



## HSPN – IFIC Canada – Emerald Webinar

### How should we be evaluating integrated care?

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June 22, 2021 - 12pm EDT

@infoHSPN

#IFICCanada

#NACIC2021

**Welcome & thank you for joining us!**

Please let us know who you are  
by introducing yourself  
(name & location)

to all panelists and attendees

in the chat box

## Land acknowledgement

We wish to acknowledge this land on which the University of Toronto operates. For thousands of years it has been the traditional land of the Huron-Wendat, the Seneca, and the Mississaugas of the Credit. Today, this meeting place is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work on this land.

# National Indigenous People's Day June 21<sup>st</sup>, 2021



# Today's event

## Co-Hosts



Jodeme Goldhar  
Strategic Advisor  
Ontario Health, CA



Henk Nies  
Strategy Director  
Vilans, NL

## Presenters



Philippa Darnton  
Associate Director Insights  
Wessex AHSN



Andrew Liles  
Strategic Advisor  
Wessex AHSN



Dr. David Brown  
Clinical Director & GP  
Farnham PCN



Adam Steventon  
Director Data Analytics  
The Health Foundation



Walter Wodchis  
Principal Investigator  
HSPN



Mark Fam  
VP Clinical Programs  
Toronto East Health Network



Sara Shearkhani  
Evaluation Lead  
Toronto East Health Network

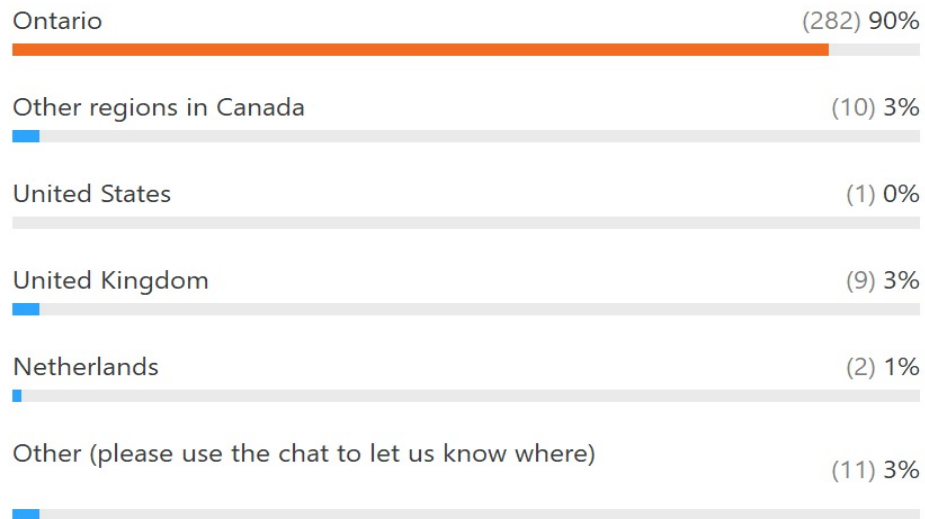


Anne Wojtak  
Lead, Integrated Care  
Toronto East Health Network

# Poll 1

## Where are you joining us from today?

### 1. Where are you joining us from today?



# Welcome and Overview



Jodeme Goldhar  
**Strategic Advisor**  
Ontario Health, CA



Henk Nies  
**Strategy Director**  
Vilans, NL

# How to Deliver Integrated Care

## A Guidebook for Managers

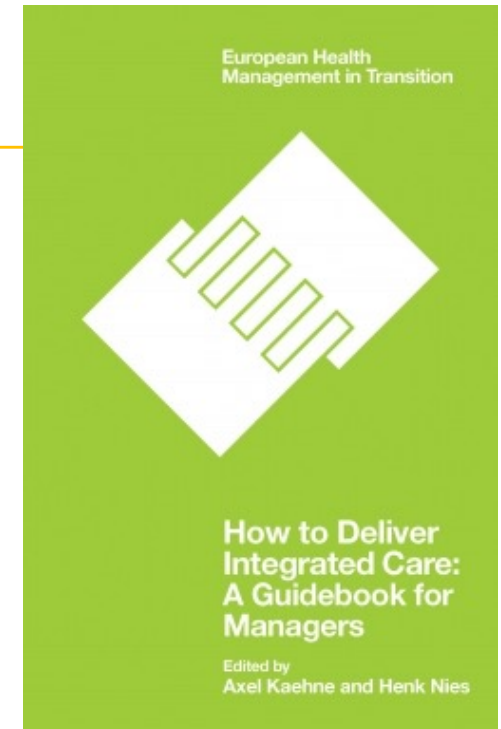
**Edited by Axel Kaehne and Henk Nies**

Care integration has become an important part of managing health and social care services all over the world. Bringing organisations together is thought to produce better access to care, reduce health care expenditure and improve quality of care for patients and service users.

This book helps managers to think about how to collaborate in integrated care programmes. It provides practical advice on how to implement various aspects of care integration, such as finance, digital technology and evaluation.

Receive a 30% discount you ordering your copy online through the Emerald Publishing bookstore – use code EMERALD30 at checkout.

<https://books.emeraldinsight.com/page/detail/How-to-Deliver-Integrated-Care/?K=9781838675301>



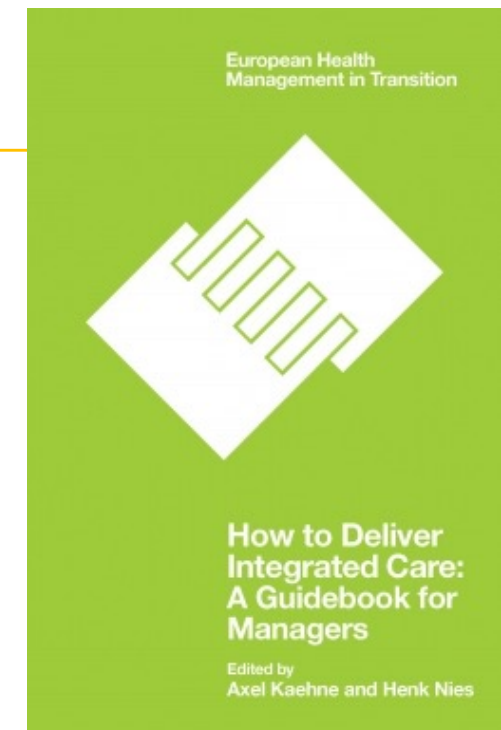


# How to Deliver Integrated Care

## A Guidebook for Managers

Edited by Axel Kaehne and Henk Nies

1. Integrated Care – An Introduction <i>Axel Kaehne and Henk Nies</i>	1	7. Digital Health Enabling Integrated Care <i>Carolyn Steele Gray, Dominique Gagnon, Nick Guldemon and Timothy Kenealy</i>	115
2. Financing Care Integration: A Conceptual Framework of Payment Models That Support Integrated Care <i>Eric van der Hijden and Jeroen van der Wolk</i>	15	8. Implementing Integrated Care <i>Axel Kaehne</i>	137
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# How to Deliver Integrated Care

## A Guidebook for Managers

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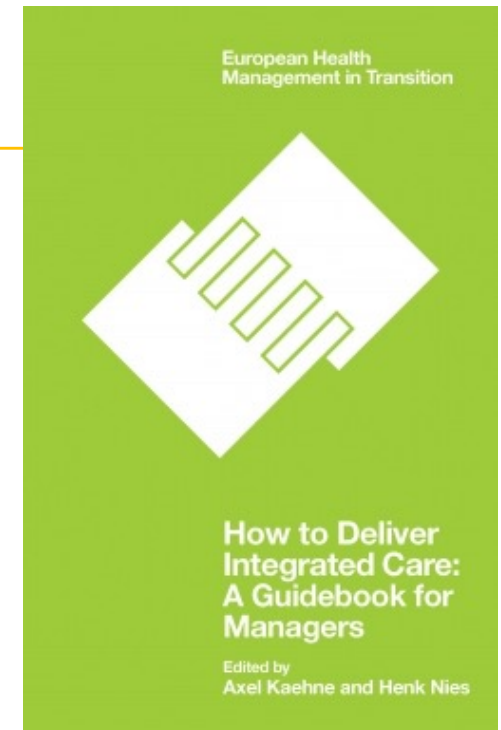
**Edited by Axel Kaehne and Henk Nies**

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<https://books.emeraldinsight.com/page/detail/How-to-Deliver-Integrated-Care/?K=9781838675301>

<https://tinyurl.com/2x3rhn23>



# Further reading and resources

## Journal of Integrated Care

Edited by Axel Kaehne

Facilitating the dissemination of research and practice about the integration of health, social care and other community services to the benefit of service users, patients and health care providers.

