Central Highlands Division of General Practice Ltd

CENTRAL VICTORIAN HEALTH ALLIANCE

Bendigo & District GP DIVISION OF GENERAL PRACTICE

QUALITY FEEDBACK BETWEEN GENERAL PRACTICE AND OTHER PRIMARY CARE PROVIDERS: A KEY COMPONENT OF A COORDINATED CARE SYSTEM

MOUNT ALEXANDER SHIRE COUNCIL

MT ALEXANDER HOSPITAL CASTLEMAINE
Quality, Care and Commitment

QUALITY FEEDBACK BETWEEN GENERAL PRACTICE AND OTHER PRIMARY CARE PROVIDERS: A KEY COMPONENT OF A COORDINATED CARE SYSTEM

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PROJECT FUNDING DETAILS

The Department of Human Services funded this project through a one-off grant - *Service Coordination With General Practice - Small Grant*.

These funds were made available for a number of small-scale projects to support General Practice engagement through Primary Care Partnerships PCP(s). This funding was specifically aimed at building on work already underway with General Practice in relation to implementation of Service Coordination.

In addition, the Department requested that participating General Practices complete the University of Melbourne GP integration index. Specific additional one off funding was provided to offset costs for GPs completing the index.

This project was part of the Central Victorian Health Alliance Service Coordination Sub-Committee – General Practice Integration Working Group's projects and tasks. Accountability was to the Central Victorian Health Alliance Board through the Service Coordination Sub-committee via the Project's reference group.

The Project was managed and implemented by a reference group comprising:

Integration Health Manager - Central Highlands Division of General Practice
Program Manager - Bendigo and District Division of General Practice
Outreach Nursing Services Manager – Mt Alexander Hospital
Service Coordination Project Manager - Central Victorian Health Alliance

Agencies initiating the feedback were Mt Alexander Hospital and Mount Alexander Shire. All 6 General Practices in the Mount Alexander Shire were possible recipients of the feedback.

Mount Alexander Shire was the fund holder for this project.

REPORT

This report was written by Central Victorian Health Alliance in collaboration with the Project's reference group. All Small Grant Projects used a RE-AIM framework for their reports.

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PROJECT SUMMARY

Central Victorian Health Alliance (CVHA) has focused on enhancing Feedback Systems as a major part of its service coordination work. The 2 main reasons for this have been:

- After consultation, General Practitioners, General Practice staff, Service Providers and Consumers identified improving feedback as priority work
- During the course of CVHA Service Coordination projects and tasks, it became clear that the Feedback Process was a separate process from the Referral Process. The Feedback Process was the key link between other service coordination processes:
    - Referral and Assessment
    - Assessment and Multi-disciplinary (discharge and community) Care Planning

Enhancements sought to address issues of "chasing information", "duplication of workloads", "not knowing" or "feeling kept in the dark", receiving "glib" or "useless tick box" information and having poor or reduced patient/client management outcomes due to lack of feedback.

The project sought to improve both the quality and quantity of feedback episodes to General Practitioners as well as to other referring Service Providers. The CVHA Feedback project was extremely successful in meeting these objectives. Most participating General Practitioners, Service Providers, and Consumer Reference groups received the project positively. The feedback information in the *Assessment Outcome* section was highly valued.

Developing "quality" feedback practices and systems was the emphasis and major element of the project work. The project set out to develop and trial a number of elements essential for a Quality Feedback System:

- A set of "quality" feedback criteria
- A Feedback Process that described the practices and pathways that integrate the "quality" feedback criteria and avoided over / under feedback practices
- Inter-agency Feedback Protocols that promoted "quality" feedback practices
- A feedback form:
    - That enabled or prompted "quality" and tailored feedback content
    - That met the format criteria identified by Service Providers:
        - Its applications support the multiple feedback processes / pathways
        - It is a one page form for these multiple applications
- Other tools and resources that supported the Feedback Process:
    - Training tools
    - Information Kits
    - Support personnel or lead staff / trainers

Service Providers generally embraced and "owned" the Feedback Project. It was viewed as a Quality Assurance activity – aimed to improve patient/client health outcomes. Via the new Feedback Process, staff undertook the responsibility for informing other Practitioners who were working with a mutual patient/client: staff tailored feedback; sent relevant information. Participating services noted a culture change from "not another form" to "how can we make it work for the patient/client". The form was easy to complete and prompted useful content.

122 known written feedbacks were sent to 16 GPs in the 2 month trial audit period by 3 Aged Care Services: Home Nursing (including District Nursing, Palliative Care, Post Acute Care), Aged Care Assessment Service and Home and Community Care Service. Many General Practitioners stated that feedback information was most useful for the patient's "next visits".

Service Providers stressed that it was the "process" and not the form that was the focus of the project: this needs to be the focus with future implementation. The area where the project did least well was with the intra-agency integration of the CVHA Feedback Protocols. Opportunities were needed for staff to discuss and develop local implementation practices. This, and local support, needs to be incorporated into future implementation strategies.

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SUMMARY RECOMMENDATIONS

The CVHA Service Coordination Feedback Project Reference Group makes the following implementation recommendations. It is recommended that CVHA and member agencies:

1. Maintain a quality feedback process (written content and practices)
    - Use the "quality" criteria developed by the project reference group as the foundations for CVHA feedback practices
    - Integrate "quality"' criteria into the CVHA feedback process
    - Link / integrate the "quality" criteria into other service coordination processes
    - Review the criteria to ensure meaningfulness, applicability and workability of the feedback process over time
    - Use the criteria as indicators or measures of quality practice when evaluating or reviewing the process
2. Ensure Intra-Practice or Intra-Agency systems are in place to maintain functionality, applicability, and workability of feedback practices
    - Integrate the "quality" practices into Practice / Agency Policy and Procedures
    - Practices / Agencies identify their own capacities to implement feedback to other Practices / Agencies, and plan strategies to implement the process
    - Internal support personnel or lead workers be identified to implement the process
    - Implementation working group or discussions group opportunities be in place to problem solve local implementation issues as they arise
    - Internal review / evaluation processes planned or in place at implementation
    - Bring implementation issues to the Service Coordination Implementation and Workforce development working group to ensure CVHA practice consistency
3. Ensure Inter-Practice /Agency systems are in place to maintain quality practices
    - "Quality" criteria for feedback practices embedded in the CVHA Inter-Agency / Practice Feedback Protocols
    - Review / evaluate the implementation process with other services in the natural team or network. Brainstorm / problem solve implementation issues; bring implementation issues to the Service Coordination Implementation and Workforce development working group to ensure CVHA practice consistency
4. Implement the CVHA Inter-Practice / Agency protocols
    - "Quality" criteria for feedback practices embedded in the CVHA Inter-Practice / Agency Feedback Protocols. This includes telephoning with urgent feedback
    - Protocols articulate that following assessment/change, there is a responsibility to inform other multi-disciplinary team members e.g. referrer, GP, Key worker
    - Review the Feedback Protocol with local teams after initial implementation
5. Implement the feedback process using the *CVHA Feedback Form* as the common feedback tool to either (a) request for feedback or (b) initiate sending feedback.
    - Implement the *CVHA Feedback Form* in its current format as:
        i. Core feedback information is all on the one form, i.e. referral acknowledgments; first assessment and reassessment outcomes
        ii. This format is preferred by GPs, Service Providers and Consumers
        iii. Attach additional information to the form if required.
            - Some Service Providers have stated that they would like to attach some of their existing documentation, i.e. The *CVHA Feedback form* is viewed as a part A and their specific documents are like a part B to the feedback form
    - Recommend this one page multi-purpose format to DHS and GPDV for quality feedback applications: assessment outcomes integrate patient/client care plans
    - *CVHA Feedback Form* to be modified:
        i. <u>Immediately</u> to include some minor changes eg
            - Prompt section if [urgent] verbal feedback has been given

    - Section made available for Agency logo
  ii. Following future evaluations, as issues are identified

6. Ensure a review (or tracking) of the Feedback Process implementation (quantity and quality of feedback episodes)
   - Develop or enhance IT tracking or auditing systems (for audit of feedback at the points of referral/first assessment and re-assessment/re-view/exit). It is outside the capacity of services to undertake this IT work (see IT resources recommendation 7). Services can however undertake manual audits over a pre-set period of time.
   - Review implementation initially regularly within the first year until full implementation, then annually:
     i. Set evaluation measures to "quality" criteria. Being proactive in promoting and frequently monitoring for "quality" feedback.
     ii. Be proactive in avoiding and frequently monitoring for over-feedback practices. Problem-solve and adjust feedback pathways to address this issue.
       - Develop a pathway that focuses on decision making about feedback to GPs in instances where a multi-disciplinary plan exists e.g. a discharge plan which includes Post Acute Care services
       - Re-enforce the use of goal "end dates" in training to ensure that when care is traveling a routine/anticipated path that multiple steps can be documented in one feedback e.g. assessment and planned exit information
     iii. Adjust the CVHA pathways and protocols, and the *CVHA Feedback Form* to meet the needs of the majority of senders and receivers.

7. Explore IT resources and opportunities required for e-communications and develop systems integrations based on agency and software capabilities / capacities. IT systems integration was outside the capacity of this project. There needs to be further work with the Department of Human Services on IT feedback standards. These standards include:
   - IT capacity to audit feedback at the points of:
     i. Referral/first assessment
     ii. Re-assessment/re-view/exit

     The audit information needs to allow for feedback to be sent to more than one individual/service per feedback. It should include:
     i. Date[s] of feedback[s]
     ii. Who the feedback[s] was sent to
     iii. How the feedback[s] was sent
   - IT capacity to address functional integration issues:
     i. IT capacity to exchange feedback information to the receiver's data (patient management software)
     ii. IT capacity to link to multi-disciplinary care planning
     iii. IT software integration of form: auto-populate fields
     iv. IT auditing at all feedback points (referral, first/re-assessment)
     v. IT capacity to incorporate extra forms that may be attached
   - Messaging standards for e-communications for feedback. Standards need to focus on "quality" meaningful content for both GPs and Service Providers.
     i. Issues, goals and planned action.
     ii. Target dates (exit dates)

     It is recommended that standards address points feedback on the continuum:
     i. Referral/first assessment
     ii. Re-assessment/re-view/exit
   - IT Systems Integration (receiver and sender)
     i. Capacity of the of IT system to work within established workflow practices.
     ii. Integration of communications systems to be a seamless component of the overall system: introduced systems should ensure interoperability
     iii. The introduced systems should include a ' Quality of Service' aspect where some assurance is given that the messages are actually delivered to the intended recipient.

