Evaluation Report: Business of Aged Care in South West Victoria Project.

Prepared by the Consulting Group within the School of Psychology and Centre for Early Emotional and Social Development (SEED), Deakin University for the Barwon South Western Region, Business of Aged Care Project: Hesse Rural Health Service

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Summary

This report documents a Deakin University evaluation of the Business of Aged Care (BAC) project that was designed and delivered in 2014-15 by Hesse Rural Health, a regional health service in South West Victoria. The Hesse BAC project team: conducted multiple meetings with ten regional health service Boards across South West Victoria with the objective of offering training and technical assistance to increase the capacity of these organisations to plan and implement effective aged care services; successfully organised two regional seminars on aged care; and developed new tools to guide Board decision making in aged care. The present evaluation report documented the BAC project activities and intended benefits in the context of existing literature evaluating interventions to enhance aged care services. The evaluation report analysed pre-program and post-program changes reported in repeat interviews with Board members within the health services that were targeted by the project. The findings suggest that the BAC project evaluation targets were met. The project appeared to be successful in delivering valued training and technical assistance to health services across South West Victoria and effective in increasing their capacity to plan and implement aged care services. The BAC project is significant in demonstrating the potential of a regional health service to take a leadership role in effectively enhancing regional health service capacity. Based on the evaluation findings it was recommended that: (1) the Business of Aged Care Project be maintained and offered in other regions; (2) similar training and technical assistance models be offered to increase targeted areas of regional health service capacity.

Chapter 1: Introduction

The Barwon South West Region (BSWR) is one of eight Victorian Department of Health divisions. Within the BSWR Hesse Rural Health Service has emerged as a lead rural health-care service serving the three local government Shires of Surf Coast, Colac Otway and Golden Plains. Hesse manages a broad range of services that include: Aged Residential, Acute Hospital, Emergency, Community Health, Home Nursing, Medical, Rehabilitation and Palliative Care.

While the Australian population is ageing (Australian Bureau of Statistics, 2009), this phenomenon is having a disproportionate impact on rural and regional Australia where those aged 65+ are increasingly moving and retiring (Australian Bureau of Statistics, 2013). For example, in the Barwon region, 15-17% of the population is aged over 65 on average, placing the region at approximately the midrange for the state. In some towns in the BSWR such as the Surf Coast region the proportion of persons aged over 65 is rapidly increasing from 18% in 2008 to 19.4% in 2012.

Population ageing in rural and regional areas such as the BSWR has important implications for health services. Although health service Boards in the BSWR recognise that aged care services are important, many have been unclear as to how they might manage priorities to direct strategic improvements in the operational and financial performance of this area of their work. Recognising the opportunity to offer assistance Hesse in 2014 developed a proposal that was supported by the Victorian Department of Health to offer a training program for regional health care services to develop their capacity to manage aged care services. The BAC project aimed to facilitate rural Public Sector Residential Aged Care Service (PSRACS) boards to pilot new approaches in the strategic management of aged care services in the BSWR. The project was designed to work with the ten PSRACS Boards in the BSWR to develop a responsive business culture to improve the viability of their aged care services. The project was conceived as providing direct assistance to develop a business approach to aged care service delivery, supported with tailored tools to enable boards to navigate the environmental, operational and policy changes, resulting from the Commonwealth's aged care reforms and local community demands.

Objectives. The first objective of the BAC project was to enhance the capacity of Boards to strategically lead PSRACS through aged care reforms. The second objective was to ensure that aged care remained a priority for health service Boards. Thirdly, the project sought to ensure that Boards

had access to the necessary tools and information to strategically lead the PSRACS. The final objective was to ensure that new approaches to the business of aged care were piloted, refined, evaluated and shared with the region's Health Services.

Twelve health services participated in the BAC Project, but information was gathered from the following 10 Boards; Casterton Memorial Hospital, Cobden and District Health Services, Colac Area Health, Hesse Rural Health Service, Heywood Rural Health, Lorne Community Hospital, Moyne Health Services, Portland and District Health, Terang & Mortlake Health Service and Western District Health Service (WDHS). The BAC project was initiated in 2014 with a series of interviews with the target health service Boards. The project also involved the organisation of two seminars in 2014 and 2015. The first seminar was titled "The Taste of Aged Care" and was conducted on the 15th of November 2014. This seminar provided an introduction to aged care as a business. The second was conducted on the 1st of August 2015, with the title of "The Competitive Edge Seminar" providing an introduction to major resources and expertise available for assisting the development of aged care as a business.

