

Evaluation Module

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Evaluation Module

Evaluation Module—Objectives

At the end of this session, participants should be able to:

- Describe 4 levels of outcomes in an evaluation framework
- Develop a plan for evaluation of the care coordination curriculum
- Identify practical tips for using data generated from an evaluation

Introduction

Measuring the effectiveness of the care coordination training is a key part of its success. Perhaps it is necessary to show that the curriculum is effective in order to receive or maintain funding support. At a minimum, it is important to learn about what does and does not work well so that improvements can be made for future trainings. Regardless of how the results are used, it is important to build an evaluation plan into the curriculum from the start.

Following are some basic principles for evaluating a curriculum:

- Keep it short and simple to reduce the burden on participants and to ensure that most learners complete the evaluation—this means only asking what is necessary.
- Allow participants to say what is important to them—this means including some open-ended questions or response options.
- Identify the stakeholders—learners and their supervisors or organizations, the facilitator’s supervisor or organization, or those who are providing financial or other resources to conduct this training—and what is important to them. They may all have different opinions about the goals for the training, what they want to get out of it, and how they define success. Make sure to get their perspectives and find some way to capture the information that will help them to determine whether or not the training was successful.

This module discusses a framework for evaluating training and practical how-to tips for creating, implementing, and utilizing data from a personalized evaluation plan for the care coordination curriculum. Please be aware that if this module is being implemented, it is crucial to include local-, state-, and region-specific content. The curriculum authors recommend identifying local needs and priorities wherever an **L** is indicated in the curriculum. The role of the facilitator is to solicit input from all of the key stakeholders of the curriculum to identify these priorities in support of evaluating the impact of the curriculum and its implementation.

Identifying Outcomes for the Evaluation

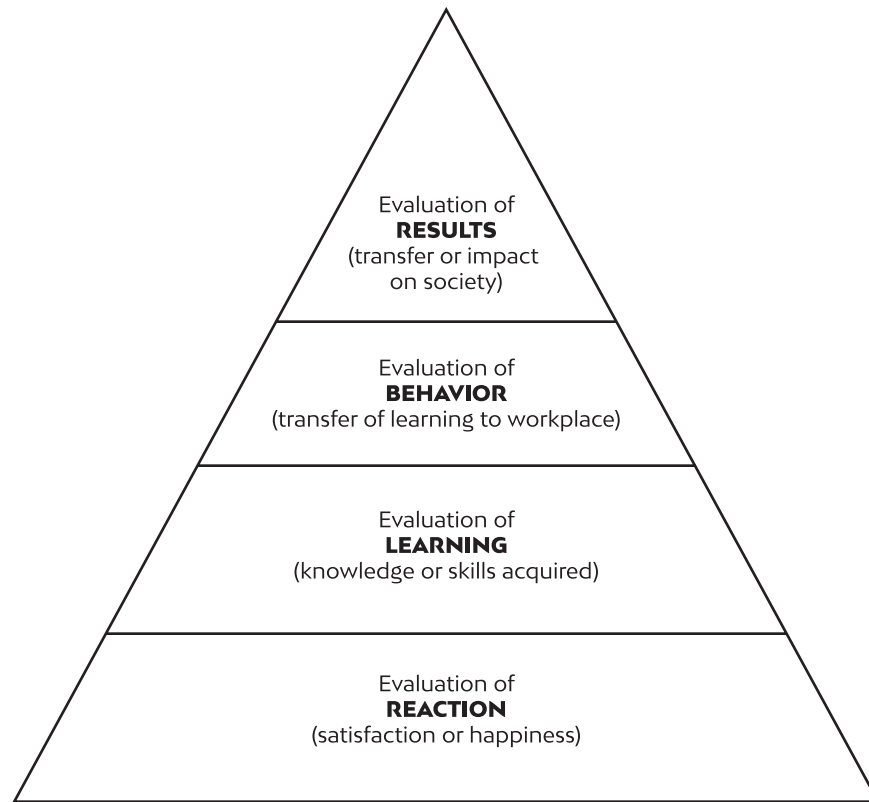
A comprehensive evaluation plan can help identify whether changes have occurred for the learners after participating in a training program¹. The Kirkpatrick model provides a practical approach for evaluating learner-related outcomes² and encourages facilitators to consider outcomes beyond learner satisfaction. Consider the following types of outcomes when developing an evaluation plan:

Satisfaction	<ul style="list-style-type: none">• What is the learner's reaction to the training?• Did he or she think it was a valuable learning experience?
Learning	<ul style="list-style-type: none">• Have the learning objectives been met?• Has there been a change in learner knowledge, skills, or attitudes?
Behavior	<ul style="list-style-type: none">• Has the learner applied the acquired knowledge or skills beyond the training session?• Has there been a change in learner behavior on the job?
Results	<ul style="list-style-type: none">• What is the impact of the training program?• Has there been a change in clinical outcomes, patient and family experience, health care utilization and cost, team performance, etc.?

