

Monitoring and Evaluation for Community Health in King County, WA



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CSTE Pre-conference workshop, June 2018

What I'll cover in our last session



Set the context for understanding some about King County, WA

Overview of PHSKC's approaches to M & E and other potential options

Discuss data sources we routinely use for assessment, monitoring, and evaluation

Lessons from the field of evaluation of larger projects

An example of how to calculate impact of interventions

Monitoring and evaluation of LE changes (emerging information)

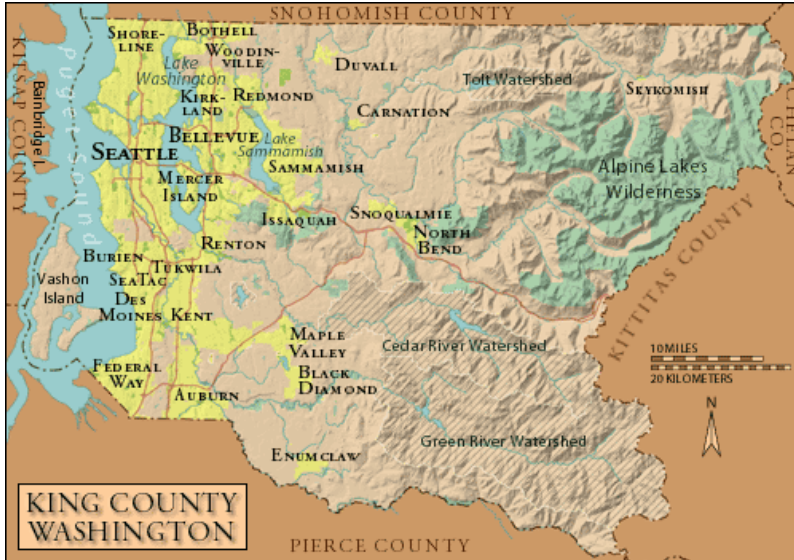
A winding road



Context setting about evaluation and monitoring

- No “right” or “wrong” questions; many different approaches
- All about the data
- Changes in knowledge, attitudes, beliefs, practices can take years to result in outcomes; hold the course and set expectations
- Fail forward faster
- Plan for evaluation and monitoring in budget
- In order to be Chief Health Strategist, requires knowing where you are, where you want to go and a plan of how to get there
- Relevant data partners
- Programs and services make sense for community
- Cross-sector rather than data siloes: how can data tell the story
- Don’t forget about the impact of qualitative data
- Collective impact with the community

King County: Speed Dating Statistics



2.2 million people



450,000 additional weekday commuters



39 incorporated cities. Seattle largest at 710,000



More land than 14 states



Median home price (Q1 2018): \$640,200*

Median rent, (Q1, 2018): \$2,495*



Average household income(2016): \$78,800

9.3% of persons in poverty



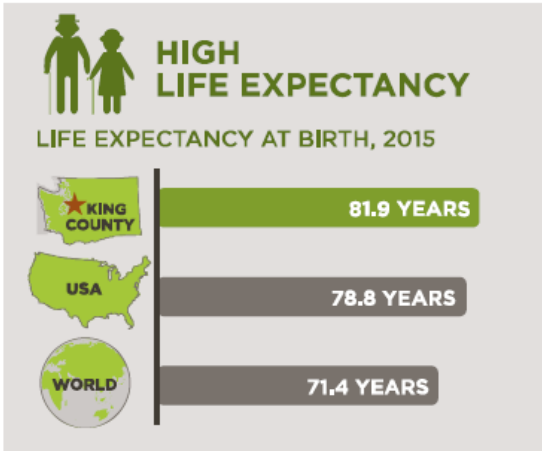
Increasing diversity



The health of King County

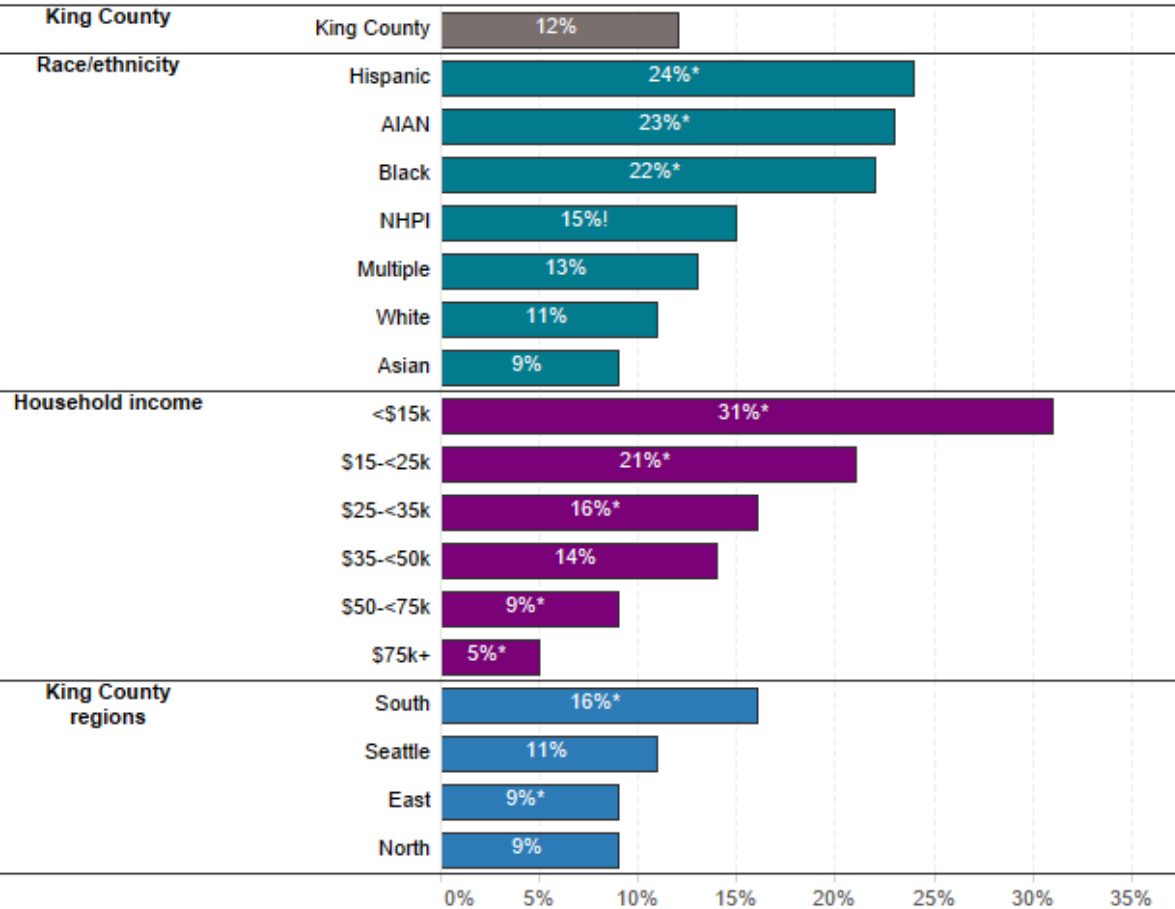
King County ranks among the top counties in the U.S. on measures of health and wealth

However...
despite high rankings on measures of socioeconomic status and health, county residents continue to experience differences in social and health outcomes by *race, income and place*



Source: WA State Department of Health, Center for Health Statistics, death certificates

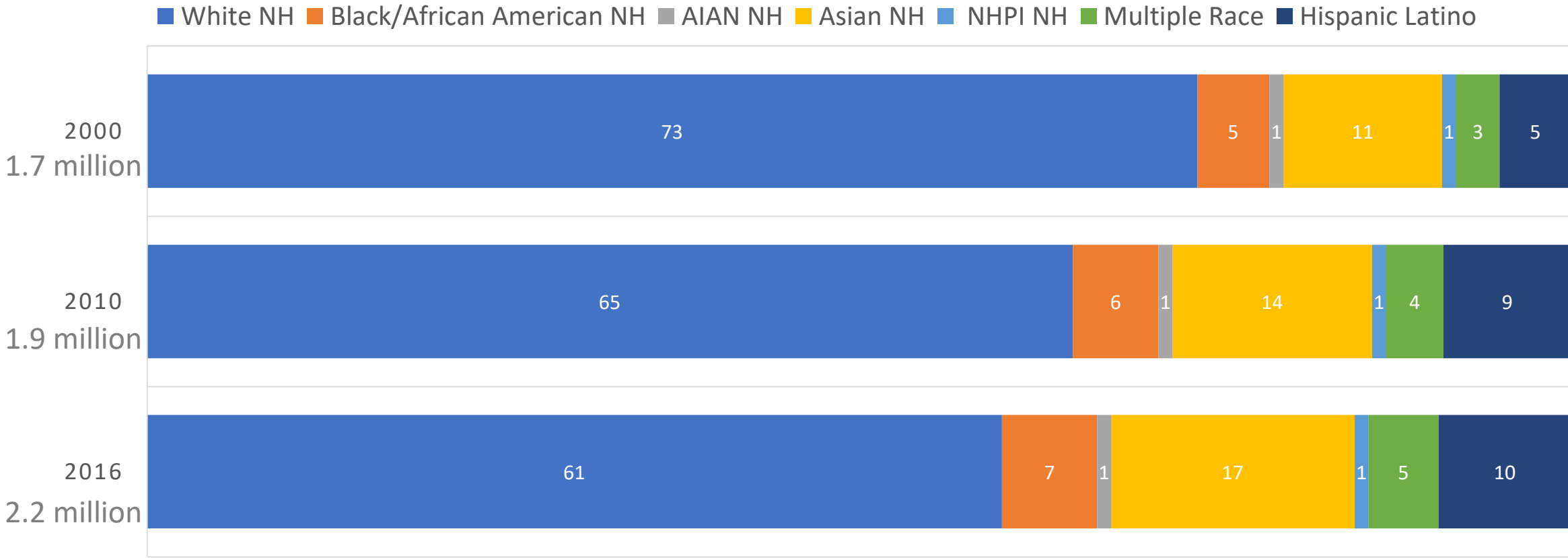
Fair or poor health (adults), King County (average: 2011-2015)



