

Integrated Home and Community Care Monitoring & Evaluation Plan

Abbreviations

- C&C DHB – Capital & Coast District Health Board
- CCC – Care Coordination Centre
- CM – Care Manager
- CAP – client assessment protocols – triggered following assessment process using Interrai eg client at risk of institutionalisation
- E.H.R – Electronic Health Record
- FFT – future funding track
- HCP – Home & Community care Package
- HCQI – Health care Quality Indicators – calculated following assessment process using Interrai
- DAP – District Annual Plan
- RUG III /RUG grouper – Resource Utilisation Group, casemix measure for home & community services

Introduction

This document summarises the evaluation and monitoring plan for the Integrated Home and Community care Programme.

This evaluation and monitoring plan notes the outcomes expected and the benefits realisation corresponding to the following programme deliverables most of which are in place:

- Care Coordination Centre (established September 2005)
- Care Manager positions (established December 2005 and to be expanded through 06/07 to approx 20)
- Package of Care providers – (two providers established to date – provision will increase from 06/07)
- Older Persons service – (established 2005 though reduced Geriatrician capacity)
- Stroke service – (awaiting full establishment)
- Single assessment process using Interrai – (incrementally developing through 2006-2008)

The baseline for part of this evaluation is the 02/03 data analysed for the original ‘Supporting Document v1.2’, available at http://www.ccdhb.org.nz/planning/homecommunity/home_community.htm.

This analysis of service utilisation will be repeated with data from 03/04 onwards.

Note that 03/04 to 05/06 cover the programme development, consultation and establishment period.

For this evaluation the stroke baseline is 03/04 and baseline Interrai data will be taken from QTR 2 05/06 to QTR 2 06/07.

Outcomes - Process of Development

Development of the Integrated Home and Community Care model occurred through a number of processes, including, but not limited to:

- Consumer advisory and focus groups held during 2003/04
- Service development groups held during 2003/04
- Public consultation during 2004
- Involvement of DHB senior management (Integrated Care Steering Group) in approving and finalising the model and service specifications
- Final approval through C&C DHB Board and DSAC committees

The outcomes for the programme have been developed across a number of sources and processes, these include:

- Key statements from the Health of Older People Strategy (policy context)
- The C&C DHB vision statement and goals (DAP context)
- The development and consultation noted previously and review of approved Integrated Home & Community Care documents (consultation paper, Board paper, Supporting document v 1.2)
- Work completed by Stephen Jacobs (Ministry of Health) who provided assistance to develop some outcome statements and performance management measures for the programme (primarily related to consumers, Care Managers, Home Care Providers and the Care Coordination Centre). This included consultation and development work with key stakeholder groups, for example
 - Provider workshops
 - Funder workshops
 - DSAC workshop

Working drafts of the evaluation framework were reviewed and critiqued by Stephen Jacobs for quality assurance.

The monitoring and evaluation model has been developed to allow analysis by several specific interests, for example acute service utilisation by:

- Ethnicity
- Age group
- Domicile

In addition specific indicators such as ASH admissions for those seen through the programme can be tracked.

Note that all Interrai data can be analysed across ethnicity, domicile age group and chronic disease groups to establish the effect on addressing disparities and the impact of chronic disease.

For the purposes of this evaluation the outcome statement used from the Health of Older People Strategy is:

- Older people have timely access to integrated home and community health services that proactively improve and maintain their health and functioning (reworded from objective 6)

For the purposes of this evaluation, the C&C DHB vision and goals are also noted as outcome statements. (The goals are reworded to past tense to reflect an outcome)

- Better Health and Independence for People, Families, and Communities.
- Reduced disparity
- Reduced incidence & impact of chronic disease

Outcome statements developed with Stephen Jacobs:

