The retrospective development of a monitoring and evaluation framework for the NT Chronic Conditions Prevention and Management Strategy: Unpacking the problems and possibilities

James Smith, Moira Stronach & Jenny Summerville

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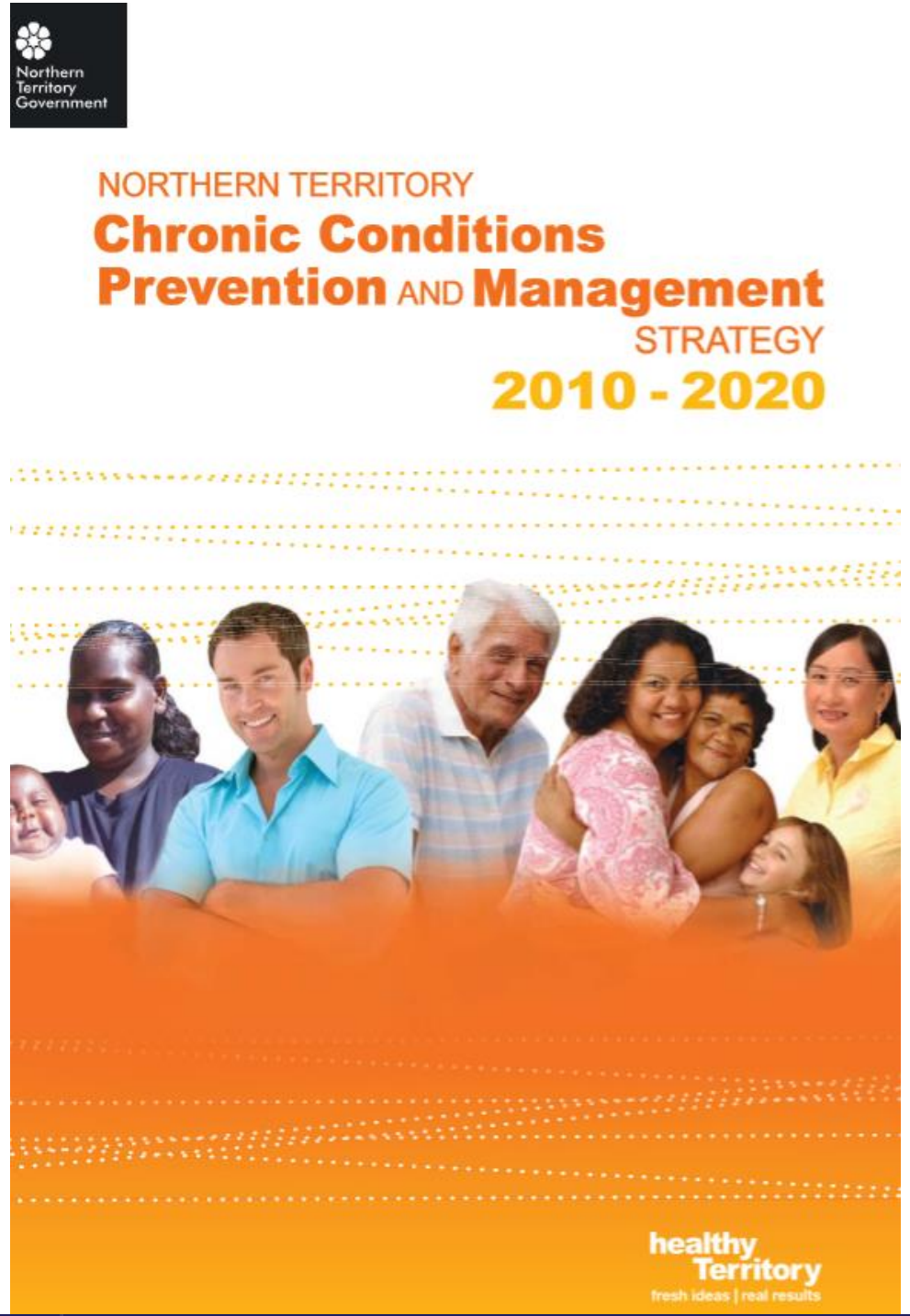

Acknowledgement of Country

We would like to acknowledge the ongoing social, cultural and spiritual relationships that the Gadigal people of the Eora Nation have with this land. We pay respects to Elders past, present and emerging.

