REICHERT & ASSOCIATES
PROGRAM EVALUATION & RESEARCH

Central Okanagan PCN

Evaluation Plan – April 2021

Submitted to:

Central Okanagan PCN
Collaborative Services Committee and
Operations Group

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We are honoured to evaluate the health services provided within the shared ancestral, traditional, & unceded territories of the Syilx Nation

Purpose

This document is designed to guide the evaluation of the Central Okanagan Primary Care Network (CO PCN) Initiative. It includes an overview of the initiative, a description of the evaluation's approach, key questions, indicators, and proposed data collection methods.

About the Initiative

The Primary Care Network Initiative is a provincial strategy, intended to create clinical networks of providers in a geographic area that enable patients to receive expanded, comprehensive care and improved access to primary care. PCNs are expected to include GPs, NPs, nurses and allied health care providers in patient medical homes (PMHs), First Nations communities, health authority services and community health services. The intention is for everyone to work together as a team to provide all of the primary care services for the local population[1].

The stated goals of the CO PCNs are to increase patient attachment, improve quality of care, and create better access to primary care for people living in the Central Okanagan. These goals will be realized through the clinical integration of services and team-based care (TBC) with PMHs and Indigenous Health Services[2].

Central Okanagan PCNs

	Kelowna Central	Rutland/ Lake Country	West Kelowna/ Peachland
Indigenous Health Services	• NP: 0.5 FTE • Allied health: 1.0 FTE	• NP: 0.5 FTE • Allied health: 1.0 FTE	• NP: 0.8 FTE • Allied health: 1.0 FTE
Nurse Coordinators	• 28 FTE RN	• 4 FTE RN	• 5 FTE RN
Team-based Care Hubs	• 1 clinical pharmacist • 8 allied health	• 1 clinical pharmacist • 6 allied health	• 1 clinical pharmacist • 5 allied health
Family Physicians	• 1 FTE (Outreach Urban Health – target attachment 650 patients)	• 1 FTE (Rutland Aurora Health Centre – target attachment 650)	• 2 FTE (target attachment 2,500 patients)
Nurse Practitioners (+2 FTE NP not assigned to specific PCN geography)	• 0.5 FTE (target attachment 300 pt)	• 1.5 FTE (target attachment 900 pt) *Under consideration:* Community Health Centre: Lake Country *3 FTE FP; 1 FTE NP; 2 FTE AHP*	• 2 FTE (target attachment 2,000 pt)

[1] GPSC, 2019 https://gpscbc.ca/sites/default/files/uploads/GPSC%20Infosheet%20PCN%202019.pdf
[2] Central Okanagan PCN Service Plan, June 2019

Central Okanagan Primary Care Network priorities:

- Strengthen and expand PMHs
- Integrate patient care between PMHs, urgent and primary care services, and IH
- Optimize and integrate Indigenous primary and community care services
- Increase overall number of attached patients

The CO PCNs also intends to achieve the core PCN attributes outlined by the Ministry of Health:

Figure 1. PCN Attributes outlined by the Ministry of Health

Primary Care Network Core Attributes
1. Process for ensuring all people in a community have access to quality primary care, and are attached within a PCN.
2. Provision of extended hours of care including early mornings, evenings and weekends.
3. Provision of same day access for urgently needed care through the PCN or an Urgent Primary Care Centre.
4. Access to advice and information virtually (e.g. online, text, e-mail) and face to face.
5. Provision of comprehensive primary care services through networking of PMHs with other primary care providers and teams, to include maternity, inpatient, residential, mild/moderate mental health and substance use, and preventative care.
6. Coordination of care with diagnostic services, hospital care, specialty care and specialized community services for all patients and with particular emphasis on those with mental health and substance use conditions, those with complex medical conditions and/or frailty and surgical services provided in community.
7. Clear communication within the network of providers and to the public to create awareness about and appropriate use of services.
8. Care is culturally safe and appropriate.

Please see Appendix B for a logic model of the Central Okanagan PCN.

About the Evaluation

Evaluation Approach

The evaluation intends to employ a **utilization-focused, participatory** approach wherein the primary users of the evaluation (those who can apply evaluation findings and implement recommendations) are engaged throughout the evaluation process, including identifying the key evaluation questions, determining what data to collect and how to interpret results. By engaging with primary users and focusing on how evaluation information will be used, **the evaluation seeks to facilitate decision-making, as well as support learning and relationship-building across the partners of the initiative.** In keeping with this participatory approach, scoping interviews were conducted with the PCN Steering Committee, who will be the primary users of the evaluation. As identified in these interviews, the evaluation approach will be developmental (able to change as the initiative progresses), and able to report on both formative (e.g. operational processes) and summative (e.g. outcomes, impacts) findings.

