EVALUATION PLANNING & TOOLKIT | 2021

SharedCareBC.ca

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EVALUATION PLANNING TOOLKIT

The Importance of the Evaluation to the Shared Care Portfolio

The Shared Care Committee has funded hundreds of Quality Improvement (QI) projects since the committee's inception in 2011. By supporting physician-led QI projects, the Shared Care Committee creates opportunities for family physicians and specialists to collaborate and directly apply their expertise and experience to specific issues and gaps in the health system. With the aim of supporting high quality planning, implementation, monitoring and reporting processes, the Shared Care team has created a number of templates and tools for use by project teams. By offering a unified approach to evaluation and reporting, project teams will be better equipped to share their results and impacts in a way that can be effectively spread by the Shared Care team to key stakeholders, including the Shared Care Committee, the health authorities and the Ministry.

Purpose of the Toolkit

The purpose of the Planning & Evaluation Toolkit is to provide project teams with:

- a practical framework to assist in planning a project evaluation, including when in a project life cycle an evaluation consultant should be hired if this expertise does not exist on the team
- the required templates and survey tools that Shared Care has implemented as a way to help strengthen evaluation and reporting practices at the project level
- additional surveys that may serve as a resource or assist project team's in data collection

Evaluation Framework

The Centers for Disease Control and Prevention Evaluation Framework highlights the key steps in planning an evaluation. This guide is a useful tool for project teams, even if the team does not have the skill set or capacity to conduct the evaluation themselves and must hire a contractor to complete this required component. Ensuring that your project plan has incorporated the identification of expected outcomes, data collection strategies and analysis are key to determining if the project was successful in achieving the desired change or impact that it set out do. Planning for this at the beginning will ensure that participants and stakeholders can be actively involved in capturing this change, either through interviews, surveys or other means of capturing their experience. As project planning is within the scope of a project lead, this graphic and step-by-step guide highlights key steps around incorporating an evaluation approach into the planning of a project. The guide also indicates where external support and expertise should be hired if needed.

Tools

Shared Care templates & tools: These tools have been created to support project teams in organizing their project evaluation plan, and in collecting data that will highlight the impact of the work at both the project and provincial levels. Interview and focus groups can also serve as excellent data collection strategies to receive more thorough responses from participants. Interview and focus group guides will need to be developed specifically for your project. By providing tools that will assist project teams in capturing key data from the physician leads and project participants, the Shared Care team will be better positioned to highlight learnings and impact achieved, and will support accountability to the Shared Care Committee, Doctors of BC and the Ministry of Health. In addition to the PDF forms in this document, you will find them in word format on the Shared Care Learning Centre: https://sharedcarelearningcentre.ca/

- **Physician Leads survey**
- **Evaluation Plan Template**
- **Event Feedback survey**
- **Meeting Satisfaction survey**
- **Needs Assessment questionnaires developed for Network projects**
- **Overview of Shared measurement**

• **Overview of Shared measurement**

What this Toolkit Does Not Provide

This Toolkit does not include a guide on how to conduct an outcome evaluation. An outcome evaluation determines whether an activity has effectively met its target objectives or expected outcomes. Outcome evaluations measure progress made on meeting project/activity goals. Some examples of an outcome evaluation include assessing whether an intensive training program resulted in more effective counseling, screening and treating of patients, if the training program had any unintended (beneficial or adverse) effects on the target population, and if the benefits of the training justify a continued allocation of resources[1].

