TITLE: REALIST EVALUATION: OPENING THE BLACK BOX EVALUATION

Date: 27 February 2017
Presented by: Hubertus J.M. Vrijhoef PhD MSc, Singapore
Realist Evaluation: opening the black box evaluation

Hubertus J.M. Vrijhoef PhD MSc,

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Tsao Foundation
Longevity is Opportunity
OBJECTIVE OF TODAY’S LECTURE

• Why do we need Realist Evaluation in what circumstances for whom and how does it work?
CONTENTS

• Setting the scene
• Realist Evaluation: theory
• Realist Evaluation: illustration
• Q&A
“Where is the randomized trial?” is, for many purposes, the right question, but for many others it is the wrong question, a myopic one.

[Berwick, JAMA 2008]
SETTING THE SCENE

• “Many have pointed out that there is, and ought to be, a strong relationship between what is studied and how it is studied. To study a linear, mechanical or natural, tightly coupled causal relationship most efficiently (for example, determining benefits of β-blockers for heart failure), an OXO design (such as an RCT) may be exactly correct.”
“Many have pointed out that there is, and ought to be, a strong relationship between what is studied and how it is studied. To study a linear, mechanical or natural, tightly coupled causal relationship most efficiently (for example, determining benefits of β-blockers for heart failure), an OXO design (such as an RCT) may be exactly correct. But with social changes—multicomponent interventions, some of which are interpersonal, all of which are nonlinear, in complex social systems—then other, richer, but equally disciplined, ways to learn are needed.”
“The introduction of rapid response systems in hospitals is a complex, multicomponent intervention—essentially a process of social change. The effectiveness of these systems is sensitive to an array of influences: leadership, changing environments, details of implementation, organizational history, and much more. In such complex terrain, the RCT is an impoverished way to learn. Critics who use it as a truth standard in this context are incorrect.”
BLACK AND WHITE BOX EVALUATION

• Black box “problem” refers to the practice of viewing social programs primarily in terms of effects, with little attention paid to how those effects are produced.

• “White box” evaluation/ clear box evaluation/ theory-driven evaluation involves attempt to “unpack” the black box so that the inner components or logic of a program can be inspected.
PROGRAM EVALUATION

Assessment of programme cost and efficiency
Assessment of programme outcome or impact
Assessment of programme process and implementation
Assessment of programme design and theory
Assessment of the need for the programme

CONTENTS

• Setting the scene
• **Realist Evaluation: theory**
• Realist Evaluation: illustration
• Q&A
REALIST EVALUATION

• Drawn from Pawson and Tilley’s ‘Realistic Evaluation’ (1997)

• Realism is a school of philosophy and sits between positivism and constructivism
# REALISM

<table>
<thead>
<tr>
<th>Ontology</th>
<th>Positivism</th>
<th>Constructivism</th>
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</thead>
<tbody>
<tr>
<td>Epistemology</td>
<td>There is an objective reality, which exists independent of us.</td>
<td>Subjective reality – we ‘create’ reality</td>
</tr>
<tr>
<td>Causation</td>
<td>Truth and final knowledge exists.</td>
<td>No way to choose between interpretations. What we jointly believe is true.</td>
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<tr>
<td>Implications for evaluation</td>
<td>Constant conjunction, linear causation. Programs cause outcomes.</td>
<td>Co-constructed interpretations lead to actions and outcomes.</td>
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<td>Qualitative methods.</td>
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# REALISM

