Patient Medical Home (PMH)

GPSC Evaluation Framework

Presented for Divisions of Family Practice

Overall vision & goals

The GPSC's vision is to enable access to quality primary health care that effectively meets the needs of patients and populations in BC, using the PMH to form the foundation for care delivery within a broader, integrated system of primary and community care.

The four goals the GPSC is aiming to achieve are:

- Increase **access**, to appropriate, comprehensive, quality primary care for each community.
- Improve support for **patients**, particularly vulnerable patients, through enhanced & simplified linkages between providers.
- Retain & attract **Family Physicians** and teams in healthy & vibrant work environments.
- Contribute to building a more effective, efficient & **sustainable** health care system in order to increase capacity & meet future patient needs.

Evaluation Approach

The PMH Evaluation Framework was designed to focus on fulfilment of **PMH goals (outcomes)** instead of just realization of PMH model. However, ***progress indicators*** are also set to monitor implementation at the different levels to learn & adapt the implementation process accordingly. *For example*, if communities struggle with networks, resources can be created to help with this PMH attribute. The list of progress indicators was shortlisted to core GPSC priorities and communities may include their own progress indicators in an iterative manner along the way.

Evaluation Purpose

The evaluation is not designed to assess the achievements of individual divisions but is intended to track progress toward goals at the provincial level. The approach of each individual division to the PMH work is unique. As a result, different sets of indicators in the framework will align to the work of each division, and not all indicators will be directly related to work of each community. Nevertheless, it is important that all indicators be collected from every community in the province. This approach was chosen so that a broad enough set of indicators would be available to track provincial out-comes related to all of the GPSC's goals.

Evaluation Partners

The evaluation will triangulate data from multiple perspectives & sources in collaboration with partners at three levels ;

Practice level	Community level	Provincial level
Physicians, Practice Support Program	**Divisions of Family Practice (DoFP)**	Ministry of Health & Health Authorities

Data sources & Divisions contributions

The following table outlines the evaluation methods & the anticipated contributions from the divisions for each method.

Method	Contribution of Divisions
Most Significant Change	Engage & work with evaluation in identifying key participants to share stories relevant to PMH attributes
Physician Survey	Administer physician survey to track outcome and progress indicator
Case studies (e.g., patient journey maps, interviews, focus groups)	Engage, identify & participate in the collection & analysis of case studies demonstrating PMH work

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GPSC
General Practice Services Committee

Provincial Evaluation Framework Patient Medical Home

Prepared for the General Practice Services Committee

May 9th , 2017

Table of Contents

1. Patient Medical Home in British Columbia 4
   Vision and Goals 4
   Evaluation Purpose 4
2. Evaluation Purpose and Questions 4
   Evaluation Questions 5
3. Outcome Areas 6
   Physician Experience 6
   Cost 6
   Access 6
   Patient Experience 6
4. Progress Areas 7
   Patient Medical Home Model 7
5. Methods, Data Sources and Implementation Details 8
   Most Significant Change 9
   Physician survey questions 9
   Patient Survey 10
   Administrative indicators 10
   Case studies 10
   Document Review 11
6. Conclusion 11
7. Appendix I – Data Collection Methods and Instruments 12
   A – Most Significant Change 12
   B – Physician Survey Questions 12
   C – Canadian Community Health Survey (CCHS) 14
   D – Administrative Indicators 15
   E – Case Studies 16
   F – Document Review 16
   H – Additional Potential Mechanisms and Sources of Data 16
8. Appendix II – Progress Indicators 17
9. Appendix III – Implementation Timelines 18
10. Appendix IV – Patient Medical Home Graphic 19

1. Patient Medical Home in British Columbia

The GPSC has set out a vision to enable access to quality primary health care that effectively meets the needs of patients and populations in BC. It is advancing the patient medical home (PMH) model as the foundation for care delivery within a broader, integrated system of primary and community care.

A PMH is a model of family practice where patients feel most comfortable to discuss their personal and health concerns. It uses a team-based care approach to deliver patient-centered care and enhance the quality of care. Primary care providers – family physicians and sometimes nurse practitioners – work collaboratively in teams and networks with other health professionals to bring services together around patients. Patients have timely access to a primary care provider and coordinated, continuous, comprehensive care. The PMH positions family practice at the centre of an integrated system of primary and community care.

