Learning Objectives

Upon completion of this session, participants will be able to:

• Understand AMCHP’s definition of best practices and how this conceptualization can be useful to AMCHP members and MCH programs

• Understand the need and benefit of building a strong evidence base into an MCH program

• Identify strategies and resources to build evidence-base into an MCH practice
What is a “Best Practice”?

AMCHP defines “Best Practices” as a continuum of emerging, promising and best practices.

**Emerging**
- Evaluation plan in place
- Incorporates continual quality improvement
- Based on guidelines, effective models
- Incorporates theoretical foundations or uses a novel approach

**Promising**
- Strong evaluation data presented, which demonstrates effectiveness

**Best**
- Program has been peer reviewed
- Replicable in many settings
- Positive results linked to practice
Innovation Station: AMCHP’s database of best practices

- Provides AMCHP website users with information on best practices in an easy-to-use, searchable format

- Encourages replication of best practices in other states through information sharing

- Provides useful resources about other organization’s best practices programs as well as information about evaluation

The site can be found at: www.amchp.org/innovationstation
Pediatric Preparedness in Alaska: Building the Evidence for Sustainable Programming

Laura Andersen, MPH
CYSHCN Emergency Preparedness and Early Childhood Manager
Section of Women’s, Children’s, and Family Health
Alaska Division of Public Health
Department of Health and Social Services
MCH Preparedness: Making “What-if?” Meaningful in Alaska

Earthquakes
Wildfires
Flooding
Volcanoes
Outbreaks

-Not to mention many Alaskans’ love of outdoor activities and “extreme” environments!
Exploring the Terrain

586,412 square miles

Longest coastline in U.S.

Sparse population
1.26 persons per square mile

Limited road system
Case history: 2007 RSV outbreak
Or, Why Planning for Peds Disasters Is Important

Barrow, Alaska
Population ≈ 4,200
720 air miles from Anchorage
53 children hospitalized
28 transported to Anchorage
Alaska, five years later

Statewide population of 710,231
Growth over 10 years: 13.3% (versus 9.7% average across U.S.)
26.4% of population under age 18
Wait, what else has happened since 2007?

AMCHP: State Emergency Planning and Preparedness Recommendations for Maternal and Child Health Populations

National Commission on Children and Disasters: Final Report to the President and Congress:

“In our final analysis, meeting the needs of children in disaster planning... is a national responsibility lacking not only sufficient funding, but also a pervasive concern, a sustained will to act, and a unifying force.”
2010 Commission Recommendations

1. Disaster Management and Recovery
2. Mental Health
3. Child Physical Health and Trauma
4. Emergency Medical Services and Pediatric Transport
5. Disaster Case Management
6. Child Care and Early Education
7. Elementary and Secondary Education
9. Sheltering Standards, Services, and Supplies
10. Housing
11. Evacuation
Challenges

• Access to services
• Availability of preparedness information for varied literacy levels and multiple challenges
• Limited funding
• Cultural differences
So what can one section do?

Our mission: To promote optimum health outcomes for all Alaskan women, children, teens and their families

Improve access to services

Deliver family-centered and culturally appropriate services

Provide data that can improve programs and guide policy, thereby preventing poor health outcomes
Redefining “vulnerable” using systems-level thinking

Children are uniquely vulnerable.
But not just during or after a disaster.
And what about the rest of us, and our functional needs before during, and after a disaster?
We need a better model!
CARD: Collaborating Agencies Responding to Disasters

ICS (incident command system) becomes:
A new way of thinking
A bridge to services
An opportunity for leadership training and economic development

CARD, 2009
Program objectives for 2011-2012

• Leverage existing contacts to build and sustain long-lasting community partnerships

• Evaluate existing preparedness materials to ensure their continued utility and quality

• Develop and disseminate additional materials to more adequately reflect the needs of our target population(s)
Program activities, round one

MEP-P (Medical Emergency Preparedness-Pediatrics)

• Curriculum (“Just-in-time” training modules)
• Exercises
• Ethics
• Equipment “ventilators and statewide “Go Kits””)
Program activities, round two

- CYSHCN booklet
- Brochure for pregnant women and women who have recently given birth
- Training modules for daycare providers
Supporting data

• External sources: PRAMS, CUBS, NS-CSHCN

• Internal sources: document review, interviews with stakeholders, existing needs assessments

• Future sources: Medical home surveys, preparedness needs assessment surveys
Sample questions for peds providers...