Identifying Outcomes for the Evaluation

continued

The Kirkpatrick model³:



Evaluating higher levels of outcomes is more challenging but is often critical for making meaningful, sustainable improvements to care delivery. Levels 3 and 4 require follow-up after the training session—perhaps weeks, months, or a year or more later—in order to identify changes in behavior and outcomes of the initiative to implement care coordination tools, measures, and processes. Some of these outcomes may include patient and family experience as well as utilization measures, such as unplanned hospitalizations, emergency department visits, and the number of care coordination encounters, to name a few. Choosing what to measure has profound implications for sustainability. Be mindful that experiential data may be solicited from stakeholders who did not attend the training. For example, if the tools of care coordination are implemented following the training, it is reasonable to ask families 6 months after the training whether care processes are more coordinated and integrated than before. In sum, when developing an evaluation framework for the Pediatric Care Coordination Curriculum, consider each of these 4 levels of outcomes in the context of local resources, improvement priorities, and stakeholder interests.

Creating and Implementing an Evaluation Plan

First, identify WHAT information is needed.

Types of information include:

- Characteristics of the participants
- What the participants did or did not like about the training
- What the participants learned or anticipated the impact to be
- What the participants did with the information or how their behavior changed
- What the impact of the training program has been
- What the change has been in clinical outcomes, patient and family experience, health care utilization and cost, and/or team performance

Second, identify WHEN to collect evaluation data.

The best times to collect data are:

- Before the training if there is a plan to measure a change in knowledge or behavior from before to after the training or to become familiar with who the learners are
- Right after the training to measure change in knowledge and/or to measure reaction to the training*
- At a later date to measure knowledge retention, behavior change, and/or patient-related outcomes (Set a follow-up point that is far enough in the future to give people enough time to make behavior changes but close enough to the end of the training to be able to reasonably claim that the change may be due to the training. Common follow-up points tend to be about 3–6 months later.)*

Third, identify from WHOM information needs to be collected.

This may include:

- Learners who attended the curriculum training
- Patients and families (Please see Module 4 for performance indicators and measurements that capture patient- and family-reported experiences and outcomes.)
- Other care coordination stakeholders who may not have attended the curriculum training

Creating and Implementing an Evaluation Plan

continued

***TIP:** If responses from 2 or more points in time need to be linked to individual participants but respondent anonymity is necessary, then a unique ID can be generated for each participant by asking all of the participants the same questions at every evaluation point. The questions should generate answers that will not change between evaluation points. For example:

- What are the first 3 letters of the city in which you were born? _ _ _
- What is the 2-digit number for the day of the date you were born? _ _

Someone born in Boston on March 7 would answer BOS and 07 to these questions and have the unique ID BOS07. This will link their responses on multiple surveys where they were asked the unique ID questions.

Create the questions that will be used to collect the necessary information.

Sample questions about the characteristics of the participants:

What is your role in your practice?

- Administrative assistant
- Care coordinator
- Clinical manager
- Nurse
- Nurse practitioner
- Office manager
- Physician
- Other: _____

How many years have you been in this role? (counting previous practices where you were also in this role)

- 0-5 years
- 6-10 years
- 11-15 years
- More than 15 years

Are you involved in any of the following care coordination activities in your practice? (check all that apply)

- Conducting patient and family needs assessments and/or goal setting
- Creating care plans
- Coordinating appointments with other providers or for diagnostic testing
- Communicating with other providers about shared patients
- Facilitating care transitions (eg, to new providers or to adult services)
- Connecting patients and families with community resources and/or schools
- Helping families to access benefits or authorize services
- Other: _____
- None

Creating and Implementing an Evaluation Plan

continued

Sample questions about what the participants did or did not like about the training:

How was the amount of information presented in this session/module?

- Too much
- Just the right amount
- Too little

How was the pace of this session/module?

- Too fast
- Just right
- Too slow

To what extent did this session/module meet your expectations?

- A great extent
- Some extent
- A little extent
- Not at all

How would you rate the quality of the following components of this session/module?

The didactic presentation?

- Excellent
- Very good
- Good
- Fair
- Poor

The cases?

- Excellent
- Very good
- Good
- Fair
- Poor

Working with the small group?

- Excellent
- Very good
- Good
- Fair
- Poor

The large group discussion?

