



REICHERT & ASSOCIATES
PROGRAM EVALUATION & RESEARCH

Chilliwack North, Chilliwack South and Fraser Health Rural

Primary Care Networks

DRAFT Evaluation Plan | Updated February 16, 2021

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We are honoured to evaluate the health services provided within the shared ancestral, traditional, & unceded territories of the Tsel'weyeqw, Teit, Pilalt, Stó:lō & Nlaka'pamux Indigenous peoples.

Purpose

This document is designed to guide the evaluation of the Chilliwack North, Chilliwack South, and Fraser Health Rural Primary Care Network (PCN) initiative. It includes an overview of the initiative, a description of the evaluation's approach, key questions, indicators, and data collection methods.

About the Initiative

What is a PCN?

The intention of a Primary Care Network (PCN) is to create networks of family practices (including traditional physician-owned family practices, community-governed health centres, and health-authority-delivered primary care clinics, also referred to as the "Patient Medical Home" or PMH) in a defined geography linked with each other and with other primary care and wellness services delivered by the health authority and other community-based organizations. The PCN is also intended to support teams of allied health professionals, other health care providers and community groups to work with family physicians (FPs) so that everyone can work to their strengths, support and rely on each other, and provide the best care to all residents.

Fig. 1 - The core attributes of the PCN, as outlined by the Ministry of Health (MoH)

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.

Vision of the Chilliwack North/South and Fraser Health Rural PCN initiative

The Chilliwack Division of Family Practice (CDoFP) and Fraser Health, along with other community partners, are working collaboratively to implement three PCN's in Chilliwack North, Chilliwack South and Fraser Health Rural (including Agassiz/Harrison and Hope, and communities in the Fraser Canyon up to Boothroyd, and east to Sunshine Valley and Manning Park). The geographic span of this work covers 47% of the Fraser Valley region and 7% of the Fraser Health population, including 22 Indigenous communities.

The initiative will build on foundational work in the region to provide team-based, relational care that supports both patients and providers. The development of the service plan for the three PCNs was based on data gathered from several sources, including feedback from patients/family members and community leaders collected in Fall 2018 around access to care, comprehensiveness of care, communication pathways, and cultural safety and humility. Engagement events were hosted by the Chilliwack Division of Family Practice and Fraser Health, including three engagement sessions hosted in collaboration with First Nations Health Authority with the 22 Indigenous communities in the geographic region.

Vision

“Our shared vision for our three Primary Care Networks is an integrated, collaborative community-based system for health that supports wellness and care.”

Mission

“Our mission is to build and strengthen partnerships for sustainable, quality team-based health care that is person-centred, culturally safe, and fosters shared responsibilities.”

The three PCNs will work to address the unique needs in each region, taking into account the distinct geographic and socioeconomic factors impacting wellbeing and access to care. As outlined in the PCN service plan, the work will also focus on key populations in the communities who would benefit from improved access to care, including: Indigenous communities, people with mental health and substance use conditions, children under 18 years, street entrenched populations, and people with chronic conditions.

The PCN Steering Committee provides overall direction to the work and the initiative is lead by a team of three Project Managers. Working groups have also been developed for specific aspects of the initiative.

See the Logic Model (Appendix A) for more information.

About the Evaluation

Evaluation Approach

The evaluation is designed to report on both **formative and summative** findings. It will provide an opportunity for initiative stakeholders to comment on the initiative's operational processes, as well as identify impacts as they relate to the initiative's goals and objectives. Overall, the evaluation intends to be **developmental**—it will mirror the ongoing needs and activities of the initiative and seek to provide timely information to inform decision making.

Further, the evaluation is designed to be **equity-focused and participatory**. This means that the evaluation will actively seek to enable all stakeholders, including marginalized or under-represented groups, to have input into the evaluation process, as well as in using the findings to learn and inform decision making. This evaluation will also be informed by **empowerment evaluation**, which seeks to address health and social inequities by amplifying

historically excluded voices and building capacity amongst these individuals and the organizations that support them. This will be accomplished by directly involving key partners in the evaluation's design and implementation to foster a sense of ownership of the evaluation and its results.