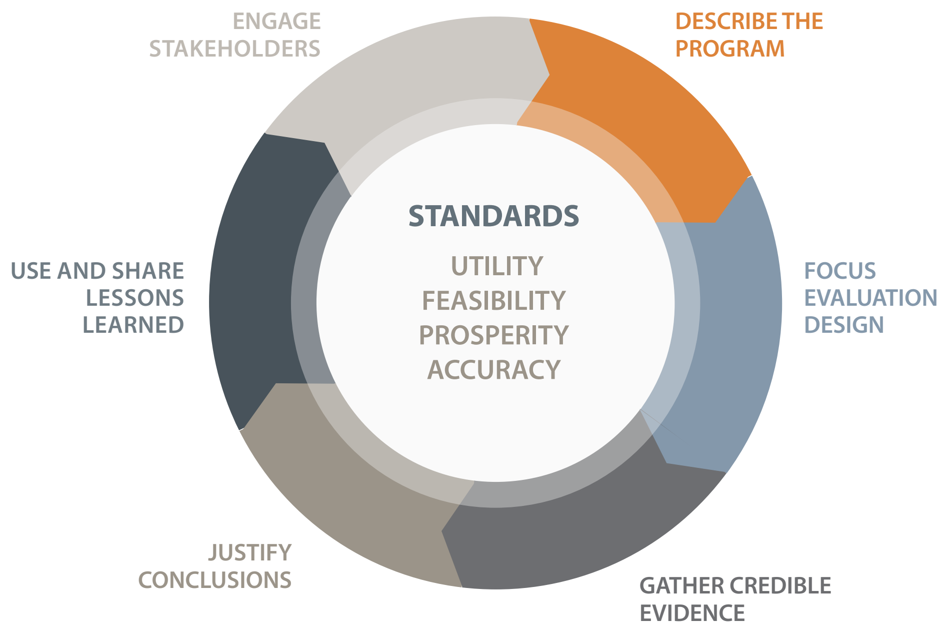
The Shared Care Committee requires all project proposals (with the exception of EOI-phase proposals) to include an evaluation plan. If the project team does not have the skill set or expertise to plan and conduct an evaluation, they are required to hire an external consultant to do so. Consultant costs vary widely depending on the complexity and length of the project; however, a standard estimate for evaluation costs is approximately 10% of a project's total resources.

[1] https://www.cdc.gov/std/Program/pupestd/Types%20of%20Evaluation.pdf

EVALUATION FRAMEWORK

An evaluation framework offers a practical, nonprescriptive step-by-step guide for summarizing and organizing fundamental elements of an evaluation. This framework can be utilized for relatively straightforward activities, such as an education event with speakers, or more complex activities such as a Quality Improvement project involving aggregate clinical data. If the activity requires a thorough outcome evaluation and your team does not have the evaluation expertise or capacity, this framework still serves to highlight key steps to consider during the planning phase. For example, the *Engage Stakeholders and Describe the Program* stages are within the scope of the project lead. Outsourcing the evaluation to a consultant would come in at *Focus Evaluation Design, Gather Credible Evidence, and Justify Conclusion* stages. The *Use and Share Lessons Learned* stage would be up to the project team to determine who should receive the results, and how to engage your key stakeholders and end users.

Figure 1: Centers for Disease Control and Prevention Evaluation Framework



STEP 1: ENGAGE STAKEHOLDERS

This first step is to identify and reach out to stakeholders to understand their unique perspectives, interests, and needs. Participating in this inquiry process will provide you with insight into factors that may influence the project's execution and effectiveness (e.g., high staff turnover, rural vs. urban regions), help you form the question that the evaluation is meant to ultimately answer (i.e., the evaluation question), and help you make informed decisions when designing the evaluation (either in-house or with a consultant). Consider the following questions:

- What are the needs and expectations of each stakeholder?
- Who is knowledgeable about the issue and would have insights to share?
- Who has unique perspectives that might highlight nuances?
- Who are the people that you need to involve to ensure you have the necessary permissions?

STEP 2: DESCRIBE THE ACTIVITY

Step 2 is to clearly define the goals and objectives of the activity. Use the information you gathered in Step 1, develop SMART (Specific-Measurable-Achievable-Relevant-Timed) objectives and describe any factors within the context of the project that will affect its success. At this stage, it is important to identify potential challenges that may arise and to develop corresponding mitigation strategies. Consider the following questions:

- What is the project trying to improve (e.g. enhanced communication between nurses and physicians in the ER)?
- What resources are available to implement the project (e.g., funds, time, leadership buy-in)?
- What activities will help to achieve the project objectives (e.g., bimonthly strategic planning session with stakeholders)?
- What are the direct results of these activities (e.g., improved knowledge and attitudes, improved patient self-management)?

STEP 3: FOCUS EVALUATION DESIGN

An evaluation design is, simply put, the blueprint of the evaluation. It is the methodology used to capture the information required to answer the evaluation question. If the team does not posses the level of evaluation expertise required of the project, a consultant should be hired. Choosing the most appropriate evaluation design often depends on the stage that the project is in and the specific evaluation question to be answered. An outcome evaluation design is most suitable for a project to assess whether the evaluation question addresses the success of the project in meeting goals and objectives.

In Step 3, when formulating an evaluation question and choosing the most appropriate evaluation design, consider:

- What is the primary purpose of the project, and/or what is the project trying to achieve?
- How will you incorporate information gathered from stakeholders during Stage 1 into the evaluation design?
- Who will use the conclusions of the evaluation?

