COMMUNITY WATCH PARTNERSHIP PROJECT

October 2020

PILOT EVALUATION REPORT

Supporting vulnerable clients during the COVID-19 pandemic

Executive Summary

The Community Watch Partnership Project is an innovative pilot that leverages local digital health knowledge and practice through a systems transformation platform. In its essence a capacity building project, participating organisations were provided with a range of guiding resources and a service directory to support them to implement and/or deliver their tailored wellbeing check service in a coordinated way. This project is our argument that facilitating enhanced well-being in the community requires the vulnerable client to be empowered as much as possible.

All people can experience vulnerability and associated poor health outcomes at any point in time because vulnerability can be temporary or permanent. By acknowledging that vulnerable health clients in our context are often not informed, connected, empowered and active participants in their own health journeys, this pilot project was created.

As the pandemic grew and persisted over time, community and health services identified the need to find innovative and sustainable ways to adapt their engagement with clients, community members and staff to ensure the local community continued to receive appropriate and adequate health care and wellbeing supports during the pandemic; and minimise potential adverse health risks associated with delaying access to care.

The Community Watch Partnership Project is designed upon the belief that it is essential to communicate effectively and openly with clients to build trust and ensure effective service provision and value creation for all clients. We took the principle of value creation as our guide to designing our partnered approach to this project pilot and our partnerships more broadly across the catchment, and recognises the importance of effective and transparent dialogue and communication between stakeholders and sharing mutual resources and process to eliminate information and service access barriers to clients.

Key findings

While the difficulty rating self-reported by partners to adapt their organisations to the new COVID-19 world was high, over 90% of partners undertook active, passive and/or a combination of both types of activities, in order to support their vulnerable clients. By the time the second wave was in full effect, 90% of partners had implemented some type of wellbeing check program to engage with clients.

All partners reporting disruptions to services and experiencing some degree of change fatigue. The ongoing nature of the public health restrictions exacerbated existing gaps in service delivery and referral options. Both the developed Service Directory and Compendium of Guiding Resources proved beneficial to organisations across the region building their capacity to support their clients during COVID-19 public health restrictions.

The HWPCP developed Service Directory was the first of its kind to systematically collate the varying service providers and community organisations available in the region and was identified as a key motivating factor for many in joining the partnership project. While the service directory highlighted gaps in local health and support sector knowledge of service and referral options, it was very successful in raising awareness among partners of the range and depth of services and supports available in Hume and Whittlesea and what extra services and supports are needed in the future.

Building the capacity of partners to conduct wellbeing checks required a robust and focussed partnership. All partners recognised the importance of forming the CWPP partnership and there was significant trust in the Project Leads in their provision of secretariat supports and backbone functions. There is also a significant appetite among partners to continue to share knowledge and create best practice evidence through the formation of a Community of Practice for as long as the COVID-19 pandemic persists.

The findings and learnings detailed in the report indicate that the CWPP team and partnership are well positioned to undertake future steps to implement and trial a focussed wellbeing check intervention within the region that incorporates both the CWPP and CASSI initiatives, maximising impact and reach and reducing duplication. The opportunities available to partners to further develop workforce skills and partner capacity are detailed.

As the pandemic has shown in 2020, vulnerability does not discriminate. We are grateful to all our partners who have supported this pilot Community Watch Partnership Project with special thanks to Banksia Gardens and Whittlesea Community Connections.

We would also like to thank everyone who dedicated their valuable time to meet, share expert knowledge and challenge us to think differently during this project, surveys and evaluation during what has been a difficult 2020 for us all.

Acknowledgments

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Introduction

The Community Watch Partnership Project (CWPP) commenced late April 2020 led by DPV Health and the Hume Whittlesea Primary Care Partnership, in partnership with Whittlesea Community Connections and Banksia Gardens. The project quickly grew to include additional health and community service organisation members and a reference group of 13 partners. It then rapidly evolved into a whole of catchment (Hume and Whittlesea) partnership project aimed at building the capacity of 42 health, wellbeing and community support partners to support local vulnerable people during the COVID-19 pandemic.

The CWPP was designed to be a client-centred and partnered approach pilot project. The pilot leveraged existing local knowledge around wellbeing and health check type program models that utilise a health coach or guided referral style approach. In its essence a capacity building project, participating organisations were provided with a range of guiding resources and a service directory to support them to implement and/or deliver their tailored wellbeing service in a coordinated way.

Context

Melbourne's outer north is experiencing rapid population growth. Coupled with a historically under-resourced service sector, this contributes to an intense form of place-based isolation, disadvantage and social disconnection. The associated risk factors of these growth corridor environmental conditions include increased rates of family violence, debt, housing and mortgage stress, and family breakdown. These factors in conjunction with a generally higher rate of chronic health conditions such as diabetes in the growing north, there is an urgent and growing need for integrated, innovative, and placed based health supports and services.

Local evidence supports the applicability of integrated models of service delivery to address the physical and social barriers that disadvantage communities in Melbourne's outer North. Health and social support providers who work with vulnerable client cohorts widely acknowledge the influence of social and economic determinants—including, for example, income, educational achievement, employment status, social connectedness, access to food, and housing status. Yet despite this awareness, until recently comparatively little has been done at the system level to ensure high need clients receive adequate community-based, preventive health and social supports, to support and enhance clinical service provision.

Recognition is growing that a relatively small percentage of the community use a disproportionate share of health care and wellbeing services. These individuals often face multiple clinical, behavioural health, and social challenges, which contribute to often ineffective interactions with the health care system. In addition, clients with complex physical and behavioural health needs (e.g., diabetes, chronic obstructive pulmonary disorder, congestive heart failure, substance abuse, and psychiatric disorders etc) typically require more intensive, ongoing treatment models than the fragmented care available in emergency department (ED) and primary care settings. During the onset of the COVID-19 pandemic, providing appropriate care was always going to be a challenge without adaptation and innovation.

With rapid health care transformation efforts underway across the nation in response to the COVID-19 pandemic, there is increasing attention on improving health and wellbeing outcomes across the general population and reducing avoidable hospitalisations, particularly for vulnerable clients. As innovative models continue to emerge, policymakers and providers are eager to identify and scale

effective strategies for serving high-need clients as one component of broader efforts to build more efficient and sustainable systems of care.

Background

The Community Watch Partnership Project (CWPP) was developed initially as a short-term proactive response to Victoria's COVID-19 first state of emergency and subsequent public health orders and restrictions announced on 16 March 2020.

It was identified early by DPV Health and the Hume Whittlesea Primary Care Partnership that essential public health and social distancing measures introduced to reduce the potential transmission of COVID-19, were likely to result in disruptions to health and social support organisations' regular activities, programs and service delivery within the catchment. It was then hypothesised that this disruption in service access and delivery would more likely adversely impact people already vulnerable to poorer health and wellbeing outcomes across the Hume and Whittlesea local government areas.

As the pandemic grew and persisted over time, there was also growing concern in the local community that these potential risks to ongoing health and wellbeing could become exacerbated due to the social, economic, and health impacts of the pandemic if clients did not take actions to maintain their health whilst they were unable to access routine care. It was recognised that community and health services needed to find innovative and sustainable ways to adapt their engagement with clients, community members and staff to ensure the local community continued to receive appropriate and adequate health care and wellbeing supports during the pandemic; and minimise potential adverse health risks associated with delaying access to care.

This report details the period of the CWPP's formative design and implementation between April to August, with implementation data extending to October 2020. Broken into sections this report aims to answers the following questions:

1. Why a community watch type project?
2. What happened during the pilot project?
3. What are our learnings and opportunities for improved practice in the future?

Section one: Why a community watch type program?

With increasing knowledge regarding the possible modes of transmission and infection from the virus (COVID-19) during the first quarter of 2020, face to face health service delivery was quickly identified as a high-risk activity without adequate precautions and safety equipment. To address this, the CWPP team looked to known online or phone-based programs that have been successful in other clinical settings or locations around Australia and the world in minimising adverse health outcomes and risks associated with factors such as delaying access to care, avoidable hospital admissions and readmissions etc.

In looking at developing and implementing a phone or online based wellbeing check type program, we had four hypotheses that underpinned the development of our program:

1. That phone or videocall based health outreach calls was an accepted form of communication among people identified as vulnerable to poor health outcomes;
2. That people identified by partners as vulnerable to poor health outcomes were more likely to accept health and wellbeing information, supports and referrals from a provider they knew and already had a relationship with;
3. That people identified by partners as vulnerable to poor health outcomes were likely to delay accessing care during the pandemic; and
4. That delaying access to care during the pandemic will result in poorer health outcomes mid to long term.

Acceptance of phone or videoconferencing healthcare provision

With a pandemic, the use of a digital or phone-based approach care is not new practice but has quickly become the norm instead of the exception, particularly in the support of clients in remote and rural areas, young people and people at risk of hospital readmission.[1-3] While some studies on the use of videoconferencing report benefits in patient care particularly in reduced travel times and convenience, particularly for those with long-term conditions,[4,5] systematic literature reviews found that health outcomes using the technology is roughly the same as routine face to face healthcare[9,10]. In addition, patients accept and are largely satisfied with the use of videoconferencing for their health care interactions.[6-8]

Evidence however is lacking regarding the effectiveness of phone based approaches to mental health related care.[11] With unprecedented funding for phone crisis lines during the pandemic, hopefully these services are being evaluated for effectiveness. Research to date suggests they are effective in times of crisis (e.g. in the pandemic) but there is limited evidence to support long term health benefits.

Trust in care provider

The provider-client relationship is crucial to all types of health and wellbeing care delivery and is built upon trust. Trust increases the likelihood the client will display loyalty toward a service provider and maintain the therapeutic benefits of the provider-client relationship. However, this relationship has been changing with advances in technology and accessibility to alternative health care information online.