The principles of empowerment approach are in line with best practices in program evaluation with Indigenous communities, as they emphasize:

- Valuing community knowledge
- Ensuring the evaluation and its findings are useful to, and benefit, the community
- Empowering the community to play an active role in every aspect of the evaluation
- Ensuring community ownership over the evaluation's approach and its findings

Patients/families and other community members will be actively engaged to help inform the evaluation itself, as well as provide feedback on the current state of health services and their needs, as well as feedback on the changes and outcomes resulting from the PCN initiative. Feedback previously shared by patients/families and community members in 2018 will act as a foundation for this work.

It is recommended that a local **evaluation working group (EWG)** with key partners of the PCN, including (but not limited to) the project management team, a Fraser Health representative (an individual with knowledge of available data and access to Fraser Health's databases), key partners from the Indigenous communities, and a patient/family member from the region. The EWG evaluation will help to refine the evaluation approach, develop evaluation tools, and vet the evaluation's findings. This will also help to ensure that the evaluation is conducted in a safe way and that the unique local context of each PCN is taken into account.

In addition, the evaluation team will correspond regularly with Doctors of BC to ensure alignment with any directives or evaluation frameworks that are developed at the provincial level.

Evaluation Questions

The following central questions will guide the evaluation:

1. How was the initiative planned and 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) case study examples (see Case Studies below). See Appendix B for a complete breakdown of evaluation sub questions, as well as proposed indicators, data sources, methods and timing of data collection.

Since the implementation of the initiative spans multiple years, the evaluation has proposed a phased approach. In years 1 and 2 of the initiative, the focus of the evaluation will be on questions 1,2 and 4 above, as well as early outcomes of the work. In years 3 and 4, the evaluation will address all questions, with a particular focus on progress towards outcomes at the provider, patient, community and system levels.

Methods

The evaluation will incorporate the following data collection methods:

Initiative documentation and file 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 to provide information relating to the initiative's operations and implementation.

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 Fraser Health (data related to service provision), MoH (attachment), and GP/NP EMRs (for example: patient panels, access). The evaluation will work closely with the Division, Fraser Health, the MoH, as well as GPs/NPs to access data and analyze it within the context of the PCN.

Key stakeholder interviews | A sample of interviews with key stakeholders will be conducted at various stages over the course of the initiative. These interviews will gather information about the development, engagement, implementation and outcomes of the initiative from a variety of perspectives. Interviewees and the number of interviews will be identified through consultations with the PCN management team and the EWG. 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 issues or to emphasize a given issue in a more flexible, conversational style.

Focus groups | In addition to interviews, focus groups may be conducted with key stakeholders (e.g. patients/families). These focus groups will provide an opportunity for the evaluation to collect qualitative information from a variety of perspectives to gain a greater understanding of specific aspects of the initiative, and may be used as part of the case study design (see below). Focus groups will also be semi-structured and include open-ended questions. Focus group participants and the number of focus groups will be determined in consultation with the PCN management team and the EWG.

Surveys | Surveys will be used to provide the evaluation with quantitative and qualitative data to evaluate the impact and outcomes of the initiative. Surveys will be conducted with GPs/NPs, other care providers (nurses, allied health), and potentially with patients/family and communities.

The evaluation will utilize provincially developed surveys where available (e.g. Practice Support Program (PSP) patient experience tool, PCN patient survey to be developed). Additional surveys may be developed by the evaluation as needed to support the initiative team's decision making and learning throughout implementation.

Case Studies | For a few of the key strategies, a case study approach will be used to take a deeper look at innovative interventions and the unique community contexts in which they are being implemented. Additional evaluation information for case studies is included in Appendix B. Case studies will be chosen in consultation with the PCN management team and the EWG. Potential examples include:

- MHSU prototype
- Vulnerable persons work in collaboration with researchers from the University of the Fraser Valley, as well as the Mission and Abbotsford Divisions of Family Practice.
- Initiatives in Indigenous communities (e.g. Traditional wellness mentors)

Reporting & Communication

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

- Attendance or participation in Steering Committee meetings, where applicable
- Development of an EWG with regular check in meetings. Membership to be determined in consultation with the PCN team.
- Annual and quarterly reports (timing to be determined with the PCN team)
- Final PCN Report (March 2024)