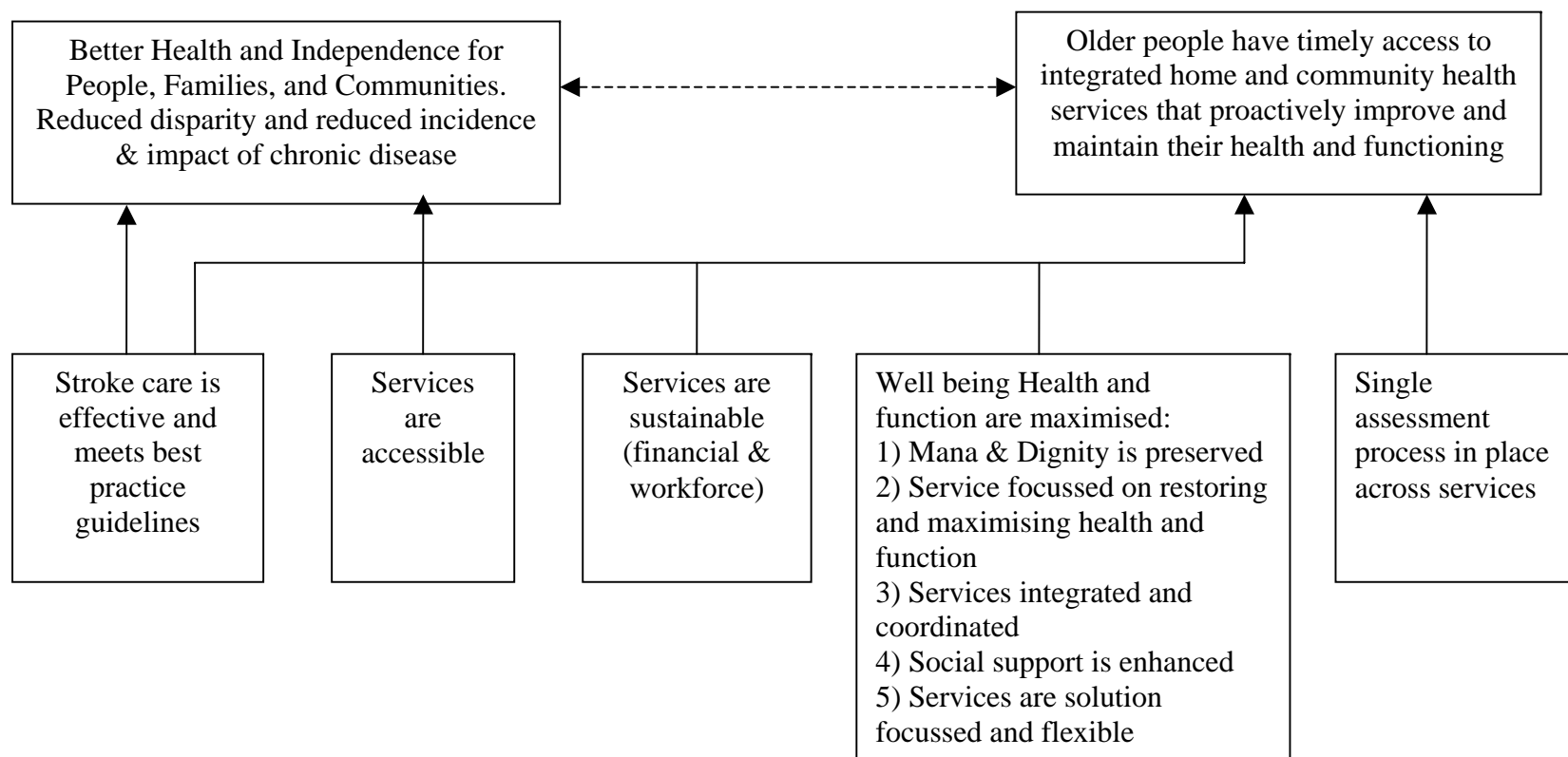
- Well being Health and function are maximised:
 - Mana & Dignity is preserved
 - Services focussed on restoring and maximising health and function
 - Services integrated and coordinated
 - Social support is enhanced
 - Services are solution focussed and flexible
- Services are sustainable (financial/workforce)