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<tr>
<th></th>
<th>Positivism</th>
<th>Realism</th>
<th>Constructivism</th>
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</thead>
<tbody>
<tr>
<td><strong>Ontology</strong></td>
<td>There is an objective reality, which exists independent of us.</td>
<td>Material &amp; social reality – we interact with reality.</td>
<td>Subjective reality – we ‘create’ reality</td>
</tr>
<tr>
<td><strong>Epistemology</strong></td>
<td>Truth and final knowledge exists.</td>
<td>No final truth or knowledge, but improvement in knowledge is possible.</td>
<td>No way to choose between interpretations. What we jointly believe is true.</td>
</tr>
<tr>
<td><strong>Causation</strong></td>
<td>Constant conjunction, linear causation. Programs cause outcomes.</td>
<td>Mechanisms operating differently in different contexts generate patterns of outcomes.</td>
<td>Co-constructed interpretations lead to actions and outcomes.</td>
</tr>
</tbody>
</table>
| **Implications for evaluation** | Evaluators ‘tell facts’.  
  Context factors should be eliminated: Randomised Control Trials/ Quasi-experimental methods. | Evaluators explain how and where programs generate outcomes.  
  Mixed methods (qualitative and/or quantitative). | Evaluators describe stakeholder interpretations.  
  Qualitative methods |
ASSUMPTIONS OF REALIST EVALUATION

- A complex intervention works in quite separate ways,
- it gets implemented in different ways,
- it is more effective with some groups rather than others,
- it will find more use in one location rather than others,
- it has intended and unintended consequences,
- it effects are likely to be sustained or taper off.
REALIST EVALUATION

• Drawn from Pawson and Tilley’s ‘Realistic Evaluation’ (1997)

• Realism is a school of philosophy and sits between positivism and constructivism

• A member of the family of theory-based evaluation approaches - start by clarifying the ‘program theory’
• Programs are embodiments of theories:
  - programs comprise an expectation that the introduction of a program or policy intervention will help ameliorate a problem;
  - programs involve an assumption about how and why program activities and resources will bring about change for the better.
• Program logic is often used to identify and describe the way in which a program fits together, usually in a simple sequence of inputs, activities, outputs, and outcomes.
PROGRAM LOGIC

A Series of “If...Then” Statements

- **Certain resources are needed to operate your program.**
  - If you have access to them, **then** you can use them to accomplish your planned activities.

- **If you accomplish your planned activities, then you will hopefully deliver the amount of service that you intended.**

- **If you accomplish your planned activities to the extent you intended, then your participants will benefit in certain ways.**

- **If these benefits are achieved, then certain changes in groups or communities are expected to occur.**

**Diagram:**

1. **Resources/Inputs** → **Activities** → **Output** → **Outcome** → **Impact**
   - Your Planned Work
   - Your Intended Results
Logic model: older people

This logic model illustrates the main links between service activities and better outcomes for older people. It suggests broad groupings of activities, benefits of culture and sport to individuals, communities and places, and how these in turn contribute to the achievement of intermediate and overarching strategic outcomes.

<table>
<thead>
<tr>
<th>Culture and sport activities</th>
<th>Service outcomes</th>
<th>Benefits</th>
<th>Intermediate outcomes</th>
<th>Overarching strategic outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development and outreach work</td>
<td>Increased attendances and active participation by (disadvantaged/vulnerable) older people in culture and sport</td>
<td>Improved health and wellbeing</td>
<td>Reduction in injury and falls among older people</td>
<td>More older people have optimum health throughout their later life</td>
</tr>
<tr>
<td>Sessions and clubs</td>
<td>Increased efficiency and productivity in the delivery of culture and sport</td>
<td>Increased social interaction and new relationships</td>
<td>More older people adopting active and healthy lifestyles and proactively managing their health</td>
<td>Older people are more physically, socially and mentally active</td>
</tr>
<tr>
<td>Performances and events</td>
<td>More older people involved in designing, commissioning and promoting culture and sport provision</td>
<td>Increased confidence, self esteem, personal responsibility and resilience</td>
<td>More older people enjoying life to the full</td>
<td>Older peoples’ contribution to their local community is valued</td>
</tr>
<tr>
<td>Facilities</td>
<td>Increased satisfaction among older people with culture and sport in their local area</td>
<td>Increased understanding of local services and community issues</td>
<td>More older people playing a full part in their local community as active citizens</td>
<td>More older people live longer in their own homes and regain their independence after illness or injury</td>
</tr>
<tr>
<td>Information provision</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Volunteering opportunities</td>
<td></td>
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<tr>
<td>Knowledge and learning/skills courses and programmes</td>
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<tr>
<td>Training, employment and mentoring schemes</td>
<td></td>
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<td></td>
<td>Increased personalisation, choice and control for older people</td>
</tr>
<tr>
<td>Leadership programmes</td>
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<td></td>
<td>Increase dignity and safety of vulnerable older people</td>
</tr>
</tbody>
</table>
• Program logic is often used to identify and describe the way in which a program fits together, usually in a simple sequence of inputs, activities, outputs, and outcomes.