Vision and Goals

GPSC's vision is to enable access to quality primary health care that effectively meets the needs of patients and populations in BC, using the patient medical home to form the foundation for care delivery within a broader, integrated system of primary and community care.

The stated goals of the patient medical home are to:

- Increase patient access to appropriate, comprehensive, quality primary health care for each community.
- Improve support for patients, particularly vulnerable patients, through enhanced and simplified linkages between providers.
- Contribute to a more effective, efficient and sustainable health care system that will increase capacity and meet future patient needs.
- Retain and attract family doctors and teams working with them in healthy and vibrant work environments.[1]

2. Evaluation Purpose and Questions

Evaluation Purpose

The primary purpose of the GPSC Patient Medical Home Evaluation is to measure ***system-level outcome changes*** *based on adopting the PMH model in British Columbia.*

The framework primarily focuses on long-term goals that will be observable as the PMH model reaches maturity over the course of several years. As such, the overarching purpose of the evaluation is to gauge overall impacts and inform the GPSC's decision-making. In this framework, the realization of the PMH model and associated attributes is not seen as a goal in-of-itself, but rather as a process to achieving long term system outcomes.

In addition to long-term system level changes, the GPSC has also expressed a desire to track a small set of progress indicators to understand the process of implementing the PMH model as work unfolds at the community and provincial level.

As the focus of this evaluation is on long term system level outcomes, results will not be reported at the division or community level. Rather, data will be analyzed at the provincial and, potentially, regional level. While some data may be collected at the Division level, this data will be aggregated for the purposes of the GPSC PMH evaluation.

Evaluation Principles

The GPSC Patient Medical Home Evaluation Framework was developed using a number of guiding principles. First, there was a strong desire to build on previous evaluation work. In particular, the evaluation team carefully examined the lessons learned during the implementation of the GP for Me evaluation to ensure that those successes were leveraged and that some of the challenges were avoided. One important lesson learned during the implementation of the GP for Me evaluation was the importance of an evaluation framework that was feasible and manageable to implement. Real attempts were made in the development of this framework to keep it as simple as possible. In particular, it includes a smaller set of indicators and proposes methods that we hope will be less onerous to implement for stakeholders. Moreover, to help stakeholders participate and contribute to the evaluation, it is being published earlier in the lifecycle of the PMH work.

Another important principle is alignment. Other organizations such as Health Authorities and the Ministry of Health are conducting their own evaluations of primary care transformation. While each evaluation focuses on a different set of priorities, there may be some areas of overlap. As such the implementation team will work to streamline and avoid duplication.

Evaluation Questions

The evaluation is primarily focused on answering two outcome related questions and one progress related question.

Outcome:

1. To what extent are intended provincial outcomes achieved for access, patient experience, physician experience and cost?
2. What other intended or unintended provincial outcomes were achieved?

Progress:

3. What themes and early lessons have emerged through the implementation of the PMH model?

3. Outcome Areas

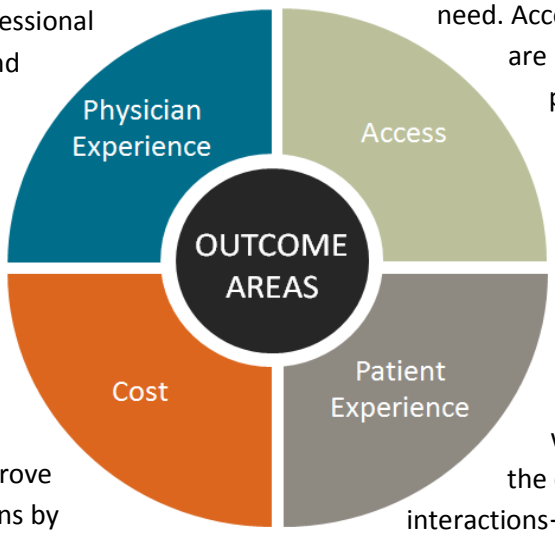
The GPSC selected four key outcome areas to align with their vision and goals for primary care transformation. These outcomes are patient experience, access, physician experience and cost. In line with the evaluation questions listed above, these outcomes will be measured to gauge whether the strategy is having the intended impact. While patient experience, access, physician experience and cost are distinct concepts, they overlap considerably in the ways that they are measured. For example, when patients are asked about their experience of accessing care, the resulting data can be informative about patient experience as well as how access to care is achieved in the health system.