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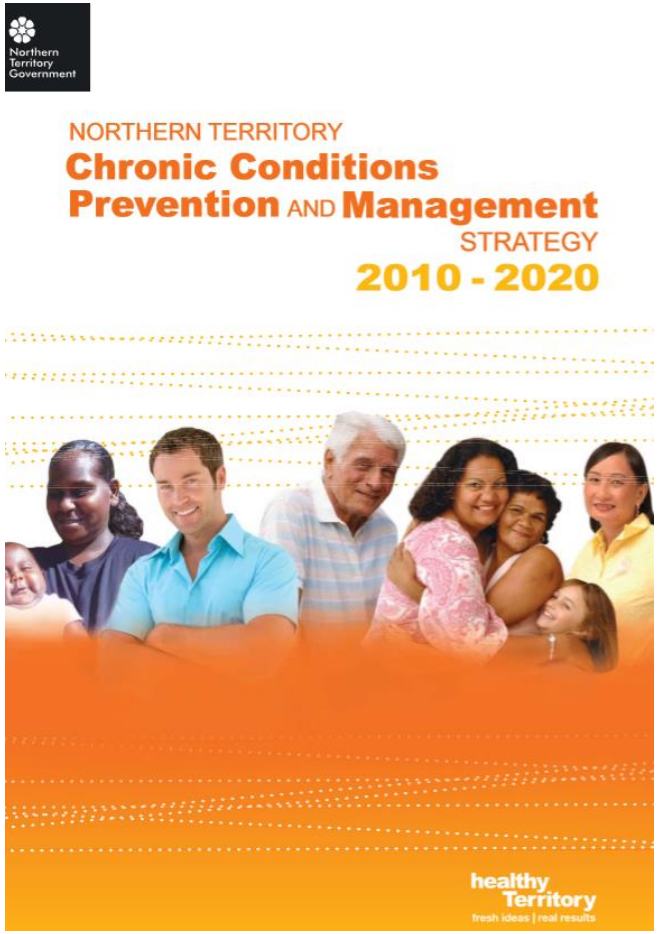
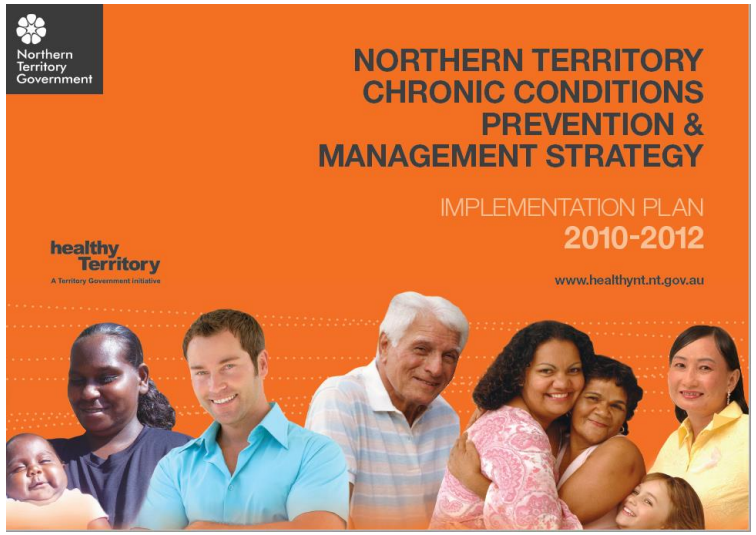
Background to CCPMS

- 10 Year Strategy (2010-2020)
- Focus on promoting health equity and addressing SDH
- Cross-sectoral (WoG)
- 3 Action Plans (2010-2012; 2014-2016; 2017-2020)
- Annual Reports (2010; 2011; 2012-2013)
- CCPMS Self-Management Framework (2012)
- Mid-Term Evaluation (2016)