The literature shows that patient centred communication is known to be a significant mediator between client perceptions of the quality of the health care they receive and the client's trust in the healthcare provider.[12]. Similarly, it is an important factor in influencing positive health outcomes, with studies showing that positive face to face healthcare provision translates into positive online health care interactions.[13] Trust in care provider is also related to value creation for vulnerable clients.[14] In a pandemic, trust requires two way communication and an understanding by the provider of the unique vulnerability of clients in terms of clinical and social aspects of health and health outcomes as well as acting as a mediator to create trust.

Delaying access to care and health outcomes

The pandemic has resulted in large scales changes to the Australian health system through reinforced public messaging campaigns to "stay home, stay safe". As fear grew that people may be delaying access to care the messaging adapted to encourage people, especially those with chronic disease conditions to access routine care. This adaptation in the messaging has meant that delays in accessing care appeared to be temporary. However, there is emerging evidence that access to cancer services has been significantly adversely affected through removal of service provision[15,16]; where people with cardiovascular conditions appear to have been delaying access to life saving care.[17,18]

Health disparities in social determinants are well known among people identified to be vulnerable such as the criteria listed in this project (e.g. low income, live alone, some cultural backgrounds, chronic health conditions, mental health concerns etc). Many of the gaps in health care outcomes for vulnerable people can be attributed to conventional public health interventions or system approaches that are designed as a one-size fits all. Digital health interventions such as this community watch program provide the opportunity to support vulnerable clients maintain their health through innovative approaches.

Review of other wellbeing check models

A growing number of health providers are using sophisticated risk stratification tools and predictive analytics to identify vulnerable or at-risk clients and implement tailored outreach, engagement, and care delivery strategies. This is in our view best practice as these organisations seek to assess not only health status, utilisation, and outcomes, but also account for social factors, such as housing, food insecurity, and income instability. But is this type of model appropriate in settings outside of health or in partnered approach projects with non-traditional partners?

To address this, we conducted a brief literature review of programs that had similar aims and purposes at the CWPP. Our search looked for phone or online health check in programs, health coaching programs, anticipatory care models and social prescribing interventions that utilised a guided referral approach. We found relevant models and program types that informed our CWPP model design. These are outlined below.

Monash Patient Watch – Anticipatory Care Model

Developed in a major Melbourne Metropolitan Hospital, the Monash Patient Watch program is an anticipatory care model approach to reducing potentially preventable hospitalisations and hospital readmissions.[19,20] Utilising individual patient journey maps and clinical data (Patient Journey Record System or PaJR), this innovative program utilises an algorithm to predict health tipping points to get appropriate care to patients early to avoid the need for hospitalisation. Led by clinical staff, this program has a comprehensive operational framework to address potentially preventable

hospitalisations, and expertly considers a person's biopsychosocial needs and changes as well as caregiver concerns and clinical treatment impacts.

Understanding anticipatory care models and approaches was important for the CWPP team as avoidable hospitalisations are expensive from a public health point of view but are also too often unhelpful or even harmful to patients. Anticipatory care models focus on improving the coordination of care within a health system particularly within the first 30 days of a patient's discharge from hospital. As the CWPP did not have access to health outcome prediction algorithms or in some cases, access to client's clinical data, we could only adopt an "anticipatory care approach" in principle. However even the adoption of this approach in principle meant that the pilot and how partners conducted wellbeing checks was a combination of addressing health needs in a crisis and could also be future focussed.

For more information on this program go to: https://monashhealth.org/services/monashwatch/

Health Coaching approaches

Telephone health coaching for people, especially those with chronic conditions, has the potential to improve health behaviour, self-efficacy and health status and outcomes. Health coaching approaches are particularly used for and are of most relevance to vulnerable populations who have difficulty accessing health services in a normal health environment, much less a pandemic. The planned and goal focussed telephone coaching services have the advantage of regular contact and helping people progress self-management skills over time. The semi-scripted aspect allows the coach to tailor support to the individual patients' needs and appears to be appropriate for people from all population cohorts including vulnerable people. The literature showed that most health coaching services and programs are planned and target patients with complex needs who have one or more chronic disease. Planned and scripted telephone health coaching models seemed to be more effective for patients at moderate risk of poor health outcomes or hospital readmission; especially where motivational interviewing was used. Overall, telephone coaching does not improve patient adherence to treatment but improves self-efficacy and satisfaction with care.[21]

This model was of interest to the CWPP team as it was similar to approaches already operational in the area. The scripted aspects of the evaluated approaches, as well as the risk management elements and the focus on maintaining health during key risk periods was very important to understand. The health coaching approach was consistent with the CWPP project aims of helping clients stay well during the pandemic through providing information and guided supports to clients tailored to their health and wellbeing needs. The approach is also complimentary to CWPP as it had the potential to helps clients stay connected to their trusted service provider during the pandemic.

Social Prescribing approaches

Social prescribing approaches are based on the premise that psychosocial problems impact on the health and wellbeing of people. However, they also recognise that what information and supports people need to support themselves with self-care and chronic disease management vary from person to person. Non‐medical referral, community referral or social prescribing interventions has been proposed as a cost‐effective alternative to help those with long‐term conditions manage their illness and improve health and well‐being.[22] A 2019 study found that in the UK for every $1 spent on social prescribing services, there is a saving of 15c in primary care.[23] Social prescribing interventions typically involve accessing activities run by the third sector or community agencies and thus of interest to the CWPP team.

While there are six different approaches to social prescribing that have been identified in the literature[22], only a few were application to the CWPP team given the pandemic. These were:

1. Primary care referral: where primary healthcare workers assess patients and refer them to a social prescribing service. This is based upon an appointment leading onto non-clinical issues and is opportunistic.
2. Practice-based specialist referral worker: a worker or volunteer works from a primary care or community-based practice but may offer clinical and non-clinical service referrals and information provision.
3. Non-primary care based: —referrals from practice and community-based staff are sent to a central referral centre. This could be an outreach service, set in the community, offering a one-to-one service. All local health, community and support organisations can use this service and facilities.

As the literature on social prescribing approaches highlights, it is the link worker that talks to and supports the person with a referral or just a social connection that makes the difference in the success of any intervention helping people stay well. It is this key learning that we adopted in the development and design of our community watch program.

What did we set out to do?

Our Purpose

The Community Watch Partnership Project (CWPP) identified that while some partners were already conducting wellbeing type checks of their clients others weren't. We also identified that some partners would like to start a wellbeing check type program and all partners in the catchment would benefit from sharing resources and developing tools that would be mutually beneficial. To this end the purpose of the CWPP became the development a whole of region coordinated approach to amplify partner-client support efforts and minimise duplication for clients that accessed multiple services within the catchment.

Our Objectives

In developing a whole of region coordinated approach, we had the following five objectives:

1. To minimise the worsening of health issues predicted to be exacerbated by the public health restrictions implemented to minimise the spread and impact of COVID-19;
2. To improve access to health and wellbeing services to vulnerable community members during the pandemic online or over the phone;
3. To identify community organisations that are conducting wellbeing checks during the pandemic and to build their capacity to support them do this;
4. To ensure a consistent and coordinated approach to wellbeing checks regionally and reduce duplication; and
5. To identify, develop and co-design resources, guides and tools required by local organisations to conduct wellbeing checks.

Defining vulnerability

While vulnerability is a common term used to describe specific health care clients, we have adopted Baker's (2005) definition[24] as:

" A state of powerless that occurs when control is not in an individual's hands, creating a dependence on external factors (e.g. service providers) to create fairness in the marketplace and where service access (consumption) goals may be hindered (p.134)."

Vulnerable consumers typically include those with disabilities, the elderly, those from the LGBTIQ+ community, Aboriginal peoples, refugees and migrants, those with mental health concerns, obese people, those living in remote communities and/or children. In health settings, vulnerable clients are also defined as people who may not be able to navigate the service system, they may lack the information to set care goals, and they may lack the freedom or ability to achieve goals.

As the pandemic has shown in 2020, vulnerability does not discriminate. All people can experience vulnerability at any point in time because vulnerability can be temporary or permanent. It is with the pandemic in mind that we argue that vulnerability should also be understood in terms of ongoing uncertainty and tensions that arise when experiencing or attempting to reduce vulnerability.

For the purpose of this CWPP, vulnerable clients were identified as:

- People in possession of a Health Care Card or Pension Card
- Newly arrived refugees, migrants and asylum seekers
- People over the age of 70
- Aboriginal and Torres Strait Islander people, especially those over the age of 50
- People on waitlists for support programs and services
- People that live alone
- Single parents, especially those home-schooling their children
- Parents of children with a disability
- People with chronic disease and multi-morbidities
- People with mental health conditions
- People experiencing or at risk of family violence
- People experiencing or at risk of financial stress
- People experiencing or at risk of homelessness and housing insecurity

Section two: What did we do?

A partnered approach

From experience we know that partnering on projects can result in a higher level of quality on a project and can also significantly increase the probability of the project meeting its aims and objectives. A partnered approach also encourages greater innovation through open communication and trust. As this pilot project had the potential to ensure that people in Hume and Whittlesea had increased capacity to stay well during the pandemic, so enlisting the skills, connections and real world guidance of our partners was identified as an essential driver of success.

As one of the objectives of the pilot project was to reduce duplication, a partnered approach enabled us to achieve higher quality resources through focusing on mutual goals for the whole of region. In designing this project and with the aim of reducing duplication, the activities we undertook focussed on developing complementary operational procedures; shared risk and problem solving approaches; collaborative tools for best practice across the region; and accelerated learning through group thinking and networking.

While the Department (DHSS) did fund local government authorities for a very similar and competing initiatives at the mid-point of the pilot project, our partnered approach meant that our partners were not side tracked into potential adversarial relationships until the end of the pilot phase and were able to leverage the work of the CWPP pilot and utilise that work for their new initiatives.

Strategy and Design

In determining the best approach for the design of the pilot project we posed the following: How can we support and build the capacity of community organisations to support their clients using staff, volunteers, and technology in the context of COVID-19 public health restrictions and beyond? Our solution was to develop a whole of region coordinated approach for a wellbeing checks and the development of a comprehensive service directory for local community organisations to support their clients during the COVID-19 and beyond through the three interventions.