The BAC project also developed a "Board Navigator Tool" (Dashboard) in 2015. The Navigator was designed to assist BSWR Board Directors to develop insights into service performance, by comparison of their services with indicators from non-government (NGO) and private sector organisations. The Navigator Tool aimed to stimulate enquiries from Board members about options for ways to improve the viability of their PSRACS. It was designed to ensure that, at a minimum, the Directors understood the "Top 5" indictors of viability for their PSRACS. The Tool also enabled Boards to drill down into more detailed information on specific aspects of their services.

Health services were able to pull out relevant Key Performance Indicators (KPIs) from the Board Navigator Tool worksheets and to access source documents to facilitate benchmarking. The KPIs in the Board Navigator were selected through the interviews with Board members and senior executives conducted as part of the BAC project. It provided a comparison of information obtained through two large NGO aged care providers, aged care benchmarking services, and two publically listed private providers. The private benchmarking services used by the NGOs interviewed by this project were QPS Benchmarking and Provider Assist. The NGOs use benchmarking data on revenue and expenditure obtained from participating (free) to Bentley's Aged Care Survey and Stewart Brown Aged Care Financial Survey.

Professor Toumbourou's consulting team at Deakin University were invited by Hesse Rural Health to assist with the evaluation of the BAC Project. The Deakin evaluation was designed to: complete a rapid literature review; document the logic of the BAC project and intended outcomes; and to collect and analyse quantitative and qualitative data to assist the evaluation of the project.

The report that follows described each of the Deakin evaluation activities. Chapter 2 describes the rapid literature review. Chapter 3 then documents the BAC project and the evaluation indicators. Chapter 4 reports on pre and post program data collected from Board members regarding indicators of change in practices that followed from the BAC project. Chapter 5 presents an integrated discussion.

Chapter 2: Literature Review

Introduction

An initial component of the Deakin evaluation of the Hesse project was a literature review that examined the features of good governance in quality aged care. The review identified, summarised and appraised the evidence for models of governance practices to enable evidence-based recommendations to be made regarding the best practices for aged care service management in rural areas. Provided below is a brief summary of the findings of the review reported in more detail in Skvarc, Varcoe, Hall & Toumbourou (2015).

Method

This "rapid review" firstly identified and examined available information on the context of rural aged care, with particular attention paid to the BSW region where information was available. Secondly, the review searched available literature to identify policy recommendations set out by the Victorian and Australian Commonwealth government where available. Thirdly, the review identified and appraised evaluation findings relevant to rural aged care service models. Finally, the review examined components of board governance models that propose to promote sustainability and efficiency in health services, using the highest standard of evidence available.

Several search terms and strategies were utilised in obtaining the literature used in the review; "aged care sustainability", "aged care governance" "health service + board functioning" and variations of the above were entered into several peer-reviewed databases on Google Scholar, EBSCO Host, PubMed, and the Cochrane Database. The reference lists of included articles were also manually scanned for relevant literature, and the databases of the Australian Bureau of Statistics, Departments of Social Services, Health, Health and Ageing etc. were individually searched using similar terms. The review was constrained by a narrow window of time available for its completion.

Results

Results of the literature review provided a summary of some of the central themes in aged care provision. It begins by identifying some of the main trends in aged care present in rural and regional Australia, then continues by focusing on Victoria. The following summary reviews the evidence base for good governance, sustainability of aged care and developing an effective board.

Trends in Aged Care

The review began by identifying trends in ageing and aged care in rural and regional Australia. Firstly, the review noted that the population of Australia is getting older (Australian Bureau of Statistics, 2013) This has had a disproportionate impact on rural areas as younger people are increasingly moving to metropolitan areas while those aged 65+ are increasingly moving and retiring to regional and rural areas (Australian Bureau of Statistics, 2009) For example, in the Barwon region, 15-17% of the population is aged over 65, placing the region at approximately the midrange for the state. In contrast, in the city of Melbourne, the population aged over 65 is relatively low at 12.6%. Furthermore, in towns in the BSW region the proportion of persons aged over 65 is increasing rapidly. For example, in the Surf Coast region the proportion of persons aged over 65 increased from 18% in 2008 to 19.4% in 2012.

Rural and country areas have different healthcare needs compared to capital cities, and there are fewer services to address these needs**.** The shift in demographics between metropolitan and non-metropolitan areas results in differing healthcare needs. In a series of interviews with staff from 11 rural hospitals in NSW, Bail et al. (2013), examined and described some of the difficulties for aged care services in rural Australia, particularly the lack of access to specialist staff and secure beds within facilities for dementia patients (Bail, et al, 2013). While many difficulties associated with aged care in rural Australia are associated with geography and demography, the economic sustainability of small aged care service organisations is an additional challenge.

