Model of Health and Wellbeing Evaluation Framework & Data Entry Manual

Presented by:
CHC Regional Decision Support
June 2015
• Model Evaluation Framework:
  ❖ Role of Model Attributes
  ❖ Results Based Logic Model
  ❖ Link to Data Entry Manual
  ❖ Data Standards
We make our Model evaluable by clearly describing our common approach to PHC and building a measurement framework that can be used to demonstrate our effectiveness.
Vision: Highest Quality, People and Community-Centred Health and Wellbeing

Values

• Health Equity and Social Justice
• Community Vitality and Belonging

Attributes

• Anti-oppressive and Culturally Safe
• Accessible
• Interprofessional, integrated and coordinated
• Community-governed
• Based on the determinants of health
• Grounded in a community development approach
• Population and Needs-Based
• Accountable and Efficient

Every One Matters.
Chaque personne compte.
Role of Evaluation Framework

- Suggests how our Model of Care is designed to achieve specific outcomes
- Supports local – program specific evaluation efforts:
  - drill-down to identify specific outputs, outcomes and indicators that are meaningful within the context of the program.
- Mandatory Data Identified in the Data Entry Manual informs at least one of the objectives.
Purpose
Statement
Values
Model of Health and Wellbeing
Attributes
Inputs
Activities
Outputs
Direct Outcomes
Intermediate Outcomes
Longer term Outcomes

Commitment to health through the lens of social determinants, community vitality and belonging, health equity and social justice.

Increased community capacity - building with empowered clients to address the determinants of health elements of their health needs.

Reduced risk, incidence, duration and effects of acute and episodic physical, social or psychological conditions.

Increased civic engagement and social capital.

Improved level and distribution of population health and wellness.

Improved capacity of communities to be involved in decision-making about their health.

Increased seamless delivery of services, appropriateness of time, place and interprofessional team through integration and coordination.

Improved functioning, health, resilience and wellbeing of individuals, families and communities.

Improved Health Equity across Sectors.

Reduced risk, incidence and effects of chronic diseases (e.g., diabetes, mental health & addictions) through health promotion.

Increased access for people who experience the greatest barriers to health.

Resources - Financial, Material and Human

Community Knowledge Synthesis - Community and client input, Needs assessments, Environmental scans

Client and community driven health care programs, services and initiatives with particular focus on those who face barriers to health.

Highest Quality, People and Community Centred Health and Wellbeing

Improve equity in access to CHC services by eliminating barriers and advocating for healthy public policy.

Reduce negative impact of SDOH on health and wellbeing of clients.

Volumes (aggregated #s of clients, group programs etc.)

How Many?

Types (interprofessional teams of primary health care, health promotion and community initiatives)

What?

Qualities (Interprofessional, Integrated and Coordinated; Accountable and Efficient; Population and Needs-based; Community governed; Community Development approach; based upon the Social Determinants of Health; Accessible; Anti-oppressive and Culturally Safe)

How?

Distribution and Engagement (priority populations e.g. seniors, homeless, racialized)

With Whom?

Accessible Interprofessional, integrated and coordinated Community governed Based upon the Social Determinants of Health Anti-oppressive and Culturally Safe Accountable and Efficient Community Development Approach Population and Needs-based

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From Logic Model to Evaluation

- Evaluation questions are organized by the Attributes (x8) of the Model
- Indicators are identified for each evaluation question that evaluate a Model output
- Questions & Indicators from:
  - Previous 4 CHC EFs
  - Sector consultation
  - PHC evaluation literature
How does it work?

• Domain #6: Anti-Oppressive and Culturally Safe

• Evaluation Questions:
  1. Do centre staff reflect the diversity of the community?
  2. Is the centre organized to support socio-cultural competency?
Question #1:
Do centre staff reflect the diversity of the community?

• Indicators:
  – % of staff that reflect centre priority populations (e.g., culturally, linguistically, etc.)
  – Evidence of culturally-specific programming
  – % of clients from vulnerable groups aligns with community % (also informs population needs-based planning)
Question #2:
Is the centre organized to support socio-cultural competency?

• Indicators:
  – Increase % of clients being offered services in their language of choice
  – Increase in % of encounters that involve discussion of a psychological or social issue (rather than only medical)
  – Evidence of staff education on social inequity or cultural safety
  – Client satisfaction stratified by DOH
Mandatory Data

- MUST be collected
- A field for mandatory data must not be left blank and must be accurately filled in

Required Data

- Should be collected when it is appropriate to do so.
- E.g. if a client was born in Canada, there is no need to enter a Date for Arrival to Canada. However, if the client was born outside Canada, then the arrival date is required.
- Required information is extremely valuable for analysis
- It is important that it be recorded whenever the opportunity arises to do so.

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Chaque personne compte.
<table>
<thead>
<tr>
<th>Data Field</th>
<th>Status</th>
<th>Indicator</th>
<th>Model of Health &amp; Well-being Domain</th>
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Recording information for combined Annual Household Income

From the Detailed Registration section, select the choice that describes the range of the annual household income. This range should reflect the income of all household members contributing to the household’s income.
Individual Service Events
<table>
<thead>
<tr>
<th>Data Field</th>
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<td>Accessibility</td>
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<td>Required</td>
<td>OHRS</td>
<td>Accessibility</td>
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<tr>
<td>Mode of Contact</td>
<td>Required</td>
<td>OHRS</td>
<td>Accessibility</td>
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<td>Time of Contact</td>
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<td>OHRS</td>
<td>Accessibility</td>
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<td>Reason for Visit</td>
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<td>Accountability and Efficiency</td>
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ISE Example - Importance of Required Data

Cultural Safety & Anti-Oppression

Recording information about the use of cultural interpreters

To calculate this indicator, providers must select the “Cultural interpretation” item as part of completing the Services and Languages Provided template.

