A Guide to Framing Evaluation of Initiatives Addressing Complex Health & Social Challenges

Background

The Health Neighborhood (HN) includes the entire care continuum from Patient's Medical Home (PMH) to community and encompasses the services provided by all healthcare and community supports such as community pharmacists, psychologists and community programs like tax clinics, employment programs or Family & Community Support Services (FCSS). Initiatives focused on complex health and social challenges of patients (PMH-HN initiatives) require strong links between PMH team members and community partners. Evidence shows that multi-sector teams with strong links between partners and sharing of information in the health neighbourhood results in improved patient outcomes, safety, experience, and lower costs through reduced duplication of services.

Evaluation of PMH-HN initiatives should consider a variety of perspectives about whether initiatives work but also how they work, and how they interact with the context in which they are being implemented. Based on the learnings from the Reducing the Impact of Financial Strain (RIFS) project and building on the Alberta Healthy Communities Approach, this Guide was developed to assist PCNs and their multi-sector teams help focus evaluation of PMH-HN initiatives by offering sample evaluation questions and indicators.

The sample questions address quality and implementation outcomes[1] taking into account perspective of individuals with personal experience of a health/social issue (patients), health care providers in the PMH (PMH team), and connections with community resources, community-focused partnerships and structures (the community). Sample evaluation questions and indicators are organized according to the following four broad focus areas:

1. Implementation
2. Experience of the initiative
3. Effectiveness, and
4. Sustainability (capacity for spread & scale)

A definition of outcomes in each focus area is provided in Table 1. The questions have been adapted from the *Evaluating Quality and Implementation* (EQUIP) tool[2] (see Appendix A for the original EQUIP outcomes).

Table 1: Focus Area & Outcome Definitions

Focus Area	Outcome	Definition
Implementation	REACH	The proportion of paneled patients who receive the initiative
	ADOPTION/UPTAKE	Intention or attempt to use or implement an initiative
	FIDELITY-ADAPTATION CONTINUUM	Degree to which the initiative was implemented as planned. Adaptations that were made; differences by site[3]
	FEASIBILITY	Practicality of what is being implemented
		Optimal and sustainable use of resources to yield maximum value
		Resources and costs required to implement an intervention
Experience of the Initiative	APPROPRIATENESS	Care that is relevant to a patient's needs Compatibility of what is being implemented
	ACCEPTABILITY	Honouring a person's choices, needs and values Satisfaction with what is being implemented
	SAFETY	Avoiding harm and fostering security
	ACCESSIBILITY	Ease with which health and wellness services are reached
	EQUITY	Fair distribution of services according to need
Effectiveness	PATIENT	Care that is known to achieve intended outcomes
	INITIATIVE	The extent that initiative goals and objectives were achieved
Sustainability		Extent to which initiative is maintained, including capacity for spread and scale

[1] Alberta Quality Matrix for Health and Outcomes for Implementation Research

[2] Alberta SPOR SUPPORT Unit https://www.ktalberta.ca/kt-alberta-resources-1/2021/9/2/the-evaluating-quality-and-implementation-equip-tool)

[3] Because complex initiatives are so context dependent, this outcome looks at both what was planned (fidelity) and adaptation to implementation context

How to Use the Guide

Multi-sector teams can use the Guide to select evaluation questions and indicators that support their initiative objectives and intended outcomes which, in turn, can contribute to the evaluation framework development. To support this use, an example logic model and evaluation framework based on the RIFS grant-funded project (2018-2022) is provided in Appendix B. The intent of the example is to demonstrate how, in alignment with the logic model and purpose of the evaluation, evaluation questions were selected and used to guide the development of an evaluation framework. Appendix C includes some suggestions for how to capture service utilization if recommendations were made after a patient screens positive.

Other Considerations

The guide is not intended to be prescriptive. If questions are selected, they may still need to be tailored based on the context of an initiative and its specific goals and objectives.

The Guide addresses planning the evaluation but does not include the doing evaluation (who will collect the required data) or using evaluation (how multi-sector teams come together to discuss the data, its analysis and how learnings can be shared and used to strategically (i.e., to support decisions).

1. **Implementation** Sample Questions & Indicators by Perspective

Patient

REACH: Who is participating? How does this compare to the panel segment targeted?