STEP 4: GATHER CREDIBLE EVIDENCE

How will you and your team collect the information needed to answer the evaluation question? While working within the structure of the evaluation design, consider which aspects of the project will help you clearly judge the project's performance. Consult the Shared Care shared measures implementation guide to identify the key measures that will be used for the project and reported to Shared Care on a quarterly basis. Aside from the shared measures used and administered via surveys, consider what other data collection methods will be used. Who will the data be collected from, when will the data be collected and how (i.e. interviews, focus groups, more surveys, etc.). Indicators that represent a variety of perspectives and sources (e.g., from physicians, patients and health authority administrators) will enhance the credibility of both the evaluation and the project, generate more objective findings, and promote trust among stakeholders. Depending on the project, this stage requires some knowledge of evaluation methodologies. Examples of reliable, valid indicators include participation rates, participant satisfaction feedback, and changes in policies and practices. Once you have determined which indicators you will track, think about the most appropriate form of data to collect: quantitative, qualitative, or both. Quantitative data refers to a measurement of a quantity expressed through numbers, or information that can be measured (e.g., how much, how many). This is the focus of the shared measures developed for Shared Care. Qualitative data refers to a measure of quality expressed through observations or that can be described by participants.

Consider:

- Is the data collection tool used likely to produce objective, consistent findings when administered to a population with similar characteristics? In other words, will the data be reliable?

STEP 5: JUSTIFY CONCLUSIONS

The purpose of this step is to draw clear, credible conclusions from the data as it relates to the evaluation question and to make practical recommendations based on those conclusions. This step involves effectively analyzing and synthesizing the data collected. To effectively analyze the body of data, evaluators must organize, categorize, and compare the data to detect trends. Synthesizing the data requires evaluators to combine the trends to gain high-level insights and pursue recommendations (ideally developed jointly by the project team, including the evaluator, and policymakers). Your plan for analysis and synthesis will depend on the type of data collected, the volume of the data, and the questions answered. For qualitative data, the plan may involve grouping emerging themes from the results of open-ended survey questions. For quantitative data, statistical analysis is generally required to draw conclusions, which is often a very technical process requiring assistance from a professional statistician.

In Step 5, when drawing conclusions from the data and forming recommendations, consider:

- Do the results represent the sentiment of the majority? In other words, is the data valid?
- Could responses from a few individuals contain extreme biases (i.e., outliers)? If yes, how can these outliers be explained?
- What recommendations would best align with the values and priorities of the stakeholders?
- What recommendations can be feasibly implemented when considering varying interests and limited resources?

STEP 6: USE AND SHARE LESSONS LEARNED

The final step is taking action based on recommendations and disseminating evaluation findings and lessons learned with broader audiences. The objective is to use results and documented lessons-learned (e.g., successes, challenges) to mobilize action that will inform and improve future program planning—perhaps, for example, starting a new phase in the program or making course corrections based on what has been learned. The use of findings is not always straightforward: it requires strategic thinking that incorporates stakeholder feedback, and endeavours to implement recommendations while considering contextual factors such as political will. As mentioned in Step 1, designing an evaluation that meets the needs of the end user at the onset of planning is essential and will be invaluable when deciding how to use evaluation findings. For this reason, the evaluation framework is typically presented as a feedback loop—the feedback is continuously provided to allow for constant program improvement. This can be accomplished through various avenues, including interactive in person presentations, infographics, briefing notes, and written reports. In Step 6, when sharing lessons learned and implementing recommendations, consider:

- Who is the audience to be informed of the findings? What method will you use to share the results?
- Is your communications method accessible and meeting the needs and interests of each stakeholder group?
- If the results warrant further investigation, do you have the right people at the table to develop the next steps?

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SHARED CARE
PROJECT TEMPLATES & DATA COLLECTION TOOLS

SHARED MEASUREMENT

Purpose

Shared measurement involves a set of processes that require diverse organizations to consistently gather, analyze, and report data to ensure efforts remain aligned and participants hold each other accountable. The Shared Care portfolio has agreed upon a set of shared measures related to the goals and objectives of the Shared Care Committee that can be used across the province to assess and compare local innovation projects and provincial initiatives. Implementation of this approach will facilitate the collection and reporting of data to highlight the collective impact of Shared Care funded work.

In 2021 we are embarking on a phased implementation approach, working with specific teams who are keen to adopt the approach. The Shared Care team plans to implement shared measurement across all funded Shared Care projects by 2022. Connect with your liaison to find out more about how to integrate Shared Measures into your project and evaluation plan.

