

MCHB/DHSPS April, 2010 Webcast

Local Evaluation: Beyond the DGIS

April 20, 2010

JOHANNIE ESCARNE: Good afternoon, my name is Johannie Escarne from HRSA's Division of Healthy Start and Perinatal Services in the Maternal and Child Health Bureau. On behalf of the division I would like to welcome you to this webcast titled "Local Evaluation: Beyond the Discretionary Grant Information System," or DGIS.

Before I introduce our presenters today I would like to make some technical comments. Slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speaker's presentations. You do not need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window. A 12 second delay typically provides the best performance for the audience.

We encourage you to ask questions to the speakers at any time during the presentation. Simply type your question in the message window, select question for speaker from the drop down menu and hit send. Include your state and organization in your message so that we know where you're participating from.

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icon. Those of you who selected accessibility features when you registered will see text captioning underneath the video window.

At the end of the broadcast, the interface will close automatically and you'll have the opportunity to fill out an online evaluation. Please take a couple minutes to do so. Your responses will help us plan future broadcasts in this series and improve our technical support.

We are very pleased today to have Dr. David de la Cruz, who is the Director of Policy and Program Development ,and a task order officer, for the National Healthy Start Evaluation in the Division of Healthy Start and Perinatal Services. Our other presenters are Dr. Jeffery Guidry, who is an associate professor at Texas A & M University. Dr. Sharon Merzel who is the director of the Master of Public Health Program at the Albert Einstein College of Medicine and Jim Masterson, who is the owner and senior partner of Hamilton Bell Associates.

In order to allow ample time for the presentations we'll defer questions to the question and answer session following the presentations. However, we do encourage you to submit questions via email at any time during the presentations. If we do not have the opportunity to respond to your question during the broadcast, we'll email you afterwards.

Without further delay we would like to welcome our presenters and the audience and begin the presentation. Dr. de la Cruz.

DAVID de la CRUZ: Thank you, Johannie. I'll start with a couple of brief comments about how the Division of Healthy Start and Perinatal Services supports evaluation and local evaluation and our thoughts on how local evaluations and local evaluators can assist you as you move forward with your project.

I think many of you have heard me say that if we all could do a better job of more completely telling the Healthy Start story, we would get all the money, resources and funding we could possibly need or want. It is truly my belief that the good and high quality work that all of you do every single day is saving lives and improving communities. All we need to do is keep doing that good work and be able to tell our story better and more completely. So this is where I believe more active use of local evaluations and a local evaluator come into play. Let me just start -- stop there and start with we know that even with all of your good work and all of your successes, funding is still limited. We know this. We're sensitive to this. I know that every single time and every single day especially during these times of limited funding and resources, all projects are looking for ways to find money to fully implement their activities and services. And we know that you have to make difficult funding-related decisions all the time. So let's just get that out on the table. We know this and we understand this and we're aware of this. However, the purpose of this webcast is to demonstrate how local evaluation can help you tell your story. And help you in many other ways as well. Including ultimately to possibly secure you additional funds. That is local evaluation can be used as a sustainability tool. But I get a little ahead of myself.

Let's start with clearly stating that local evaluation can be and should be more than just data submission. Healthy Start fully supports and encourages local evaluation above and beyond the submission of your annual Discretionary Grant Information System performance measures. So we believe that local evaluations should be more than that. While we're confident that the performance measures are an important mechanism of looking at Healthy Start across the projects, we also know that each one of you do more than what is captured by these performance measures. Therefore, we strongly encourage more individualized project-specific studies. We all know that each Healthy Start project must implement the nine core components but we've also always allowed each project to implement its services and activities in a way that is most appropriate for each unique community. So therefore although we collect uniformed Healthy Start-wide performance measures, we know that there are lots of things that each of you is doing that is not being captured and reported to us using the performance measures. We know performance measures are pretty good but we know they aren't complete. So this is where local evaluation comes in. Using a local evaluator to highlight some of the uniqueness of your community and how you implement your project in your community is highly recommended. You all have been able to change the lives of the women and families you serve. A local evaluation study can help to highlight these successes. But furthermore, we encourage you to share with others these areas of successes and lessons learned. We strongly support evidence-based practices. We're often asked by our partners and funders for success stories that are evidence-based. We know you have those successes. We know you have things to tell us. Stories of how you

overcame barriers, implemented Healthy Start in a special and unique ways and ways you changed your community. We'd love for you to work with your project officer to publicize these stories in articles and peer review journals.

Publishing articles is something else a local evaluator can help you with. Not everything a local evaluator does has to end in a formal study or paper. The things that a local evaluator can do are numerous and they include things like, you know, conducting studies or helping write articles. But they can also do other things like reviewing your funding application each year. Sort of a very knowledgeable person on your project but also someone who is a little bit maybe half a step removed and can read it with a more objective, clear lens. Or they can help with sustainability. As evaluators who work in the community, they are often linked into other agencies and groups that may be different from those agencies and groups that are already on your consortium. They're a good, useful tool. We believe there is a benefit when a project uses a local evaluator who conducts studies and guides the project's future activities and identifies areas of focus. Let's get back to money. The costs of a local evaluator, so if you want to have a local evaluator or want to conduct local evaluation studies, those costs are allowable using Healthy Start funds. You just need to work with your project officer to make that happen. And we believe that if you use a local evaluator for more than data collection and submission but also to help guide the project and provide you and your project with evidence-based results, that you'll also feel that the money spent on local evaluation and local evaluation studies is well worth it. So let me stop there, let me turn to the folks who do the work that you -- that can help you move your project forward. Today we've

identified and are very grateful to have three local evaluators that will tell us what they've done beyond data collection to help their projects tell their story. We've asked them to highlight what some of these extra things are, specifically what's the value added that a project can get from having a local evaluator? I'll turn it over to Jeff Guidry who is going to talk a little bit about some of the work he's done across a few different Healthy Start starts. Jeff.

JEFFERY GUIDRY: Thank you, David. First of all I think you did my entire presentation already, okay?