Aged Care in Victoria

Some of the current features of aged care services in Victoria and the frameworks for quality assurance are described in the section that follows. Of aged care providers in Victoria 24% are within the public sector (Public Sector Residential Aged Care Services, PSRACS), and 80% of PSRACS operate as part of a hospital (Department of Health and Ageing, 2010). In 2010, the Victorian government published a model through which PSRACS outcomes can be optimised through the identification and management of purported barriers and drivers of healthcare. In establishing this model, the Department of Health proposed a framework for the promotion of high quality aged care. The framework consisted of 5 broad components: (1) The creation of strategic goals, priorities, and targets set for each aspect of care that are clinically and environmentally safe, person centred, interactive and social, and service

focused; (2) The establishment of a governance body supportive of the achievement of these goals; (3) The development of a strategic quality plan; (4) A system through which feedback and appraisal can be obtained; (5) Evaluation through feedback and appraisal systems. The Victorian government has also provided a readiness questionnaire to assist in meeting these guidelines (Department of Health Organisational Readiness Tool, undated).

The suggested components of effective aged care have been guided by the Beyond Compliance Initiative from the Victorian Government. It has been proposed that the continued move toward a more formalised model of quality care would help promote greater consistency and foster continued improvement (Baulding, 2011). A similar model used in rural Montana in the USA achieved a high degree of success in attaining the ideals of high quality aged care management (Rosenfeld & Donoghue, 2014)

Good Practice Themes Identified in the Literature Review

A systematic review by Nicholson, Jackson and Marley (2013) examined integrated healthcare performance systems to investigate the most effective elements of management. The results were strongly supportive of the type of governance set out in the model espoused by the Victorian government, with a focus on strategic management of resources and an understanding of the uniqueness of each healthcare service provider. In terms of sustainability, the authors found strong evidence to suggest that investment in the elements of integrated healthcare governance could be financially sustainable, with some services reporting multiple investment returns from cost-reduction and avoidance of service duplication. As an example of regional service investment return, research conducted in regional New York indicated that post-discharge interventions for elderly patients had economic cost-benefits, with $1.09 saved for every $1 spent (Saleh, Freire, Morris-Dickinson, Shannon, 2012). The evidence showed strong support for the following elements of governance of healthcare services described in the sections that follow; Joint planning, change management, professional development and innovation.

Joint Planning: involves the establishment of mutually beneficial strategic alliances between service and organisational stakeholders. It places emphasis upon joint planning as necessary through strategic meetings and alliance between stakeholders to promote staff, patient, and community buy-in to the goals of the organisation. This is measured through community engagement, goals based on evidence, collaborative and multi-level decision making while maximising professional and organisational autonomy. For example, alliances between

academic institutions and the healthcare industry are widespread and can be extremely beneficial. Academia can gain from the increase in both professional development capacity and opportunities to translate research into new practices or technology. Industry gains greater access to ideas, exploitable technology, and research paradigms. Extremely common in health and medical research, numerous landmark medical interventions have been borne through academic-industry alliances (Wellenreuther, Keppler, Mumberg, Ziegelbauer, & Lessl, 2012).

Change Management: can be understood as enacting strategies to enhance and better integrate healthcare systems. In some cases this may involve strong executive leadership and a willingness to step outside traditional role boundaries. Effective change management is measured by the capacity to engage in organisational change and to promote change at the staff level. One example involves large scale implementation of information technology in the form of electronic patient records, amongst other components. In the United Kingdom this was initially met with difficulties by early adopters. The software developers noticed this, and through focus groups and engagement with the end-users developed a change-management strategy that ensured staff received sufficient training to use the software, among other management strategies. The introduction of this sort of change management was extremely successful in helping to facilitate the rolling out of the new technology (Salerno, 2014). Attempts of enacting similar change through less proactive means, such as leaving individuals and organisations to adapt on their own, were much less successful (Takian, 2011).

Shared Clinical Priority Areas: denotes inter-disciplinary agreement regarding what would promote the most effective service improvements as evidenced by available data. Measuring shared clinical priority areas involves assessing improvements to service delivery, improved partnerships, improved care planning and coordination. Shared clinical priority areas in healthcare tend to be heavily related to prevention in many healthcare services. Good examples include promoting vaccination and discouraging tobacco use, and use of aspirin in adults at risk of heart attack (Maciosek, Coffield, Edwards, Flottemesch, Goodman, & Solberg, 2006).