Participants

Most of the shared measures can be easily translated into a survey question posed to either providers or patients.

Method

At the project level, the shared measures can be integrated into an evaluation strategy as one component of the plan, or can standalone as the primary evaluative approach. Surveys can be administered via Checkbox 7 or other electronic survey tools. If the fundholder does not have a current subscription, SharedCare can support use of Checkbox 7 - please reach out to your liaison for more information.

Results

Results should address the evaluation questions of the individual project. Results will also be aggregated across the province to highlight collective impact. Please connect with your liaison to learn more.

PHYSICIAN LEADS SURVEY

WHEN & HOW TO USE THIS FORM

This required survey is to be answered by the physician leads at the conclusion of the project.

Purpose

The responses to these questions can be aggregated across the province to establish a provincial snapshot related to the general impact that Shared Care-funded projects are having on physician leads.

Participants

The Family and Specialist physician leads of a Shared Care project.

Method

Please submit one collective response for each question. Questions can be administered via email or answered verbally during a project meeting and transcribed and submitted in the project's final report.

Results

Survey results should be included in the project final report.

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PHYSICIAN LEADS SURVEY

Project Title: ______________________________

Physician Participants: ______________________________

Date: ______________________________

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. This project improved the coordination of care between family practice to specialist care (SharedCare mandate).					
2. Participating in this Shared Care project has re-energized me in my work.					
3. Patients were effectively engaged as project participants in this project.					
4. This project led to **improved provider experience**[i]					
5. This project led to **improved patient experience**[ii]					
6. This project led to **improved population health**[iii]					
7. This project **reduced the per capita cost of care**[iv]					

Definitions:

i Improved provider experience is defined as engaging physicians to work with each other, the health care system and their communities, to lead and /or support quality improvement and the spread of effective innovations. Physician engagement is also considered a component of provider experience, and is defined as the active participation in the health system at the patient, organization and system level

ii Improved patient experience is a construct that includes the patient's entire journey through the health care system. It includes the ability to access healthcare services, the degree to which care is coordinated, and the safety of care. It also includes the degree to which care honours a person's choices, need and values including cultural safety and humility

iii Improved population health refers to improving patient outcomes by improving the quality of health services

iv Reduction in per capita cost of care includes the development of a sustainable healthcare system, providing value or money, including measurable savings and improvements

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EVENT FEEDBACK SURVEY

WHEN & HOW TO USE THIS FORM

Purpose

This optional survey can be used at one-time or a limited number of events, such as educational or networking events.

Participants

Providers, health authority representatives, patient partners and other key stakeholders.

Method

This tool is best used immediately or soon after the event has taken place. It can be administered through paper form if the event is in person, via electronic platforms during the event such as Slido or via Zoom, or after the event through Survey Monkey, Checkbox or other online survey tools.

Results

This survey offers an easy to use tool to capture participants' perspectives – the results can assist the project support staff in making improvements to the meeting structure if participants highlight a need. The results of this survey should be included in the project's final project report.

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EVENT FEEDBACK SURVEY

Event Name: ____

Event Date: ____

1. Please identify the group that represents you best:

☐ Physician ☐ Provider ☐ Health Authority Partner ☐ Patient Partner

☐ Other: ____

2. Please rate the extent to which you agree with the following:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Overall I am satisfied with this event/meeting / workshop					
2. This meeting/event was a valuable use of my time.					
3. This meeting/event met the stated objectives.					
4. I would recommend this EVENT / MEETING to a colleague.					
5. I am satisfied with the venue, location, food and overall organization of this event.					

6. What could have improved your meeting/event experience?

7. Other comments:

Thank you for completing this feedback survey. Please return this form at the end of the event.

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MEETING SATISFACTION SURVEY

WHEN & HOW TO USE THIS FORM

Purpose

This optional survey can be used to assess the satisfaction of project members and /or stakeholders participating in re-occurring meetings, such as Steering Committees, Working Groups, etc.

Participants

Project team members including physicians, Health Authority partners, allied health partners , and patient partners.

Method

This survey can be administered at any time – we suggest bi-annually (twice) or annually (once) to minimize survey fatigue. It can be administered through paper form if the event is in person, via electronic platforms during the event such as Slido or via Zoom, or after the event through Survey Monkey, Checkbox or other online survey tools.

Results

This survey offers an easy to use tool to capture participants' perspectives – the results can assist the project support staff in making improvements to the meeting structure if participants highlight a need. The results of this survey can be included in the project's final project report.