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Systems Integrations: A Framework For How To Make Feedback Work

Goal: To enhance General Practice / Primary Care Agencies Feedback systems
Why? Feedback was a priority for General Practice, Service Providers and consumers

Systems Integration: Feedback is a separate process from, yet key link between other processes:

1. Referral and assessment
2. Assessment and multi-disciplinary (discharge and community) care planning

Assessment Outcome details were highly valued as tailored "quality" feedback information by General Practitioners, Service Providers and consumers:

- i.e. Record of: issues /diagnosis; goals; target dates; planned action
- Details integral to the receiver's patient /client management

Enablers

How To Develop A "Quality" Feedback System:

Develop Inter-Practice/Agency systems:

- "Quality" feedback criteria defined
- Feedback Process - define practices & pathways that support the process
- Inter-Practice/Agency Protocols
- CVHA common inter-Practice /Agency feedback form (1 page)
- Other tools / resources / support e.g.:
  - Training resources
  - Information Kit
  - IT capacity to exchange feedback information to the receiver's data (patient management software)
  - IT capacity to link to multi-disciplinary care planning

Develop Intra- Practice/Agency systems:

- Internal Feedback Policies and Procedures to support the Inter-Practice/Agency Protocols
- Internal implementation practices
- CVHA multi-purpose feedback form
  - Request /send feedback
  - Add own attachments
- Other tools / resources / support e.g.:
  - Orientation Kit
  - Personnel / lead staff
  - IT software integration of form: auto-populate fields
  - IT auditing at all feedback points (referral, first/re-assessment)

How To Promote Enabling Practices (intra and inter Practice/Agency practices):

Provide opportunities to explore benefits

- Combined agency planning
- Patient / client benefits e.g.
  - Informed management
  - Improved health outcomes
  - Not the "lay" messenger
- Practice/Agency benefits e.g.
  - Common format – easy to scan; links to care planning
  - Sharing of relevant information
  - Reduces "chasing", "not knowing"

Develop good communications

- Plan well - Clarification of roles, tasks and practices re the feedback process
- Discussions re internal implementation

Understand implementation requirements

- Capacity to undertake new process
- Clarify training and support needs
- Opportunities to discuss needs/issues

Develop "Ease of Information Flow"

- Build on existing workable practices
- Clarify "when to/not to" feedback
- "Quality" criteria ⇨ meaningfulness
- Training and information support
- ICT systems to support the process

Develop positive relationships

- Build on / link meaningful co-activities
- Opportunities to share experiences
- Opportunities to review the process

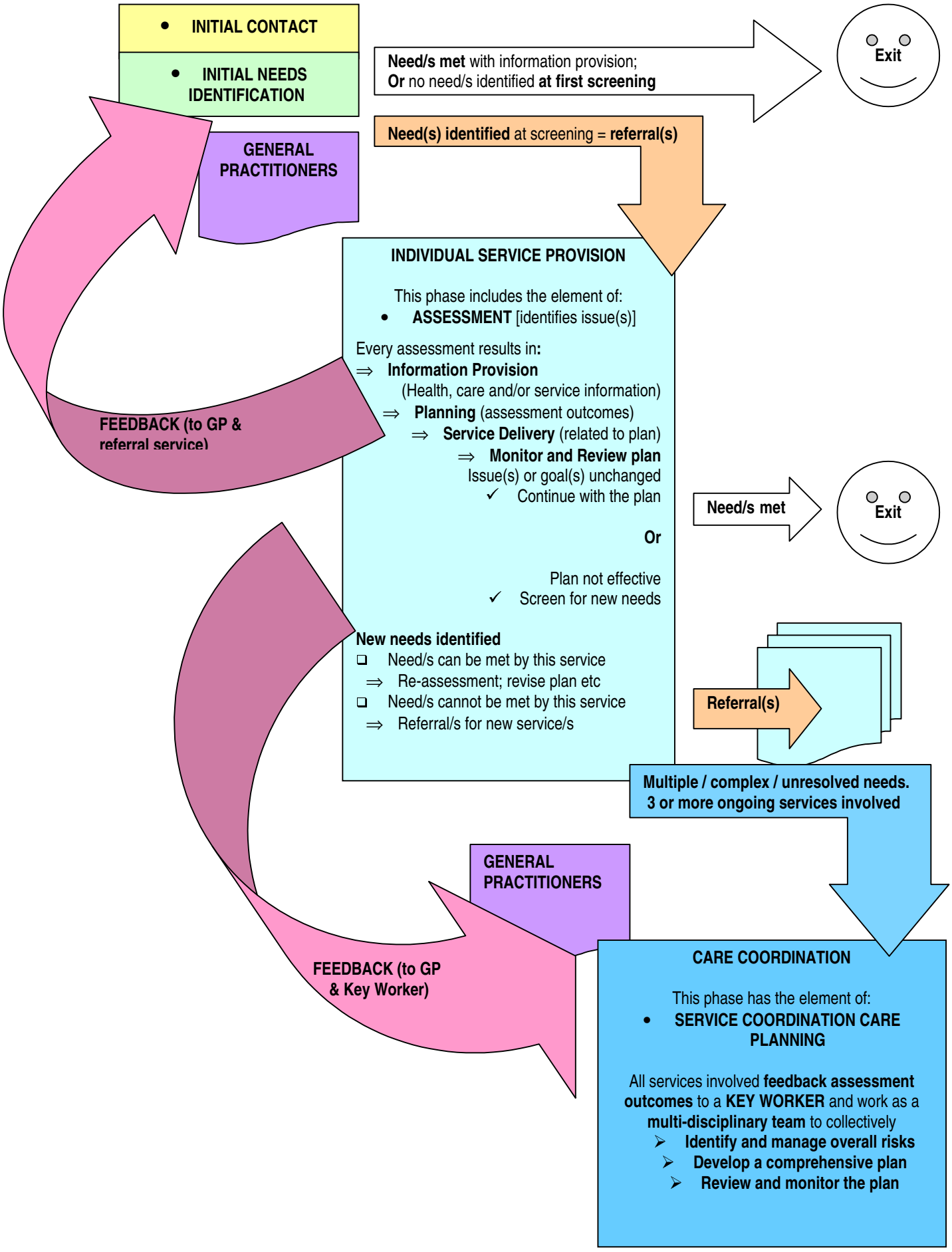
Develop sustainable practices

- Build on /link existing systems /reports
- Develop ownership of the process
- Enhance patient /client management IT systems - audit feedback; add form
- Explore and enhance ICT capacities for future e-communications
- "Quality" criteria = indicators for review

Acknowledge and Reframe Barriers (intra and inter Practice/Agency barriers)

- Time; resources; varying capacities etc
- Inter-agency coordination needed

CENTRAL VICTORIAN HEALTH ALLIANCE
SERVICE COORDINATION CONTINUUM OF CARE



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INTRODUCTION

CVHA Feedback Trial Information/Training Sessions – August 2003
***CVHA Feedback Form* and Protocol Trial – 1st September to 31st October 2003**
CVHA Feedback Trial Evaluation – November 2003
CVHA Feedback Trial Report – December 2003

The Project Outline:

During September and October 2003, all 6 General Practices in the Mount Alexander Shire were possible recipients of the Central Victorian Health Alliance (CVHA) Feedback Form. Targeted Services at Mt Alexander Hospital and Mount Alexander Shire were the senders of written feedback to General Practitioners during this trial period. A new Feedback Process was on trial: Service Providers were to send written feedback to GPs for (a) all new referrals and (b) following re-assessments, if there was new issues or changes in the service's plan.

Rationale for the project:

The trial and evaluation of a common Feedback System for agencies in the Central Victorian Health Alliance area was developed in response to General Practitioners, Practice Staff, other Primary Care workers and consumers articulating that feedback was poor and systems needed improvement or to be developed. This project built on work from previous CVHA projects. It had been articulated that feedback was a key component of multidisciplinary care, however quality feedback was not common practice:

- There was a poor feedback response time, or no feedback at all to GPs
- There was poor response to GP referrals, e.g. did the patient attend the service
- There was poor feedback information relating to assessment outcomes or re-assessment outcomes (i.e. planned / changed service delivery)
- Feedback that was provided was often inappropriate or not relevant, too much or too little, or illegible
- There was no consistent system/s developed for feedback, different formats existed e.g. letters, photocopied notes, phone feedback etc
- There were no protocols developed between agencies in relation to feedback

The Project aimed to address these previously identified issues.

Who was involved in the project?

Central Highlands Division of General Practice:	Practice support in Castlemaine
Bendigo & District Division of General Practice:	Practice support in Maldon
Mt Alexander Hospital, Home Nursing Service:	District Nursing, Palliative Care, Post Acute & Sub Acute Care
Mt Alexander Hospital, Welfare Department:	Aged Care Assessment Service
Mt Alexander Hospital, A&E (Acute ward):	Attempted Suicide Follow-up project
Mount Alexander Shire Home Care Services:	Home and Community Care and Aged Care Packages

What was evaluated?

Evaluation of the trial occurred in November 2003. There was input into the evaluation from recipients and senders of the CVHA Feedback Form. The project objectives were:

- To improve the quantity and quality of feedback to General Practitioners
- To develop processes and system/s to implement the CVHA Feedback Protocols.

The evaluation recommendations are available in this report. These recommendations will direct Feedback systems implementation to all CVHA member agency services in 2004.

KEY PROJECT ACTIVITIES

Develop the Project Reference Group – July 2003

Review Background Documents, Feedback Form & Protocols – July 2003

Refine Work Plan And Develop Training and Support Resources – July 2003

Consumer Reference Groups Consultations – August 2003

CVHA Feedback Trial Information / Training Sessions – August 2003

Pre-trial GP Integration Scale Survey – August 2003

CVHA Feedback Form & Protocol Trial – 1st September to 31st October 2003

Develop The Evaluation Based On The Program Logic Plan – October 2003

CVHA Feedback Trial Evaluation (focus groups & interviews) – November 2003

CVHA Feedback Project Report– December 2003

Report Dissemination To General Practice, Service Providers And Consumers

CVHA undertook the trial implementation of a new Feedback Process. In summary, the new process required that Service Providers automatically send "quality" written feedback to GPs.

1. For all new referrals (even if the GP has not made the referral)
2. Following all re-assessments, if there are new issues or changes in the care plan

The new Feedback Process also required Service Providers to send feedback to the referrer and Key Worker or Case Manager (if relevant). [Refer to the Central Victorian Health Alliance Service Coordination Continuum of Care model on page 8]

In addition, the Feedback Project working group developed a set of "quality" feedback criteria. Feedback was to meet the following set of criteria (standard indicators).