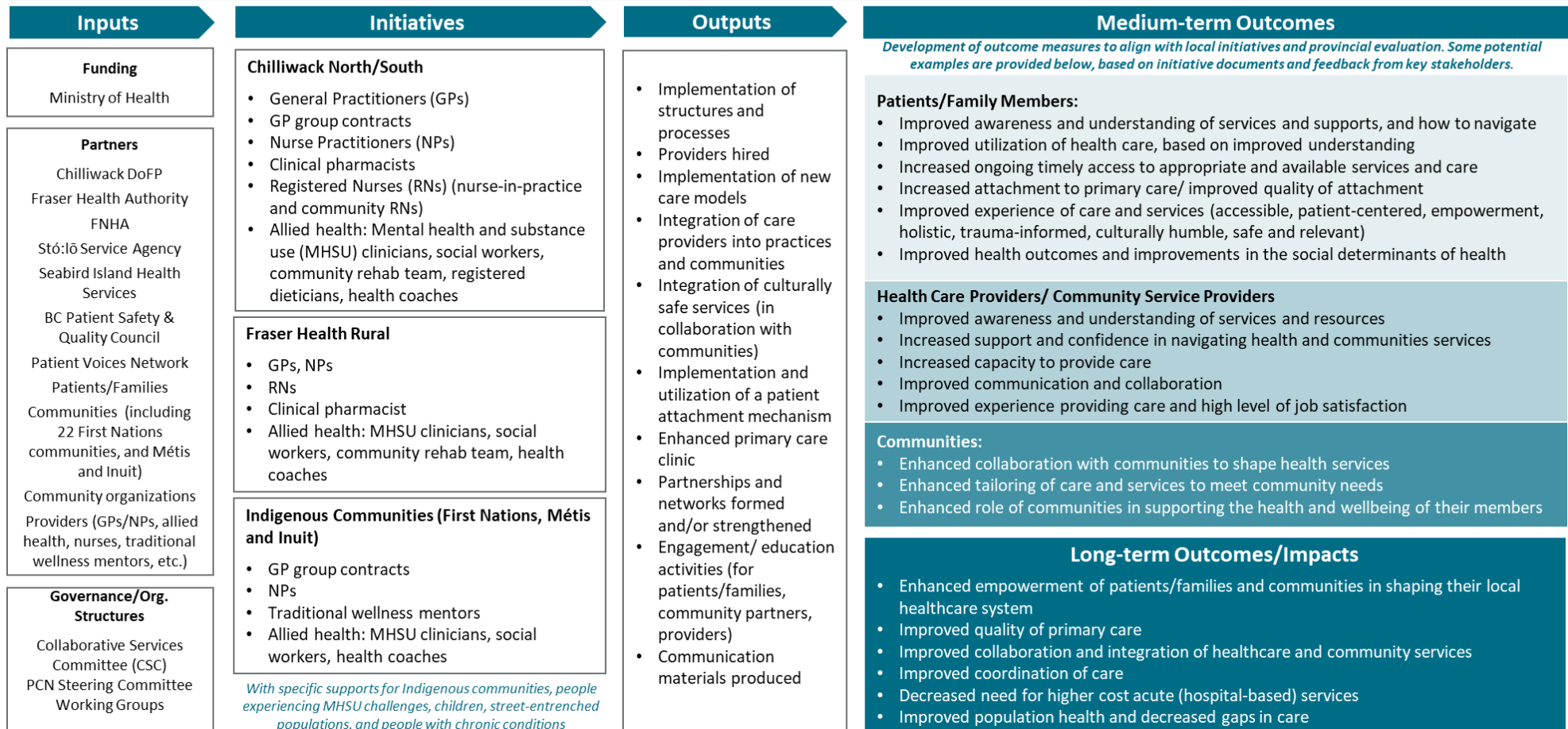
Appendix A: Logic Model

Chilliwack North/South and Fraser Health Rural PCN - Logic Model DRAFT

VISION: "An integrated, collaborative community-based system for health that supports wellness and 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



Appendix B: Evaluation Framework

The following framework outlines the evaluation questions, as well as the proposed indicators, data sources, data collection methods and timelines. This framework will be refined through discussions with the PCN management team, the EWG and other key stakeholders. It is also expected that this evaluation framework may change over the course of the evaluation as the initiative progresses and adapts to meet the needs of the communities, and as a provincial evaluation framework is developed by the MoH.

Question 1: How was the initiative planned and implemented?