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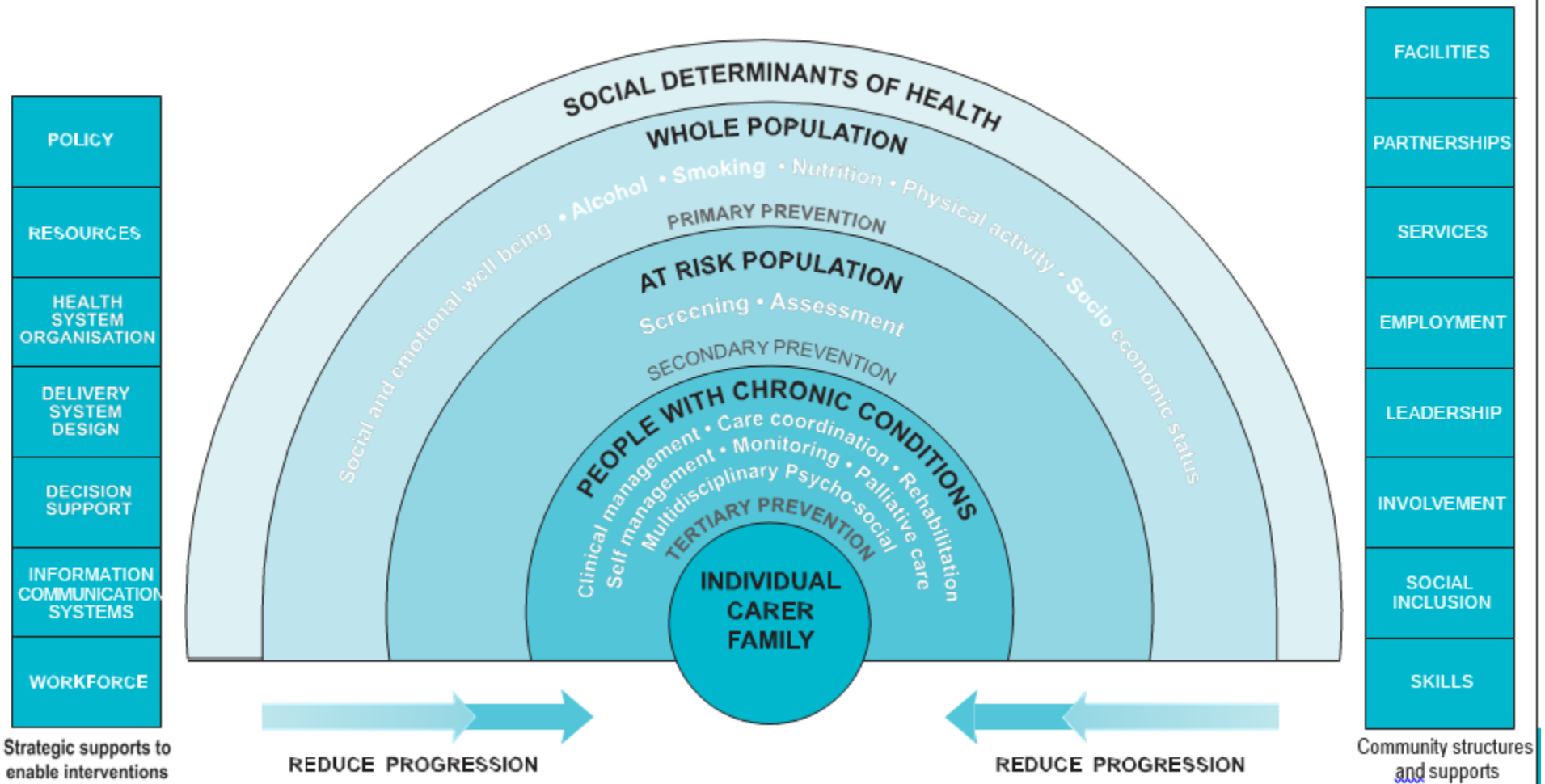
Northern Territory Chronic Conditions Prevention and Management Framework



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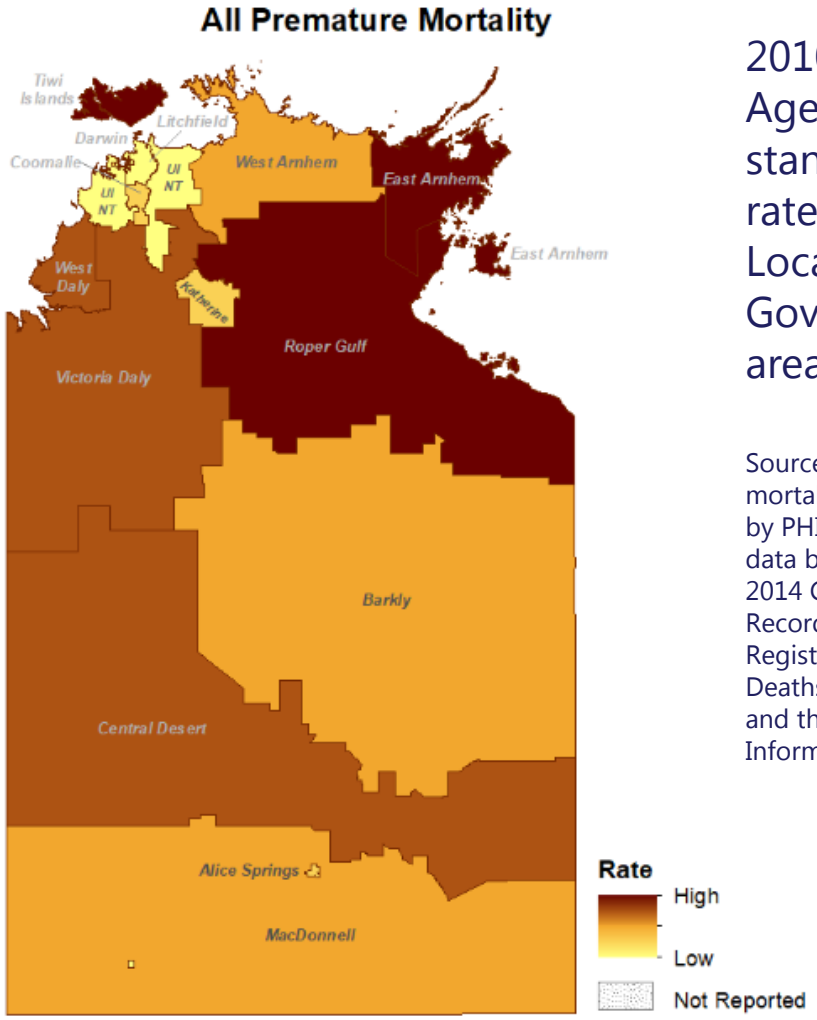
Key Action Areas and Principles

