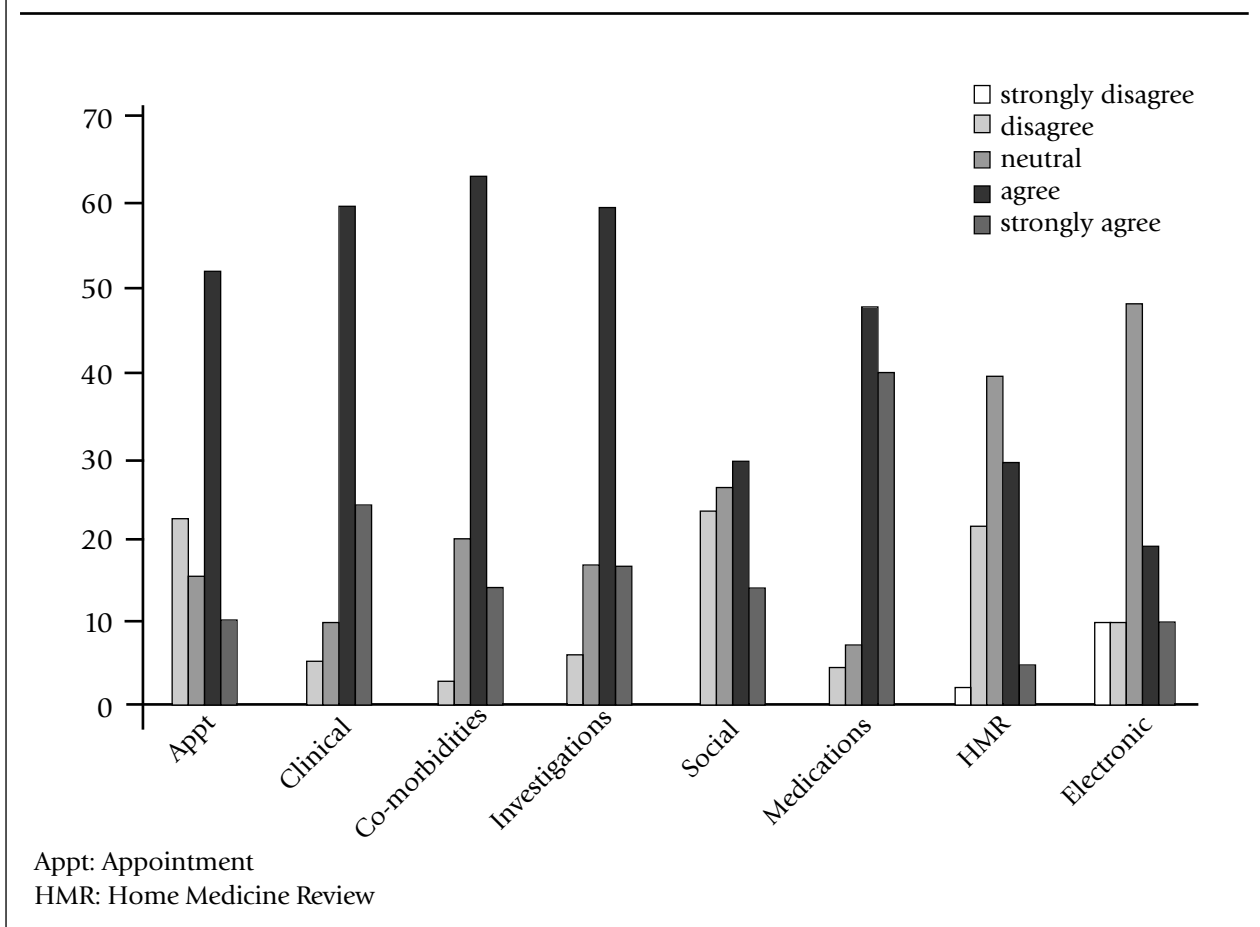


Following the audit, the working party reviewed the protocol for information transfer to narrow the cohort of patients for whom this process is necessary (for example, by excluding uncomplicated dental procedures). Clearer instructions were provided on the covering letter about the requirement for patients to make an appointment with their GP prior to attendance at the POA Clinic and to contact their GP with any queries about the process. The project officer from the Division of General Practice undertook to investigate ways to increase the uptake of electronic templates. The information transfer process continues to be monitored and evaluated by the working party, and the information received by the POA Clinic continues to yield useful information and the occasional gem or critical piece of information that would have otherwise been missed.

Results

The multi-disciplinary cross-sectoral workshops focusing on different elements of health care integration were attended by 88 health professionals from 37 different clinical or community settings. These opportunities for discussion with other health care service providers were both readily embraced and appreciated by participants. The workshops played an important role in engaging the participants and fostering development of solutions for locally identified clinical issues. The capacity-building process fostered attitudes and behaviours of reflection, critical enquiry and action among participants who were responsible for the integration programmes. This approach assisted participants in carrying out change at local levels as a result of their evaluations. Networks formed have been vital in sustaining

Figure 2: GP EVALUATION OF POA INFORMATION TRANSFER FORM (N=40)





integration efforts, which are continuing more than two years after the project's end, driven by health professionals working on the ground.

A critical limiting factor in bringing about sustained changes in people's behaviour and social and physical environments is the engagement and commitment of people to the issue or goal (King & Wise, 2000). The capacity-building approach adopted by this project was a crucial success factor, as it enabled the project team to engage senior managers and clinicians in the hospital and community setting in a meaningful way, which was particularly important as the project proposal was developed at the hospital's corporate level.

Conclusion

Education sessions such as this project's workshops ensure that health care integration remains on the agenda of relevant organisations. These workshops fostered a continuous quality improvement approach while focusing on skills required and systemic barriers to health care integration. The success of these workshops is evidence of the need and desire for shared education opportunities. The interdisciplinary focus is a powerful tool for developing an appreciation of cultures within disciplines as well as linkages between them. The capacity-building evaluation approach also built a sustainable process for future evaluation through capacity-building with the practitioners involved.

Participatory action research facilitated by external agents can build the capacity of participants to identify and make changes that improve health care integration at local levels. This project has shown that a capacity-building approach to research and evaluation can also mediate tensions between top-down initiatives and on-the-ground practitioners. Leutz's (2005) recent review of his five laws for integrating medical and social care points out that it is up to those with the authority to design an integration programme to hand out power and resources to empower people who share the goals of the programme to take the

integration forward. He also notes that all integration is local. A capacity-building evaluation approach is a practical expression of empowerment that can operationalise integration at the local level.

Key points for implementation

- A capacity-building approach to evaluation can mediate tensions between top-down initiatives and on-the-ground practitioners.
- Multi-disciplinary workshops play an important role in engaging the participants and fostering the development of solutions for locally identified clinical issues.
- Use a mix of qualitative and quantitative data relevant and useful to the stakeholders and develop strategies to provide these data to those who require such information for decision-making at management and practitioner level.
- Devise the evaluation to cover multiple aspects of the integration initiatives, including evaluation of processes and outcomes of care from the perspectives of institutions, practitioners and patients.
- Develop clear links between the evaluation and quality improvement processes.
- Consider the ethical implications of the evaluation to ensure the rights of participants (patients and practitioners) are respected and protected.

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