<https://www.emeraldgrouppublishing.com/journal/jica>

Also see Emerald's **Healthier Lives** page, <https://www.emeraldgrouppublishing.com/our-goals/healthier-lives>, a home for research that influences thinking, changes practice and policy, and positively makes a difference to lives beyond the walls of academia, aligned to the UN's Sustainable Development Goals. We're looking for new partnerships to help the research we publish reach its widest audience – if you'd like to be involved, please get in touch.



## Poll 2

# What should be the main objective of an evaluation of integrated care? (check 1-3 priorities)

1. What should be the main objective of an evaluation of integrated care? (check 1-3 priorities) (Multiple choice)



# Evaluating Integrated Care From a System Perspective: The Health Foundation Approach



Adam Steventon  
**Director Data Analytics**  
The Health Foundation

# Evaluating integrated care

Adam Steventon

21 June 2021



# The Improvement Analytics Unit

We are working in partnership with NHS England to establish a resource that can:

- Evaluate whether local change initiatives, implemented as part of national programmes, are improving care
- Feed back to local and national level quickly, to help improve care
- Use state-of-the-art evaluation methods from causal inference, as applied to existing data sets




# Example 1: Principia

**Briefing**  
March 2017

**Briefing: The impact of providing enhanced support for care home residents in Rushcliffe**

Health Foundation consideration of findings from the Improvement Analytics Unit  
Therese Lloyd, Arne Wolters and Adam Steventon

**About this briefing**  
The analysis within this briefing was conducted by the Improvement Analytics Unit, a partnership between NHS England and the Health Foundation. This Health Foundation briefing considers the findings of the analysis.  
The briefing looks at the impact of a package of enhanced support for older people living in care homes. The enhanced support was introduced in April 2014 and was developed by Principia, a local partnership of general practitioners, patients and community services that aims to provide better quality of care for people in Rushcliffe in Nottinghamshire, England.  
The briefing outlines the enhanced support package, then describes the methods the Improvement Analytics Unit used to derive the linked data used in the analysis, select a matched comparison group, and compare hospital utilisation between the two groups. The briefing describes the results of the analysis and discusses the findings. It concludes by looking at the implications and priorities for future research and improvement activity. More detail about the methods used is available in an accompanying technical appendix, available from [www.health.org.uk/publication/improvement-analytics-unit-analysis-principia](http://www.health.org.uk/publication/improvement-analytics-unit-analysis-principia)

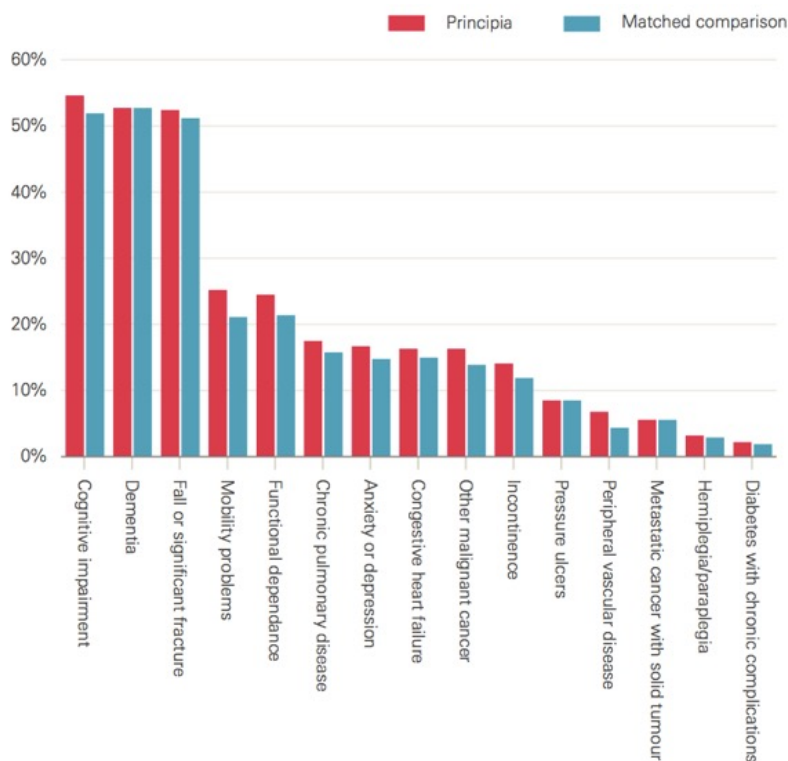
 **The Health Foundation**



# Enhanced support for care home residents

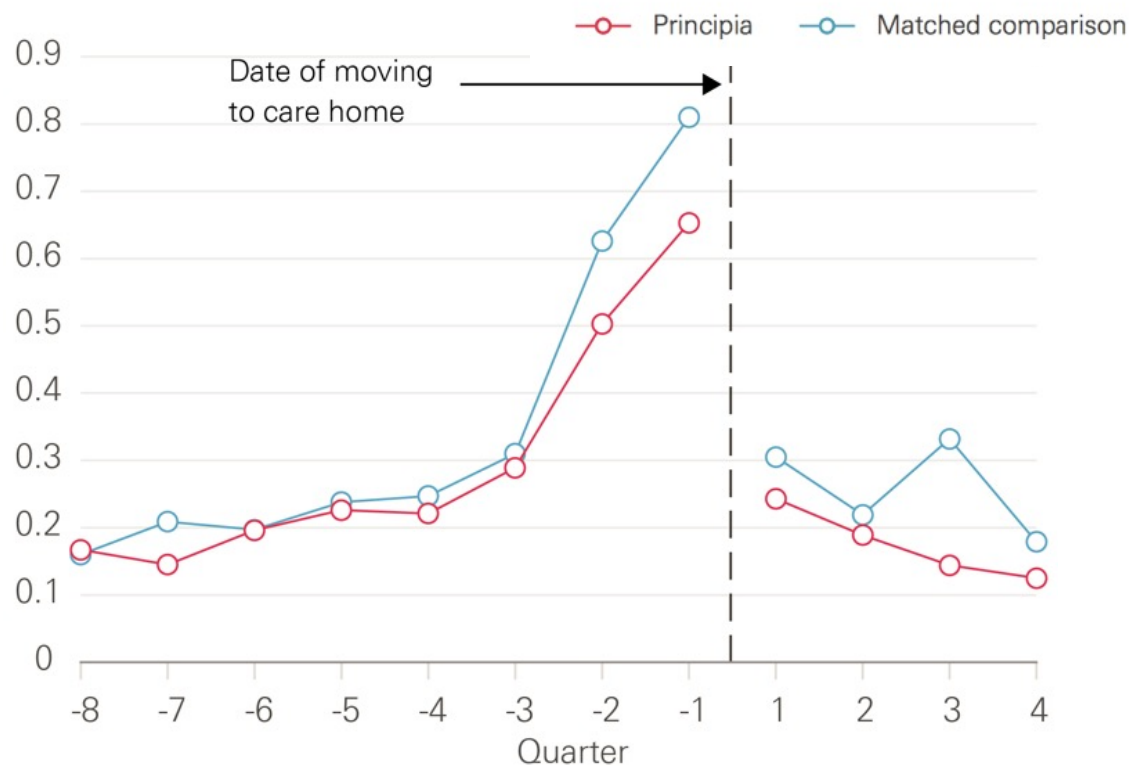
- Aligning care homes with general practices
- Regular visits from a named GP
- Improved support from community nurses
- Independent advocacy and support from the third sector
- Programme of work to engage and support care home managers

# Selecting a matched control group



Lloyd, T. et al. The impact of providing enhanced support for care home residents in Rushcliffe. The Health Foundation. 2017

# Trends in emergency admissions



Lloyd, T. et al. The impact of providing enhanced support for care home residents in Rushcliffe. The Health Foundation. 2017

# Example 2: Mid Nottinghamshire


Briefing  
September 2020

## The long-term impacts of new care models on hospital use: an evaluation of the Integrated Care Transformation Programme in Mid-Nottinghamshire

Geraldine M Clarke, Paris Pariza and Arne Wolters

**Key points**

- This report presents the findings of an evaluation of the long-term impacts of the Mid-Nottinghamshire Better Together Integrated Care Transformation Programme (ICTP) over a 6-year period from its launch in April 2013 until March 2019. The programme was established by Mansfield and Ashfield clinical commissioning group (CCGs) and Newark and Sherwood CCG, together with local partners. In March 2015, the Mid-Nottinghamshire Better Together programme achieved vanguard status as an integrated primary and acute care systems provider, one of the first of the new care models announced in the Five year forward view.