But I will go ahead to the next slide to the Healthy Start local evaluation expertise. I've been working with Healthy Start for the past 11 years. I got my start with neighborhood centers and Sunny Futures Healthy Start back in 1999 when we were a planning grant and since then have worked with Healthy Start New Orleans, Pee Dee Healthy Start South Carolina and Sunny Futures in Houston and provided technical assistance as requested by the project officer for other projects that I've worked with.

Next slide, please. The role of a local evaluation. Just to give a little more background. David has addressed these as external validation. In my experience over 20 years in working in evaluation, external evaluation allows more valid tea to the findings.

Communication and training. One of the major things I do with all my projects is provide annual training for all staff. All staff on the role of evaluation. I make it more participatory process. I want feedback from staff and management about what questions do

you have. You're directly in the field and that I can conceptualize into an evidence-based evaluation and looks at the role of local evaluation. Over the 11 years I've seen different things related to projects that understand and exactly how we're beyond just basic collecting data for number counting and also specialized studies. That has been a major interest. I know many of the projects remember when I think it was last year when the doctor asked us for information on home visitation. That was one of our specialized studies and we were able to pull not only client satisfaction but numbers on home visitations to supply that information to the national Healthy Start. And the last thing is dissemination.

Next slide, please. Healthy Start New Orleans and I want to also acknowledge Charlotte parent as the project director. We work closely on a monthly visit and conference calls about the work that I'm doing as it relates to local evaluation and also the project. We do specialized evaluation studies. The Mall of Moms, an incentive program to look at not only the point system but we'll compare birth outcomes from those that participate in the incentive program based on their participation in healthy education, pre-natal classes versus those that don't participate. We'll look at the birth outcomes. Partnership assessment tool. One of the things that's very big in Healthy Start New Orleans is that they have a strong consortium with over 150 to 200 members. One of the things that we look at, how does this consortium can add to the effectiveness of the program? So one of the things I've developed is called a partnership assessment tool where the members of the consortium not only evaluate that consortium but evaluate their collaborative projects. How many collaborations did you get? How did you provide a continuum of

care for all clients with the Maternal and Child Health system? That's an example of its being very successful. We take those results and not only bring them back to the consortium but bring them back to the project, of course, and they look at different ways where they can document collaboration to strengthen the Maternal and Child Health system there in New Orleans. The other is the Geographical Information Systems that I implement. As you know, Hurricane Katrina back in 2005 what we did with GIS is pulled data from 2003 and 2004, pre-Katrina and we applied it where the clients and services were being disseminated and provided in the communities.

Next slide, please. The slide with the map on it. And as you can see we were able to apply it to see where the clients were and the places for Maternal and Child Health services. We did the family clinics, the WIC clinics and OBGYN clinics. This is pre-Hurricane Katrina. Then we did analysis to look at post Hurricane Katrina. The major resettlement and redevelopment was a major factor. This allowed us to start looking at - as you can see, where they start resettling back into New Orleans and we were able to use this information not only for the Healthy Start New Orleans, but Charlotte parent brought this information to the health department and working with Dr. Stevens in the health department and excited about this information because it was able to document where the population resettled and where can we provide the local Maternal and Child Health services. That's an example of how successful and how the utilization of it not only helped the project but also helped the health department and other Maternal and Child Health providers in the community.

Next slide, please. Now I want to talk about Pee Dee Healthy Start with Ms. Robertson in South Carolina. Some of the things we do there is training and updates because I make at least four visits a year. We do a consortium assessments where we looked at how can we redirect the development of the consortium. Pee Dee Healthy Start services rural counties. One of the issues that was brought to my attention was when the consortium is so spread out. We did analysis, met about the members in different counties. Provider assessments. One of the issues I always have a meeting with all the lead staff and outreach staff. One of the issues they said was that their clients were having issues accessing other services outside the consortium. We did a provider assessment to find out where our clients were referred to, what type of services were available to them in the community and we were able to develop a plan of action for each one of the counties to increase the utilization of local Maternal and Child Health services based on the local evaluation. We do consumer assessments to find out as part of the health education what types of programs and information do they want. One of the major factors I want to highlight here is the community presentation. Every year we have a community-wide presentation. It was highlighted in the local newspaper and Miss Robinson was able to develop partnerships with other individuals that we'll meet with this year that will probably help to sustain some of the activities of the project. Because they got wind of the project from reading about it in the local newspaper when I did the presentation. Because the local newspaper came and interviewed me and talked about the work that PD Healthy Start is doing. That's an example with that project.

Next slide, please. The last project the Sunny Futures Healthy Start I want to discuss that once again the role of training and updates, we worked closely in providing training and updates and also looking at specialized studies. As the local evaluator and part of the consortium data subcommittee and able to work with the data subcommittee to look at not only data within the project but within the county and the city. So we worked together to bring this information back in a collaborative with county health officials, city health officials and other Maternal and Child Health health providers together. So once again they see my role as the local evaluator coming in from the perspective we want to look at. One of the studies we did was on breastfeeding trying to increase the number of clients doing breastfeeding. I was able to develop an assessment tool on what were some of the barriers to breastfeeding. Within the project we implemented the tool and we came up with results that currently are helping to case management and healthy education staff to redirect their teaching and also promoting breastfeeding. Another factor we're working at is looking at post partum assessment, why women don't go to postpartum. A large percentage were continuing with the postpartum visits. We developed a specialized study to look at what are the barriers and we'll implement them within the case management program and also the education. And another major factor that we're doing that I recommended as part of the consortium is that I present my local evaluation results on an annual basis where after the last evaluation which was August of last year presented some of the other Maternal and Child Health providers came up and said this is good information. Why don't we as a consortium present our information on our projects? So starting this fall I'm working with Ashleigh Garrett and a data

subcommittee and we'll ask the other consortium people to present some of their evaluation results of the work they're doing within our target community.

Last slide, please. The last slide I think one of the most important factors from lessons learned over 11 years is commitment and understanding. The understanding of the importance project directors of local evaluation so I explain to them the history, back to when the project was originated with the national evaluations so they can understand that level of commitment. And as David mentioned money is a factor. But like in any case, it is what you're definitely going to support and understand. Program improvement. We have improved the program from outreach to case management based on the local evaluation specialized studies, program development. We've also looked at developing new incentive-type programs based on the local evaluation results and we also have demonstrated program effectiveness beyond performance measures in basic number counting. The last factor is sustainability as David mentioned. One of the roles I played is that when they see other grant opportunities I am able based on my expertise to use my information from the local evaluation that can support the grant application and we have been successful in different arenas. That's it. Now I will turn it over to Cheryl Merzel.