Associated Sub-questions	Proposed Indicators	Proposed Data Source	Possible Methods of Data Collection	Proposed Timeline
<p>ORGANIZATION/OPERATION</p> <p>What structures/processes are in place to guide and support the initiative?</p> <p>Have they been effective?</p>	<p>Existence of structures/ processes/documentation in place to support initiative implementation</p> <ul style="list-style-type: none"> • PCN Steering Committee • Working group(s) • Initiative plans • Communication strategies and feedback loops 	<p>Initiative documents</p> <p>Initiative stakeholders</p>	<p>Document review</p> <p>Key stakeholder interviews, surveys</p>	<p>Annually</p>
<p>STAKEHOLDER ENGAGEMENT</p> <p>Have the appropriate stakeholders and partners been engaged? And how have they been involved?</p> <p>Have patients/family/caregivers and community members been engaged? And how have they been involved?</p> <p>Were there any barriers to participation in the initiative?</p> <p>How have the unique contexts of participating communities been taken into account?</p>	<p>List of stakeholders and project partners</p> <p>Roles of committee & working group members</p> <p># and type of engagement activities (e.g. working group meetings, focus groups, etc.)</p> <p>Perception of initiative stakeholders around:</p> <ul style="list-style-type: none"> • Effectiveness of engagement • Satisfaction with level of engagement amongst those engaged • Barriers to engagement • Satisfaction with partnerships formed • Level of collaboration 	<p>Initiative stakeholders</p> <p>Initiative documentation</p> <p>Administrative tracking data</p>	<p>Key stakeholder interviews, surveys</p> <p>Document Review</p> <p>Admin data review</p>	<p>Annually</p>

	<ul style="list-style-type: none"> • Appropriate representation from all stakeholder groups and communities • How the unique contexts of participating communities have been considered 			
COLLECTIVE IMPACT To what extent is there evidence of collective impact across partners involved in the initiative?	Perception of stakeholders and partners around: <ul style="list-style-type: none"> • Strong backbone of support • Common visions and agenda • Shared measurement of success • Continuous communication • Mutually reinforcing activities 	Initiative stakeholders	Key stakeholder interviews, surveys	End of year 1/early year 2 and end of year 4
DATA TO INFORM DECISION MAKING Does the initiative have access to necessary data to make informed decisions?	Documentation of data collection processes and how data was used to inform decisions Perception of initiative staff and other key stakeholders	Initiative documents Initiative stakeholders	Document review Key stakeholder interviews	Annually

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?	# providers hired # new models of care implemented # partnerships formed and/or strengthened #/type engagement/education activities (for patients/families, community partners, providers); attendees (roles) Integration of culturally safe services (developed in collaboration with communities) # communication materials produced	Initiative documents PCN managers and other key stakeholders	Document review Key stakeholder interviews	Ongoing

	<p>Implementation and utilization of the patient attachment mechanism (PAM)</p> <p>Enhanced primary care clinic</p> <p>Integration of care providers into practices and communities</p>			
<p>Did the initiative activities reach its target population(s)?</p>	<p># GPs/NPs involved</p> <p># AHPs, RNs and other providers hired and integrated</p> <p># health authority and community services integrated</p> <p># patients impacted per clinician/new care model implemented</p> <p>Specific patient populations reached through initiatives</p>	<p>Initiative documents</p> <p>Administrative data (clinic EMR and FH data)</p>	<p>Document Review</p> <p>Admin data review</p>	<p>Ongoing</p>
<p>Were any planned activities not implemented?</p>	<p>Evidence of planned activities/ initiatives not implemented and explanation of changes</p> <p>Evidence of changes to better meet community needs</p> <p>Evidence of changes due to challenges such as COVID-19</p>	<p>Initiative documents</p> <p>Initiative stakeholders</p>	<p>Document review</p> <p>Key stakeholder interviews</p>	<p>Ongoing</p>

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?	<p>Increased attachment to primary care (#/% GPs/NPs accepting new patients, #/% patients attached through PAM, # net new attachments)</p> <p>Improved timely access to care (#/% GPs/NPs offering extended hours, routine/urgent appts same day and within 24-48 hours, 3rd next available appts, virtual care options)</p> <p>Care is culturally safe and appropriate (#/% providers offering culturally safe and appropriate care)</p>	<p>MoH data, clinic EMR, Fraser Health service data</p> <p>Providers and other key stakeholders</p>	<p>Admin data analysis</p> <p>Provider surveys, key stakeholder interviews</p>	<p>Ongoing</p> <p>End of year 1/early year 2 -> collect baseline as</p>
	<p>Improved experience of care for patients/families.</p> <p>#/% reporting...</p> <ul style="list-style-type: none"> improved awareness and understanding of services and resources through PCN (and how to navigate) improved utilization of services and resources being able to access a provider when they need to (timely access) 	<p>Patients/ family members</p> <p>Providers and other key stakeholders</p>	<p>Patient surveys (provincial survey in development), focus groups, interviews</p> <p>Provider surveys, key stakeholder interviews</p>	<p>Ongoing</p> <p>End of year 1/early year 2 -> baseline data from patients as part of patient engagement work to determine their current perception of care, and what improvements they would like to see</p>

