Qualitative evaluation in a positivist landscape

Evaluation of the NSW Stroke Reperfusion Program

AES International Evaluation Conference 2016

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Collaboration.
Innovation.
Better Healthcare.

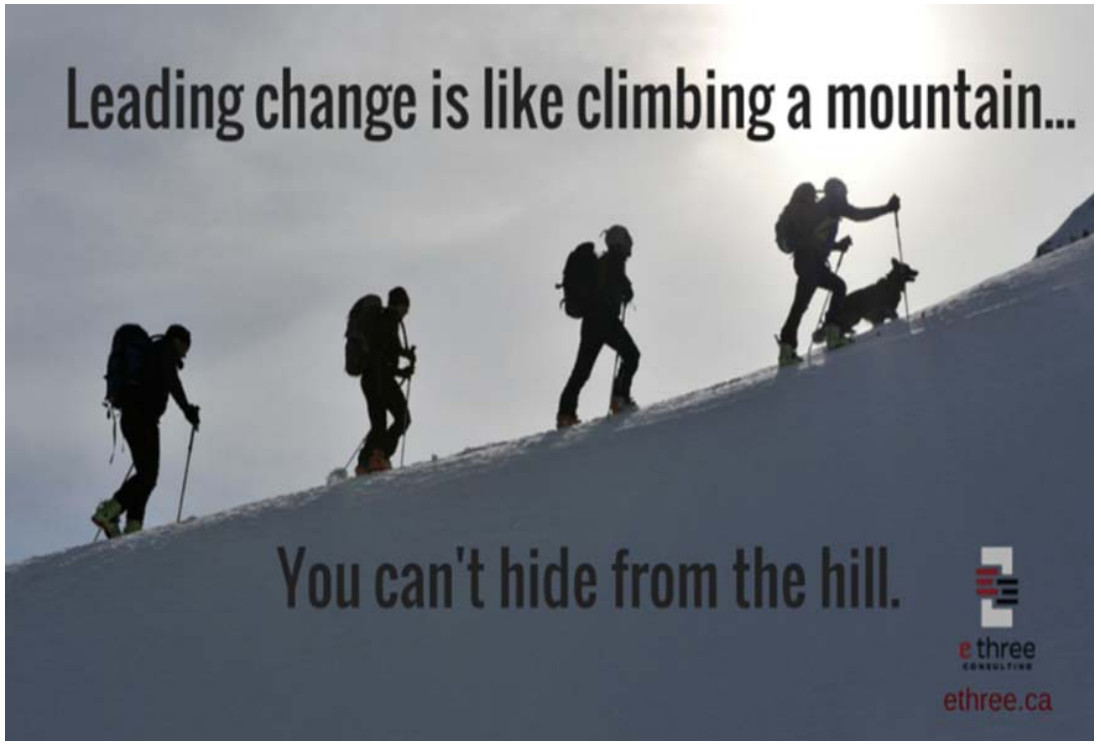
The landscape to be prevailed

Acute care – critically ill patients

Clinical efficacy

Randomised controlled trials & experiments

Doctors are innovative



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Stroke Reperfusion Program

Thrombolysis - clot busting drug – ischaemic stroke

Time critical – decline in efficacy for up to 4 hours from time of onset

Serious contraindications if used after 4 hours

Collaboration between Ambulance NSW and NSW Health

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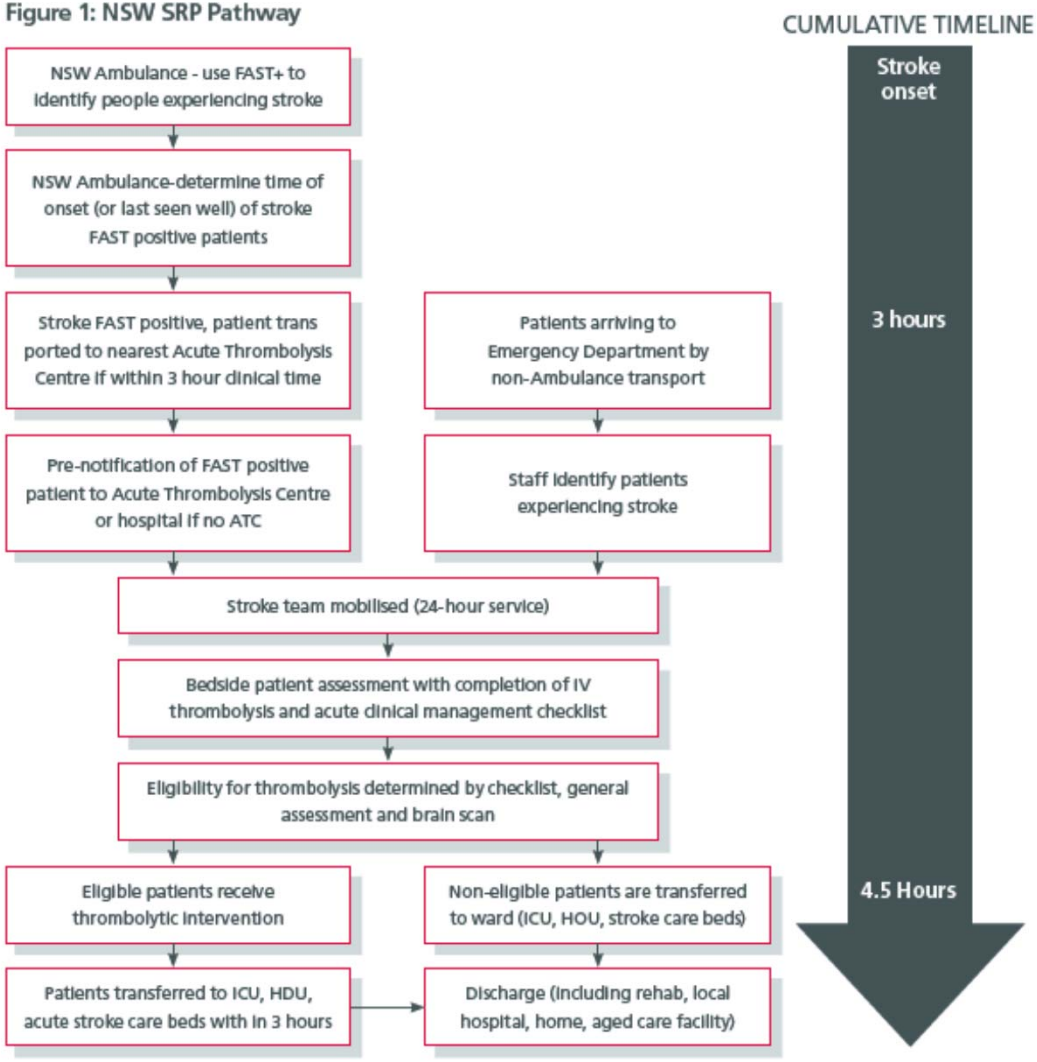
Figure 1: NSW SRP Pathway



- In 2012/13, there were almost 15,000 episodes of stroke in NSW
- 18 sites across NSW are formal Stroke Reperfusion (thrombolysis) Centres
- Patients at these dedicated sites had only a slightly higher length of stay and yet higher complexity compared to the NSW average (maybe indicative of effective stroke care)

Challenges

Acute care, positivist landscape prevailing

Thrombolysis is not coded! Can't identify patient cohort

Each site collected different data in different format

Self assessment format – yes/no format

Agreement across site on outcomes to measure with no data to measure those outcomes

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So, what to do?

Three phase evaluation:

1. descriptive, qualitative: design, implementation fidelity and delivery, facilitators and inhibitors to success – patients, systems, staff (data capture assessment)
2. Outcomes of SRP sites compared to non-SRP sites (QALYS, DALYS)
3. Impact including economic appraisal