CHERYL MERZEL: That was a wonderful presentation. I'm so impressed with the wonderful work you've been doing. Let me just briefly give you a little bit of my background with Healthy Start. I started off in 1992 as the local evaluator for one of the original demonstration projects. So I think I could be called a long-term survivor of

Healthy Start. I've been involved with this project for a very long time. In several different capacities. But local evaluation is something to echo what David said is something that I do see as being a very important part of program development and something that as evaluators we all feel a commitment to work with the projects to come up with local evaluation studies that really serve the needs of the local programs. What I'm going to talk about today is how the down state New York project uses local evaluation as a way of developing programs and providing information back to the program team and our community partners. And I'll focus on two particular local evaluation studies that the project is conducting. There are several more that I won't talk about today. But there are more activities going on in this area.

Next slide, please. The first I would just like to acknowledge all the partners with the down state New York Healthy Start project. We have partners at Columbia University which serves as the grantee. And I want -- then we have three community organizations that really are the -- serve as our lead agencies and that's where all the action really takes place. And I would like to just call out for special mention here Kevin English, a doctoral student in public health at Columbia who was instrumental in developing many of the things I'll talk about today and also very much the directors and case management teams at the agencies. Our work really reflects a true partnership of efforts.

Next slide, please. So just to give a little bit of background about the down state project, it is a community academic partnership. The academic partner serves not just as the

local evaluator but is the grantee for the entire grant. So Columbia wears many hats. And the community partners are the local lead agencies responsible for all of the core services delivery and for the consortia activities and we cover a broad area ranging from queens in New York City extending out into the Long Island area of New York State and so that spans probably over 70 miles and so it's a quite diverse project. We cover urban communities in Queens. The nausea county area is suburban and rural in Suffolk but communities with high area of need and poverty. Pockets of poverty amid great wealth. Long Island is one of the most wealthy areas in the country. Our communities are characterized by a number of immigrants particularly from the Caribbean and Central America and Mexico. Our community partners provide all the core services, as I mentioned. And they use essentially a lay health advisor model to deliver the case management health education, interconceptional care, all the core services an generally three to four case managers at each agency.

Next slide, please. So this diagram shows our partnership model. You can see on the left the university as the grantee does all of the typical grantee, grants management kinds of activities and also the data and evaluation activities and then on the right the community-based organizations really provide leadership in the area of service delivery and the consortium activities. But the intersection of the two is in terms of leadership and particularly capacity building. And that really reflects what we're trying to do with all of our local evaluation activities. It is all done very much with the commitment to building the capacity of all the partners to improve the work that we're doing and better serve our communities. And the academic partner in this particular case of the local evaluation is

able to provide expertise in terms of looking at the evidence-based for program design and development and evaluation and then work closely with the community organizations planning an implementation and feedback of the evaluation findings with the purpose of program improvement. It is a true partnership model.

Next slide, please. So now I'm going to talk about some of the specific local evaluation work that we did and first as a bit of background, because what we're doing is evaluation, very much in the spirit of evaluation, program planning as a cycle, very difficult to separate the two out I'll talk about some of the program development activities that we did that really fed right into the local evaluation. We have done a lot of work in this project over the past few years in the area of smoking cessation. All of us in the project recognize and this is the academic partners, community partners recognize that smoking along our Healthy Start participants was a major issue and previously we had asked only very minimal kind of screening questions. We basically asked women when they enrolled in the program do you smoke, yes or no, and if they said yes, hand out a brochure they said leave it at that and move along which probably sounds familiar to a lot of agencies. And recognizing the limitations of that, the academic partner, local evaluators, examined the literature for evidence-based and user-friendly programs that we could then try and implement in our agencies and we came up with several evidence-based approaches. We developed a three-pronged approach for improving our smoking cessation activities. The first area was in improving assessment. It gets back to the issue of going beyond simply asking yes or no do you smoke but asking a number of questions, in particular we're interested in finding out about previous smoking

behavior because as I will discuss in a moment, and as many of you know, post partum relapse to smoking is a major public health issue and generally the literature shows that up to 80% of women who give up smoking during pregnancy start again. We need to find out what is currently smoking. We used the smoke-free families protocol from the Robert Wood Johnson Foundation for that. And it was improving counseling. We went to the preventive services task force clinical smoking intervention guidelines and found that the five As they're known, a brief counseling intervention that has been found to be very effective when delivered by healthcare providers in terms of getting people to smoke combined with motivational interviewing, a technique that helps people come up with solutions on their own to overcoming some of their behavioral issues they confront. So we developed a protocol that involved the five As and motivational interviewing. Finally, the third prong of our approach was to improve referrals to cessation services out there. In particular the New York State smokers Quitline where we developed a referral relationship with them. So that briefly is the program that we developed. And then as part of the development and evaluation, we pilot tested all the materials with our agencies and this is an area now we started working very closely with our agencies and they were very helpful in telling us when the wording of some of the questions on the assessment tools wasn't quite right or the flow of the way we were asking things didn't quite go smoothly so that we were able to adjust things. And also to help us identify areas for things like Spanish translation. Then we also provided training or capacity development workshops for the case managers, another important part because we recognize you can't simply give people a written protocol. We developed a series of four one-day workshops that were conducted over a three-year period that involved very

much interactive hands-on activities such as role playing. And we also worked closely with the agencies to develop the implementation tools. So, for example, we worked with the case managers to come up with a flow chart that would help essentially give a decision tree to show if a woman answered in such a way, said she was a current smoker, this is what you do. If she said she was a former smoker, this is what you do. Color coding the charts so the case managers would know is this a current smoker, non-smoker or someone who quit. David said the importance of publishing. We're very pleased to say that the findings from the development of this project and the process evaluation that I'll talk about in a moment are going to be published in the journal of public health management and practice. So when that comes out there will be more details available to all of you about how we developed and evaluated this program.