- Excellent
- Very good
- Good
- Fair
- Poor

Creating and Implementing an Evaluation Plan

continued

What was the most valuable thing you learned from this session/module?
(open response)

What is something about this session/module that could be improved?
(open response)

Determine how to capture what the participants learned or what they anticipate the impact of their new knowledge will be.

To capture changes in knowledge, formulate some sample knowledge questions that could be asked right before and right after each session/module.* Preferably, the questions will align with the learning objectives for each module and be of strategic priority for the learners (eg, improving measurable quality outcomes, improving patient and family engagement, or optimizing outcomes in value-based contracting). To measure retention of knowledge, these questions can be asked again at a later follow-up point.

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***TIP:** One of the biggest challenges to writing good knowledge questions is minimizing the chances that people can guess the right answers, which can cause problems for evaluation results. The first problem with good guessing is that it generates inaccurate data—participants may have learned less than what the data suggest. Without accurate data, it will be difficult to determine what about the program works well and what needs to be fixed—important reasons for conducting an evaluation. The second problem is that good guessing makes it difficult to show improvement in participant knowledge between assessments conducted before and after the training. For example, if a participant answers 93% of the questions correctly on a pre-session assessment, then there is very little room for improvement with a post-session assessment, making it difficult to demonstrate that the training has added value. In addition, participants could answer most of the questions correctly on the pretest because they are typically based on common knowledge rather than the new knowledge imparted through the training.

Short cases or scenarios provide useful information for creating application questions. For example, in a few sentences, describe a situation that would feel realistic to the learners then ask a follow-up action question, such as: “What should (person in the case) do next?” An example of an information question is: “What strategy would be most effective for helping this family resolve its situation?” When developing the response choices, the correct answers should reflect key learning points that will be made in the training. At least one of the incorrect answers should reflect common mistakes or misperceptions that people have.

Creating and Implementing an Evaluation Plan

continued

Following are examples of case-based questions for each module within the Pediatric Care Coordination Curriculum:

Module 1

You are working in a primary care clinic that regularly performs developmental screenings. You refer patients to the local early intervention (EI) agency whenever they screen positive. You do not know how many of those children end up accessing services. What is a potential next step?

- a) I do not need to make any changes since I will check on the status of the child's development at the next health maintenance visit in a year.
- b) I always rely on the parents to let me know if they have concerns about the referral to EI.
- c) I can use a tool that outlines my concerns about the child's developmental screen to the EI agency and track receipt of the EI report back to my office.
- d) Since I do not get paid to track EI referrals, there is nothing I can do about this.

Module 2

Your daughter has many long-standing medical conditions, and as a result, you spend many hours ensuring she gets the best possible care. Her pediatrician and several (but not all) of her pediatric medical subspecialists have often called her a "child with special needs." On more than one occasion, tasks that you were told were supposed to occur did not occur. These gaps in care required you to reschedule appointments, pull your daughter out of school extra days, and miss work. You appreciate how hard each of the team members caring for your daughter works, but you are often unsure about whether they work together on your daughter's needs. You feel nervous about telling each of the team members that you want them to collaborate more effectively. You know they are really busy, and you do not want them to get the impression that you are ungrateful. What is a potential next step?

- a) Identify at least one member of your daughter's care team with whom you have a trusting relationship and share your experiences of care with specific examples. Ask this individual to support you in sharing this message with all members of the care team.
- b) Send a letter to the chief of the hospital.
- c) Send anonymous information after your next visit, using the satisfaction survey you get after each visit.
- d) Remove the whole team and find new physicians.

Creating and Implementing an Evaluation Plan

continued

Module 3

Over the past month, several of your patients presented to the emergency department with asthma exacerbations. You work in a community health center, which predominantly serves a low-income community. Many of your patients live in housing projects located 45 minutes away by bus. All patients and caregivers receive routine education about the prescribed asthma medications and have established asthma action plans. What is a potential next step to reduce the number of emergency department visits due to asthma exacerbations?

- a) Continue to deliver the patient education as recommended by national guidelines.
- b) Ask the caregivers about their housing, transportation, utility, food, and safety needs.
- c) Hire an asthma educator for the practice.
- d) Refer the caregivers to a social worker.

Module 4

You are developing a referral system to connect pediatricians and other physicians, pediatric medical subspecialists, pediatric surgical specialists, and regional services for children with complex medical needs. You are implementing a pilot in a subset of local clinics and hope to eventually scale up to serve all children in the region. What is a potential next step as you prepare for pilot implementation and eventual scale-up of the referral system?

- a) Identify what you need to measure to demonstrate the need for and value of your new referral system, and select measurement tools accordingly.
- b) Hire a new nonclinical staff member to manage all referrals to free up time of physicians and nonphysician clinicians.
- c) Implement, without modification, a referral system that has been shown to be effective in other regions.
- d) Ask insurers to pay for care coordinators at the outset.