Figure 1: Selecting "Cultural interpretation" from the Languages and Services Provided template.
Group Service Events
<table>
<thead>
<tr>
<th>Data Field</th>
<th>Status</th>
<th>Indicator</th>
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<tr>
<td>From</td>
<td>Required</td>
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<td>OHRS</td>
<td>Determinants of Health</td>
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<td>Group Lifespan</td>
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<td>Determinants of Health</td>
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<td>Nature of Group Membership</td>
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<td>Determinants of Health</td>
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<td>Timing of Sessions</td>
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<td>OHRS</td>
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<td>Plan</td>
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<td>Start / End Date</td>
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<td>OHRS</td>
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<td># from intended population who completed group</td>
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<td>Internal</td>
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<td></td>
<td></td>
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<td>Determinants of Health, Cultural</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Safety &amp; Anti - oppressive</td>
</tr>
<tr>
<td>Encounter Date &amp; Time</td>
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<td>OHRS</td>
<td>Accountability &amp; Efficiency</td>
</tr>
<tr>
<td>Location</td>
<td>Mandatory</td>
<td>Internal</td>
<td>Accountability &amp; Efficiency</td>
</tr>
<tr>
<td>Reason for Visit</td>
<td>Mandatory</td>
<td>Internal</td>
<td>Accountability &amp; Efficiency</td>
</tr>
<tr>
<td>Staff involved &amp; role</td>
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<td>OHRS</td>
<td>Accountability &amp; Efficiency</td>
</tr>
<tr>
<td>Headcount / attendance</td>
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<td>Accountability &amp; Efficiency</td>
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<tr>
<td>Outcome for each member of group</td>
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<td>Outcomes</td>
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</tbody>
</table>
Group Service Events Example – Objectives of Group

Determinants of Health

Recording information for combined Annual Household Income

Internal or Funder’s Indicator

Click the Add Objectives button from the Manage Group Programs window. Select the objectives for your group from the list. Click the Add button.

- Description
- change in behaviour
- developing strengths or talents
- enhancing lifestyle or the quality of life
- identifying or improving potential
- improving health
<table>
<thead>
<tr>
<th>Sector Commitment</th>
<th>Indicator</th>
<th>Possible Data Field/s (not all Mandatory Data is shown here but should be included)</th>
</tr>
</thead>
</table>
| Expand the number of people we serve who face the greatest barriers to accessing health services | MSAA Access to Primary Care | • Issues Addressed  
• Insurance Status  
• Postal Code  
• Date of Contact  
• Procedures  
• Services |
| Commit to serve the “1-10%” of the population AKA the heavy users of the acute care system | Increase in the ratio of social v medical issues addressed during encounter (Process Indicator) | • Type of contact  
• Mode of contact  
• Issues Addressed  
• Services provided |
| Continue to work with partners in the community support and mental health and addiction organizations to review and coordinate services | % of centres that offer: (P)  
a) liaison with home care or;  
b) the provision of home care services | • Referrals Made  
• Location of contact  
• Mode of Contact  
• Issues Addressed  
• Reason for Visit |
## Sector Commitments (cont’d)

<table>
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<th>Sector Commitment</th>
<th>Indicator</th>
<th>Possible Data Field/s (not all Mandatory Data is shown here but should be included)</th>
</tr>
</thead>
</table>
| Ensure all members of the inter-professional teams are working to full scope of practice | % of clients accessing interdisciplinary teams by type of providers | • Client Socio-demographics (stratify for health equity measures)  
• Type of contact |
| Ensure all those served receive system navigation and care coordination across the health and social services systems | Reduced unnecessary hospital admissions | • Issues Addressed  
• Insurance Status  
• Postal Code  
• Date of Contact  
• Procedures  
• Services  
• Reason for visit |
| Timely Access and Extended Hours | % of encounters that occur during evenings or weekends | • Day of contact  
• Time of contact |
Data Entry Manual

• Mandatory and required data
• Major sections:
  ▪ Client Registration
  ▪ Individual Service Events
  ▪ Personal Development Groups
  ▪ Reporting Indicators
  ▪ Glossary

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Cervical Cancer Screening Among Income Groups in Ontario CHCs

- Greater than $60,000: 19% received, 23% eligible but not received
- $40,000-$59,999: 14% received, 15% eligible but not received
- $35,000-$39,999: 5% received, 5% eligible but not received
- $30,000-$34,999: 5% received, 5% eligible but not received
- $25,000-$29,999: 5% received, 5% eligible but not received
- $20,000-$24,999: 7% received, 6% eligible but not received
- $15,000-$19,999: 10% received, 9% eligible but not received
- 0-$14,999: 34% received, 31% eligible but not received

- Eligible for PAPs (but did not receive)
- Clients that received PAPs
Community Health Centres
Equity data Example
So when will it be ready???

NOW

- PMC-approved and shared with ED Network in May 2015

Most recent version on AOHC portal
THANK YOU

Cooperative work of many:

- Data entry manual development and reviewing
  - Data Quality Working Group members, Konnie Maxfield, Wael Jalal, Jesse Cocjin, Rima Al Dajani, and Jack Cooper
  - DMCs, Liz Vanderhorst, Avi Kant, and Neil Mentuch; Gina Palmese (SW LHIN)
- RDSSs
  - Arron Service, Rachelle Arbour Gagnon, Jennifer Rayner, Nancy LaPlante
- Christine Randle, Provincial DMC, AOHC
- And many others...