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Family and Child Health

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EVALUATION in MCH

In This Issue:

MCHB
MATERNAL AND CHILD HEALTH BUREAU

U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau

Introduction:

Evaluation! It's like housework! Some people might say they like it or don't mind it. A few even admit enjoying it. But, more than a few are overwhelmed and ultimately terrified of it. And the rest of us just shrug our shoulders, heave a sigh and resent the time and money that we would rather spend elsewhere. We wish we were rich enough to hire an expert so we wouldn't have to think about it and could just enjoy the end product!

Well, like housework, doing evaluation is really in the best interests of us all. Evaluation demonstrates the value of what we do every day. It keeps us honest. It lets the folks who use the services and those who pay for the services know how well what we are doing works. It also tells when things are not working and provides data to diagnose the problem. And for many of us, the Government Performance Results Act (GPRA) means that by law we MUST do it. So this issue of *Northwest Bulletin* is about evaluation.

The lead feature discusses GPRA. What is it? Who does it affect and how? It is accompanied by articles demonstrating a state agency's and a private not-for-profit agency's response to GPRA.

Janice Rabkin, Ph.D., guest editor, answers questions from programs in the region, to demonstrate how an evaluator might look at program evaluation questions.

The editorial calls MCH practitioners to the challenge of accountability. On page 6 is a general "how to" article defining terms and providing tips that can help improve evaluation. The resource section includes internet sites devoted to evaluation as well as a bibliography.

The GPRA Challenge - Measuring Performance in Maternal and Child Health

by Carolyn Gleason

Accountability - "It's the Law." The Government Performance Results Act of 1993 (GPRA) is a law of the land and as such demands that every program receiving federal dollars pay attention to planning, budgeting, measuring performance, and reporting to the Congress. This includes the federal Maternal and Child Health Bureau, which oversees federal funding in many state, local and private agencies. Appropriations in future years will be directly related to the effectiveness of performance planning and measurement. In the words of President William J. Clinton, in signing GPRA, "The law simply requires that we chart a course for every endeavor that we take the people's money for, see how well we are progressing, tell the public how well we are doing, stop the things that don't work, and never stop improving the things that we think are worth investing in."

GPRA requires federal agencies to prepare
(1) strategic plans that define an agency's mission and long-term general goals,
(2) annual performance plans with specific targets ("performance measures"), and
(3), annual reports comparing actual performance to the targets set in the annual performance plans.

While only federal agencies will be required to meet the planning and performance reporting requirements of GPRA, all state, local and private programs that receive federal funds will be called on in some way to account for their federal funds. In most instances, the appropriate federal agency will call on its constituent programs to provide data and information that will be used in their aggre-

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Contributions to the **NW BULLETIN** on news from throughout the Northwest, activities of state legislatures, upcoming meetings and events, as well as investigative articles and reviews are welcome; however materials submitted for publication are printed at the discretion of the Editorial Board. Notices for the Calendar should include a brief description of the event, the date, time and place, and the name of a contact person for further information. Submissions must be typewritten, double-spaced; illustrations and graphs should be in a form suitable for reproduction. Manuscripts and correspondence should be addressed to:

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Editorial: Doing the Right Things,

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from scratch to build the capacity to conduct ongoing evaluations may prove prohibitively expensive for programs already strapped for funds. Many MCH programs have found themselves in that bind, asking themselves if they can cut services to free up funds for data and evaluation. In other words, "Do we serve our clients or do we count them"? This is a hard question, but the demand for accountability may dictate a redirection of some funds.

Even if MCH Programs have funds, personnel, and equipment, the current state of the art in evaluation research is far behind our need for analytical methods and tools for evaluating most of our programs. For example, there is no consensus on an operational definition of "children with special health care needs," that would meet our needs to establish health status and outcome indicators for this population.

Finally, our target populations are served by multiple programs in fragmented health and social services systems. To evaluate results and outcomes of our efforts, we will have to collaborate with other programs and agencies that serve the same constituents. Again, this is time consuming, often confusing, and difficult if collaboration is not a high priority for other agencies or if they do not have the time or staff to participate.

In conclusion, many MCH programs face a difficult, but necessary task in developing and instituting accountability and evaluation into their programs. We face seemingly insurmountable barriers, and it will take a great deal of time, effort and resources to have reasonable success. It will take partnerships, cooperation and collaboration within our MCH programs, as well as with researchers, other public programs, and our constituents. We are used to extreme challenges in this MCH profession, and we are up to this one.

Kathy Carson and Carolyn Gleason are members of Northwest Bulletin's Editorial Board. Kathy is the Manager of Child and Maternal Services, Seattle-King County Department of Public Health. Carolyn Gleason is Regional MCH Consultant, HRSA, Region X.

Northwest Bulletin goes to the Internet!

During the next few months the editors of *Northwest Bulletin* will explore putting the Bulletin on the internet in addition to providing our paper issue. The *Northwest Bulletin* is part of a larger effort to provide training and continuing education to MCH professionals in the HRSA Region X. Internet space would provide an opportunity to further incorporate the Bulletin into the continuing education opportunities for MCH professionals.