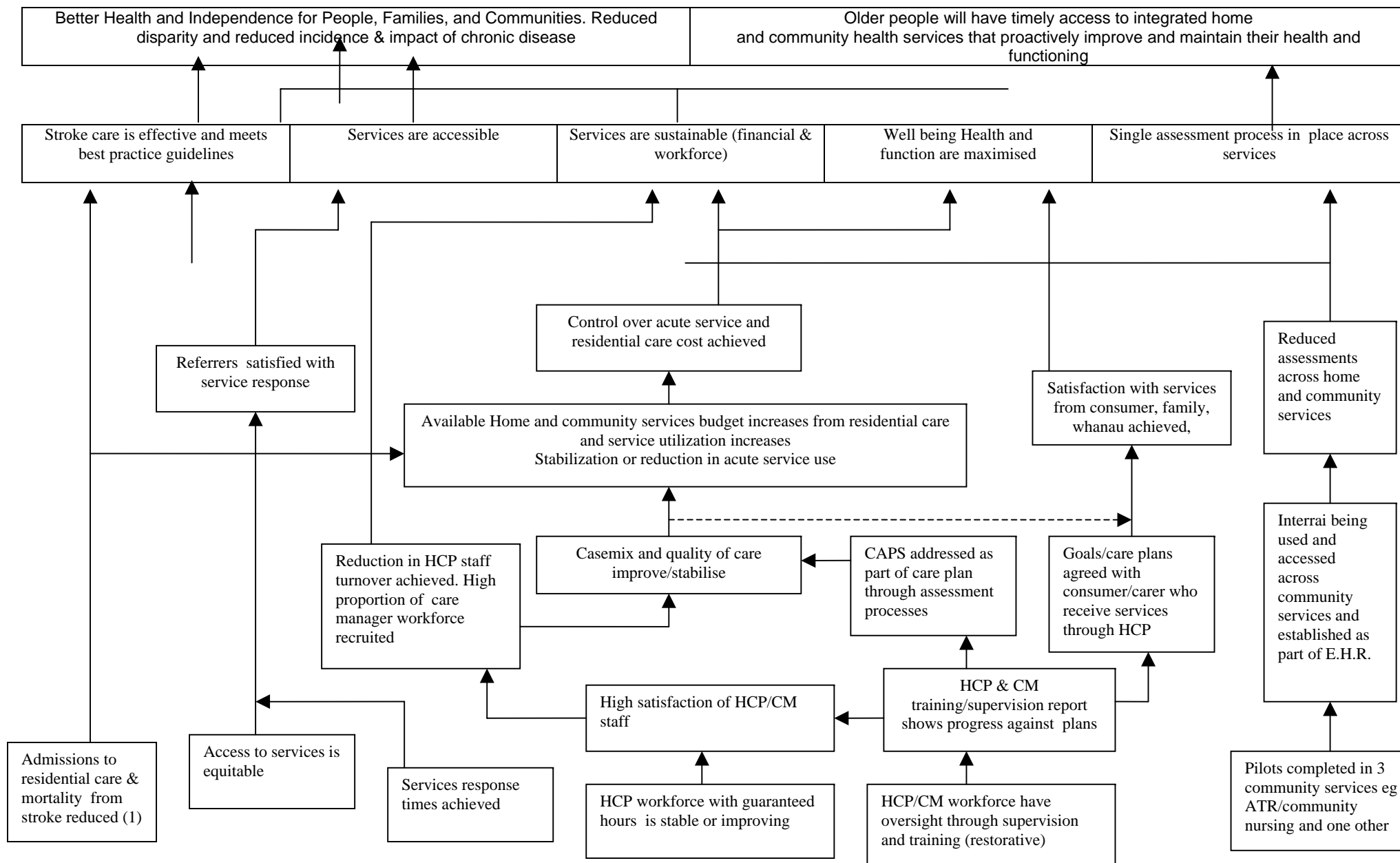
For the purposes of this evaluation the following outcome statements for the programme worded from approved C&C DHB papers have been used:

- Control over acute service and residential care cost achieved
- Satisfaction with services by consumer/family/whanau
- Single assessment process in place across services

Overall Outcome Chart

The relationship between the policy context of the Health of Older People Strategy and the C&C DHB context is depicted below. The high level programme outcomes are noted in the first diagram, intermediate ones in the second.





Note that the majority of outcome in the central portion of the diagram relate to the CCC, Care Managers and Home Care Package providers. Together these establish 'Restorative' approach to home based services i.e. the backbone of the programme.