- Sent as soon as possible, within 7 days depending on urgency and service provider's planned action or capacity to reply
- ☎ **If Urgent**: details are phoned through to the designated worker
- Tailor feedback information to meet the needs of the receiving service in relation to planning care/treatment for the consumer
- Write legibly or type information
- Keep information succinct (not too much or too little) e.g. summarize
- Use a consistent format i.e. *CVHA Feedback Form*
- Build on feedback information over time if time-lapse between referral acceptance and assessment (eg on waiting list)

These criteria were used as indicators by Services Providers to self-monitor / self-evaluate their own practice standards.

To promote consistency and prompt relevant / useful / meaningful feedback information, a feedback form had been developed. This form included assessment information, a key component of feedback information that GPs had previously identified as being most useful.

The practice pathways of the feedback process and the tools/resources to support feedback (e.g. the CVHA Feedback Form) were all documented in the CVHA Feedback Protocols.

The main 2 key activities of the project were:

1. The trial of the CVHA (one page, multi-purpose) Feedback Form
2. The trial of the CVHA Feedback Protocols (i.e. Process and Practice Pathways)

It was anticipated that the feedback form and protocols would be pivotal in the development of a quality feedback system. This would be supported by other activities such as training or information dissemination for the target audience.

KEY ACTIVITY RESULTS

The project was completed within the designated time frame and met and exceeded all the objectives set out in the project submission.

As stated, the 2 Key Activities were:

1. The trial of the CVHA (one page, multi-purpose) Feedback Form
2. The trial of the CVHA Feedback Protocols (i.e. Process and Practice Pathways):
    a. Feedback practice adheres to "quality criteria" (standards)
    b. Service Providers feedback assessment outcome information to GPs, and other relevant Service Providers (e.g. referrer, Key Worker), after a:
        i. Referral/first assessment
        ii. Re-assessment/review, were there have been a change(s) in the service's plan (i.e. new issue(s), changed goals(s), or significant changes to actions when the issue(s) and goal(s) remain unchanged)

The results of these 2 key activities emphasize the project aim:

- Improve the quantity and quality of feedback to GPs by enhancing feedback systems.

Results of the *CVHA Feedback Form* trial

1. The format of the *CVHA Feedback Form* generally met the feedback needs of most GPs (receivers of the form for this trial):
    a. The content of the Assessment Outcome section was the information most highly valued by the GPs:
        i. "It has what is needed – issues, goals and planned action"
        ii. "It was comprehensive information, the right amount of information"
        iii. Information can be used for patient management at the next visit
        iv. It has the capacity to be integrated into the Multi-disciplinary Care Planning Process. The applicability of assessment information to inform multi-disciplinary care planning was theoretically acknowledged by some.
    b. The form was "easy to scan"; "user friendly"; "easy to read and understand".
    c. The form kept the information brief – "it is better than reading an essay on the patient".
    d. Some found it cluttered but also stated, "Once the use of the form is more widespread we'll get more familiar and be able to scan information quite quickly".
2. The format of the *CVHA Feedback Form* met the needs of Service Providers (senders):
    a. It was easy to fill in
    b. It prompted the sender to record information that needed to be fed back
    c. It ensured that Service providers kept the information brief and succinct
    d. It prompted for attachments if more details were required
3. The format of the *CVHA Feedback Form* demonstrated links between the processes of referral and assessment and assessment and multi-disciplinary care planning. The fields in the Assessment Outcomes section are the same as the Service Coordination Plan:
    a. Promotes transferability and integration between processes
    b. Promotes future IT auto-population from assessments and in e-communications
4. The applications of the form are multi-purpose / multi-functional i.e.:
    a. The format enables the form to be used for either the requesting of or for the sending of written feedback following referrals, first / re-assessments or for multi-disciplinary care plan development
    b. Feedbacks can be staged if there was a wait between intake and assessment i.e. Referral acknowledgements and Assessment Outcomes can be either staged or one step processes
    c. Either first assessment or re-assessment outcomes can be fed back, thus the primary link is to assessments.
    d. By including goal end dates, assessment and routine planned exits are one step
5. Due to the one page multi-purpose make-up of the form, the format of the *CVHA Feedback Form* is unfortunately cramped (in the top section). However, both GPs and

service Providers also stated that they liked just one page. It was felt that one page was desirable and the entire content of the form was required. It was recognized that in an electronic format the "cramping" issue of a paper-based feedback form could be resolved. GPs and Service Providers also commented that:

a. It was easy to fill out and read once GPs and Service Providers got used to the layout of the paper-based form
b. Familiarization was the key to changed practices in using a multi-purpose form

6. It was noted that there was no prompt to indicate that a phone call had been made for urgent feedbacks. Also, there was no logo indicating that the source of the patient/client information being fed back (just the senders details at the bottom of the page). It was stated by one GP that a logo or service ID would be useful. It is recommended that inclusion of these points be considered in any form alterations.
7. Written paper based feedback poses a filing problem for receivers. This will be over-come with future e-communications messaging standards. However the paper-based trial highlighted the need to avoid over-feedback practices. The CVHA's one page, multi-purpose format that includes goal end dates for planned action can address this issue.

Results of the CVHA Feedback Protocols (Process and Practice Pathways) trial

1. Written feedback to GPs after assessments promoted improved patient health outcomes:
    a. Written feedback avoided reliance on memories re a verbal information exchange
    b. Written feedback was filed and available for the patient's "next visit"
    c. Was not reliant on the patient / client to be the "lay" messenger of professional assessment information. Consumers were concerned about misinterpretations or missed information when the Practitioner was reliant on them for feedback.
    d. Written feedback practices could be integrated into the Multi-disciplinary Care Plan Process
2. The Feedback Process is separate from, yet intrinsically linked to other service coordination processes: referrals, assessment (first / re-assessment), care coordination. The CVHA Feedback Protocols (practices, pathways, feedback form) facilitated the links.
    a. It was identified during the trial that the Hospital Rehabilitation Unit's Multi-disciplinary Discharge Plans were referred to by GPs as feedback forms. The revelation of the different processes behind each form enabled the Feedback Project working group to advance its understanding of the 2 processes and begin thinking about the different feedback pathways required when multi-disciplinary plans are in place. It is recommended that more work be undertaken on this pathway.
    b. Feedback Pathways were developed from discussions with the Feedback Project working group and implementation services. The 2 feedback pathways were:
        i. What to do, and who to feedback to, for a new referral and first assessment
        ii. What to do, and who to feedback to, for a re-assessment or review
3. The CVHA Feedback Protocols (practices, pathways, Feedback Form) proved to be practical, meaningful, functional, and applicable, promoting relevant tailored feedback.
    a. "Quality" feedback criteria were developed and underpinned practice standards
    b. Protocols were adopted by Service Providers as they were functional/applicable
    c. Common inter-Practice/Agency feedback practices were set through the Protocols
    d. It was identified that further work and problem solving was required when multi-disciplinary (discharge / community) plans where in place: proactive avoidance of the duplication of information from both care plans and feedback.
4. Intra-agency implementation practices needed more attention within training support:
    a. Support and/or a lead worker proved essential for implementing a new process
    b. Absence of a lead worker reduced the capacity of a service to internally develop their systems and/ or created potential for miscommunications about the process
    c. Exploration of how to implement the new processes internally is essential
5. Resources / support (information kit and personnel) proved important to implementation.

PROJECT REACH DETAILS

REACH is the absolute number, proportion, and representation of individuals willing to participate in a given initiative.

	ANTICIPATED REACH	ACTUAL REACH
General Practices targeted for the trial	6 Practices	**6**
General Practices informed of trial	6 Practices	**6** = 100%
Practice Mangers (PMs) informed of trial	6 Practice Managers	**6** Practice Managers
General Practitioners (GPs) informed of trial	17 GPs	**11** = directly informed (65% trial GPS) **6** = informed via the Kit and Practice Manager
General Practices participating in trial	6 Practices	**6** = 100%
General Practices who received feedback (i.e. the client group of the Services had to match that of the Practices)	5 Practices (NB 1 anticipated no feedbacks at the beginning of the trial)	**5** Practices 1 sole practice did not receive any feedback due to the nature of the practice not matching the trial client group.
GPs who received feedback	17 GPs	**15** GPs (88% trial GPs) 1 sole & 1 new GP did not receive feedback
Total number of written feedback sent to GPs using the *CVHA Feedback Form*	80-100 feedbacks	**122** known (auditable) feedbacks from the referral process 10-15 from reviews
General Practices (and Practice Managers) participating in evaluation	5 Practices 5 Practice Managers (NB 1 anticipated no feedbacks at the beginning of the trial)	**4 Practices** **4 Practice Managers**
General Practitioners participating in the evaluation (focus group / interview)	16 GPs	**11 GPs**
Services that received training session	2	**4**
Services' staff trained re the process	15	**22**
Services participating in trial	2	**3**
Services' staff participating in trial	15	**17**
Service Providers who sent feedback to GPs	15	**14** of the 17 (82%) participating staff ▪ 16 of the 17 had opportunity to feedback ▪ 2 of the 17 staff misinterpreted the new process
Services participating in the evaluation	2	**4**
Service Provider' Staff participating in the evaluation (focus group / interview)	15	**11** (NB includes indirect feedback – via lead staff)
Findings of Feedback Trial - Network Evening for both General Practice and Service Providers	0	**2** GPs**; 1** PM**;** **4** Services' staff; **2** Div GP staff; **2** CVHA
Consumer Reference groups consulted pre-trial	2	**2** Reference Groups **16** Consumers
Consumer Reference groups contacted post trial (disseminate findings)	0	**2** Reference Groups

Anticipated REACH of project

- The 6 General Practices in Mount Alexander Shire area were targeted in the project submission (17 GPs; 6 Practice Managers)
  - All **6 General Practices** participated (**17 GPs**; **6 Practice Managers**) = **100%** Practices (GP and Practices Managers) **Reached**
  - 1 Practice did not expect feedback from Aged Care Services due to the nature of the Practice (1 GP) and their Practice base (anticipated at the beginning of the trial)
- 2 Services were targeted in the submission to participate (15 staff anticipated in total: 10 Home Nursing; 5 Aged Care Assessment Service)
  - **3 Services** actually participated = **150 % Reach (17 staff)**
    - The shire's Home and Community Care service joined the trial as they had already adopted the CVHA Feedback Form
    - The hospital's acute ward also attempted to join the trial but withdrew as lead staff had extended unplanned leave
- 80 – 100 written feedback episodes using the CVHA Feedback Form were anticipated in the project submission (i.e. for the 2 original service participants)
  - **122** known auditable written feedbacks were sent to GPs after service's first assessment **= 122% - 152.5% Reach**
  - Approximately 10 –15 additional feedbacks were known to be sent to GPs as the second part of a staged intake or re-assessment process (these were unable to be tracked in auditing)
  - Written feedback sent to other Service Providers was not recorded unless these were not sent to GPs also (approximately 20 feedbacks)
  - 14 of the17 actual participating staff sent written feedback to GPs (**82.35%**)
    - 16 of the 17 had opportunity to send written feedback (**94.12%**). 1 Home and Community Care Service's Case Manager sent multi-disciplinary plans, but had no new referrals so sent no Feedback Forms
    - 2 Aged Care Assessment workers accidentally gave either non written feedback or sent it to the referrer (miscommunication)
- 2 Consumer Reference Groups (16 consumers) were targeted in the submission to be consulted in the project. Information sessions occurred twice for both groups during the trial **= 200% Reach**