^ = Data suppressed if too few cases to protect confidentiality and/or report reliable rates
* = Significantly different from King County average
! = Interpret with caution; sample size is small, so estimate is imprecise

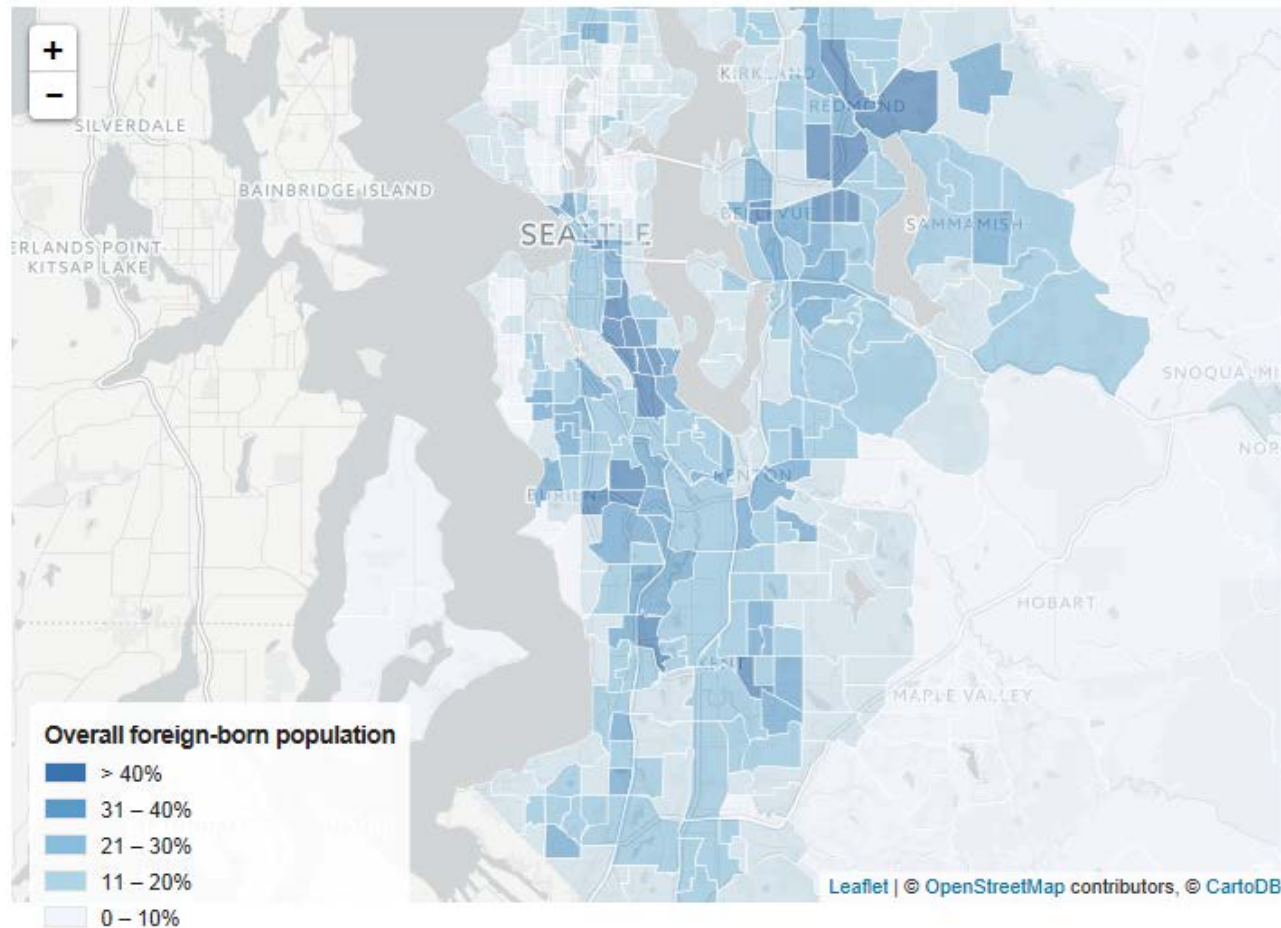
AIAN = American Indian/Alaska Native
NHPI = Native Hawaiian/Pacific Islander

King County demographics: Rapidly changing and growing



King County demographics: Rapidly changing and growing

King County's foreign-born populations (over 460,000, ACS 2016)



1 in 5 residents of King County were born outside the United States (ACS 2016)

170 different languages and dialects are spoken in King County (ACS 2016)

50% of growth since 2000 in King County is from Africa, Asia, Eastern Europe, and Latin America (ACS 2014)

King County serves all residents by promoting fairness
and opportunity and eliminating inequities.

King County Strategic Plan-Fair And Just Guiding Principle



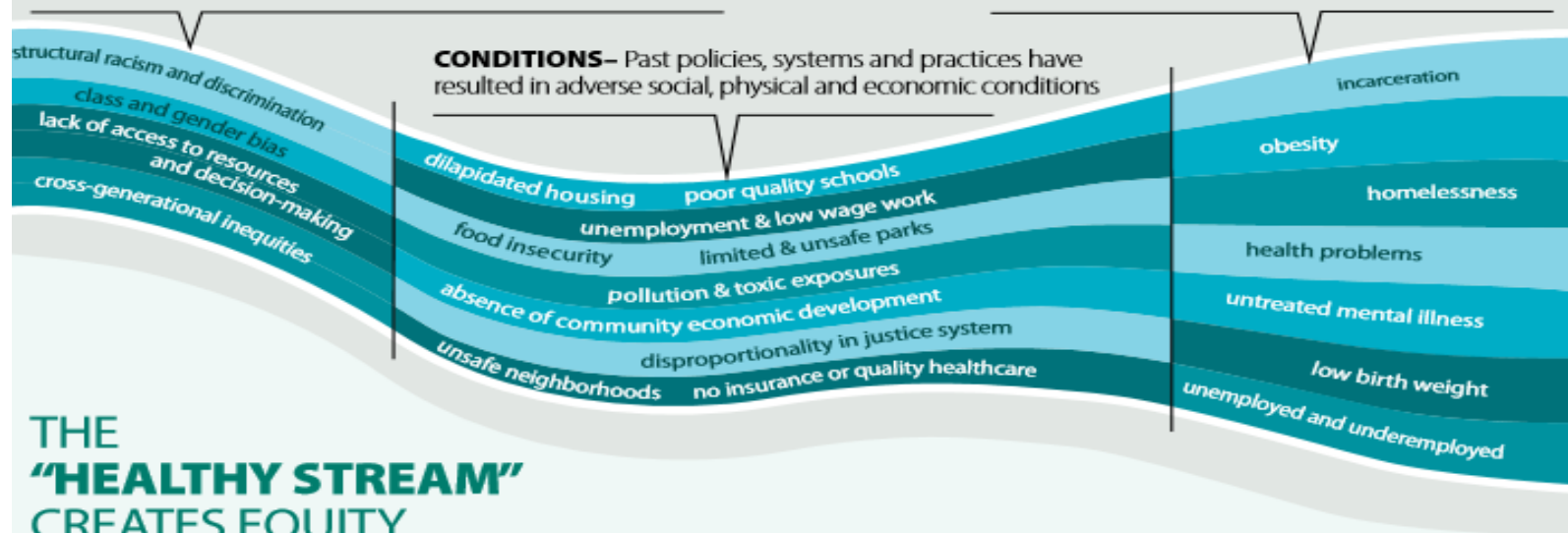
Affordable, safe, quality housing
Access to parks and natural resources
Equity in county practices
Access to affordable, healthy, local food
Equitable law and justice system
Community and public safety
Access to safe and efficient transportation
Quality education
Access to health and human services
Healthy built and natural environments
Family wage jobs and job training
Early childhood development
Economic development
Strong, vibrant neighborhoods

DETERMINANTS OF EQUITY

THE “UNHEALTHY STREAM” CREATES INEQUITIES

POLICIES, PRACTICES & SYSTEMS– Policies, structures and systems – including those in government – have sustained and even contributed to inequities