Evaluation Questions

The central questions guiding the evaluation of the CO PCN and its stated goals are as follows:

1. **How was the initiative implemented?**
2. **What was implemented over the course of the initiative?**
3. **What progress has been made towards the intended outcomes?**
4. **What are the strengths, challenges, lessons learned and areas of opportunity?**

These questions will be asked at two levels of intervention, to ensure the evaluation is able to give an accurate representation of (1) the overall initiative, and (2) a case study to explore a specific component of the initiative. *Please see Appendix A for a full list of sub-questions, proposed indicators and data sources.*

Proposed Methods

The evaluation team suggests using the following data collection methods:

Key stakeholder interviews: the evaluation will conduct interviews to gather information about the implementation, operations and outcomes of the initiative. Interviews will be semi-structured and will consist of open-ended questions, allowing interviewees to comment on pre-determined issues while providing an opportunity for them to raise previously unidentified issue in a flexible, conversational style. The following interviews are proposed:

- Interviews with PCN operations group members, PCN managers and other key partners as identified by the PCN operations group (e.g., CSC, First Nations Health Authority, Ministry of Health)
- Interviews with GPs/NPs of clinics/health centers involved in and/or hired through the PCN
- Interviews with nurses, allied health and Indigenous Health coordinators hired through the PCN

Surveys: Surveys will be used to provide the evaluation with quantitative and qualitative data on the impact and outcomes of the initiative. Whenever possible, surveys will be integrated into existing activities and we will utilize provincially developed surveys where available. The following surveys are proposed:

- Patient surveys – distributed in clinics/health centers/team-based care hubs
- Provider surveys - distributed to allied health practitioners at team-based care hubs/health centers, Indigenous Health coordinators and GPs/NPs/RNs of clinics/health centers
    - For example, for family practices that have integrated a nurse coordinator (RN), a check-in and team functioning survey will be administered at 3 months and again between 9 months/1 year post-implementation.

Additional surveys may be developed by the evaluation as needed to support the initiative team's decision making and learning throughout implementation.

Focus groups: Patients may also be invited to share additional feedback in a focus group format. These focus groups will provide an opportunity for the evaluation to collect qualitative information to gain a greater understanding of specific aspects of the initiative. Focus groups will also be semi-structured and include open-ended questions. Focus group participants and the number and format (e.g. in-person or virtual) of focus groups will be determined in consultation with initiative staff and the evaluation working group.

Administrative data review: Administrative data collected through various sources will be analysed within the context of the goals and objectives of the initiative. Anticipated data sources include data related to service

provision (e.g. clinic/health center EMR data, CAMP tool data, Interior Health data) and attachment (e.g. Ministry of Health reporting). Please see Appendix A, which outlines anticipated indicators and data sources.

Document review: the evaluation will review on an on-going basis all relevant file information such as stakeholder agreements, initiative planning and management documents, and background literature in order to provide information relating to the initiative's operations and implementation.

Reporting & Communication

To support the initiative, the evaluation intends to provide regular updates as follows:

- Development of an Evaluation Working Group (EWG), suggested to include the evaluation consultants, Division staff (PCN Project manager), and the IH PCN Manager with monthly meetings, with the opportunity to include additional representation (GP/NP and First Nations partner) as needed.
- The opportunity for the EWG to discuss evaluation strategies with the Change Management Committee and to attend Change Management Committee meetings, where applicable
- The opportunity for the EWG to present evaluation findings to the PCN operations group and to attend PCN operations group meetings on a quarterly basis
- The opportunity for the evaluation consultants to present strategies/findings to PCN operations group members one-on-one, as desired/requested
- Quarterly or bi-annual data summaries (dates TBD), focused on ongoing data collected (e.g. document review, admin data) and key findings from annual data collection activities completed during the quarter (e.g. interviews, surveys, etc).
- Final Report (date TBD), content and format to be decided by PCN Steering Committee (e.g. final data summary of the overall initiative and highlighted learnings and areas of opportunity)

Proposed Evaluation Timeline

Proposed timeline for implementation	Key Evaluation Activities
March-May 2021	• Develop evaluation plan • Validation of evaluation plan with PCN operations group • Develop an evaluation working group