Intermediate outcomes	Measure	Monitoring method	Frequency
Admissions to residential care & mortality reduced for stroke	20 fewer people admitted to residential care following acute stroke Between 20 and 30 fewer people die following acute stroke As per stroke SLA and service KPIs	Trends of discharge destination from HHS Mortality rate of stroke Through SLA for stroke service	Annual Annual See SLA for stroke service
Access to services is equitable	Referral rates comparable to C&CDHB ethnicity ratios Referral rates comparable to C&CDHB deprivation distribution	Report from CCC	6 monthly
Services response times achieved	% of response times achieved as per service specifications	Report from CCC Report from providers	6 monthly
Referrers satisfied with services (CCC)	85% of referrers satisfied according to surveys	Report from CCC	Annual
Reduction in HCP staff turnover achieved	10% improvement from 06/07 baseline	Report from providers on staff turnover	Annual
High proportion of care manager workforce recruited	90% recruited at any one time	Report from CCC on staff turnover	Annual
High satisfaction of HCP staff	85% of staff satisfied according to surveys	Report from providers	Annual
HCP workforce with guaranteed hours is stable or improving	% of HCP workforce with guaranteed hours is stable or improving	Report from providers	6 monthly
HCP/CM workforce have oversight through supervision and training (restorative/goal setting) and work within team approach	100% occurrence	Report from CCC/providers re: progress against supervision and training plans	Annual
Control over acute service and residential care cost achieved	5% control over acute service cost achieved 5% control over residential care cost achieved	Tracking of unplanned acute services use by clients seen through the programme Tracking of residential care expenditure over period of programme	Annual
Available Home and community services budget increases from residential care and service utilization increases	Evidence of available home and community services budget and service utilisation increasing independent of external funding ⁽⁴⁾ primarily via use of residential care funding	Analysis of home and community budget and internal transfer from residential care budget	Annual

Intermediate outcomes	Measure	Monitoring method	Frequency
Stabilization or reduction in acute service use	Evidence of stabilization/reduction in acute use % changes to HCQI W31 (Prevalence of hospitalisation/visit to ED since last assessment)	Tracking of unplanned acute services use by clients seen through the programme	Annual
		Tracking HCQI W31	Quarterly
Casemix and quality of care improve/stabilise	RUG groupers remain static or trend towards lower casemix overall HCQI indicators remain static or trend towards better quality	Tracking RUG groupers and HCQI's	Quarterly
CAPS addressed as part of care plan through assessment processes	100% achievement	Interrai software analysis	6 monthly
Satisfaction with services from consumer, family, whanau achieved	85% Satisfaction with services consumer/family/whanau	CCC/HCP provider consumer satisfaction survey.	Annual
Goals/care plans agreed with consumer/carer who receive services through HCP	100% of goals/care plans agreed with consumer/carer who receive services through HCP	Interrai software analysis	Annual
Reduced assessments across home and community services	20% reduction in assessments across home and community services	Portion of assessments from services that result in packages of care without re-assessment	Annual
Interrai being used and accessed across community services and established as part of E.H.R	Numbers of services/users who use interrai as core tool	Post implementation review	End 07/08
Pilots completed in 3 community services + one other	Completed pilots	Project closure reports	End 06/07

The table below notes the benefits realisation plan.

Intermediate outcomes	06/07	07/08	08/09
Admissions to residential care & mortality reduced for stroke			
Access to services is equitable			
Services response times achieved			
Reduction in HCP staff turnover achieved			
High proportion of care manager workforce recruited			
High satisfaction of HCP staff			
HCP workforce with guaranteed hours is stable or improving			
HCP/CM workforce have oversight through supervision and training (restorative/goal setting) and work within team approach			
Control over acute service and residential care cost achieved			
Available Home and community services budget and service utilization increases			
Stabilization or reduction in acute service use			
Casemix and quality of care improve/stabilise			
CAPS addressed as part of care plan through assessment processes			
Satisfaction with services from consumer, family, whanau achieved			
Goals/care plans agreed with consumer/carer who receive services through HCP			
Reduced assessments across home and community services			
Interrai being used and accessed across community services and established as part of E.H.R			
Pilots completed in 3 community services + one other			