OUTCOMES– Organizations and their programs historically have tended to react to problems and treat poor individual and family-level outcomes

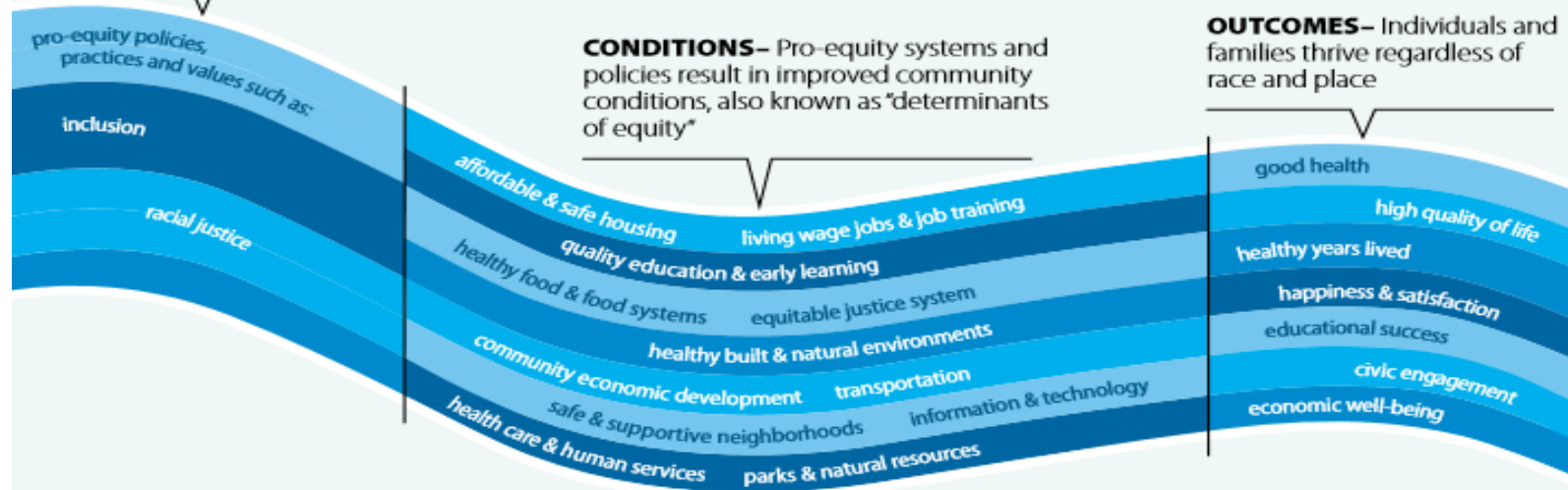


THE “HEALTHY STREAM” CREATES EQUITY

PRO-EQUITY POLICIES, PRACTICES & SYSTEMS– For greatest and most effective impact, King County is focusing “upstream” to address root causes and be pro-equity

CONDITIONS– Pro-equity systems and policies result in improved community conditions, also known as “determinants of equity”

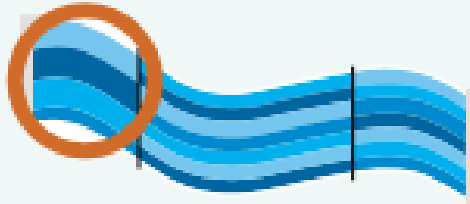
OUTCOMES– Individuals and families thrive regardless of race and place



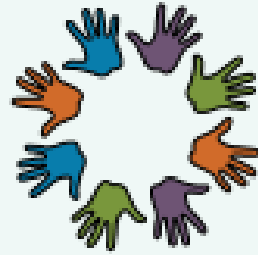
The King County Experience:
How we started with sub-county LE and what happened next

SO ALL PEOPLE HAVE OPPORTUNITIES TO THRIVE

KING COUNTY INVESTS...



Upstream, and where
needs are greatest,



In community
partnerships,



and in employees,

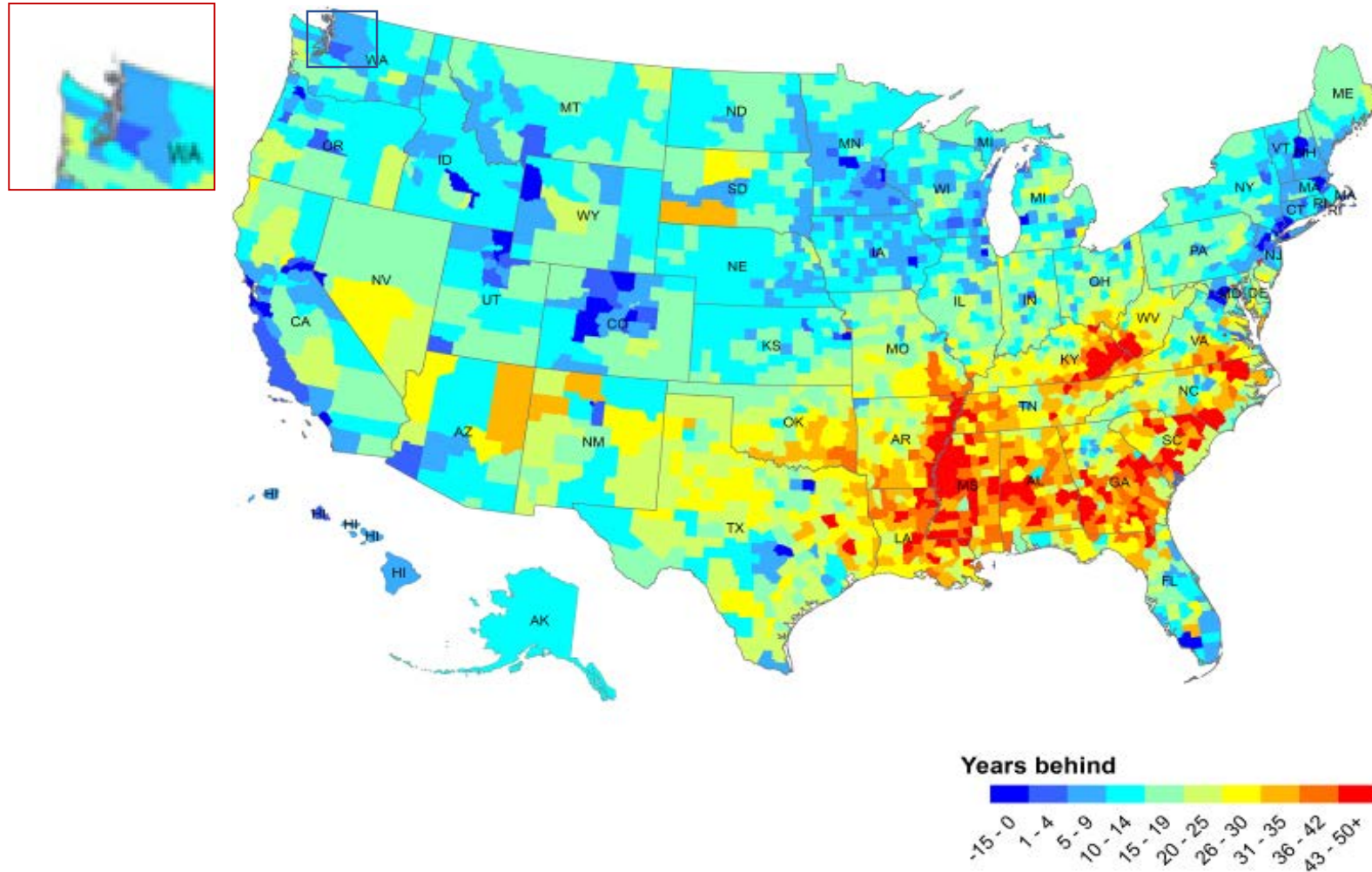


with transparent
and accountable
leadership.