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MEETING SATISFACTION FORM

1) Please identify the group that represents you best:

☐ Physician ☐ Provider ☐ Health Authority Partner ☐ Patient Partner

☐ Other: ______________________________

Please circle the number that reflects your assessment of each of the following 1 = Very Little / 5 = Very Much					
1. Participation at the meeting / committee has facilitated an improvement (direct or indirect) in the topic area of focus	1	2	3	4	5
2. Participation at the meeting / committee was informative and contributes to an enhanced understanding of the current issues and potential opportunities for change	1	2	3	4	5
3. Participation at the meeting / committee gave me the opportunity to improve communication with my colleagues (physicians, allied health and HA staff).	1	2	3	4	5
4. Continued participation at the meeting / committee will contribute to change and improve relationships and collaboration between specialist and family physicians.	1	2	3	4	5
5. I will continue to participate in the meeting / committee and would recommend involvement in future SharedCare funded projects to my colleagues.	1	2	3	4	5
6. Support from the Shared Care Committee enables me to address local gaps in care.	1	2	3	4	5
7. Support from the Shared Care Committee enables me to increase collaborative practice between Family Physicians and Specialists and/or improve care coordination among physicians in my community.	1	2	3	4	5
8. Overall, support from the Shared Care Committee is making a positive impact in my community.	1	2	3	4	5

General comments, and feedback for improving the meeting / committee:

NEEDS ASSESSMENT QUESTIONNAIRES

WHEN & HOW TO USE THIS FORM

Purpose

These optional surveys are designed to identify current gaps in care and areas requiring support or attention.

Participants

Surveys are specific to patients / family / community members and to providers.

Method

These surveys are best administered at the start of a project when there is a desire to understand the current state of care related to specific areas of care. They can be adapted in any way to meet the needs of your project. Surveys can be administered through paper form, or through an electronic tool such as Survey Monkey, Checkbox or other online survey tools.

Results

The results of these surveys can assist in identifying areas requiring attention from both the patient and provider perspectives. The results of this survey can be included in the project's final project report.

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NEEDS ASSESSMENT QUESTIONNAIRES

ADULT MENTAL HEALTH AND SUBSTANCE USE

Provider needs assessment survey tool: *Needs Assessment Survey: AMHSU Provider (MH Focus)*

Patient needs assessment survey tool: *Needs Assessment Survey: AMHSU Provider (MHSU Focus)*

Provider needs assessment survey tool: *Needs Assessment Survey: AMHSU Provider (SU Focus)*

Patient needs assessment survey tool: *Needs Assessment Survey: AMHSU Patient*

MATERNITY

Provider needs assessment survey tool: *Needs Assessment Survey: Maternity Providers*

Patient needs assessment survey tool: *Needs Assessment Survey: Maternity Patients*

CHRONIC PAIN

Provider needs assessment survey tool: *Needs Assessment Survey: Chronic Pain Provider*

Patient needs assessment survey tool: *Needs Assessment Survey: Chronic Pain Patient*

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Shared Care Evaluation Plan Template

HOW TO USE THIS TEMPLATE

Purpose

This template will help project teams to organize the evaluation of the project. An evaluation plan for each project will be included at the time of proposal submission, or submitted with the first quarterly report once funding has been approved.

Users

Evaluation is an important component of Shared Care projects. If the project team does not have the expertise or capacity to plan and conduct the evaluation, a consultant should be hired to support. The responsibility of the project lead is to ensure that the evaluation meets the needs of the projects. This template can be completed by the project lead / team member or the evaluation consultant. While an evaluation plan should be incorporated into all Shared Care project, the use of this *template* is optional if teams already have an existing approach that meets their needs. An evaluation plan is required at either the time of proposal submission, or by the first quarterly report once funds have been received.

Method

The best evaluations are those that are planned at the beginning of the project so that clear objectives, data collection and data analysis strategies can be integrated at key times. This evaluation plan includes elements that are likely in your project proposals, such as *Objectives* and *Deliverables* – they are included here to encourage the user to consider key elements of a project, and how they will be addressed in the evaluation. Adjusting the evaluation plan as the project matures is strongly recommended – this will ensure the plan reflects the needs and scope of the project. You will find a copy of this template without the examples in Appendix C of the Project Funding Request form.

Examples

There are two examples in this document – the blue example is an improvement project that is conducted in a single Emergency Department. There is a clear problem, aim statement, objectives and deliverables. The orange example[1] is less clear cut – the issue at hand is complex and involves numerous physicians, allied health and organizations. The components of the project – aim, objectives, deliverables – may change depending on the activities and learnings gleaned throughout the project. Both examples are provided here to reflect the different types of projects funded through Shared Care.