- % eligible patients who received the initiative
- Characteristics of patients who received the initiative
- Characteristics of patients who declined the initiative
- Patients' perceptions of barriers and facilitators to participating in the initiative

Patient's Medical Home

ADOPTION/UPTAKE: Which PMH providers are participating? Which are not?

- % eligible team members using the initiative (by role)
- Team members (and role) declining to use the initiative
- Perceptions of barriers and facilitators to participating in the initiative

FIDELITY-ADAPTATION CONTINUUM: How is the initiative integrated into workflows? How does it differ from what was planned?

- Description of how team members are using the initiative
- Changes made to the initiative (and reasons why) Framework for Reporting Adaptations & Modification Expanded (FRAME)

FEASIBILITY: How practical is implementation?

- Number of team members (by role) required to implement the initiative
- Team member time spent on implementing the initiative (& associated costs) if they are offering the initiative and what is this taking them away from
- Training & support required to implement
- Feasibility of Intervention Measure (FIM)
- Specific initiative results (e.g., screening results)
- Referral & Service Utilization (see Appendix C)

Community

ADOPTION/UPTAKE: Which community partners are implementing the initiative? Which are not?

- % eligible community partners implementing the initiative
- Description of services offered by community partners implementing the initiative
- Perceptions of barriers and facilitators to implementing the initiative

FIDELITY-ADAPTATION CONTINUUM: How is care coordinated? How does it differ from what was planned?

- Description of established referral pathway(s)
- How care is coordinated (process-structure)
- Change made to care coordination (and reasons why) Framework for Reporting Adaptations & Modification Expanded (FRAME)

FEASIBILITY: How practical is implementation?

- How practical are referral pathways
- Staff time spent on implementing the initiative (& associated costs) if they are offering the initiative and what is this taking them away from
- Training and support required to implement
- Connections established between community organizations
- How are the partners connected to each other and the multi-sector team

2. **Experience of the Initiative** Sample Questions & Indicators by Perspective

Patient

EQUITY: How does the initiative improve health, access, and/or acceptability of care for groups in need?

- Existing gap in Effectiveness, Accessibility, Acceptability indicators
- Change between groups' Effectiveness, Accessibility, Acceptability indicators over time (compared to baseline)
- Patients' perceptions of barriers and facilitators to accessing care

ACCEPTABILITY: What experiences do patients have when accessing healthcare services?

- Patient-reported experience measures (PREMs)
- Patients' satisfaction ratings
- Patients' perceptions of care received
- % patients who feel their care preferences were respected
- Difference in groups or over time (e.g., from baseline)

APPROPRIATENESS: Are patients receiving care that meets their needs?

- Patient-reported outcome measures (PROMs) (e.g., EQ-5D)
- % patients who received inappropriate services
- Patient's perceptions of collaborative decision-making
- Difference in groups or over time (e.g., from baseline)

SAFETY: Do patients feel safe when receiving care?

- Patients' perceptions of safety when receiving care
- % patients who had adverse outcomes (by type)
- Difference in groups or over time (e.g., from baseline)

ACCESSIBILITY: Are patients able to obtain care when and where they need it?

- Median wait time
- Patients' access to referred services/resources
- % patients with follow-up appointments booked prior to discharge
- % patients seen through different mediums (e.g., online vs in-person)
- Difference in groups or over time (e.g., from baseline)

Patient's Medical Home

EQUITY: To what extent are team members aware of healthcare disparities experienced by groups in need?

- % team members who have witnessed care disparities
- Perceptions of barriers and facilitators to addressing care disparities
- Team members' perceptions of disparities experienced in the healthcare setting

ACCEPTABILITY: How acceptable is the screening process to team members?

- Team members' experience (or satisfaction) ratings
- Acceptability of Intervention Measure (AIM)
- Evidence-Based Practice Attitudes Scale (EBPAS)

APPROPRIATENESS: Is the initiative compatible with team members' roles

- % team members who agree delivering the initiative is compatible with their role
- % team members who agree the initiative fits their context
- Intervention Appropriateness Measure (IAM)

Community

EQUITY: How are community partners improving care for groups in need?

- Equity-focused training programs provided
- Innovations implemented to address inequity
- Investments made to address and monitor inequities (e.g., data sharing initiatives)
- Policies and standards enacted to provide support to groups in need
- Perceptions of barriers and facilitators to improving care for groups in need

ACCEPTABILITY: How acceptable is the screening process to community partners?

