Department of Health and Human Services
COMMUNITY HEALTH SERVICES

Tasmania

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Tasmania's Health Plan
Primary Health Services Plan
Program Evaluation Framework

15 November 2007

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1. Overview

Tasmania's Health Plan, released in May 2007, is supported by two detailed documents: a Clinical Services Plan and a Primary Health Services Plan (PHSP).

This reflects the structure of the Tasmanian Department of Health and Human Services (DHHS). The Acute Health Services Group is responsible for the delivery of hospital and ambulance services and most acute public hospital services are provided from the Royal Hobart Hospital, Launceston General Hospital, and the North West Regional Hospital.

The Primary Health Services Unit, within the Community Health Services Group, has responsibility for 24 community-based health centres, and regional services such as palliative care, various community services and youth health. It also has 19 small rural health facilities which provide inpatient care and some aged care, and act as a base for community health and domiciliary services. Fourteen facilities are DHHS-run and five facilities are DHHS-funded and run by other organisations.

The PHSP sets out a series of objectives[1] and overall outcomes[2] for service redevelopment into the future. These are listed in Appendix 1.

Tasmania's Health Plan is a road map for the development of all health services for the next 5 – 15 years. Both the Clinical Services Plan and the PHSP have developed implementation plans to guide activity in the short-to-medium term. These implementation plans, and other information on Tasmania's Health Plan may be found at http://www.dhhs.tas.gov.au/futurehealth

2. Why do we need an Evaluation Framework?

No matter what the size or complexity of the project or program,[3] it is possible to measure its success against the goal/s it set out to achieve.[4] The PHSP evaluation framework sets out the high level evaluation questions that can be applied across all projects. These questions fall into three categories:

Project questions

These questions investigate the way in which the project has been carried out. They are the first questions that can be answered as they are about the planning that goes on before new services are implemented.

- Have project outputs been delivered as outlined in the PHSP implementation plan?
- Has the delivery of these outputs facilitated achieving the objectives set out in the PHSP?
- Have the objectives facilitated achieving the desired outcome?

Process questions

These questions investigate the changes that have been made to the process of health service delivery and relate to project outputs. They are questions that can be answered within the first 12 months of service change occurring.

- What changes have been made in the service characteristics?
- What changes have been made in the linkages between services?
- What changes have been made in the way health service consumers experience these services?

Outcome questions

These questions investigate the changes that have resulted from new services or ways of delivering services and relate to project outcomes. They are questions that can only be answered some years after the service change has occurred.