Key Action Areas (KAA)	Objectives
1. Social Determinants of Health	To contribute to improving the SDoH through improving living conditions, food security, education, employment and health literacy.
2. Increase focus on primary prevention to prevent and reduce risk factors	To reduce the impact of behavioural and lifestyle factors and create supporting environments for healthy behaviours
3. Early Detection and secondary prevention	To increase the early detection and management of disease markers in 'at risk' populations to delay or halt the progression of chronic conditions.
4. Self-Management	Implement a Territory-wide approach to self-management
5. Care for people with chronic conditions	To ensure clients with chronic conditions receive high quality clinical care and coordinated and integrated multidisciplinary care across services, settings and time.
6. Workforce planning and development	To recruit, develop and retain appropriately skilled workforce
7. Information, communication and disease management systems	To improve connectivity, sharing of useful information and access to appropriate services to support chronic conditions prevention and management
8. Continuous Quality Improvement	Improve chronic conditions prevention and management through continuous quality improvement activities.

- Addressing the social determinants of health
- Demonstrating effective leadership and governance
- Working in partnership and collaboration
- Encompassing prevention across the continuum of care
- Focusing on the early years of life
- Addressing services for Aboriginal populations
- Promoting respectful and committed person centred care
- Addressing social and emotional well being
- Promoting active self management support
- Providing evidence based care
- Promoting integrated multidisciplinary care
- Providing care coordination by multidisciplinary teams
- Promoting effective organisational and service delivery systems
- Demonstrating commitment to monitoring,outcomes and evaluation

Timeframe and context

- 30% Aboriginal
- Geographical Dispersed 1,349,129 km^2
- NT Emergency Response ('Intervention') (2007)
- WHO CSDH (2008)
- Expanding Health Service Delivery Initiative (2008-2010)
- Territory 2030 Strategic Plan 2009
- National Partnership Agreements (2009-10 to 2014-2015) – Preventative Health
- Local Implementation Plans (2011) (Closing the Gap)
- National Health Reform (2011 amended 2016)
- For Stronger Futures NT 2012 (10 years)
- NT E-Health Record



2010-2014 Aged standardise rates Local Government areas.

Source: Premature mortality data complied by PHIDU from deaths data based on the 2010-2014 Cause of Death Unit Record File supplied by Registries of Births, Deaths and Marriages and the National Coronial Information System

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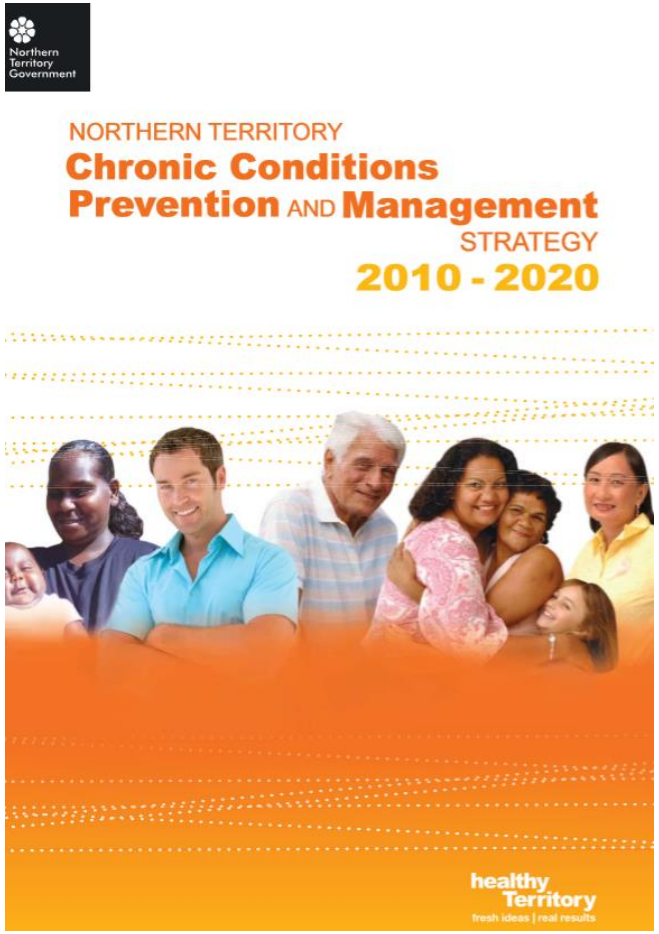
Background to CCPMS MEF

- No monitoring and evaluation framework developed at outset
- Need to evaluate CCPMS retrospectively – impact and outcomes?
- CCPMS had goals, but indicators not necessarily measurable
- Difficulty for annual reporting and ongoing monitoring
- Links between strategy and Action Plans not always clear
- Mid-Term Evaluation



MEWG Terms of Reference

Purpose

Members of the M&E WG will work collaboratively and contribute their knowledge and experience to develop an agreed process to monitor, evaluate and report on the CCPMS 2010-2020 and CCPMS Implementation Plan 2017-2020.

