Principles of Rapid Innovation and Evaluation: Responding to COVID-19
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Introduction

ARACY has produced these Principles in response to the way in which organisations of all kinds have rapidly modified their practice in the face of a global pandemic. As a hub of cross-sector activity and innovation, ARACY has seen many examples of creative changes to the way organisations deliver their work. These changes have ongoing value as we adapt to living with Covid-19.

We know that changing social outcomes is a long game. Deep, rich knowledge acquisition takes decades, building on the work of those who have gone before us and laying the ground for those who will come after. The exceptional circumstances of COVID-19 and the innovative, inventive responses we have seen to these circumstances are a unique opportunity to capture solutions and learnings created in the short term and apply these to enhancing our knowledge development over the long term.

These Principles are designed to support organisations to capture and evaluate these learnings: to identify what has worked, what has utility going forward, and what could or should be discarded as Australia moves forward.

They are offered as a starting point for tailoring to your own situation, organisation and workforce. Adapt them, translate them, share them widely. Please credit ARACY using the suggested citation below, and please share your learnings with us at communications@aracy.org.au.

Suggested citation


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Thank you

These Principles were produced with the support of The Ian Potter Foundation, The Australian Centre for Social Innovation, and the members of the Great to Eight Governance Committee.
First principle: don’t reinvent the wheel.

In an emergency situation, there is no time to build a perfectly tailored response designed to meet every need of the services and people you support. This is the time to look at what already exists that can be re-purposed and engineered to fit. Which brings us to our second principle:

Second principle: Don’t let the perfect be the enemy of the good.

The adaptations made need to be consistent with the theory of change or program logic that underpins the service – this is how positive change is created by the intervention the service makes. However, don’t wait until the redesigned response is as good as it can possibly be. This is the time for the Pareto principle: 80% there is close enough. There will be opportunities to adjust course as more information is gathered – see below.

Third principle: Document decisions.

Take the time to document not only the adaptations being made, but the rationale behind them and how they align with the core program logic or theory of change. It will help when planning monitoring and evaluation (below) and when communicating the changes to the people you support and staff, not to mention funders and regulatory bodies.

Fourth principle: Measure as you go.

Monitoring and evaluation is probably the last thing on people’s mind as services scramble to keep going and support vulnerable people. However, when making changes, it is essential to understand if those changes are making things better or worse. Services need to think about and plan for what can be measured in the short and medium terms to know if the changes are helping or hindering.

Fifth principle: Stay connected to your communities.

While it adds a layer of difficulty, now is not the time to skimp on engaging with people you support and staff. Their feedback is essential to know if the adapted ways of working are successful or not, and why. Community engagement and lived experience enriches understanding of the success of the adaptations made and the impact of programs in general.

Sixth principle: Adapt as you learn.

As information is collected, it becomes possible to identify what’s working and what’s not, and change tack accordingly. Document adjustments, along with the thinking behind them, and tweak monitoring to evaluate the changes as well as the original adaptations.
How to plan an emergency response

It can be helpful to split planning into two areas:

1. What is known about the people you support and the service
2. What can be learned about disaster response and recovery in general

This prevents the wheel being reinvented, and applies the most relevant learnings and best practice to the needs of the people you support and the service.

Understanding the program and its clients

The IDEAS Impact Framework\(^1\) is a joint initiative of the Center on the Developing Child at Harvard University, the University of Oregon Center for Translational Science, and the University of Washington College of Education. The Center on the Developing Child describes it as “a structured but flexible approach that facilitates program development, implementation, testing, evaluation, and fast-cycle iteration.”

The IDEAS framework asks:

“**What about the program or service works?** If we understand the key ingredients, we can replicate them. **How does it work?** Being specific about the underlying mechanisms can help us increase the impact.”

Knowing the key ingredients means they can be replicated in another format.

**Consider:**

- The detail of the service or program – what are the elements that make it work? Any prior evaluations or feedback can help here.
- The people you support – the core ingredients of the service may not be the same for all clients. Understand what works for whom.
- Also consider what else goes on in the lives of the people you support, and how the current circumstances are likely to affect them. Think about both risk and protective factors, and how these have changed. COVID-19 is a unique case in that a classic protective factor – the support of family and friends – may have now turned into a risk factor.
- Program staff – what information and equipment they need to be able to do their work safely and effectively, and any support they might require to manage their personal circumstances.

Deloitte’s Insights paper *Reimagining Insight* (2017) describes “the discipline of being clear about purpose, then about approach, and only then about the right indicators.”\(^2\)

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\(^1\) https://developingchild.harvard.edu/innovation-application/innovation-approach/

Best practice elsewhere

With a clear understanding of the strengths, risks and priorities of the service, staff and people you support, program managers can look externally to find existing resources that can be adapted. Some immediate areas that might be relevant under COVID-19 are:

- Remote and indirect contact service models
- Trauma response and trauma-informed practice
- Effects of isolation and loneliness
- Anxiety and depression
- Loss of income and material basics
- Personal safety and risks of family violence

Some additional resources are listed in the Resources section.
Putting it together

By this stage of planning, program managers should have a solid understanding of:

- the critical elements of the service
- the needs of the clients and staff
- the likely ways in which clients and staff are/will be affected
- the areas of learning that can be applied to mitigate those affects

In an ideal world, there would be time to spend putting together a revised theory of change, a MEAL plan (monitoring, evaluation, accountability and learning) and maybe even plan a pilot and a control group. None of that is likely to happen in an emergency situation, so here is the bare minimum.