The Spring 999 Issue of *Northwest Bulletin* will focus on Technology. To begin that process a technology needs assessment will be in the next issue. Please share your ideas and concerns with us. We are particularly interested in learning about any needs that could be better addressed by bringing the Bulletin on-line. Please send your comments to the address at the bottom of the column to the left.

Editorial

Doing the Right Things and Doing Them Right

by Kathy Carson and Carolyn Gleason

Maternal and child health (MCH) programs, like all of public health, have always focused on "doing the right things." We now know that is not enough - we must also prove that we are "doing them right." Citizens and elected officials are demanding tangible returns on the dollars they invest. Even within agencies, the scramble for scarce resources forces tough decisions among competing priorities, and programs with documented results have a distinct advantage. An era of enormous change, both in health care financing and in the role of public health, is a good time for MCH programs to examine our mission and goals, what we do and how we do it, and the outcomes of our efforts. In fact, federal legislation now requires these analyses for all federally funded pro grams. At the bill signing for the Government Performance and Results Act (GPRA) of 1993, President Clinton stated: "The law simply requires that we chart a course for every endeavor that we take the people's money for, see how well we are progressing, tell the public how well we are doing, stop the things that don't work, and never stop improving the things that we think are worth investing in."

The Fiscal Policy Studies Institute has outlined four questions of accountability:

1) What do we want for our children, families and communities? (outcomes)
2) How do we know if we have achieved the outcomes we want? (indicators)
3) What do we think works to achieve the outcomes we want? (strategies)
4) How do we know the elements of our strategies are performing as well as possible? (performance measures)

For MCH programs, these questions are not easily answered. Indicators of preventive services - "what would have happened if we didn't do this" - are difficult and expensive to measure. How do we translate an objective such as "all children in our program will achieve optimum functioning for their medical conditions" into something measurable? We have used indicators such as mortality, health status and risk factors, but these are rarely tied directly to our program efforts, and are the result of numerous influences, most of which are beyond our control.

How have MCH programs survived so far? The neediness of the populations we serve has been politically popular, so we have relied on needs assessments to justify our programs. Most of our reporting activities have been to count numbers served. Even these data driven approaches are difficult, as evidenced by the difficulties many MCH programs faced when federal legislation in 1989 mandated Title V needs assessments, program plans and data reporting.

We have traditionally viewed evaluation as limited to a research model with a control group, an effort that is usually elaborate, difficult, and expensive. While we are often required to build that kind of evaluation into new or demonstration projects, it often seems unreasonable to allocate time, resources and money to this kind of evaluation of our usual activities. It is important that we expand our view of evaluation to include methods appropriate to existing efforts and feasible in the practice setting with reasonable investments of time and money.

What changes are needed to meet the need for more accountability and evaluation in MCH programs? First, adequate funding for evaluation must be built into MCH program budgets. For major new projects and demonstration grants, a significant portion of the budget should be allotted for evaluation. For ongoing programs, the set-aside may be proportionately less, but should still be maintained. A promising trend in State and local MCH programs is to establish a data unit within the overall program, building capacity to develop ongoing evaluation protocols as well as to conduct epidemiologic surveillance and analyses.

Since evaluation must be integrated into all levels of program activity, all management staff should be adequately trained to participate in evaluations of their programs. Adequate time and resources should be built into their program plans, while adequate technology and resources, such as hardware and software, must be available. If data systems and evaluation protocols have not been built into an MCH program, starting

Understanding Performance Measures

Performance measures answer questions about quantity and quality crossed with input and output.

	Quantity	**Quality**
Input	How much service did we deliver?	How well did we deliver the service?
Output	How much effect/change did we produce?	What quality of effect/change did we produce?

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Another Perspective: MCH Programs Ask an Evaluator

To provide another perspective on program evaluation, the editors of Northwest Bulletin solicited program evaluations from MCH Programs in Region X. Programs briefly described their program and then posed a question. Guest Editor Janice Rabkin, Ph.D., Evaluator, Seattle-King County Department of Public Health, in consultation with staff epidemiologists responded to the first two questions and Marcia Weaver, a Health economist answered the final question.

Designing an evaluation is a complicated process involving purpose and what a program wants to accomplish, as well as design methods, sample and recruitment, measures, outcomes, and data analysis. These responses are meant as a beginning --a place to start a dialogue with staff about issues of evaluation.

Alaska Program Profile

Name: Healthy Families Alaska
Description: This program identifies families having children at risk of poor health outcomes and provides intensive paraprofessional home visitation services. Alaska has eight Healthy Families programs in seven areas providing interventions specific to the needs of each families but for each family, collects similar data elements for outcome measurements.

Healthy Families Alaska seeks to find accessible antecedent events in the causal chain leading to poor child health and social outcomes. While many of the precipitators of poor child outcomes are common--including poverty, stress, anger, and neglect, the events leading to these common pathways differ widely among different families. Thus, home visitation providers deliver a variety of services which will be directed towards the needs of the individual family.