Pre-trial information / training sessions – August 2003

- All 6 General Practices were contacted **(11 GPs, 6 Practice Managers) = 100% Practices Reached;**
  - 11 GPs were individually contacted = **64.71% GPs reached**
  - 6 Practice Managers individually contacted = **100% Managers reached**
  - Information Kits were left for GPs unable to be individually contacted
- 4 Services' staff trained (**22 staff** – 10 Home Nursing; 5 Aged Care Assessment Service; 2 Home and Community Care; 5 Acute Ward staff for a co-existing Accident and Emergency project) = **146.67% staff training reached**
  - Train-the-trainer sessions were held for lead workers who were going to implement the process within their service = 5 staff trained for 3 services
  - Internal training sessions were arranged for staff by the trainers
  - Training kits were available to staff in all 4 areas.
- 2 Consumer Reference Group sessions (**16 consumers**) **= 100% Consumer consultation reached**

Trial of the CVHA Feedback Form & Protocols – Sept & Oct 2003

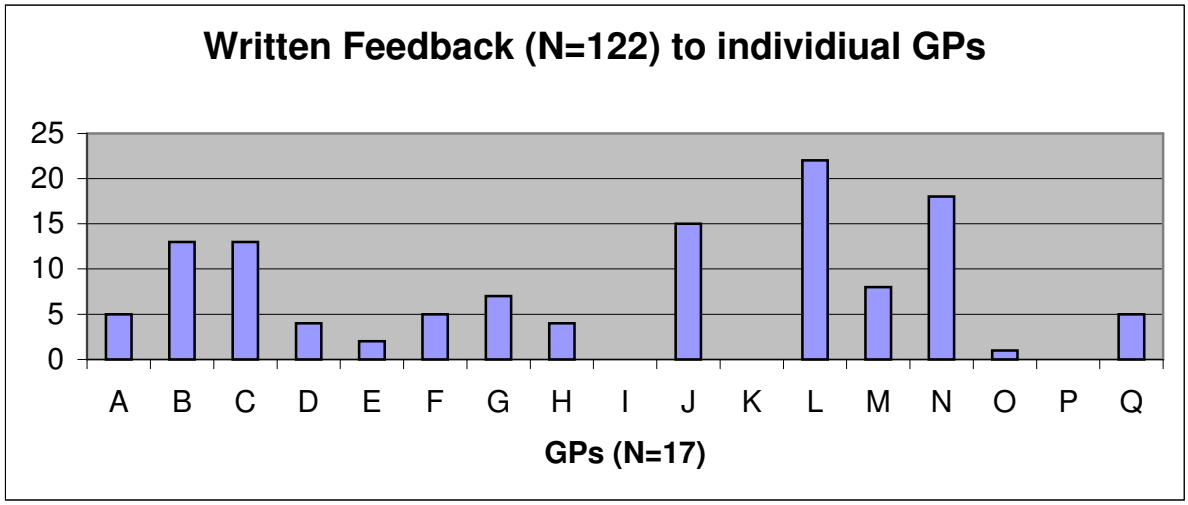
- 5 General Practices received feedback **= 83% Practices Reached;** 16 GPs received feedback **= 94.12% GP reach**
  - 1 Practice had no Aged Care type patients and expected no feedbacks from the participating Aged Care services. This was correct.

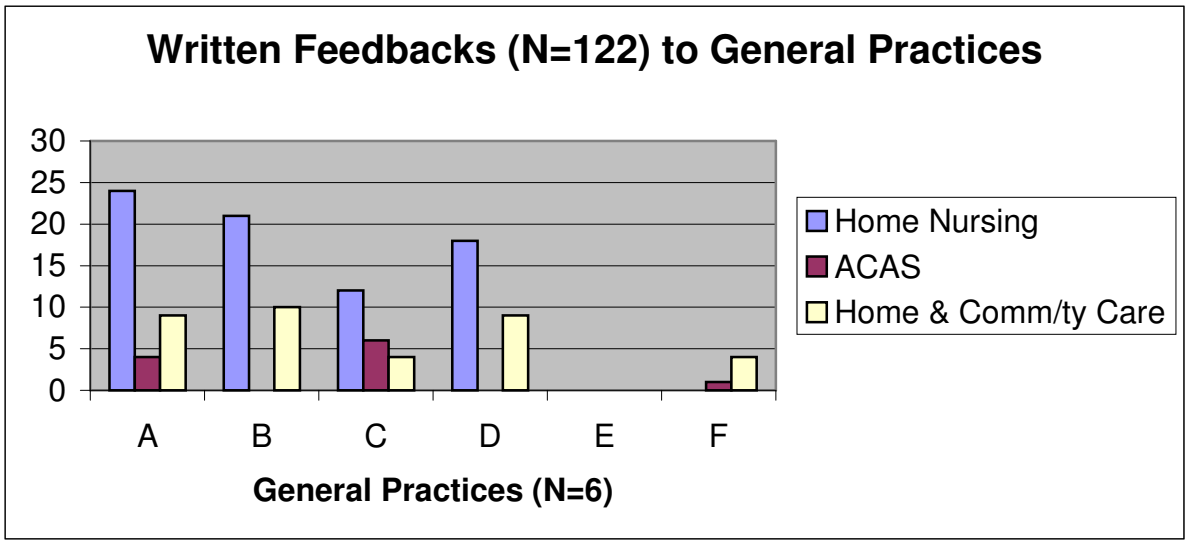
- 1 out of town Practice used a different District Nursing Service, and anticipated a small number of feedbacks from the Palliative Care and Post Acute Care Home Nursing Service. This was also correct.

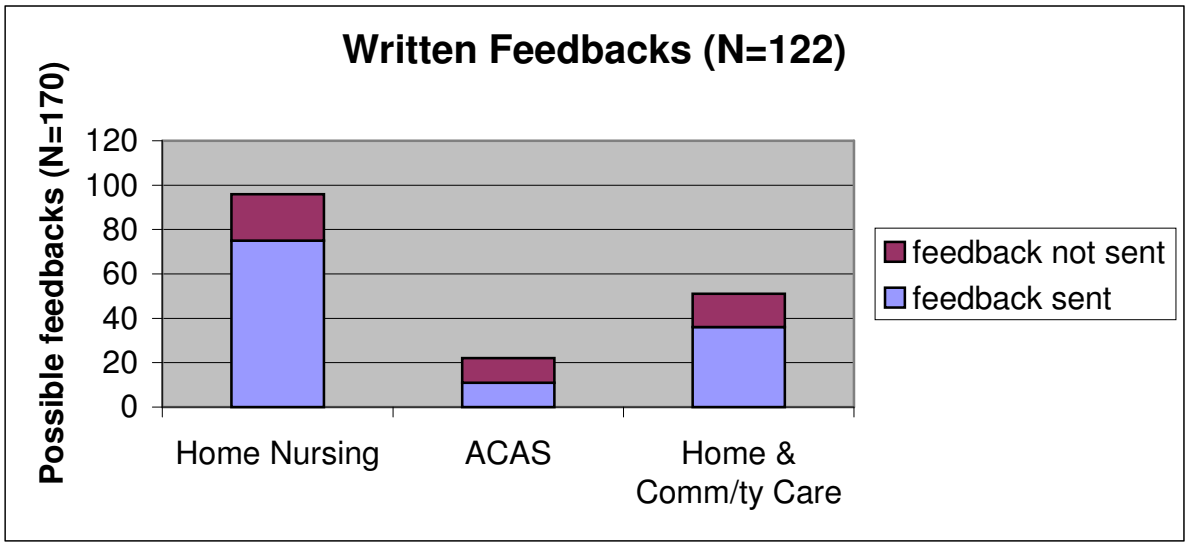
- 3 services participated in the trial
  - Home Nursing:
    - All 10 staff sent written feedback using the CVHA form = **100%** staff
    - There were 100 new referrals to the District Nursing, Palliative Care or Post Acute Care service during the trial period
    - 96 of the new clients had Doctors in the Mount Alexander Shire (3 were outside the area; 1 had no GP at the time of the trial)
    - 75 of these referrals were able to be audited as written feedbacks (the auditing process was identified as problematic – 50% of feedbacks were recorded on the database for new clients, 25% were found to have been sent but not recorded when files were accessed; 25 % were unknown as files either archived or not accessible for auditing)
    - **78.13%** possible written feedbacks were known to be sent
  - Aged Care Assessment Service:
    - 3 of the 5 (**60%**) staff sent written feedback to GPs using the *CVHA Feedback Form*
    - Due to miscommunication 1 staff member sent 5 feedback forms to the referrers (who were not GPs), the other staff member rang GPs
    - There were 22 new community referrals to the Aged Care Assessment Service requiring feedback during the trial period
    - 11 (**50%**) possible written feedbacks were known to be sent
    - The Aged Care Assessment Service sent 61 multi-disciplinary discharge plans from the Rehabilitation Unit during this period
    - The Aged Care Assessment Service also had staffing issues, but persisted in the trial during this busy period
  - Home and Community Care Service:
    - Only the Assessment Officer (1) of the 2 staff (**50%** staff) sent written feedback using the *CVHA Feedback Form*
    - The (1) Case Manager sent multi-disciplinary plans, but had no new referrals or (non-care plan related) re-assessments during this period
    - 36 out of a possible 51 written feedbacks were sent to GPs = **70.59%**
    - Approximately 10 –15 additional feedbacks were known to be sent to GPs as the second part of a staged intake or re-assessment process (these were unable to be tracked in auditing)
  - Acute ward's A&E withdrew due to staffing issues at the beginning of the trial.