Next slide, please. So this is what we did for the process evaluation of this program and we focused on the process evaluation which was really getting at how is this program being implemented. How it is working in the agencies? Because we really want to make sure that we were developing something that could be sustained internally that was going to be adopted by the case managers, not something that they would say oh, well, you know, it sounds good on paper but doesn't work in practice. It's taking too much of my time. I don't see the importance of it. We really wanted it to fit. So this really reflects the three evaluation domains that we focused on. We wanted to examine the feasibility of program implementation, what we were doing, was it something -- is it possible for our case managers to be able to deliver a brief counseling intervention and track and follow women? The next thing we looked at, well, does -- do these tobacco cessation

activities fit into the overall project context? These are women who -- case managers do home visits and they do sometimes meet with the women in the office. Does it fit in with the assessments they're doing? Is it going to interrupt with the case manager/client relationship? These were the kinds of things we wanted to look at. Finally we examined fidelity. Whether or not the case managers were able to follow the protocol as intended. And we used a number of different evaluation methods in order to answer these questions. We looked at the actual chart reviews to look at whether or not the forms were being filled out and then we also did pre-and post tests of the case manager trainings to make sure the information was being relayed and the case managers felt they were able to take this information and now use it. And then finally, we did qualitative interviews with the case managers to get their views on how the program was working. And all of these were done with the purpose of program improvement. So what were some of the major lessons learned from the evaluation? I'm not going to go into the interest of time details about all of the findings here. So we found that it was very important to have user-friendly, brief tools for the case managers to use and if we kept it that way, it was very feasible for the case managers to implement this program. They told us that it basically took them only about five minutes to go through the assessment instruments forms with their clients. And that was very critical as helping them adopt this program and make them feel that the work they were doing was something that would fit well with their current work to not be an unnecessary -- not unnecessary but be an additional burden. Also, another important finding is the importance of continuous capacity development and training. It was really important for us to -- throughout the process, keep examining what were the factors that facilitated

adoption and implementation of this program and what were some of the barriers to this and things that would affect program quality. So we came up with a number of things that are called system tools which are also part of the recommended guidelines in the preventive services task force which says if you're going to implement provide-oriented cessation programs you can't focus in between the provider and the patient or the client, you also have to put in place systems in the setting that will help the providers remember to ask women whether or not they smoke, things like that and that refers to things like the stickers that we put into our case management forms and that was an idea the case managers came up with and they came up with a very interesting color-coded system of red, green and yellow that would be easy for them to remember who was a smoker, the red, and who was a former smoker, yellow, and who was a non-smoker, green. We also found it was very important to have multiple interactive workshops. We found that the case managers who attended more of the trainings were the ones who were better at implementing the smoking cessation program. So that was a very important finding. We also found that they really liked the interactive nature of the workshops and that really helped them master the material better. And so these were all issues that were related to the fidelity of the implementation.

Next slide, please. So the next study I'm going to talk about again pretty briefly is also about our smoking cessation activities. This one now was one where we decided to look at the information that we're collecting to get a better idea. Well, one of the reasons why we wanted to undertake this program is we wanted to be better able to identify women who were current smokers or at-risk for smoking. How are we doing in this area? Are

you able to identify these women? We looked at the data from the smoking assessment forms used by the case managers and analyzed the initial smoking assessment and the first follow-up assessment that was typically conducted about two months after the initial assessment, typically at a home visit. And we compared current, former and non-smokers and again, these are findings that will be published coming out soon in Maternal and Child Health journal and we're very pleased about this, too. We think these findings have a lot of implications for the way many perinatal providers go about providing smoking cessation services to women. I'm summarize the finding from this study so that you can get a taste at -- of what we were able to find in some of the important things we identified. First we found out that 17% of the women were identified as at-risk for smoking resumption. That means these were former smokers who if we were asking the original question of do you currently smoke, yes or no, we would have missed them entirely. We would have thought no problem and move on when they said no but they're at risk for resuming smoking.

The next bullet point shows, by the time of the reassessment two months later, 22% of the former smokers, one in five, had actually resumed smoking and again, the -- all the studies tell us is that probably within one year close to 80% of former smokers, perinatal women who formerly smoked will return to smoking. This is just the tip of the iceberg. And we also found that the former smokers who resumed smoking were heavier smokers before pregnancy than the women who managed to stay quit and we see this as being a useful screening tool that is easy to use for the case managers to use as a flag to see if this woman was a heavy smoker beforehand, then to help tailor the nature

of the counseling the case manager would provide. Finally the other significant findings that we had were in the area of partners who smoke and having household rules about smoking. That all the women who resumed smoking, the former smokers who resumed smoking, 100% of them had a partner that smoked compared to only 29% of those who stayed quit and the former smokers really were much higher than non-smokers in terms of being around partners and other people who smoke. So again these we see as being important risk factors for relapse to smoking and important areas to target for health education by the case managers.

Next slide, please. So -- this is my last slide here. Just to talk about some of the next steps for the program development that the program is using based on these local evaluation findings. We identified the importance of having in each agency tobacco cessation coordinators, staff who would take the responsibility of making sure the program was being implemented. The case managers weren't having any problems with implementing the activities and really sort of like being the internal champions for the program, that that was really key. The next finding that we had -- this was based on feedback from the case managers is that we really need to probably provide additional training and motivational interviewing. One or two times we provided training was not enough for them to feel comfortable to continue doing it. The third important next step is recognizing that as a project we probably need to increase our efforts about environmental tobacco smoke exposure since a lot of that was going on in the home and that's something that case managers would want to focus on for educational efforts. Including focusing on partner tobacco use and finally, the importance of not overlooking

the former smokers because these are the women we need to target when it comes to relapse prevention. So this I hope gives some examples of how we use the local evaluation findings to -- for the purposes of program development and quality improvement.