May-June 2021	• Design quarterly reporting templates to support communication with change management team/POG
	• Develop data collection tools:
	  ○ Nurse in practice integration surveys/process
	  ○ Allied health hubs
	  ○ POG survey
	  ○ General:
	  - Partner and provider interview guides
	  - Provider and patient experience surveys
	  - Patient focus group guides (as needed)
	  - Admin data requests (as needed)

Fall 2021	• Implement POG Survey
	  - Analyse and summarize results
	  - Present to POG

TBD (quarterly)	• Quarterly data summaries • Findings shared with Change Management Committee & PCN operations group

TBD (ongoing)	• Collect and analyze evaluation data in accordance with quarterly reporting template/plan
	  - Document review (ongoing)
	  - Admin data (ongoing)
	  - Surveys (annually)
	  - Focus groups (annually)
	  - Key informant interviews (annually)

March 2024	• Final collection and analysis of evaluation data • Synthesize and summarize data • Final report

Appendix A: Evaluation Framework

OVERALL INITIATIVE

Question 1: How was the initiative implemented?

Associated Sub-questions	Proposed indicators	Proposed data source	Possible Methods of Data Collection	Proposed Timeline
What structures/processes are in place to guide and support the initiative?	Existence of structures/ processes/documentation in place to support initiative implementation • Governance structure • PCN operations group (POG) • Working group(s) • Initiative plans/ processes	Initiative documents Initiative stakeholders *(e.g. PCN Steering Committee/Working Group members, PCN managers)*	Document review Key stakeholder interviews	Annually
To what extent do these structures/processes support the partners involved? *Are there are any structures/processes missing?* *Are there any barriers to accessing/using these structures/processes?*	Roles of committee/working group members # and type of activities (e.g. Committee meetings, etc.) Perception of initiative stakeholders around: • Appropriate representation from all stakeholder groups • Understanding of how different stakeholders group work *(e.g. organizational culture, strengths, limitations)* • Effectiveness of structures/processes *(e.g. for decision-making, funding, hiring/orientation processes)* • Cultural appropriateness of structures/processes • Satisfaction with partnerships/relationships formed • Barriers to collaboration	Initiative documents *(e.g. terms of reference, meeting minutes)* Initiative stakeholders	Document Review Key stakeholder interviews POG Survey	Annually Annually Fall 2021

To what extent is there a common vision across the partners involved?	Perception of stakeholders and partners around their collective impact: • Common agenda • Shared understanding of success *(e.g. of cultural safety, attachment, access)* • Mutually reinforcing activities	Initiative stakeholders	POG Survey Interviews	Fall 2021

Question 2: What was implemented over the course of the initiative?

Associated Sub-questions	Proposed indicators	Proposed data source	Possible Methods of Data Collection	Proposed Timeline
What activities were implemented?	Hiring and retention of: # GPs/NPs/RNs (new and existing) # AHPs # Clinical Pharmacists # Indigenous Health Coordinators #/types of services provided by health care providers Development and roll-out of recruitment and retention strategies/activities Onboarding and integration of providers across clinics/team-based care hubs; creation of workflows, referral mechanisms, communication processes # team building, provider engagement/retention activities provided (e.g. provider network/community of practice meetings) # cultural learning opportunities/cultural safety training provided; #/% of providers trained	Initiative documents *(e.g. contracts, workflow documents, referral forms)* EMR/Clinic data PCN Managers and other initiative stakeholders	Document review Key stakeholder interviews	Quarterly Annually

	# education/awareness raising activities to patients, community, community partners regarding PCN Integration of providers and services in PCN structure; system linkages developed			
Were any planned activities not implemented? If yes, why?	Evidence of planned activities/initiatives not implemented and explanation of changes Evidence of changes to better meet community needs	Initiative documents PCN Managers and other initiative stakeholders	Document review Key stakeholder interviews	Ongoing

Question 3: What progress has been made towards the intended outcomes of the initiative?