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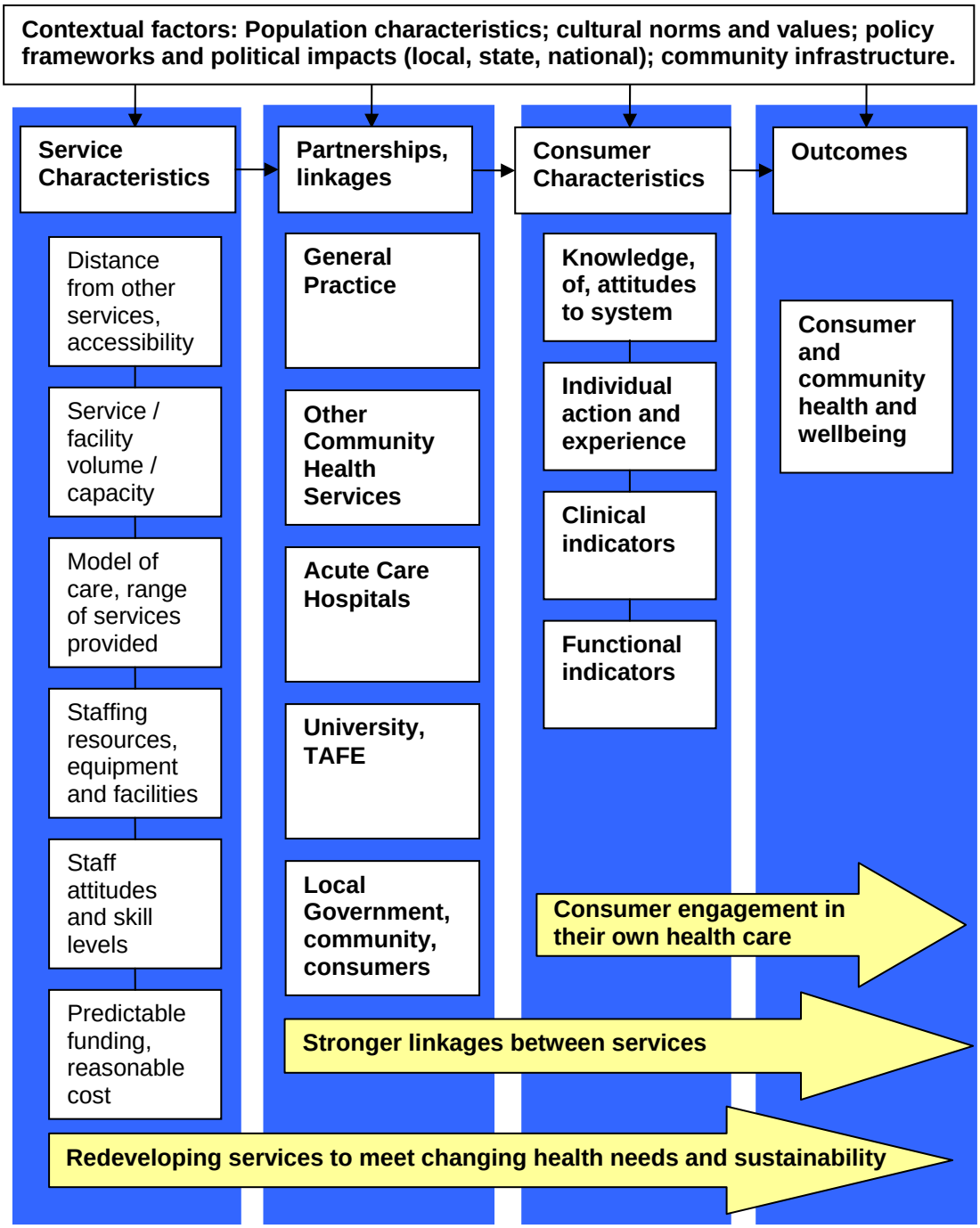
1 'Objectives' are the activities or processes carried out in the project or program.
2 'Outcomes' are the consequences or results of the program.
3 A project is a carefully defined set of activities that use resources (money, people, materials, energy, space, provisions etc.) to accomplish change. Programs are the name for a set of related projects.
4 More information on project evaluation can be found at http://www.egovernment.tas.gov.au/themes/project_management

- What evidence is there that this outcome has been achieved for consumers and communities?
- Are there any additional or unintended outcomes?

Program Logic

'Program logic' is an evaluation tool which identifies 'what causes what'. This evaluation framework uses program logic as a way of showing the expected effects of changes in activities or resources across all the PHSP projects. This is illustrated in Figure 1 below.

Figure 1. PHSP Evaluation Program Logic[5]



[5] This diagram was inspired by the program logic contained within the Australian Institute for Primary Care, *An Evaluation of the Primary Care Partnership Strategy Report 3*, December 2003. http://www.health.vic.gov.au/pcps/downloads/publications/pcp_eval_finalrpt03.pdf

3. Explanation and Data sources

The PHSP program logic links health service characteristics with partnerships, health consumer characteristics and health and wellbeing outcomes. The arrows represent the impact of the PHSP projects in redeveloping services, developing partnerships, and consumer engagement.

These are expected to have a measurable impact within their own domain (eg an increase in the number of services provided and or patient volume) prior to having an impact on other domains (eg an increase in linkages with other community health services) and will be influenced by others (eg consumer characteristics) before having an impact on outcomes.

Data sources have been identified for the contextual factors and each of the four domains (service characteristics, partnerships, consumer characteristics, and outcomes). While PHSP program logic covers all variables, the guiding principle for PHSP evaluation is economy. Not all data sources may be relevant to individual evaluations and just because we can collect information about an aspect of a service doesn't mean we need to do so in order to evaluate that service.