- Partners' experience (or satisfaction) ratings
- Acceptability of Intervention Measure (AIM)
- Evidence-Based Practice Attitudes Scale (EBPAS)

APPROPRIATENESS: Is the initiative compatible with established structures and processes

- % team members who agree delivering the initiative is compatible with established referral pathways
- % team members who agree the initiative fits their context
- Intervention Appropriateness Measure (IAM)

3. **Effectiveness** Sample Questions & Indicators by Perspective

Patient

EFFECTIVENESS: To what extent are patient outcomes being achieved?

Targeted patient health outcomes, for example:

- % patients with clinically meaningful indicators (e.g., high blood pressure~~s~~, overweight)
- Patient-reported outcome measures (PROMs) (e.g., EQ-5D)
- Patient experience surveys
- % patients who are connected with referrals
- % patients utilizing referred services (see Appendix C)

Patient's Medical Home

EFFECTIVENESS: To what extent ~~-~~are patient and/or initiative outcomes being achieved?

- Team review of patient data audit and feedback
- Referral processes (standardized intake and communication)
- Closed loop referrals
- Median hospital length of stay
- % patients re-admitted within 30 days
- % patients who visit the ED within 30 days of discharge
- Rates of morbidity and/or mortality
- Difference in groups or over time (e.g., from baseline)
- Depending on initiative goals: Indicators from other outcome areas are relevant

Community

EFFECTIVENESS: To what extent ~~-~~are patient and/or initiative outcomes being achieved?

- Clinic-community (multi-sectoral team) coming together - sharing of data and information
- Referral processes (standardized intake and communication)
- Closed loop referrals

4. **Sustainability** Sample Questions & Indicators by Perspective[4]

Patient

SUSTAINABILITY: To what extent are patient outcomes maintained? Are patients receiving the initiative over the [defined time]?

- Changes in Effectiveness indicators [over defined ~~time period~~period]
- Changes in Reach indicators [over defined ~~time period~~period]
- Patients' perceptions of barriers and facilitators to maintaining gains

Patient's Medical Home

SUSTAINABILITY: What resources & supports are required to maintain the initiative? How has spread and/or scale been achieved?

- Changes in Adoption/Uptake [over defined time period]
- Resources and supports identified by team members to maintain the initiative
- Perceptions of barriers and facilitators to maintaining the initiative
- Normalisation Measure Development Questionnaire (NoMAD)
- Description of spread and/or scale (e.g., number of physicians, clinics etc.)

Community

SUSTAINABILITY: How is the multi-sectoral team working to maintain ?

- Changes in Adoption/ Uptake [over defined time period]
- Required resources and supports identified by team members to maintain connections
- Perceptions of barriers and facilitators maintaining community connections
- Normalisation Measure Development Questionnaire (NoMAD)
- Community of practice – establishment of ongoing multi-sectoral team

[4] The defined time period for sustainability indicators should be determined within the context of the initiative

References

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Appendix A: Quality and Implementation Dimensions

The original definition of the quality and implementation outcomes used in the EQUIP Tool are compared with outcome definitions in the current context of addressing complex health and social challenges.