Table 1. CWPP proposed interventions

Proposed intervention	Aligned objective
Partnership: Develop a partnership comprising governance and working groups to identify supports to community organisations and ensure a consistent and coordinated approach.	**Objective 3:** Build the capacity of partners to conduct wellbeing checks during the pandemic **Objective 4:** Ensure consistent and coordinated partnership approach.
Program: Design and implement a model by organisational staff/volunteers to reduce isolation and increase access to services.	**Objective 2:** Improve client access to services during the pandemic. **Objective 1:** Minimise the potential risks to health and wellbeing exacerbated from COVID-19 public health restrictions.
Participatory research: Collect data to assess the impact of the model, whether objectives have been met and lessons learned.	**Objective 5:** Identify and codesign resources to support partners.

Volunteer preparedness, ethical implications pertaining to anonymity, confidentiality, privacy, consent and data security were also discussed in the design of the CWPP pilot. Concerns over volunteers potentially lacking the advanced practitioner skills required to work with vulnerable people facing complex barriers to wellbeing was highlighted as a risk especially given the timeline of the project and no resources to provide training. To address this each organisation that used volunteers would implement a robust supervision and support program to minimise risk to the volunteer and clients.

With these risks identified and other issues which were likely to arise during the pilot, a governance structure was developed with four subgroups within the working group being: Design and Evaluation; Communication; Service Directory; Resource development.

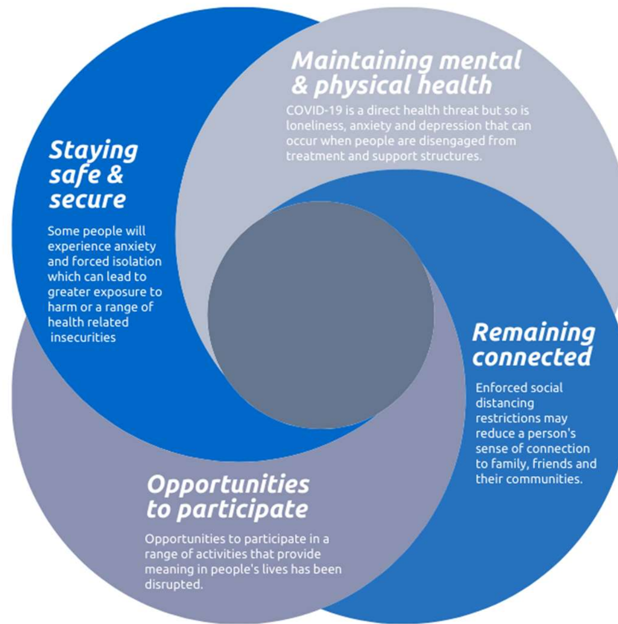
Wellbeing framework

The design of the project was presented at the first Working Group meeting in May 2020. This included the development of an outcome's framework, modelled from the Victorian Government's Wellbeing Outcomes Framework. The framework reconfigured into a conceptual framework to inform the definition of wellbeing for the project. This would then form the basis through which measurement indicators would be developed against to track project performance. The proposed outcomes for participants based on the selected domains were:

Table 2. Wellbeing domains and descriptions

Wellbeing Domain	Domain Rationale	Proposed Outcome
Security	Personal safety is an issue for people vulnerable to forms of family violence. Security includes economic security which if affected can have effects for food and housing security.	Staff/volunteers assess the safety needs of clients and provide information and referrals should they be wanted. This assessment may provide an indication of unmet needs or gaps in the region.
Participation	Participation is more difficult under social distancing restrictions, and to the extent that groups and connections have moved online, this poses challenges for people with low levels of digital literacy and access to technology.	By contacting clients either by phone or through technology, clients can access health care and have a meaningful connection with their service provider. It also gives clients information about what they can and can't do in terms of participation in social activities during public health restrictions.
Connection	For the same reason as above, connections to culture, religion, and community such as sport, education and work have been disrupted.	Conversations are in of themselves opportunities for connection, but the program will be supported with a service directory to connect people to additional services where required.

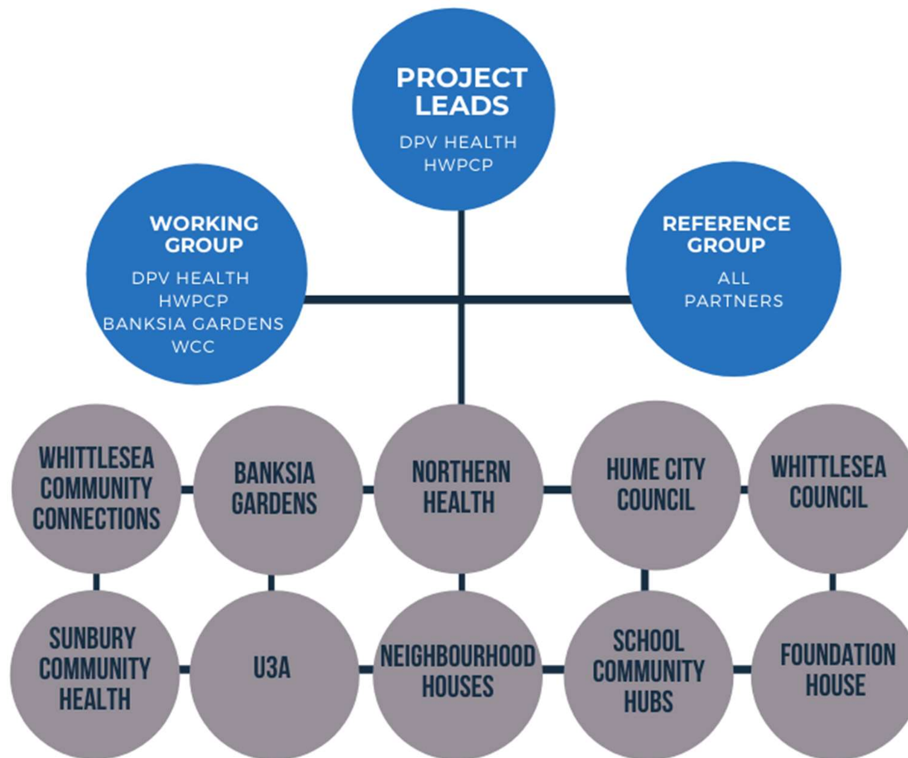
Figure 1. CWPP Wellbeing Conceptual Framework



Governance structure

To oversee governance arrangements of the project a Reference Group and Working group were formed. Each had defined responsibilities and cross-sector representation. The purpose of the working group was to oversee the operational model, its design and implementation within a cross sector partner context. Where the function of the reference group was to provide the working Group with expert advice and guidance regarding core operational elements of the pilot CWPP model. The project leads, DPV Health (funds holder) and HWPCP provided overall project management and secretariat supports.

Figure 2. CWPP Governance structure



Implementation Plan

The implementation plan and proposed timeline built upon the approved in the initial project brief and activities listed within the program logic.

Figure 3. CWPP implementation plan overview

Table 3. Projected CWPP Timeline

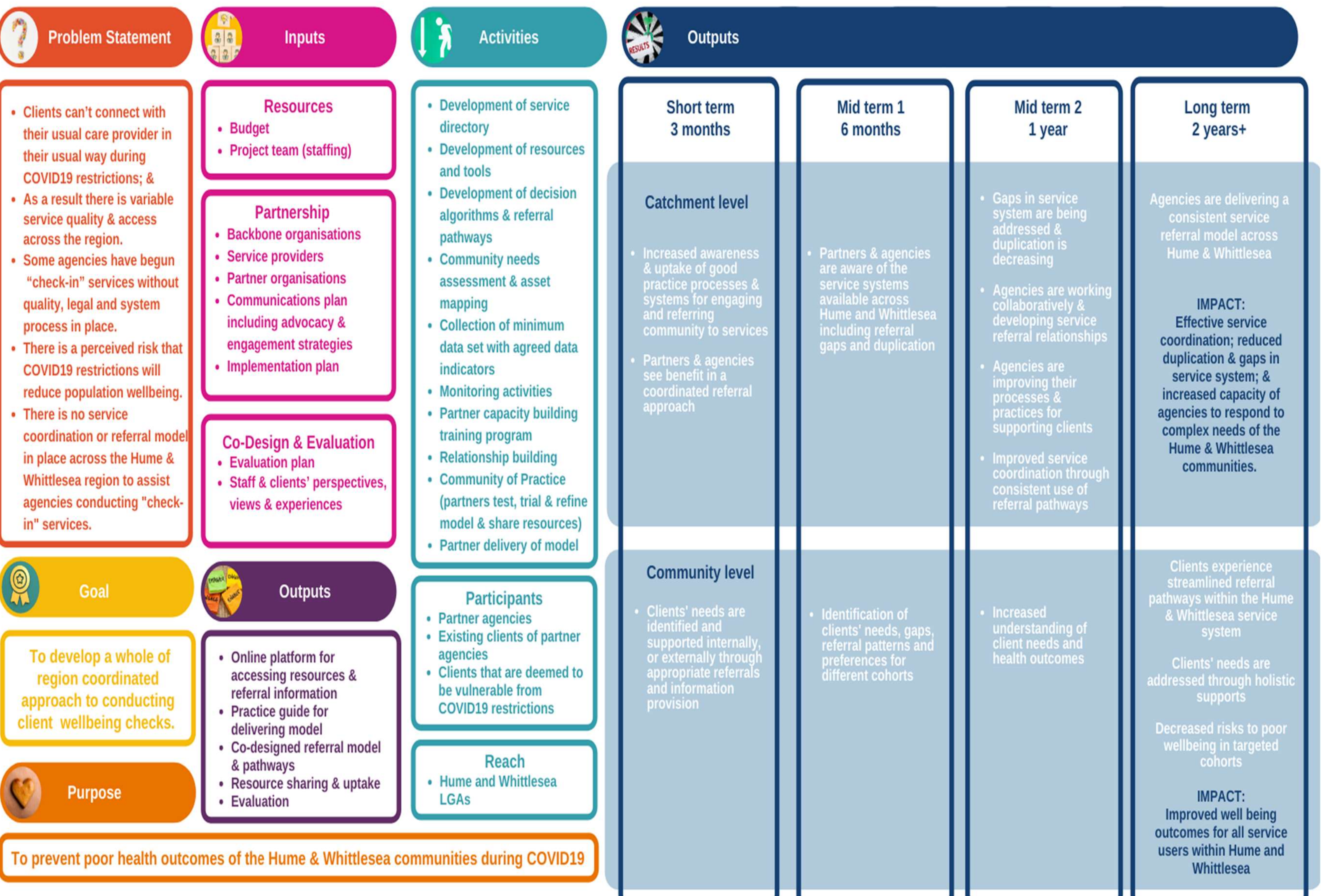
ACTIVITY	END
Project approval and commencement (including onboarding of external consultant)	29 April 20
Establish Governance and identify roles and responsibilities	10 May 20
Develop Project Plan and Outcomes and Evaluation Plan	29 June 20
Develop materials to engage local organisations (including community needs survey, promotional material, FAQs)	09 June 20
Develop suite of guiding resources to support local organisations implement CWPP model	19 June 20
Establish Community of Practice to support participating organisations	19 June 20
Continue to identify and support changing needs of local organisations	29 June 20
Review and refine guiding resources and service model based on feedback	14 August 20
Develop and finalise research report	30 Sep 20
Disseminate report to key stakeholders	30 Oct 20