1. Document

Write down what will be done differently, why those changes are being made, and the effect the change is intended to have.

2. Monitor

How to know if it’s working?

Asking people you support after each contact “How is this (way of communicating/level of contact/other change) working for you?” on a simple scale that can be quickly aggregated, perhaps with a space to record any extra comments, will provide valuable data.

Try for both quantitative and qualitative indicators – eg, number of calls answered/Skype meetings attended, plus a single scaled question as described above.

Is there a baseline that can be used? This can be an aggregated measure (number of successful visits per month) or an individual measure (person X usually attends more than 10 weekly face-to-face meetings each quarter). What is already measured for grant funding or standard evaluation processes? Timeframes will most likely preclude outcomes measures, but if there are process or activity measures that are gathered as part of ongoing evaluation, these may provide a benchmark for “usual care” that changes can be measured against.

Decide when there will be enough data to make an assessment – two weeks, a month? Keep it short at this stage.

3. Review

At the chosen assessment point, look at the data available. Talk to staff and see how they have been finding the new way of working, and any additional feedback they have received from clients. Feed that in as well.

How has the environment changed? What government initiatives, etc, have been put in place and how might they affect the people you support? Assumptions and educated guesses are acceptable at this point provided they are captured as such in the documentation. There will be the chance to revisit them as more information comes in.
4. *Adapt*

Decide what changes should be made based on what has been learned so far. Document those changes and start the cycle again.
Case study 1 – Sustained Nurse Home Visiting

Critical elements of the service:
- the trusting relationship between mothers and nurses
- the structured but flexible module content
- self-efficacy and mental health support for mothers

Helpful but modifiable elements:
- ability to “have eyes on” mother and baby for wellbeing check
- watch interactions between mother and baby in person

Impact of COVID-19 on service and staff:
- home visits now a health risk
- nurse workforce at possible risk of redeployment

Likely impacts of COVID-19 on people you support:
- increased adversity – insecure housing, loss of support networks, isolation
- some mothers may give birth alone and/or return home to no support
- possible changes in financial status: loss of income due to loss or reduction of employment, potential increase in income due to COVID-19 supplement and free childcare

Areas of knowledge/best practice to draw on:
- remote and indirect contact service models
- rapid upskilling of workforce with weak ICT skills
- barriers to remote/indirect engagement for clients facing adversity – looking at homelessness, regional and remote communities, etc for knowledge and ideas

The service carried out a rapid SWOT analysis:

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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</thead>
<tbody>
<tr>
<td>Good understanding of critical program elements</td>
<td>Workforce not strongly IT literate (known because of rates of ICT support required for usual fidelity data collection)</td>
</tr>
<tr>
<td>Some flexibility for delivery already built in</td>
<td>Always easier to develop and maintain trusting relationships face to face</td>
</tr>
<tr>
<td>Learnings from implementation in remote communities over last three years</td>
<td></td>
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<tr>
<td>Workforce already used to using mobile technology (iPads/tablets) to collect data</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Opportunities</td>
<td>Threats</td>
</tr>
<tr>
<td>More families will face more adversity – targeted program with proven evidence base</td>
<td>Preventative programs lose urgency in crisis situations</td>
</tr>
<tr>
<td>State and federal governments opening purse strings to respond to crisis</td>
<td>Nurse workforce could face redeployment</td>
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</tbody>
</table>
The program managers had previous experience trying out models of distance learning and mentoring to train the practitioners delivering the service. Although in the early stages and not yet evaluated, these formed a good basis on which to build.

Program managers looked at alternative models of service delivery and in particular barriers to online engagement for families facing adversity. Homelessness research told them that while most people have a smart phone, lack of data was likely to be a problem for Skype interactions or downloading and uploading video.

Video interactions also needed to take into account smartphone screen size compared to tablets or computers, and issues of interrupted and non-confidential spaces in families’ homes.

Being a long term program (from ante natal to child age two years) most families had already received multiple visits and had a pre-existing relationship with their nurse. The program managers believed that the experienced nurses would be able to continue building trust and supporting families by telephone and video calls.

The program managers were also confident their workforce have an excellent understanding of the program content and were able to apply it flexibly and responsively using their professional judgement. The weakness of the workforce was expected be in their adapting rapidly to new IT requirements. The program managers recognise they needed both to make the online adaptation as simple as possible, and to build in and resource plenty of tech support.