The EQUIP Tool			Initiatives Addressing Complex Health & Social Challenges	
Outcome	**Description**	**Focus Area**	**Outcome**	**Description**
REACH	Willingness to participated in an intervention	**Implementation**	REACH	The proportion of paneled patients who receive the initiative
ADOPTION/ UPTAKE	Intention or attempt to use or implement an initiative		ADOPTION/ UPTAKE	Intention or attempt to use or implement an initiative
FIDELITY	Degree to which an intervention was used or implemented as intended		FIDELITY-ADAPTATION CONTINUUM	How was the initiative used? How did it differ by site?[5]
FEASIBILITY	Practicality of what is being implemented		FEASIBILITY	Practicality of what is being implemented
EFFICIENCY	Optimal and sustainable use of resources to yield maximum value			Optimal and sustainable use of resources to yield maximum value
IMPLEMENTATION COST	Resources and costs required to implement an intervention			Resources and costs required to implement an intervention
APPROPRIATENESS	Quality - Care that is relevant to a patient's needs Implementation - Compatibility of what is being implemented	**Experience of the Initiative**	APPROPRIATENESS	Care that is relevant to a patient's needs Compatibility of what is being implemented
ACCEPTABILITY	Honouring a person's choices, needs and values Satisfaction with what is being implemented		ACCEPTABILITY	Honouring a person's choices, needs and values Satisfaction with what is being implemented
SAFETY	Avoiding harm and fostering security		SAFETY	Avoiding harm and fostering security
ACCESSIBILITY	Ease with which health and wellness services are reached		ACCESSIBILITY	Ease with which health and wellness services are reached
EQUITY	Fair distribution of services according to need		EQUITY	Fair distribution of services according to need
EFFECTIVENESS	Care that is known to achieve intended outcomes	**Effectiveness**	PATIENT	Care that is known to achieve intended outcomes
			INITIATIVE	E~~The e~~xtent to which initiative goals and objectives were achieved
SUSTAINABILITY	Extent to which the initiative is maintained or institutionalized	**Sustainability**		Extent to which the initiative is maintained, including spread & scale

[5] Because complex initiatives are so context dependent, this outcome looks at both what was planned (fidelity)y and adaptation to implementation context.

Appendix B: Example Logic Model and Evaluation Framework for the RIFS Project

Problem Statement: (what issue will be addressed)

Income is one of the most powerful social determinants of health (SDoH) and individuals living with financial strain typically have worse health outcomes. It can be challenging to address the health impacts of living with financial strain, both for health providers and communities.

Initiative Objective (What will the initiative do)

To test a collaborative approach to address income as a determinant of health across the continuum from the Patient's Medical Home to the Health Neighbourhood.

Who will we reach (who will directly benefit): Eligible panelled patients: 18+ who live in Beaver County & 19-65 who live in Vermilion County

Inputs
What resources do we need?

Funding

Human resources
- Project team
- PCN staff
- Physicians & Allied Health Team
- Clinic Staff
- Community Partners

Patients

Key stakeholders
- AHS, AMA, ACPLF, AH
- Community partners
- HQCA Panel Report

Activities
What is our plan?

- Establish a QI team to test tools and processes
- Identify paneled patients who would most benefit to initially test (target population segment for screening)
- Standardize documentation in EMR
- Develop screening tool and script for team members
- Identify the health neighbourhood - community supports and resources
- Work with community stakeholders to define roles, develop shared vision and mutual goals
- Establish referral pathways
- Establish clear roles and responsibilities among the PMH team members
- Identify and respond to training and support needs of team members
- Screen patients and refer as appropriate
- Follow up as required
- Determine plans to expand screening

Outputs
What will happen soon?

- PDSAs (process improvements and practice changes)
- EMR templates
- Screening tool and script
- Process map (clinic flow)
- Referral pathway(s)
- Process for coordinating care across the Patient's Medical Home and the community
- Community asset map
- Type of training/supports identified
- Staff trained
- Screening results (screened, screened positive, refused)
- Referrals (referred, accessed services)

Outcomes[6]
What change do we expect

Short-Term
- Patients experiencing financial strain are identified
- Integration of screening & referral into workflows
- Patients are connected to relevant services
- Care management is optimized

Mid-Term
- Spread and scale (PCN sites, practices, community partners)
- Continuity of care (PMH to health neighbourhood & back)
- Appropriate vs inappropriate utilization of services
- Targeted patient outcomes improve

Long-Term
- Health status improves
- Chronic disease & cancer rate decrease

[6] Actual time frames will vary but short-term outcomes are typically expected in under a year, mid-term outcomes in about 1 to 3 years and long-term outcomes after 3+ years. Most mid-term and long-term outcomes aren't expected on the basis of a single initiative.

Evaluation Framework: Evaluation questions and indicators selected from the Guide that were in alignment with the logic model (above).