Question: How can the program set up a low/no cost control group to measure the Healthy Families against?

Evaluator Response: The first question I would want to ask is what are the health outcomes you are interested in measuring? Will your program have an impact on repeat hospitalizations, ER use, reports of child abuse, childhood diseases or infection, grade promotion, for example? These are some out-comes where you might see the influence of program effects. On the other hand, if you are interested in measures like grad-uating on time, you might not be able to see an immediate pro-gram effect. Sometimes, programs intended for early childhood end before the children reach school, and the program effects may not last long enough to use school information as an outcome measure.

A second concern is that the program is set up so, "the home visitation providers will deliver a variety of services." If there is literature to support the notion that this variable or individualized approach in service delivery leads to a change in a particular outcome, then you are on solid ground in selecting the outcome. If this is uncertain, then having variable interventions may make it even more difficult to interpret results. The reasons for lack of effects may be due to differences in program implementation. You might include a process evaluation or measures of program implementation effectiveness to document program successes and challenges. These are often helpful for policy makers and may be extremely important if there are no significant effects on intended outcomes.

It may be possible to divide families, randomly, into two groups. You will have a group receiving intensive Healthy Families services and another receiving, for example, an assessment and a 1-800 number for advice and resources. At baseline, you compare the intervention and control groups on selected measures. Then you compare at one year or some other time period to see if there are differences between the groups. If there are no significant differences, you may want to change direction or discontinue the program. If there is an effect, you may want to introduce the services to the control group. Of course, there are ethical issues in delaying services that you will have to take into consideration.

There are two resources you may find helpful:
Pecora, Peter J., Mark W. Fraser, Kristine E. Nelson, Jacquelyn McCroskey, and William Meezan. (1995) *Evaluating Family-Based Services*. NY: Aldine De Gruyter.

Whitney, Grace-Ann Caruso. "Early Intervention for High-Risk Families: Reflecting on a 20-Year-Old Model." In *Primary Prevention Works.* George W. Albee, Thomas P. Gullota (Eds.) CA; Sage Publications.

Idaho Program Profile

Name: Idaho Reproductive Health

Description: This is the state family planning program serving approximately 38,000 women from 10 to 55 years of age.

Question 1: Federal MCH funding requires the inclusion and evaluation of abstinence-only programs. Abstinence programs feature a large media campaign and the activities of local coalitions. In 1996, prior to the abstinence programs, Idaho experienced a decrease in adolescent pregnancy. As part of a comprehensive evaluation, how could Idaho determine if future declines are attributable to abstinence efforts or other program interventions?

Evaluator Response: There may be several ways to approach this evaluation question. The Youth Risk Behavior Survey (YRBS) is a National Center for Disease Control-sponsored survey that queries students about health behavior and risk. A question on sexual behavior and reproductive health asks students if they have ever had sexual intercourse. Your state may already participate in this survey and have a percent of students who are abstinent or a baseline rate on abstinence based on these data. One way to evaluate the

impact of the media campaign and activities of local coalitions is to administer the survey after the abstinence programs have been in effect for some time to see if the percent or rate changes in the hoped for direction. This approach will work only if you can assume that no other teen programs focus on abstinence and that there are no confounding program effects that make data hard to interpret.

Another approach makes some assumptions about the program. First, it assumes abstinence programs can increase the abstinence rate significantly enough to see a significant change in the pregnancy rate. Using the word *significant* indicates these changes will have to stand the test of statistical significance. Next, it assumes the pregnancy rate is the best outcome measure for an indication of abstinence program effects. For example, if the abstinence rate remains stable, but an effective use of contraceptives among teens increases, the drop in preg-nancy rates will have nothing to do with abstinence. Finally, it assumes the state collects abortion data at the state and small area level to make it possible to calculate pregnancy rates.

Based on these assumptions, you may want to look for a dramatic discontinuation in the trend line or a change in the shape or slope of the line indicating a decrease in the teen pregnancy rate after the activities were implemented. It may not be possible to tease out effects of these activities over others. Consider dividing the state into areas that do and do not receive the media campaign and local coalition activities. Using part of the state as a natural control group, you may be able to compare the impact of the program activities by looking at a discontinuation or a change in the shape and slope of the trend line indicating program effects. The control areas of the state may receive the same interventions at a later date allowing additional comparisons of trend data.

Finally, you may be able to compare your state's data during the time of program activities with the data from other states that have no abstinence-related program activities to see if there are differences in the rates of teen pregnancy over time.

Of course, all of these approaches to program evaluation focus on quantitative measures that involve enough cases to detect significant differences. While it is tempting to evaluate the media blitz with qualitative approaches like key informant interviews or focus groups, these methods will not provide you with enough information, alone, to help interpret the drop in adolescent pregnancy rates.