	<ul style="list-style-type: none"> • <i>receiving comprehensive, quality care</i> • <i>continuity of care between providers and services</i> • <i>satisfaction with coordination of care</i> • <i>satisfaction with their involvement in care decisions; feeling empowered to make care decisions</i> • <i>care is culturally humble, safe and relevant</i> • <i>care and services are meeting their needs (appropriate, available and accessible)</i> • <i>empowerment in terms of shaping their healthcare system</i> 			
	Improved health and wellbeing (at population level)	MoH data	Admin data review	Year 4
<p>What impact has the initiative had for GPs/NPs?</p>	<p>Increased teamwork with other GPs/NPs</p> <p>Increased teamwork and communication with other providers, such as AHPs (<i># practices with AHPs in practice; perception of teamwork</i>)</p> <p>Improved awareness and understanding of services and resources</p> <p>Increased confidence providing care</p>	GPs/NPs	Provider survey, key stakeholder interviews	Annually (or as needed based on initiative activities)

	<p>Increased perception of support in providing care, especially for specific patient populations (e.g. Indigenous communities, MHSU, chronic conditions, children and youth)</p> <p>Increased capacity to provide care (i.e. enhanced attachment and access for patients, more time in the day, etc.)</p> <p>Increased satisfaction providing care</p> <p>Improved GP/NP wellness</p>			
What impact has the initiative had for other care providers?	<p>Increased teamwork and communication with GPs/NPs</p> <p>Increased teamwork and communication with other types of providers</p> <p>Increased satisfaction providing care and with scope of practice</p> <p>Improved provider wellness</p>	<p>Nurses (RNs), social workers, traditional wellness mentors, physiotherapists, MHSU clinicians, registered dietitians, clinical pharmacists, etc.</p>	<p>Provider survey, key stakeholder interviews</p>	<p>Annually (or as needed based on initiative activities)</p>
What impact has the initiative had for the care system in Chilliwack and Fraser Health Rural?	<p>Increased collegiality and trust among health care providers</p> <p>Enhanced integration of healthcare and community services</p> <p>Enhanced coordination of care (indicators identified by MoH)</p> <p>Enhanced collaboration with communities to shape health services</p> <p>Enhanced tailoring of care and services to meet community needs</p>	<p>GPs/NPs, Allied health</p> <p>Key stakeholders (e.g. Division, Fraser Health, community services, etc.)</p> <p>MoH / Fraser Health / Hospital / Health Matrix data</p>	<p>Provider survey, key stakeholder interviews</p> <p>Admin data analysis</p>	<p>Year 4</p>

	<p>Enhanced role of communities in supporting the health and wellbeing of their members</p> <p>Enhanced empowerment of communities in shaping their healthcare system</p> <p>Decreased need for higher-cost hospital-based care (<i># ED visits for CTAS 4/5, ED diversions – more indicators to be determined</i>)</p> <p>Decreased wait times for acute care services (<i>e.g. MHSU crisis intervention</i>)</p> <p>Decreased gaps in care (population health indicators identified by MoH)</p>			
Were there any unintended outcomes or consequences?	Identification of other outcomes/impacts (and whether positive or negative)	Initiative stakeholders	Key stakeholder interviews Patient/Provider surveys	Annually (or as needed based on initiative activities)
<p>To what extent are the outcomes of the initiative sustainable?</p> <p>What factors would enable sustainability?</p> <p>Are there any barriers to sustainability?</p>	<p>Documentation of enablers and barriers to sustainability</p> <p>Perception of initiative stakeholders</p>	<p>Initiative documents</p> <p>Key stakeholders</p>	<p>Document review</p> <p>Key stakeholder interviews</p>	Year 4