• *Program theory goes a step further* and attempts to build an explanatory account of how the program works, with whom, and under what circumstances. Thus, program theory might be seen as an elaborated program logic model, where the emphasis is on causal explanation using the idea of “mechanisms” that are at work.
REALIST EVALUATION

• Realist approaches assume that nothing works everywhere for everyone, and that ‘context’ really does make a difference to programme outcomes
REALIST EVALUATION
REALIST EVALUATION

**Context**
Contextual factors that shape theories of how the intervention works
Contextual factors that affect (and may be affected by) implementation, intervention mechanisms and outcomes
Causal mechanisms present within the context which act to sustain the status quo, or potentiate effects

**Implementation**
Implementation process (How delivery is achieved; training, resources etc)
What is delivered
Fidelity
Dose
Adaptations
Reach

**Mechanisms of impact**
Participant responses to and interactions with the intervention
Mediators
Unexpected pathways and consequences

**Outcomes**
The Realist Evaluation of a Palliative Integrated Care Pathway in Primary Care: What Works, For Whom and in What Circumstances?

Sonia Michelle Dalkin

A thesis submitted in partial fulfilment of the requirements of the University of Northumbria at Newcastle for the degree of Doctor of Philosophy

Research undertaken in the Faculty of Health and Life Sciences and in collaboration with the NHS North of Tyne

February 2014
• Finding effective ways to care for people with palliative care needs is a national priority.

• A primary care locality has developed and implemented an Integrated Care Pathway (ICP) for those with life limiting illnesses. It focuses on identifying patients early, regardless of disease type, and uses proactive and patient centred interventions to plan for a good death.

• Although palliative care pathways present a promising practice framework, the literature does not allow for an assessment of how and when they work best. This thesis aimed to explain which parts of the ICP worked best, for whom and in what circumstances.
• To understand realist evaluation, an understanding of social programmes or interventions must be developed.

• Social programmes are active, they do not operate in laboratories, they are affected by contexts which are changeable and thus although two social programmes may have the same name, they will never behave in exactly the same way. The ICP can and will thus be considered as social programmes in this thesis.
Social programmes are delivered under the hypothesis that if the programme is delivered in a certain way it will improve outcomes. This means that whenever a social programme is implemented, it has an underlying theory about what might cause change, which is being tested.

However, this theory is not always explicit. It is the role of the realist evaluator to make these theories explicit, and ensure that the right questions are asked of the data. For example, the underlying theory in ICP may be that planning for a good death results in more patients dying in their location of choice.
4 CONCEPTS THAT FORM THE BASIS FOR UNDERSTANDING AND ASSESSING PROGRAMS IN REALIST EVALUATION

1. **Mechanisms** describe what actually produces the program effects (levers to change / outline the logic of program theory)

2. **Context** relates to the description of the elements, conditions, or social relationships, which have a bearing or influence of the program mechanisms
4 CONCEPTS THAT FORM THE BASIS FOR UNDERSTANDING AND ASSESSING PROGRAMS IN REALIST EVALUATION

3. **Outcome** patterns include the (un)intended program results as stimulated through the different mechanisms and contexts.

