Operationalizing Evaluation Strategy

1. Identify key:
   - Process phases;
   - Information required to move forward;
   - Decision points.

2. Develop living work plan;

3. Develop tools to support movement through work plan;

4. Engage your stakeholders across all phases.
Developed stakeholder packets to provide project summary information to all stakeholders, including:

1. Executive summary;
2. Logic model;
3. Project slide summaries describing DSRIP metrics, MLIU%;
4. Budget;
5. Formal assessment and stakeholder feedback tools to drive discussion around sustainability planning.
At the logic model repair shop ...

So, I'm guessing this is for a comprehensive program-level intervention.

Mother Goose Logic

You're right, after thinking it through, I'm not sure how the one leads to the other.
Logic Models

1. Find a template online that works for you or create your own;
2. Ensure the template is in a user-friendly format;
3. Conduct at least one training to ensure definitions/process are clear;
4. Person or team with greatest knowledge of project details should be responsible for logic model completion;
5. Logic model should fit on one page.
### Palliative Care

<table>
<thead>
<tr>
<th>Regional Vision</th>
<th>Create a coordinated healthcare system where good health is achievable for all people across the region.</th>
</tr>
</thead>
</table>
| DSRIP Goals     | 1. Improve individual experience of care  
2. Improve health of populations  
3. Reduce per capita cost of care |
| DSRIP Objectives| Improve care quality  
Improve patient health status  
Improve patient experience  
Improve care coordination  
Improve care cost-effectiveness  
Increase access to care  
Improve population health  
Improve system infrastructure |
| Project Goal    | To create a new palliative care (PC) program devoted to providing palliative care to patients through a serious illness that may be chronic, terminal or acutely debilitating. |

1. **Regional Vision**: specific to your RHP  
2. **DSRIP Goals**: triple aim  
3. **DSRIP Objectives**: from HHSC 1115 waiver website  
4. **Project Goal**: specific to your project; could be a SMART goal.
## Inputs

- **What resources are required to perform activities?**
  - Staff
  - Time
  - Money
  - Partners
  - Facilities
  - Equipment
  - Software

- **Focus on what you think is important.**
  - Don’t drive yourself crazy with too much detail!
## Breaking Down Logic Models

### Activities
- Using the stated resources, what activities are performed to create (measurable) outputs?
- What activities are performed to support the project goal?
- Exclude administrative activities that have no outputs relevant to your intended outcomes
- Activities that drive the same output should be grouped

### Outputs
- What are the direct, measurable products of the activities?
- What quantifiable products demonstrate that you completed your activities?

<table>
<thead>
<tr>
<th>Activities</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using the stated resources, what activities are performed to create outputs?</td>
<td>Number of training/educational sessions</td>
</tr>
<tr>
<td>Provide training to primary care and specialty practice physicians, nurses and case managers regarding palliative care concepts</td>
<td>Number of palliative care consults satisfaction survey responses</td>
</tr>
<tr>
<td>Provide patient and family/caregiver consults (including assessments and education)</td>
<td>Number of PC patients with symptom management</td>
</tr>
<tr>
<td>Provide symptom management (pain, nausea, mood changes, etc.)</td>
<td>Number of patients with documentation of family meetings</td>
</tr>
<tr>
<td>Provide family/caregiver support to help prevent “caregiver syndrome”</td>
<td>Number of patients with documentation of treatment preferences</td>
</tr>
<tr>
<td>Ensure documentation of treatment preferences for life-sustaining treatments</td>
<td>Number of patients with coordinated care</td>
</tr>
</tbody>
</table>

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### Short-term Outcomes

- What immediate changes in knowledge, skill, attitude or motivation result from your defined outputs?

### Intermediate Outcomes

- What changes in behavior or decision-making result from your defined short-term outcomes?

### Long-term Outcomes

- What changes in social, political, administrative conditions or perceptions result from intermediate outcomes?

- What is the impact of your project?
## Breaking Down Logic Models

### Example of how the components relate:

<table>
<thead>
<tr>
<th>Activities</th>
<th>Outputs</th>
<th>Short-term Outcomes</th>
<th>Intermediate Outcomes</th>
<th>Long-term Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide training to primary care and specialty practice physicians, nurses and case managers regarding palliative care concepts.</td>
<td>What are the direct products of the activities (usually quantifiable)?</td>
<td>What immediate changes in knowledge, skills, and attitude result from activities/outputs?</td>
<td>What changes in behavior, decision-making, policy result from outputs/short-term outcomes?</td>
<td>What changes in social, political, administrative conditions or perceptions result from outputs/intermediate outcomes (impact)?</td>
</tr>
<tr>
<td>Number of training/educational sessions</td>
<td>Provider/Patient Level</td>
<td>Increased provider knowledge of palliative care services</td>
<td>Increased identification of patients with early stage serious illness</td>
<td>Enhanced quality of care</td>
</tr>
<tr>
<td>Number of training/educational sessions</td>
<td>Increased education on the benefits of palliative care among providers</td>
<td>Increased provider utilization of palliative care services</td>
<td>Improved patient family quality of life</td>
<td></td>
</tr>
<tr>
<td>Number of training/educational sessions</td>
<td>Measurement/Indicator</td>
<td>Number of provider training/educational sessions, Providers survey (pre/post), Annual competency</td>
<td>Number of patients with a serious illness who were screened for palliative care eligibility, Number of PC consults requested (by referral source)</td>
<td>Improved patient outcomes</td>
</tr>
<tr>
<td>Number of training/educational sessions</td>
<td>Measurement/Indicator</td>
<td>Number of provider training/educational sessions, Providers survey (pre/post), Annual competency</td>
<td>Number of patients with a serious illness who were screened for palliative care eligibility, Number of PC consults requested (by referral source)</td>
<td>Number of patients with comprehensive pain assessments, Number of patients with documentation of treatment preferences, Decreased potentially preventable readmissions (due to lack of symptom management)</td>
</tr>
</tbody>
</table>
Next Steps

- Continue to engage stakeholders
- Identify key metrics for measurement
- Resource assessment and prioritization
- Measurement
- Ongoing process improvement
- Ongoing sustainability planning