Physician Experience

Physician satisfaction with their professional experience including interpersonal, remunerative and clinical aspects, as well as the relationship between professional life and personal health and wellbeing.

Access

Ease with which health services are reached. Accessibility is the extent to which individuals can easily obtain the care when and where they need. Accessibility aims to ensure there are not physical, financial or psychological barriers to receiving information, care and treatment.[2]



Cost

Optimal use of resources to yield maximum benefits and results. Cost is about delivery of services to improve health of British Columbians by maximizing capacity and avoiding waste in the health system. Health care services are considered in light of value for money or providing the maximum amount of positive impact on the health of British Columbians.[1]

Patient Experience

Patient experience refers to the patient's cumulative evaluation of their journey with the healthcare system. It is the quality and value of all of the interactions—direct and indirect, clinical and non-clinical— across the entire continuum of care and includes health care processes, patient-provider interactions, involvement in decision-making, support for self-care and overall ratings of care.[3]

[1] Adapted from BCPSQC Health Quality Matrix

[2] BCPSQC Health Quality Matrix

[3] Wolf et al. (2014). *Defining Patient Experience*. Patient Experience Journal, 1, 1, pp 7 – 9.

4. Progress Areas

In line with the purpose and evaluation questions above, this framework focuses primarily on measuring system-level outcomes of adopting the PMH model in British Columbia. However, the GPSC has also expressed a desire to track a set of progress indicators to understand the progress of implementation. These progress indicators will be used to paint a picture of how the initiative is unfolding across the province.

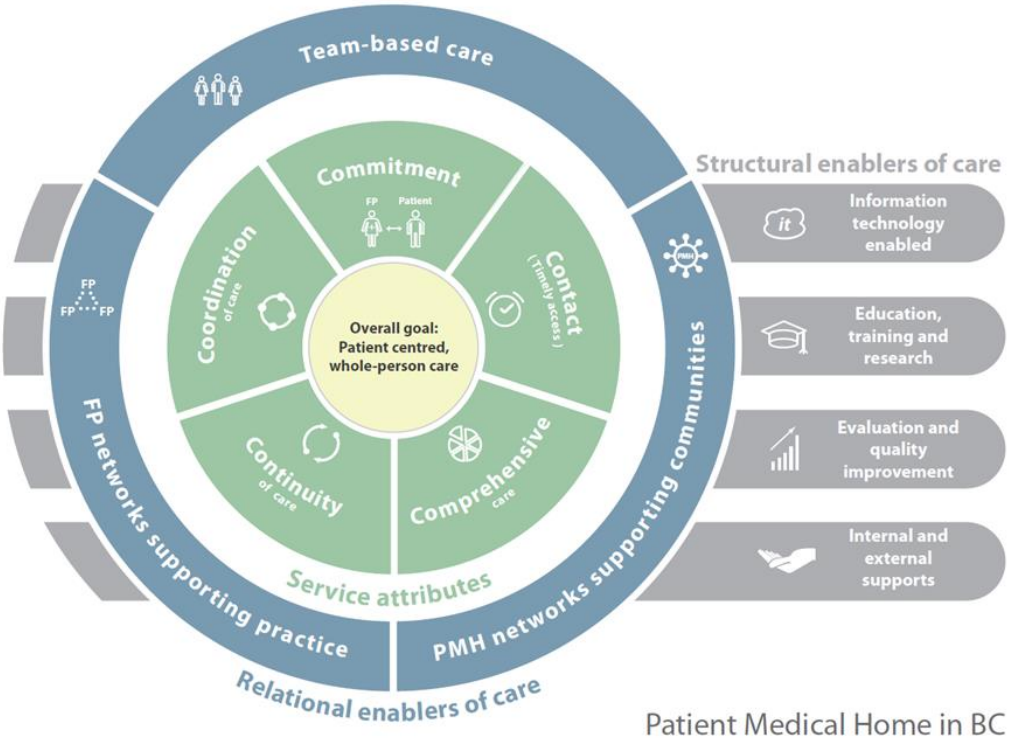
Transforming the primary care system in BC is recognized by the GPSC as a multi-year endeavor. The goal is to have the foundation of a system of PMH and PCH significantly underway across communities in the province by March 31, 2019. The GPSC approved focusing on an initial set of priority areas to support the development and sustainment of replicable, spreadable solutions and models for team-based practices operating to full scope. Based on evidence and experiences from BC, as well as other jurisdictions, these include Engagement and Data-Driven Readiness, Patient Panel Assessment /Understanding, Team-Based Care and Networks.