The program managers are now researching easily accessible, low data options for video calls, including Skype and Zoom. Concurrently, they are investigating funding options to provide vulnerable families with additional data and, where necessary, loan or provision of devices.

The program managers have applied for expedited ethics approval to contact nurses and families to carry out rapid qualitative research. This will seek to identify additional stresses on families, barriers to engagement for both families and nurses, and ideas for getting around these barriers and maintaining service.

The program managers have also set parameters for acceptable variation from the usual standards for fidelity, and are increasing the monitoring of fidelity data from quarterly to monthly. This will help them to identify issues and put measures in place to support nurses and families.
RESOURCES

Remote and indirect contact service models

The Australasian Telehealth Society (ATHS) and the Australian College of Rural and Remote Medicine (ACRRM) have released two guides to getting started with telehealth to help manage the COVID-19 outbreak. There is a quick guide (173kb pdf) to getting started with telehealth, using video conferencing or the telephone. There is also a comprehensive guide (217kb pdf) that offers advice on managing appointments and conducting remote consultations. These resources have useful information for services outside the health sector as well.

The UK’s Early Intervention Foundation have produced a report on evidence, challenges and risks relating to virtual and digital delivery. The paper can be found at:

Trauma response and trauma-informed practice

Common consequences of disease outbreaks include anxiety and panic, depression, anger, confusion and uncertainty, and financial stress, with estimates of between 25% to 33% of the community experiencing high levels of worry and anxiety during similar pandemics. The Black Dog Institute predicts that “Health care workers, people placed in quarantine, and individuals with life-threatening cases of COVID-19 are at increased risk of long-term mental health problems.” It offers practical responses in its document Mental Health Ramifications of COVID-19: The Australian context.

Emerging Minds has a dedicated section on their website containing resources on helping children with the effects of COVID-19, including fact sheets on typical trauma responses in children of different age groups. Emerging Minds also offers a variety of online training on understanding trauma responses and supporting children who have experienced trauma.

Effects of isolation and loneliness

The European Public Health Alliance notes that those with pre-existing mental health issues, children, the elderly, and specific socio-economic groups are more likely to experience ill effects due to isolation and loneliness caused by social distancing and confinement. Supporting clients to use digital services where possible, and to access neighbourhood support groups and service (with appropriate safety measures) can help. Dr Michelle H Lim, scientific chair of the Australian Coalition to End Loneliness and senior lecturer in psychology at Swinburne University of Technology, and Joanna Badcock, Adjunct Professor, School of Psychological Science, University of Western Australia have some additional suggestions in this article from The Conversation.

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5 https://epha.org/the-dangers-of-social-isolation-during-a-pandemic/
Anxiety and depression

The Federal Government launched a $1.1 billion package on 29 March 2020 to boost mental health services, domestic violence support, Medicare assistance for people at home and emergency food relief. Providers including beyondblue, Lifeline, Kids Helpline, Gayaa Dhuwi (Proud Spirit), and Perinatal Anxiety and Depression Australia (PANDA) are providing additional services and support targeted at mental health concerns exacerbated by COVID-19. Beyondblue’s dedicated support resources can be found here: https://coronavirus.beyondblue.org.au/.

Loss of income and material basics

The United Nations Sustainable Development Group’s policy brief The Impact of COVID-19 on children (15 April 2020) describes the socioeconomic effects of the virus and related measures to suppress transmission and control the pandemic, and states:

“While children are not the face of this pandemic, its broader impacts on children risk being catastrophic and amongst the most lasting consequences for societies as a whole.”

Large numbers of people have either lost work completely, or are facing significant underemployment. This burden is falling disproportionately on young people and women. Most economic analysis points to Australia entering into a recession following the impact of COVID-19. Previous research has shown that young people has severely affected by recession, with long term implications for their wealth and wellbeing. Dr Jenny Chesters of the University of Melbourne writes about “economic scarring” here: https://theconversation.com/recessions-scar-young-people-their-entire-lives-even-into-retirement-137236

The “digital divide” affecting remote education is closely related to income and socio-economic status, as is overall health and wellbeing, both of which have the potential for lasting effects on entrenched disadvantage.

Personal safety and risks of family violence

Some family violence organisations in Australia are already reporting a rise in demand for services as families cope with the multiple pressures of job loss, confinement, anxiety and stress. A dedicated COVID-19 family and domestic violence taskforce has been set up within the Department of Communities to work with police and service providers to ensure services remain open during the pandemic.

ARACY founder Fiona Stanley AC and a number of colleagues and peers provide practical and policy suggestions in this article.

Half of families affected by domestic violence have children in their immediate care. With the Federal Government’s recent announcement of free childcare and emerging research that children are not COVID-19 super-spreaders, more children will be returning to early education and care. Early Signals. First Responses, a program developed by Early Childhood Australia, resources and supports early childhood educators and carers to better recognise and respond to young children who have been exposed to or experienced family violence. The program includes online learning techniques and webinars as well as expert coaching.