Let me close now with just talking about a few of the challenges that I think we face in doing all of this. So clearly there is a need for ongoing support, technical assistance and training and that involves time and money. Before, you know, David spoke about the issue of resources. Now, this project as a whole didn't require a lot of additional resources. It was really mainly services of the graduate research assistant and all the in-kind time from the case managers but still it does require some kind of upfront attention to this and then the additional ongoing time is really probably one of the major factors. And then the other challenge that we've really confronted which I'm sure some projects can identify with, is the challenge of integrating the tobacco assessment forms into our project database because things got developed across schedules when we changed our project database and were unable to integrate these forms into it. So that has affected things a little bit. Hopefully we'll get them in there and the final challenge has been trying to do a good outcome evaluation so we can address the question of how successful are we in changing smoking behaviors? In conclusion, again, I hope this provides all of you with an example of how Healthy Start projects can integrate program efforts with local evaluation and use the findings for the purposes of program improvement and to help sustain these programs within the agencies. So I'll turn things over now to our next speaker, Jim Masterson.

Jim Masterson: Thanks, Cheryl. I've taken notes here. I'm sure how it's value added to your project. My name is Jim Masterson and I have an MPH special emphasis in biostatistics. In my first life I spent 20 years in public health practice. I started as a senior statistician working with vital records and developing methods to evaluate programs. Over the course of 20 years I was able to move my way up the first step of the commissioner of the health department in the City of Chicago. I think what I got out of that and the reason I bring that up is I have come to the conclusion that implementation of programs is very challenging. MCH programs trying to reach the hard to reach population that we're serving now is a very difficult chore. Designing them is also important but that implementation. So I'm a big proponent of incremental improvements. Currently I'm the owner and senior partner of Hamilton Bell institutes which is a management and healthcare consultant firm in Chicago and we serve clients in both the private and public sector. I am now locally evaluator for two projects in the Chicago area. The Chicago Healthy Start project, which is in the inner city, and it's a pleasure to work with the project director, Jerry WINN and it's a Healthy Start project in the Chicago suburbs and Ms. Jackson is the project director and a pleasure to work with. Both of these -- I'm fortunate. Both these project directors recognize the importance of local evaluation. They use me differently. But they both recognize and, I hope, continue to recognize the value of having a local evaluator and local evaluations.

Next slide, please. Today's objectives. Jeff and Cheryl and I were asked to provide examples how projects with meaningful -- examples of projects with meaningful local

evaluations. Jeff and Cheryl have done their job, now I'll try. I'll describe and document the local evaluations and local evaluators through project directors. My purpose is to encourage and motivate project directors in this tough economic times to continue to support meaningful local evaluations. My bias is that it's done clearly in the CQI context.

Next slide, please. The overall goals for the Healthy Start just to put us in the right frame of mind here is to improve access to quality Maternal and Child Health services and this is providing these services to hard to reach, high-risk populations, to reduce the high rate of infant mortality and reduce, eliminate racial disparity. That's a very challenging set of goals.

Next slide, please. All right. The expectations that the Maternal and Child Health Bureau has. The first in red quote is local evaluations will have added focus during this funding cycle. That's a quote taken from the October 31st, 2008 technical assistance meeting in the competing application mode. I list some of the areas in which local evaluators can provide enhanced support to project directors. This is not a total list, just things that came to mind as we were preparing. Facilitating the initial needs index and institutionalization of CQI. The initial needs index, it's initial when you're a new project and there are probably six new projects and I encourage you to get involved with your Title V director because they have to do that every so often. But you need to do it locally and enhance whatever is being done at the statewide level. And we do it in Chicago every four years and we use a Maternal and Child Health index as the fundamental basis of looking at the smaller area data, 77 community areas in Chicago, for example.

Things shift. You have to make sure that those big underlying trends in population is understood. Then secondly I would like to touch on institutional CQI. When you first start you won't get it right the first time. It just won't happen. So if you concur with that statement, then you've got to plan for improvement and base decisions on what is working and what isn't working so you can work to improve is central to your success, in my view. And a local evaluator with analytical skills helps with that. Measuring the extent the project reduces or eliminates disparity. It's important to have using matching sets and understanding the nuances of small numbers, developing risk assessment tools and profiles. I'll talk more about that later. We need to serve the highest risk, given our dollars, the highest risk even within the highest risk communities we try to find the highest risk individual and the development of risk assessment tools. Local evaluators can help you there. I'll spend more time on risk profiles in a minute. Measuring the impact on core services. The outreach, case management, health education, etc. These need to have an impact. We need to measure their impact on improving access. Why do it? So that what we're all about. Ultimately if that access should do anything it should affect health status. As Cheryl said some of the outcome evaluations are challenging and difficult but we have to try. We have to do it and early evidence suggests that we are successful. Measuring improvement in O and B performance and outcome measures are the bottom line. The perinatal -- these have to be able to look at them separately because there are different causes for neonate. We see what we're doing in those areas to make sure our interventions cover the waterfront by a statistician or a local evaluator with skills and familiar with vital records can really help you there. The last thing and probably the bottom line is as David mentioned, the local Healthy Start

story. Evaluators can help that be empirically based. Anecdotes aren't going to do any good anymore. We have to give the feds the numbers and that's where the local evaluator can be of assistance and it translates to sustainability.

Next slide, please. All right. Let me talk a little bit of the most of my comments will be about the Chicago Healthy Start project. Occasionally I'll reference the Aunt Martha's project but it's too hard to go back and forth because they're different. Let's profile the Chicago Healthy Start project. Conducting needs assessment. Very important. We have to know the baseline, where we're at. We have an in-house index which is basically five parameters and we're taking the communities of Chicago and weighting them. It's an index. What areas in terms of MCH are the neediest? We look at the upper -- we target the most at-risk communities for our attention. This project area for the City of Chicago is -- includes the seven neediest areas. I'm talking real need. So now helping us serve the high-risk population is four family centers. FQATs. That's the hub and where the action is. The Henry Booth house, near north health center. Each of these partners have their own communities and their own issues. They serve different populations. Chicago is an area of neighborhoods. Area family center, heavy Hispanic etc. It's not even just as we're so different as projects so are our partners implementing them and they have latitude as given to them by the funding agency which is the Illinois Department of Health and human services to implement their programs but we monitor their performance in implementing them. It creates a one top shopping for culturally appropriate services and it works. One thing I want to tag in here is we have to be integrated into our larger perinatal healthcare systems. Can't do it alone. In Illinois we're

fortunate. We have a statewide regionalized family healthcare system. Our hospitals are designated, as most states are. There is a working relationship between the level one, two and perinatal centers and we tie into that. Martha has done a wonderful job tying a level two facility where most of the births occur at with a prestigious perinatal center. We need high risk patients to deliver in the hospitals that have the resources to save those little bitty babies and that's why tying into the larger system does.