Progress indicators were chosen to align to these priority areas as well as to shed light on the progress of implementation at the practice, community and provincial levels. In addition to including priority areas, several progress indicators were chosen to highlight the achievement of early outcomes. For a complete list of progress indicators see the Appendix 2. For the methods and data sources associated with the progress indicators see Appendix 1.

Patient Medical Home Model

The following illustration shows the framing of a patient medical home in BC.[4] It depicts the attributes of the patient medical home grouped into three areas. The **outer blue ring reflects** the importance of relationships and includes working as a team, the development of networks of physicians and the broader network of physicians through their divisions of family practice working in partnership with key stakeholders. The **inner green ring** represents the practice level service attributes. The **grey bars** represent the structural enablers of care which provide foundations supports with the aim of supporting the physician-patient relationship and physicians in practice.

[4] A larger version of this image can be found in Appendix G.



5. Methods, Data Sources and Implementation Details

A variety of complementary methods will be utilized in the Patient Medical Home Evaluation. As is evident in the table below, most methods will collect data that is relevant to examining a variety of key outcome and progress areas. Moreover, there is a balance of qualitative and quantitative methods.

Primary Methods	Key Outcome Areas				Progress Areas	Required Contribution from Divisions
	Access	Cost	Patient Experience	Physician Experience		
Most Significant Change	✓ qualitative		✓ qualitative	✓ qualitative	✓ qualitative	Light
Physician Survey				✓ quantitative	✓ quantitative	Light/Moderate
Patient Survey	✓ quantitative		✓ quantitative			None
Administrative data	✓ quantitative	✓ quantitative	✓ quantitative		✓ quantitative	None
Case studies	✓ qualitative		✓ qualitative	✓ qualitative	✓ qualitative	Moderate
Document review					✓ quantitative	

Several of the methods will be implemented in collaboration with Divisions of Family Practice. Implementation details are provided under the headings below for each of the methods that require a contribution from divisions.

Most Significant Change

This method includes collection and selection of stories in a systematic and consistent way, which provides rich narratives around a variety of stakeholder experiences and perspectives of PMH. The Most Significant Change evaluation technique asks participants to tell their stories related to specific domains of change. These stories will be elicited from patients and physicians to capture aspects of patient and physician experience.

Implementation Details

- **Required contribution from Divisions:** Divisions will work with central supports to develop a small number of patient and physician stories
- **Central Support/Resources:** Story collectors/interviewers will be hired centrally and will visit each division to do story collection. For divisions who wish to collect stories using their own staff or consultants, additional funding will be available. Sessionals and travel expenses are covered.

Physician survey questions

This method consists of a set of questions that will be asked of physicians directly through paper-pencil or an online survey. The questions are formatted in a closed-ended fashion with a likert-style scale. Many of the questions were previously used in the A GP for Me evaluation and were originally created by CIHI[5].

Implementation Details

The GPSC has developed sets of survey questions for various purposes in connection to the PMH strategy. One set of questions is the PMH Evaluation physician survey. It is likely that the various sets of questions will be combined into a single integrated questionnaire to minimize the number of surveys that GPs are asked to complete.

- **Required contribution from Divisions:** Divisions will develop and implement a plan for collecting responses from members.
- **Central Support/Resources:** The questionnaire will be loaded into an electronic survey platform and made available to each division. Reasonable expenses, such as sessionals, will be reimbursed to help divisions collect responses from members. Divisions can earmark a portion of their PMH budget to cover administrative costs associated with collecting responses from members.