3.1. Contextual Factors

There are significant differences in the health status, community expectations, community infrastructure and policy frameworks across Australia. Collecting information on these 'contextual factors' provides one level of explanation as to why a policy output may or may not have the expected policy outcome. In the evaluation of an individual projects under the PHSP, contextual factors answer the question *'what other factors have impacted on project outputs and outcomes?'*

Basic **population characteristics** are the most important contextual factors. These provide a *benchmark* for Tasmania in relation to other jurisdictions. The most important of these would come from the questions posed by a population health surveillance system which, if established, could be mirrored at local health consumer level.

3.2. Service Characteristics

Service characteristics data is the most important source of evidence that *individual project outputs have been achieved*. Changes in service characteristics are relevant to a number of the PHSP objectives,[6] as well as to the success of individual projects.

- Unless the service is to be relocated, the **distance from other services** will not change, while **accessibility** may change based on the transport and other arrangements that are put into place. This data will answer the question *'is there an increase in health service accessibility?'*
- Unless the service is to be physically remodelled, **facility size** will provide parameters to the **volume** of clients passing through that service. This data will answer the question *'is there an increase in the volume of primary health services provided?'* Data sources include:
- **Model of care** data will provide evidence to answer the question *'is there an increase in the **range of primary health services** provided?'*
- **Staffing resources, equipment and facilities** data will answer the question *'is there an increase in the sustainability of the primary health services provided?'*
- Data on **staff attitudes and skill levels** will answer the question *'is there an improvement in the capacity of staff to delivery contemporary primary health services?'*
- Data on **predictable funding, reasonable cost** will also answer the question *'is there an increase in the sustainability of the primary health services provided?'*

[6] These are: (1) promoting the primary health approach, (2) implementing health planning principles, (4) the prevention and management of chronic conditions, (9) strengthening the health workforce, (10) safety and quality initiatives, (12) community transport and (13) infrastructure.

3.3. Partnerships and Linkages

No matter how well an individual primary health service may be operating, it will not be entirely effective in improving health and wellbeing outcomes unless it is part of a broader health care system. Information on service partnerships and linkages will answer the question *'is there access to adequate clinical and non clinical support?'* Changes in the frequency and quality of partnerships and linkages are relevant to a number of the PHSP objectives,[7] as well as to the success of individual projects.

- Data to answer the question *'is there an effective relationship with **general practice**?"*
- Data to answer the question *'is there an effective relationship with **other community health services**?"*
- Data to answer the question *'is there an effective relationship with **acute health services**?"*
- Data to answer the question *'what on-gong training is available to staff?"* will pick up staff uptake of orientation/ training/ upskilling/ professional development activities both internal to the organisation and provided through **University and TAFE** college.
- Data to answer the question *'what on-gong local relationships have been established?"* will pick up partnerships with **local government, community and consumers**.

3.4. Consumer Characteristics

The existence of a well functioning health care system can only improve health and wellbeing outcomes within the parameters achievable by the individual health care consumer. As population characteristics provide a jurisdictional context, so do consumer characteristics provide a health service context. Information on consumer characteristics will answer the question *'what impact do consumers have on their own health and wellbeing outcomes?'* Changes in consumer characteristics are relevant to community participation objectives of the PHSP as well as to the success of individual projects.

- Data on the **knowledge of and attitudes to the health service system** will answer the question *'what kind of understanding do health consumers have of the health system?'*
- Data on the **individual action and experience** of consumers will answer the question *'what kind of engagement do health consumers have in their own health care?'* Data elements include:
- Data on individual **clinical and functional indicators** of health and wellbeing will indicate where the group of health consumers in question sit in relation to the benchmark population characteristics.

3.5. Health and Wellbeing Outcomes

Health and wellbeing outcomes are mediated by contextual factors such as population characteristics, health service characteristics, the partnerships and linkages across the health care system and the characteristics of the individual health consumer. The measurement of health outcomes, while problematic, is undertaken at a national[8] and international level.[9] The measurement of health and wellbeing outcomes amongst specific populations assist in answering the questions *'what worked well? what could be improved?'* in the context of long-term policy change.