Program Logic

A program logic was developed to describe and visually represents how the CWPP pilot project will work. It aimed to show the intended causal links of a project by linking the resources and activities with outputs, and short and long-term outcomes. It was agreed that a program logic was necessary to support program planning, implementation, and evaluation. Importantly, it helped to ensure common language between stakeholders and a clear articulation of the purpose and goals of a project.

In developing the program logic it became clear that there was a level of uncertainty regarding the purpose of the project among some partners. While the majority of partners understood the purpose of the project to be one focussed on supporting and building capacity of partners to deliver wellbeing checks to their own clients, some partners believed that the CWPP would deliver wellbeing checks on behalf of other partners. The program logic clarified this.

Figure 4. CWPP Program logic

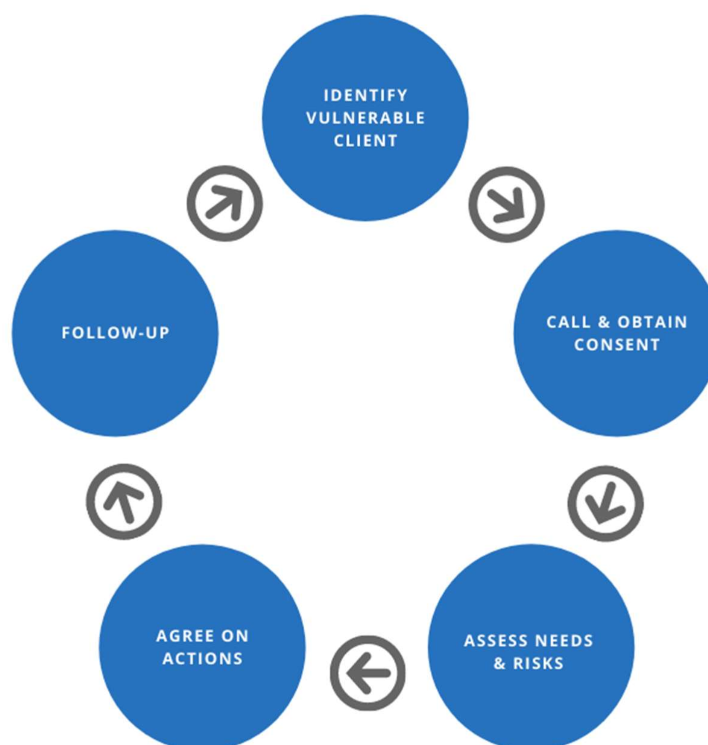


Proposed wellbeing check model

The service model comprised five elements for its delivery (see Figure 5):

1. **Call:** staff/volunteer *calls* client from existing client database, introduces themselves and why they are undertaking a wellbeing check using the guiding script from *Guidelines: How to undertake a wellbeing check-in.*
2. **Obtain consent:** Verbal consent is obtained from the client to participate in the check-in using *Guidelines: Privacy, data collection, and management.*
3. **Assess:** Staff/volunteer confirms language support needs and arranges appropriate service. Staff/volunteer commencing wellbeing check using guiding script to assess client's wellbeing.
4. **Action:** Any identified risks are discussed with the client. If immediate risks are identified, the call is escalated according to the guiding script. Staff/volunteer provides requested or appropriate service support options using the *Online Service Directory*. Staff/volunteer obtains additional consent to provide assisted referral if requested using *Guidelines: Privacy, data collection, and management.*
5. **Follow up:** Staff/ volunteer verbally confirms outcome of the call with client and schedules a follow-up. The outcomes of the call are recorded, and referral is made to requested support service using *Template*: *Service referral information.*

Figure 5. The CWPP wellbeing check model



Our Actions

The following section describes the actions undertaken by the CWPP team and partners between March 2020 and October 2020 as part of the pilot project. Available secondary qualitative data collected throughout the project's implementation was used to assist this description. This comprised observational notes from stakeholder consultations; meeting minutes; presentations;

and progress reports. Data was analysed using discourse analysis. A timeline of activities undertake is presented in figure 6.

Partner Engagement

The CWPP proposal was developed in March by the Project Leads, DPV Health and HWPCP. Before the project was approved, the project leads proactively consulted Whittlesea Community Connections and Banksia Gardens to enlist them as partners in the working group due to their expertise in providing a range of health and social supports to vulnerable people in Whittlesea and Hume respectively.

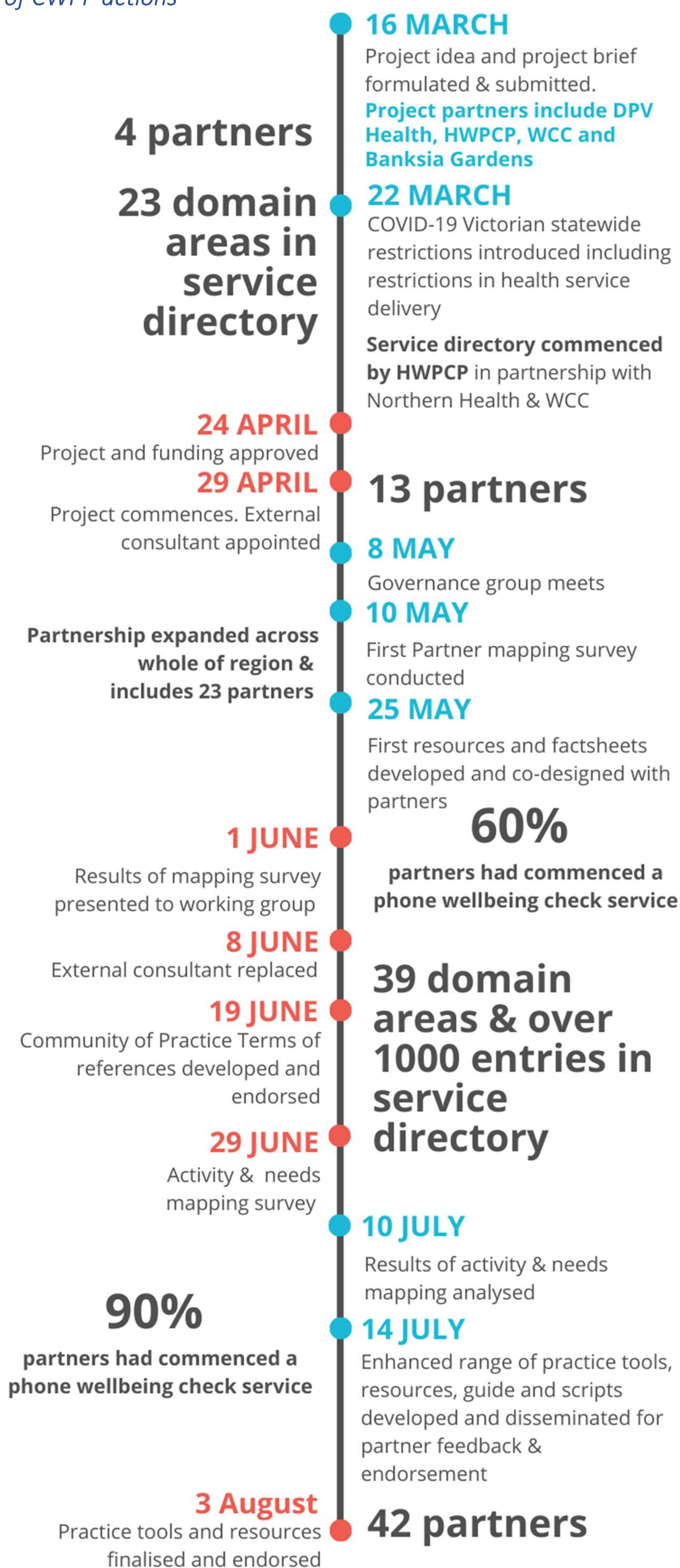
While the project was approved by DHHS on April 24, further engagement and onboarding of partners had already commenced with the two local government authorities engaged as members of the project Reference Group in partnership with the Department (DHSS). Northern Health joined the project as an essential partner and provided support to the HWPCP team developing a whole of region service directory. The working group members also recruited Sunbury Community Health, Neighbourhood Houses, School Community hubs in the City of Hume and Foundation House. Within weeks, partners grew from four partners to 13 partners to 23 partners, with more joining the project as the details of the project were refined and communicated.