****

[1] *Adapted with permission from a project led by the Kootenay Boundary Division of Family Practice*

Shared Care Evaluation Plan Template

Project Title	
Estimated Timeline (start to end)	

OVERVIEW / BACKGROUND

State what problem you are addressing and why it is important. Include relevant data, literature, best practices, or sources to support the project. Describe who will benefit from the project (consider both the individual and organization) and how it will impact patients.

Example:
The accepted standard of care is Door to Door (D2D) within 30mins; the current mean D2D in hospital X is approximately 120 mins (administrative data). Research suggests that the time from when a patient arrives at the Emergency Department (ED) to when they are seen by a provider has significant implications on "left without being seen" rates. The time it takes for patients to be seen at the ED has a substantial impact on patient satisfaction (Hneiny 2018; Sayed et al. 2015), and clinical impacts for those patients with conditions whose mortality and morbidity increase with delay in treatment. Improved D2D time will benefit the individual patient by reducing wait time, it will benefit clinicians by reducing crowding in the ED and allowing more space for care delivery, and it will benefit the organization by supporting a more efficient delivery of care.

Example: There are significant disparities in cancer survival between urban and rural cancer patients (Butow 2012, Olson 2011) due, in part, to delays in diagnosis, shortages of health care professionals, high staff turnover, and a larger population with lower socioeconomic status (Jong 2005, Jiwa 2007). Worse outcomes among rural residents may also be secondary to lower adherence to follow-up recommendations, given barriers to accessing services. Most rural cancer patients commute long distances or even relocate to receive treatment, resulting in financial difficulties related to missing work and the high cost of travel (Hegney2005, Zucca 2011, Wilkes 2006). Those leaving their communities for treatment are removed from their social support systems, experience stress and fatigue related to travel, and distress waiting for treatment (White 2011).

In the X Region, the BC Cancer Agency estimates that there will be 660 new cancer diagnosis in 2022 alone, with an average increase of 10 additional diagnosis each years[2]. The situation described in the literature mirrors the experience of many patients in our region, with the current delivery model leaving many to feel responsible for coordinating their own care. Given our rural geography and lack of resources to support cancer care, a regional, team based approach is greatly needed.

Add text

[2] http://www.bccancer.bc.ca/statistics-and-reports-site/Documents/HSDA_incidence_projections_2019_2034_20210117.pdf

AIM STATEMENT

What is the problem or opportunity, who will the project benefit, where, by when and by how much? Provides initial orientation toward activities of improvement initiatives. See Appendix B for IHI Aim Statement Worksheet for additional guidance.

***Example**:* Lean change management techniques and tools identified by the ED Improvement Committee will be implemented in the ED in order to reduce time between patients entering the Emergency Department to time they are seen by a physician ("Door to Doc" or "D2D time") at hospital X, by 25% by June 2020.

***Example**:* Over the next 12 months, we will identify and implement processes to foster a team based approach to delivering cancer care that will address the unique needs of rural patients, and foster improved coordination and collaboration between cancer care providers, including Family Physicians, General Practitioner Oncologists, Specialists and allied health.

Add text

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OBJECTIVES

Objectives are specific and measurable steps. Objectives are narrow, precise and concrete. Make your objectives SMART – Specific, Measurable, Achievable, Realistic, and Time bound. In the section titled *Evaluation Framework*, be sure to identify the measures and data collection tool that will capture the necessary data to indicate if the objective has been achieved.

Example
By June 2021:
1. Reduction in mean D2D time by 25%, from 120 minutes to 90 minutes
2. Patient satisfaction scores will increase from a current, pre-implementation rate of 60% to a post-implementation score of 80%
3. 30 nurses and physicians will be engaged and educated to implement the Lean tools and processes

Example
In 12 months:

1. Approximately 20 local cancer care providers will report improved understanding of patient flow and coordination of care
2. Local GPOs and Oncologists will report improved communication, coordination and follow up of care for patients between their practices
3. Cancer care providers, including GPOs, FPs and specialists, will participate in at least 1 networking / educational event, and report it as a good use of their time
4. Patients with cancer will report satisfaction with:
   - the coordination of their cancer care
   - access and referral to education and support services
   - communication regarding their cancer care, including having had a discussion with their provider about advance care planning
   - overall satisfaction with experience of care

Add text

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TARGET POPULATION

Identify who will your participants be, how will you select them and why? How will you approach people to participate in your project? What are your inclusion and exclusion criteria and why? Consider including a brief Participant Communication Plan (optional). This component of the plan will likely need to be updated / altered as the project progresses and the problem / issue is better understood.