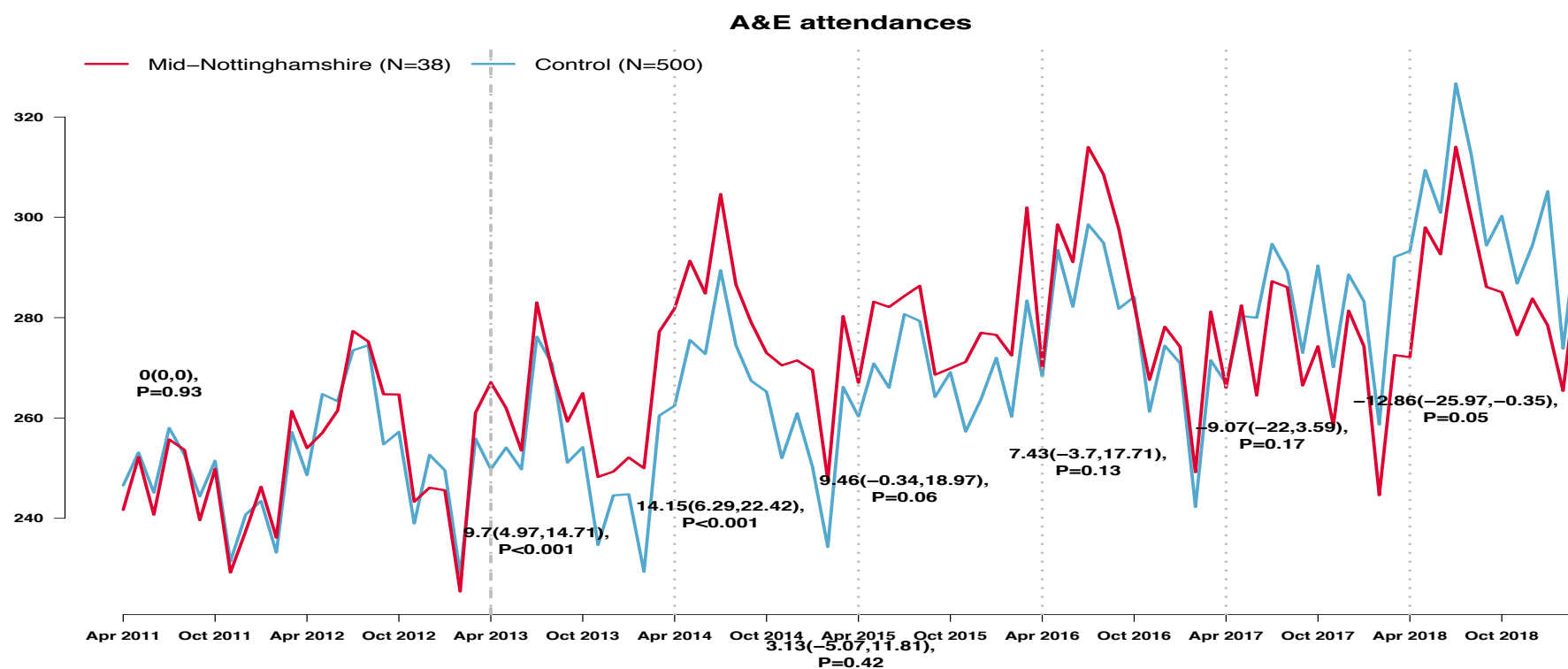
 The Health Foundation

# Better Together Mid-Notts PACS vanguard

- Mid Nottinghamshire (Mansfield & Ashfield and Newark & Sherwood) CCGs serve a population of ~330,000, typically older, with high incidence of multi morbidity, and high levels of deprivation.
- Mid-Notts Better Together Integrated Care Transformation Programme (ICTP) established in 2013 in response to concerns about disjointed and fragmented care, and confusion about available services
- Won vanguard in March 2015 funding to continue the ICTP as a PACs vanguard.
- Formed Alliance across Mid Notts in April 2016 and now operates as part of Nottingham and Nottinghamshire ICS



# A&E Visits



# Reflections

# Reflections

- Counterfactual is needed in situations like the ones presented; otherwise we would have reached the wrong conclusion
- Resources are available to help health care analytics teams implement these methods – see [health.org.uk/iau](https://health.org.uk/iau)
- Routine data useful – but gives partial picture
- Impacts on hospital admissions can take many years to materialise – we need leading indicators of change



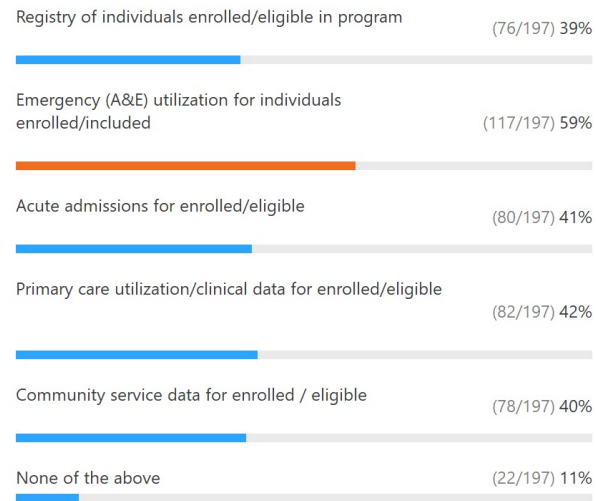
# Thank you



## Poll 3

# What data sources are you able to use to evaluate your integrated care programs (✓ all that apply)?

1. What data sources are you able to use to evaluate your integrated care programs (✓ all that apply)? (Multiple choice)





## Discussion Question & Engagement

What are your challenges in implementing evaluation for your (integrated care) improvement programs?



Use the chat to all panelists and attendees to respond to this and ask questions.



## Two Inspiring Examples



**Philippa Darnton**  
**Associate Director, Insight**



**Mark Fam**  
**Vice President, Clinical Programs**



**Andrew Liles**  
**Strategic Advisor**



**Dr. David Brown**  
**Clinical Director, Farnham PCN**



**Sara Shearkhani**  
**Evaluation Lead**



**Anne Wojtak**  
**Lead, Integrated Care**



**Wessex**  
Academic Health  
Science Network



# Evaluating integrated care delivery in an NHS health and care system

2015-2019

## In this 10 minute presentation you'll be hearing from:



**Dr David Brown**

General Practitioner (Family Physician)

Clinical Director for the Farnham Primary Care Network



**Andrew Liles**

Strategic Advisor, Wessex AHSN

Consilium Partners

Royal Holloway College, University of London



**Philippa Darnton**

Associate Director, Insight

Wessex Academic Health Science Network



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Science Network



## Quick context setting

*“The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need.”* **Five Year Forward View** (FYFV) October 2014.

50 **vanguards** established to create learning for the wider roll-out of **new integrated health and care models** to the rest of the NHS. North-East Hampshire and Farnham (NEHF; 200,000 population) were one of these.

Each vanguard were required to appoint an **independent evaluation partner** – and Wessex Academic Health Science Network were appointed by NEHF.

Integrated care is now the **dominant national policy** for the NHS.

- NEHF were part of one of the first, and leading, larger **Integrated Care Systems** (ICSs) in the NHS – Frimley Health and Care (c.850,000 population). ICSs now cover all of England.
- The integrated care models developed and evaluated in NEHF are now widespread across the NHS.



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# Happy, Healthy, at Home – NEHF Vanguard



The new  
care  
model



## Example – The Farnham Integrated Care Team (ICT)



### Patients supported by ICT:

- Reactive caseload initially
- Proactive caseload added in phases

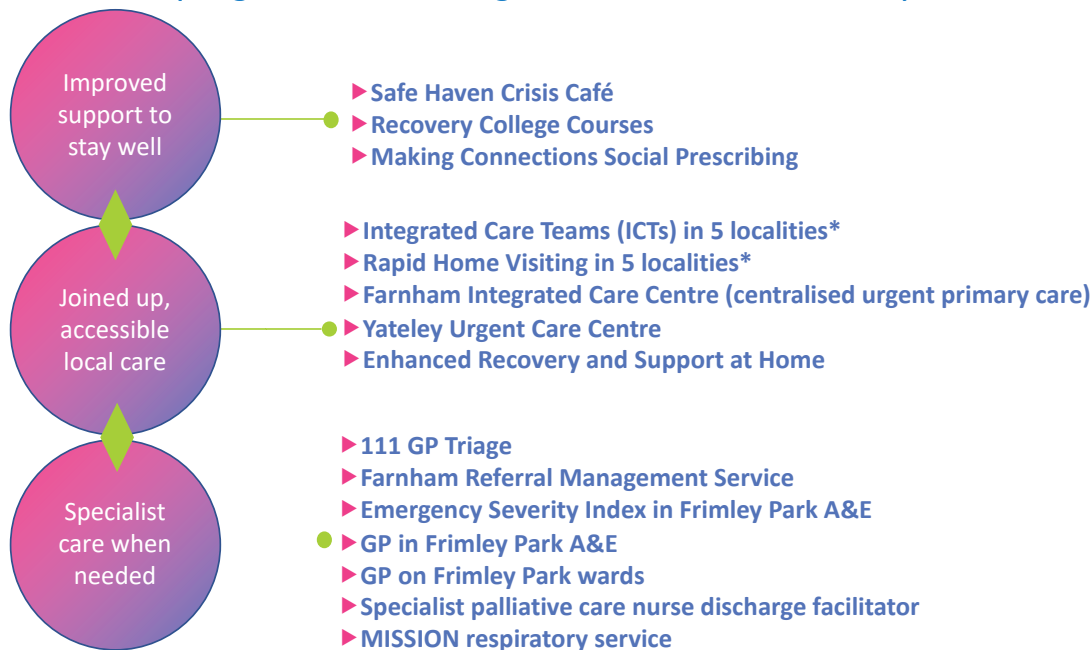
### Process:

- Weekly team meeting – Wednesday 1pm to 3pm
- Core team attend in person
- Extended team can attend, dial in or video call
- 20-30 patients discussed at each meeting
- ICT Coordinator completes Action Plan and a Tracker to monitor completion
- “Discharge” decisions based on professional consensus



# Evaluation scope and process

We evaluated 23 services over 2 years



## A typical evaluation process:

- ❑ A meeting with the service to understand the service and its aims and to develop a **logic model**.
- ❑ **Co-design** the evaluation, methods and timescales.
- ❑ **Circa 3 months** of focused data collection, observation, interviews and analysis.
- ❑ **Report writing**, discussion with the team, presentation and approval from evaluation steering group.
- ❑ Joint presentation by service team and evaluation team at a **Symposium**.