Partner engagement levels

Three levels of Partnership engagement were identified to address the level of supports the different partners required depending upon the varying stages of response and adaptations organisations were experiencing in response to the disruptions to core business caused by the COVID-19 public health restrictions.

1. ***Organisations with limited resources and processes in place:*** The CWPP would enable and build capacity in these agencies interested in undertaking telephone wellbeing checks who may not have the requisite resources and systems in place. Engagement from partners at this level would be through accessing the Service Directory and associated guiding resources.
2. ***Organisation with systems and processes in place needing additional support:*** CWPP would provide additional support as needed to improve the services that have already been established by organisations in a limited time period who may need supplementary advice or resources. In addition to the first level, engagement from partners at this level would be through their participation in a Community of Practice to share knowledge, experience, resources, and practice approaches to co-create a coordinated approach to wellbeing across the regions.
3. ***Organisations with well-established systems and processes in place:*** The CWPP would build the foundations for a coordinated approach to community referrals and support within and across Hume and Whittlesea by building a trusted network of local organisations to work together to improve access and information to additional services for their clients and participants. In addition to level two, engagement at this level would comprise a commitment to regular collection and sharing of deidentified data pertaining to the outcomes of the phone wellbeing check-ins and the impact this has had for their wellbeing.

Figure 6. Summary of CWPP actions



Partner needs and activity mapping

Survey one: April 2020

The first survey of partners sought to gather baseline data about what activities the partners had taken to “check-in” with clients and whether the process (if any) they were undertaking was a formal wellbeing check with supported referrals to services, or a phone service to maintain social connection to clients or something else. The survey also sought to ascertain what activities partners had undertaken in response to the disruption of core business caused by the COVID-19 pandemic and public health measures.

Survey Results

Participant responses have been grouped below.

Define Vulnerability

Feedback showed that there was a clear need for an agreed definition of vulnerability that could be opertaionalised. Some partners use well defined categories for vulnerability that reflected the CWPP pilot program criteria, while others used looser definitions. As anticipated, some partners indicated that the needs of vulnerable cohorts, and their clients in general, had changed due to COVID-19 with new and more people experiencing vulnerability and often new or different ways.

Existing practice

Most of the partners had made changes to core business and practice including “welfare checks”. Respondents indicated that different partners had implemented different systems to engage with their clients and the community. Some partners were interested in practical, hands on support from the CWPP while others were more interested in practice frameworks and guidance. Some already had documented process and service directories to assist in referrals, where others were new to the space and needed tools and resources to build their capacity in supporting their clients.

At this time the HWPCP, in partnership with Northern Health and Whittlesea Community Connections, had already made significant progress in developing a whole of region service directory. Starting with smaller directories from Northern Health and Whittlesea Community Connections, the HWPCP team consolidated these with directories the HWPCP directories into a comprehensive searchable directory that was being built on and refined daily.

Understanding of COVID-19 and pandemics

Feedback from partners suggested that public health restrictions were likely to ease as the number of active cases in the first wave had significantly declined (May 2020). Unfortunately, this did not occur and the second wave of the pandemic in our region, and worldwide was much worse that than expected.

Preliminary findings of wellbeing checks

Outcomes were asked with respect to clients, partnership, and the region with the following issues raised:

For clients

- General perception that there was no escalation/exacerbation of health complaints and/or other indicators of vulnerability of clients even with initial concerns and media reports about people delaying access to care;

- Highlighted the need for a clearer understanding of client needs and/or where there are service gaps to meet these needs;
- Critical need for more accessible referral pathways and supported transition between service types;
- Social connection or re-connection/ re-engagement with critical services where this has been disrupted due to COVID-19 was an early success.

For partnership

- No identified duplication of other COVID-related networks and projects in the region;
- Need for improved and clear communications that can be shared with whole of organisation given participation in governance committees may be limited;
- Partners agreed in principle to collective efforts to improve service co-ordination, including sharing practice learnings and information.
- Sharing of data was highlighted as a possibility but privacy was of paramount importance.

For region

- Identified need for a more connected service system with higher level of responsiveness to vulnerability.
- An evaluation of the CWPP was agreed as important. However greater clarity on purpose and type of evaluation was noted as a requirement in order to manage expectations and partner resources.

Survey two: May 2020

This second survey of the Community Watch Partnership reference group sought to understand what partner organisations have done to maintain contact with vulnerable clients during the period of the first Victorian COVID-19 restrictions. The responses comprised baseline data pertaining to the environment in which the CCWPP would be implemented. There were nine responses to the survey.

Survey Results

All organisations indicated they had altered service delivery, with all expanding telephone support and moving to face-to-face virtual delivery. Most organisations ceased group activities but maintained home visiting when safe to do so as these clients are typically more vulnerable and require additional supports. Half the organisations had also implemented other program modifications including direct mailouts and use of SMS to keep in touch with clients.

All partners had developed a COVID-19 response plan to maintain contact with clients who may experience vulnerability. In addition to telephone contact, provision of referral information and the direct delivery of wellbeing resources/packs were the most common. Two thirds indicated that they would continue with online/telephone support post COVID restrictions and the remainder indicated that they probably will. In fact, two thirds were considering expanding this work into the future recognising a significant shift in practice.

Again here, partners *did not* note high levels of client disengagement from services, with only a third (33%) of partners agreed that this had happened in some areas of their operations. Yet, two thirds (66%) of partners either agreed or strongly agreed with the statement that clients' needs had changed and that there had been changes to typical requests for advice and information.

Of the nine partners, seven partners use volunteers to conduct wellbeing checks. Overall partners indicated clear appetite to develop a re-engagement strategy for vulnerable clients when the restrictions eased.

Survey three: June 2020

The results of this survey indicated interested partners wanted to be involved in an evaluation and continued data collection. Partners who did not require additional assistance or support were interested in engaging with a Community of Practice and looked forward to future participation.

While all organisations had managed to undertake varying forms of engagement with their clients, assisting those lacking digital literacy was a gap many organisations required support to address. This was of particular concern for organisations servicing CALD cohorts with greater challenges experienced among newly arrived refugees and asylum seekers. Specifically, the lack of internet connection, or the availability of suitable technology experienced by clients regardless of background was a key barrier for organisations in maintaining contact with clients in a meaningful way.

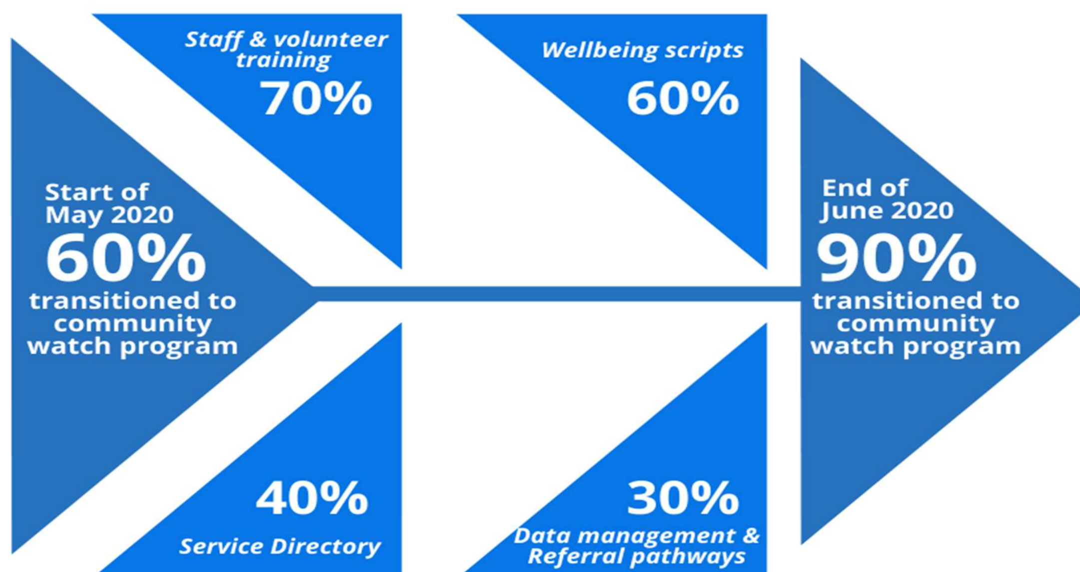
A key priority raised by organisations who do not provide direct service delivery was the provision of more practical support to clients such as delivering food or medical scripts. Limited staff and volunteers, however, were identified as the main barrier to achieving this especially with the introduction of local travel restrictions. Partner feedback also indicated the need to align newly introduced and existing initiatives to avoid duplication.

The results of this survey were consistent with previous surveys.

Programs in place

Approximately 90% of respondents had transitioned to phone wellbeing checks during lockdown (compared to 60% prior) with online dissemination of information and understanding community needs undertaken by 80% of respondents. Only 40% were providing packs. All respondents undertook new activities. Partners reported that they felt that they were able to respond to client needs quickly, including transitioning to phone checks, as well as disseminating online information. A wellbeing check script (60%) and training (70%) were the most sought-after resources, followed by the service directory (40%) and service pathways and data management (30%) (see Figure 6).

Figure 6. Comparison of partner activities May to June 2020 & CWPP supports provided



Ongoing assistance needs

Identified needs of partners included more staff or volunteers to undertake calls and doorknocking (where permitted). Assistance with improving digital literacy was also a common need, as was providing access to related technology for partners who utilise volunteers such as the internet, phones, laptops etc; though the latter is more relevant for community houses and hubs that don't offer direct service provision. Again, this reflects the results of prior survey results.

Partner benefits

The greatest benefit of being a partner according to the respondents was the ability to be part of a network (81%) and to contribute to an evaluation (81%). Access to existing resources like guidelines and the online directory were perceived as secondary benefits but still much needed supports (72%).