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
<p>What factors contributed to the success of the initiative?</p> <p>Were there any challenges/barriers (cultural, relational, structural) that were faced by the initiative, and how were they overcome?</p>	<p>Perception of:</p> <ul style="list-style-type: none"> Initiative team members/ PCN Steering Committee GPs/NPs Other providers <p>Documented facilitators of success and how they contributed to initiative outcomes</p> <p>Documented challenges/ barriers</p>	<p>PCN Steering Committee and initiative stakeholders</p> <p>GPs/NPs and other providers</p> <p>Initiative documents</p>	<p>Key stakeholder interviews, surveys, focus groups</p> <p>Document review</p>	<p>Annually (or as needed based on initiative activities)</p>
<p>Was there anything that could have been done differently to improve the implementation and/or outcomes of the initiative?</p>	<p>Perception of:</p> <ul style="list-style-type: none"> Initiative team members/ PCN Steering Committee GPs/NPs Other providers 	<p>PCN Steering Committee and initiative stakeholders</p> <p>GPs/NPs and other providers</p>	<p>Key stakeholder interviews</p>	<p>Annually (or as needed based on initiative activities)</p>
<p>What are the larger implications of these findings for the health care system in BC?</p>	<p>Perception of:</p> <ul style="list-style-type: none"> Initiative team members/ PCN Steering Committee GPs/NPs and other providers 	<p>PCN Steering Committee and initiative stakeholders</p> <p>GPs/NPs and AHPs</p>	<p>Key stakeholder interviews</p>	<p>Year 4</p>

EXAMPLE OF CASE STUDY EVALUATION: MHSU Prototype

Evaluation activity	Timeline
<p>Document review</p> <ul style="list-style-type: none"> MHSU clinicians, social workers and GPs/practices involved Existence of processes and structures in place to guide prototype Activities taking place/services provided 	<p>Ongoing throughout each phase of prototype</p>
<p>Administrative data review (PARIS client data, other Fraser Health data, physician EMRs)</p> <ul style="list-style-type: none"> # 'requests for collaboration' and source # patients seen Response time # patients linked to other services/resources # patients attached <p><i>Other indicators to be determined with the PCN management team and the MHSU working group</i></p>	<p>Ongoing throughout each phase of prototype (collected and analyzed on a monthly or quarterly basis)</p>
<p>Key stakeholder interviews with MHSU clinicians and social workers</p> <ul style="list-style-type: none"> Processes and structures (including virtual care options) Successes, challenges, lessons learned Experience of care: team-based care (scope of practice, collaboration with physicians, integration of services, capacity, etc.) Experience of care for patients: timely access, continuity of care, comprehensiveness, coordination, improved health outcomes, improvements in social determinants of health Impacts for the broader healthcare system: decrease in acuity of care and crisis interventions 	<p>At the end of each phase</p>
<p>Key stakeholder interviews with physicians</p> <ul style="list-style-type: none"> Understanding of model Timeliness of access to service Improved support for mild-moderate MHSU patients Changes in capacity Experience of care for patients: timely access, continuity of care, comprehensiveness, coordination, improved health outcomes, improvements in social determinants of health Impacts for the broader healthcare system: decrease in acuity of care and crisis interventions 	<p>At the end of each phase</p>

<ul style="list-style-type: none"> • Overall satisfaction with services 	
<p>Patient survey</p> <ul style="list-style-type: none"> • Timely access • Continuity of care • Coordination of care with other services • Improved health outcomes • Improvements in social determinants of health • Overall satisfaction with services 	<p>Ongoing throughout each phase</p>

Appendix C: Proposed Timeline

December 2020 – November 2021

Proposed timeline	Key Evaluation Activities
Dec 2020 – Jan 2021	<ul style="list-style-type: none"> • Conduct scoping interviews with PCN team, PCN Steering Committee and other key stakeholders • Develop evaluation plan • Validate and refine evaluation plan with key stakeholders • Develop an evaluation working group
Feb – Mar 2021	<ul style="list-style-type: none"> • Continue to refine evaluation plan/metrics for specific initiative activities (e.g. meeting with MHSU working group) • Select case studies • Develop data collection tools and processes
Mar - Nov 2021	<ul style="list-style-type: none"> • Collect evaluation data (including baseline data) <ul style="list-style-type: none"> - Administrative data review - Surveys - Key informant interviews
Quarterly reports Final in Nov 2021	<ul style="list-style-type: none"> • Quarterly reports • Final evaluation report <ul style="list-style-type: none"> - Draft shared with PCN management team (and potentially Steering Committee) to validate findings - Edits and finalizing report

This timeline will be updated and modified as the initiative and evaluation progress.