Example:
The project team will reach out to the ED manager and the Department Head for a list of staff and physicians. The project and activities will be shared at Staff and Department meetings and a one page info sheet will be posted in the break room

Inclusion criteria:
- Full time nursing staff in the ED
- Physicians scheduled to work in the ED at least twice / month
- Patients presenting at the ED. When a patient registers at reception, their phone number is taken down. A follow up call is made within 48 hours to assess their satisfaction. This is standard hospital procedure and ongoing.

Example:
A Cancer Planning Steering Committee will be convened to provide guidance and direction to this work. Members of this Committee will consist of a representative provider from each community in the region, as well as Health Authority staff with roles and responsibilities related to the delivery of cancer care. Members will serve to identify other providers who should be involved either as participants in this project, or as beneficiaries to the work. Patients will be identified by providers.

Inclusion criteria:
- Local cancer care providers in the region (General Practice Oncologists, Oncologists, Family Physicians, Nurse practitioners, allied health).
- Patients ages 20-80 years with Breast Cancer, Colon Cancer, Prostrate Cancer, Multiple Myeloma, Lymphoma, Lung Cancer, and Melanoma diagnosed within 6 months of the start of the project

Add text

***

PROJECT DELIVERABLES

Provide a list of the deliverables that you will produce at the conclusion of your projects. In addition to having a clear aim statement and objectives, clearly identifying the deliverables may assist you in focusing your evaluation plan. This list can be added / adjusted throughout the life of a project as new ideas emerge over time.

Example
At the conclusion of the project, the study team will provide:

- A Door to Door (D2D) process map
- The identification of non-value added activities / obstacles impeding efficiency
- Recommendations to redesign the processes of the ED to enhance efficiency

Example
Over the next 12 months, the following deliverables will be achieved. The evaluation will assess the satisfaction with these deliverables, and their impact of these activities on the above anticipated outcomes.

Deliverables – Enhancing coordination of care & communication

- Map triage, referral and follow up processes between Community Oncologists and GPOs & create a process guideline document
- Map the roles and responsibilities across cancer care providers and create patient flow map for region
- Care Plan & communications / process guidelines document
- Consult letter template
- Library / Resource list of patient and family / caregiver resources that can be accessed locally or virtually
- Other resource / guides as required

Deliverables – Supporting networking & relationship development

- Host 4 networking / educational events over 12 month period
- Identify and advertise advanced training and education opportunities (in-person or virtual) for cancer care providers
- Develop a clear two year succession plan for both Community Oncologists

Add text

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EVALUATION FRAMEWORK (EXAMPLE)

Define measures (quantitative and/or qualitative) used to monitor the impact of this improvement effort. Customize the table and include additional columns according to your approach.

IHI Modified Triple Aim	Outcome	Data Source	Measure
Improving the patient experience of care (including quality and satisfaction)	Shortened door to doctor time	Manually collected (by MOA or clerk) Daily for three months **The pre implementation** D2D time has been tracked by the ED Improvement Committee. Data for 3-month period will be analyzed. **Post implementation** of the lean tools, a representative sample of patients will be selected for a three month period. Access to administrative data has been granted to the ED Improvement Committee and will be shared with the project team	Time the patient registered at ED reception until the time an attending physician saw the patient
Improving the patient experience of care (including quality and satisfaction)	Improved patient satisfaction scores	Patient surveys, 48 hours, post visit Patients are called 48 hours after their ED visit by a hospital administrative assistant. A question related to satisfaction with timeliness will be added to the existing questionnaire. Data will be extracted from the current database in use by the hospital	# and % of patients who agree / strongly agree that they were satisfied with the timeliness of their ED visit
Improving provider experience	Improved provider knowledge of LEAN techniques and tools	Provider surveys, Survey administered post 4 education sessions Education sessions that are done virtually will post the questions via the zoom technology at the conclusion of the session. The same questions will be posed via paper for in-person sessions	# and % of provider who agree / strongly agree that their understanding of LEAN techniques and tools has improved following learning sessions
Improving provider experience	Provider application of identified LEAN techniques and tools	Regular meetings, ad hoc meetings, and via email. Collected monthly – ongoing feedback collected via department meetings Project lead will pose qualitative questions during department meetings Project manager will facilitate the lunch and learn discussion At conclusion of the project - a lunch and learn session with all providers at the conclusion of the project	Qualitative data will be collected from providers # and % of providers who agree that the initiative improved their overall satisfaction with the provision of care