4. **Context-mechanism-outcome patterns configuration** allow for the testing of different interventions under different combinations or conditions. This ‘configurational’ approach to causality aims to show that particular outcomes will likely result from the alignment of a combination of attributes.
The realist’s CMO-configuration

- **Project resources**
- **Context**
- **Mechanism**
- **Initial situation**
- **Changed situation (Outcome)**
- **ACTORS**
• **Context** refers to not just the physical, but to the culture and drivers (professional cultures, power dynamics within GP practices, cost effectiveness, disease specific clinical reasoning), institutional features (patient list sizes in GP practices, shared nursing teams, staffing levels in care homes) and ethical issues (equality of care, capacity to make a decision).
RE OF A PALLIATIVE INTEGRATED CARE PATHWAY (DALKIN 2014)

• For example, if it is thought that the number of patients who have anticipatory medication is higher (outcome) in practices (context) where the ICP is more embedded and adopted as routine practice (mechanism), then the degree of how embedded the ICP is must be investigated by the evaluator, despite embeddedness not being an explicitly measurable factor.

• Scientific knowledge begins to accumulate when the same mechanism is commonly attributed to the same outcome or the absence of a mechanism is linked to the lack of an observable outcome.
HOW DOES REALIST EVALUATION WORK?

Based on existing assessment of mechanisms, contexts, outcomes (M, C, O)

Theory and models of intervention or service provision

What works for whom contexts

Programme

Hypotheses

What might work for whom contexts

Observations

Multi-method data collection on M, C, O
HOW DOES REALIST EVALUATION WORK?

• Development of a **realist program theory**: “If we do ‘x’, ‘y’ will happen, because....” (CMO configurations)

• Definition of the 4 most basic **research questions**:
  1. For whom will the program theory work and not work, and why?
  2. In what contexts will the program theory work and not work, and why?
  3. What are the main mechanisms by which we expect the program theory to work?
  4. If the program theory works, what outcomes will we see?
HOW DOES REALIST EVALUATION WORK?

• Often one has **multiple guiding questions** of which some are descriptive and some explanatory:
  • For whom does the intervention work and not work and why?
  • In what respects does it work and not work for different groups?
  • To what extent does it work or not work, for different groups or in different contexts?
  • When it works, how (i.e. by what mechanisms) does it work?
  • When it doesn’t work, why doesn’t it work?
  • What matters about how it is done, in order for it to work?
  • What matters about the contexts into which it is introduced, in order for it to work?
HOW DOES REALIST EVALUATION WORK?

• Generating hypotheses may require a workshop involving evaluators, commissioners and program and policy staff
• The results of hypothesis generation can usefully be constructed as a chart listing multiple CMO configurations, where each CMO must be able to be read as a sentence across the rows of the chart ("In this context, that mechanism generates this outcome")
• Ideally, a priori generation but concurrent or retrospective development is also possible
Program Theory 1:

The number of people who die in their chosen location (outcome) will depend on the GP practice (context) they are registered with and how embedded the ICP is as indicated by the number of interventions used per patient (outcome). Thus, this is a programme theory about the process of implementation, considering implementation as an intermediary outcome.

- Does the use of more interventions result in better outcomes?
- Do CQI initiatives increase intervention use?
- What characteristics do ‘high performing’ GP practices have?
• Program Theory 2:
• Palliative care registrations should increase (outcome) due to a focus on identifying patients early using the palliative care register (mechanism) in a health care domain that appreciates the palliative care needs of patients (context).
  – Are palliative care registrations increasing in the locality and if so why?
  – Are both cancer and non-cancer patients appropriately put onto the palliative care register?
RE OF A PALLIATIVE INTEGRATED CARE PATHWAY (DALKIN 2014)

• **Program Theory 3:**
  • There will be an increase in the use of preference discussions and ICP (outcome) as health care professionals become more confident with broaching the subject of death and dying with patients (mechanism) and aware of the importance of having and documenting preference discussions, which has been highlighted by recent policy (context).
    – Are preference discussions increasing and if so why?
    – Are preference discussions occurring earlier in a patient’s illness trajectory (green traffic light phase)?
    – Is the number of locality advance care plans carried out with patients increasing and if so why?
    – Do preference discussions predict the use of advance care plans?
Program Theory 4:
The innate coping style of the GP and patient (context) facilitates a consultation if matched (mechanism), making a preference discussion and use of the locality advance care plan more likely to occur (outcome).