Evaluation plan has -- next slide, please, I'm sorry. I wanted to sort of unbundle a three-part focus or evaluation plan. The first level is project and HT specific performance in implementing the core services. What we do is generate standard reports. We look at the data, the reports look at agency-specific issues and if we find on one of our parameters and measures in materials of performance that one of the agencies is going in the wrong direction, it's an incident. Maybe the next quarter, we need to say we need to do focus review. Let's take a look at it. We meet and talk about it. Those that are doing better share what they're doing, etc. Sometimes what's working in community A doesn't work in community B but just talking about it identifies barriers and we have been successful with once we identify something what you guys call evaluations. And we call them focus reviews and then that translates into informed decisions. We also have to look at project effectiveness. That's the bottom line. Did we improve outcomes? Have we improved the health status of mothers and infants we serve? We don't want to be data rich in information pool. We need to know are we doing a good job. It's beyond the data. The data -- what I think I want to say is that local evaluations sort of are the bridge between data and actionable intelligence. They're the bridge because data in

itself doesn't allow you to make the more informed decisions. It has to be analyzed, make sure it's reliable, and complete. I'm getting off on a tangent. Health systems. Integration with larger healthcare systems. Can't emphasize that enough. We need -- a lot of things we do are about good babies. Having babies that are bigger than they might have been. Beyond the low birth weight. But we're not always successful. So we need to get those little bitty babies into the right place and that's a key in our approach and we monitor that.

Next slide, please. New issue here. Risk assessment and risk profile. It's been mentioned a couple of times. We need to seek the serve the highest-risk women. We don't -- there are women who are motivated to go knock on the door and get the prenatal care, etc. That's not who we're really targeting. We don't have -- we need to target and go after the hardest to reach and first of all we talked about women first standing point of age in the neediest community isn't enough. We assess each woman, our out reach program finds for their eligibility. We look at nine factors. The nine factors that are medical and four that are social. If they're eligible, they get enrolled in Healthy Start. If they're not, they still get enrolled in the Title V Maternal and Child Health program but there are more intense services provided for the Healthy Start clients. The risk profile, once they're enrolled and they deliver, we know what their risk factors were and it would be -- we'd be missing a bet if we didn't go back and examine those risk factors. Perhaps get down to training on those but anyway, I'm going to speak a little more about how valuable the risk profiles are. The risk factors are reviewed and revised. -- they looked and evaluated. The evaluator is useful even in the beginning

when you're developing the tools. I'm pushing for consideration of local evaluators from the get-go.

Next slide, please. This risk profile of pregnant participants puts a face on the numbers. It is very useful. I know, Jerry, when project director of the Chicago Healthy Start program uses this with the consortium. We used it with legislators. This is very motivating to me when I see the high-risk population we're serving who wouldn't get these services if it weren't for Healthy Start makes me want to improve quickly because the woman who is coming through now needs the best of care. So we don't have time to wait. We have to keep working to get it better and better. Let me just bear with me. The typical Healthy Start pregnant participant can be described as inner city black female from 15 to 34 years of age at high risk for poor outcome of pregnancy. The typical is likely to have a disease that can affect pregnancy. 22% of our pregnant participants in the Chicago Healthy Start project have a disease that can affect their pregnancy. Have been homeless or that should say or in temporary housing. I omitted that. 20% of our high-risk women that we serve have either been homeless or in temporary house. Low educational attainment 14%. Less than high school education with the history of many pregnancies, 9% have multiple pregnancies. Sneaking up on one of these criteria is the -- 7% have diagnosed mental health problems. This is very useful. I can't stress it enough talking to legislators, advocates, consortium. We create these profiles not only for the overall program but for each of our partners because they serve different clients. One serves a Hispanic population, we have a large Chinese population as well. The diseases or the risk factors do change but this is for -- taking all the patients together.

So that's very useful and there is a chapter in our story. We are reaching the hard to reach population and we can define what those risk factors are.

The next slide, please. Three phase implementation process. I sort of thing that as a project matures the evaluation shifts. It changes dramatically. And Johannie asked to talk a little bit about the new projects and how it might be different and why would a new project need a local evaluator. Some of the things to do in the formative phase, you need to collaborately develop a local evaluation plan. You need to get out there and talk to the partners, even do some work with your clients, potential clients. You need to start defining the data system requirements. Developing relationships with local health departments. You need access to vital records. I could talk about the challenges that is for quite a while. Again, preliminary do an evaluation of your implementation. We use incentives. Are they working? You only have a little bit of money. If they aren't working you're wasting your dollars. So incentives to come in for prenatal visit, etc. Design and data collection documents. With Jeff and Cheryl both mentioned. And then initially you have to decide on your long term data collection system. It would be very important to have your local evaluator available during this formative phase. The process phase overlaps with the formative phase as with the outcome phase. You identify performance measures, finalize the local evaluation plan. Defining objectives related to the local evaluation. You're getting your data collection system going and most importantly getting a good edit or correction cycle. The PDSA kind of stuff. Once you're there and you have the milestone out of the way you start to generate what I call standard reports so you are not data rich and information poor. You aren't just collecting the data. It has

to be used. Get it out there and you're looking at it. So we do that quarterly and then we sit around in a meeting and evaluate the agency performance and have open and honest discussions and we implement change that we can afford to implement. One of the things that I see critical and available to you if you use a local evaluator is somebody play a leadership role in implementation of continuous quality improvement. You get to the outcome phase. This is a longer-term outcomes and usually requires access to vital records. You have to examine the outcomes both at the target level and the project participant level. And low birth weight, very low birth weight, the determinants of infant mortality need to be scrutinized. And we need to be sure we're looking at post neonatal mortal as well as neonatal mortality.