# Farnham ICT – what they did and what they wanted to understand



Happy  
Healthy  
atHome



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## FARNHAM INTEGRATED CARE TEAM LOGIC MODEL

### A Our CONTEXT and RATIONALE

The Health and Wellbeing of the local population is generally better than the England average. However despite the overall picture of general good health, there are areas of deprivation and child poverty concentrated in parts of Rushmoor, where over 40,000 people live in the most deprived quintile nationally for health deprivation and disability. People living within deprived areas tend to have poorer health and be high users of healthcare services. Life expectancy in North East Hampshire and Farnham is higher than the average for England, at 81 years for men and 85 years for women. However, people in the most affluent parts of Hart can expect to live for at least 10 years longer than those living in the most deprived area of Rushmoor. Addressing health inequalities is a key strategic priority. The key strategic issue relevant to our long term planning is the ageing population and its impact on health needs, including that the prevalence of long term conditions will increase over the next five years.

Through a new model of integrated primary and community care, GPs with other care professionals will identify those individuals at risk, develop a holistic care plan with each of these individuals, and proactively manage the health and social care of the population. Our model is based on the findings of successive reviews of the successful national and international integrated care systems. The current model of care being delivered is unsustainable, this method aims to create a more sustainable and person-centred approach to care.

### B with these INPUTS

Core ICT members:  
Community Matron/nurse  
ICT Coordinator (administrative)  
(E)  
Community Psychiatric Nurse  
Social Care Practitioner  
GP  
Voluntary Sector  
Representative  
Medicines Management  
Therapist / Occupational  
Therapist  
District Nurse

Enhanced ICT members:  
Consultant Psychiatrist  
Domiciliary Care  
Palliative Care  
Geriatrician  
Reablement Team Leader  
Care Navigator (new role TBC)  
(E)

Enhanced Out of hospital care  
Secondary care consultants  
Specialist Nurses  
Paediatrics  
cancer  
Out of Hours  
Fire service, ambulance, police  
Voluntary groups with special  
interests  
Community teams

### C we will carry out the following ACTIVITIES

Use of a joint care plan/assessment to look after patients during routine meetings to create patient centred outcomes

Patient centred and involvement in discussion/ Work alongside the individual to draw out the goals most important for them

Regular review of patient care plans  
Signposting and access to support services

Continuing Professional Development/Team development activities

Additional support and outreach to into Multi-Disciplinary teams

Information sessions for the wider health and social care providers

Communications on the Integrated Care Team to wider health and social care teams

### D Creating the following OUTPUTS

Number of patients seen in an MDT meeting who have been actively involved in designing their single care plan (number of patients attending meeting; record of follow up; number of single care plans)

Number of patients seen in an MDT meeting who have been actively involved in designing their single care plan (number of patients attending meeting; follow up record)

Number of referrals to other services (e.g. social prescribing/ voluntary sector)  
Number of intensive early interventions

Staff satisfaction outcomes  
Attendance at meeting  
Higher level of job satisfaction  
Staff turnover

Those members external to the team are aware of their role and use the ICT

### E to deliver the following OUTCOMES

A closer level of working with partner agencies and improved communication between providers and shared learning from satisfaction/ Health Confidence Score

Clinical Outcomes (improved clinical outcomes for the patient)

Service users are proactively involved in their own care, asking for changes to be made (number of service users involved in the design phase/ review of service)

Partners and patients know and understand about the ICT and value the work

Understanding services better and knowing which services and how to access them and understand how to manage their own condition

The variety of services being used is greater, with a greater emphasis on voluntary sector services and health promotion services

Reductions in ambulatory care reductions in delayed transfers of care And in length of stay

Improved levels of trust amongst the team, greater levels of teamwork

Increased knowledge of community services

Those members external to the team feel there has been a greater impact on the healthcare community

Understanding services better and knowing which services and how to access them

### F with these long term IMPACTS

Supports independence, engagement and wellbeing people encouraged to take the lead in managing their own care

Improved health and wellbeing outcomes with a reduction in health inequalities and a better quality of life for all

Home is the safest place to be

Seamless provision of care 24/7

Right place, right time, right professional

Sustainability is delivered and a local community identity is evident

Improved personal wellbeing; confidence to take responsibility for their own health; and experience of care.

Closer level of working with partner agencies and improved communication and understanding between providers.

Reduce A&E attendances and emergency admissions to hospital – driving financial savings.

Improved levels of trust and greater levels of teamwork

# Evaluation methods

These are the principal **evaluation methods** that have been used.



## Self reported outcomes

A set of short, generic, validated person reported outcomes measures that can track changes in how people feel over time as they experience a new care model. Widely used for patients and staff.



## Activity impact

Analysing pseudonymized patient records to measure the impact of new care models on activity levels in other services – principally hospital emergency services.



## Economic evaluation

Modelling evidence of an impact on activity levels over time to estimate potential system savings. Comparison with costs to identify a potential return on investment.



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## Team observation and evaluation

Observing teams in practice using Normalisation Process Theory - a validated evaluation tool to understand the extent to which a team was able to embed the implementation of the new care model.



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## Qualitative interviews with patients, carers and staff

Experienced researchers undertaking structured interviews using qualitative methods to explore the extent and nature of a change.



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OF LONDON

## Themed analysis of case studies

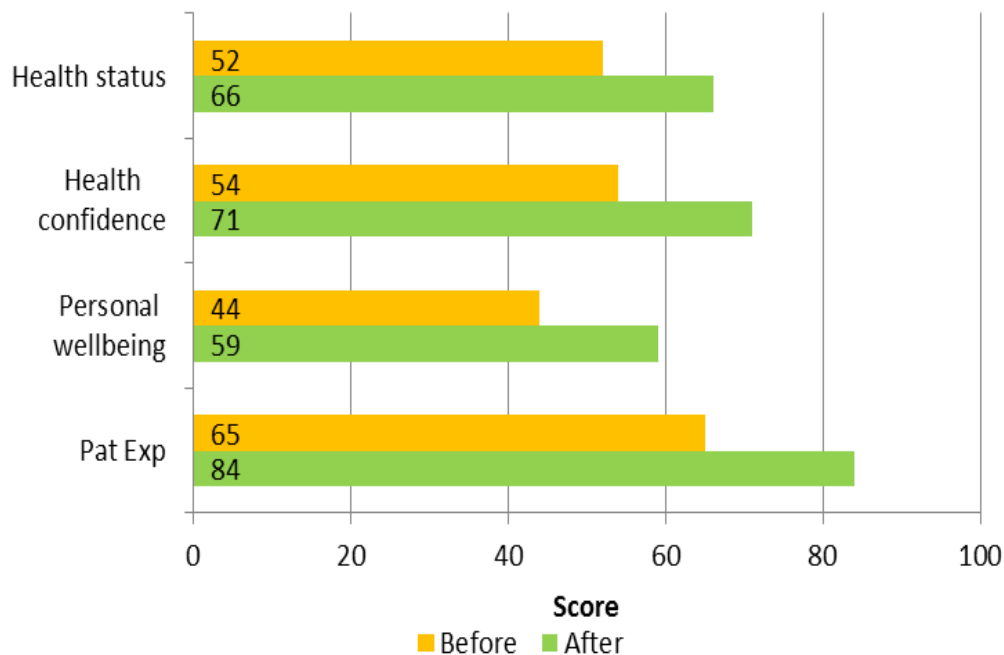
Experienced researchers undertaking thematic analysis of case studies collected by staff.