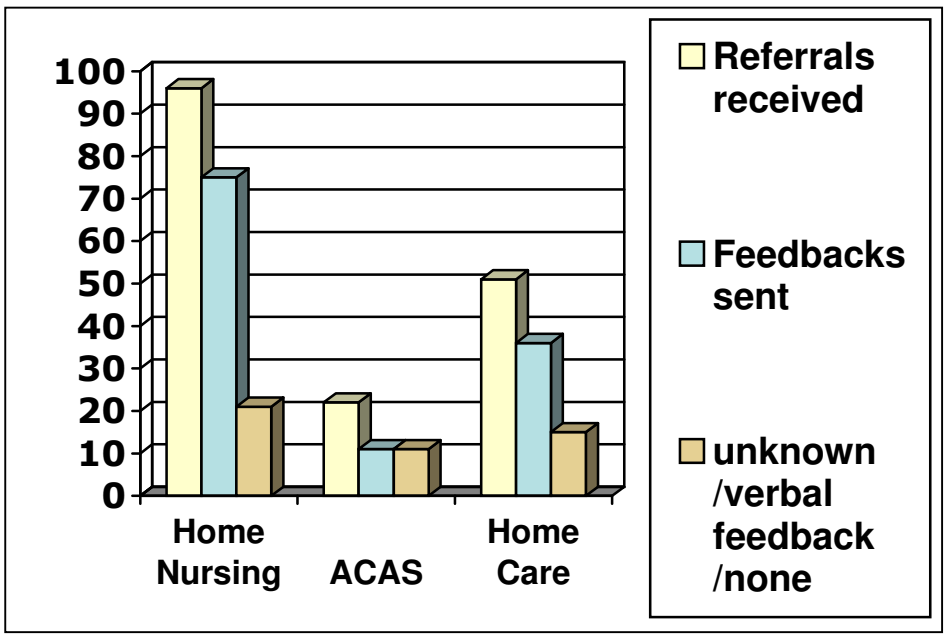
Evaluation of CVHA Feedback Form & Protocol Trial - Nov 2003

- 5 General Practices received written Feedback on the CVHA Feedback Form and were contacted for focus group sessions / interviews = **83% Practices Reached**
  - 4 Practice Managers provided evaluation feedback = **66.67%**
  - 11 GPs provided evaluation feedback = **64.71% GPs reached**
- 4 Services participated – group/interviews (The Acute ward also provided comments)
  - 11 staff provided (direct / indirect) evaluation feedback = **61.11% staff**
- 2 Consumer Reference Group sessions to inform consumers of the project outcomes = **100% Reach**
- A Feedback Networking Evening to enable GPs and Service Providers to exchange experiences and suggest implementation strategies (this was an additional session)
  - 2 GPs; 1 Practice Manager; 4 Service Providers
  - 2 Division of GP staff; 2 CVHA staff


Written Feedback (N=122) to individiual GPs
25
20
15
10
5
0
A B C D E F G H I J K L M N O P Q
GPs (N=17)


Written Feedbacks (N=122) to General Practices
30
25
20
15
10
5
0
A B C D E F
General Practices (N=6)
Home Nursing
ACAS
Home & Comm/ty Care

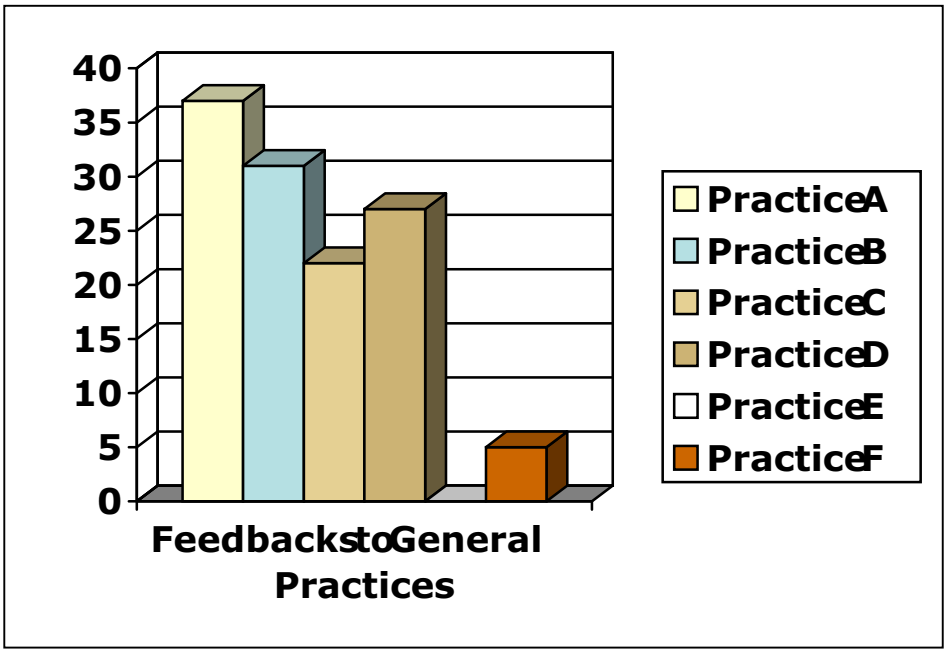

Written Feedbacks (N=122)
Possible feedbacks (N=170)
120
100
80
60
40
20
0
Home Nursing
ACAS
Home & Comm/ty Care
feedback not sent
feedback sent



Home Nursing
75 feedbacks
96 referrals
(78%)

ACAS
11 feedbacks
22 referrals
(50%)

HACC
36 feedbacks
51 referrals
(71%)



Practice **A** = 37/122 **(30%)**

Practice **B** = 31/122 **(25%)**

Practice **C** = 22/122 **(18%)**

Practice **D** = 27/122 **(22%)**

Practice **E** = 00/122 **(00%)**

Practice **F** = 05/122 **(04%)**

PROJECT EFFICACY / EFFECTIVENESS

EFFICACY / EFFECTIVENESS is the impact of an intervention on important outcomes, including potential negative effects, quality of life, and economic outcomes. Within the RE-AIM framework, efficacy or effectiveness is measured at the level of the individual and is reflective of the success of an intervention when implemented as per intervention guidelines under optimal conditions or in real-world situations, respectively.

The CVHA Feedback Project was completed within the designated time frame and met and exceeded all the objectives set out in the project submission.

This project's successful outcomes could be attributed to program logic based planning:

- Used program logic as the basis for the submission (evaluation built into the project)
- Built on prior experiences and evidence
- Based on needs analysis
- Strategies reviewed and refined work plan adhered to as the monthly progress review (process evaluation) demonstrated that the plan was operating well
- Minor changes to strategies were instigated where the need was identified
- The strategies were able to be well contained or controlled by the reference group, thus the plans only needed minor alterations as "real-life" inter-faced with the project

Also integral to successful outcomes of the project were:

- The common agreed and meaningful project goals
- Consultation, listening to and understanding implementation needs
- Clarity and containment of the project tasks
- Collaboration on inter-Practice/Agency activities
- Internal ownership of the feedback practices by service providers
- The positive tangible impacts and immediacy of receiving assessment feedback for GPs

There were 3 target audiences for this project:

1. General Practice (GPs and General Practice staff, namely the Practice Managers)
2. Participating Service Providers
3. Consumer Consultation groups – (x 2)

The key activities of the project, namely trial of the CVHA Form and Protocols, involved the first 2 groups, however all 3 groups were involved in the tasks of training / information dissemination and consultation (needs analysis, evaluation and findings dissemination). It is important to comment on the effectiveness of all these strategies.

Effectiveness of information dissemination to / training for the target audience

1. Divisions of General Practice Consumers Reference Groups (2) information sessions
    a. Information Kits were developed for the Reference Groups. The kit contained:
        i. The *CVHA Feedback form*
        ii. A one page Information Sheet on project
        iii. The draft CVHA Protocols
    b. Both Consumer Reference groups appreciated the opportunity to comment on the project and make recommendations to the draft Protocols before the project implementation. The kit and awareness raising of the project appeared effective
        i. Recommendations were noted and incorporated into the Service Provider training and protocols
    c. Concerns were expressed about possible over-feedback practices – "a deluge of paperwork" negating the positive implications of feedback e.g. large amounts of [non-quality] feedback clouding urgent / important feedback.
        i. Action was taken to review the "quality criteria" and practice pathways to avoid non-quality or over-feedback practices
        ii. Action was taken to ensure this message was disseminated to Service Providers in the training sessions
        iii. A recommendation has been put to the CVHA board to promote regular review of the Feedback Process following implementation

2. General Practice Information sessions and Practice support
    a. Information Kits were developed for General Practice. The kit contained:
        i. The *CVHA Feedback form*
        ii. A one page Information Sheet on project
        iii. The draft CVHA Protocols were available in the Practice Managers' Kit
    b. The one-page Information Sheet that was developed for the GPs appeared to be useful (also for Consumers and Service Providers – same sheet was used for all)
        i. The one page sheet outlined the project tasks dates, rationale, project participants (senders of the forms and support personnel for each Practice) and the evaluation process.
        ii. The project rationale was grounded in findings and quotes from previous projects – this provided discussions for "quality" criteria, criteria that were integral to the CVHA Feedback Protocols. The discussions re-enforced that the project's Protocols were meaningful and functional for GPs
    c. Each Practice was contacted and information disseminated by a Division of General Practice. At the evaluation sessions, GPs indicated that this information session prepared them for what to expect/ look out for in their in-trays.
        i. Divisions' staff organized a "quick" group session for as many GPs as possible.
        ii. Practice Managers were viewed as "key" staff to inform due to their management role of the Practice's internal systems, so every Practice Manager was notified and Kits left for staff. There was awareness that the CVHA form did not have an agency logo on it so it may have been overlooked as client information. The information sessions provided an opportunity to make certain with Practice Managers that internal systems were in place to process incoming forms – these existed for all Practices.
        iii. Individual follow-up was arranged for GPs who were unable to attend. GPs appeared to be appreciative of this quick "informing" by Division staff
        iv. Kits were left for those GPs where no contact could be made prior to the commencement of the trial. Some GPs did not see the kit information. One who did stated they were "a bit baffled by it all" [kit information] until a form actually arrived. However, these GPs stated they had no difficulty receiving and processing the CVHA form
        v. At the evaluation sessions all Practices (GPs and Practice Managers who were attending) were cognizant of the CVHA Form and were able to compare it to other agency feedback and discharge forms and practices