Professional Development: includes intra- and inter-disciplinary opportunities to increase capacity through workshops, seminars and training. Expanding multi-disciplinary capacity building opportunities is important for integrated healthcare. Outcome measurement involves

improved alignment between disciplines and organisations, increased efficiency (return-on-investment), adaption of skill set to meet community needs. An example is the significant effects upon patient health outcomes achieved by continuing professional development, particularly that which crosses traditional disciplinary boundaries. For example, the completion of a memory clinic workshop by health service staff was significantly associated with improved understanding and confidence in working with patients with dementia (Lee, Weston, & Hillier, 2013).

Innovation: is defined as encouragement and provision of resources for professionals to implement new ideas, and try new models of care. Achieving this can be measured by encouraging flexibility in strategy when dealing with illness prevention, chronic care optimisation, workforce shortages, and role flexibility. This has been put into practice and it was discovered that encouragement of innovation by management of clinicians (and other end-users) is essential in responding to rapidly changing needs in healthcare services. For example, in part to address the need to stay at home for as long as possible, researchers in Italy have begun piloting a Telemedicine scheme. A portable device is used to conduct basic health checks in the home without the need to attend a clinic in person (Lattanzio et al, 2014).

Elements of Good Governance that Impact upon Healthcare

Sheaff et al. (2014), examined the effect of governance models on a strategic change program in aged healthcare services that sought to reduce the length of time the elderly (aged 75+ years) spent in an emergency ward. Nine different sites were surveyed for elements of board governance and compared against 11 evidence-based criteria of integrated aged health care services. There were numerous similarities between the elements of good governance identified as associated with effective change outcomes by Nicholson (Nicholson, Jackson, & Marley, 2014; Nicholson, Jackson, & Marley, 2013) and those outlined by the Victorian Government (Department of Health, 2012; Tricker, 1994). These elements included Governance network membership sufficient to ensure programs can be effectively executed; structures for service user representation in place; approximately equal power between member-organisations; one pre-existing body operates as the change steering group; multi-dimensional links exist between the steering group and other members; member-organisations delegate control of decisions, resources and implementation to the governance network rather than retaining control; absence of alternative network with similar remit (Sheaff et al, 2014). The findings suggested that a *combination* of some of the above

elements were associated with sustainability and success. The authors suggested that best-practice governance appears to be a combination of successful integration of a "network" of like-minded health services, supportive organisational and managerial structures and practices, "joined-at the-top" governance, an integrated strategic leadership and absence of service duplication.

Ensuring Sustainable Aged-Care Practice in Australia

Humphreys et al. (2009), conducted a large review of rural and remote health care services in Australia to examine the key factors influencing the sustainability of those services. Workforce retention was identified as a particularly challenging factor in sustaining health services, given the costs in time and resources necessary to replace staff. Some of the main findings were that remote workers were more likely to leave their position compared to those closer to capital cities. Allied Health workers were among the most likely to leave positions, with nurses and indigenous health workers amongst the most likely to stay on. Smaller services (<50 people) typically retained staff for longer.

Developing an Effective Board for a Non-Profit Organisation.

The Australian Centre for Philanthropy and Non-Profit Studies (ACPNS) based out of the Queensland University of Technology has developed an online portal to assist in the creation of effective board structures for non-profit organisations, encompassing the elements of successful and sustainable governance outlined earlier in this review by the Victorian Government (Department of Health, 2012; Tricker, 1994), Nicholson and colleagues (Nicholson et al. 2014; Nicholson et al. 2013), and Humphreys et al. (2009). Further, these elements can be focussed upon the business of successful aged care in accordance with the accreditation and quality standards of the Australian Aged Care Quality Agency.

Discussion and Recommendations for Rural Aged Care

The literature review findings were synthesised by Skvarc et al., (2015) to identify recommendations for rural and regional health services. The report recognised that good board governance is integral to good organisational practice and service sustainability. Rural healthcare service boards in Australia face increasingly difficult challenges in responding to ageing population trends. The identification and promotion of good board function can have profound influences on the effectiveness and sustainability of aged-care organisations. In the context of rural aged care good practices include: focusing upon integration of systems,

rigorous self-examination, and identification of inefficiencies and service duplications. In the review presented above a number of inclusive models and systems of management were outlined that have been endorsed by authorities and exemplified in available evaluation studies. In response to the available literature, the following recommendations were made by Skvarc et al., (2015): Develop mechanisms for monitoring and addressing local needs; use strategic management frameworks; and encourage innovation through strategic partnerships.

The BAC project was responsive to the above evidence in: communicating with local Boards in the BSWR to identify requests for advice and assistance; assisting the development of strategic management frameworks through training and the development of resources such as the Board Navigator; and encouraging innovation by providing contact with national expertise and resources. The chapter that follows describes the program logic for the BAC project.