Do you have pediatric mass casualty protocols in place?

Does your disaster plan include pediatric-specific issues?

Are local schools involved? If yes, how?
Lessons learned (or observed)

• Prioritize communication
• Leverage existing connections
• Create plans alongside communities
• Preparedness messaging must be reality-based
PASOs and the Journey to Best Practices

Julie Smithwick-Leone, LMSW
Executive Director, PASOs Programs
PASOs: Background

The Latino population in SC has increased 148% between 2000-2010

The Latino population is younger, less insured, of lower socio-economic status and has higher fertility rates that other racial and ethnic groups

Significant barriers exist for Latinos to access medical care, social services and health information
PASOs: Background

Vision
Healthy Latino families with access to needed resources.

Mission
To empower Latino families to optimize maternal and child health within their social and cultural context through education, outreach, partnership, and advocacy.
PASOs: Model

- Pregnant Latinas and support persons
  - Community-based prenatal classes
  - Individual interventions
- Latinas of childbearing age and Latino community
  - Access to care information sharing through outreach
  - Support networks
- Health care providers
  - Bridge building
- Public health system
  - Advocacy systemic changes
Evidence building timeline

- **2005**: PASOs created, one staff member; data collected for grants and standard templates used for collection. Quality measured from beginning.
- **2007**: Formal data collection began in prenatal classes; instruments tailored
- **2008**: Program moved to USC and staff grew; new processes developed
- **2009**: Expanded program to other sites; data collection and collation formalized. Had to go backwards somewhat to look at old data and change processes.
Evidence building timeline

2010:
• Advisory Council requested each objective and activity on strategic plan have measurements
• Constant revision and incorporation of feedback from staff and participants.
• Applied for AMCHP best practice status based on accumulated data and results thus far.

2011:
• Received “promising practice” status from AMCHP
• Incorporated new tools and practices based on feedback
• Everything being measured/ accumulating and producing more evidence to get to “best practice” level
Logic model

PASOs | Logic Model

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC PASOs Program Locations</td>
<td>Prenatal &amp; Parenting Classes</td>
<td># PASOs programs across state</td>
<td>Latino families throughout SC are empowered with adequate knowledge of reproductive, maternal &amp; child health and with skills to increase access to health care</td>
<td></td>
</tr>
<tr>
<td>PASOs Program Director/Coordinators</td>
<td></td>
<td># PASOs program participants/graduates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latino families</td>
<td></td>
<td>Education &amp; outreach evaluation results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence-based information on reproductive, maternal/child health</td>
<td>Community Health Outreach &amp; Navigation</td>
<td># Community based outreach events by Program Coordinators</td>
<td>Peer-based learning sessions provided by community health navigators expands reach of PASOs into grassroots level of Latino community throughout state</td>
<td></td>
</tr>
<tr>
<td>PASOs Program Director/Coordinator</td>
<td></td>
<td># PASOs graduates recruited as Community Health Navigators (CHNs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informal &amp; Formal Outreach Events</td>
<td></td>
<td># receiving CHN training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PASOs Graduates</td>
<td>Community Health Navigator Training</td>
<td># Latino persons reached by CHN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agencies, Organizations, Coalitions &amp; Businesses</td>
<td>Collaborative Partnerships Established &amp; Expanded</td>
<td># Partners identified</td>
<td>Partnerships with a diverse group of stakeholders ensure access to care and achieve optimal health of Latino families</td>
<td></td>
</tr>
<tr>
<td>Community Coalition Meetings</td>
<td></td>
<td># Community Coalitions formed across state</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PASOs Leadership &amp; Representatives</td>
<td>Access to Care Education &amp; Advocacy</td>
<td># Health access issues discussed</td>
<td>Latino health advocacy produces self-empowered Latino community and increased informed community about relevant issues</td>
<td></td>
</tr>
<tr>
<td>PASOs Clients</td>
<td></td>
<td># Collaborative approaches identified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Outreach/Small Group</td>
<td>Training Material</td>
<td># Trainings provided</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizations &amp; Agencies</td>
<td></td>
<td># Clients receiving resolution services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to Care Education &amp; Advocacy</td>
<td>Program Sustainability &amp; Growth</td>
<td># Agencies &amp; organizational representatives educated regarding PASOs client issues</td>
<td>Lasting program infrastructure created and sustained</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td># Latinos educated through PASOs Programs &amp; Community Outreach Events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current &amp; Future Funders</td>
<td></td>
<td># Technical Assistance encounters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PASOs Advisory Council</td>
<td></td>
<td>PASOs: Policy &amp; Procedures Document</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communications Plan</td>
<td></td>
<td>PASOs Marketing Material</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Evaluation Results</td>
<td></td>
<td>Funding Awarded/Revenue Generated</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Building evidence: On-going evaluation processes