3. Service Provider Training and Support
    a. CVHA and Mt Alexander Hospital project working group members developed a training package (PowerPoint presentation CD and hard copy Training Kit). On evaluation the participants stated that the information was adequate to meet their training needs. However, gaps in the implementation identified the area on intra-agency implementation practices need to be included. The training kit included:
        i. PowerPoint presentation handouts
        ii. The *CVHA Feedback form*
        iii. A one page Information Sheet on project
        iv. The draft CVHA Protocols
    b. Training sessions were provided for key /lead workers of each service by the CVHA and Mt Alexander Hospital project working group members. It was decided that these key/lead workers would undertake a train-the-trainer approach to internal training. This had both positive and negative effects.
        i. Training was well received and the Feedback Process well implemented where the Service's key/lead worker provided the training and support for implementation. Both elements were essential for internal "ownership" and discussions re internal implementation practices.
        ii. Training that focused on the "quality" criteria and the feedback process rather than just the form facilitated discussion of internal implementation practices, and made implementation easier to achieve its REACH. There was no control by the project over the focus of sessions run internally.

iii. In the Aged Care Assessment Team (ACAS) miscommunication occurred at the point of internal training. It was acknowledged from the outset that the ACAS staff were extremely overloaded at the time of the trial due to changes in ACAS workloads and staff leave. More training support from the Project team could have been provided to overcome this issue. The ACAS lead staff were not aware of the miscommunication until the audit:
    - One staff sent written feedback to the referrers only, thus did not send feedback to GPs in 5 instances (GP not the referrer)
    - Another staff phoned feedback to GPs and did not follow-up with written feedback (5 instances)

iv. The Acute Unit withdrew retrospectively from the trial as the lead worker went on extended leave during the trial and no internal practices had been developed to implement the trial. The trial was to cover a group of clients who received multi-disciplinary care at A&E, hence other services also had to be informed and consulted in any changes in practices – this had not occurred prior to the staff's leave. Staff who attended the training (5) did not initiate any feedbacks for the trial's target group - these were not senior staff.

c. The training focused on inter-agency protocols, but neglected to ensure a local discussion for internal implementation practices.
    i. The Home Nursing and Home and Community Care services included this aspect and both appeared to have a greater impact on the success of the project.
    ii. The training sessions also failed to raise awareness of the internal auditing processes required to be undertaken by each service. This was highlighted at the end of the trial when auditing was requested. There were variations on a theme of difficulties in auditing: inconsistency by staff in recording/logging feedbacks sent; variations in the service's department on auditing practices; IT software only able to audit referral feedbacks or referrals in and not re-assessments

d. The focus of the project was improving the Feedback Process at all points of the care continuum. This was emphasized in the training materials, but the capacity for services to change practices varied and depended on their starting point:
    i. Home Nursing had not been providing written feedback at all, so they focused initially on Assessment Outcomes feedback from referrals during the trial period. They plan to focus on re-assessments and exit feedbacks in their staged implementation
    ii. Home Care Services and ACAS had previously provided occasional Referral Acknowledgement feedback. Both services changed to providing Assessment Outcomes feedback and acknowledged the client benefits in providing this level of detail.

e. Training also focused on 'quality" feedback. Whilst self reporting was all the evaluation could undertake, one Service Provider stated that they had changed their practices of writing jargon and acronyms, and had also now included the reasons for the service provision which had not previously been reported. Another services stated there had been a cultural shift from "the form" to quality.

Effectiveness of the *CVHA Feedback Form*

Please also refer to the Key Activities Results (pages 11-12) for effectiveness of the form.

1. In the Key Activities Results section, the *CVHA Feedback From* was noted to be:
    - Effective in meeting most GPs needs for feedback information. The form provided GPs with Assessment Outcomes details that were highly valued: i.e. issues, goals, actions
    - Easy for Services Providers to complete and GPs to scan:
        "The use of the feedback form was a quick and easy way of receiving and reading information from other services. [He] liked the practice of receiving feedback and also the form itself"
    - Efficient in the one page multi-purpose format of the form:

- Theoretically able to request feedback (a) when referring or (b) when developing a Multi-disciplinary Care Plan [NB not tested in this trial]
- Able to send feedback to key members of the patient/client's care team at relevant point in the care continuum as needs/goals/care changed
- Able to record end dates in the first/re-assessment phase to avoid over-feedback practices

2. The negative aspect of a one page multi-purpose form is that it is cramped (top section).
   - A minority of GPs stated that it was difficult to read due to this factor.
     - "I like the outlay of it (the form) – it keeps me in the loop of what's going on"
     - "There's too much in the form – just need to know has the person been seen, assessed and what will happen next with planned goals"
   - Service providers commented that the limited space kept the feedback brief /succinct.
3. The development and refining of the *CVHA Feedback Form* was based on previous consultations with GPs, Service Providers and Consumers. The development of the CVHA Feedback Process was also integral to the development of the *CVHA Feedback Form.* These 2 developmental aspects dictated that a feedback form should relate directly to the process from where it was derived, as opposed to limiting it to the referral process. For this reason there was a strong emphasis on Assessment Outcomes as the more valued feedback information. This has proved to be correct, and the *CVHA Feedback Form* is integral to informing patient management and multi-disciplinary care planning.
4. One of the project's evaluation questions focused on the CVHA Feedback form (as a tool within the Feedback System). The focus was on the usefulness of the form for promoting quality feedback. Both GPs and Service Providers generally agreed that the format promoted relevant succinct content. Service Providers commented that the sections were useful in prompting information. One Service Provider stated that by informing GPs when Case Managers were involved in a patient's care, the GP made contact with them directly. This was due to the "care coordination" prompt on the *CVHA Feedback Form*.
5. A couple of GPs expressed concern about the amount of paperwork and automatically sending "glib" or "useless" feedback. This emphasizes the need to get the process right: e.g. quality meaningful feedback, and understanding the receiver/sender's requirements.
   - "A standardized form leaves people thinking they have to fill form in for the sake of it – often the quality of information is lacking."
   - "The gems can be lost in the huge bulk (of information received)". … "I just need to know when I need to take action…. not when the referral is taking an expected course". However, he stated for the aged who may be poor historians, it can be useful to get feedback to know who's involved in their care. And also if he hadn't made the referral, he definitely wanted feedback.

Effectiveness of the CVHA Feedback Protocols (process & practice pathways)

Please also refer to the Key Activities Results (page 12) for effectiveness of the Protocols

1. The CVHA Feedback Process is an integrated process. Whilst it is separate from the Referral Process and the Multi-disciplinary Care Plan Process, it is the integral link between Service Coordination processes: referral and assessment, first/re-assessment and multi-disciplinary care planning. For this reason the CVHA Feedback Protocols are integrated with /linked to other CVHA Service Coordination Continuum of Care Protocols.
   a. The trial demonstrated a functional link between referral and assessments
   b. Service Providers did not have the capacity to test the link between the assessments and multi-disciplinary care planning in this trial, however 2 of these trial services are undertaking a care coordination pilot in which it will be tested
   c. GPs did acknowledge the potential of the form's application for multi-disciplinary care planning
2. Service Providers stated that they adopted the CVHA Protocols. Local practices needed to be incorporated into the Service's Policy and Procedures Manual. The project had no control over the latter, but services reported consulting their manual to clarify practices.

3. The project reference group developed evaluation questions to measure the effectiveness of the CVHA Feedback Protocols. These focused on elements deemed to be important in terms of measuring the success of the trial implementation:
    - Timeliness of feedback (urgent and non-urgent feedback)
    - Quality of content (as per CVHA protocol's "quality criteria")
    - Were there systems/practices to send or receive written feedback
    - Usefulness /applicability of receiving written feedback to patient management
    - Attitudes / value placed on receiving and sending written feedback
    - Impact of receiving feedback on sending and receiving service's understanding of other services e.g. referral pathways, eligibility criteria, referral information needed etc
    - Barriers and enablers to sending or receiving written feedback

   The findings of the evaluation were generally positive. Consumer concerns about privacy and urgent feedback practices were both addressed in the protocols. Adjustments are still required to the pathways to incorporate multi-disciplinary (discharge or community) planning to reduce over-feedback practices.

4. The new feedback process required that Service Providers send written feedback back to GPs for all referrals /assessments or reassessments / reviews where there were changes in the issues/goals. This meant that GPs were informed of service provision relating to their patients in instances that they had not initiated referrals. This type of informing GPs of feedback from non-GP initiated referrals occurred in all 3 Services during the trial. It was difficult to quantify this information without IT systems that could generate this type of report, but each of the services reported variation in their referral sources:
    a. ACAS reported that the majority of referrals came from GPs / the Rehabilitation unit; a small number came from the community (approximately 5 / 22 referrals)
    b. Home Nursing reported approximately ½ from GPs and ½ from the community
    c. Home and Community Care reported the majority of referrals came from community services

   As a result, the feedback from the participating services kept GPs informed of care / services being proved to their patients. All GPs commented that they wanted to be better informed as to what service their patients were receiving:
    - It's important to know things are being followed through, reports from others are very important; I often don't know what's happening e.g. when they go to a specialist
    - It only takes a few seconds to scan and chasing up takes up my time – it's valuable to have it in the file for the patient's next appointment

   The new CVHA Feedback Process was effective in keeping GPs better informed.

The new CVHA Feedback Protocols were effective in providing both GPs and Service Providers with the practice standards, practice pathways and tools to enable more effective, comprehensive, and integrated patient/client management.

Effectiveness of consultation

Consultation proved to be an effective tool for developing relationships, enabling dialogue and understanding issues, and problem solving. Consultation and collaboration was demonstrated at several levels:

- Consumer consultations
- GP and Service Provider consultations
- Reference group meetings and workshops
- GP information sessions
- Service Provider training sessions
- Evaluation focus groups
- The existing Aged Care Network (local problem solving)

Service's internal consultations/discussion with staff were also valuable in the success of implementation of the project.

The trial audit and evaluation showed strengths and weaknesses of each participating service and this internally generated discussions for self-identified goals to improve their inter-General Practice / Agency "quality" feedback practices.

ADOPTION

ADOPTION is the absolute number, proportion, and representativeness of settings and intervention agents who are willing to initiate a program.

There can be no understating the value of having had willing participants on the project's reference group, attending the projects 2 workshops for project participants, and as the participating services sending feedback. The project even extended the number of willing participants due to an interest in, and demand for, feedback implementation.