Chapter 3: The BAC Project Logic

Program Logic Mapping

This chapter describes the work completed by the Deakin team to document (map) the BAC project logic and to develop indicators for evaluating the project outcome. The program explication technique (Bamberg et al, 2011) was used to provide an overview of the BAC project. The technique sought to document the proposed procedure by which the BAC Project aimed to assist aged care organisational change.

The documented BAC project proposal (Hesse and Department of Health, 2014) set out the project rationale to "assist Health Service Boards of Governance in the BSWR to direct strategic improvements in the operational and financial performance of rural Public Service Residential Aged Care Services (PSRACS)". The BAC project proposal (Hesse and Department of Health, 2014) aimed to provide best practice information and educate rural PSRACS Boards around the business principles and opportunities available to aged care services.

The explication was designed to provide further detail on how the BAC project would be conducted. The explication sought to document the activities that the Hesse BAC project team would use to encourage Boards to develop a greater focus on aged care in their business plans.

Method

The program explication method (Bamberg et al, 2011) aimed to firstly document the assumptions of the project designers regarding the critical activities and their contribution to intended service targets. The first output of the present evaluation activity was a draft document incorporating the components, their activities and anticipated benefits. This document was then circulated among project staff to ensure all necessary details were captured. Once finalised this document became the working plan that was used to develop indicators to evaluate the BAC project outcomes.

Dr Matin Ghayour-Minaie, from the Deakin University consulting team, interviewed the BAC project team regarding their proposed activities and their intended benefits. A 2-hour interview was carried out with the Hesse Business of Aged Care project team (Mr Peter

Birkett, CEO of Hesse Rural Health, Ms Ami Hodgkinson, Project officer at Hesse Rural Health and Ms Rennis Witham, Board Governance Consultant). Relevant project documents were also obtained from the developers to inform questions for the interviews. Following the documentation of the project activities and intended benefits the Deakin team developed indicators that would be used to evaluate the intended project changes.

Based on the information obtained from the BAC project team, the activities were conceived as occurring in three phases. The first of these involved introducing the business of aged care to the PSRACS Boards and recruiting partners for phase 2. Phase 2 involved implementing the organisational change project with PSRACS Boards of governance recruited in phase 1. Finally, phase 3 involved sustaining change and evaluating and reporting on the findings.

Results

Table 1 below summarises the BAC project logic and describes the objectives and activities for each of the three phases together with their intended outcomes/ benefits. Table 1 also describes the indicators that were agreed to be used to evaluate the BAC project activities.

Table 1. *Action Plan to achieve the project outcomes and indicators to be used for evaluation:*

Phases	Activities	Outcomes/Benefits	Indicators
Phase 1: Introduce the BAC Project to the PSRACS Boards and select partners for Phase 2. **Objectives:** • To meet with PSRACS Boards of Governance to introduce the BAC Project such that: • Boards of Governance would increase their understanding of the BAC Project and the key environmental factors that influence the sustainability of their individual PSRACS.	Hold a Board development and leadership seminar day in order to introduce the BAC Project and expose Board Members within BSWR to innovations in aged care and encourage services to participate in the ongoing project. Follow up meetings with PSRACS Boards.	Boards acquire knowledge on: • The BAC Project. • New approaches to aged care business governance at the strategic level. • Current system constraints impacting on the functioning of the PSRACS within local catchment. Boards are motivated to: • Enter the BAC Project.	Number of Boards that entered leadership seminars and or were visited in Phase 1. Feedback from participating Board members. At least 70% of Boards (7) enter Phase 2

Phases	Activities	Outcomes/Benefits	Indicators
Phase 2: Implement an organisational change project with PSRACS Boards of Governance recruited in Phase 1. **Objectives:** • Boards of Governance make changes to prioritise aged care in their internal governance systems and	• Engaging and appointing a team to manage and implement the project. • Surveying the Board on their aged care governance attitude and needs. • Pre and post program surveys of CEOs and Boards to assess their understanding / awareness of the aged care reform challenges and community needs. • Identifying individual Board's gaps and strengths in decision making	• Baseline surveys and interviews will establish a baseline to measure attitudinal and practice change opportunities. • Understand Boards' strengths and weaknesses through a gap/needs analysis. • Identification of the process for focussing Board agendas on aged care to enable strategic decision making on PSRACS. Documented analysis of the strengths of the Board operations to support strategic decision making and opportunities for future development.	• Number of Boards that provided baseline activity information. Whether this information justified the need for the BAC project. • At baseline Board minutes and pre survey/inter views