[5] CIHI Measuring Attributes of PHC: Provider Survey

Patient Survey

Canadian Community Health Survey. The CCHS[6] is a cross-sectional survey conducted by Statistics Canada that collects information related to health status, health care utilization and health determinants for the Canadian population including British Columbians. It relies on a relatively large sample of respondents and is designed to provide reliable estimates at the health region level every 2 years.

GPSC Patient Experience Data Collection and Reporting Platform. This potential data source is a tablet-based platform for collecting and reporting on actionable patient experience data to optimize patient-centred whole person care in the primary care setting. It is currently being piloted in five clinics throughout British Columbia.

Administrative indicators

Ministry of Health/Health Authority. These indicators will be calculated using administrative data from Ministry of Health (and Health Authority) databases. The analysis of these indicators will occur at provincial and regional levels, and will not distinguish or compare individual communities or Divisions of Family Practice. Additionally, these indicators will be reported as rates of change over time, rather than absolute values, and will be interpreted with the help of stakeholder groups including Divisions of Family Practice. In addition, administrative data from the GPCS and the Practice Support Program will be used to report on several of the progress indicators.

Case studies

A case study is an in-depth examination of a particular case to understand its unique context from various perspectives. Case studies utilize multiple sources of information and a variety of methods. Case studies will examine both successes and lessons learned. The GPSC also plans to conduct a limited number of developmental evaluations (DE) in prototype communities. The focus of DE is on understanding the emergence of innovative strategies in a local context.

Implementation Details

- **Required contribution from Divisions:** Each division will participate in 1 case study. Participation in multiple case studies voluntary.
- **Central Support/Resources:** Case study researchers will be hired centrally and will connect with each division as required. Time spent by division staff consultants to support case studies will be compensated. Sessionals and travel expenses are covered.

[6] B.C. Ministry of Health, Health Sector Information Analysis and Reporting Division. *Your Community: Information to Support the Establishment of an Integrated and Coordinated Primary and Community Care Service System*. December 2016.

Document Review

A document review is a way of collecting data by reviewing existing documents. The evaluation will review internal documents including PSP documents and CPQI documents to get a picture of how PMH is rolling out across the province (e.g., number of physicians who have completed various PSP modules; number of Divisions who have applied for PMH funding).

6. Conclusion

The GPSC PMH Evaluation Framework has been developed over time and in collaboration and consultation with various stakeholders through a number of engagement processes. The consultation process included a patient representative group (through Patients as Partners), the GPSC Evaluation Task Force, the Divisions Evaluation Reference Group, various Divisions of Family Practice, Health Authorities and the Ministry of Health. Physician leadership and engagement has and will continue to be crucial to the process. This framework development is the first step in a process for ongoing monitoring and evaluation of GPSC's impact on transformational health system change in BC. Through its implementation, this evaluation reflects the commitment of GPSC to promoting quality and innovation.

7. Appendix I – Data Collection Methods and Instruments

A – Most Significant Change

Stories of significant change collected from patients and physicians on various domains of change including the 5 service attributes of the PMH model (Commitment, Contact, Comprehensive, Continuity and Coordination) and care pathways.

B – Physician Survey Questions

The evaluation will not compare physicians or communities to each other or determine the acceptability of absolute values. Rather, the evaluation will examine change over time by examining the results of the survey at two different time points.

The GPSC has developed sets of survey questions for various purposes in connection to the PMH strategy. One set of questions is the PMH Evaluation physician survey. It is likely that the various sets of questions will be combined into a single integrated questionnaire to minimize the number of surveys that GPs are asked to complete. The table below outlines the PMH Evaluation physician survey only.