Question 2: The program is in the process of getting a Medicaid eligibility waiver, making all women eligible for family planning services. The waiver requires an evaluation to demonstrate that the addition of new clients is cost neutral.

Evaluator response: The first task is to find out who uses the family planning program with expanded eligibility. Do women who are not eligible for Medicaid take advantage of it? If so, what is their income? Have they been eligible for Medicaid in the past?

There is an extensive literature on income dynamics that could provide estimates of the likelihood of someone with low-income becoming eligible for Medicaid. In general, we know that there is not as much upward mobility in the U.S. as our cultural myths suggest. Someone who is middle-income is unlikely to need medicaid and neither are his/her children. The likelihood is greater for someone with low-income, so the focus should be on them.

The second task is to estimate the cost of the family planning service. Imagine something like the implants that cost $6 per quarter or $25 per year. The total cost for 10 years of care would be $250. The evaluation would need estimates that reflect the actual methods used and duration of use. (# of women using method x duration x cost of method = cost of family planning service.)

The third task is to estimate the cost to Medicaid of a child. For example, the average cost of a prenatal care & delivery is about $4000, 10 well-baby visits during the first 5 years is about $1000, and 20 illness visits during the first 5 years to be about $2000, for a total of $7000. (These numbers are for purposes of example. The program would of course substitute the actual Idaho specific numbers.)

Fourth, look at effectiveness. There are two key questions: 1) Is the program effective in reducing "unplanned births?" We know that access to family planning has an effect on teen pregnancy rates. You may want to rely on the literature for these estimates, unless you have considerable time and resources to devote to the evaluation.

2) Are the unplanned births among women who would have needed Medicaid? This relates back to task 1: you may not be able to estimate this, but you should be able to establish some reasonable bounds. For example, if the cost of family planning is $250, and the savings is $7000, you would need to demonstrate that at least 1 out of every 30 births prevented was a mother and child who would have needed Medicaid.

All this begs a more subtle question -- what if the program effects the timing of births, but not the number of children born? Are teen mothers who are not currently using Medicaid more likely to become eligible than older mothers? Are mothers with children spaced 2 years apart more likely to become eligible than those with children spaced 4 years apart? This kind of question may be beyond the scope of the evaluation.

Planning and Implementing an Evaluation: A Generic Guide

Evaluation is an involved process with many factors to be considered. This is a generic guide for planning and implementing an evaluation. Included is a glossary, a list of questions to always consider (on page 5) and several references. In the resources section, page 11, are more references and web sites.

Done best, the evaluation plan is part of the program design. This ensures the appropriate data is collected and ensures the data collection is a part of the everyday process of the program. This is the most efficient method. However, many evaluations are implemented after program design and after program implementation has begun.

Step 1: Define the program goals and objectives.
Goals and objectives usually explain the purpose of the program. The program goals reflect the mission statement. The objectives are the measurable ways to demonstrate the program has achieved the goal. Defined goals and objectives will also help determine the components of the program to be evaluated.

Step 2: Why and for whom is the evaluation being done?
These questions will help to define the evaluation. For program staff, an evaluation can help to improve a program by determining which interventions work (outcome) and why others are less successful (process). Funders often want to know if what they paid for made a difference (impact). They may also want to know if what they paid for saved money or resources or was worth the expense (cost-benefit). Clients, boards of directors, managers and others may want to know if the program or the intervention worked.

Step 3: What is the question and how is the answer found?
Questions fall into several general categories: planning questions, implementation questions (process), performance questions (outcome) or impact questions. Once the question is determined, the source for the answer and method to find the answer often follow.

Examples of Planning or Implementation questions:
- Who participates?
- Do those most in need receive services?
- Did the service/program meet "community perceived local need?"
- What would different groups; program staff, clients, other agencies, community members, change about the Program?

Examples of Performance questions:
- Were the objectives met?
- How many people were served?
- What percent of the target population was served or participated?

Examples of Impact questions:
- Positive or negative results in/on the community?
- Were behaviors, attitudes or risk factors changed?
- What were the costs?

As the questions become apparent, it is always helpful to start considering where the answers will be found. It doesn't hurt to identify any barriers to finding answer. Both data sources and potential barriers will help to refine the methods for data collection.

Examples of Data sources:
- Census data and local, state and federal statistical data bases can provide a lot of information about the community, its composition, behavior and community indicators. They may also help you develop comparison groups.
- Epidemiologists found in local, state and federal organization can also be a wealth of information about populations, risk factors and statistics.
- Program participants-- those receiving the service or their support system (parents, relatives, other providers)
- Program records of clients served, number of classes held, # of participants, # of hours of training received, etc.
- Others: internal clients, external clients, community opinion leaders/gatekeepers, other agencies

Examples of barriers to data collection:
- Reluctant participant. They may feel threatened or "at-risk' if they participate. Some communities and/or groups have been over studied and their members resent data collection.
- Meaningful statistical analysis may require sophisticated calculations not available.
- Clients cannot be located.
- Detailed records were not kept.
- Cost figures were never kept.
- Client confidentiality.
- Geographical area of Census may not match with the program's geographical area.
- Language or cultural difficulties.
- Reading difficulties
- Not enough time. It takes time to change behaviors. The time between program intervention and evaluation may not be long enough to document behavior or attitude change.