Partner retention

While the majority (70%) of partners wanted to continue in the project, the remaining 30% need more information indicating a possible need for improved communication, messaging, and promotions from the CWPP team

Resource development

The first draft resources and tools were developed in May 2020. After a codesign and review process some of the resources and tools were re-developed and new resources added to reflect the findings of the various partner surveys. As a result, a compendium of plain language tools and information was developed and updated to provide further guidance to partners and potential partners wishing to undertake wellbeing check-ins with their usual clients and participants. These underwent a further round of feedback and co-design and were finalised in August 2020.

The overarching guide contains detailed sections, each with links to external organisations and supports for partners to access further information and resources should they require it. The compendium of tools comprised information factsheets, guides and tools on the following topics:

- service provision and coordination;
- managing staff and volunteers;
- project planning for the establishment of a phone wellbeing check-in;
- a wellbeing script;
- conducting telehealth and videoconferencing calls with clients;
- privacy, data management and sharing information;
- a proforma template for service referrals; and
- Online Service Directory of local organisations and wellbeing supports across the Hume and Whittlesea catchment.

Focussed webpage

Both project leads created unique webpages for the Community Watch pilot project. Both pages contained general information about the pilot and links to the various resources and service directories. From the Project period from June to October 2020 the DPV Health hosted page had 656 visitors, where the HWPCP page had 455 unique visitors with the majority accessing the service directory.

Feedback on the resources

Both the Service Directory and Compendium of Guiding Resources proved beneficial to organisations across the regions working to re-engage and support their participants and clients during COVID-19. The Service Directory in particular was the first of its kind to systematically collate the varying service providers and community organisations available in the region.

Consistent feedback from the partnership during the service directory's development added value to this work by expanding its content and reach across the region, but also for relationship building. Both of these elements are essential first steps towards reducing duplication and increasing service coordination across the community. This is also testament to the relationship building and collaboration the CWPP has been able to produce. Many partners felt the information contained in the service directory provided access to existing providers and service information that prior to the CWPP, had not been available, easily accessible or known.

The Compendium of Guiding Resources in themself, became a comprehensive tool to assist organisations establish their wellbeing checks but also to improve quality assurance within their organisations. With many local organisations across Hume and Whittlesea relying on small staffing and resourcing, the guidance in relation to privacy, data management, volunteering and other legal and regulatory frameworks established the foundations for quality service provision and coordination.

As the community needs surveys and consultations indicated, the wellbeing scripts and service directory were of high demand. While the second iteration of the resource compendium contained some technological guidance for using videoconference platforms like Zoom, further resources pertaining to digital literacy and access is needed. This was reflected in both the survey and stakeholder consultations.

Table 4. Categories of Service Directory

CATEGORIES			SEPTEMBER	OCTOBER
COVID Information - English COVID information -Translations Aged Care Alcohol & other drugs Aboriginal and Torres Strait Islander services Bushfire & disaster recovery Cancer Cardiac Carers	Community Health Community Hubs Counselling Diabetes Disability Emergency Relief/Food parcels Family Violence Financial counselling Gambling General Practitioners (GPs) Helplines Hospitals	Homelessness/ Housing Legal Services LGBTIQ Local Government Maternal & child health Mental Health Neighbourhood Houses Pharmacy Refugee Health Translations Volunteers Youth Services	**New Categories:** Exercise, Exercise Physiologist, Hydrotherapy, Pain Management, Physiotherapy, Walking Groups **New Services included in Helplines** **Services update for City of Hume**	**New Categories:** Libraries & Book Clubs Podiatry Occupational Therapy Men's Sheds Continence Asthma **Additions to** Volunteers, Exercise, Pain Management

Section three:

What were our learnings?

The following section provides a discussion of the learnings and findings collected from the CWPP's implementation and evaluation process conducted between March to October 2020 as outlined in this report. These findings point to the successes and areas for improvement that can be capitalised for future projects.

Findings

Partner modes of service delivery prior to COVID-19

Over half (52%) of partners provide services in Hume, 30% in Whittlesea and 18% covered both local government areas. Prior to the COVID-19 pandemic and associated public health restrictions, 92% of partner services and supports were delivered face to face through traditional centre based methods but also included outreach, home visits and events. Prior to the pandemic 15% of partners used phone based service delivery and only 8% used online service delivery approaches. Based of these numbers it is unsurprising that 100% of partners reported disruptions to service delivery as a result of COVID-19 public health restrictions.

Client cohorts prior to COVID-19

Client cohorts of our partners covered the range and breadth of the local community populations however 65% of clients were health care card holders. The majority of clients were families and children (73%), people from a refugee, asylum seeker or recent migrant background (73%). In addition, partner clients were likely to be experiencing mental health issues or distress (62%) or experiencing family violence (62%). Over half of clients (58% respectively) were socially isolated and/or had chronic health conditions.

Partner concerns of community during COVID-19 restrictions

Unsurprisingly due to the nature of the public health restrictions introduced to curb the spread of COVID-19, partners overwhelmingly feared that clients would become isolated (92%), reduce contact with service providers (84%), develop or experience a worsening of mental health conditions (77%) and that many clients will experience increasing financial insecurity (70%).

Actions taken by partners during COVID-19 restrictions

Partners reported significant difficulties in adapting their organisation to respond to the challenges of the COVID-19 pandemic with an average difficulty score of 7/10. Larger organisations with the infrastructure in place that supports work from home arrangements and the use of digital technologies faired better in their ability to adapt and implement actions quickly.

CWPP partners undertook a mix of active and passive interventions during the first phase of restrictions and maintained these actions throughout the CWPP pilot period. Passive actions included online dissemination of information (81%) and the promotion on community online engagement activities (73%). Active interventions included phone calls and wellbeing or needs checks (88%), service referrals (69%) and client food and support goods packs (54%). Only a small percentage (8%) or two partners took no new actions.

Reason for joining the CWPP pilot

While being part of an evaluation that looked at the effectiveness of actions taken by partners during the pandemic and the opportunity to be part of a network, to share resources and reduce

duplication were big drawcards, the main reason partners joined the CWPP pilot partnership was to access the service directory. Many also joined to access the compendium of resources. Those with no experience in conducting wellbeing checks or engaging with clients digitally found the resource compendium and guide very important to their organisation. For those who felt they had adequate resources in place, the opportunity to access the service directory and be part of a community of practice was given greater priority.

Learnings

What worked well?

Partners reported that the most successful part of their involvement in the CWPP pilot was their ability to keep connected to their clients. While some partners would have achieved this result without the CWPP pilot, many others achieved successful client engagement through the utilisation of the CWPP resources. In particular, some partners reported that they used the videoconferencing "how to" tool to not only upskill themselves, staff and volunteers, but they used the tool to support clients to access videoconferencing for their health and other care appointments.

The evolving composition and inclusions of the service directory was a key success outcome. Not only did partners report that the service directory and the resources in general were easy to use, but they also highlighted critical gaps in local service delivery, capacity and resourcing. On a positive note, the service directory increased organisation and whole of catchment knowledge of available services not just for vulnerable clients but for staff and volunteers as residents. Overall, partners believed that if they had not already utilised the resources or service directory they would in the future.

While using telehealth and technology assisted partners engage with clients, some partners reported that it did not facilitate ongoing engagement and retention of clients. Partners reported that vulnerable clients were less likely to have the internet, sufficient data or the appropriate technology available to them that would support adequate client engagement levels. This was particularly evident among those partners whose provided training, education and skills building type activities.

Having appropriate staff or volunteer levels or the ability to redeploy staff was a critical success factor in partners' ability to participate in wellbeing check type programs. Some partners reported that they would have liked to utilise the skills of their staff and volunteers more in client engagement activities but also lacked the ability to provide adequate IT support and data connections.

The importance of partnerships

Diverse organisations often need to join resources to achieve shared goals around capacity building and community improvement and thus form a partnership. One of the key features of the CWPP project is that the CWPP partnership was recognised as being essential to position the project and partnership in a sustainable and replicable way; maximising resources and minimising barriers in supporting vulnerable clients access locally relevant services. Local health, wellbeing and social support organisations also believed our partnership was important which is evidence by the growth in partners 2 to 4 in April, up to 13 by May and a staggering 42 partners by July 2020 (see figure below).

Figure 7. Growth in partner numbers during the CWPP pilot phase.

The CWPP partnership managed to connect and draw interest from the wider community. The results of the community needs assessment and consultations throughout point to this clearly; local organisations indicated a growing appetite to join the CWPP partnership and establish a network to share learnings, troubleshoot problems and innovate further community led responses. The CWPP has therefore built promising foundations that can be capitalised into the future as COVID-19 recovery begins to take place. Increasing service coordination across Hume and Whittlesea will only strengthen this.

The partnership approach holds great promise for organisations with a commitment to addressing the health and well-being of disadvantaged and underserved populations during times of crisis such as the COVID-19 pandemic. The partnered approach we utilised offers a flexible and useful structure that can be adapted to reflect the diverse needs of the local community and the organisation.

Partner engagement

Successful partnerships require sustained cooperative effort and an accountable commitment to effective decision making. The CWPP enjoyed good engagement at all levels and on all elements of the project. The one area the CWPP pilot experienced concerns regarding partner engagement was in getting traction and buy-in from partners in follow-up actions. Engagement was particularly low on anything action item that was a non-practical aspect of the project e.g. design of terms of reference or program logic, governance in general and evaluation interviews.

As the pandemic grew throughout July and August low partner engagement on non-practice elements of the CWPP was particularly evident. Feedback from partners indicated that they were focussed on addressing often changing client needs and supports during this time. Partners reported that they lacked the resources (staff & time) to assist the CWPP partnership with these tasks. It is however worth noting that most CWPP partners already had a working relationship with the project leads (HWPCP and DPV Health) and reported that they trusted those partners in their provision of secretariat and backbone supports.

Partners had much higher levels of engagement in the review and co-design of the compendium of resources and tools. They were also interested in providing practical support to the development of the service directory to ensure all the categories of services they needed to support clients were included. This is also evidenced by the work of the HWPCP in compiling the directory, its downloads and new service additions (see Table 4). Further to this, as the service directory grew and matured between May and June 2020, so did the growth in numbers and the engagement with and between CWPP partners. With each new version of the service directory released and communicated to members, partners actively accessed the HWPCP project site and the DPV Health CWPP site to access the project tools and resources.