Evaluation measures. As the project matures, local evaluations are refreshed to shift away from process measures and toward more intermediate outcome measures. Those are more than just, you know, rubrics to categorize things. As a general guide, process measures are things staff does, things that our staff does. Intermediate outcome measures are client based. The things the client does as a result of what we did. Eventually you get these linked to your actual outcomes so you start with process, intermediate and the whole analytical construct that a local health evaluator can keep you on track with.

Next slide, please. I think I may be running a little fast -- a little long here but this slide is sort of in green are the intermediate outcomes. We didn't start out by having confidence about our figures on adequate prenatal care we were counting visits. Through time

we've improved our adequate prenatal care and it's something we're very proud of. We're improved our rate of child exams and immunization levels and postpartum visits. Getting that woman back so that she can start to make her own decisions. Reproductive life plan going maybe for the first time. We often get them late in the pregnancy the first time. The interconceptual period is huge. The ones in green are intermediate outcome measures. Then there is quality improvement. Here are the elements, meaningful local - - done in a process. They don't have to be but I think these examples that were given by Jeff and Cheryl you'll see most of them do. The purpose of us doing the special studies is to improve things. To make evidence-based practices useful and see what's working and what's not. Complete, valid and reliable data. Another thing. Is data by itself -- can it can incomplete, it might not be valid. All of that has to be checked out again before your local evaluator will put his name on it. So there are some preliminary work that needs to be done so you have the right information to make the decision project directors. And that's what they can do for you. Capacity for data information. Data is not sufficient. It needs to be analyzed. Compared to control groups perhaps. So somebody with analytical skills that has the training and background can do that. I have those in green. I think that's where local evaluators can be the most helpful. They can keep the discussion going around the issues that seem to be falling off the target levels. They can start the discussion with empirical data and they can be your ally as you begin to try to find and identify areas for improvement. They have to be selected within your own resources. Ability to implement change. These are things they work with you on. They come back in and get in the front of the room and help you monitor the impact of that

change. That change doesn't necessarily -- it isn't necessarily any better than what you were doing before. You have to prove it.

Next slide, please. Healthy Start story effectiveness. I won't spend much time on this but the bottom line is the components of infant mortality need to be examined separately.

The underlying causes, they're very different. Therefore the interventions have to be different. Determinants. We all know about very low birth weight being a determinant. It is a struggle to improve that in our high-risk population. Also very low birth weight survival. We know in Chicago and the State of Illinois that babies born in perinatal centers with all the resources have better survival rates at the lower weights than if they're born in a level one or two facility. So that's why we like to track and develop relationships and hospitals -- we're fortunate. Level two does have relationships with a perinatal centers. They must by code. All you have to do is tie into that system.

Next slide, please. Probably the most -- I'm happy to share is the impact of the local evaluations. The Healthy Start -- the -- remember, the profile of our patients. We moved adequacy of prenatal care for our patient high-risk, hard to reach women from 44% to 65%. It was focused reviews, we called them. We found out we weren't doing well. Sometimes it's data entry. Sometimes it's completeness of data. We did that on each of these. Well child exams. 42 to 72%, wow. Initial postpartum exams coming back and entering that very important interconceptual period where we can start from the beginning. We went from 31% to 71%. All of these were targeted and found to be areas

of focus review. We've sent our stories in on these in the form of our impact reports, etc. And this is an important part of our story. How to get over the barriers.

Next slide, please. Findings. I think this is the same as lessons learned. First I would encourage project directors to assess their analytical skills that are available to them. They're necessary to provide local evaluations and to provide you with the actionable intelligence. Data alone is not going to do it. You need to -- I'm using army-type terms. You have to attack the things that are your barriers. Independent local evaluators. I underlined independent because you do need somebody who isn't your best friend telling you about your program. You need -- you don't need people who work for you telling you how good you are. You need somebody that gives you the right skinny and in the right way they have to give it to you, too. It's all about improvement and working as partners. A local evaluator adds that dimension. Bottom line is real progress is challenging and can only be attained incrementally. The definition of insanity is doing the same thing over and over and expect something different. You need a change but how do you change and what do you change? It needs to be empirically-based.

My last slide, please. I'm hoping that our Healthy Start stories, we know they'll vary widely but I think they can have a common theme. I heard of successes, I see successes. I'm in successes. Local Healthy Start you can put your own name in there. We need to get the stories out there. The theme or the story line is we're successful at implementing innovative community-based programs. At this point I think we're going to go into the Q and A. I'll turn it back to Johannie.

>> Thank you, Jim. Thank you everybody for your great presentations. We do have a couple questions that came in so I will go straight into the question and answer session. The first question is for Cheryl Merzel. You mentioned the use of a client chart review. Did you create a formalized document, audit, that was used to guide the record interview? If so, can this document be shared with other Healthy Start projects?

>> Sure. First of all let me say we're happy to share everything with Healthy Start projects and even non-Healthy Start projects, too. And we have all of our protocols available, too, regarding the smoking cessation program. For the chart review we created a structured review form that we use to help us assess whether or not the -- what we were finding in the chart reviews were what we wanted to see and what we were expecting to see. So what I would suggest is if -- I don't know how we can make -- I should have put my email address on the slide. But if that's available feel free to email me and we can share this or should I send that maybe to someone centrally and it can be distributed?

>> You could send it to me or go ahead and say your email address.

>> Okay.

>> And they can write it down but send it to me as a backup.

>> Okay. My email address is CHERYL.MERZEL @ Einstein.YU.EDU.

>> Thank you, Cheryl. The next question is for Dr. Guidry. The audience member says Dr. Guidry discussed a breastfeeding assessment tool. Could it be made available to other Healthy Start organizations?

>> Definitely. Of course most definitely as part of the process. I will just work with the project director on disseminating it. We're in the stages of validating it. It definitely can be disseminated. We're validating it right now as part of the process so we can be in contact with Ms. Dunn, the project director. I'm doing that under her project. They can contact she or I or Bonita Baker, the project officers but I will allow it to be disseminated out.