The key contacts within the participating services were keen to undertake the CVHA Feedback Trial. They cited various "altruistic/ philosophical" and "what's in it for me" reasons for their involvement. Before and during the trial and at evaluation they demonstrated eagerness to start and continue the Feedback Process. Some of the reasons or themes for their keenness to implement the feedback process were:

1. A strong belief in the need for written feedback, and need to ensure quality feedback processes to advance systems that enhance patient/client health and care outcomes. These workers saw and valued the intrinsic link between feedback and other service coordination processes.
2. Commencing or improving feedback practices was valued as a Quality Improvement activity that needed to be undertaken for both patient/client better health outcomes and service Quality Assurance /Accreditation reasons.
3. Using the form to feedback to GPs was considered a time saver – saves chasing GPs by phone; the form prompts quality responses not quickly achievable in a letter; written feedback reduces duplication of planned action that results from "not being informed"; the form is more user friendly to fill in with tailored information than a letter.
4. Written feedback was evidence of a service's actions; written feedback could be checked / used later for patient management or care reviews.
5. Written feedback was viewed as a responsibility of the assessing service to inform those who needed to know – a duty of care.

The participating staff inevitably imparted their strong beliefs to other staff in their service, citing culture changes during and at the end of the trial. These belief systems helped in developing "ownership" at local levels. This was the next most valued element of adoption of the project.

"Champions / passionate leaders" and passionate local trainers helped with adoption in this project. Passionate staff members drove the project locally and were pro-active in problem solving internally and also inter-agency. E.g. Post Acute Care practices were problem solved outside the project; and the lead staff instigated problem solving at the local Aged Care Service Network meetings.

The third element that was crucial in the project adoption was service capacity and ability to implement at the level or starting point that was most relevant to the individual service.

1. Capacity to undertake training / capacity to support staff with change practice
2. Capacity to implement the *CVHA Feedback Form* and Protocols:
    a. Local systems availability and agreed local practices
    b. Worker capacity (e.g. workloads not excessive at implementation) and willingness of staff to undertake process
    c. Ability to stage implementation if identified as the best process to aid adoption
    d. Start where the service is at – identify starting needs and plan steps /strategies
3. Capacity to develop internal policy and procedures and systems to adopt the change process

The GPs were more passive recipients of the process, yet adoption of the project was still required in the General Practice setting. All were prepared to be included. In the General Practice setting, adoption was aided by:

1. Strong beliefs in the value of feedback evidenced in pre and post evaluation findings.
2. Having systems to process and utilize feedback e.g. patient management.
3. Having immediate and positive applications for, or experiences with, "quality" feedback.

4. Identifying services that they would value written feedback from – having relevance to their patient management practices.
5. Ability to request feedback from private practitioners using a *CVHA Feedback Form.*

IMPLEMENTATION

IMPLEMENTATION, at the setting level, refers to the intervention agents' fidelity to the various elements of an intervention' s protocol. This includes consistency of delivery as intended and the time and cost of the intervention.

The consistency and conformity in implementation of the CVHA Feedback Project can be explored under 3 broad headings: planning, application of the form and protocols, and information dissemination / training.

Planning: incorporating control and ownership enablers

A benefit this project had in terms of successful implementation was the amount of control the project had over the process. This is essential for service coordination, where each element in a project can impact positively or negatively on the implementation process. Some of the factors that the project took into consideration during the planning stages were:

1. Was this a common issue for all parties involved? Did all parties want to address it?
2. Did all the project participants agree upon the goal/aim?
3. Were the objectives logical? Were the objectives functional and have the capacity for early positive impacts?
4. Did the objectives build on existing knowledge and work being undertaken by all the participants?
5. Were the objectives manageable and achievable? e.g. targeted work / audience.
6. What services have the capacity and desire to be participants of a trial?
7. Were the participants cognizant of the developmental phases of the form and protocols? If not, what needs to be done to ensure common starting point of all participants before the trial begins?

After addressing these, the project's work-plan was developed and the project commenced.

There was ownership by the member agencies of both the *CVHA Feedback Form* and Feedback Protocols. This ownership assisted implementation. Both the form and protocols had been part of a long developmental process, which included consultation with GPs, Service Providers and Consumers. The CVHA Service Coordination Implementation and Workforce Development working group (consisting of member agency staff) felt that both were at a level to test functionality. The checking, refining, re-checking, refining and more refining process had been important in "getting it right" before testing.

Application of the *CVHA Feedback Form* and Feedback Protocols

Generally there was a good uptake of both the *CVHA Feedback Form* and Feedback Protocols. All 3 services implemented the feedback tool and protocols, and have continued to implement the CVHA Feedback Process in varying degrees or staged implementation.

Where there were episodes of reduced applications of the Feedback Process there was usually sound explanations e.g. functional, resource or training issues. These included:

1. Problem solving to avoid over-feedback (i.e. sound and encouraged non-application):
    a. The Home and Community Care service did not send over 40 referral feedbacks to the GPs when there was a straight funding change from HACC to DVA, and the care and goals had not changed. These non-feedbacks were not included in the Reach analysis but need to be noted as good / preferred practice
    b. The Home and Community Care (HACC) service and Post Acute Care (PAC) service did not duplicate feedbacks in the cases where a HACC referral was made and these were re-directed to PAC due to eligibility criteria. The PAC service agreed to be the initiator of both Referral Outcome and Assessment Outcome feedback, rather than the HACC service sending the former and

PAC service sending the latter. This was also evidence of good collaborative feedback practices.

c. It was later identified by the Aged Care Assessment Service that patients/ clients being discharged from hospital and eligible for PAC services would have a multi-disciplinary discharge plan and this may negate the need to send feedback to GPs if care was as planned (as they would already know). Again, the project recognizes this identification as good collaborative work.

2. Lack of agreed internal practices to enable consistent implementation. In the case of the Acute Ward there was no application due to this and lack of a lead staff person.
3. A need for a staged implementation process: increase feedback from referrals first, next implement feedback after reviews and then for exits/discharges from the service.
4. Staffing shortages or staff leave that increased the service's workload thus reducing optimal implementation settings. However, this provided useful lessons for applications in the "real world".
5. Miscommunications in training session lead to a varied application of the process.

For service providers, the level of consistency in application also reflected by:

1. The degree of closeness that the service's "lead worker" had to the project development: the closer to the project, the higher the application success.
2. The amount of support available to staff for implementation from within the project and within their service (e.g. a service "lead worker / champion"). The more support, the higher the application e.g.:
    a. Home Nursing had a higher application due to support compared with the Acute Ward of the same hospital, in which the same trainer was used.
    b. The Home and Community Care Service had higher application as there were only 2 staff members implementing the trial, one of which was a key participant and project support person.
3. The level of knowledge and understanding the workers had about the new Feedback Process: the higher the level the higher the application.
4. The level of skills and resources workers had to implement the new process
5. The degree of positive attitudes workers had in implementing a new process. And the degree of satisfaction the workers had in seeing the impacts of the applications.

Usability and functionality of the *CVHA Feedback Form* and Feedback Protocols was highly valued as a predictor of implementation success.

All 3 Service Providers reported to having improved their quality and quality of feedback to GPs. The quantity of feedbacks was auditable and consistency of implementation has been demonstrated in the REACH section. However, the quality of the feedbacks was self-reported. Services gave examples of achieving the "quality" criteria, hence a level of consistency. On evaluation:

1. GPs generally reported that there was consistency in the quality of the feedback: timely feedback, tailored and relevant information, legible and understandable content.
2. Service Providers also made comments to having improved the quality of the information being sent e.g.:
    a. All Services stated that they now reported the reasons why actions were taken rather than just stating they had accepted the referral.
    b. One Service stated they were reporting changes in care provision after a re-assessment had been made.

Services reported that it took little time to manually fill in and forward the CVHA Feedback Form. GPs reported that it took little time to scan the form before it was filed for use at the patient's "next visit". Both acknowledged that the written feedback saved time taken in "chasing information" or fixing up patient management problems resulting from "not knowing".

Information Dissemination and Training: opportunities to raise awareness and problem solve

GPs acknowledged that the process of informing them of the new feedback process enabled them to prepare for use of feedback. There were reports that some GPs did not routinely collect mail from their hospital pigeonholes. These GPs did not see this as a failure of inter-

agency feedback protocols. Awareness that internal mail may not be collected daily alerted Hospital staff to the need to ensure phone calls for urgent feedback.

The support required for training and consistency of trainers in a "train the trainer" model was under-estimated. These need to be considered and reviewed before further implementation.

MAINTENANCE

MAINTENANCE is the extent to which a program or policy becomes institutionalized or part of the routine organizational practices and policies. At the individual level, maintenance has been defined as the long-term effects of a program on outcomes after 6 or more months after the most recent intervention contact.

For the Central Victorian Health Alliance's Feedback Protocol implementation to continue to maintain the high degree of implementation success of this short-term trial in the longer term, the following implementation recommendation need to be considered.

The CVHA Feedback Protocols have statewide applicability, and the trial offers enablers that can help promote sustainability. [Refer to Systems Integration: A Framework for How to Make Feedback Work page 7.]

The subtle difference between the CVHA protocols and any current feedback practice is that the CVHA focus is on feedback from across the entire service coordination continuum rather than just from referrals. CVHA has separated the feedback from the referral processes – differentiating as 2 processes rather than feedback as a sub-set of the referral process. Yet CVHA has identified feedback as the key link between referral, assessment and multi-disciplinary care planning. This integrates the entire service coordination continuum, which includes GPs and other Key Workers, through the feedback process [refer to the Central Victorian Health Alliance Service Coordination Continuum of Care diagram page 8]

CVHA argues that developing and implementing quality feedback practices is the key to enhancing patient /client health outcomes. It is the bridge between GPs and Service Providers and a stepping-stone by which to advance other "quality" client information exchange processes (referral and multi-disciplinary care planning). More-over feedback provides the tool to enable multi-disciplinary care planning: without this tool multi-disciplinary care planning is too labour intensive and unachievable in the long-term.

For long term sustainability of an integrated functional feedback process, CVHA strongly urges that DHS and GPDV recommends the format of the *CVHA Feedback Form* and the CVHA Feedback Process as the basis for future development of statewide applications e.g. the data dictionary. We advocate this position on behalf of GPs and consumers who identified "quality" feedback as:

- The information obtained from an assessment – i.e. issues, goals and action
- Needing to be provided in a way that would not waste GPs time or produce unnecessary or extra paperwork – e.g. preferred one-page and one-step opportunities

These elements were promoted by the format of the *CVHA Feedback Form*

How to promote a sustainable Feedback Process that includes feedback to GPs?

1. Service Providers in the CVHA area send GPs and other Key Workers written feedback that is meaningful, i.e. feedback of the outcomes of an assessment (first assessment and re-assessment /review) as:
    a. Summary information from assessments was highly valued information by GPs, Service Providers and Consumers – the information was seen as relevant to, and useful for patient/client care.
    b. The process of feeding back written assessment information was seen as an effective way of keeping all Key Workers informed of new care arrangements or changes to care – it was seen as the professional responsibility or duty of care of the assessing service.

c. Written assessment feedback from "professionals" to the GP [or other Key Workers] meant that the system was not solely dependent on patients/clients having to relay health and care information. Written assessment feedback between professionals:
    i. Reduced the need for "lay interpretations" of health and care information
    ii. Stopped the patient/client from having to be the "lay messenger".

