**

# Evaluation Framework

# Rural and Remote Division of Family Practice

**Patient Medical Home**

July 2018

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# Abbreviations and Acronyms

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|  |  |
| GP | General Practitioner |
| GPSC | General Practice Services Committee |
| MoH | Ministry of Health |
| PMH | Patient Medical Home |
| RRDFP | Rural and Remote Division of Family Practice |
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# Purpose

This document is designed to guide the evaluation of the Rural and Remote Division of Family Practice’s Patient Medical Home initiative. To this end, the framework describes the Rural and Remote Division, the provincial PMH initiative, and each Chapter’s PMH objectives. The document also outlines the scope of the evaluation, including the identification of the evaluation objectives, key questions, indicators, data collection methods, and stakeholder involvement. Proposed evaluation activities are consolidated in an evaluation workplan and matrix.

# About the Rural and Remote Division of Family Practice

The Rural and Remote Division of Family Practice (RRDFP) is a community-based organisation established in 2012 that represents family physicians in rural and remote communities around BC. The structure of the Division is unique from all existing divisions in that it includes thirteen chapters across Island Health, Vancouver Coastal Health, Northern Health and Interior Health authorities. The chapters represent the following communities: Salt Spring Island, North Vancouver Island, Long Beach, Gabriola Island, Pemberton, Bella Bella, Bella Coola, Merritt, Western Interior, Revelstoke, Hazelton, Clearwater plus an Open Chapter. The members of the Rural and Remote Division work together to improve patient access to local primary care, increase local physicians’ influence on health care delivery and policy, and provide professional support for physicians.

# About the Patient Medical Home (PMH) Initiative

Patient Medical Home (PMH) is a provincial initiative driven through a partnership between the General Practice Services Committee (GPSC) and the Divisions of Family Practice. The GPSC vision associated with the PMH is to develop a foundation within a broad, integrated health system to deliver quality health care that effectively meets the needs of the British Columbia (BC) population[[1]](#footnote-2).

The GPSC describes the PMH through 12 attributes[[2]](#footnote-3) as using a collaborative, team-based, patient-centred approach to provide high quality care. The PMH situates itself within an integrated primary and community care system, affording its patients timely access to coordinated, continuous, and comprehensive care within the broader system, along with a primary care provider within the PMH itself[[3]](#footnote-4).

To guide local and provincial transitions to the PMH model, the GPSC has defined four overarching goals associated with the initiative:

* To **increase** **patient access** to appropriate, comprehensive, quality primary health care for each community.
* To **improve** **support for patients**, particularly vulnerable patients, through enhanced and simplified linkages between providers.
* To contribute to a more effective, efficient, and **sustainable health care system** that will increase capacity and meet future patient needs.
* To **retain and attract family doctors** and teams working with them in healthy and vibrant work environments.

Finally, to align their vision and goals for PMH, the GPSC has selected four key outcome areas of interest: **physician experience**, **access to care**, **patient experience**, and **cost**.

# Evaluation Approach

The evaluation is designed to be developmental and use multiple lines of evidence (including both qualitative and quantitative methods) to provide formative (process) and summative (outcome) data to the local project team. To this extent, the evaluation framework is designed to guide the evaluation of the PMH initiative and can be used as a working document that may be adapted over the course of the initiative in response to changes in implementation or as new learnings arise.

Using a quality improvement lens, all findings will be analysed and reported back to the project team in a timely manner to better understand the implementation of practice changes or models within each chapter, as well as be able to identify and share outcomes, lessons learned, strengths and areas of opportunity.

Further, the evaluation intends to use a participatory approach to refine the evaluation plan, develop the data collection tools, and vet the findings. In working closely with the project manager and chapter coordinators, the evaluation will also ensure that the data collected is utilization-focused and responsive to the feedback, needs, and activities of key stakeholder groups.

## Objectives

Specifically, the evaluation is designed to:

* Support the implementation of PMH initiatives within each chapter by enhancing data collection and analysis using a quality improvement approach.
* Identify strengths, challenges, areas of opportunity during implementation that could be used to improve local initiatives and be shared as lessons learned to other communities.
* Report on outcomes related to the stated PMH goals and objectives.