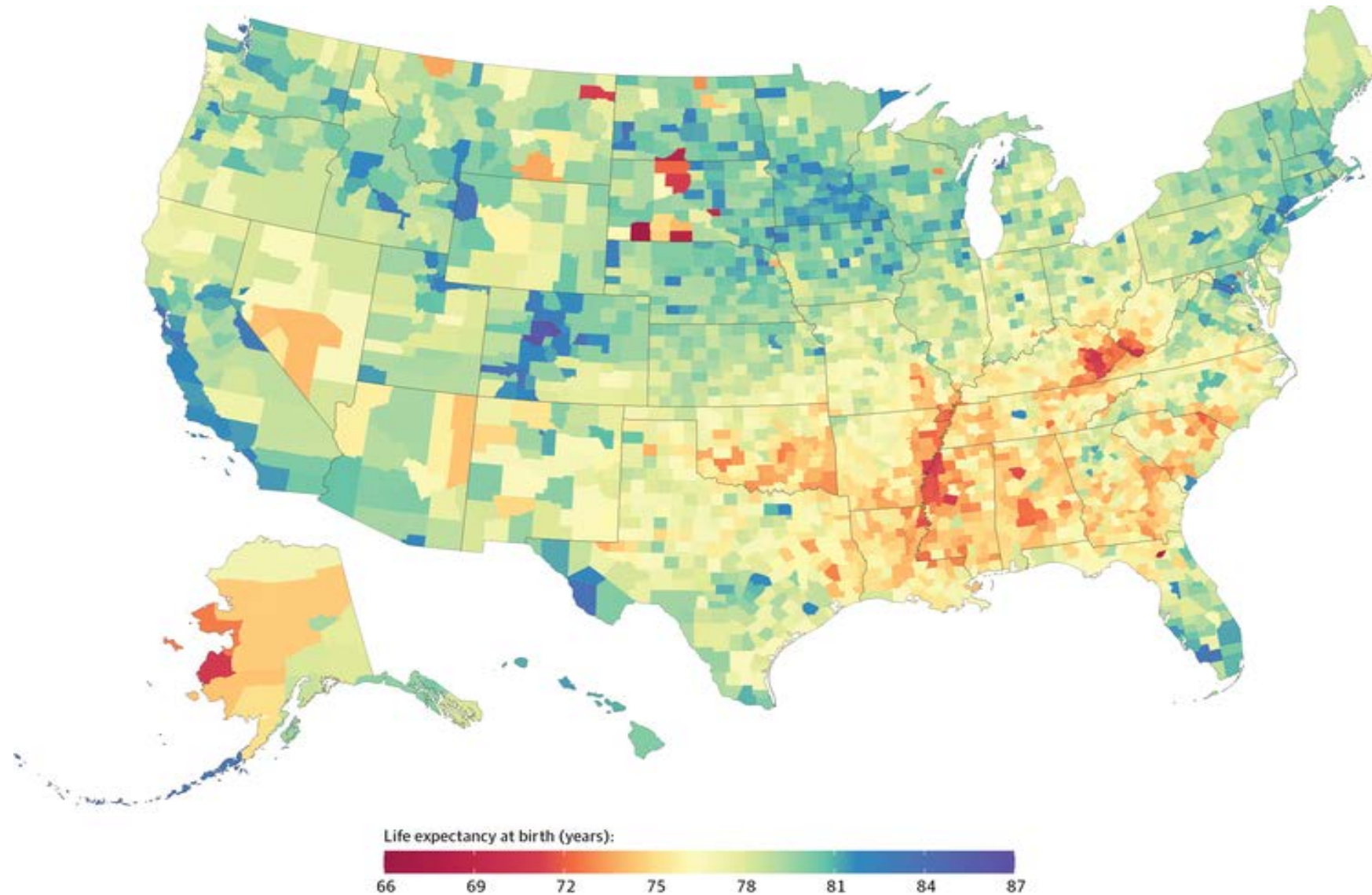
Where to get the data for understanding what is upstream? How to define what indicators to track?

PH didn't have access to all the different types of data listed in the determinants of equity (and are still working on building out our portfolio).

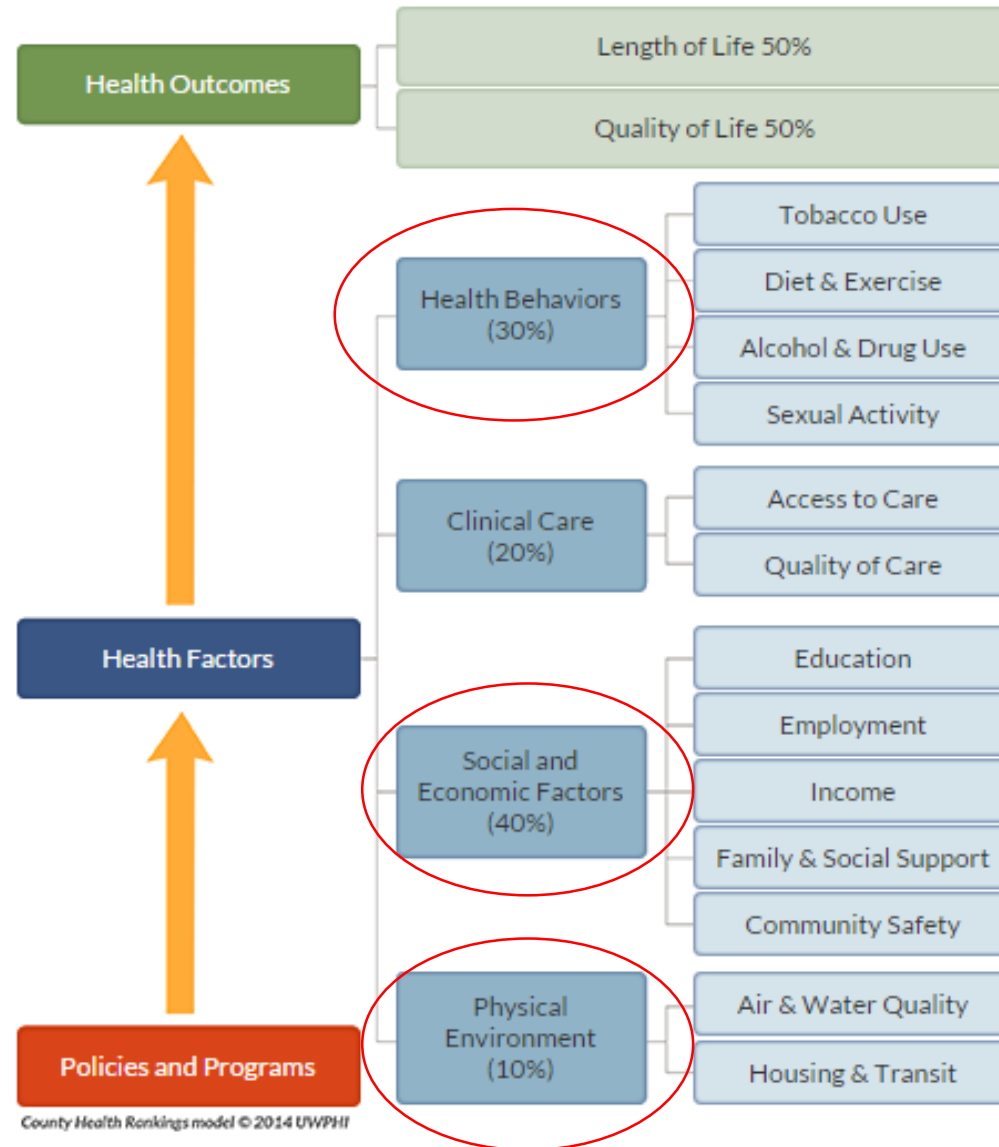
County-level LE compared to the 10 longest lived countries