Phases	Activities	Outcomes/Benefits	Indicators
concentrate on the PSARCS as a discrete business unit. • Boards of Governance have a dashboard tool and reporting systems in place that provide information to enable strategic decision making for the PSRACS. • Selected Health Services Board of Governance will have the opportunity to	practises relating to aged care services. • Introduce tools and business reports that assist the Board to address their priority areas ascertained through the gap/needs analysis. • Interview Board members and executives to identify existing board structures, processes and knowledge to support strategic decision making of PSRACS. • Investigate governance and reporting mechanisms used by specific PSRACS.	• Enabling the project worker to review: Details that the Boards measure; what tools and data they use, how the Boards assess the application of aged care reforms within the PSRACS. • Business reports and dashboard monitoring tools focus the Board's attention on the key drivers of PSRACS. • Focus on achieving high functioning and sustainable PSRACS and more effective strategic decision making. • Understanding the different approaches used by non-government aged care providers making strategic RACS decisions.	demonstrate there is room for the Board members to improve PSRACs performance against key indicators. • The Dashboard tool is successfully drafted. • Piloting reveals the tool's governance

Phases	Activities	Outcomes/Benefits	Indicators
pilot new methodology to improve the strategic planning of the PSRACS and share the key findings with other PSRACS in the BSW Region.	• Develop options for key indicators of sustainable PSRACS to be included in a dashboard. • Interview Executives and Boards to establish key criteria to be included in dashboard and governance reports. • Develop and test dashboard tool and governance reports for Boards. • Introduce dashboard tools/ business reports to Boards and monitor effectiveness.	• Identifying a range of key indicators and data sources (consider existing KPIs for inclusion) for dashboard. • Pilot a dashboard indicating key drivers for PSRACS, and Governance Reports provideing analysis of PSRACS performance. • Dashboard refined based on Board feedback and use. • Consultant appointed with experience in Boards of Governance in both NGO and public health services to engage the Boards in a change management process and assist in prioritising aged care.	reports provide Boards with indicators that influence positive changes in PSRACS performance .

Phases	Activities	Outcomes/Benefits	Indicators
Phase 3: Sustaining changes, evaluation and reporting of the findings. **Objectives:** • Evaluating and reporting the utilisation of dashboard, standardised reports and tools in building the capacity of Board of Governance to strategically lead the PSRACS in changed practices aligned with the BAC objectives.	Document and report the project findings and recommendations for the future.	• Report documented with key findings and recommendation for future implementation. • Board members reflect on the change process that they have participated in and can identify next steps. • Board members will be able to recognise their newly acquired knowledge and how the change process can be utilised and transferred to other settings.	• Pre and post program surveys to measure health service Boards' responses to project. • Boards are able to identify additional resources needed to enhance their ability to make strategic decisions for PSRACS. • Board members are able to recognise and articulate positive changes that have occurred through the project.

Chapter 4: Survey of Board Members

Introduction

This chapter describes surveys completed with health service Board members to obtain information relevant to the needs that would be addressed through the BAC project and changes made in association with participation in the project.

Method

The Deakin team provided advice on the survey tools used in this evaluation. Staff from Hesse Rural Health implemented the evaluation survey as part of their interviews with Board members in the ten regional health services across the BSWR. Responses to survey one were collected prior to the Boards attending the Business of Aged Care "Competitive Edge" Seminar. The ten health service Boards targeted by the BAC project were; Casterton Memorial Hospital, Cobden and District Health Services, Colac Area Health, Hesse Rural Health Service, Heywood Rural Health, Lorne Community Hospital, Moyne Health Services, Portland and District Health, Terang & Mortlake Health Service and Western District Health Service (WDHS). Participating boards provided responses on key indicators targeted through the evaluation. The first survey was completed by the Boards from September to November 2014. Board members were invited to describe aged care committee structures and reports and information they routinely brought to their meetings. The second survey was conducted by the Hesse team from August 2015 following the completion of the Competitive Edge Seminar. Nine of the ten originally surveyed health service Boards completed the second survey. In some cases Boards completed the second survey as a group, in others one or more Board members responded. The results below present the findings for each Board based on the responses of the majority of their members.

Results

At the first survey ten Boards described a range of aged care information as being brought to almost all Board meetings including: Financial and business data (100%); Occupancy rates/ margins (100%); and Aged Care Funding Instrument (ACFI: the classification instrument used by the Commonwealth Department of Health to pay subsidies to residential aged care services) daily rate (80%). The majority of Boards responded yes to the following questions: "Are there Board member/s championing the Aged Care Business?" (Yes 90%); "Is the Board structured to have a portfolio/delegation approach to Business items including Aged

Care" (Yes 90%); "Is there a future plan for Aged Care?" (Yes 90%); "Is there a market analysis for Aged Care?" (Yes 80%); "Was Aged Care an item in the Board Minutes?" (Yes 80%); and "Was time spent in the Board agenda on Aged Care?" (Yes 70%).