EVALUATION FRAMEWORK (EXAMPLE)

IHI Modified Triple Aim	Outcome	Data Source	Measure
Improved provider experience	Improved understanding of patient flow	Post intervention / project survey	# and % of cancer care providers who agree / strongly agree that the *patient mapping diagram* has resulted in an improved understanding of patient flow # and % of cancer care providers who agree / strongly agree that the *triage, referral and follow up process guidelines* have improved your coordination of care with other health care providers
	Improved team based care between GPOs and Oncologists	Post intervention / project survey	# and % GPOs and Oncologists who agree / strongly agree that *the development of a patient care plan* has improved coordination of care between physicians
		Post intervention / project survey	# and % of GPOs and Oncologists who agree / strongly agree that *the consult template letter* have improved communication between FP and SP
		Post intervention / project survey	# and % of GPOs and Oncologists who agree / strongly agree that the activities implemented for this project have improved their confidence to provide care
	Improved job satisfaction of local cancer care providers	Post intervention / project survey	# and % of cancer care providers who agree / strongly agree that the activities implemented for this project improved overall provider satisfaction with provision of care
Improved provider experience	Improved uptake of training for cancer care providers	Registration data Post event survey	# of cancer care providers who participated in 1 training opportunity (in-person or virtual) over the last 12 months # and % of providers who agree that the training was a good use of their time
	Improved understanding of patient and family available resources	Pre and post survey	# and % of providers who agree / strongly agree that they have a good understanding of patient and family available resources

		Administrative data: Intake form of participating cancer support programs in the region	# of referrals made to local cancer care support programs
Improved patient experience	Patient satisfaction with care	Patients that are 6 months post diagnosis will be flagged by the MOA. Providers will ask if they are interested in completing a brief survey about their experience. Those who agree will be given a paper survey to complete	# and % of patients who are satisfied with the coordination of their cancer care # and % of patients who are satisfied with access to and referral to educational and support services # and % of patients who are satisfied with communication related to their cancer care # and % of patients who reported having a discussion with their provider about advanced care planning
	Patient satisfaction with care	4 Focus groups throughout the region Providers will identify potential patients to participate in focus group	Explore experience of cancer care related, but not limited to ability to make informed decisions, overall system navigation, overall satisfaction with care

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EVALUATION FRAMEWORK

Define measures (quantitative and/or qualitative) used to monitor the impact of this improvement effort. Customize the table and include additional columns according to your approach.

IHI Modified Triple Aim	Expected Outcome	Data Source	Measure

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APPENDIX A: ADDITIONAL SECTIONS FOR EVALUATION PLAN

Appendix A contains additional sections for the Evaluation Plan. These may be helpful to complete for your project, depending on its needs. Borrow content from this Appendix accordingly.

Evaluation Team

e.g. RACI diagram of who leads evaluation, who does the data collection, who has oversight/governance? This will help set the expectations of project teams, SCC team, etc.

Stakeholder Assessment

Table including stakeholder, interest, role in evaluation, and engagement plan…etc.

Operational Definitions Worksheet

Evaluation Timeline

Risk Assessment (of Evaluation)

Logic Model Templates

Simple tables that outline resources, inputs, activities, outputs, outcomes.

APPENDIX B: AIM STATEMENT WORKSHEET

Adapted from Institute for Healthcare Improvement (IHI) Quality Improvement Practical. ihi/org/QI.

An aim statement is the answer to the first question in the Model for Improvement, "What are we trying to accomplish?" Effective aim statements delineate clear, specific plans for the work ahead. Use the prompts below to write an effective aim statement. Then use the checklist to double-check your work.

What? What's the problem or opportunity? Make sure it relates to a fundamental customer need.

How much? By how much will you improve? Or "how good" do you want to get?

By when? What is the date by which you will achieve the level of improvement you've set out to accomplish?

For whom? Who is the customer or population who will benefit from the improvement?

Where? What are the boundaries of the process or system you're trying to improve? Where does it begin and end?

Complete Aim Statement

Ask a colleague to double-check your work and recommend improvements:

- Is the problem or opportunity clearly stated?
- Do you know what the team is going to do about the problem?
- Has the team set a numerical goal to quantify the amount of improvement they'd like achieve?
- Do you know the calendar date by which the team plans to achieve the goal?
- Is it clear who will benefit from the improvement?
- Is the scope of the project clear?
- Do you know why this improvement effort is important?