Step 4: What method? Quantitative vs. Qualitative?
Quantitative methods. For some questions, numbers are the answer, (i.e., 60% of all eligible clients received the intervention; There are 30% fewer cases of “x” disease.) Program implementation cost "x" dollars and "y" dollars were saved by the program. A quantitative design will probably best answer these questions. Program data describing the clients and the services received, cost information, surveys, behavioral

surveys and observations are all quantitative methods.

Qualitative methods are often used for answering "why" or "to what extent" questions. Sometimes we want to know why something happened. If the question is why, or the answer is not clearly ordinal (yes or no or a number), qualitative methods are used. Some questions can only be answered with qualitative data. Both qualitative and quantitative methods can be used in the same evaluation. Key informant interviews, focus groups, case studies, and observations are examples of qualitative data.

As you develop you methods remember not to reinvent the wheel. Often a search of the literature, a phone call to professionals or a query to a professional list serve can lead to already tested and validated questions and scales. This saves time and energy and can in the long run add impact to the results of the evaluation.

Step 5: Analysis, Reporting and Timelines.
Once the questions and the methods are determined, plan ahead for the analysis. A few minutes with a data analyst can insure that the data collected will be appropriate for analysis. This consultation can also ensure that the data collected answers the evaluation question.

There are computer packages for qualitative and quantitative data that run on pc's which can do some pretty sophisticated analysis, so check out what is available. On the other hand, don't think that a sophisticated computer analysis a mandatory requirement of a successful evaluation. Sometimes percentages are just fine. In other cases, qualitative summaries are the best analysis. And, the use of stories and quotes or a case vignette can be as valuable as a hundred data points. So always look at the question and see what analysis you really need.

Determine how much time will be necessary for data collection, analysis and report writing. Know when and what type of reports are due and plan your timeline accordingly.

Materials for the Generic Guide were developed from The Community Tool Box: http://ctb.lsi.ukans.edu/

Lorig, K. Patient Education: A Practical Approach, Mosby, St. Louis 1992

The Evaluation Forum, Outcomes for Success!, Seattle, 1995

Fink, A. & Kosecoff, An Evaluation Primer, Sage, Beverly Hills, 1978

Herman, J.L., Morris, L.L., & Fitz-Gibbon, C.T., Evaluator's Handbook, Sage, Newbury Park, CA,1987

Fitz-Gibbon, C.T., & Morris, L.L. How to Design a Program Evaluation, Sage, Newbury Park , CA, 1987

Questions to Ask When Developing an Evaluation

Getting Started

- Why is the program being evaluated?
- How will the evaluation be most valuable to you?
- How are previous evaluations of the program described?
- What groups of people are involved with the program or are affected by it?
- What groups should receive information about the evaluation when it is completed?
- Are any major changes in the program anticipated in the near future?
- How much money is there to spend on evaluation?

Design Questions

- How many measurements should I make?
- When should the measurements be made?
- How many institutions, groups, or persons should be included in the evaluation?
- How will institutions, groups, or persons be chosen?

Posing Evaluation Questions

- Did the program achieve its goals and objectives?
- What are the characteristics of the individuals and groups who participated in the program?
- For which individuals or groups was the program most effective?"
- How enduring were the effects?
- Which features of the program were most effective (e.g., activities, settings, strategies)?
- How applicable are the program's objectives and activities to participants in other settings?
- What are the relationships among the cost of the program and its effects?
- To what extent did changes in external circumstances influence the program's outcomes?

Process Evaluation Questions

- What were the key activities?
- Were activities implemented as planned?
- How well was the program administered?
- Did the program's influence carry over to other programs? Institutions? Consumers?
- Did social, political, financial circumstances change and influence program effectiveness?
- What were the comparative costs?
- For every __$ spent on ___, how much is saved?
- If those running the program were to leave, would the program continue to be effective?
- Is the political environment supportive of the success of the program? Is the program well funded?

Sources; Stecher, B.M., and Davis, W.A., (1987) *How to Focus an Evaluation*, California, Sage Publications

The GPRA Challenge, continued from page 1

plans and reports. For the Maternal and Child Health Bureau (MCHB), the first step in complying with GPRA has been the total restructuring of the Annual Block Grant Application and Annual Report that are required of all fifty-seven states and territories that receive MCH Block Grants. A Title V Block Grant Measurement Performance System has been developed, and is described below. The MCHB is also examining potential methods of bringing the Special Projects of Regional and National Significance (SPRANS) programs and projects into compliance with GPRA requirements.

The Title V Block Grant Measurement Performance System begins with the identification of priorities and culminates in improved outcomes for the MCH population. (See the diagram with examples below.) After choosing a set of priority needs from the five year statewide needs assessment, States assign resources and implement programs (services) to specif-ically address these priorities. These services are categorized into four levels:

- direct health care services,
- enabling services,
- population based services, and,
- infrastructure building services.