## Key Questions

The following questions guide the evaluation objectives:

1. To what extent is the initiative being implemented as planned?
2. To what extent are the necessary stakeholders involved in the planning, development and implementation of the initiative?
3. To what extent is the initiative achieving its expected outcomes?
4. What are the strengths, challenges, lessons learned and areas of opportunity for the initiative?
5. To what extent are the changes that have been made or outcomes sustainable?

## Stakeholder Involvement

The following have been identified as stakeholders in the project and potential sources of information for the evaluation.

* Rural and Remote Division of Family Practice staff
* Rural Physicians
* Patients
* GPSC & Ministry of Health
* Health authorities (Island Health, Vancouver Coastal, Interior Health, Northern Health and First Nations Health Authority.)
* Nurses and allied health professionals (RNs, NPs, SW)
* Community partners
  + Local governments
  + Community organizations
* Practice Support Program (PSP)

## Data Analysis and Reporting

Using multiple lines of evidence and intersecting data from several sources, the evaluation will provide information designed to help inform the implementation of the initiative. The evaluation recommends the development of a data/evaluation working group to support access to health authority and Ministry of Health data, as well as ensure the data collection needs are being consistently met across chapters.

Communication between the project manager and evaluation team will be ongoing to facilitate evaluation planning and implementation. Periodic briefs of the evaluation findings will be provided to the chapter coordinators as well. Quantitative data arising from surveys, health service utilization, and demographic data will be reported descriptively. Where appropriate, statistical analyses (e.g., univariate and multivariate) will be used. Qualitative data analysis will be driven by a thematic approach, enabling key themes to be identified and stories exemplified.

# Evaluation Methods

The evaluation intends to utilize a developmental and participatory approach. The evaluation team will consult with identified key stakeholders, including (but not limited to) project manager, chapter coordinators, and data working group to create tailored data collection tools. The four methods suggested below to address the stated objectives are not exhaustive; the methods may be adapted as the needs of the evaluation evolve.

## Document and Literature Review

As part of the evaluation, materials produced by chapters including project proposals, operational processes, and program documents will be reviewed on an ongoing basis. Secondary data, including background literature, will also offer insights that may be relevant or transferable.

## Administrative Data Analysis

Depending on nature of the projects implemented in Rural and Remote communities, data requests from the following administrative databases may be made:

* Ministry of Health – eg. MSP billing code use
* Health Authority – eg. emergency department use, hospital admissions
* Health System Matrix – eg. Health service utilization by population segment (ie., healthy, frail elderly, end of life, severe MHSU, high chronic conditions, etc.)
* Local Division/Chapter data – eg. event attendance, engagement of GPs
* Clinic level EMR data – eg. Patient panel, encounter codes

## Key Stakeholder Interviews

To capture qualitative data, semi-structured interviews may be conducted with a selection of key stakeholders either in-person or by telephone. It is expected that the interviews will provide an opportunity for the evaluation to collect qualitative information from a variety of perspectives on the development and implementation of PMH. Interviews allow stakeholders to comment on predetermined issues or to emphasize any given issue in a more flexible, conversational style. In this way, the interviews embed a feedback mechanism for early learnings, while also providing insight into previously unidentified issues relevant to the evaluation.

A comprehensive list of key stakeholders and the timing of interviews/requests will be determined in consultation with the project manager and chapter leads. Interviews will likely occur at various stages throughout the evaluation to gather information about the development, engagement, impact, and outcomes of the initiative as it is established in the community.

## Surveys

A provincially developed PMH Assessment tool has been provided to divisions to support the consistent collection of data about GP practices. The data is aggregated by division and provided for planning and evaluation if physicians consent to having their data shared.

A provincially developed patient survey is also in development and may be useful to this evaluation.

Surveys may also be used to engage a larger number of stakeholders in an anonymous, timely, and resource-efficient manner. Surveys will be developed, as necessary, to capture additional perspectives of the identified stakeholders, including the patient perspective. The tools will draw on the document and literature review, as well as the analysis of early interview learnings. They will be designed to optimize results, minimize selection bias, and mitigate fatigue with varied forms of questions, including closed and open-ended questions.