- Are matched coping style consultations more successful (in terms of producing outcomes such as preference discussions and advance care plans)?
- Can matched coping styles facilitate practice?
• **Program Theory 5:**
• The ICP can facilitate preferred place of death (*outcome*) and prevent emergency admissions (*outcomes*) through identifying patient preferences (*context*) and using ICP (*mechanism*).

  – *Are home deaths increasing?*
  – *Are care home deaths increasing?*
HOW DOES REALIST EVALUATION WORK?

• Realist Evaluation requires outcome data
• Realist Evaluation requires that outcomes data can be disaggregated according to sub-groups and contextual features identified in the realist program theory
  • outcomes data at unit level (individual or organisation)
  • data about features of context
  • data about outcomes and features of context can be linked for analysis
• Realist Evaluation requires data about mechanisms
HOW DOES REALIST EVALUATION WORK?

**Context**
- Stakeholder interviews
- Quantitative testing of hypothesised moderators

**Documentary analysis**
- Qualitative observation

**Qualitative observation**
- Routine monitoring data

**Description of intervention and its causal assumptions**
- Development of a model through:
  - Consultations with intervention developers/implementers
  - Discussion within wider evaluation

**Implementation**
- Stakeholder interviews
- Documentary analysis
- Qualitative observation
- Structured observation
- Implementer self-report
- Routine monitoring data
- Implementer interviews
- Participant interviews

**Mechanisms of impact**
- Routine data
- Mediation analysis of quantitative mediators
- Interviews with participants and implementers

**Outcomes**

*Fig 3 | Commonly used data collection and analysis methods for process evaluation*
Table 1: Data framework

<table>
<thead>
<tr>
<th>Major Research Question Answered</th>
<th>Programme Theory Tested</th>
<th>Participants Providing Data</th>
<th>Data Source</th>
<th>Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the palliative care ICP work?</td>
<td>Programme Theories 1, 2, 3 and 5</td>
<td>Palliative care patients from one of the practice sites</td>
<td>MIQUEST data base/ Locality Death Audit</td>
<td>Statistical analysis</td>
</tr>
<tr>
<td></td>
<td>Programme Theories 3 and 5.</td>
<td>Relatives of deceased palliative care patients and the health care professionals previously involved in the patients palliative care</td>
<td>Quality of Dying and Death Questionnaire</td>
<td>Descriptive comparisons</td>
</tr>
<tr>
<td>What are the conditions of effectiveness of ICPs in palliative care?</td>
<td>All programme theories</td>
<td>Health care professionals involved with the ICP</td>
<td>Focus Groups</td>
<td>Soft systems methodology</td>
</tr>
<tr>
<td></td>
<td>Programme Theory 3 and 5</td>
<td>Palliative care patients and their families and bereaved families of palliative care patients</td>
<td>Interviews</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td>Who does the ICP work for?</td>
<td>Programme Theory 4</td>
<td>Palliative care patients and their GPs</td>
<td>Coping Style Questionnaire</td>
<td>Classified as monitor or blunter</td>
</tr>
<tr>
<td></td>
<td>Programme Theory 4</td>
<td>Voice Recording of Consultations</td>
<td>Thematic analysis</td>
<td></td>
</tr>
</tbody>
</table>
HOW DOES REALIST EVALUATION WORK?