For all levels of services, there are performance measures - a set of National "core" performance measures and up to ten State "negotiated" performance measures - that are categorized into three types;

capacity,
process, or
risk factor.

Because of the flexibility built into the MCH Block Grant, the program activities or the role that Title V plays in the implementation of each performance measure varies among States (i.e., monitor, advocate, provide, supplement, assure). Yet the program activities, as measured by these "core" and "negotiated" performance measures, should have a positive impact on the National outcome measures for the Title V population.

Accountability is determined in 3 ways;

(1) by having budget and expenditure figures for the four levels of service;
(2) by measuring the progress towards successful achievement of each individual performance measure; and
(3) ultimately, by having a positive impact on the outcome measures, if the program activities are effective and successful.

While improvement in outcome measures is the long term goal, more immediate success may be realized by positive impact on the capacity, process, and risk factor performance measures which are shorter term, intermediate, and precursors for the outcome measures. This is particularly important since there may be other significant factors outside of Title V control, that affect outcomes.

Editor's Note: The two articles on page 9 are published to show a state and a non-profit agency's response to GPRA.

GPRA On the Net

Full text of the Government Performance and Results Act of 1993. http://www.npr.gov/library/misc/s20.html

Continued on page 9

Title V Block Grant Measurement Performance System

continued from GPRA article above

gated, federal level

Priorities ——>
Chosen from the 5 year statewide Needs Assessment.

Resources are now assigned.

Services Implemented ———>
Examples:
Direct Health Care (Gap Filling):
Personal Health Services
Enabling Services:
Transportation, Outreach, Case Management
Population-Based Services:
Newborn Screening, Immunization, Injury Prevention
Infrastructure Building Services:
Needs Assessment, Evaluation, Standards Development

Performance Measures --->
Examples of each type:
Capacity:
The percent of children with special health care needs (CSHCN) in the State who have a "medical/health home."
Risk Factor:
The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
Process:
Percent of potential Medicaid eligible children who have received a service paid by the Medicaid Program.

Outcomes
Examples:
The infant mortality rate per 1,000 live births.
The child death rate per 1,000 children aged 1-14.

Healthy Mothers, Healthy Babies' Compliance with GPRA

by Cynthia Shurtleff, Ginny (Sprenkle) English, Sheryl Vick

The Healthy Mothers, Healthy Babies Coalition of Washington, a 501 (c)(3) organization, has contracted with the Washington State Department of Health since 1990. This contract covers the statewide toll-free Information and Referral Line and the Immunization Action and Breastfeeding Promotion Coalitions. Since state and local dollars used for outreach to low income women and their families are matched by Medicaid, HMHB expects to be subject to GPRA requirements.

A strategic plan is being generated by the HMHB Board which covers a three year period extending beyond the parameters of the state contract. HMHB is focusing on methods of data collection to identify and improve services and outreach to maternal and child health populations. This has positioned us to respond to the requirements of the GPRA. Currently HMHB reports quarterly on process and impact/outcome measures which define data monitoring procedures, detail program activities and determine clients' success in connecting with referred services.

In addition, HMHB Board and staff are developing a mechanism for identifying priorities, programs, and targets through a Performance Plan. This Plan will provide decision making guidelines on strategies for program planning by comparing actual performance with annual strategic goals.

In conclusion, compliance with GPRA requires a visionary and dedicated Board and staff. How an organization uses its strategic planning, data collection and performance measures will determine accountability towards improving outcomes for targeted populations.

More GPRA On the Net

Reaching Public Goals: Managing Government for Results - A Resource Guide. (1996) This is a publication of the National Performance Review (NPR). http://www.npr.gov/library/papers/bkgrd/cover.html

Government Performance and Results Act- Public Law 103-62. This site describes major features of the law. http://www.itpolicy.gsa.gov/mkm/pathways/pp2bgrp.htm

Implementing the Results Act - The 9th National Conference on Strategic Planning for Government: Washington, DC January 21 - 22, 1998 Federal Communicators Network Summary. http://www.npr.gov/library/gpra/012198.html

GAO Reports on Performance Measurement: http://www.itpolicy.gsa.gov/mkm/pathways/gao-rep.htm

Initial Impacts of GPRA on Washington's Department of Health

byNancy Welton

In Washington, Governor Locke shares the philosophy represented by GPRA to increase accountability via strategic plans, annual performance measures, and annual reports. After taking office in January of 1997, Governor Locke instituted a strategic planning process for all executive agencies and has made quality improvement and restoring trust in government two of his main priorities. Accordingly, the Washington Department of Health (DOH) is involved in a process to develop increased accountability in keeping with both the Governor's priorities and GPRA.

The greatest impact of GPRA on MCH has been on the development of the annual block grant application/report. Because the block grant includes a number of components that grow out of the GPRA requirements, the process also works as a learning tool for moving toward GPRA objectives.