1. Monthly data reporting by program coordinators:
   - Prenatal class participants and graduates
   - Individual interventions and resource navigation
   - Advocacy issues and successes
   - Partnership processes
Building evidence: On-going evaluation processes

2. Prenatal Class Evaluation Tools

• Pre and post-tests, interview style, combination of quantitative and qualitative methods. Data coded, entered and analyzed by epidemiologist.
• Focus groups
• Quality assurance observations and follow-up
• On-going training and practice
Building evidence: On-going evaluation processes

3. Leadership initiatives

- Pre-intervention skills assessment, repeated annually
- Focus groups to determine development needs, access issues
- Community partner interviews around service provision and access issues
- Intervention data reporting by leaders
Building evidence: On-going evaluation processes

4. Outreach activities

• Outreach evaluation form turned in at each event
• Measures information given, help provided at each event, types of participants reached
• Used to determine most successful interventions and materials for reaching target audiences
Building evidence: On-going evaluation processes

5. Folic acid project:

- Numbers, places, types of events
- Data collection on pregnancy status, current usage, knowledge
- Follow-up phone calls and survey to determine continued use
Building evidence: On-going evaluation processes

6. PASOs for Parents program:
   • Protective Factors survey (per funder)
   • Satisfaction survey
   • Parental abilities survey (piloting)
Building evidence: Current initiatives

• Use of external data to monitor and compare health outcomes of target population (PRAMS, MCH data, Vital Stats)
• Return on investment project
• Additional focus groups
• Postpartum follow-up surveys
• Submission of articles to peer-reviewed journals
Building evidence: Future plans

• Qualitative analysis of program coordinator reports, monthly conference call minutes, program coordinator interviews for evidence of:
  • Advocacy
  • Resource navigation
  • Outcomes

• Birth outcomes study
Lessons Learned

• Need to incorporate evaluation methods of all activities and from very beginning
• Must have patience and be prepared to revise forms and plans as they play out
• May not get results you want—may need to go back to the drawing board.
• Use information gathered to make changes to programs and model
• Need someone with specialty knowledge dedicated to evaluating the program
• Use partners from universities and organizations!
Oregon Care Coordination Program

An AMCHP Promising Practice

Marilyn Sue Hartzell, M.Ed.
Director, Oregon Center for Children and Youth with Special Health Needs (OCCYSHN)
CaCoon’s – Background

Began as pilot project in three Oregon counties in the late 1980’s

• To assure that children moving from tertiary care centers back to their communities would receive necessary care coordination to assure implementation of recommendations & referrals.