## Synthesising findings

Synthesis meetings bring together all of the people involved in gathering the data and evidence from quantitative and qualitative sources. All of the material was pooled and worked through together to triangulate the evidence and identify and agree findings.

# Self reported outcomes from patients

The **total vanguard scores** before (at referral) and after (once supported) – covering 3300 responses



The **biggest improvements** were:

- Experience: Well Organised
- Health Confidence: I can get the right help if I need it
- Experience: Listen and explain
- Experience: See you promptly

Improvement ■ Before ■ After



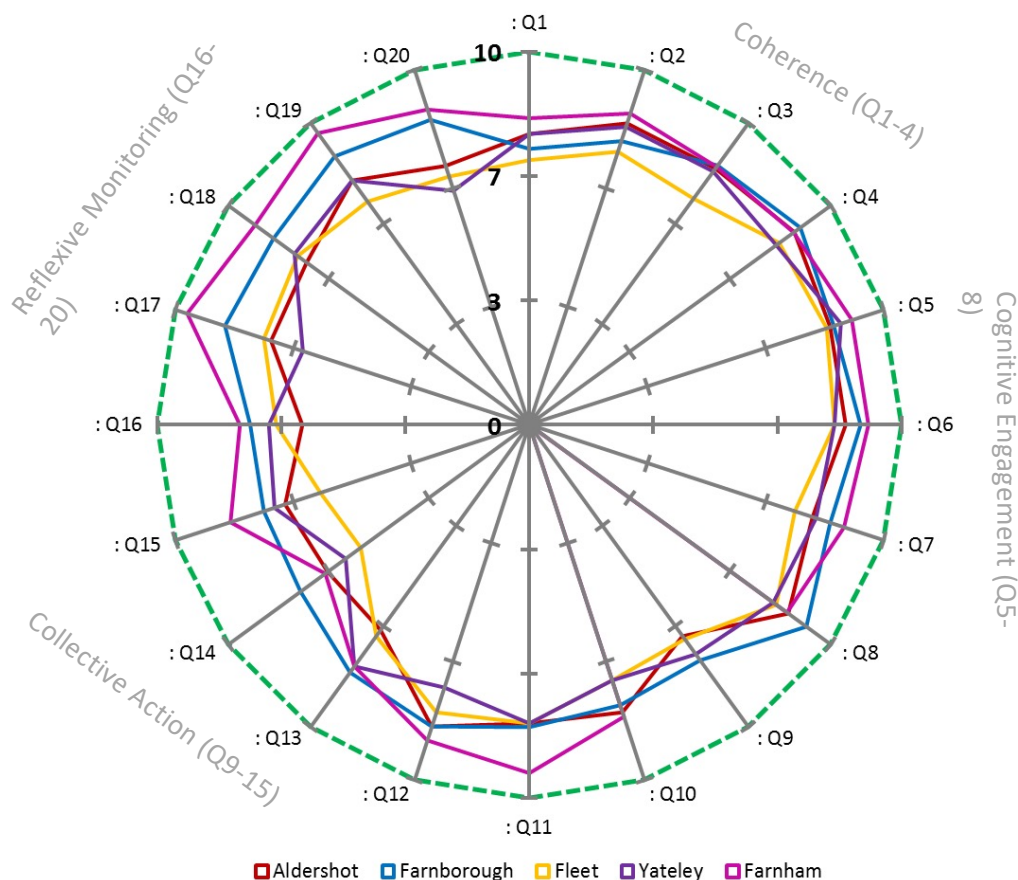
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# Team Evaluation for 5 different locality ICTs

## NPT survey scores for each locality Integrated Care Team



Scores closest to the green line are better (higher scores are positive/ better)

- **Coherence** – evidence that team members believe there is a move from reactive to proactive care. The role of the Paramedic Practitioner was widely recognised to have made a big contribution to the teams' practice
- **Cognitive engagement** – non-participant observation and focus groups confirmed high levels of buy-in in all ICTs.
- **Collective action** – focus groups identified the following common barriers and drivers to the work of the ICTs:
 

<b>Barriers:</b>	<b>Drivers:</b>
Staff shortages and competing demands	The multidisciplinary team
Not understood by other parts of the system	Improving patient outcomes
IT and Information Governance	Flexibility and autonomy
- **Reflexive monitoring** – ICTs were able to follow individual patients but have less information on the overall impact they are having and how they are perceived by others.

# How we ensured that evaluation influenced action

- A **co-designed** approach
- **Symposia** to share the learning
- Interim feedback to **Community of Practice** events
- NPT evaluation at **team away days**
- Self-reported outcome measures included in **monthly system dashboards**
- **Flash cards** of summary findings
- **Timely evaluation reports**



## Our tips for successful evaluation of integrated care

- ✓ Relationships
- ✓ Understanding value
- ✓ Maximising benefit through the formative use of findings
- ✓ Evaluation champions
- ✓ Adaptability
- ✓ Evaluability
- ✓ Understand 'how people feel' about integrated care
- ✓ Independent analysis, but co-designed process



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# THANK YOU



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## Using a Learning Health System Approach to Evaluating an Ontario Health Team in East Toronto