>> Thank you, Jeff. Let's see. Those are all the questions that have come in so far. I'll give the audience a few minutes. Some people might be typing to get the questions in. If there are any other comments that anyone would like to make, either the presenters or David, if you guys want to say a little something this would be your time to do it.

>> I just think one of the things I do want to say. Part of the process, I think, all of us touched on the role of educating and I'm glad Jim brought up at the end with new projects on educating the role on evaluation because it's so important. It tells so many stories. I know Cheryl, Jim, David, everybody has -- I could have done this whole talk by myself with all the things over the 11 years that have actually shown improvement from the focus groups with the clients, from using that information to improve service

delivery. So I think the biggest issue is education and I'm very excited that this webcast has come to fruition because it's so important to let them know that local evaluation is very significant and Healthy Start program, just like other programs, abstinence and other programs are pushing local evaluation because we must tell our story. I just wanted to add that.

>> There was a comment that came in. Thank you for sharing the great work everyone is doing. Gives me a lot of ideas being new to evaluations. So I haven't gotten any other questions. I'm trying to give people just a minute or two so that they can submit questions if they want. Does anyone else have any closing remarks?

>> This is Cheryl. Yeah, I just want to echo all of this to say that when it comes to these kinds of local evaluation, to really just don't try and do everything but really sit down and identify what are a couple of the really important issues you think are critical to -- for your project to examine either for the purposes of the program quality improvement or because you need it for advocacy purposes and really start there. And the key is, we know with all of this, is making sure everybody is on board. Certainly as Jim was saying the quality of the data is so important and if the people who are completing the forms don't understand how it is going to be used and why it is going to be used you aren't going to get good quality data. Everybody has to be involved in this effort together.

>> Thank you, Cheryl. We have a couple of questions that have come in. This one is to each of the speakers. Does each of your project design objectives with annual goals

that go beyond the required performance measures? If so, what are they and also are data provided for program participants or broader than the project area?

>> I'll go first. Basically, yes, because we use the performance measures that are required and each one of my projects is one requirement I have we sit down and develop objectives. For example before breastfeeding came out sleeping position, we sat down and we developed objectives. In addition to that that are required by DGIS and Maternal and Child Health Bureau. That's a factor. Do you disseminate beyond? Yes, we disseminate the information. In New Orleans our focus is New Orleans parish but so other parishes. In Houston we go beyond there to tell people.

>> Thank you, Jeff.

>> I'll go next, I think. The local evaluation plan does have its own set of objectives and measures. They do overlap. With some of the ones that are in the annual reporting procedures as captured on the DGIS but not exclusively. We do go beyond them. We do have project period and annual objectives on all of our objectives that are in the local evaluation plan. We do use those same measures to measure our own cohort of patients. Example, adequate prenatal care. We're comparing that with adequate prenatal care for our geographic region. Our city, the county and the state. So we have benchmarks that compare how we're doing against the overall population and dissemination is within the individual agencies routinely and then out of the consortium and on occasion as we're speaking getting advocates we're talking about our outcomes.

>> And for the down state project we tend to focus our objectives on things that are part of the performance measures but we choose judiciously so we don't include every performance measure but select the ones that we think are meaningful for our projects and the ones we want to target for ourselves for areas of improvement. In terms of the dissemination we try to get it out through our consortia. We've also tried to do it because the local evaluators we're academics and done a lot of conference presentations and publications also. And have found the audiences to be very receptive.

>> Do any of you discuss some training that you may provide to the program staff at the Healthy Start project?

>> I'll take that. For example, David knows when they did the national evaluation of the program I used that as a training tool. I took the slides down from the Maternal and Child Health Bureau's website and each one of my projects I went over the findings that the national program had conducted so I used that as a training. Then every year there is a training about my role and what I'm going to be looking at and how local evaluation fits in. That's required of all staff to attend. Thank you.

>> In New York we developed a few years ago a training module that was based on this approach called getting to outcomes that we adapted for our project that really is a way of kind of boiling things down and making it accessible to program staff, importance and how to conduct evaluation. We saw this really important as a way of developing the capacity of our community organizations to be able to do evaluation themselves. So we

had modules for example that gave focus groups 101, developing a brief survey, things like that. These are materials that we're happy to make available to other projects.

>> For us the role of training is very specific and localized. It has to do with helping improve the quality and completeness of the data so we're using a system that is used by many, many providers. It wasn't developed strictly for Healthy Start. It takes some time to select out the handful -- maybe 17 or 18 key fields and make sure it is coded right, that it's entered in the right place. That took some time and oftentimes the edit cycles. It's very, very focused on improvement quality of data. Those kind of training efforts are part of the local evaluators role.

>> I think one of the things I wanted to add. For example, when I do a qualitative assessments I've noticed the outreach and line staff are so excited to get the groups together for me. When I present the results and they see what they actually have made a difference in their clients it boosts their self-esteem in doing their jobs. They're excited to get the results. Thank you.

>> Thank you, Jeff. Okay. I don't think we have any other questions right now. So actually I think another question just came in. This question is for any of the speakers. How do you communicate evaluation results to program participants and the community at large? How do you take this highly technical information to these audiences?

>> Good question. That's what we do on the annual. When I do the annual presentation to the consortium and the community I take a lot of the technical information out and you have to be selective on the information that you present so basically there are two presentations. One for staff and management that's more technical and one more community-based. It's knowing your audience. I adjust my results, thank you.

>> That is an excellent question and I think the sharing of results is with the agencies that are our partners. They take it back to their staff. Additionally the consortium is largely has a significant number of former participants and on occasion we will invite participants into a meeting where we're sharing results.

>> Sheryl, did you have anything else you would like to add?

>> I think we sort of nothing different from what the others have talked about.

>> Okay. I believe that was the last question that came in. So on behalf of the Division of Healthy Start and perinatal services I would like to thank our presenters and the audience for participating in this webcast and also like to thank our contractor the Center for Advancement of Distance Education at the University of Illinois at Chicago School of Public Health for making this technology work. Today's webcast will be archived and available in a few days on the website mchcom.com. We encourage you to let your colleagues know about this website. Thank you and we look forward to your participation in future webcasts.