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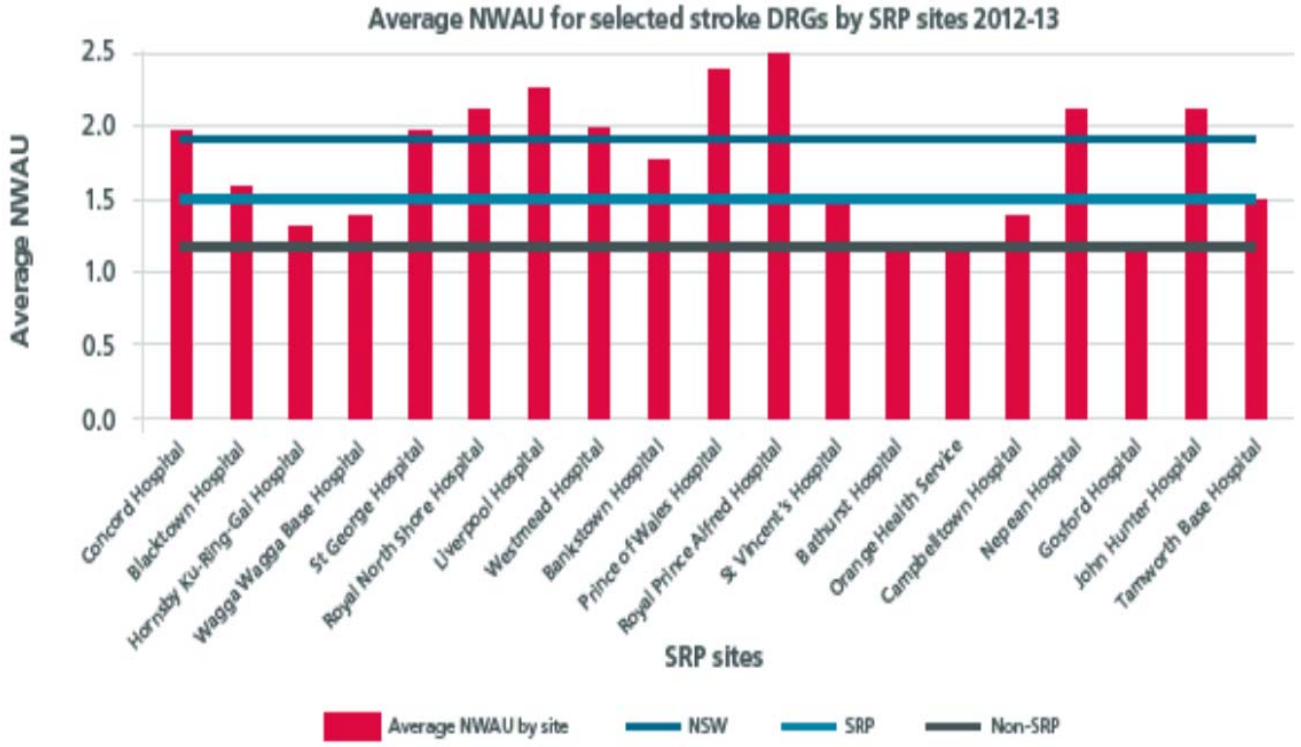
Still no buy in……

Discussion of descriptive analysis at state and site level

Promoted discussion

Promoted interest

Promoted suggestions



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And considerations…

> As the growth in volume started to occur before the formal implementation of the SRP, care needs to be taken in terms of attribution. A number of factors may have influenced this including the establishment of stroke units prior to the SRP, differences in access to post-acute care, consolidation of stroke patients in formalised stroke units and transfer patterns at non-stroke unit hospitals. Detailed work around attribution will occur in the next evaluation stages.

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Capacity building

Difference between evaluation and research (source: Helen L. Chen)

Program evaluation – not performance management and indicators

Value of formative evaluation for improvement – but not the only stage that we will do!