Nine of the ten originally surveyed health service Boards entered the BAC project and completed the second survey. The 9 Boards were asked "Has the BAC project been of value?" and "Has your Board made any changes as a result of the BAC project?" "Does your Board plan to make future changes as a result of the BAC?" and 89% (8/9) answered yes to all three questions. Theme analysis of qualitative responses revealed improvements in areas including: awareness and emphasis; strategic decision making; reporting and monitoring; marketing; guidance from the Navigator Tool resource; and networking with experts.

Table 2 lists eight areas that were listed in the first survey by 60% or less of the Boards and hence were monitored for potential improvement in the second survey. The responses from the first and second surveys can be found in Table 2. All of the eight areas showed an impressive increase from the first to the second survey.

Table 2. Areas of aged care information bought to Board meetings: first and second survey

Area of information routinely used by Boards at meetings	**Boards using information at first survey[a]**	**Boards using information at second survey[b]**
Waiting lists	30%	67%
Ratio of costs to income	10%	56%
Concessional / supported versus bond / Refundable Accommodation Deposit paying clients	50%	89%
Average ACFI daily rate	30%	67%
ACFI rate performance	10%	67%
Concessional / supported resident rate	40%	89%
Rate of bond / Refundable Accommodation Deposit paying residents	40%	89%

[a] Response from 10 Boards. [b] Response from 9 Boards.

The findings presented in Table 2 revealed there was an increase in over 40 percentage points in the eight areas of aged care information being brought to Board meetings at the second survey after the completion of the BAC project. Areas that required more specialised analysis such as ACFI rate performance and Concessional / supported resident rates showed the highest increases from the first to the second survey. We averaged the scores for the eight areas and performed a paired samples t-test. This showed a significant improvement from the first survey (M=.30 SD=.15) to the second survey (M=.68, SD=.17), t = -4.973, p=.003.

The Boards were also asked whether specific areas had increased due to the BAC. The following areas were rated by most Boards as having increased due to the BAC: Information on concessional resident rate (78% said yes); Information on refundable accommodation

deposit (78%); Benchmarking information on ACFI rates (67%); aged care service revenue information (56%); and information on aged care risk assessment (56%).

Respondent Comments Following the Seminars

Qualitative comments were also recorded from participants at the end of the two seminars. Respondents commenting on the first seminar (The Taste of Aged Care: 15th of November 2014) reported that they valued it as an opportunity to learn about the business of aged care and to network on this issue. This seminar was also evaluated as helpful in increasing communication and interest in aged care across the region.

At the completion of the second seminar (The Competitive Edge: 1st of August 2015) respondents reported that they valued the improved capacity for Board decision-making, assistance with marketing strategies and links to experts. A number of Boards that had limited prior experience reported that they planned to increase their involvement in the future.

The chapter that follows provides a discussion of the results in the context of: the available literature on aged care management (Chapter 2) and the BAC project activities and intended benefits (Chapter 3).

Chapter 5: Discussion

This chapter presents a discussion of the Chapter 4 results in the context of the intended BAC project activities and benefits outlined in Chapter 3. Findings are also discussed in the context of the available literature on aged care management outlined in Chapter 2.

Table 3 below summarises the BAC project evaluation indicators outlined in Chapter 3 and presents a summary of the evaluation findings relevant to each indicator from Chapter 4.

BAC project evaluation indicator	Evaluation findings relevant to the indicator
Phase 1	
Number of Boards that attended the first seminars and or were visited in Phase 1	Ten Boards were visited in Phase 1 and eleven attended the first seminar.
Feedback from participating Board members	Out of 21 board members responding to surveys, 19 indicated that the project was valuable. Furthermore, 18 of these provided further comment, many of which revealed an increased desire to change their practices regarding board governance strategy and marketing.
For at least 70% of Boards (target 7) enter Phase 2	Nine (90%) of the ten Boards participated in Phase 2 of the project.
Phase 2	
Number of Boards that provided baseline activity information. Whether this information justified the need for the BAC project	Ten boards provided baseline activity information with eight indicators demonstrating areas for potential improvement through the BAC project.
The Dashboard tool successfully drafted.	The Dashboard "Navigation Tool" was successfully developed and received positive evaluations in providing guidance for key Board management indicators.
Piloting reveals the tool's governance reports provide Boards with indicators that influence positive changes in PSRACS performance.	Results of the first and second survey comparisons presented in Table 2 and Chapter 4 revealed that there were a range of areas of information that the Boards more actively utilised following the BAC project.