Associated Sub-Questions	Proposed indicators	Proposed data source	Possible Methods of Data Collection	Proposed Timeline
What impact has the initiative had for patients? What facilitated/hindered these impacts? (*e.g. if patients report care is culturally safe, what makes it safe? What has changed?)*	Ability to provide **culturally safe and appropriate care** *(#/% providers reporting they have the training, tools and ability to practice cultural humility and provide culturally safe and appropriate care)* Care is **patient-centered** *(#/% providers reporting care to be patient-centered)* Increased **attachment** to primary care *(#/% GPs/NPs accepting new patients, #/% patients attached, # net new attachments, vulnerable patient attachment)* Improved **access** to care (#/%GPs/NPs/RNs offering extended hours, # routine/urgent appts same day, #/type of encounters by AHPs, type of patients (ICD9)) Improved **experience of care for patients/families:** • *#/% reporting that care is culturally safe and appropriate* • *#/% reporting being able to access a provider when they need to and where (e.g. in their community, virtual/telehealth)*	Providers MoH reporting Clinic/Health Center EMR/ MoH data Patients	Provider survey/key stakeholder interviews Admin data analysis Admin data analysis Patient survey/focus groups	Annually Quarterly Annually

	• *#/% reporting they trust and feel understood holistically by their provider (if identified as a need/priority by the patient/family)* • *#/% reporting continuity of care* • *#/% reporting to receive comprehensive care* • *#/% reporting satisfaction with coordination of care* • *#/% reporting the care available meets their needs*			
What impact has the initiative had for GPs/NPs? What facilitated/hindered these impacts? *(e.g. if capacity to provide care increased, what enabled it?)*	Increased teamwork with other GPs/NPs Increased teamwork with other providers, such as RNs, AHPs, Indigenous health coordinators Increased capacity to provide care *(# appointments or patients seen per month/ clinic*) Increased perception of support in providing care Increased satisfaction providing care Increase satisfaction with working environment	GPs/NPs MoH billing data/ EMR data	Key stakeholder interviews Team functioning survey Admin data analysis	Annually/As needed 3 months and 9 months/1 year post integration of team member
What impact has the initiative had for other care providers? What facilitated/hindered these impacts? *(e.g. if satisfaction increased, why?)*	Increased teamwork with GPs/NPs Increased teamwork with other types of providers (as applicable) Perception, or increased perception (as applicable), of support in providing care Satisfaction, or increased satisfaction (as applicable), providing care Satisfaction, or increased satisfaction (as applicable), with working environment	RNs, AHPs, Indigenous Health coordinator, clinical pharmacists	Key stakeholder interviews Team functioning survey	Annually / as needed 3 months and 9 months/1 year post integration of team member

What impact has the initiative had for the health care system in the Central Okanagan region? What facilitated/hindered these impacts? *(e.g. if there is greater trust, what contributed to it?)*	Increased adherence to the BCPSQCs Health Quality Matrix (*indicators)* Increased understanding of cultural humility/cultural safety amongst health care providers Increased collegiality and trust among health care providers Understanding the implications/sustainability of provider contract/payment models Enhanced integration of services/providers within PCN Enhanced coordination of care Decreased gaps in care	Ministry of Health data, EMR data GPs/NPs, RNs, AHPs, Indigenous Health coordinators, clinical pharmacists Initiative stakeholders	Admin data analysis Provider survey Key stakeholder interviews	End of Year 3 End of Year 3
Were there any unintended outcomes or consequences?	Identification of other outcomes/impacts (and whether positive or negative)	GPs/NPs, RNs, AHPs, Indigenous Health coordinators, clinical pharmacists Initiative stakeholders	Key stakeholder interviews	Annually
To what extent are the outcomes of the initiative sustainable? What factors would enable sustainability? Are there any barriers to sustainability?	Documentation of enablers and barriers to sustainability Perception of initiative stakeholders	Initiative documents GPs/NPs, RNs, AHPs, Indigenous Health coordinators, clinical pharmacists Initiative stakeholders	Document review Key stakeholder interviews	End of Year 3

Question 4: What are the strengths, challenges, lessons learned and areas of opportunity for the initiative?