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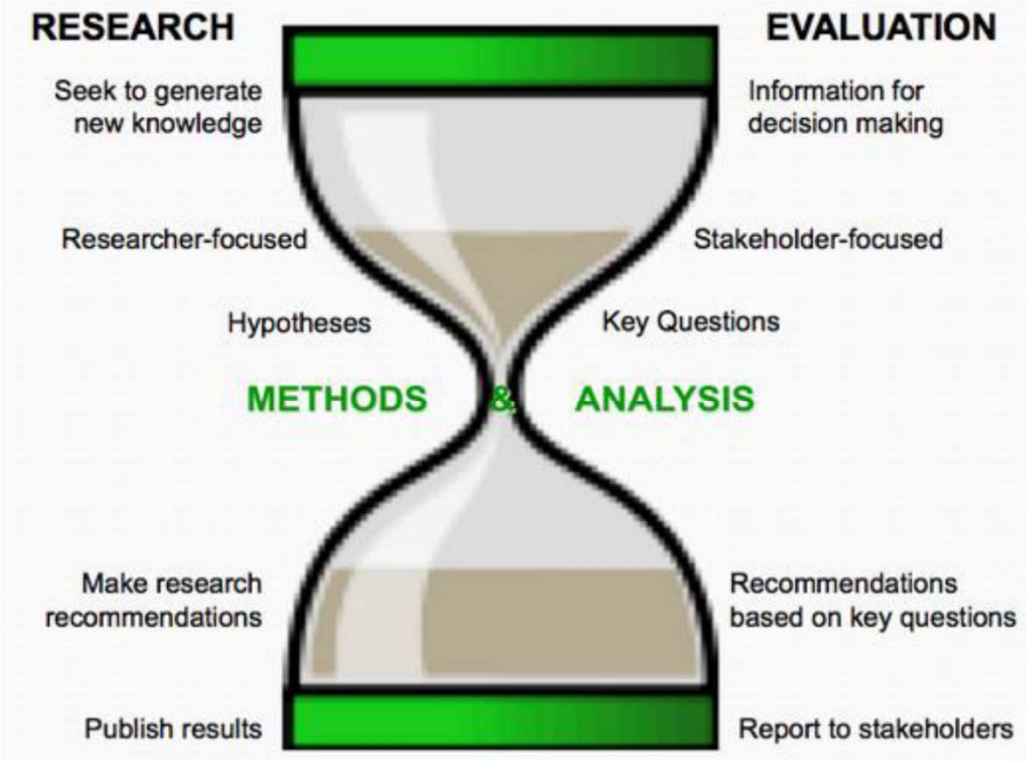
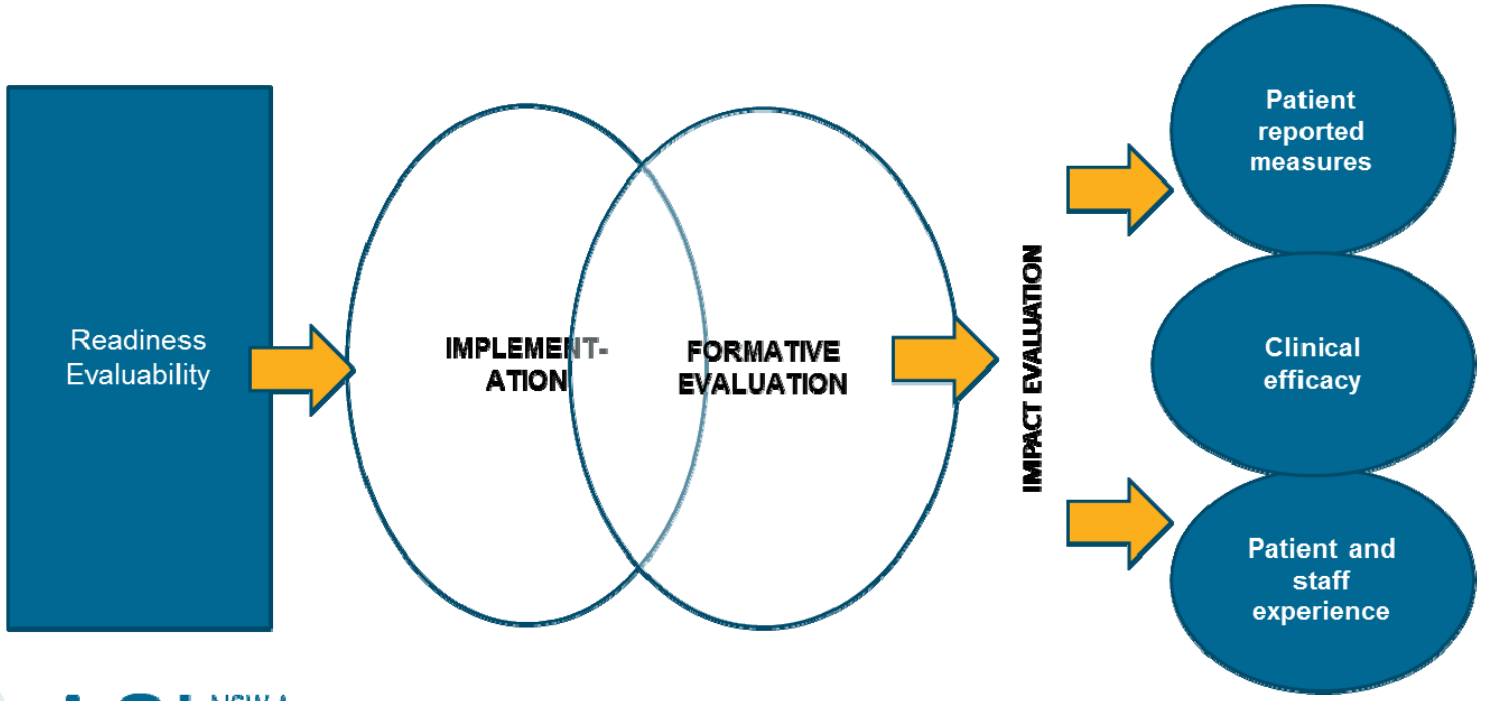