# Implementation of the Evaluation

The table below outlines the evaluation activities, along with a proposed timeline. *Italicized* items indicate deliverables and their deadline.

### *Table 1. Summary of workplan*

|  |  |  |
| --- | --- | --- |
| **Proposed timeline** | **Key evaluation activities** | **Notes** |
| June/July 2018 | Evaluation planning | * Connect with project manager and chapter leads * Review existing literature * Develop a framework to outline the key evaluation questions, methods, and indicators to be measured |
| July 30, 2018 | *Evaluation Framework* | |
| September 2018 | Connect with chapters about specific needs | * Tailor data collection needs to each chapter * Submit case study proposal to GPSC if appropriate |
| Fall 2018 | *Data collection tool* development | * Develop and submit data requests as necessary * Create interview guides and survey tools as necessary |
| Fall-Winter 2018 | Data collection | * Review progress and documentation * Conduct interviews with identified stakeholders * Access data from requested sources |
| December 2018 | *Evaluation Update report* | * On activities to date, early findings, lessons learned |
| February 2019 | Data analysis | * Analyze admin data that was collected * Verify that the data is meeting evaluation needs * Analyze all qualitative and quantitative data |
| *March 1, 2019* | *First Draft* | |
| March 1-30, 2019 | Report review | * Assess and attend to feedback received from project leads |
| *March 31, 2019* | *Final Report* | |

Process Evaluation

1. **To what extent is the initiative being implemented as planned?**
2. **To what extent are the necessary stakeholders involved in the planning, development and implementation of the initiative?**

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| --- | --- | --- |
| **Associated Sub-Questions** | **Suggested Indicators** | **Data Source (Data Collection Method)** |
| What activities have taken place?  What structures are in place to guide and support the initiative’s activities?  How have GP practices been engaged/ prepared for the initiative?  Were changes made during implementation, and if so what was changed and why? | Implementation of initiative activities  Structures developed to support the initiative (e.g. protocols, planning meetings, workflow changes, space considerations, financial incentives, technological factors) | Initiative planning documents (document review) |
| Perception of Division staff and other stakeholders | Division staff, health authority staff, CSC members (interviews) |
| Were the appropriate stakeholders identified and engaged? Were any stakeholders not engaged who should have been?  What are the roles and responsibilities of each stakeholder?  How has collaboration between stakeholders through the PMH strengthened partnerships?  To what extent is there a shared vision for the initiative across stakeholders?  Were there any challenges to stakeholder involvement? | Existence of engagement activities   * Development of CSC * #/type/attendance of Division/chapter engagement events/meetings * #/type of stakeholder   Documentation of roles and responsibilities of stakeholders | Initiative planning documents (document review)  Division documents (e.g. engagement spreadsheet, attendance at events) |
| Perception of key stakeholders   * level of engagement * meaning of involvement * nature of involvement * relationship building * strengthening of partnerships | Key stakeholders (interviews) |
| What data collection processes have been put in place to support the operation and outcomes of the initiative?  Are these processes sustainable and meeting the data needs of the initiative? | Existence of data collection processes  Existence of confidentiality and privacy procedures | Initiative documents (e.g. planning documents, data collection tools) |
| Perception of CSC, Division staff, health authority staff | CSC, Division staff, health authority staff (interviews) |

1. **What are the strengths, challenges, lessons learned and areas of opportunity for the initiative?**

|  |  |  |
| --- | --- | --- |
| **Associated Sub-Questions** | **Suggested Indicators** | **Data Source (Data Collection Method)** |
| What factors contributed to the success of the initiative?  Were there any challenges/barriers faced, and if so, how were the overcome?  Was there anything that could have been done differently to improve implementation and/or outcomes of the initiative?  Have local learnings been shared with other chapters? | Perception of key stakeholders  Dissemination of information with other chapters  Application/EOI submitted for PCN | Key stakeholders (interviews)  Division documents (document review) |
| To what extent has being rural/remote had an impact on the initiative?  To what extent is the initiative meeting the unique needs of the community? | Perception of CSC, Division staff, health authority staff  Unique strengths/challenges associated with rural/remote implementation | Key stakeholders (interview) |