**Mark Fam**, Vice President Clinical Programs, East Toronto Health Partners (ETHP)

**Sara Shearkhani**, Evaluation Lead, ETHP

**Anne Wojtak**, Lead, ETHP

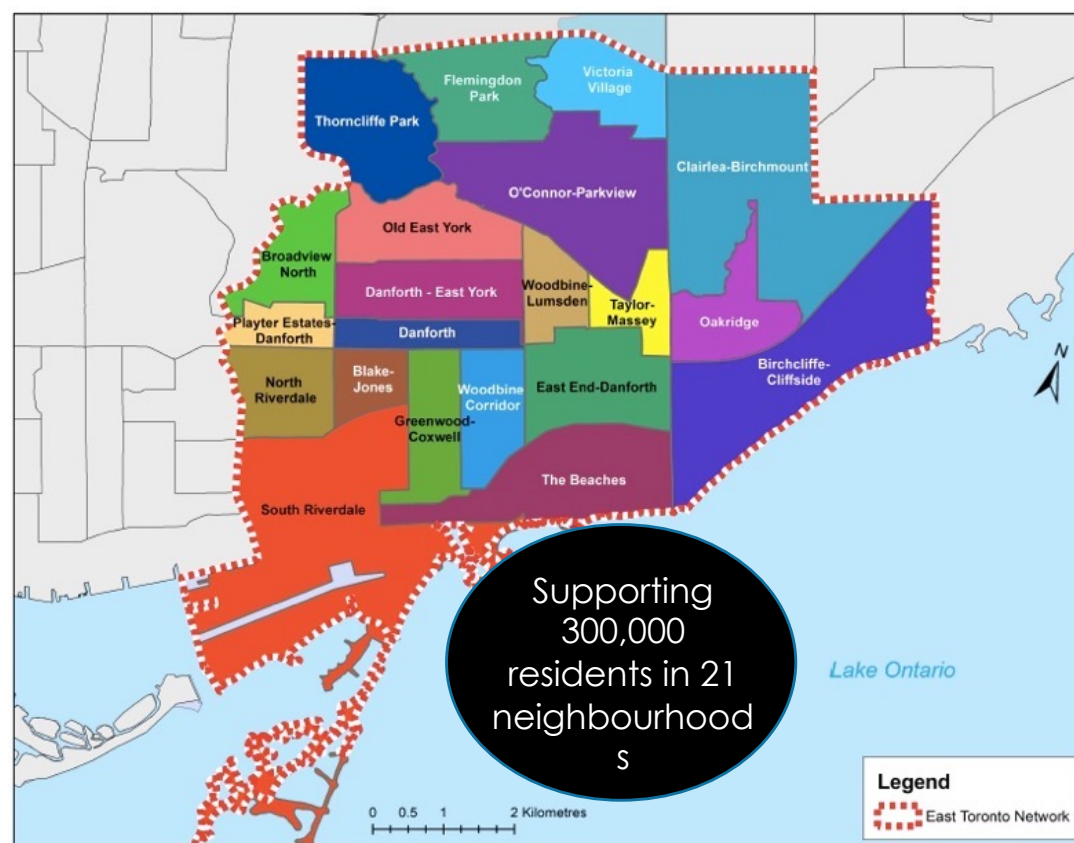


# Building an Ontario Health Team for East Toronto.



# Who We Serve in East Toronto

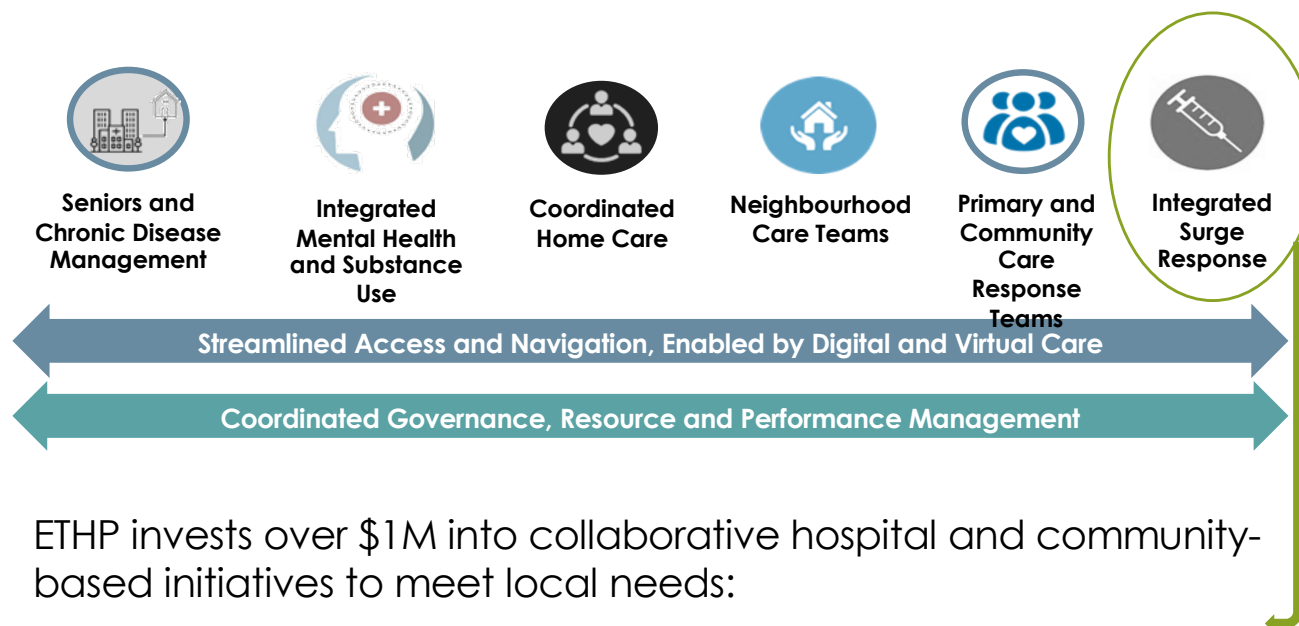
**Partnership Model:** An Anchor Partnership model with an evolving network of health, community care and social service providers.



## Achieving the Quadruple Aim via our ETHP Vision



**Vision:** *A System without Discharges: A Seamless Continuum of Care that is Population Health-focused, with Programs Tailored to Local Communities*



ETHP invests over \$1M into collaborative hospital and community-based initiatives to meet local needs:

Flu vaccinations, community outreach, primary care capacity, enhanced home care, ED capacity....

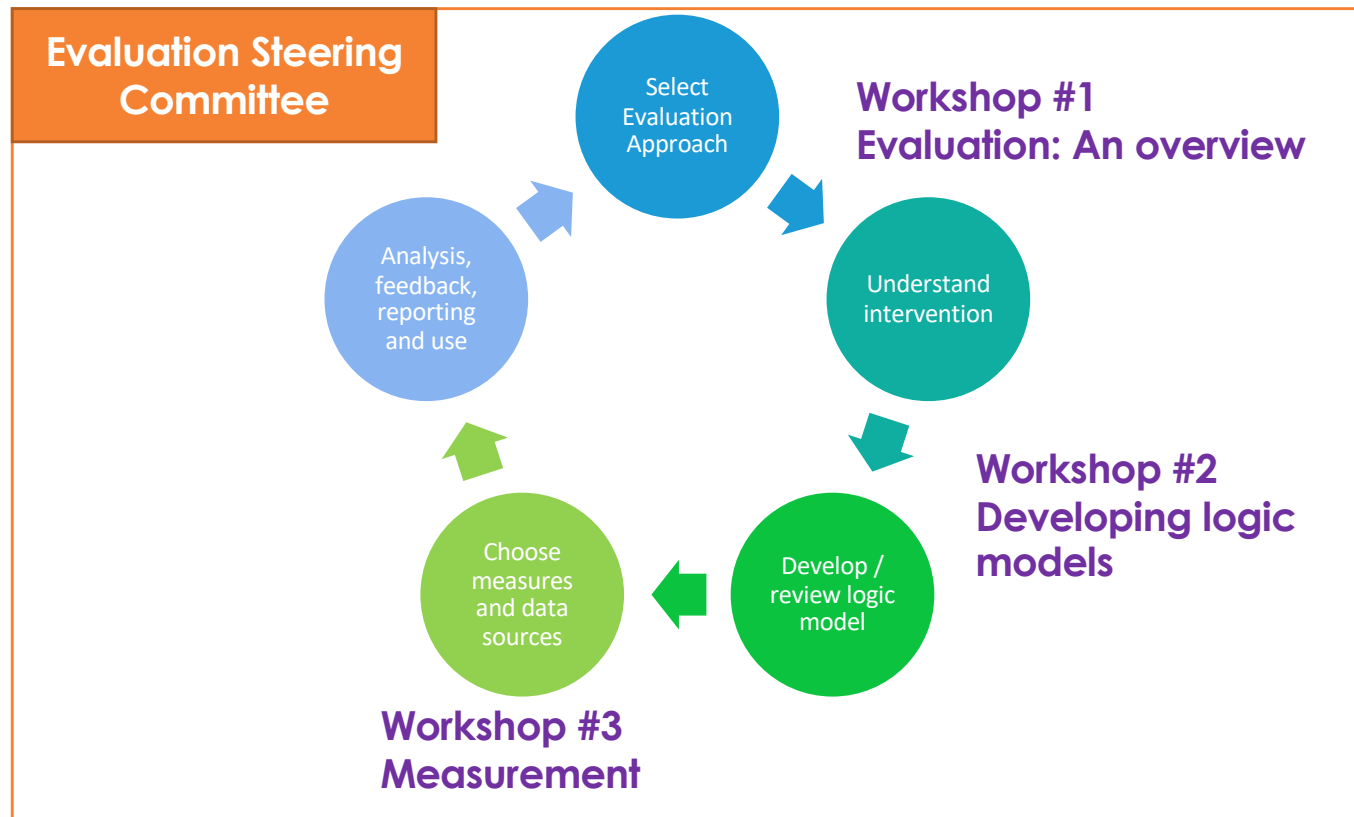
# Evaluation

# Evaluation Aim and Approach



- **Aim:** Creating a learning system within East Toronto OHT by embedding rapid cycles of evaluation to support learning, knowledge transfer, and decision making for scale and spread of our new model of care by:
  - Co-developing an OHT evaluation framework
  - Creating an evaluation community of practice
  - Supporting decision-making and Knowledge Translation (KT)
- **Approach:** Developmental Evaluation (DE)
- 15 Surge projects were chosen to be part of DE

# Evaluation Framework







# Evaluation Plan: EHP Template

## 1. Logic model: Flexible funds to support early discharge for patients with non-medical needs (A Surge project)

Resources	Activities	Outputs	Outcomes	Impact
<ul style="list-style-type: none"><li>• Staff</li><li>• Admin support</li><li>• Community partners</li><li>• Funding</li><li>• ...</li></ul>	<ul style="list-style-type: none"><li>• Identify &amp; assess patients</li><li>• Identify barriers to discharge</li><li>• Put in a request</li><li>• ...</li></ul>	<ul style="list-style-type: none"><li>• #requests</li><li>• # enrolled patients</li><li>• Type of services</li><li>• ...</li></ul>	<ul style="list-style-type: none"><li>• Reduced length of stay</li><li>• Improved discharge process</li><li>• ...</li></ul>	<ul style="list-style-type: none"><li>• Alleviate winter surge pressure</li></ul> <div><b>Population:</b> Patients who are eligible to be discharged but are unable to leave due to non-medical issues</div>



## Evaluation Plan: ETHP Template

### 2. Evaluation questions: Flexible funds to support early discharge for patients with non-medical needs (A Surge project)

Type	Questions
Process focused questions	<ul style="list-style-type: none"><li>Who are the patients being identified? (How does that compare with the intent?)</li><li><b>What are the common barriers to discharge?</b></li></ul>
Outcome focused questions	<ul style="list-style-type: none"><li>Did the program reduce length of stay?</li></ul>