BAC project evaluation indicator	Evaluation findings relevant to the indicator
Phase 3	
Pre and post surveys to measure health service Boards responses to project.	The results of the pre and post program surveys are displayed in Table 2.
Boards are able to identify additional resources needed to enhance their ability to make strategic decisions for PSRACS.	In Chapter 3 Board members reported increased links with relevant experts and plans to improve the marketing of their services.
Board members are able to recognise and articulate positive changes that have occurred through the project.	Chapter 3 described a range of positive changes in areas that included: strategic planning, marketing, better use of indicators through the dashboard navigation tool and links with experts.

The findings in Table 3 suggested that the BAC project was successful in achieving the intended evaluation indicators outlined in Chapter 3. *During Phase 1*, the BAC team were active in visiting ten boards across the region and in introducing the project and providing invitations to the first seminar. All the targeted boards provided baseline information. This baseline information revealed that the BAC project met a need for the PSRAC boards in the region. The findings in Table 2 revealed that the BAC project met an identified need in that only a minority of the Boards were making optimal use of key aged care information prior to the project. The first seminar was well attended and was positively evaluated as raising awareness of aged care as an important issue.

In Phase 2, nine (90%) of the ten Boards entered the BAC project. The dashboard Navigator Tool was successfully drafted and received positive endorsement from the participating Boards. The second seminar was successfully organised and was again well attended. Evaluations revealed many Boards taking on the key messages to market services and to make strategic use of the available expert assistance. The BAC project team maintained active Board communication through this Phase. A second round of surveys completed after the second seminar revealed an increased a range of relevant indicators. Members reported the project to be valuable and that their Boards were making improvements as a direct result of the BAC project.

Phase 3 will clearly require a longer period of time to fully emerge. The evaluation indicators were positive in demonstrating that the Boards were taking concrete steps to improve areas that are likely to lead to long-term improvements in aged-care services across the region.

The BAC project met a number of the good practice criteria (Nicholson et al, (2013) recommended following the literature review (Skvarc et al, 2015). The project completed interviews with ten health services in the BSWR and assisted them to identify key areas of data they can strategically monitor to improve services. In this context the BAC project assisted the region toward the recommended practice of developing "mechanisms for monitoring and addressing local needs" (Sheaff et al, 2014). The BAC project assisted the region toward the second recommendation to "use strategic management frameworks" to advance aged care. The direct advice provided by the BAC team to the regional health services together with the expert links made through the seminars and the information conveyed by the dashboard Navigator (an example of new technology considered beneficial by Salerno, 2014) were evaluated by the Boards as having advanced their strategic capacity. The BAC project also assisted the region toward the third recommendation to "encourage innovation through strategic partnerships" (e.g., Wellenreuther et al, 2012). Beginning from the first seminar the participating Boards commented on the benefits that they were receiving through increased networking, regional prioritisation and strategic leadership.

Strengths and Limitations of this Evaluation

The evaluation presented in the present report has strengths in being completed by an academic team that are external to the project design and delivery team. The evaluation is timely and important in being one of few that has documented a project with the explicit aim of increasing regional aged care service capacity. The evaluation has high external validity in examining a project that was designed to have practical "real world" utility. The key limitation of the evaluation is that it is based on an observational design and hence it cannot confidently assert that the positive observed changes were due solely to the BAC project. For example it is possible the regional services may have had a high readiness to increase capacity to improve aged care. The fact that the evaluation was able to describe the project logic and evidence that many process indicators were achieved, strengthens the argument that the BAC project contributed to positive change processes.

The BAC project is significant in demonstrating the potential of a regional health service to take a leadership role to effectively enhance regional health service capacity. In response to

the results of the review of literature and program explication, the following recommendations were made:

Recommendation 1: That the Business of Aged Care Project be maintained and offered in other regions. The Business of Aged Care Project indicators and board navigator tool are general enough in scope that they can be applied to a wide range of aged care services. Additionally, the large increase in attendance at the second seminar would indicate a successful outcome if it were to be repeated in other regions. It is, therefore, proposed that Hesse Rural Health Service continue to maintain the program in the BSW region and consider offering the project to health services Australia wide.

Recommendation 2: Similar training and technical assistance models be offered to increase other areas of health service capacity. In light of the findings, it is recommended that similar training and assistance models be considered to be offered to Boards to enhance other areas of health service capacity. This could be in the form of a consultancy approach or a published document for purchase by other organisations.

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