Target population: Children with special health needs

Community-based PHN care coordination program for CYSHN

Administered by OCCYSHN in partnership with Oregon local health departments
CaCoon’s – Program Objectives

To assure:

• Access to health care services for CYSHCN

• Increased family confidence/competence in caring for their CYSHCN

• Coordinated care

• Knowledgeable and skilled workforce to implement PHN care coordination
CaCoon’s – Practice Objectives

• Child health and family assessment
• Tier assessment
• Monitoring of CYSHN health and development
• Linking families to specialty care and resources
• Advocacy
• Service coordination
• Consultation with other agencies/providers about CYSHN
CaCoon: Early measures

• Family satisfaction

• Family and child needs met

• Fidelity to program design, principles, & standards in implementation communities

• Appropriate referrals for services
CaCoon Program Logic Model

**Inputs**
- **FUNDING**
  - State Title V Match Funding
  - Federal Block Grant Funding
- **TARGET POPULATION**
  - Children and Youth with Special Health Needs (CYSHN) and their families (birth to 21)
- **PROGRAM STANDARDS & GUIDELINES**
  - CaCoon Program Standards
  - CaCoon Manual
  - Tier Level Tool
  - OCCYSHN/LHD Contracts
- **PERSONNEL**
  - State CaCoon Nurse Consultants (CYSHN expertise)
  - Local Health Department (LHD) Public Health Nurses (PHNs) in 36 counties
  - CaCoon Promotoras – one in each of 4 counties
- **RESOURCES**
  - Webinars
  - CaCoon Modules
  - CaCoon Tool Kit
  - Reference Materials
- **EVALUATION/ASSESSMENT**
  - OCCYSHN Assessment and Evaluation Staff
  - Oregon Child Health Information Data System (ORCHIDS)
- **STATE AND LOCAL PARTNERS**
  - Local Health Departments
  - Office of Family Health
  - Early Intervention/ECSE

**Activities**
- **Identification and referral of CYSHN to CaCoon**
- **CACOON HOME VISIT**
  - Conduct Nursing Assessment of CYSHN health status
  - Assess complexity of child and family need for care coordination (Tier Level Tool)
  - Screen for develop, behavior, vision, hearing and Parent-Child Interaction
  - Develop Care Plan in partnership with the family to include nursing intervention:
    - Case Management
    - Teaching & Education
    - Anticipatory Guidance
    - Referral & Linkage
    - Follow-Up
- **Provide support to Hispanic families (CaCoon Promotoras)**
- **Represent CYSHN on Local Inter-agency Coordinating Council (CaCoon PHNs)**
- **Collect and enter** home visit data into ORCHIDS
- **Evaluate, assess and monitor ORCHIDS data**
- **Train LHD PHNs to further clinical expertise in the care of CYSHN**
- **Provide training and technical assistance on accessing community services for CYSHN and their families**
- **Orient new PHNs to CaCoon program standards, assessment and care of CYSHN**

**Outputs**
- Data collected - client demographics, tier level, assessment, referral & follow-up
- # of CYSHN served
- # of visits to CYSHN and their families
- # of CYSHN screened for develop, behavior, vision and hearing
- # of CYSHN referred to community-based services
- # of interventions delivered to CYSHN and their families
- # of trainings offered to LHD CaCoon PHNs
- # of site visits to LHDs
- CaCoon Annual Report - State & Local
- # of LICC meetings attended by LHD CaCoon PHNs

**Short-Term Outcomes**
- Increased # of CYSHN & their families linked to needed services & supports
- Increased # of CYSHN served
- Increased # of visits to CYSHN and their families
- Increased # of CYSHN screened for develop, behavior, vision and hearing
- Increased # of CYSHN referred to community-based services
- Increased # of interventions delivered to CYSHN and their families
- Increased # of trainings offered to LHD CaCoon PHNs
- Increased knowledge and skills of CaCoon nurses