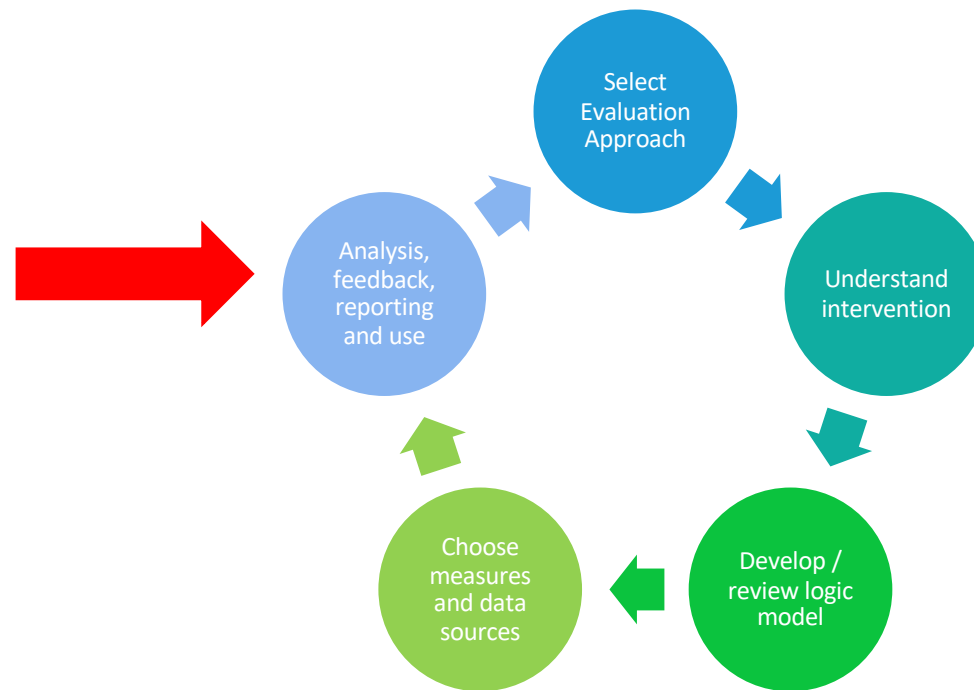


## Evaluation Plan: ETHP Template

### 3. Measurement table: Flexible funds to support early discharge for patients with non-medical needs (A Surge project)

Activity/Output/ Outcome	Identified Measures	Source of data	Approach to data capture	Frequency of reporting & Audience	Associated Actions & Responsibility
Identify barriers to discharge	Identified barriers by staff	Staff perception	Focus group	One time (end of March)	X to run a focus group; analysis by Y
	Type of services/ equipment purchased	Patient's record	Document analysis	Twice (mid Feb–end March) with evaluation team, executive & staff	Z to update tracking sheet/ analysis by Y

# Analysis, Feedback, & Reporting



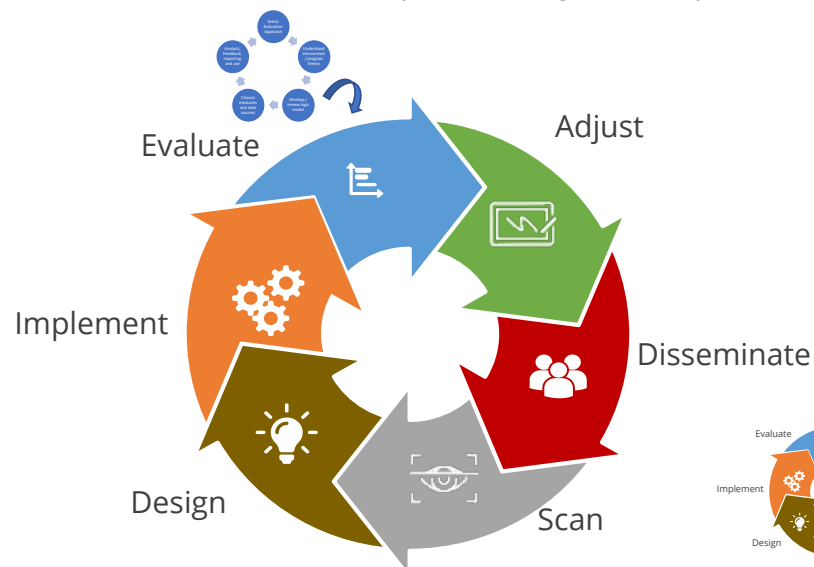
# Next Steps

# Maturing as a Learning Health System

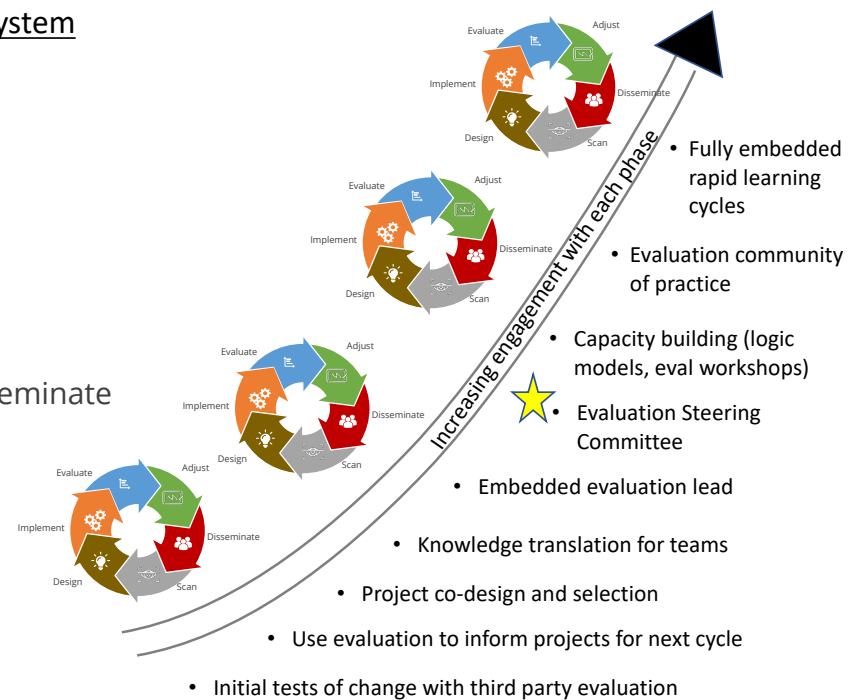


## East Toronto Health Partners – Maturing as a Learning Health System

### The Six Phases of a Rapid-Learning Health System



Greene SM, Reid R & Larson E. Implementing the Learning Health System: From Concept to Action. *Ann Int Med* 2012: 157: 207-210





**East Toronto  
Health Partners**

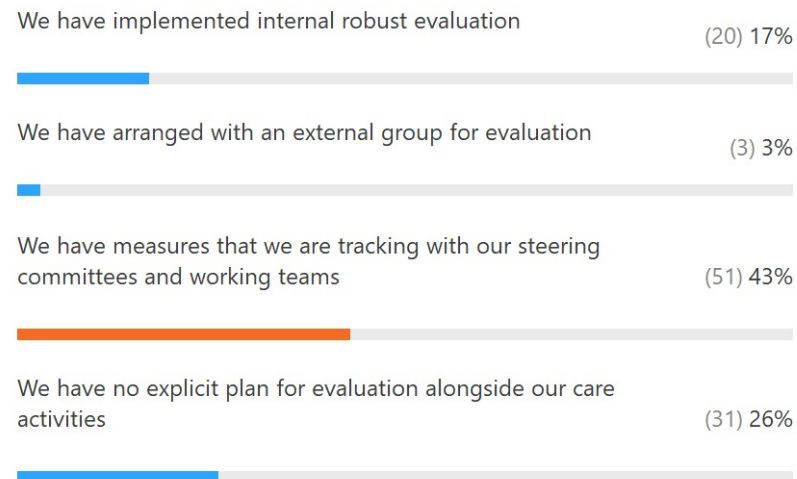
**Thank You**



## Poll 4

# How are you evaluating your integrated care initiatives (select one)?

1. How are you evaluating your integrated care initiatives (select one)?





## Discussion Question & Engagement

**How would you understand how integration feels for (is experienced by) staff and patients?**



Use the chat to all panelists and attendees to respond to this and ask questions.

# Linking System Evaluation with Local Implementation



Walter Wodchis  
Professor & Research Chair

# Evaluating Integrated Care



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## EVALUATING INTEGRATED CARE

Walter Wodchis, Carolyn Steele Gray, Jay Shaw, Kerry Kuluski, Gayathri Embuldeniya, G. Ross Baker, and Maritt Kirst

### INTRODUCTION

While integrated care programs are proliferating around the world, rigorous measurement and evaluation of the intended and unintended effects of these programs are rarely undertaken or reported on outside of well-funded research programs. There are a number of reasons for this lack of evaluation, including a failure to include measurement and evaluation in implementation plans, a lack of funding for evaluation activity, limited local evaluation expertise and resources, and persistent challenges associated with measurement and evaluation in complex interventions. Therefore, aside from a few notable international examples, much of our understanding of integrated care programs is descriptive, focusing on case studies that typically summarize what was implemented, and in some cases how it was implemented, but far less often on what outcomes were achieved.