LE by county varied by 21 years in 2014



Social Determinants of Health



ZIP code health conditions in King County, 2008-2012

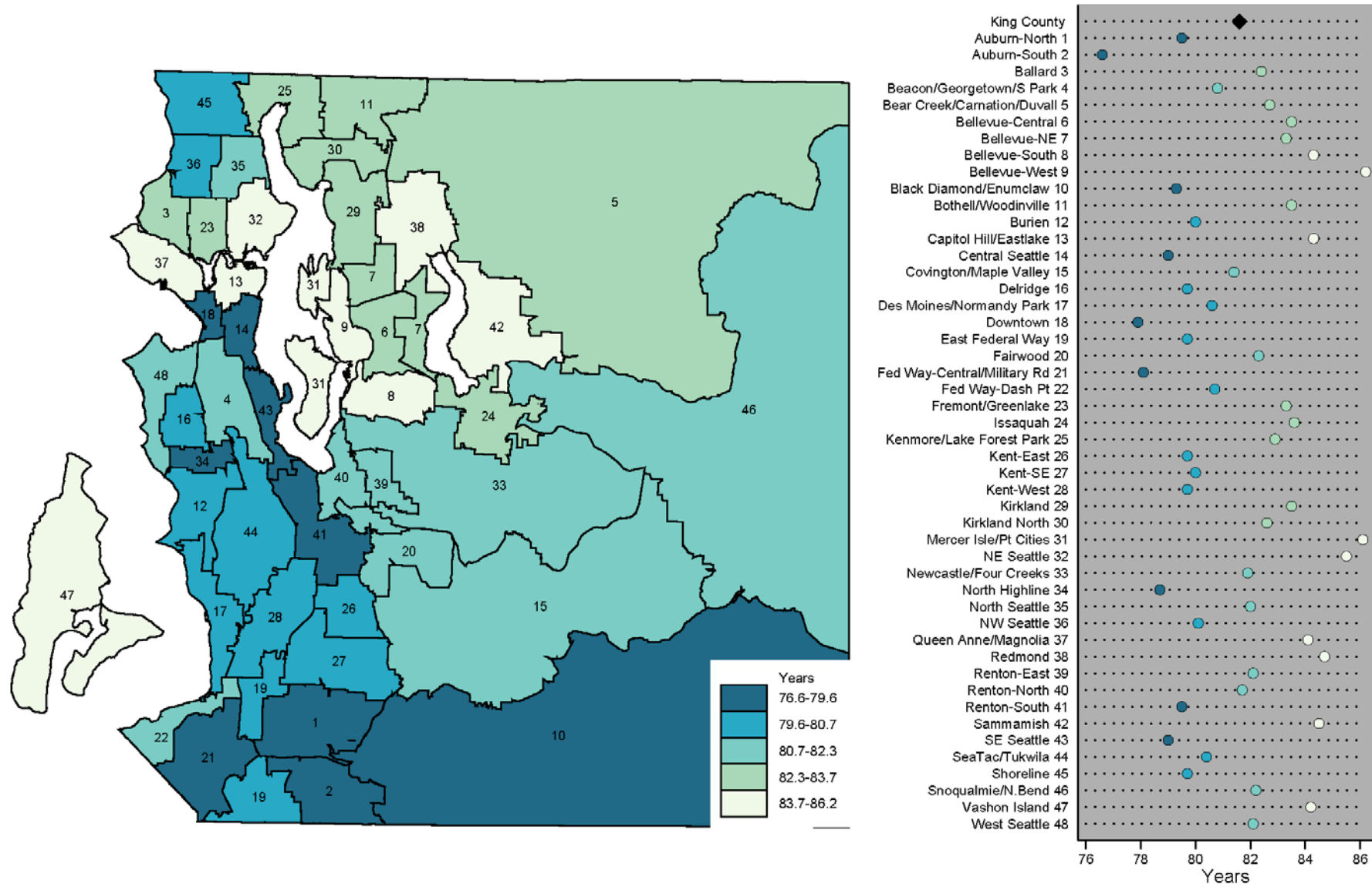
Obesity
9% - 34%



Uninsured
2% - 32%

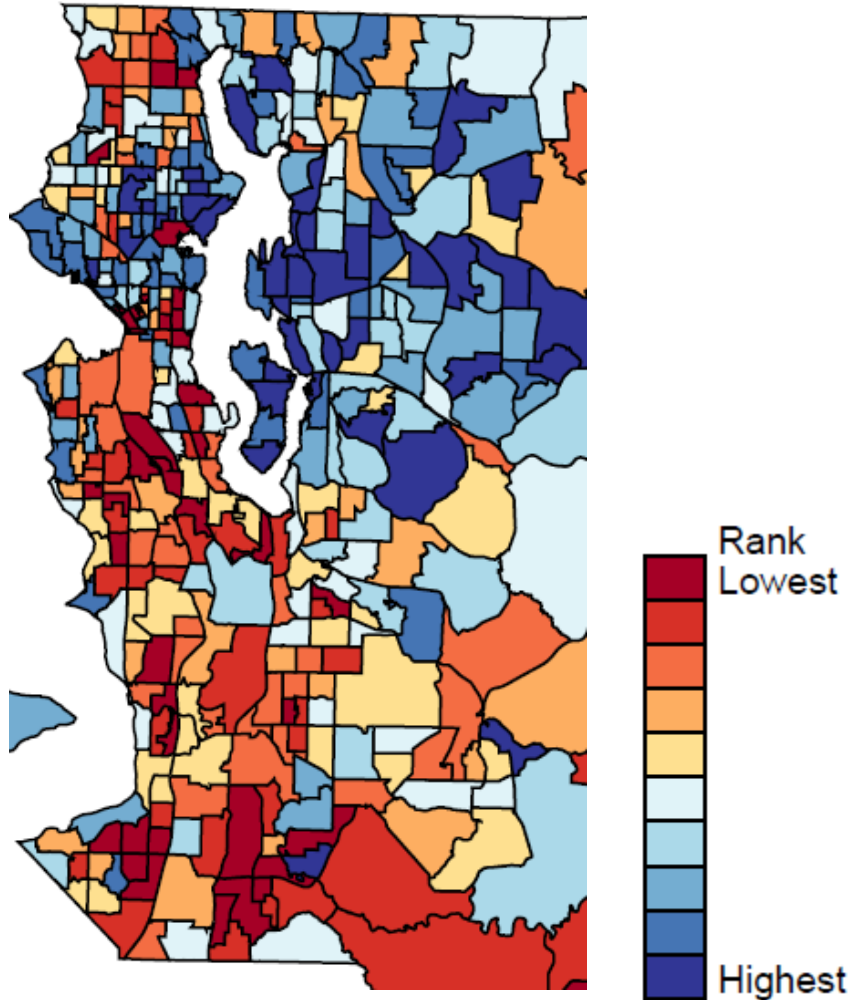
Smoking
2% - 22%

Life expectancy at birth by health reporting areas, King County, 2008-2012



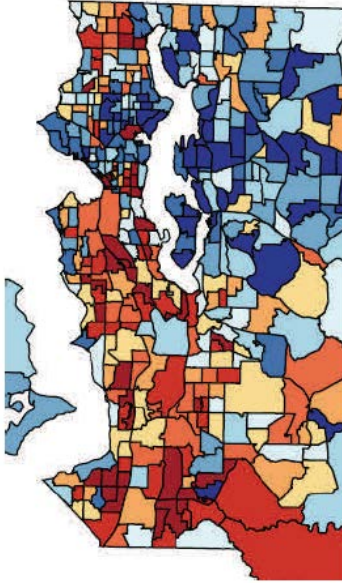
Note: HRA labels on the map match the chart on the right, listed in alphabetical order.
 Source: WA State DOH, Center for Health Statistics, Death Certificates.
 Prepared by Public Health - Seattle & King County, APDE on 11/6/14.

Life Expectancy in King County by Census Tract

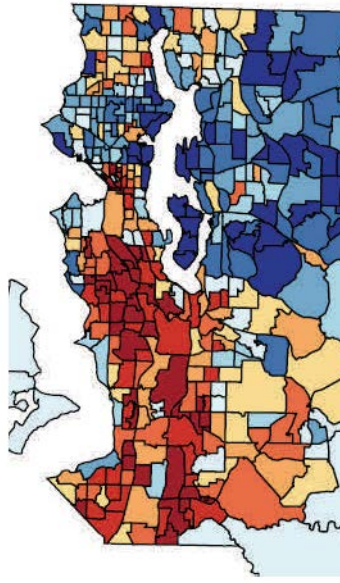


- Difference of **25** years, accounting for unreliable tracts! (Low of 70; High of 95)
- King County average: **81.6**
- The next question became: **what is driving this extreme disparity?**