    These elements of written feedback were highly valued by consumers, who promote the implementation of a "quality" feedback process.

The application of a meaningful process will enable sustainability as the benefits to patient/client care further impact.

2. Service Providers use the "quality" feedback criteria developed by the Project working group as the foundation for feedback practices and as the indicators or measures of quality feedback. The benefits of having standards means that the implementation is grounded and the results indicate sustainability:
    a. The focus was on "quality" practices, rather than just implementing a form. The content of the form could be measured against these criteria to evaluate if the form was a useful tool for promoting "quality" feedback practices.
    b. Service Providers can self-monitor practices.
    c. When evaluation is undertaken across the CVHA area, there is a standard measure. This has been tested in the trial to be effective.

3. The format of *The CVHA Feedback Form* should remain unchanged. The trial showed that the format was functional, flexible, and promotes relevant and meaningful feedback information: these elements are essential for sustainability. The trial of *The CVHA Feedback Form* format proved:
    a. A one page multi-purpose format addressed the needs of both the GPs and Service Providers in sending and receiving feedback:
        i. Service Providers in the trial did not have waiting lists, thus only needed to provide assessment outcome information. Waiting list availability varies from service to service, so any tool needs to be flexible to accommodate different intake situations and enable staged feedback if required.
        ii. The provision of referral acknowledgement, assessment outcomes and exit dates could all potentially be one step, reducing the potential for over-feedback practices.
        iii. A form needs to be simple to fill in by senders and scan by receivers – the *CVHA Feedback Form* was reported to have met this criteria.
    b. The *CVHA Feedback Form* is a tool that both complements and links the referral and assessment, and review and care coordination processes.
    c. The format prompted the givers of feedback to send the information the GPs most valued (i.e. assessment outcome information), and in a format that was highly valued (issues, goals, planned actions sections).

4. Service Providers who engaged in the trial have plans to advance the staged approaches that they applied to the implementation of the CVHA Feedback Process during the trial period. Services viewed a staged /stepped approach as being the best way to implement the process in their department. The ability to tailor the implementation to the Service Providers capacity was an essential learnt lesson: tailoring enables sustainability.

5. It should be noted that all participating services in the project were at the same starting point: i.e. that all Services send written assessment feedback to GPs from all referrals, even if GPs had not sent the referral. This was "change practice" for all services, which meant the same starting point could be measured and compared. Services need to be able to plan and review local implementation at an internal level for sustainability:
    a. Where there were variations, services could reflect on their own implementation strategies and how they had faired and how they wanted to progress. This developed a degree of "ownership" over the internal implementation process which is essential for sustainability

6. Training support needs to continue with the roll out of the feedback process across the CVHA area. Sustainability can be promoted by including the following elements in training:
    a. Training and information dissemination need to maintain a focus on "quality" practices.
    b. Training needs to provide the opportunity for local teams to discuss their local implementation strategies:
        i. Within the training sessions
        ii. Outside the training sessions e.g. in existing team meetings, and at service network meetings to also advance the integration of the process.
    c. The existing training package and training process can be enhanced by:
        i. Finding local/internal "champions" to promote the new process with a "passion" and follow up on the implementation process at local meetings
        ii. Finding local stories of good outcomes/quotes
        iii. Adding in local practice requirements e.g. checklists for readiness; the "fit" with Agency's Policy and Procedures
        iv. Adding in "quotes" or experiences gained from the project trial
        v. Adding in the practice pathways developed for feedback when there is a referral or re-assessment, and feedback for multi-disciplinary care.
        vi. Adding more training support structures in for imminent / early implementers [senders of written feedback]

7. Implementation of a new process requires a planned and strategic targeted roll out of the process. Sustainability is enhanced through a planned targeted implementation that is also coordinated by "lead" staff internally in each service and externally.
    a. Planned and strategic targeted roll out is dependant on:
        i. Capacity and ability of a service to undertake implementation at a given time
        ii. The implementation process building on, making links with and/or complementing other projects/ tasks being undertaken by a service.
    b. Senders of feedback need to be clear on the local Policy and Procedures:
        i. If local procedures do not exist for the new feedback process then they need to be defined before implementation
        ii. Ensure that there is a good "fit" between the CVHA Protocols and internal procedures – one building on the other or integrated
    c. Any strategic roll out will continue to require Practice Support from the Divisions of General Practice:
        i. To inform the GPs and Practice staff of the new feedback process, and common feedback form,
        ii. To inform Practices of what to expect
        iii. To ensure Practice have systems in-place to receive written feedback
        iv. To inform Service Providers of any nuances pertaining to individual Practices.
    d. Any strategic roll out will continue to require support from Service Coordination staff or coordination of the process by an implementation working group

8. Regular reviews of the inter-agency feedback process need to occur to enable any changes/updates to the CVHA Protocol to be made. Maintenance of the inter-agency feedback process will be enhanced by the opportunities to:
    a. Exchange positive experiences (what's working well) and build on these
    b. Reframe barriers (understand issues) and incorporate into the Protocols (process and practice pathways)

9. CVHA used collaboration and consultation processes prior to and throughout the project period to obtain the basis for the successful project results. Consultation and collaboration needs to continue in the roll out strategies e.g. team meetings, local networking meetings, and evaluation strategies.

What needs further work to enable sustainability?

The main area of work that needs further attention to promote sustainability but is outside the capacity and control of this project is e-communication: IT infrastructure to support a "quality" feedback process outlined in this project. GPs expressed a high desire for the future ability to transfer and receive electronic feedback.

There needs to be further work with the Department of Human Services on standards for:

- IT capacity to audit feedback at the points of referral/first assessment and re-assessment/re-view (include: date of feedbacks; who the feedback was sent to)
- IT software messaging for e-communications for feedback

It is recommended that the findings of this project be used as the basis for future IT work.

There needs to be further work with the Department of Human Services on IT feedback standards. These standards include:

- IT capacity to audit feedback at the points of:
  i. Referral/first assessment
  ii. Re-assessment/re-view/exit

  The audit information needs to allow for feedback to be sent to more than one individual/service per feedback. It should include:
  iv. Date[s] of feedback[s]
  v. Who the feedback[s] was sent to
  vi. How the feedback[s] was sent
- IT capacity to address functional integration issues:
  i. IT capacity to exchange feedback information to the receiver's data (patient management software)
  ii. IT capacity to link to multi-disciplinary care planning
  iii. IT software integration of form: auto-populate fields
  iv. IT auditing at all feedback points (referral, first/re-assessment)
  v. IT capacity to incorporate extra forms that may be attached
- Messaging standards for e-communications for feedback. Standards need to focus on "quality" meaningful content for both GPs and Service Providers.
  i. Issues, goals and planned action.
  ii. Target dates (exit dates)

  It is recommended that standards address points feedback on the continuum:
  iii. Referral/first assessment
  iv. Re-assessment/re-view/exit
- IT Systems Integration (receiver and sender)
  i. Capacity of the of IT system to work within established workflow practices e.g. the established Pathology results feedback workflow system - "holding of a file/document for Review before integrating into the clinical record
  ii. Integration of communications systems should be a seamless component of the overall system. Introduced systems should interoperate with existing systems as much as possible.
  iii. The introduced systems should include a ' Quality of Service' aspect where some assurance is given that the messages are actually delivered to the intended recipient.

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Systems Integrations: A Framework For How To Make Feedback Work

From the evaluation findings of the trial CVHA has developed a Framework for how to implement a Feedback System between General Practice and Primary Care Agencies. [Refer to page 7 for this framework]

APPENDIX

CVHA Feedback Form

List of reports in the Attachment Document

Central Victorian Health Alliance Feedback Form

This common form can be used to either request feedback when making a referral or to provide feedback to other worker/s or the key worker as required.

Consumer:	**Date of Birth:**
Address:	**Gender:**

On completion of the relevant or requested section/s, mail or fax this feedback form to:

Feedback To:	**Phone Number:**
Title:	**Fax number:**
Agency	**Feedback Request Date:**
Key Worker:	**Phone Number:**
Title:	**Fax number:**
Agency	**Feedback Request Date:**

When feedback is requested please complete the section/s marked with a tick ☑

❑ Referral Outcome Section (circle / cross out & comment as relevant)

Reason for this feedback has been explained to the consumer ☐ The Consent form was checked to ensure this feedback is allowable ☐

The referral has been accepted:	***Yes /No /NA***	Date referral received:	
The consumer is on a waiting list:	***Yes /No /NA***	Waiting list time:	
An appointment date has been given:	***Yes /No /NA***	Date of appointment:	
The consumer attended / accepted the service:	***Yes /No /NA***	Service /intake proceeding:	**Yes /No**

If you answered *NO* to any of the above referral statements, was it because:

Insufficient information sent ☐ Consumer ineligible for service ☐ Consumer declined service ☐ Other ☐

Comments i.e. other reasons for *NO*, any action taken (e.g. referred on), or action requested from referrer:

❑ Assessment Outcome/s Section (circle / cross out & comment as relevant)

Reason for this feedback has been explained to the consumer ☐ The Consent form was checked to ensure this feedback is allowable ☐

Issue/s or problem/s found: First assessment ☐ Re-assessment ☐ Assessment date:

Planned Goal/s (if relevant)	**Target date/s**:
1.	*1.*
2.	*2.*

Planned Action (include intervention type, frequency, start and review dates)

Other details:

A new referral/s resulted from the assessment	***Yes / No***	Referral Summary attached	***Yes / No /NA***
Additional assessment information attached	***Yes / No***	Other attachments:	***Yes / No /NA***
3 ongoing services, needs Care Coordination	***Yes / No***	We will initiate Care Coordination	***Yes / No /NA***

List attachments:

Other Comments:

Feedback From:	**Phone Number:**
Title:	**Fax number:**
Agency	**Date Feedback Sent:**

LIST OF REPORTS IN THE ATTACHMENT DOCUMENT

To support this Evaluation document there is an attachment document that provides

a. The CVHA Work-plan

b. Evaluation responses:
    i. The General Practice Focus groups / GP interviews
    ii. The Service Providers Focus groups / interviews

c. Consumer Consultation Group comments
    Central Highlands Division of General Practice Consumer Reference Group
    Bendigo and District Division of General Practice Consumer Reference Group