**Long-Term Outcomes**
- Increased # of families report improved ability to coordinate care for their CYSHN
- Increased # of families linked to specialized health and services
- Increased # of families report satisfaction with care coordination services
- Increased # of CYSHN with a source of well child care
- Increased # of CYSHN linked with a medical home
- Increased # of CYSHN having received developmental, behavioral, vision & hearing screening by standardized tools
- Increased # of families linked with Medicaid or medical insurance
- Increased # of families report a positive impact of CaCoon on their CYSHN and family
- Increased # of families connected to CYSHN and LHD CaCoon PHNs report confidence in meeting the needs of CYSHN and their families
- Increased # of LHD CaCoon PHNs report confidence in meeting the needs of CYSHN and their families
- Increased community capacity on behalf of CYSHN via CaCoon
- Increased effectiveness in local partnerships on behalf of CYSHN
- Increased # of CYSHN optimal health outcome
Program Outcomes and Evaluation Data

Outcomes assessed:

• Referrals to services

• Successful completion of the referral process

• Access to needed health care services

• Increased family competency in caring for their CYSHN
Data Elements

**Demographic data:** Age, county of residence, insurance, income status, billing information, diagnosis and level of acuity.

**Assessment data:** Access to health care services, nutrition, parenting, safety, family knowledge of child’s condition, development, immunizations, second hand smoke, insurance, housing, food, and utilities.

**Intervention data:** Education, training, direct care, and coordination of care.
Data Elements

**Referral source:** source of referral into CaCoon program and referrals from CaCoon to other programs and services.

**Outcome data:** Follow-up data about services received, health assessment, and issues summary.
## Data Submitted for Review

<table>
<thead>
<tr>
<th></th>
<th>FY2008</th>
<th>FY2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Children Served</td>
<td>1,363</td>
<td>1,669</td>
</tr>
<tr>
<td>Number of visits</td>
<td>5,864</td>
<td>7,763</td>
</tr>
<tr>
<td>Children aged 0-3</td>
<td>67%</td>
<td>67%</td>
</tr>
<tr>
<td>Children aged 3-5</td>
<td>15%</td>
<td>18%</td>
</tr>
<tr>
<td>Children aged 5-12</td>
<td>13%</td>
<td>12%</td>
</tr>
<tr>
<td>Children 13+</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Medicaid/other</td>
<td>*</td>
<td>84%</td>
</tr>
</tbody>
</table>

*Missing data due to data system issues makes estimates unreliable*
Data Submitted for Review

<table>
<thead>
<tr>
<th>Assessment-Coordination-Outcome</th>
<th>FY2008</th>
<th>FY2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to medical care</td>
<td>89%</td>
<td>95%</td>
</tr>
<tr>
<td>Child Development</td>
<td>87%</td>
<td>93%</td>
</tr>
<tr>
<td>Community resources</td>
<td>89%</td>
<td>95%</td>
</tr>
<tr>
<td>Family knowledge of chronic condition</td>
<td>87%</td>
<td>91%</td>
</tr>
<tr>
<td>Injury</td>
<td>68%</td>
<td>75%</td>
</tr>
<tr>
<td>Insurance</td>
<td>87%</td>
<td>94%</td>
</tr>
<tr>
<td>Nutrition</td>
<td>82%</td>
<td>89%</td>
</tr>
<tr>
<td>Oral health</td>
<td>73%</td>
<td>77%</td>
</tr>
<tr>
<td>Parenting</td>
<td>77%</td>
<td>86%</td>
</tr>
<tr>
<td>Tobacco (2nd hand smoke exposure)</td>
<td>79%</td>
<td>83%</td>
</tr>
<tr>
<td>Well child care</td>
<td>90%</td>
<td>96%</td>
</tr>
</tbody>
</table>
CaCoon: Building the Evidence

What we lacked in our evidence:

• Impact data that demonstrated change in families' knowledge and/or competence in caring for their children, and

• Change in indicators of child health, or health-related factors
CaCoon: Building the Evidence

Investigation of:

• Identification of Issues, Interventions conducted and Outcomes

• Rates of Immunization
Issues - Interventions - Outcomes

FY10 thru FY11 Clients assessed, need, intervention, and Need Met

<table>
<thead>
<tr>
<th>Issue</th>
<th>FY10</th>
<th>FY10 to FY11</th>
<th>FY11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>55%</td>
</tr>
<tr>
<td>Smoke</td>
<td>31%</td>
<td>42%</td>
<td>58%</td>
</tr>
<tr>
<td>Oral Health</td>
<td>20%</td>
<td>34%</td>
<td>66%</td>
</tr>
<tr>
<td>Basic Needs</td>
<td>20%</td>
<td>47%</td>
<td>69%</td>
</tr>
<tr>
<td>Injury</td>
<td>20%</td>
<td>53%</td>
<td>69%</td>
</tr>
<tr>
<td>Chronic Condition</td>
<td>22%</td>
<td>46%</td>
<td>59%</td>
</tr>
<tr>
<td>Parenting</td>
<td>31%</td>
<td>41%</td>
<td>59%</td>
</tr>
<tr>
<td>Community Resources</td>
<td>26%</td>
<td>42%</td>
<td>56%</td>
</tr>
<tr>
<td>Nutrition</td>
<td></td>
<td>39%</td>
<td>54%</td>
</tr>
<tr>
<td>Child Development</td>
<td>15%</td>
<td>23%</td>
<td>58%</td>
</tr>
<tr>
<td>Access to Care</td>
<td>14%</td>
<td>58%</td>
<td>63%</td>
</tr>
<tr>
<td>Medical Home</td>
<td></td>
<td>57%</td>
<td>67%</td>
</tr>
</tbody>
</table>

Improving Maternal and Child Health Across the Life Span: Acting Today for Healthy Tomorrows
Products Resulting from Practice

• CaCoon Program Manual
• CaCoon Tier Level Assessment Tool
• Nursing care of children with special needs in the community
• CaCoon Eligibility Criteria
• CaCoon Program Contract Attachments
• CaCoon Program Brochure
• CaCoon Program Chart Review Tool
• Pain Cards
• Children with Special Health Needs Nutrition Screening Forms
• PHN Specialty Clinic Information Form
• CaCoon Website
• Webinar trainings
• Annual Onsite Review Protocol
• CaCoon Listserv
CaCoon’s Staying Power

• Ongoing PHN workforce development
• Continuous quality improvement efforts
• Local commitment to the program & population
• Financing
CaCoon - Challenges

• Variable local capacity to implement

• Oregon geography

• Changing state and local contexts
CaCoon - Assets

Practices and features that would be maintained include:

- Ongoing training and technical assistance to the local PHNs
- Capacity to continue to develop innovative public health nurse training and support tools
- CaCoon Annual Onsite Monitoring Protocol
- CaCoon Tier Level Assessment
Lessons Learned

Aspects of the program to change or strengthen:

- Development of formal required training curriculum based
- Greater funding support for program expansion
- Improved state data system
AMCHP Promising Practices: The Benefit

• Encouraged review and critique of program
• Highlighted opportunities for improvement
• Stimulated quality improvement initiatives within the county-based programs
• Continuing to strengthen evaluation for increased evidence of impact
• Brought within-state level recognition
Questions?
Thank you!

Presenter contact information:
Laura Andersen, MPH
Public Health Specialist I, MCH/ CYSHCN Emergency Preparedness and Early Childhood Manager
Women's, Children's, and Family Health, State of Alaska, Division of Public Health
(907) 269-3429
laura.andersen@alaska.gov

Marilyn Sue Hartzell, M.Ed.
Director, Oregon Center for Children and Youth with Special Health Needs (OCCYSHN)
(503) 494-6961
hartzell@ohsu.edu

Julie Smithwick-Leone, LMSW
Executive Director, PASOs Programs
(803) 777-5466
julie@scpasos.org