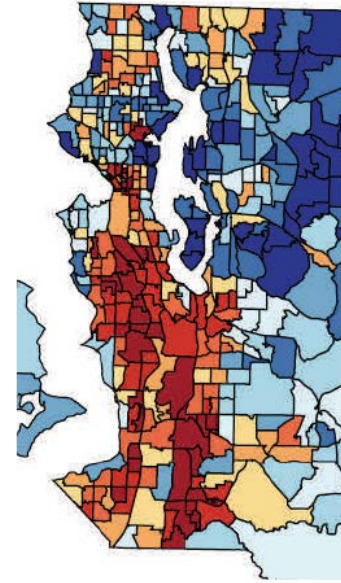
Life Expectancy



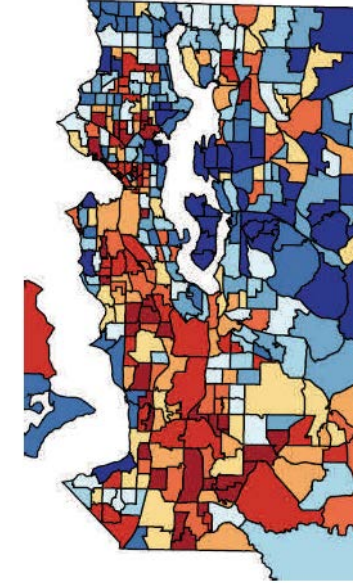
Tobacco Use



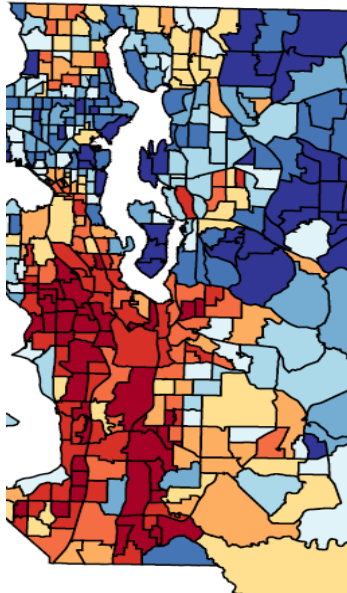
Frequent Mental Distress



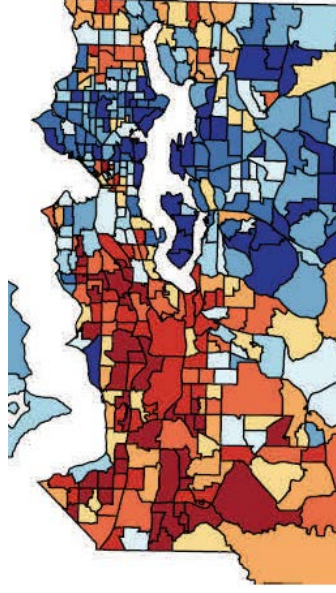
Adverse Childhood Experiences



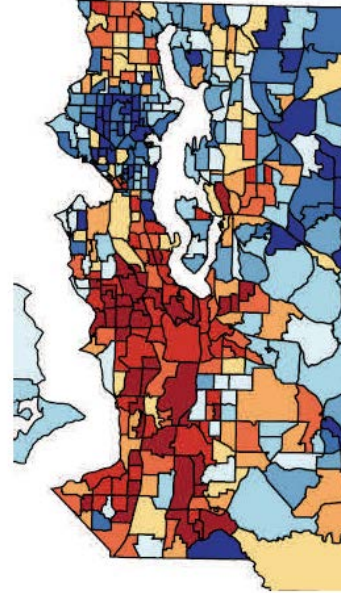
Lack of Physical Activity



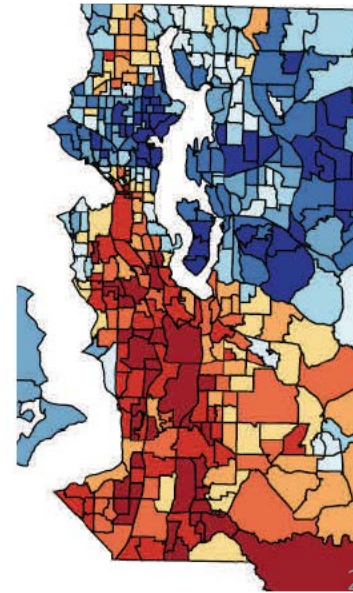
Obesity



Diabetes



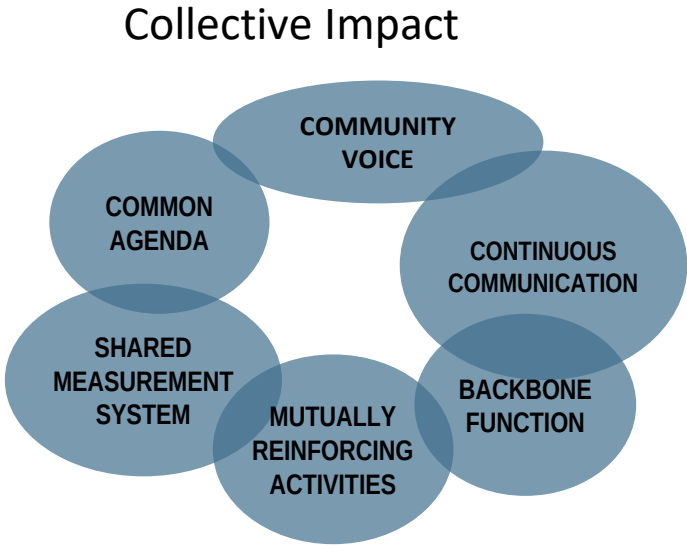
Preventable Hospitalization



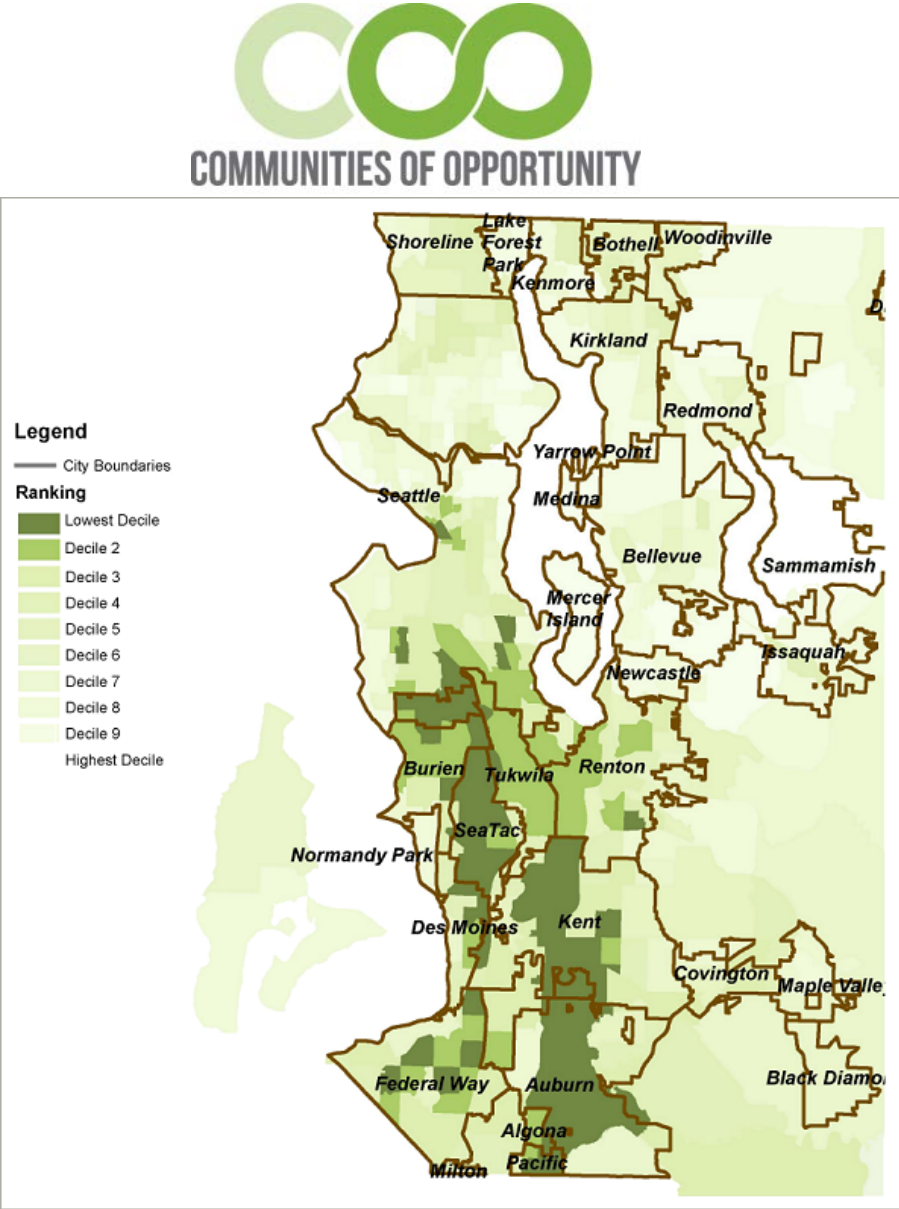
What happened from these meetings?

- Don't underestimate the power of visuals

Communities of Opportunity: Health, Social and Economic Measures



Measures	Lowest decile	Highest decile
Life expectancy	74 years	87 years
Health, broadly defined		
Adverse childhood experiences	20%	9%
Frequent mental distress	14%	4%
Smoking	20%	5%
Obesity	33%	14%
Diabetes	13%	5%
Preventable hospitalizations	1.0%	0.4%
Housing		
Poor housing condition	8%	0%
Economic opportunity		
Low-income, below 200% poverty	54%	6%
Unemployment	13%	3%



An increasing charge to monitor LE and other indicators

- Routine indicators: more interactive and robust; quicker turn around
- Thinking about the system edges
- How does data from other sectors impact health?
- How do we bring the concept of health into more sectors and understand their drivers?
- What is the community experience?
- Where are the data gaps?
- Opportunities for policy, systems, environment change?
- **ASSETS**



How are we monitoring and evaluating?

Monitoring

Evaluation



Connecting data to users: Monitoring health status and conditions

Community health indicators

A gateway to King County data

- Interact and explore data in new ways
- Opportunity for PHSKC to more actively engage with partners and stakeholders
- Use visualizations to answer questions (or ask new ones!)
- Visually accessible and searchable

Topic areas on CHI website

160+ indicators covering...

Access to healthcare & preventive services
Alcohol, tobacco, marijuana & other drugs
Chronic illnesses
Demographics
Economic & food security
Environment
Family & community
Infectious disease
Life expectancy, leading causes of death & quality of life
Mental & behavioral health
Physical activity, nutrition & weight
Pregnancy, birth & sexual health
Violence & injury prevention

Determinants of equity & intersections outside of clinic walls

In King County...



Poverty & near poverty

- Poverty impacts at least **1 of every 5 residents** and **1 in every 4 children under 18**
- Racial and regional **differences in poverty mirror disparities observed in most chronic disease indicators**



Housing

- Escalating housing prices **disproportionally burden older adults, communities of color, and people living in poverty**
- **Student homelessness has doubled since 2008**