Role and Scope

The role of the M&E WG is to work collaboratively to:

1. Develop a monitoring plan and evaluation framework for the NT CCPMS 2010-2020 that will:
   a. Inform the development of a monitoring plan with reporting timeline;
   b. Agree on indicators for reportable activities;
   c. Align and include the CDNSC agreed work plan; and
   d. Inform the commissioning of an evaluation of the CCPMS.
2. Facilitate, collaborate and coordinate a multi-agency and cross sectoral response to the proposed actions.

Membership

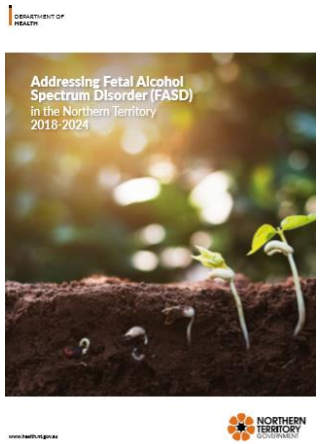
Name	Organisation
James Smith	Menzies School of Research
Kalinda Griffith	University of New South Wales
Jenny Summerville	Primary Health Networks Northern Territory
Karen Marshall	Aboriginal Medical Services Alliance Northern Territory
Sarah George	Heart Foundation NT on behalf of NT Good Health Alliance
Dee-Ann Vahlberg	Department of Justice and Attorney General
Ryan James Neve	Department of Chief Minister
Yvette Park	Department of Local Government, Housing and Community Development
Dana Fitzsimmons	NT Health Top End Primary Health Care Services
Mariam Cobson-Cobbold	NT Health Central Australia Primary Health Care Services
Michelle Ganzer	Department of Health Innovation and Research
Luana Symonds	NT Health Central Australia Primary Health Care Services
Moira Stronach	NT Department of Health Chronic Conditions and Prevention Unit
Liz Kasteel	NT Department of Health Chronic Conditions and Prevention Unit

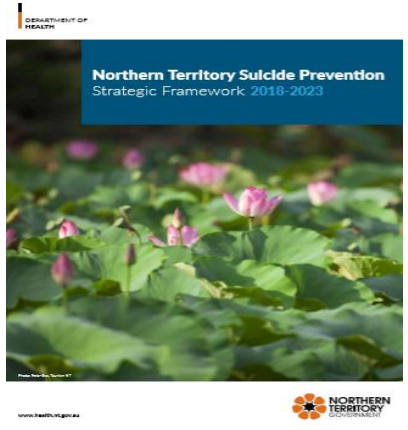
Process

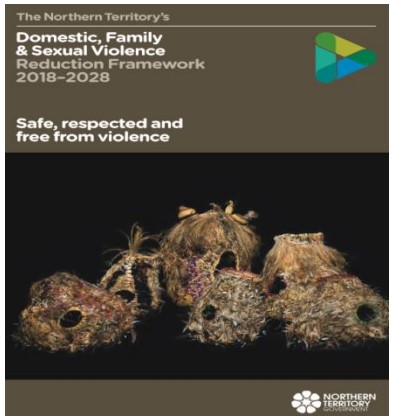
- 8 meetings across 11 months
- Agreed Terms of Reference
- Review of CCPMS, Implementation Plans, Annual Reports, Mid-Term Evaluation Report
- Mapping of health strategies/policies and related indicators
- Mapping of underpinning principles
- Retrospective development of Program Logic (Theory of Change)
- Iterative M&E Framework Development, including key stakeholder consultation, where required

Health & Social Policy/Strategy Mapping

- Desktop review of 50+ strategies/policies/frameworks – Territory-wide and national in focus
- Some KAA required broader mapping process (e.g. Social Determinants of Health; Primary Prevention)
- Some overlap in measures/indicators across agencies/sectors (but limited or no co-ordination)
- Issues encountered:
  - (a) very few explicit evaluation frameworks, particularly across NTG
  - (b) many indicators could not be measured / were not validated;
  - (c) insufficient data collected to measure effectively;
  - (d) responsible entity for monitoring and reporting on measures was unclear
  - (e) lots of research that could inform progress, but no single repository


Addressing Fetal Alcohol Spectrum Disorder (FASD)
in the Northern Territory
2018-2024


Northern Territory Suicide Prevention
Strategic Framework 2018-2023


The Northern Territory's
Domestic, Family
& Sexual Violence
Reduction Framework
2018–2028
Safe, respected and
free from violence