Module 5

You are seeing a 6-year-old patient for the first time in your clinic. He is brought in by his parent who asks you to consult on what the child's school is calling a lack of attention span. After your thorough history and physical, you recommend using a validated, standardized screening tool in the home and school to inform your final diagnosis and subsequent treatment plan. What are potential next steps to provide coordinated care for this patient?

- a) Have the parent complete the screening tool at home and mail other forms to the school to complete.
- b) Utilize a web-based, secure platform by which assessment data can be shared among members of the family-designated care team.

Creating and Implementing an Evaluation Plan

continued

An added benefit to having case-based questions on a pretest is that they cue the learners to some of the important points of the training, increasing the chances that they will absorb that knowledge during the training. Case-based questions also prime the learners to think about ways in which the information presented in the training will be relevant to their work.

To measure anticipated impact, consider asking a single, open-response question, such as: “How might your team or individual work change as a result of this session/module?” Another option is to ask a set of specific questions similar to the following:

How likely are you or your team or institution to implement the (care coordination processes, tools) discussed in this module/session?

- Very likely
- Somewhat likely
- Somewhat unlikely
- Very unlikely

Note: When asking this question, replace the italicized section with a specific process or tool taught in the module/session being evaluated. Ask this question multiple times to cover the multiple processes or tools discussed in the module that could be implemented by the participants. Consider focusing on processes or tools that align with the priorities of the learners.



Determine what the participants did with the information or how their behavior changed.

To measure behavior 3 months (for example) after the training, ask participants about what new processes or tools were implemented in the 3 months since the training. Ask specifically about processes or tools that were addressed in the training itself. Following is an example:

Did you begin implementing any of the following care coordination processes or tools in the last 3 months? (check all that apply)?

- Process/tool #1
- Process/tool #2
- Process/tool #3 (etc.)
- Other new care coordination process or tool _____
- No new care coordination process or tool was implemented in the last 3 months

Facilitators may focus on processes or tools that align with the priorities of the learners.



Creating and Implementing an Evaluation Plan

continued

To measure change in the behavior or roles of individual participants, re-ask participants about their care coordination activities and compare their answers to the ones they gave at baseline (with the goal being that they are now involved in more activities).

In the past 3 months, have you been involved in any of the following care coordination activities in your practice? (check all that apply)

- Conducting patient and family needs assessment and/or goal setting
- Creating care plans
- Coordinating appointments with other providers or for diagnostic testing
- Communicating with other providers about a patient you share
- Facilitating care transitions (eg, to new providers or adult services)
- Connecting patients and families with community resources and/or schools
- Helping families to access benefits or authorize services
- Other: _____
- None

What Next? Utilizing Evaluation Data

Evaluation data can provide important information about the program and help to make it the best possible program for the learners.

1) Evaluate the evaluation data as it arrives

For example, do not wait until after all of the follow-up data has been collected to compare it to baseline data. Check it along the way. What percentage of participants completed the evaluation? If it is low, consider rethinking the plan, such as the amount of time given to people to complete the evaluation or the length of the survey. If there are specific questions that are frequently skipped, they may not be relevant or clear.

2) Summarize the data by calculating the counts or percentages for each closed-ended question response

Look through the open-ended questions and try to identify themes. This second process is best done by having at least 2 people look through the open responses separately then convene when they are done to compare opinions about the themes they discovered from the responses.

3) Interpret the findings

What important lessons for the program are in the summarized data? This process is also best done by having at least 2 people look at the results and make independent conclusions. If possible, the conclusions could be shared with the learners to see if the important takeaway points match what they experienced. That time could also be used to ask the learners for additional feedback or suggestions for program improvement.

4) Apply the learned lessons

What changes can be made to the program to address suggestions by the learners for program improvements or any identified concerns, such as ongoing knowledge gaps, ways in which the facilitator and the learners did not develop a shared understanding of the content, or less-than-expected practice or behavior changes? If there is only one cohort of learners with whom the training will not be repeated, the evaluation data might inform the content of a booster session or follow-up materials for those learners. The evaluation data will also indicate what went well to keep for the next time there is a training session. This positive data could be shared with stakeholders who might be responsible for sending new learners or providing financial or other resources for the next training session.

Conclusion

The purpose of an evaluation is to determine whether the training met its goals. Whatever the goals are for the facilitator, learners, or other stakeholders, without a formal evaluation it is difficult to fully understand how effective the training was. With some careful planning ahead of time, a few well-chosen evaluation questions can generate a wealth of information, setting the training up for success.

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