# Evaluating Integrated Care

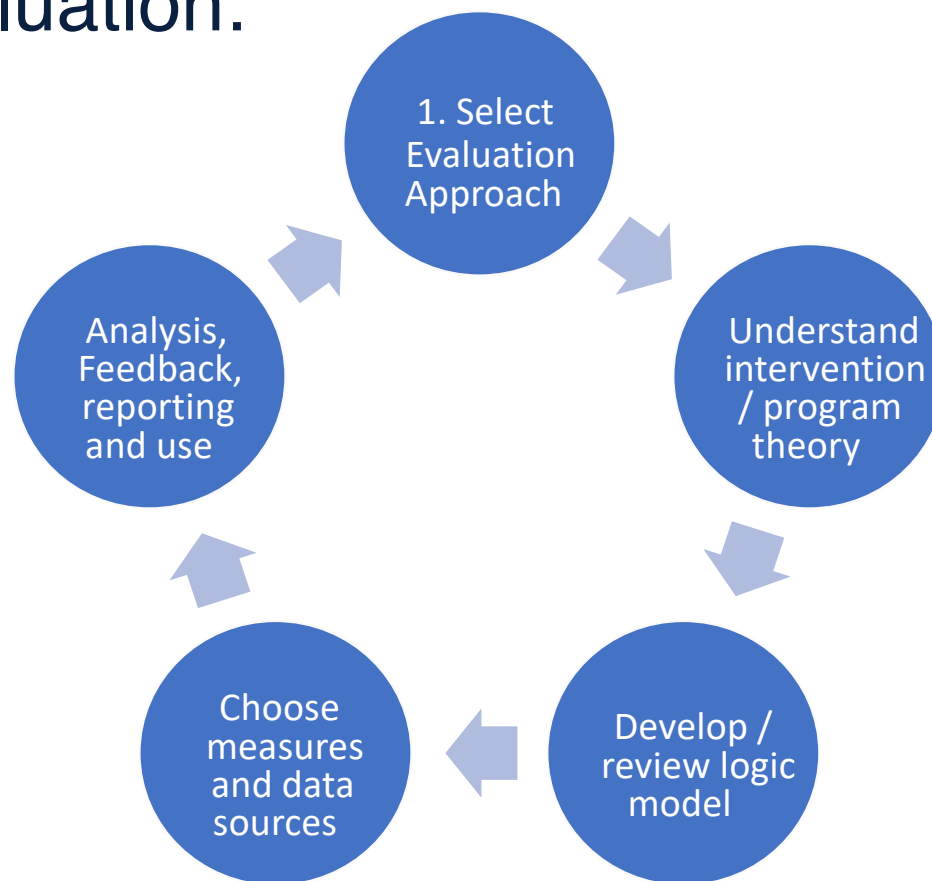
Evaluation Goal	Purposes	Methods
Summative	Determine effectiveness	Comparisons with unexposed
Formative	Improve design	Descriptive
Developmental	Support innovation & development	Qualitative & quantitative Rapid feedback
Realistic	Context and mechanisms	Qualitative & quantitative

# Evaluating Integrated Care

## Other considerations:

- Priority populations
- Conceptual frameworks
- Logic models
- Measurement & data capture
- Analysis and reporting

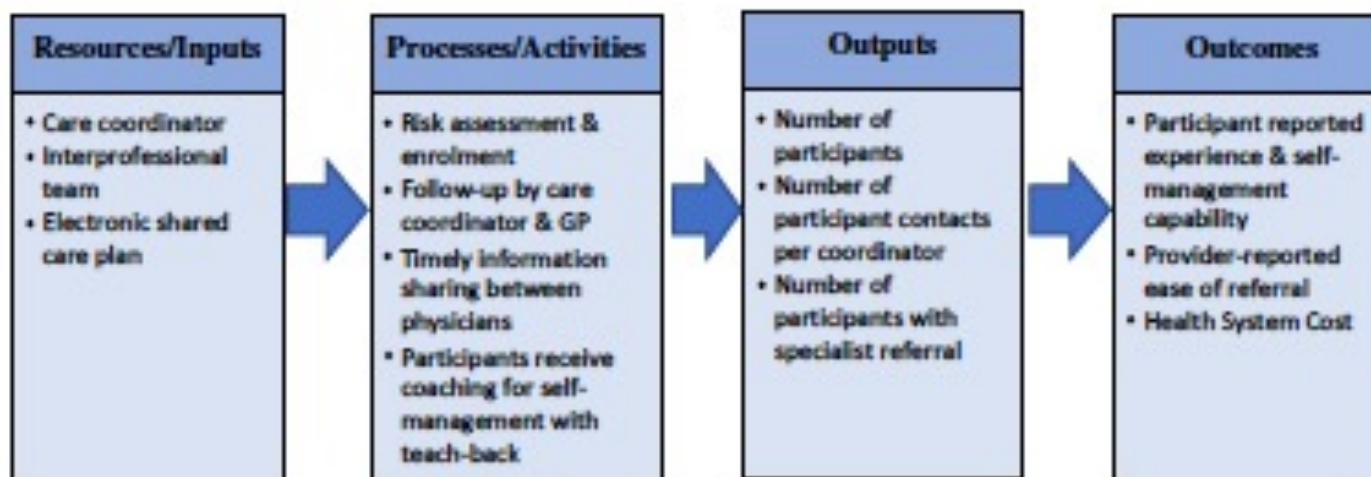
## Steps to Evaluation:



# Steps to Evaluation:

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**Fig. 9.1. Example Logic Model.**


Some resources translated to <https://hspn.ca/evaluation/oht/>

## Webinars: Feb & Nov 2020

## Logic model development guide + templates


**Today's event**

**Host**




Dr. Walter Wodchis

**Discussants**




Dr. Kaileah McKellar  
Asst. Professor (Status)  
Evaluation Consultant



Jagger Smith  
Program Director  
Baycrest  
NYT OHT


**Today's event**

**Host**




Dr. Walter Wodchis  
Principal Investigator  
HSPN


**Presenters**




Dr. Kaileah McKellar  
Evaluation  
HSPN




Judy Smith  
Patient Family Partner  
Southlake



Jennifer Andrachuk  
Physiotherapist  
Southlake



Margaret Furman  
Operations Manager  
SE Health



Gayle Seddon  
Executive Innovator  
Community Partnerships  
Southlake

HSPN

**Ontario Health Team  
Logic Model  
Development  
Exercise Guide**

Compiled by  
K. McKellar

HSPN

Resources/Inputs	Activities/Strategies	Outputs	Outcomes (Short & Long-Term)	Impact
What resources will enable the set of activities?	In order to address the issue, we will conduct the following activities. These activities are required to achieve our desired outcome.	These outputs should help monitor progress towards outcomes. Once completed or underway, the activities will produce the following evidence of service delivery.	We expect that if complete or ongoing, these activities will lead to the following changes in 1-3 years then 4-6 years	What is the goal of the program? What issue are you trying to address? We expect that if complete or ongoing, these activities will lead to the following changes.
<b>Example:</b> Human Resources: Nurse practitioner; Technology Resources: Electronic medical records	<b>Example:</b> Identify patients at risk (Accessing X service or with 3 or more co-morbidities); develop individualized action plans (for X patients)	<b>Example:</b> attendance of X staff at education program; X# patients enrolled per Y time in the program, electronic medication reconciliation (X patients per Y time)	<b>Example:</b> Example: Improved medication management, Decreased severity and duration of COPD exacerbation	<b>Example:</b> Reduce readmission frequency and duration for patients with COPD and multiple co-morbidity.



# Linking System Evaluation with Local Implementation

## External Evaluators:

- Can provide unbiased evidence regarding the development and implementation success of integrated care programs.
- Often have access and use of external datasets to identify and create 'comparator' cohorts / counter-factual information.
- Can bring expertise in advanced evaluation methods such as Developmental Evaluation, Realist Evaluation, Quasi-Experimental designs.
- Can co-design evaluation goals and objectives.
- May provide more robust results.

# Linking System Evaluation with Local Implementation

## Local Evaluation:

- Can quickly build trust through existing relationships.
- Can provide highly adaptive coaching on evaluation approaches (setting evaluation questions, developing logic models, determining data sources).
- Less expensive (in-kind resources).
- Easier access to local patient data (local use, not transferred)
- Needs to be an organizational priority.



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[integratedcarefoundation.org/ific-canada](http://integratedcarefoundation.org/ific-canada)



@IFICinfo



[ificcanada@integratedcarefoundation.org](mailto:ificcanada@integratedcarefoundation.org)

# Call for Papers Extended For This Audience! to 12 noon June 25<sup>th</sup>



 UNIVERSITY OF TORONTO  
DALLA LANA SCHOOL OF PUBLIC HEALTH

 Institute of Health Policy, Management & Evaluation  
UNIVERSITY OF TORONTO



**Innovation. Inspiration. Integration:**  
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with individuals and communities

In association with the 6th World Congress on Integrated Care





## ***Everyone is involved !***



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OHT.Evaluation@utoronto.ca



The Health System Performance Network



<https://hspn.ca/evaluation/ontario-health-teams>

## **Thank you!**