Associated Sub-Questions	Proposed indicators	Proposed data source	Possible Methods of Data Collection	Proposed Timeline
What factors contributed to the success of the initiative? **Were there any challenges/barriers (cultural, relational, structural) that were faced by the initiative team, and how were they overcome?**	Documented facilitators of success, and how they contributed to initiative outcomes, as well as documented challenges / barriers Perception of Initiative stakeholders *(e.g. PCN Steering Committee members, Working Group members, Initiative staff), which could relate to:* • Working across different stakeholders group work • Recruitment, hiring and retention activities/strategies • Integration of providers into teams • Integration of services/providers within PCN	Initiative documents (e.g. meeting minutes) Initiative stakeholders	Document review Key stakeholder interviews	Annually
Was there anything that could have been done differently to improve the implementation and/or outcomes of the initiative?	Perception of: • PCN operations group members, Working Group members, initiative staff • GPs/NPs/RNs and AHPs • Indigenous health coordinators • Clinical pharmacists	Initiative stakeholders GPs/NPs, RNs, AHPs, Indigenous Health coordinators, clinical pharmacists	Key stakeholder interviews & Provider survey	Annually (focused on implementation; TBD as resources are hired) End of Year 3 (focused on outcomes)

CASE STUDY

To explore a specific PCN activity in greater detail, the evaluation proposes a case study to capture the experience of integrating PCN resources, and capture a holistic understanding of patient attachment. Specific case study details to be determined with Evaluation working group and/or PCN operations group.

Appendix B: Logic Model

Central Okanagan Division of Family Practice | Okanagan Nation Alliance

Central Okanagan PCN - Logic Model DRAFT

Interior Health

MISSION: Improving healthcare for patients in the Central Okanagan

By working towards the attributes of the Patient Medical Home, optimizing the quality of care using the BC Health Quality Matrix and increasing the number of Central Okanagan residents with access to longitudinal primary care.

The work will be guided by the 8 PCN attributes:

Attachment • Extended hours • Same day access • Virtual and face-to-face care • Comprehensive care • Coordinated care • Communication within networks/patients • Culturally safe and relevant care

Inputs

Funding

Ministry of Health

Partners

Central Okanagan DFP
Interior Health Authority
Okanagan Nation Alliance
Westbank First Nation
Kelowna Métis Society
Ki-Low-Na Friendship Society
Duck Lake Reserve
FNHA
Providers (GPs/NPs, NCs, allied health, IHCs, etc.)
IH SCSP services/clinicians
Community resource providers
Patients/Families
Communities

Governance/Org. Structures

Collaborative Services Committee (CSC)
PCN Operations Group
Working Groups

Initiatives

Development of 3 PCNs

- Kelowna Central
- Rutland/Lake Country
- West Kelowna/Peachland

Hiring/integration of care providers

- GPs (4FTE)
- NPs (7.8FTE)
- RNs (37FTE): Nurse Coordinators (NCs)
- Allied health: social workers, registered dieticians, physiotherapists, occupational therapists (22FTE)
  - Incl. Indigenous Health Coordinators (IHC)
- Clinical pharmacist (3FTE)

Development of Team-based Care hubs

Indigenous Care Services
(including Indigenous Health Coordinators)

Outputs

- Implementation of structures and processes
- # Providers hired (by role)
- # patients attached
- Education/training for providers (team-based care, cultural safety, panel management)
- Implementation of new care models
- Integration of care providers into practices and communities
- Integration of culturally safe services (in collaboration with communities)
- Integration, and utilization, of CODF/Health Connect Registry (HCR) patient attachment mechanism
- Partnerships and networks formed and/or strengthened
- Engagement/education activities/materials (for patients/families, community partners)

Medium-term Outcomes

Development of outcome measures to align with local initiatives and provincial evaluation. Some potential examples are provided below, based on initiative documents and feedback from key stakeholders.

Patients/Family Members:

- Improved awareness and understanding of services and supports, and how to navigate
- Improved utilization of health care, based on improved understanding
- Increased ongoing timely access to appropriate and available services and care
- Increased attachment to primary care/improved quality of attachment
- Improved experience of care and services (accessible, patient-centered, holistic, trauma-informed, culturally safe and relevant)
- Improved health outcomes and improvements in the social determinants of health

Health Care Providers/ Community Resource Providers

- Improved awareness and understanding of services and resources
- Increased support and confidence in navigating health and communities services
- Increased capacity to provide care
- Improved communication and collaboration
- Improved experience of providing care (high level of job satisfaction, improved wellness)

Communities:

- Enhanced collaboration with communities to shape health services
- Enhanced tailoring of care and services to meet community needs
- Enhanced role of communities in supporting the health and wellbeing of their members

Long-term Outcomes/Impacts

- Enhanced empowerment of patients/families and communities in shaping their local healthcare system
- Improved quality of primary care (see BCPSQC Health Quality Matrix)
- Improved collaboration and integration of healthcare and community services
- Improved coordination of care
- Decreased need for higher cost acute (hospital-based) services
- Improved population health and decreased gaps in care