As noted in a number of Australian Coordinated Care Trials, service improvements may not be able to show an improvement in the health of a particular population, due to continued ageing and disability levels, quality

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[7] These are: (3) implementing a tiered service delivery model, (5) general practice integration, (7) communication and collaboration between service providers and (11) education and training.

[8] Interstate examples include the South Australian Population Research and Outcome Studies Unit http://www.health.sa.gov.au/PROS/Default.aspx?tabid=1 which provides information on health status, related risk factors, behaviours, determinants and satisfaction with health services among the South Australian population; the Victorian Public Health Branch http://www.dhs.vic.gov.au/rrhacs/publichealth.htm which provides health and wellbeing monitoring and surveillance.

[9] International examples include the Health Council of Canada (2007) *Health Care Renewal in Canada: Measuring Up?* http://www.healthcouncilcanada.ca/docs/rpts/2007/HCC_MeasuringUp_2007ENG.pdf ; the UK National Institute for Health and Clinical Excellence (2005) *Measuring Impact: Improving the health and wellbeing of people in mid-life and beyond* http://www.nice.org.uk/download.aspx?o=518183.; and the US National Information Center on Health Services Research and Health Care Technology (2004) *Health Outcomes* Core Library Project http://www.nlm.nih.gov/nichsr/corelib/houtcomes.pdf .

of life and wellbeing may improve.[10] While population characteristics may be expected to reflect these changes over time and there are a range of instruments which may be applied in this context.

4. Applying the PHSP Evaluation Framework

The PHSP evaluation framework provides a level of coordination across all PHSP project evaluation so that learning gained from any individual project contributes to the lessons leant across all projects.

In order to achieve this goal, each PHSP evaluation project will be developed within the parameters of the evaluation framework described in this paper and will be approved by the PHSP Implementation Steering Committee prior to commencement.

This common framework (program logic model/theory of long-term change in population health outcomes) allows for development of project-specific content (eg data items such as indicators and measures for shorter-term outputs) for individual projects. An example is provided in Appendix 2.

Evaluation Timing

Baseline data should be collected prior to the service intervention/introduction of the new service model.

Outputs can be evaluated via a 'snapshot' of comparative data collected within 12 months of the new service/intervention. A follow-up snapshot may be collected in the following 12 months, for additional evaluation of service outputs.

Outcomes can only be evaluated after a number of years and their effects are subject to the range of contextual factors. These may be detected in the on-going population health monitoring processes described above.

Evaluation Roles

Individual projects will establish an evaluation team (containing internal and external members). External members may consist of consultants from outside the Department of Health and Human Services and individuals representing such key stakeholders as general practice.

The Community Health Reform Unit will provide the following (as required):

- an overview of evaluation and its utilisation;
- face-to-face support at key points; ongoing availability through email and telephone; and
- over time, workshops for reflection on the evaluations, learning opportunities and potential future strategies

[10] Smith, B. McElroy, H. Ruffin, R. Frith, P. Heard, A. Battersby, M. Esterman, A. Del Fante P. McDonald, P. The effectiveness of coordinated care for people with chronic respiratory disease, *MJA* 2002 177 (9): 481-485; Shannon, E., Franz, S. Hyland, J. Ryan, B. *Final Report of the Careworks Local Evaluation*, March 2000.