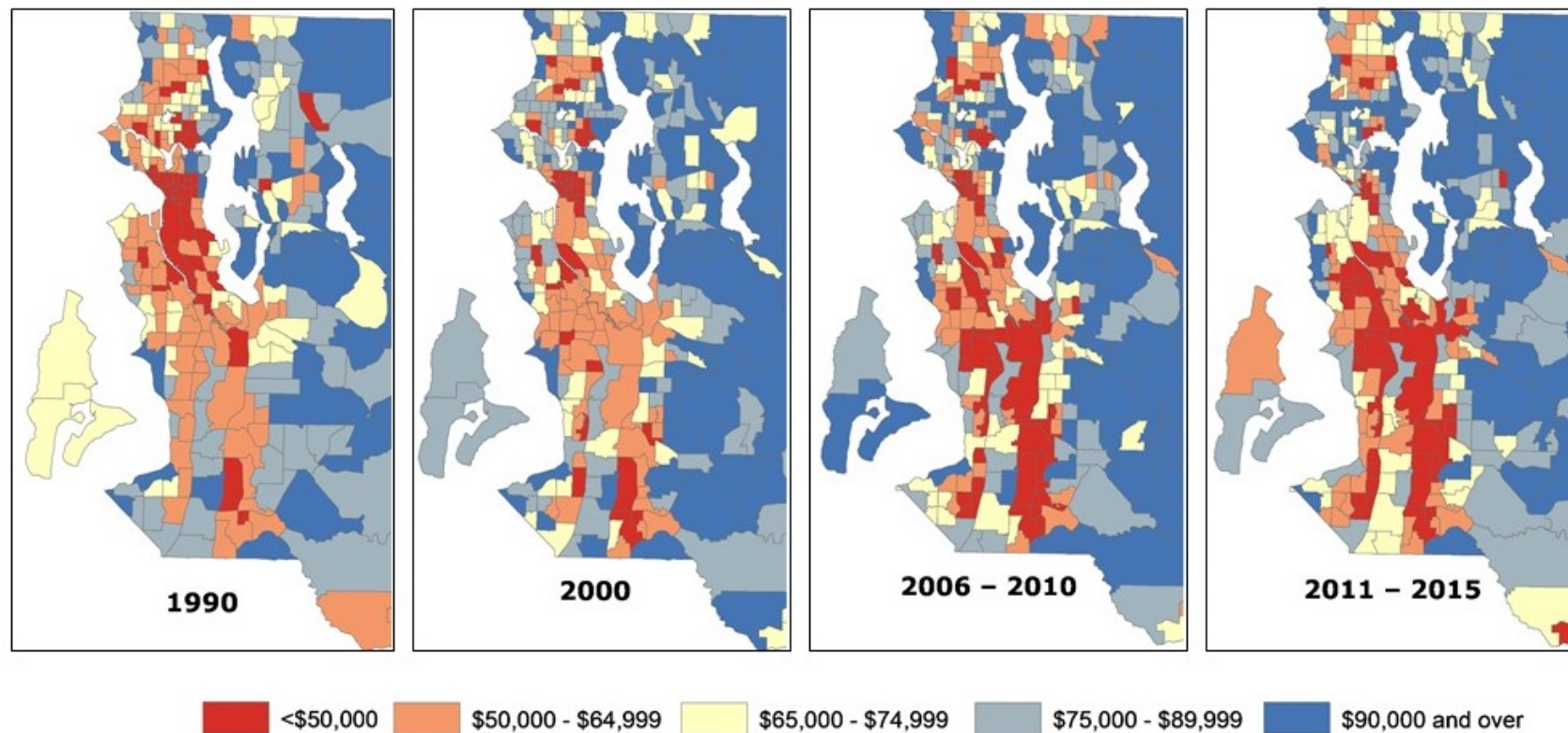
Access to care

- **Lower income households** are less likely to have a usual primary care provider.
- Despite advances in health insurance coverage with the ACA, **King County communities of color remain disproportionately uninsured**

King County's changing population

While median household income has steadily increased since 2000, there is a widening gap between the county's highest and lowest income households.

Median household income by King County neighborhood, 1990-2015



Data sources: US Census Bureau, 1990 & 2000 censuses; American Community Survey (2006-2010, 2011-2015)

- Southwest King County income decreasing
- Downtown and South Seattle income increasing
- Neighborhoods around Lake Union income increasing
- Overall, Seattle becoming wealthier, south region becoming poorer

Data sources used in KC for community health monitoring and evaluation

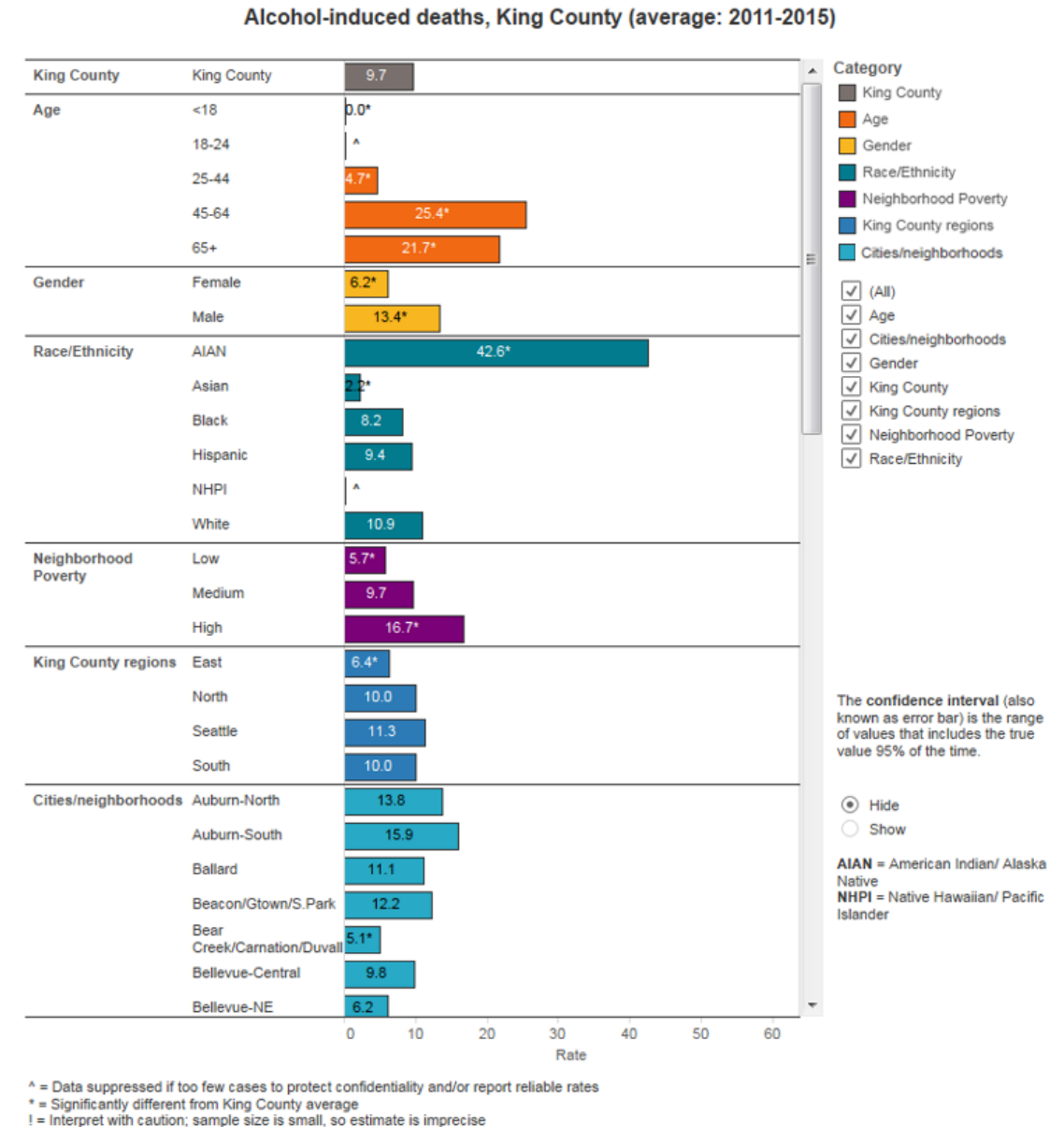
- Behavioral Risk Factor Surveillance System
- Pregnancy and Risk Assessment Monitoring System
- Vital statistics data (births, deaths, hospitalizations)
- Population data (including small area)
- Strong and supportive state DOH who makes these tasks easier (*THANK YOU!!*)
- Locally driven surveys (Best Starts for Kids), often funded out of initiatives
- Census and American Community Survey Data
- Data from public schools (school districts or the Office of Superintendent of Public Education)
- Environmental data (Toxic Release Inventory)
- Medicaid claims data
- Qualitative data gathered via focus groups and community conversations
- Qualitative data
- Cross-sector data: working on education, housing, jail, behavioral health, EMS, homeless data

Data aspects of monitoring and evaluation

- Requires strong data quality.
- Quality assurance is important
- Robust measures – and if measuring geographically, geographic matches
- Ability to automate when possible. One-off analyses are impossible to maintain in a large quantity
 - QA is important! From data acquisition, data prep, data analysis, data visualization and interpretation.
- Guidelines and templates to follow – makes standard reporting easy
 - Need opportunities to vary from the standard, though