American Evaluation Association - http://aea365.org/blog/?p=222

Stages and foci



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Commence buy in…

Co-design

So what do we want to know?

Differences between metro and rural sites (inductive interviews, patient walk throughs, self assessment audits, surveys)

What is the patient carer experience in this? (patient experience trackers)

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Methods – explicitly articulated

Interviews: verbatim transcripts, data reduction, quantum grids! (SHHH….)

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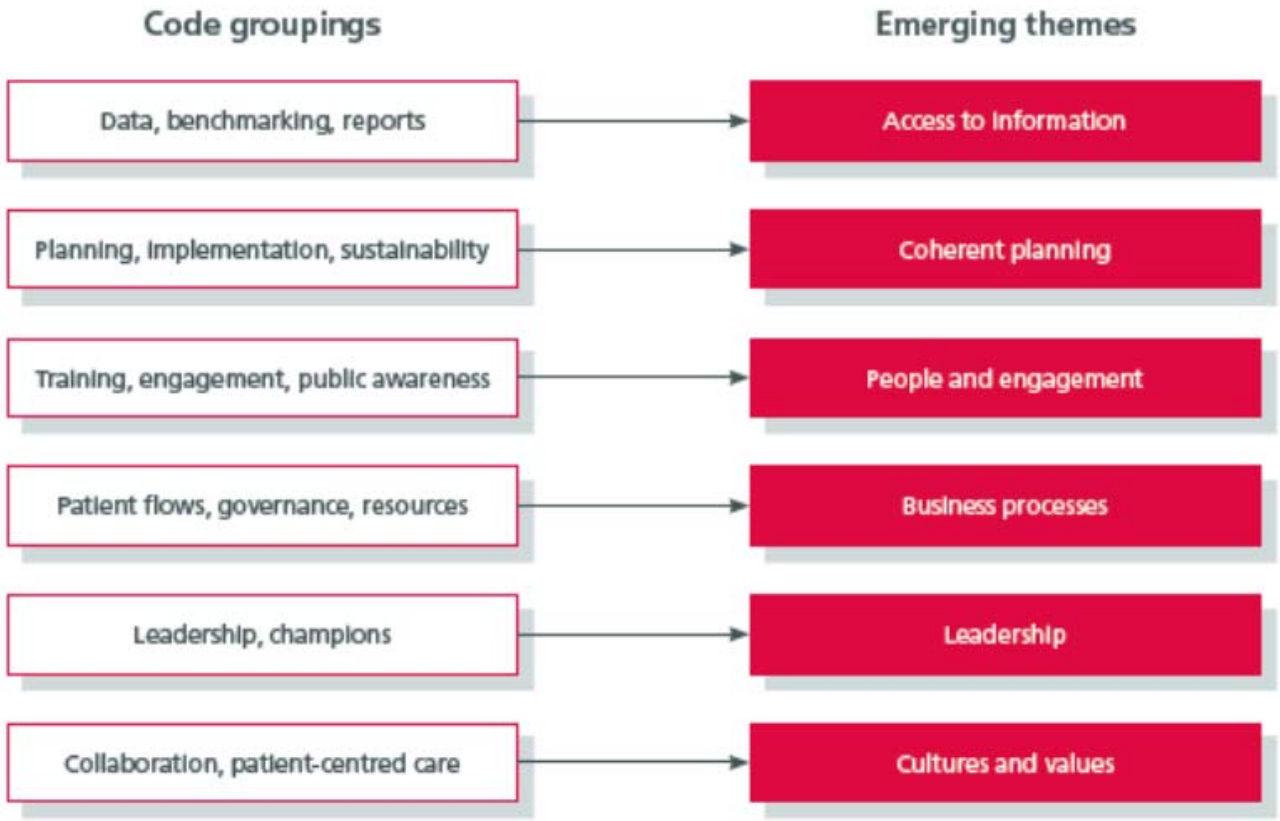