Appendix 1. PHSP Themes, Objectives and Outcomes

Objectives (PHSP page numbers)	Outcomes
1. The Primary Health Approach (p. 51)	
To promote the primary health approach • a focus on health and wellbeing, not just illness; • a population perspective on health, not only for individuals; • a multi-disciplinary team approach to care; • a partnership approach in which a range of groups and organisations need to work together on improving health; • a focus on actual health needs, such as chronic disease, rather than service needs; and • fostering individuals' control over their health and participation in health decision making.	Services that promote the primary health approach, contributing over time to improved health and wellbeing outcomes in the Tasmanian community.
2. Health Planning Principles (pp. 51-53)	
The objective of this project is to promote and apply health planning principles. 1. The services provided by Tasmania's primary health services should be: • accessible as close as possible to where people live provided they can be provided safely, effectively and at an acceptable cost; • appropriate to the community's needs; • client and family focused; • designed for sustainability; • integrated with the other elements of the health service system; • focused on health promotion, illness prevention and early intervention; and • delivered in a culturally appropriate manner. 2. Where services cannot be delivered safely, effectively and at an acceptable cost from within local communities, access to services should be facilitated through service coordination, the provision of outreach services from an external base, the use of technology, transport assistance and other appropriate community support.	A primary health system that better meets the changing needs of the Tasmanian community.
3. Service Delivery Model (pp. 53-57)	
Develop consistency across Community Health Centres around the state; develop consistency across service provision arrangements around the state between primary and acute care services; develop Integrated Care Centres (ICCs) around the state.	A tiered service delivery model establishing an integrated network of primary health services will provide a sustainable service system for Tasmania.
4. The Prevention and Management of Chronic Conditions (pp 58-60)	
Introduce service change in community based health services; introduce a multi-disciplinary team approach to action around chronic disease (with general practitioners).	Each health centre to have a role in working with key stakeholders and the local community to design and implement programs to support healthy life conditions and choices, and address local causes of illness and injury.
5. General Practice Integration (pp. 60-61)	
Develop a closer, more effective, working relationship with general practice	A new relationship between general practice and the Department will be established that better supports the sustainability of the sector and provides additional capacity to respond to the challenges of chronic disease.

Objectives (PHSP page numbers)	Outcomes
6. Rural Health Centres (pp. 61-62)	
Redevelop specific rural health sites; support emergency response in rural areas	A changed and enhanced role for rural health centres will be implemented to ensure these services better meet the needs of the Tasmanian population and their local communities.
7. Communication and Collaboration between Service Providers (pp. 62-67)	
To improve coordination across the primary and acute service sectors; strengthen multi-disciplinary, inter-sectoral, clinical support arrangements; strengthen links between a range of DHHS services and general practice; develop closer links between primary health and alcohol and drug services; extend primary mental health services through partnerships; strengthen linkages with local government and integrate population health approaches into primary health services.	Improved communication and collaboration between service providers
8. Community Participation (pp. 67-68)	
Community participation and involvement will be developed at project level.	Strengthen community participation in primary health services. Encourage an increased sense of involvement in personal health maintenance and treatment.
9. The Health Workforce (pp. 68-69)	
To strengthen the sustainability of general practice in Tasmania; strengthen retention and development of the primary health workforce; further develop the primary health nursing workforce; develop a range of new workforce models in primary health.	Sustainability of the health workforce, including a long term strategy to link Tasmania's workforce needs to healthcare education and training and research
10. Quality and Safety Initiatives (p. 69)	
To strengthen the safety and quality of primary health services	That sites have appropriate access to clinical support services, an appropriately skilled and available workforce, equipment, suitable facilities and appropriate capacity to maintain clinical standards
11. Education and Training (pp. 69-70)	
To expand the range of teaching sites in primary health; strengthen links and expand the scope of education and research in primary health	The Department will work with the University of Tasmania and other educational providers to provide sustainable health workforce training and development, including a commitment to vocational, undergraduate and postgraduate student placements in primary health care and multidisciplinary settings
12. Community Transport (pp. 70-71)	
To strengthen community transport	Access to community transport will be improved
13. Infrastructure (pp. 70-71)	
	Facilities will be located and designed for accessibility of clients, adaptable to appropriately house relevant services, established to integrate with other providers and community groups, and networked to support efficient provision of services across client catchments.

Data availability will vary at individual project level. The following list provides indicative examples of the kind of data that may be collected to evaluate under each of the program logic categories. Project level decisions are required as to which data is most relevant to that service evaluation.