Question	Response Options
1) Are you aware of the Patient Medical Home (PMH) model?	Yes, I understand the details of the model Somewhat, I have heard of the term No
2) What funding arrangement best describes the payment model for physicians in your clinic?	Fee-for-service Population Based Funding Blended Payment Plan Other Alternative Payment Plan: (Please specify)_____
3) What proportion of your patients who request a same or next day appointment can get one?	Almost all (>80%) Most (60-80%) About half (~50%) Some (20-40%) Few (<20%) Don't know
4) Other than physicians, does your practice include any other health care providers (e.g., nurses, nurse practitioners, pharmacists, etc.) who share responsibility for managing patient care?	Yes No
4a) Please indicate which of the following health professionals you have on your team (who share responsibility for managing patient care):	Advanced MOA Licensed Practical Nurse Registered Nurse Psychiatric Nurse Geriatric Nurse Nurse Practitioner Health Coach Pharmacist Clinical Counsellor

	Psychologist Social Worker Physiotherapist Chiropractor Dietitian Occupational therapist Specialist: _____ Other: _____
5) How much of your scope of practice (that is, the complete set of skills you are trained to use) do you actually use over the course of a year?	I use little of my full scope of practice I use about half of my full scope of practice I use most of my full scope of practice I use my full scope of practice
6) How efficiently are your skills used?	Not at all Not very efficiently Sometimes efficiently, sometimes not Usually efficiently Always or almost always efficiently
7) EXCLUDING ON-CALL ACTIVITIES, how many HOURS IN AN AVERAGE WEEK do you usually spend on the following activities? Assume each activity is mutually exclusive for reporting purposes (i.e., if an activity spans two categories, please report hours in only one category).	TOTAL hours worked per week_____: a. Direct patient care without teaching component, regardless of setting _____hours b. Direct patient care with teaching component, regardless of setting _____hours c. Indirect patient care (charting, reports, phone calls, meeting patients' family etc.) _____ hours d. Other _____ hours
8) Please select the option that best describes how your practice uses patient registry or panel-driven data:	Not used to assess or manage care for practice populations Used to assess and manage care for practice populations, but only on an ad hoc basis. Regularly used to assess and manage care for practice populations, but only for a limited number of diseases and risk states. Regularly used to assess and manage care for practice populations, across a comprehensive set of diseases and risk states
Family physicians are part of a clinical network working together to meet the comprehensive care and access needs of their patients and the patients of other practices including extended hours of service, cross coverage and/or on-call. 9) Which of the following networks does your clinic participate?	Network with other physicians and clinics for comprehensive care (e.g., maternity, mental health, etc.) Network with other physicians and clinics for access (e.g., extended hours…) Network for other purpose (Specify:_____) None

10) Overall experience Indicate your level of satisfaction with the following aspects of your primary care practice: ○ My ability to remain knowledgeable and current with the latest developments in my field of practice ○ The freedom I have to make clinical decisions that meet my patients' needs ○ The time I have available to spend with each patient ○ My income from clinical practice ○ Overall experience with practicing ○ my profession ○ The balance between my personal and professional commitments ○ The degree to which the system supports me in meeting my patients' needs ○ The degree to which I feel part of a group of colleagues	Not at all satisfied Not very satisfied Neutral Somewhat satisfied Very satisfied

C – Canadian Community Health Survey (CCHS)

The CCHS contains a large number of questions. A few example questions are provided below. The final list of questions to be included in the evaluation will be determined following further consultation. The evaluation will not compare communities to each other or determine the acceptability of absolute values. Rather, the evaluation will examine change over time by examining the results of the survey at two different time points.

Example CCHS Question	Response Options
Do you have a regular health care provider? By this, we mean one health professional that you regularly see or talk to when you need care or advice for your health.	Yes No
If no to above, what are the reasons why you do not have a regular health care provider?	Do not need one in particular, but you have a usual place of care No one available in the area No one in the area is taking new patients [You] have not tried to find one Had one who left or retired Other
If yes to 1, is that regular health care provider a...?	Family doctor or general practitioner Medical specialist such as a cardiologist or a pediatrician Nurse practitioner Other
In the past 12 months, did [you or a family member] require any routine or on-going care (OR immediate health care services for a minor health problem)?	Yes No

In the past 12 months, did you ever experience any difficulties getting the routine or on-going care (OR immediate health care services [you or a family member] needed)?	Yes No
Did you experience difficulties getting such care during "regular" office hours (OR evenings and weekends OR the middle of the night)?	Yes No
What types of difficulties did you experience?	Difficulty contacting a health care provider Difficulty getting an appointment Do not have a regular health care provider Waited too long to get an appointment Waited too long to see the health care provider (i.e. in-office waiting) Service not available at time required Service not available in the area Transportation problems Language problem Cost Did not know where to go (i.e. information problems) Unable to leave the house because of a health problem Other

D – Administrative Indicators

The evaluation will not compare communities to each other or determine the acceptability of absolute values. Rather, the evaluation will examine change over time by examining these administrative indicators at two different time points.