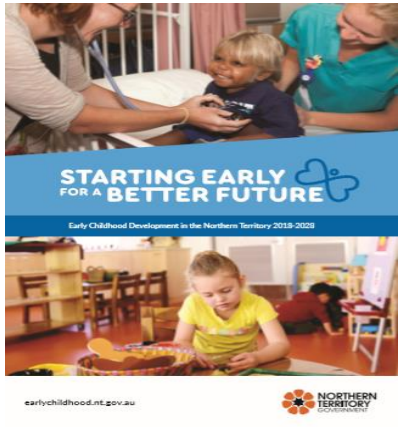

NORTHERN TERRITORY
CHRONIC CONDITIONS PREVENTION
and MANAGEMENT STRATEGY 2010 - 2020
IMPLEMENTATION PLAN
2017 - 2020

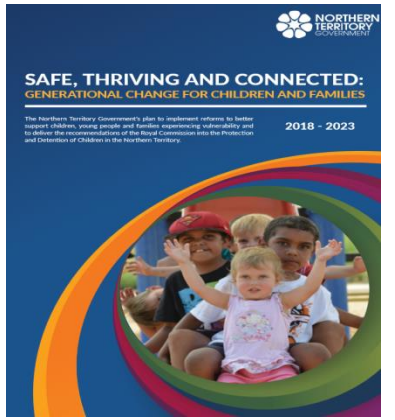
HEALTHY
LIFESTYLE


Pathways out of Homelessness
Northern Territory Homelessness Strategy 2018-23


NORTHERN TERRITORY
ALCOHOL HARM MINIMISATION ACTION PLAN
2018–2019


A share
in the future
Indigenous Education Strategy
2015–2024


STARTING EARLY
FOR A BETTER FUTURE
Early Childhood Development in the Northern Territory 2018-2028


SAFE, THRIVING AND CONNECTED:
GENERATIONAL CHANGE FOR CHILDREN AND FAMILIES
2018 - 2023

Principles

- Increased national focus on principles-based evaluation
- Indigenous data sovereignty an important consideration
- Three sets of principles:
  - CCPMS (CDN/NTG) – 14 principles
  - IAS Evaluation Framework (DPMC) – 9 principles
  - Indigenous health evaluation framework (Lowitja) – 7 principles
- Useful for guiding framework development and implementation, particularly qualitative measures

Principles

CCPMS Principles page	IAS Principles	Lowitja Principles	CCPMS Goals page 15
1. Addressing the social determinants 2. Demonstrating effective leadership and governance. 3. Working in partnership and collaboration 4. Encompassing prevention across the continuum of care. 5. Focusing on the early years of life. 6. Addressing services for Aboriginal populations. 7. Promoting respectful and committed person centred care. 8. Addressing social and emotional wellbeing. 9. Promoting active self-management support. 10. Providing evidence based care. 11. Promoting integrated multidisciplinary care. 12. Providing care coordination by multidisciplinary teams. 13. Promoting effective organisational and service delivery systems. 14. Demonstrating commitment to monitoring, outcomes and evaluation.	1. Integrated 2. Respectful 3. Evidence Based 4. Impact focused 5. Transparent 6. Independent 7. Ethical 8. Timely 9. Fit for purpose	1. Partnerships with Aboriginal and Torres Strait Islander Organisations and communities. 2. Shared responsibility 3. Engagement with Aboriginal and Torres Strait Islander people and communities 4. Capacity building of Aboriginal and Torres Strait Islander communities. 5. Equity 6. Accountability 7. Evidence based	1. Promote and support healthy lifestyles and wellbeing in the community 2. Reduce the prevalence of risk factors in the population 3. Prevent or delay the onset of chronic conditions 4. Maximise the wellbeing of those living with chronic conditions. 5. Reduce the health disparities among different population groups with regards to the conditions and risk factors in the framework 6. Reduce the gap of life expectancy associated with chronic conditions between Aboriginal and non Aboriginal people. 7. Increase self Management 8. Improve collaboration and integration across all sectors.

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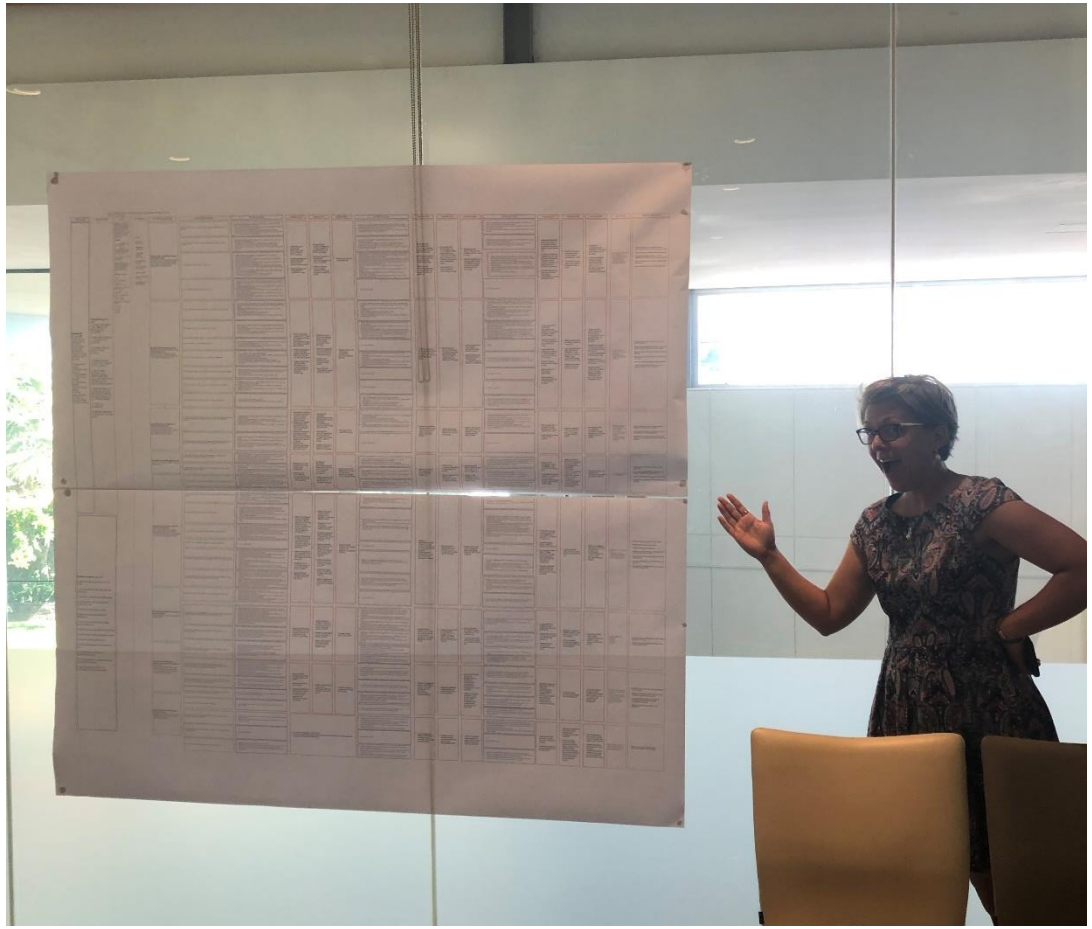
Development of Program Logic