Evaluation Objective
(What are we evaluating)

The evaluation of RIFS will assess the feasibility of implementing RIFS and the extent to which short term outcomes are achieved

Evaluation Question	Output or Outcome	Indicator	Data Source	Timeline or Target
Implementation				
REACH: Who is being screened?	◆ Screening results	◆ % of eligible patients who received the initiative ◆ Characteristics of patients who are screened ◆ % eligible patients who refuse ◆ Characteristics of patients who refuse	◆ EMR ◆ Program records	Quarterly
FEASIBILITY: How practical is implementation for PMH team members?	◆ Integration of screening & referral into workflows ◆ Process map	◆ Feasibility of Intervention Measures (FIM) ◆ # patients at risk, # offered screening ◆ # patients screened, # screened positive ◆ # and type of referrals	◆ EMR ◆ Program records ◆ PMH team members	Quarterly
FIDELITY-ADAPTATION CONTINUUM: How is care coordinated? How does it differ from what was planned?	◆ Referral pathways ◆ Process for transitioning panelled patients to the community	◆ Description of established referral pathway(s) ◆ How care is coordinated (process-structure) ◆ Change made to planned care coordination (and reasons why) (FRAME)	◆ PMH team members ◆ Multi-sectoral team	Quarterly
Experience of the Initiative				
EQUITY: How does the initiative improve health, access, and/or acceptability of care for patients in need	◆ Care management is optimized	◆ Patient perceptions of barriers and facilitators to accessing care	◆ Patients (Patient experience survey[7])	At project initiation and project close
APPROPRIATENESS: Are patients receiving care that meets their needs	◆ Care management is optimized	◆ Patient-reported outcome measures (PROMs) (e.g., EQ-5D)	◆ Patients (EQ-5D)	At project initiation and project close
Effectiveness				
Are patient able to obtain care when and where they need it?	◆ Patients are connected to relevant services	◆ # and type of services accessed per patient (of those referred) ◆ Referral & Service Utilization (see Appendix C)	◆ EMR ◆ Patients	Quarterly (starting in the 2nd quarter)
Sustainability				
How has spread and or scale been achieved?	◆ Spread and scale	◆ Description of spread and/or scale (physicians, clinics etc.)	◆ PMH team members ◆ Program records	At project close

[7] Questions may be added to existing patient experience survey in use (e.g., HQCA Primary Care Patient Experience Survey or other used by PCN) or an initiative specific survey may be developed.

Appendix C: Referral & Service Utilization[8]

Screen Positive for: *Mark with an 'X' if patient screened positive for:*
Financial Strain ____
Food-related Strain ____
Housing Strain ____
Medication Strain ____
Mental Health ____
Social Isolation ____
Social Supports ____
Transportation Strain ____

Type of service referral: *Mark with an 'X' if patient has been referred to this service:*	**Internal or external PCN service:**	**How much service:**
Education services _____	(internal/external)	# hours ____ Outcomes ____ (e.g. new educational attainment)
Employment Assistance _____	(internal/external)	# hours ____ Outcomes ____ (e.g. $/year)
Food services _____	(internal/external)	Servings/day __ $ value ___
Health/Dental Benefits _____ (e.g., medication coverage)	(internal/external)	$ benefit: _____
Home modifications _____ (e.g., repairs, installation of grab bars)	(internal/external)	# of each modification _____ $ value ____
Housing support _____	(internal/external)	Days housed ____ $ subsidized ____
Income Support _____ (e.g., AISH, Alberta Works)	(internal/external)	$ received ___
Legal Assistance _____	(internal/external)	# hours ____
Medical care supports _____ (e.g., home care, foot care)	(internal/external)	# hours ____
Mental Health support _____	(internal/external)	# hours ____ $ saved _____
Tax Assistance _____	(internal/external)	# hours ____ Outcomes ____ (e.g. $/year)
Clothing-related assistance _____	(internal/external)	# items ____ $ value ____
Transportation services _____	(internal/external)	$ value ____
Other services _____	(internal/external)	# hours ____ $ value ____ Outcomes ____
Patient did not receive any service referrals _____		

General service questions:
If patient has not received this service, is the patient on a waitlist to receive this service? (Y/N)
If patient decided not to receive this service, did the service contact them? (Y/N)
What specifically did the patient receive? (e.g. counselling, bus pass, free clothing, new health benefits) If known, how much of this service did they receive?
Was 211 or a help seeker used for this referral? If yes, which one?
Changes in services utilized by patient (compare pre- and post-screening period)
Service referral feedback (documented patient feedback or community service follow up)

[8] Based on the Reducing the Impact of Financial Strain (RIFS) Initiative; adapt as required for PMH-HN Initiative being implemented.