For example, beginning in the fall of 1997, MCH staff at DOH began the process of selecting 10 state "negotiated" performance measures. These performance measures were identified based on assessment data and evolving priorities through a strategic planning process. These 10 state performance measures, when combined with the 18 mandated national performance measures have become the measuring stick with which we will gauge our success.

GPRA will also impact our 5-year needs assessment process and the ways in which we develop contracts with the Local Health Jurisdictions (LHJs) around the state. Representatives from LHJs and from other interested organizations provide input into the needs assessment. Findings from this needs assessment will inform the selection of future performance measures and priorities.

DOH and LHJs are also designing a Consolidated Contract within the framework of the core public health service categories (i.e., infrastructure building services, population based services, enabling services, and direct medical care services). Content for developing a menu of local contract activities/options was adapted from *Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America*. The aim is to provide maximum flexibility to LHJs while meeting federal requirements.

"Quality Improvement" Techniques, Find Application in Community Health Projects

by Deborah Stewart

Quality improvement evaluation techniques from industry can be used to effectively address health care issues. These techniques can "reverse the slow pace and lack of lasting change commonly associated with traditional community health projects." This conclusion was based on an injury prevention project highlighted at the Fourth National Injury Control Conference of the Centers for Disease Control in Washington, DC in November, 1997.

Working with technical support from the Institute for Healthcare Improvement, teams in ten communities implemented the "Model for Improvement" to reduce injuries. That model uses a series of cycles of planning and imple- mention, called the "PDSA" (Plan–Do–Study–Act) to test the results of incre-mental changes. It presupposes agree-ment of all involved in the community project regarding:

- objectives,
- measurement,
- countermeasures based on interventions that have been well established as effective.

The PDSA cycle has several benefits: Changes that may seem ambitious and radical can be tried on a small scale.

- Changes can be refined over several cycles before being implemented more widely.
- People who would resist large-scale change are usually more willing to take small steps.
- Mistakes that occur or changes that are not effective can be amended quickly without great losses of time, dollars, or "face."
- A very specific population can be targeted with a flexible program that adapts to the population's needs.
- Community groups that expect quick results will see change and are more likely to stay involved.

Changes need to be measurable in a short time so feedback will be clear and point to further changes. For example, observing the change in the number of children arriving in car seats at a day care center is more useful than waiting for a reduction in injuries in emergency room data. Small scale measurement can be done frequently for relatively little expense.

The Greater Dallas Injury Prevention Center One addressed childhood injury in an inner-city Hispanic neighborhood with a particularly high rate of child passenger injury. (The PDSA method had been used in a 1995-96 project in the Njutaqsiivik Clinic, Anchorage. That project addressed post-neonatal mortality and was reported in the *Northwest Bulletin*, Winter 1996.)

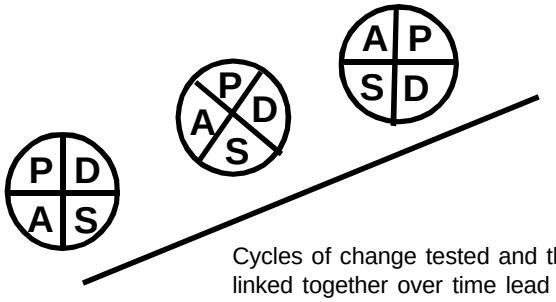
Observational surveys was the method chosen to measure change. Initial observations showed a very low usage rate (20%), although parent-reported use was 75%.

A community team conducted a variety of small-scale activities, based largely on information from focus groups of knowledge and attitudes of local women. Women attended small group education sessions and were then offered child restraints for their children's use. These sessions were advertised in area *botanicas* (shops selling medicinal herbs). Support of local *curanderos* (native healers) was gained.

Injury Prevention Center staff commented that implementing the Model for Improvement in the community setting was considerably more difficult than in more controlled industrial settings. Because the project was also following the "Safe Communities" organizational model, the community team directed the program. This meant it was subject to the ideas and priorities of the team which didn't always follow the improvement model. However, the method of evaluating each small piece of a project using an outcome measure (observed child restraint use) before proceeding, was useful. In many cases, outcomes are measured only at the end of the project.

Contacts: Institute for Healthcare Improvement, 617-754-4800
Greater Dallas Injury Prevention Center, 214-590-4461

Plan-Do-Study-Act Process



Cycles of change tested and then linked together over time lead to improvement

Plan-Do-Study-Act is a cyclical process. At the competion of each PDSA cycle new knowledge leads to change in the next cycle. Resistance to change is minimized because each change is tested and only changes with positive results are kept.

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Resources

EVALUATION ON THE INTERNET

Interactive List Serve Sites

List serves are internet locations where individuals discuss, ask questions and share information about a specific topic. An individual usually must subscribe. The following list serves/TIG (topic interest groups) can be found on the web. Many of the internet addresses are long and take two lines. You must use the entire address.