Retrospective Program Logic

Assumptions for each key action area (KAA)	Inputs (Investment/ resources)	Activities (denote KAAs)	Outputs for each KAA			Outcomes of each KAA for all IPs – addressing CCPMS goals	Impact
			Implementation Plan 2010-2012	Implementation Plan 2014-2016	Implementation Plan 2017-2020		
KAA 1 – NT Department of Health leaders act on social determinants of health. KAA 2 – Other government and non-government organisations collaborate on sustained health and wellbeing initiatives that impact on behaviours and environmental factors. KAA 3 – Health service providers have the capability and systems that identify, monitor and act on early detection and management of disease markers. KAA 4 – A Territory-wide approach to self-management will result in client's ability to self-manage their chronic conditions. KAA 5 – Health services have appropriate systems and highly skilled workforce to deliver timely high quality chronic care. KAA 6 – Sound workforce planning and development will provide effective strategies for recruitment and retainment of skilled workforce. KAA 7 – State of the art information management (IM), information & communication technology (ICT) is effective and efficient in the delivery of high quality chronic conditions prevention and management. KAA 8 – Continuous quality improvement everybody's business.	**Funding** **Workforce** **Environment** eg national (Commonwealth) direction; other related strategies, etc **Health systems**: • Delivery system design • Decision support • Clinical Information systems • Policies • Consumers/community resources **Non-government health providers**	1. Social Determinants of Health (SDoH) 2. Increase focus on primary prevention to prevent and reduce risk factors 3. Early Detection and secondary prevention 4. Self-Management 5. Care for people with chronic conditions 6. Workforce planning and development 7. Information, communication and disease management systems 8. Continuous Quality Improvement	1. Awareness activities in SDoH is evident within health sector. 2. Collaborative work completed to establish healthy environments for smoking and healthy workplace. 3. Recording and reporting of risk factors and intervention established 4. Evidence of the development and implementation of the NT Self-management Framework. 5. Comprehensive monitoring and reporting of chronic conditions management established in service management. 6. Education and training opportunity in prevention and management of chronic conditions are available and accessible. 7. All health care providers has access to electronic client health information system. 8. CQI process established and practiced by health care providers.	1. Strong leadership is apparent to communicate SDoH to health and non-health staff/organisations. 2. Population risk factors reporting increases community awareness and facilitates policy and planning processes. 3. The uptake of Adult Health Checks has increased over the last 10 years. 4. Self-management training to health practitioners are available and accessible. 5. The NT Chronic Conditions Management Program is consistently used by health care providers across NT. 6. The uptake of training in chronic conditions, face-to-face and e-learning, is consistent throughout the last 10 years. 7. Population health reporting and communication about chronic condition is in place. 8. CQI strategy is implemented by health care providers.	1. Inter-sectoral action on SDoH demonstrated in Child and Adolescent, Early Childhood, alcohol and family violence strategies. 2. Collaborative action with health and non-health organisations on the reduction of lifestyle risk factors associated with chronic conditions are in place. 3. Action on early detection and secondary prevention of chronic conditions markers has increased. 4. Self-management is recorded in electronic client health records as part of care delivery. 5. Innovative, integrated and evidenced based chronic conditions models of care established and evaluated. 6. Increasing number of Aboriginal employed at all levels /areas of health is evident in the last 10 years. 7. Contemporary IM and ICT support the coordination and integration of care. 8. CQI informing and improving evidence based service delivery established as part of core business.	1. Collaborative and inter-sectoral partnerships has resulted in action on SDoH. (Addresses goals 5 &8) 2. Behaviours and environmental factors that promote and support health and wellbeing have improved. (Addresses goals 1&2) 3. Progression and early onset of chronic conditions are delayed or stopped. (Addresses goals 3&5) 4. Self-management is embedded in day-to-day practice of care delivery. (Addresses goals 3, 4 &7) 5. All Territorians have equitable access to high quality evidence-based chronic care (Addresses goals 4 & 7) 6. Appropriately skilled workforce in prevention and management of chronic conditions are employed. (Addresses goals 4 & 7) 7. Information management (IM), information & communication technology (ICT) enables timely access to appropriate chronic conditions prevention and management services (Addresses goals 2, 3 & 5) 8. Continuous quality improvement is embedded in day-to-day practice for improved care delivery. (Addresses goal 5)	The health and wellbeing of Territorians is improved through reduced incidence and impact of chronic conditions