Outcome Evaluation

1. **To what extent is the initiative achieving its expected outcomes?**

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| --- | --- | --- |
| **Associated Sub-Questions** | **Suggested Indicators** | **Data Source (Data Collection Method)** |
| **To what extent has the initiative:**   * **increased** **patient access** to appropriate, comprehensive, quality primary health care for each community? | Degree to which practices provide accessible, appropriate, comprehensive, quality care  Patient access: # patients served/ # attached | GPs (PMH Assessment Survey)  PSP panel clean up  Patients (Survey/interview) |
| Perception of key stakeholders | Key stakeholders (interviews) |
| * **improved** **support for patients**, particularly vulnerable patients, through enhanced and simplified linkages between providers? | Increased connections with health authority programs  Increased team-based care (# practices with linked SW, RN, etc.) | Health authority data (admin data analysis)  GPs (PMH Assessment Survey)  Patients (surveys/interviews) |
| Perception of key stakeholders   * improved collaboration * simplified pathways | Key stakeholders (interviews) |
| * contributed to a more effective, efficient, and **sustainable health care system** that will increase capacity and meet future patient needs? | Increased efficiency/effectiveness of GP offices, including increased tasks by non-physicians | GPs (PMH Assessment Survey)  Encounter codes (admin data review) |
| Perception of key stakeholders | Key stakeholders (interviews) |
| * **retained and attracted family doctors** and teams working with them in healthy and vibrant work environments? | # GPs working in Rural and Remote communities | Division/ chapter data (admin data analysis) |
| Perception of key stakeholders   * professional satisfaction | Key stakeholders (interviews) |

1. **To what extent are the changes that have been made or outcomes sustainable?**

|  |  |  |
| --- | --- | --- |
| Are there barriers to enabling sustainability?  What are the facilitators/enablers to sustainability?  What ongoing supports are needed to ensure sustainability of changes? | Perception of key stakeholders   * Barriers to sustainability * Facilitators of sustainability * Desirability of sustainment | Key stakeholders (interviews) |

# Appendix B: CES Guidelines for Ethical Conduct

**Competence**

**Evaluators are to be competent in their provision of service.**

1. Evaluators should apply systematic methods of inquiry appropriate to the evaluation.
2. Evaluators should possess or provide content knowledge appropriate for the evaluation.
3. Evaluators should continuously strive to improve their methodological and practice skills.

**Integrity**

**Evaluators are to act with integrity in their relationships with all stakeholders.**

1. Evaluators should accurately represent their level of skills and knowledge.
2. Evaluators should declare any conflict of interest to clients before embarking on an evaluation project and at any point where such conflict occurs. This includes conflict of interest on the part of either evaluator or stakeholder.
3. Evaluators should be sensitive to the cultural and social environment of all stakeholders and conduct themselves in a manner appropriate to this environment.
4. Evaluators should confer with the client on contractual decisions such as: confidentiality; privacy; communication; and, ownership of findings and reports.

**Accountability**

**Evaluators are to be accountable for their performance and their product.**

1. Evaluators should be responsible for the provision of information to clients to facilitate their decision-making concerning the selection of appropriate evaluation strategies and methodologies. Such information should include the limitations of selected methodology.
2. Evaluators should be responsible for the clear, accurate, and fair, written and/or oral presentation of study findings and limitations, and recommendations.
3. Evaluators should be responsible in their fiscal decision-making so that expenditures are accounted for and clients receive good value for their dollars.
4. Evaluators should be responsible for the completion of the evaluation within a reasonable time as agreed to with the clients. Such agreements should acknowledge unprecedented delays resulting from factors beyond the evaluator's control.

(Canadian Evaluation Society, 2001-2010)

1. ‘Provincial Evaluation Framework Patient Medical Home’. May 9, 2017. [↑](#footnote-ref-2)
2. Patient Medical Home in BC. September 20, 2016. [↑](#footnote-ref-3)
3. *Ibid.* [↑](#footnote-ref-4)