Emerging themes	Issues raised	Number of responses
Access to information	Statewide consistency needed	18
	Ability to benchmark and share knowledge transfer	5
	Data collection system mandated	4
	Provision of ASNSW FAST+ data	4
	Data collection established prior to program commencement	3
	Lack of ability to identify thrombolysis patients in administrative datasets	4
Coherent planning	Limited impact of implementation	8
	Pre-notification improved timeliness of treatment	4
	Support for program delivery and sustainability required	4
People and engagement	Need for a public awareness and training campaign about stroke systems and time-critical treatment	3
Business processes	Models of care to comprise key performance indicators (KPIs) rather than processes to enable flexibility	3
	Difficulty in timely transfer to ward	4
Leadership	Perceived leadership of an evidence-based program (HNE)	5
	Local champions and leaders	3
	District-wide leadership and coordination	3
	ACI and ECI leadership in promoting thrombolysis as standard care for stroke	4
Culture and values	Positive relationships with ASNSW	3
	Adopting a patient-centred approach to stroke care	3

Lots of engagement

> EDs and people who are seeing acute patients don't like to collect data for data's sake unless it's going to drive their processes.

> The bigger hospitals, they have the formal meetings. The smaller hospitals, they have a cup of coffee and know what's happening in ward 5.

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Feedback loops

Descriptive statistics sent to sites and Ambulance NSW for comment

Analysed draft findings from interviews, surveys, audits and patient experience trackers sent to sites

Final findings used to workshop recommendations

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Key findings

Different practices around imaging

Within and after hours care

Remote reading of imaging

Visiting Medical Officer knowledge

Feedback loops for Ambulance required

Data data data

Access to medication

Stroke team activation

Patients and carers – didn't do too well on tracking this

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REPORT: Results from Evaluation, Phase One October 2014

Stroke Reperfusion Program

Improve patient outcomes through reduction of time from symptom onset to thrombolytic intervention for people experiencing ischaemic stroke

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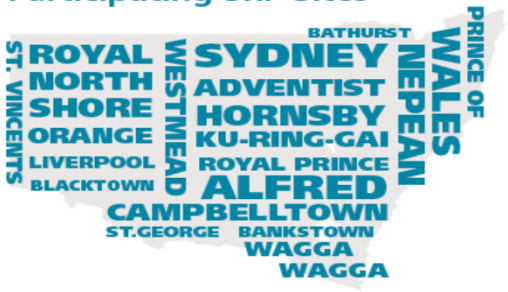
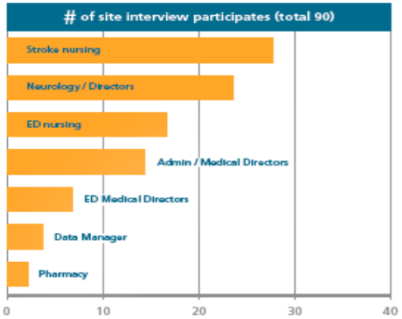
PHASE 1:

Site Visits and Group Interviews | Stroke Reperfusion Assessment Tool | Descriptive Statistics | Phase One Report

The program streamlines ambulance and hospital services to treat people experiencing the signs and symptoms of stroke through hospital pre-notification of FAST+ patients (face arms speech time) and mobilising acute stroke teams. The SRP aims to increase the use of thrombolysis for eligible patients to reduce death and disability rates.

Participating SRP Sites





Purpose of phase one evaluation - Key evaluation questions (KEQ)

FIDELITY

- Was the program design effective in delivering the SRP program?
- What processes did ACI use for program implementation across sites and is it consistent with the ACI implementation Framework?
- Were the processes consistent at each site?
- Were the processes used for each component of implementation effective?
- What inhibited implementation?
- What facilitated implementation success?
- What strategies can be used to improve the program design and implementation process?