• The usual form that analysis takes is intra-program (all subjects are within the program) and inter-group comparisons

• Dalkin (2014):
  – Realist evaluation was used to guide the analysis of multiple data strands: quantitative data from the GP practices; interviews with palliative care patients and bereaved relatives; bereaved relatives and matched health care professional questionnaires; focus groups with health care professionals; consultation recordings with palliative care patients and their GPs.
HOW DOES REALIST EVALUATION WORK? (DALKIN 2014)

Figure 2: The operationalisation of the method

GP practice data analysed early in the project to provide programme theory outcomes

All data strands fed into one another to refine and confirm programme theories

Interviews with bereaved relatives and palliative care patients

Programme Theories Refined after each focus group

Focus Group 1
Focus Group 2
Focus Group 3

Ongoing discussions and programme theory refinement with the ICPs founder and from PCQVs

Quality of Dying and Death Measure
Consultation recordings

Initial programme theories for each chapter
(formulated from the literature and integration into the field)

Final (refined) programme theories for each chapter
CONTENTS

• Setting the scene
• Realist Evaluation: theory
• Realist Evaluation: illustration
• Q&A
Supporting shared decision-making for older people with multiple health and social care needs: a protocol for a realist synthesis to inform integrated care models

Frances Bunn, Claire Goodman, Jill Manthorpe, Marie-Anne Durand, Isabel Hodkinson, Greta Rait, Paul Millac, Sue L Davies, Bridget Russell, Patricia Wilson

ABSTRACT
Introduction: Including the patient or user perspective is a central organising principle of integrated care. Moreover, there is increasing recognition of the importance of strengthening relationships among patients, carers and practitioners, particularly for individuals receiving substantial health and care support, such as those with long-term or multiple conditions. The overall aims of this synthesis are to provide a context-relevant understanding of how models to facilitate shared decision-making (SDM) might work for older people with multiple health and care needs, and how they might be applied to integrated care models.

Methods and analysis: The synthesis draws on the principles of realist inquiry, to explain how, in what contexts and for whom, interventions that aim to strengthen SDM among older patients, carers and practitioners are effective. We will use an iterative, stakeholder-driven, three-phase approach. Phase 1: development of programme theory/theories that will be tested through a first scoping of the literature and consultation with key stakeholder groups; phase 2: systematic searches of the evidence to test and develop the theories identified in phase 1; phase 3: validation of programme theory/theories with a purposive sample of participants from phase 1. The synthesis will draw on prevailing theories such as candidacy, self-efficacy, personalisation and coproduction.

Ethics and dissemination: Ethics approval for the stakeholder interviews was obtained from the University of Hertfordshire EDC (Ethics Committee with Delegated Authority), reference number HS/55/149387. The propositions arising from this review will be used to develop recommendations about how to tailor SDM interventions to older people with complex health and social care needs in an integrated care setting.

BACKGROUND AND RATIONALE
Navigating health and social care systems is particularly difficult for older people with complex health needs, including those with dementia, frailty and multimorbidity, and they are at particular risk of poor continuity and fragmentation of care. Integrated care aims to address these problems, prevent duplication of services and reduce costs. In England, the 5-Year Forward View set out new models of integrated care as part of the strategic plan for wider system change in the National Health Service (NHS). These models have been piloted in 37 vanguard sites whose brief is to address traditional divides between primary care, community services and hospitals, and achieve person-centred and coordinated healthcare through better integration. Shared decision-making (SDM) is a process in which health and social care practitioners and patients work together to select...
Including the patient or user perspective is a central organising principle of integrated care. Moreover, there is increasing recognition of the importance of strengthening relationships among patients, carers and practitioners, particularly for individuals receiving substantial health and care support, such as those with long-term or multiple conditions.