Communication

Partnerships are not effective without focussed and clear communication. As with many partnership projects working in complex, crisis and competing health and wellbeing spaces there are likely to be real or perceived communication issues. Throughout the CWPP project there was a perceived lack of clarity regarding defined roles, responsibilities, expectations, and decision making process within the partnership by some partners. While this area of concern is addressed in part previously under the heading of partner engagement, there is always room for improvement.

Role clarity and clarity regarding the purpose of the project was disrupted in July 2020 with the introduction of a competing and duplicative project funded by the DHHS statewide. The communication and other issues this caused is highlighted under the heading of "reducing duplication".

Suggested improvements to ensuring partnership role, purpose and decision making clarity include inviting partner members collectively or working with organisations individually to assess how their organisation aligns to the vision of the partnership and other key functions like reporting. While time and resources did not permit us to do so, we would normally undertake partnership workshops and utilise the VicHealth Partnership analysis tool to support this.

The key messages arising from partner feedback regarding communication are:

- ***Better balance:*** this includes balancing the costs and benefits of the partnership and how this is communicated to partners; balancing opportunities for shared roles and networking opportunities with achieving outcomes; balancing staff/volunteer involvement in decision making and operational requirements.
- ***Communication:*** includes marketing, planning, reward strategies and reporting on outcomes. Internal communication strategies to include a clear focus on defining roles, responsibilities, expectations and decision making processes within the partnership.
- ***Collective impact:*** this includes how partner actions add value to the project partnership; aligning partner organisation cultures to the project partnership vision; effective and adequate resourcing; and advocacy and influencing policy for better client outcomes.

Governance

The CWPP governance structure was designed to bring together that collective knowledge, all of the voices of our partners into two defined and targeted groups. As the partnership grew some confusion emerged regarding the role of the two governance groups. However, the meeting agendas and minutes provided a clear delineation between the roles and functions of each group and this was maintained throughout the project cycle. This is a great outcomes especially given the speed at which the project was formulated and implemented in response to the COVID-19 pandemic and the rapid growth of partners.

The role of the working group was to prioritise investment based on all the work that has been done and then develop really practical tools and resources. The role of the reference group was to provide a structure where all the voices of our partners could come together to provide expert advice and guidance on the developed tools. The reference group also undertook the task of co-designing, trialling, and refining the tools.

Partner consultations indicated the need for greater clarity around roles and responsibilities pertaining to the two key governance groups. In normal settings Terms of Reference would have

been developed for each group and will be if the pilot is extended. The following key principles of an ideal working group were achieved:

- A common agenda
- Membership with first-hand experience with the issue
- A commitment to reducing disparities experienced by the target population
- A commitment towards action-oriented tasks
- A commitment to attending meetings
- Members with authority to represent their organisation.

As new provider and system partnerships emerge to support integrated service delivery for clients during periods of pandemic, it is important that new governance models also be developed that support the agility required in such crisis environments. This includes new infrastructure and processes to support intra-agency collaboration, communications, goal alignment, and transparency. Partnership platform structures such as those provided by the HWPCP are best placed to provide this with adequate funding.

The CWPP governance structure successfully met its aim of minimising the cost to the catchment of delivering effective services and producing relevant and practical partner support tools.

Change fatigue

Change fatigue is defined as a sense of exhaustion or hopelessness people feel when facing what they perceive as too much organisational change. Throughout the COVID-19 pandemic change fatigue was reported by many partners and change was rapid, constant and required adaptation at a scale that has not occurred in the Australian health system before.

The impact of the second, more restrictive COVID-19 public health protection orders continued to reduce capacity for local organisations to commit any actions that were outside of core business and that were not practical in nature. While the CWPP aimed to trial and refine a coordinated service referral model this was not possible in the pilot phase due to the unprecedented level of change. While this change fatigue served to limit the authorising environment through which to implement (or enable) a coordinated service referral model, it did allow partners to focus on building their capacity to respond to client needs through the catchment wide adoption of the resource tools and service directory.

Best practice

The CWPP development and implementation process provides insights into what works in practice when conducting a client wellbeing check type program.

The majority of partners reported high levels of confidence in their ability to identify clients that met the criteria of vulnerable pre-pandemic. They did however report that without checking in on all clients it would be more difficult to identify newly vulnerable clients. This is where some partners opted to older traditional methods of communication like direct mailouts. Others still utilised social media. Both approaches attempt to connect with the local community and support existing and potential clients access appropriate care and supports during the pandemic.

The process of conducting wellbeing checks was successful in identifying client needs and changes in clients needs. The overall picture of whole of catchment needs were consistent throughout the pilot and consistent with general needs pre-pandemic. What did change were how clients were prioritising their needs, their behaviour in how they sought care and social supports (to some

degree driven by the public health restrictions) and their perceived health risks. However, best practice needs assessment would typically use a screening tool or a combination of short tools to assess clients needs. No partner reported using a formal, validated screening tool when assessing clients' needs. Instead all partners reported asking general wellbeing questions that were related to their organisations' core business.

As highlighted earlier in this report, clients readily adapted to accessing care through telehealth. Many partners were skilled in the provision of various types of telehealth where for others it was their first time providing digital care and support services. The development of the support and resource tools highlighted the difference in skills and digital health experience between partners. At the beginning of the pandemic, some partners readily pivoted towards the telehealth approach. Where other required significant upskilling and time to implement a wellbeing check type program (see figure 6). The "one-size fits all" approach to resource development was not appropriate for the CWPP pilot. Some partners required supports on how to initiate videoconferencing calls where others required support in developing decision making algorithms that were underpinned by the service directory and adequate referral pathways.

The development of the script to support partners when conducting a wellbeing check was highly valued. However, given the diversity of CWPP partners and the range of services they provided and clients they supported, the script had to be generic enough to suit all partner needs but also specialised enough to ensure best practice elements were used by all. These included obtaining consent, explaining the purpose of the call, ensuring privacy and confidentiality requirements were met and that the wellbeing check caused no harm to the client or the organisation.

For some partners, the development and utilisation of the CWPP tools and script highlighted the need for staff and volunteer training, and the urgent need for a comprehensive service directory. While the CWPP pilot did not have capacity to support individual partners to train and upskill staff and volunteers, the co-design process utilised to develop the compendium of resources and the service directory partially addressed this need. Ideally in the future an organisation would not commence a wellbeing type check program without adequate staff or volunteer capacity. However, the COVID -19 pandemic highlighted the adaptability of local organisations and their commitment to supporting their clients during challenging times.

Data collection during the CWPP pilot was limited to the purpose of the pilot which was to build the capacity of partners to deliver wellbeing type check programs through the development of resources and tools. The aim of the pilot was not to capture client level data. However in order to evaluate the impact of the tools on practice and whether in fact they supported best practice whilst running a wellbeing type check program, at multiple points throughout the project the CWPP team did attempt to capture baseline data regarding the number of clients that were supported by one or more of the tools developed. As detailed later in this report, there are a number of unfortunate reasons why this did not occur.

Data management

The CWPP pilot did not and was not designed to support real-time data exchange, and tracking health and social services utilisation and outcomes even though they are integral to improving care and health outcomes for vulnerable clients. Similarly, as the purpose of the pilot was to build partner capacity through the development of resources and tools, uniformed data collection tools were proposed, as were validated screening instruments however these were out of scope and did not generate initial interest among partners.

While data collection and the importance of aggregated, deidentified client data sharing was flagged at multiple points throughout the pilot, partners did not participate in data sharing due to the following reported reasons:

- Unwillingness to share client data (even deidentified data)
- Unwillingness to share general wellbeing check data (e.g. number of checks conducted)
- Lack of and unwillingness to use a shared data collection platform
- Lack of and unwillingness to use a uniform approach to screening for client needs
- Time and resources constraints related to data entry and duplication of data entry
- Not all partners provided health services and felt uncomfortable asking health related questions, and therefore collecting health data
- Some partners only wanted to access the service directory.

Further difficulties to data collection were experienced due to the varied organisational capacities to retain and store data according to legal requirements. Routine data collection that occurred within the CWPP pilot was the partner needs assessment survey as presented in this report. These survey data informed the development and refine of the project resources. The potential for greater knowledge sharing, collaboration, innovation, and cross-sector partnerships that can result from the collection and sharing of data, in addition to improved service delivery, is immeasurable.

Reducing duplication

The aim of the CWPP pilot to reduce duplication through the development of central resources, tools and a service directory was achieved. While some partners utilise their existing process and procedures, these practices are consistent with the CWPP tools. As highlighted above the requirement of partners to share data in a uniform way as part of the CWPP pilot was considered a duplication of effort by many partners.

Duplication of the wellbeing check model occurred with the introduction of DHHS funded CASSI project in June/July 2020. While significantly different projects in terms of design, the untimely roll out of the CASI model conceptually conflated the CWPP and related messaging to stakeholders and the community. Many partners reported confusion between the two distinct projects, with some believing the CASI project replaced the CWPP pilot or was the next phase of the CWPP pilot.

Evaluation

Developing and implementing a robust evaluation agenda that was aligned to the purpose of the project was a priority for the CWPP partnership. A mixed methods evaluation approach was chosen. For the pilot, the team adopted a theories of change approach to the evaluation frame to explain the rationale for the programme and to track change over time.

Given the relative youth of this field of practice (wellbeing check, community prescribing models etc), substantial gaps in the evidence base exist regarding which intervention strategies are the most effective for which population cohorts. While randomized controlled trials may be possible in some circumstances, there is considerable interest among stakeholders in research designs that are easy to implement in real-world settings. Longitudinal studies are also an option for exploring the long-term effectiveness of these programs on defined cohorts however require partners to continue to utilise online and digital health type programs for services that don't necessarily require onsite service provision, instead of reverting back to traditional centred based models of service delivery when they are permitted to do so.