CCPMS Principles

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Indicators

- Unrealistic to evaluate against all indicators listed in CCPMS
- Difficult to establish baseline assessment
- Some indicators not measurable longitudinally
- Sometimes lack of reliable/quality local data
- Difficulty in integrating data sets to tell complete picture (technical)
- Disadvantaged populations vs mainstream (equity lens)
- Agreement that both qualitative and quantitative measures were required
- Policy drift = indicator drift (noted in Implementation Plans)

Considerations in prioritising indicators

- NT Aboriginal Health KPIs
- Health Performance Framework
- GP Data/MBS/PEN/PBS
- Indicators used in other frameworks
- Research/Evaluation projects in the NT
- National Chronic Conditions Framework

Overarching Indicators

Indicator name	Low birth weight	Life expectancy	Mortality due to chronic conditions.	Morbidity related to chronic conditions	Potentially preventable hospitalisations due to chronic conditions.
Rationale	Low birthweight (<2,500gms) associated with an increased risk of developing a range chronic conditions (Australian Health Minister's Advisory Council, 2017)	Commonly used measure of overall health of a population	Death rates measure the overall health status or measure improvement overtime.	Morbidity measures the burden of disease and contribution to the overall health cost.	Measures the proportion of morbidity that could be could be avoided. "An indicator for access to primary care and its effectiveness as a measure of preventable health gains from primary care interventions"
Measure	Trend in the proportion of low, birthweight babies, 2010-2019 by health districts (Alice Springs, Barkly, Darwin, East Arnhem, Katherine).	Trend in estimated number of years a person is expected to live at birth	Trend in years of life lost by listed chronic disease group	Trend in years lived with disability by disease group	Trend in age standardised rate for potentially preventable hospitalisations, chronic
Data type	Quantitative	Quantitative	Quantitative	Quantitative	Quantitative
Data source[1] and frequency	NT AHKPI National ATSI Health Performance Frameworks (HPF)	NT BoD Every two years	NT BoD Every two years	NT BoD Every two years	AIHW Annually

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KAA 1 Social determinants

Proposed outcome: Collaborative and inter-sectoral partnerships contribute to improve living conditions, food security, education, employment and health literacy.			
Indicator name	Access to health services	Health Literacy	Inter-sectoral relationships
Rationale:	Improvement in health can be demonstrated through improved access to health service and reduced inequity. (Department of Health and Ageing, 2013)	Positive engagements, between clients and health professionals and among health professionals, are critical to improve client's health outcomes.	Inter-sectoral relationships increased the likelihood of collaborative action on social determinants such as living conditions, food security, education, employment and health literacy (Corbin, Jones, & Barry, 2018)
Measure	Claimed MBS for services provided by GP, nurse, allied health and Aboriginal Health Practitioners.	Activities undertaken to promote and improve health literacy of clients, health professionals and health organisations.	Activities undertaken to promote and improve: living conditions; food security; education; and employment.
Data type	Quantitative	Qualitative	Qualitative
Data source and frequency	AIHW ATSI HPF and MBS PCIS (specific for the prison population) Annually	Interviews to determine the nature of strategic initiatives to promote and support health literacy at the individual level and the environment. Not recorded and not reported	Interviews to determine the level or extent of collaborative action on: Living conditions Food security Education Employment Not recorded and not reported

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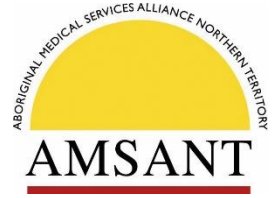
Lessons Learned

- Develop monitoring and evaluation framework at the outset!!
- A monitoring plan (with shorter intervals) is also required
- Start with outcomes in mind
- Resourcing to undertake evaluation (and parallel research processes)
- Governance and leadership with evaluation understanding
- Mapping and utilising evaluation capability/expertise
- Complexity of strategy = complexity of evaluation framework
- Linkages between actions and strategies (co-dependencies)
- Feedback from MEWG
  - Linkages to other sectors
  - Establishing connections with members of other government departments
  - Lead to other collaborative opportunities
  - Knowledge of the expertise in the sector and knowledge holders

Acknowledgements

M&E Working Group



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