The overall aims of this synthesis are to provide a context-relevant understanding of how models to facilitate shared decision-making (SDM) might work for older people with multiple health and care needs, and how they might be applied to integrated care models.
ILLUSTRATION

• The assumption of this research is that a realist review on interventions to promote SDM has to consider a range of theoretical frameworks. This is likely to include theories around the following:
  
  • ▶ agency, advocacy and candidacy and how they may impact on access to care for vulnerable groups;
  
  • ▶ the role of individual-related and system-related factors in the development of inter-professional models of SDM;
  
  • ▶ minimally disruptive medicine and complex adaptive systems;
ILLUSTRATION

• ▶ shared or proxy decision-making relevant to vulnerable groups who may lack decision-making capacity;
• ▶ the involvement of older people and their family members in their health and care, extending to co-construction or co-production theory;
  ▶ the role of technology in the involvement of patients and carers in their care, for example, patient-held records, patient portals;
  ▶ the ‘expert patient’ and self-management of long-term conditions;
  ▶ prognostic framing of death and dying and how this can shape preferences and choices;
  ▶ promoting continuity of care for older people, and the role of personal budgets or family carers in fostering continuity.
ILLUSTRATION

- Use is made of an iterative, stakeholder-driven, three-phase approach:
  - 1: development of programme theory/theories that will be tested through a first scoping of the literature and consultation with key stakeholder groups;
  - 2: systematic searches of the evidence to test and develop the theories identified in phase 1 (incl. patient experience, patient safety, clinical effectiveness);
  - 3: validation of programme theory/theories with a purposive sample of participants from phase 1.
Development of the COMIC Model for the comprehensive evaluation of integrated care interventions

Loraine Busetto\textsuperscript{1}, Katrien Luijinx\textsuperscript{1} and Hubertus Johannes Maria Vrijhoef\textsuperscript{1,2,3,4,5}

Abstract

Objective: To develop a model for the comprehensive evaluation of integrated care interventions that provides insights into when, why and how successful outcomes can be achieved.

Methods: A preliminary model was developed based on the Context + Mechanism + Outcome Model and further developed based on its application to a literature review, two case studies and an expert questionnaire. The COMIC Model for studying the Context, Outcomes and Mechanisms of Integrated Care interventions interventions assumes that an intervention is introduced using certain mechanisms (categorised according to the Chronic Care Model), which are met with particular context factors (described by barriers and facilitators and categorised according to the Implementation Model), which combined, contribute to specific outcomes (categorised by the WHO dimensions of quality of care).

Results: Application of the COMIC model to the literature review and expert questionnaires did not allow for statements to be made about the relationships between mechanisms, context and outcomes. Application to the two case studies made it possible to (1) comprehensively analyse the mechanisms, context and outcomes of the specific case, (2) to make the relationships between the mechanisms, context and outcomes within each case visible, and (3) to compare the two cases to each other in a systematic way that added value to the analysis.

Discussion: Using the COMIC Model makes it possible to comprehensively study the interplay of the mechanisms, context and outcomes of integrated care interventions and thereby provides insights into when, why and how integrated care contributes to improved outcomes.
ILLUSTRATION

Figure 4. COMIC Model: Context, Outcomes and Mechanisms of Integrated Care interventions.
ILLUSTRATION

Figure 2. Example of the interplay between the mechanisms, context and outcomes in the Dutch case.

Figure 3. Example of the interplay between the mechanisms, context and outcomes in the German case.
OBJECTIVE OF TODAY’S LECTURE

• Why do we need Realist Evaluation in what circumstances for whom and how does it work?

✓ to understand the complexity of change
✓ non-linear, multi-component interventions in social systems
✓ what works for whom in what circumstances and in what respects and how?
✓ program theory, CMO configurations, mixed methods
CONTENTS

• Setting the scene
• Realist Evaluation: theory
• Realist Evaluation: illustration
• Q&A
REFERENCES (SHORT LIST)

- Dalkin SM. The Realist Evaluation of a Palliative Integrated Care Pathway in Primary Care: what works, for whom and in what circumstances? University of Northumbria at Newcastle, 2014.
THANK YOU

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