A realistic evaluation using case studies was proposed to further explore and understand the impact of CWPP intervention and practice variations, in particular different organisation or profession approaches to reach and engagement however this was not possible given the limited resources.

Minimising risks

To mitigate identified risks, and ensure the project worked towards its stated objectives, the following solutions were proposed to lay the foundations for trialling and refining the CWPP service model using the guiding resources developed.

Table 5. Risk mitigation strategies for next stage of the CWPP

Risk	Strategies	Description
Duplication of projects across regions	Incorporate CASSI initiative into the CWPP coordinated service model	Reorient resources to focus on enabling service coordination through trialling and testing a coordinated referral service model with a select group of (3-4) champion organisations. The purpose of engaging champion organisations would be to ensure consistent collection of data to test, trial and refine this model over a 12-month period, while continuing to develop and refine resources to support non-champion partner organisations.
Improved project clarity	Workshop a program logic with key partners to agree on shared outcomes Develop an evaluation plan with stakeholders including, data collection plan and indicators for agreed outcomes to measure effectiveness of CWPP service model when implemented	Given the highlighted duplication issues in the region, and reduced capacity of organisations due to COVID-19 restrictions, the project will seek to reengage existing partners towards the design of a next phase. This reengagement will confirm the purpose of the project, the roles and responsibilities of stakeholders, and the project governance structure to ensure shared project vision.
Partner engagement and buy-in	Work with four selected champion organisations to test, trial, and refine model Develop criteria for minimum requirement of champion organisations (i.e available staffing, CMS, commitment etc).	To ensure greater clarity and purpose, the project will workshop shared outcomes and indicators for monitoring and evaluation. Once this is complete, the project will commence the design of a data collection plan and implementation plan for the duration of the project.
Data security and privacy concerns	Ensure champion organisations have existing infrastructure and data systems in place.	Routinely collecting consistent data will resolve any privacy and legal concerns and allow the Partnership to understand the effectiveness of CWPP model approach.
Safety risks and training	As above, with requirements that available staff/ volunteers have necessary training, or include provision of training as part of CWPP service model roll out	Staff and volunteer training will ensure improved service coordination if a consistent and quality practice and training approach is applied to partners using the CWPP model.

Workforce development

Effective models of care for vulnerable clients require a workforce capable of meeting this population's many, complex needs. The variation in skills and expertise across organisations to undertake wellbeing checks and respond appropriately continued to present an inherent risk to staff, volunteers and clients, particularly in organisations with no experience in conducting this type of activity. The requisite training could have been provided by the CWPP team on conducting a wellbeing check to ensure the quality of service provision with appropriate funding and resourcing.

As evidenced by partner perceptions of the impact of COVID-19 restrictions on vulnerable clients, prevalent conditions such as mental illness, substance use disorders, and chronic pain can be difficult for clinicians to address without appropriate training, skills, and staffing resources much less staff or volunteers engaged in a wellbeing check type program. Robust training models that enhance provider health knowledge (not clinical skills), as well as essential client engagement skills such as active listening, can improve morale and prevent fatigue and burnout. Opportunities for exploration include motivational interviewing, trauma-informed care and resiliency.

A myriad of traditional and non-traditional providers joined the CWPP pilot as they work to address the unique physical, behavioural, and social needs of vulnerable populations and health disparities. In the CWPP experience, it is these non-traditional partners that play such a unique role in understanding and responding to the many challenges faced by clients. These partners also have the unique capacity to fill gaps in service provision and co-manage individuals' needs outside of traditional health care models.

Given the unique complexities of supporting vulnerable clients especially during a pandemic, this area of practice will evolve over time. There is an opportunity to build momentum for this development, and to create a curriculum that encompasses team-based approaches and training in the above areas, among others.

Section Four:

Recommendations

Develop a Community of Practice

Partners identified the formation of a Wellbeing Check Community of Practice as a future direction of the CWPP pilot. As the COVID-19 pandemic has no end date without a vaccine, and arguably traditional centre-based care and support service delivery is outdated for many service types, a Wellbeing Check Community of Practice is a natural evolution of the pilot.

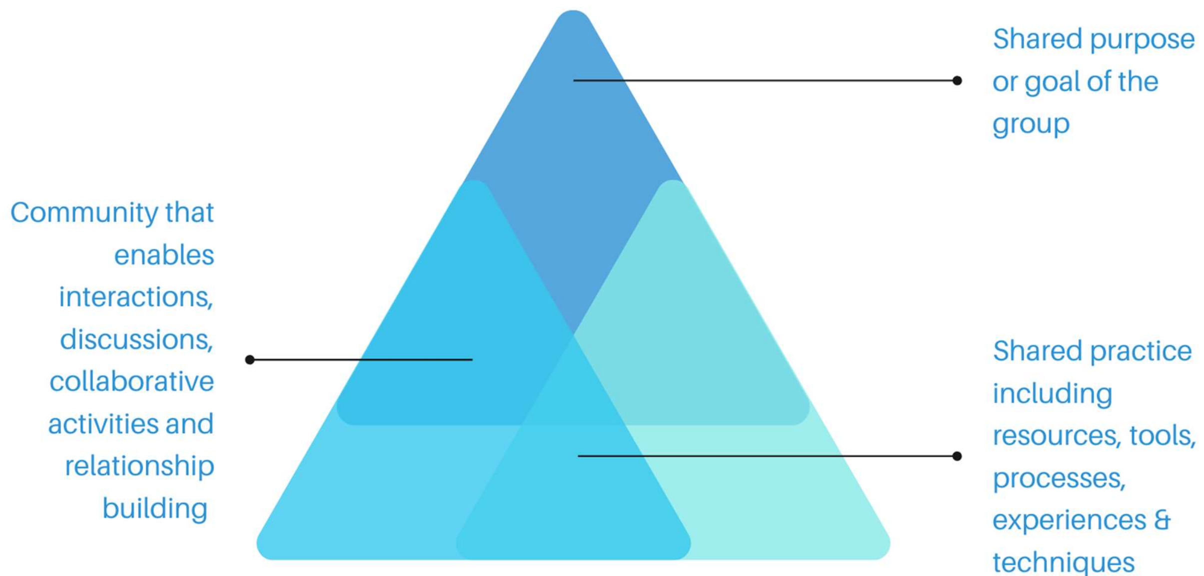
While initially developed as a tool to share information and knowledge, Communities of Practice have evolved to be utilised as tools to improve clinical and public health practice. They can also be used to facilitate the implementation of evidence based practice such as the CWPP model. To be successful in this case, barriers to partner engagement and participation must be resolved and partner engagement actively maintained. The Community of Practice must offer opportunities to share practice knowledge as well as providing relevant new and updated tools and resources developed based off partner feedback.

A Community of Practice provides a number of benefits to CWPP partners:

- Enables knowledge to cross traditional and non-traditional health and wellbeing service boundaries
- Generates a coordinated and accessible body of knowledge for partners to access
- Promotes a standardised and coordinated practice
- Facilitates innovation, create new ideas, knowledge and practice.

Like the CWPP pilot, a community of practice governance structure must have clearly defined roles, functions and desired outcomes. Wegner [25] and colleagues identify 3 essential elements of a Community of Practice as detailed in figure 8 below.

Figure 8. Ingredients of a Community of Practice



Create an online clearing house

To support the Community of Practice the CWPP should develop an online platform to act as a clearing house of resources and information support for Hume and Whittlesea. This 'community gateway' could act as a first point of call for service providers to access the existing Service Directory, Compendium of Guiding Resources, and any other resources and information contributed by local organisations as part of the Community of Practice.

Incorporate CASSI initiative into the CWPP coordinated service model

As the two projects share essential elements for success, joining the two initiatives into one program will assist in reorienting resources to focus on enabling service coordination. The best way to do this is through trialling and testing a coordinated referral service model with a select group of (3-4) champion organisations. Engaging champion organisations is in order to ensure consistent collection of data to test, trial best practice and refine this model over a 12-month period, while continuing to develop and refine resources to support non-champion partner organisations.

The 12month trial and embedded evaluation for support the refinement and testing of the program logic and:

- Expanding on the wellbeing conceptual model and domains already developed
- Developing a measurement approach
- Developing a data collection plan
- Provide greater clarity on roles and responsibilities
- Streamline governance structures
- Developing a workforce training program
- Developing new and improved resources

Develop a workforce training program

Effective models of care for vulnerable clients require a workforce capable of meeting this population's many, complex needs. As highlighted above there are many opportunities for exploration regarding the provision of training to staff and volunteers to support them in conducting wellbeing checks. These include:

- Active listening
- Cultural safety and awareness
- Understanding the social determinants of health
- Conducting a needs assessment
- Using screening tools
- Making a needs-based referral
- Using a service directory for social prescribing
- Data collection and reporting
- Developing program logics
- Understanding wellbeing
- Motivational interviewing and goal setting
- Trauma-informed care
- Critical incident debriefing
- Managing stress and minimising vicarious trauma
- And others.

Minimise barriers to partner engagement

Below are some strategies to prevent and minimise barriers to partner disengagement and therefore prevent or reduce barriers to effective service coordination.

Table 6. Strategies to prevent partner disengagement

Barrier	Prevention/ minimisation strategies
Resource constraints	• Ensure adequate funding and resourcing is available • Shared commitment and ownership to implementing service coordination model
Role transparency and governance	• Clear guidelines on roles of steering committee/advisory groups • Communication strategies to keep everyone informed and clear protocols
Lack of authorising environment	• Culture of collaboration and shared goals • Shared accountability • Leadership
Lack of understanding of different service systems	• Promote understanding (meetings, communications) • opportunities to shadow other service providers
Lack of evidence on what works	• Shared commitment to data collection, monitoring, and using national standards
Lack of flexibility	• Harness local effort to develop their own solutions • While fidelity to a model is important, it must evolve to adapt to system and local changes

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