Collaborative, Participatory and Empowerment topic interest group http://eval.org/TIGs/empower.html

Evaltalk http://eval.org/ListsLinks/ElectronicLists/evaltalk.html

EvalInfo http://eval.org/ListsLinks/ElectronicLists/evalinfo.html

Govteval http://eval.org/ListsLinks/ElectronicLists/govteval_list.htm

International and Cross Cultural TIG http://eval.org/TIGs/empower.html#xceval

Minority Issues in Evaluation List Serve http://eval.org/TIGs/empower.html#mie

Oregon Program Evaluators http://eval.org/ListsLinks/EvaluationLinks/oregon_network.htm

Washington Evaluators http://eval.org/ListsLinks/EvaluationLinks/weinfo.html

Evaluators Institute http://www.erols.com/cwisler/

Evaluation Related Sites

National Center for Research on Evaluation Standards and Student Testing http://cresst96.cse.ucla.edu/index.htm

ERIC Clearinghouse on Assessment and Evaluation http://ericae.net/

Government Performance Information Consultants http://www.sympatico.ca/gpic/gpichome.htm

Social Research Methods http://trochim.human.cornell.edu/

Beginnings is an MCH focused site with materials on evaluation, which includes an annotated bibliography on the health promotion component of perinatal care and literature reviews on a number of MCH topics. http://ww.PrenatalEd.com/

The Demography HomePage is part of an initiative to identify, document, and provide simple access to demographic information. Consists of links providing access to national data resources, on-line supporting documentation (codebooks, data dictionaries, citations). http://www.ciesin.org/datasets/us-demog/us-demog-home.html

Children Youth Family Education Research http://www.cyfernet.org/

The American Evaluation Association has a nice list of links to online evaluation information. The AEA website address is www.eval.org

The Community Tool Box: Information related to evaluation of initiatives, along with examples, tools, and step-by-step how to's. http://ctb.lsi.ukans.edu/

Federal Sites

One Stop Federal Statistics
More than 70 agencies in the United States Federal Government produce statistics of interest to the public. The Federal Interagency Council on Statistical Policy maintains this site to provide easy access to the full range of statistics and information produced by these agencies for public use. http://www.fedstats.gov/

National Institute of Health http://www.nih.gov/

Census Bureau http://www.census.gov/

Publications on the Web

Designing Evaluations. PEMD-10.1.4. May 1991. Guidance. 78 pp. GAO guide on program evaluation designs http://www.itpolicy.gsa.gov/mkm/pathways/gao-rep.htm

Improving Health in the Community: A Role for Performance Monitoring. Jane S. Durch, Linda A. Bailey, and Michael A. Stoto, Editors; Committee on Using Performance Monitoring to Improve Community Health, Institute of Medicine http://www.npr.gov/library/papers/benchmrk/nprbook.html

Performance Pathways. The U.S. GSA's Office of Government-wide Policy provides this one-stop source for information related to the development and use of performance measures. http://www.os.dhhs.gov/progorg/io/naspanel.htm

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Calendar

Spanish Language Workshops for Health Care Professionals, One-, two, or four-day accredited courses to learn how to communicate with Spanish speaking patients. The following are a list of upcoming conferences. For a list of conferences later in the year use the e-mail address or the web site listed below.**January 8-9, 1999**, Phoenix,
January 16-17, 1999, Nogales,
February 12-15, 1999, Tucson,
Contact: Rebecca Ruiz, Spanish Language Workshops, The University of Arizona College of Medicine, Rural Health Office, 520/626-7946, Fax: 520/ 326-6429, E-mail: Spanish@rho.arizona.edu
URL http://ahsc.arizona.edu/rho/spanish/

March 11-13, 1999, American Psychological Association - National Institute of Safety Health 4th Interdisciplinary Conference on Work, Stress and Health, Baltimore, Contact 202/ 336-6033 FAX: 202/ 336-6117, Email: work-stress-conf@apa.org

March 26-30, 1999, "Leadership for Healthier Communities and Campuses", Seattle, http://futurehealth.ucsf.edu/ccph.html

April 19-20, 1999, 24th Annual Adolescent Sexualtiy Conference Sponsored by Marion County Health Department Location: Seaside, Oregon. Cost: $150 (includes luncheons). Contact Kristin Nelson at 503-373-3751 or e-mail KNelson@open.org

May 8 and 9, 1999, Healthy People and Healthy Communities: A Canada – United States Dialogue on Best Practices in Public Health. Toronto, Canada. A conference for health practitioners, public policy analysts, policy makers and health administrators who deliver healthcare services and/or develop health policies. For information: Carey Hill, Healthy People and Healthy Communities. (403)264-9535) Fax : (403) 269-4776 E-mail : hillca@ucalgary.ca Or cwf@calcna.ca

January Deadline for 1999 MPH Programs at UW

Masters in Public Health Programs at the University of Washington are offered as full-time (2yr.) and part-time (3-yr.) courses. The deadline is January 15 for Health Services and Epidemiology. Contact the MCH Program, UW, School of Publich Health, 206/543-8819