Contextual Factors (sources)

Population Characteristics:

- Overall size and distribution of population (Australian Bureau of Statistics Census)
- Ageing, disability profile (Australian Bureau of Statistics Census)
- Population projections (Australian Bureau of Statistics)
- Data from population health surveillance systems (at present Tasmanian population health data is largely derived from national surveys such as the triennial Australian Bureau of Statistics National Health Survey and are at whole-of-state level only).
- Annual data on mortality and hospitalisation available at Local Government Area (These are currently used as proxy measures of population health and wellbeing in Tasmania. This approach has significant limitations.)

Service Characteristics (sources)

Distance from other services,[11] accessibility:

- Information on transport options available for clients (Home and Community Care, acute hospitals, local government)
- Client perceptions of accessibility (sampled through interview or questionnaire)

Service/facility volume/capacity:

- Service utilisation data (changes in the number of clients accessing services, number of occasions of service, number of hours of service). This may include an increase in activity in adjacent sites if some services are no longer offered by the new model of care. (Community Health Information System).

Model of care, range of services provided:

- Service provision data (changes in the scope/spread of services) illustrated through comparing the previous model of care to the new model of care. This may include changes in the type of new client admissions or discharges to services. (Community Health Information System).
- Percentage of service budget spent on particular services (eg health promotion activities) as compared to the baseline budget split – 'money-mapping the investment pattern in services. (Finance One)

Staffing resources, equipment and facilities:

- Data on whether the service is experiencing staffing difficulties or maintaining a stable level of adequate staffing ie is the levels/type of leave taken (or not taken) indicative of a high stress environment (eg above average levels of sick leave accessed and/or annual and/or long service levels that are above 'manageable leave levels'; how many shifts have been filled by locums or not backfilled when leave is taken due to staffing shortages; what proportion of staff are resident in the area of the service? (Human Resource Empower System)
- Facility and equipment assessment data: are these adequate to provide expected services? (Facilities Management)

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[11] In assessing the sustainability of services for the Primary Health Services Plan, distances from other services are described as:

- Close if it takes less than 60 minutes to drive to a major regional hospital
- Accessible if it takes between 60-90 minutes to drive to a major regional hospital
- At some distance if it takes between 90-180 minutes to drive to a major regional hospital
- Remote if it an be only reached by air or takes more than 180 minutes to drive

Staff attitudes and skill levels:

- Changes to the capacity and capability of staff to deliver contemporary primary health services as indicated by changed work practices – data from a case file audit to determine answers to questions such as 'what proportion of clients have their smoking status recorded?' (case audit).
- Data indicating a strengthened safety and quality system (as indicated by a site audit of EIMS data).
- Data indicating changes to the perception of service redevelopment (eg staff satisfaction levels).

Predictable funding, reasonable costs:

- Financial data indicating fewer service budget over-runs as indicated by annual financial reports. (With an understanding that services offering respite and palliative care services may show greater variation than average).

Partnerships, Linkages (sources)

With general practice:

- Service referral data (from/to general practice) from a case file audit, focus group or questionnaire information.

With other community health services:

- Service referral data (from/to community health services) from a case file audit, focus group or questionnaire information.

With acute care hospitals:

- Service referral data (from/to acute care hospitals) from a case file audit, focus group or questionnaire information.

With University, TAFE:

- Staff uptake of orientation/ training/ upskilling/ professional development activities (as reported by staff questionnaire, external data sources).
- Percentage of staff provided with training, satisfaction with training (questionnaire)

With local government, community and consumers

- Local relationships in place (as reporting by staff questionnaire, external data sources).

Consumer Characteristics (sources)

Knowledge and attitudes (system-level):

- Consumer survey data indicating changed understanding of health service delivery, levels of satisfaction with health service delivery.

Action and experience (individual level):

- Changes in the numbers of clients participating in chronic disease management programs etc. (case audit)

Clinical indicators:

- Random clinical client record audit, consumer questionnaire.

Functional indicators:

- Random clinical client record audit, consumer questionnaire.

Health and Wellbeing Outcomes (sources)

Population characteristics may be expected to reflect these changes over time:

- Data from population health surveillance systems
- Annual data on mortality and hospitalisation available at Local Government Area