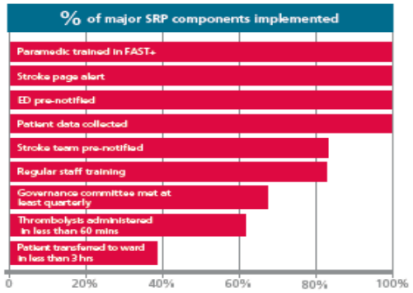
PROCESS, QUALITY AND QUANTITY

- Have the minimum requirements for stroke reperfusion been implemented and sustained (staffing / protocols)?
- Are implementation processes in place (stroke team meetings, reviews, MD thrombolysis committee, training, and education)?
- Are standards of care upheld (guidelines, pathways, protocols)?
- Are data collection systems in place and implemented?

SRP sites

- Had a higher complexity of patients with an average NWAU* of 1.9 compared to 1.5 NSW average
- There was fidelity in the implementation processes used by ACI but variation in delivery across sites
- Data collection and reporting tools vary across sites
- Access to medical imaging is the SRP component most associated with delays to treatment

NWAU = National Weighted Activity Unit



AREAS FOR IMPROVEMENT

ACCESS TO INFORMATION: Consistent data collection methods to be determined for SRP, development of a data dictionary and guidelines for collection, access and reporting.

COHERENT PLANNING: Within the mandate of ACI. Consideration given to how best ACI can support delivery and sustainability of programs beyond implementation.

BUSINESS PROCESS: Stroke Network to convene an expert group to discuss and determine the guidelines for SRP sites concerning relevant scan types required for ascertaining eligibility for thrombolysis treatment.

LEADERSHIP: ACI / ECI to continue the discussion of options for affirming thrombolysis treatment for stroke as standard practice in stroke care.

CULTURE AND VALUES: Promotion of SRP as an integrated program across ASNSW and LHDs. Define and promote a person/patient centred care focus for stroke care in NSW.

PHASE 2:

ABM Costing Study | Patient Experience Trackers | Outcomes Data Analysis | Phase Two Report

PHASE 3:

Outcomes Impact Analysis | Economic Appraisal | Phase Three Report

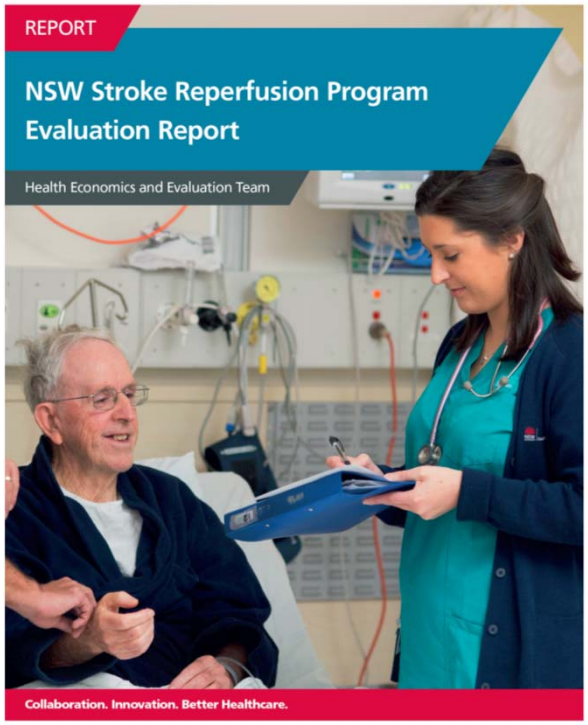
Reflective practice & benchmarking

NSW Stroke Network took up the challenge to address recommendations

Sites used findings to learn from each other and look more closely at systems – regular forums established – strengths based approached – learning together *(collaboratives)*

ACI used findings to look at ways to work across NSW in implementing programs that enable flexibility at the local level

National coding for thrombolysis commenced 1 July 2016



Next stages

Coding will now allow assessment of patient outcomes for prospective studies

Linked data – agreement to link Ambulance NSW data, NSW Emergency Department data, NSW Admitted Patient Data Collection and Births/Deaths Data to assess health system utlisation and operational activities

Still to come – patient reported outcomes and patient experience

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