Indicator	Data Source
Weekday daytime acute care utilization (CTAS[7] 4 or 5)	Health Authorities or Ministry of Health
Age standardized hospitalization rates[8], all causes	Ministry of Health

[7] Canadian Triage and Acuity Scale (CTAS): a tool that enables Emergency Departments (ED) to (i) prioritize patient care requirements and (ii) examine patient care processes, workload, and resource requirements relative to case mix and community needs. There are five levels in the scale:

- Level 1-Resucitation
- Level 2-Emergent
- Level 3-Urgent
- Level 4-Less Urgent (Semi Urgent)
- Level 5-Non Urgent

[8] Age-Standardized Rate: a technique used to allow populations to be compared when the age profiles of the populations are different. Either one population is mathematically adjusted to have the same age structure as the other or both populations are mathematically adjusted to have the same age structure as a third population, called the standard population. Source: B.C. Ministry of Health, Health Sector Information Analysis and Reporting

E – Case Studies

To highlight the different strategies and approaches that are being used around the province, case studies will provide a more in-depth understanding of community projects using both quantitative and qualitative approaches to assess progress and outcomes.

F – Document Review

Indicator	Data Source
# of GPs completing PMH assessment	CPQI
# of GPs who have completed panel clean-up and identification	PSP
# of GPs participating in PSP service offerings by type (SGLS, in-practice visits & modules)	PSP
# of Divisions with completed community profiles and plans	CPQI
# of Divisions who have applied for/received PMH funding	CPQI
# of Division PMH projects/initiatives by themes/attributes	CPQI
# of Division/HA formal partnerships established to support/guide local PMH work	CPQI

H – Additional Potential Mechanisms and Sources of Data

1. Divisions Impact Measurement Framework (IMF)
2. GPSC Patient Experience Data Collection and Reporting Platform
3. GPSC PMH Practice Assessment

Division. *Your Community: Information to Support the Establishment of an Integrated and Coordinated Primary and Community Care Service System*. December 2016.

8. Appendix II – Progress Indicators

The progress indicators will be collected through the methods and data sources listed in Appendix 1. For convenience, the complete list of progress indicators is presented here at the practice, community and provincial levels and segmented by the GPSC priority areas. In addition to including priority areas, several progress indicators were chosen to highlight the achievement of early outcomes.

Practice

Engagement and Data-Driven Readiness

Number of GPs completing PMH assessment

Number of GPs who have completed panel clean-up and identification

Number of GPs participating in PSP service offerings by type (SGLS, in-practice visits and modules)

Panels

Number of GPs who report regularly using panel-driven data to manage care for their practice populations

Teams

Number of GPs working in inter-professional teams (including description of teams)

Number of GPs who report efficiently using their skills (always or almost always)

Early Outcomes (i.e.., Access and Patient Experience)

Number of patients newly attached to practice

% of patients who are satisfied with ability to access a practice (same-day, extended hrs)

% of patients who feel the care they received was delivered in a culturally safe and appropriate manner

Community

Engagement and Data-Driven Readiness

Number of Divisions with completed community profiles and plans

Number of Divisions who have applied for/received PMH funding

Number of Division PMH projects/initiatives by themes/attributes

Number of Division/HA formal partnerships established to support/guide local PMH work

Networks

Number of GPs participating in GP networks (including description of networks)

Number of practices participating in PMH networks (including description of networks)

Provincial/System

Compensation Models

Number of GPs under various compensation models

9. Appendix III – Implementation Timelines

	2017			2018				2019			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Most Significant Change			*		*		*		*		*
Physician Survey	*				*				*		
Case studies		*	*	*	*	*	*	*	*	*	*

10. Appendix IV – Patient Medical Home Graphic