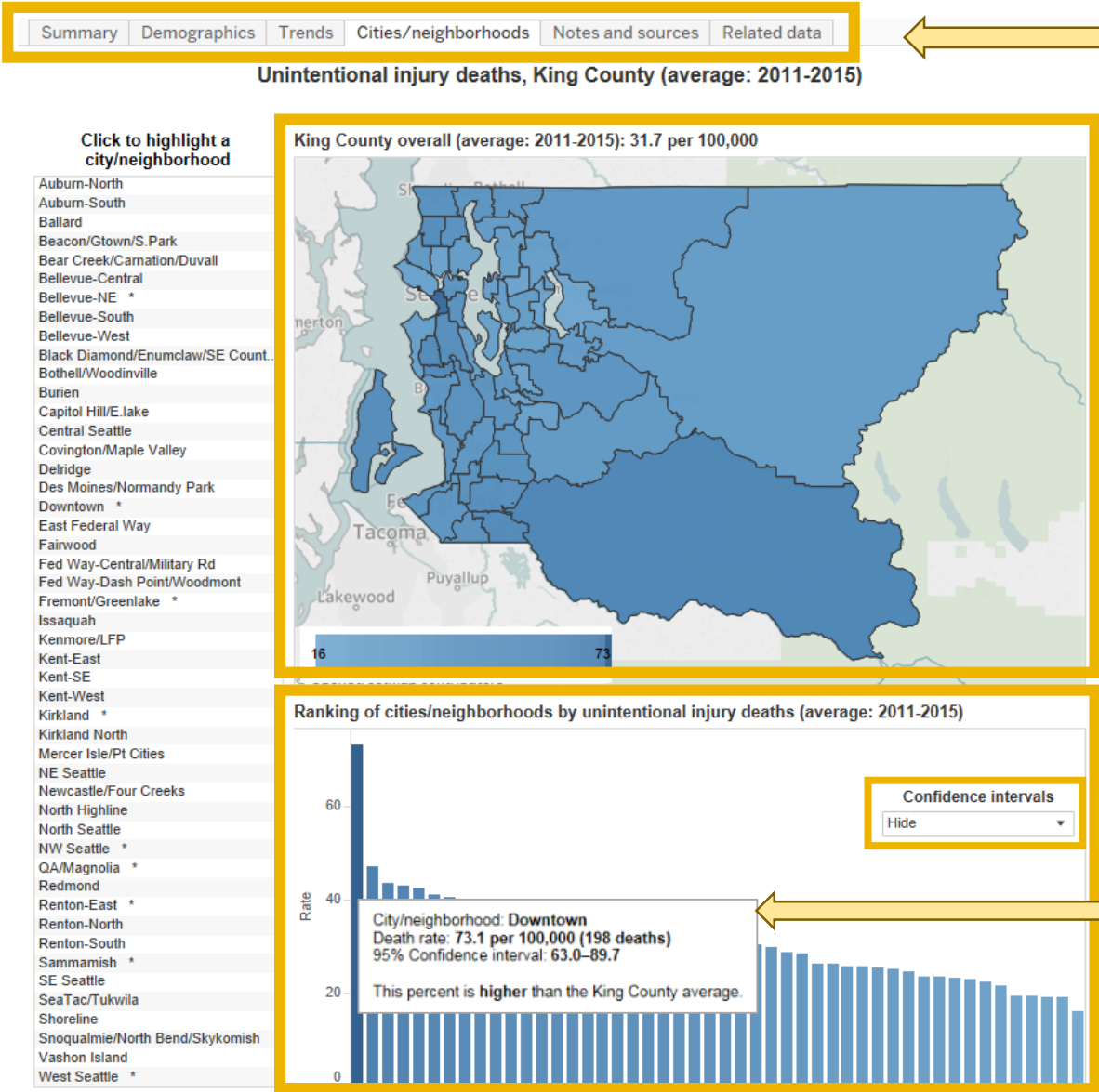
Online indicators report:

- A description of the indicator
- Overall estimate for King County
- Multiple-year averaged estimates for subpopulations as well as trends (e.g. race/ethnicity, region and smaller sub-county geography, sexual orientation status, poverty or income, disability status)
- CHNA on-line report offers narrative interpretation that highlights important findings (by race, place, income, gender, or sexual orientation)
 - CommunitiesCount.org also has more narrative
- Some have cross-tabs (e.g. race by gender)



Community
health
indicators

APDE engages
users to explore
160+ indicators
& provides data
trainings



Click tabs to see
different analysis

Maps provide data for
cities & neighborhoods

Rankings for **cities & neighborhoods**

Technical users can turn visual display of
confidence intervals on and off

Users can hover over data points to
see more information

^ = Data suppressed if too few cases to protect confidentiality and/or report reliable rates
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Source: Death certificate data, WA State Department of Health, Center for Health Statistics

PHSKC, APDE; 02/2018

What's gotten better & where can we improve ?

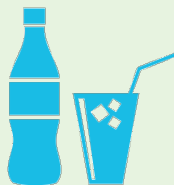
Across King County, successes include:



Increase in health insurance coverage



Decrease in cigarette smoking for adults & youth



Decline in daily sugary beverage intake for youth

Across King County, opportunities for improvement include:



Homelessness



Mental health



Lack of physical activity & obesity



Food insecurity

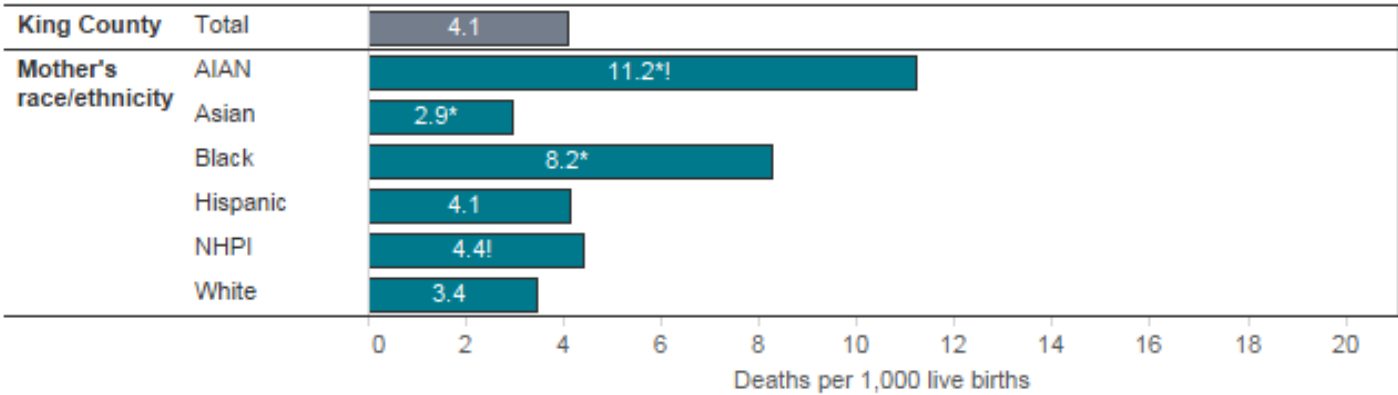


Drug related deaths

Inequities & **race**: infant mortality

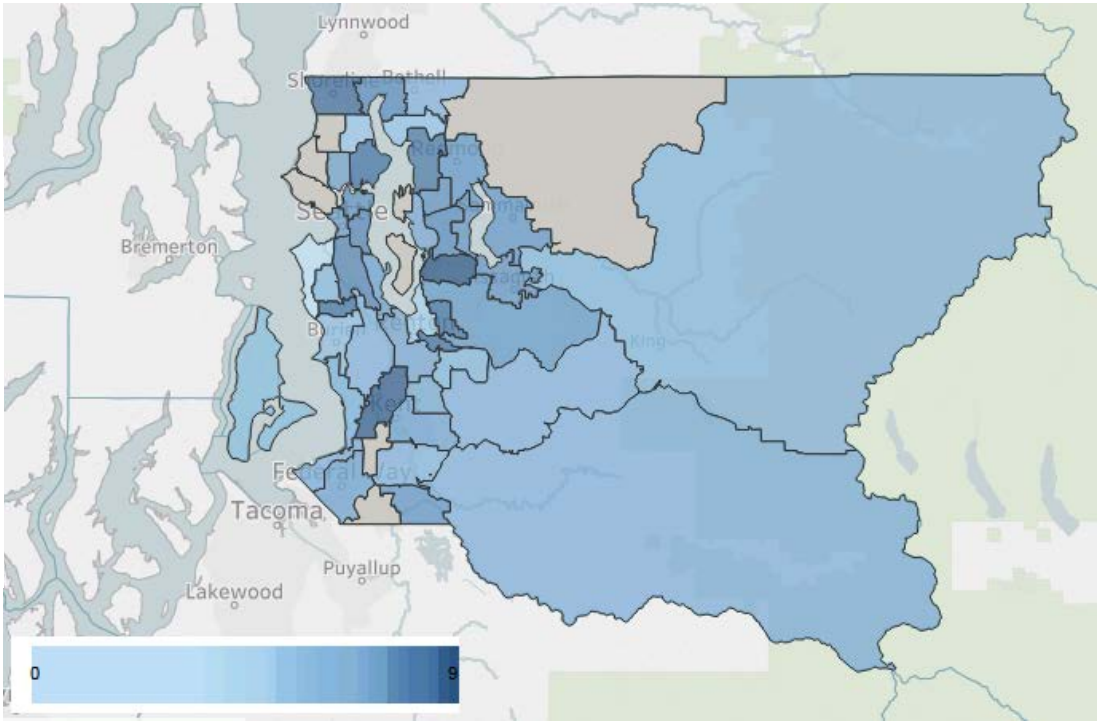
Infants born to Black or American Indian/Alaska Native mothers were *more than twice as likely* as those born to Asian or white mothers to die before their first birthday

Infant mortality, King County (average: 2011–2015)



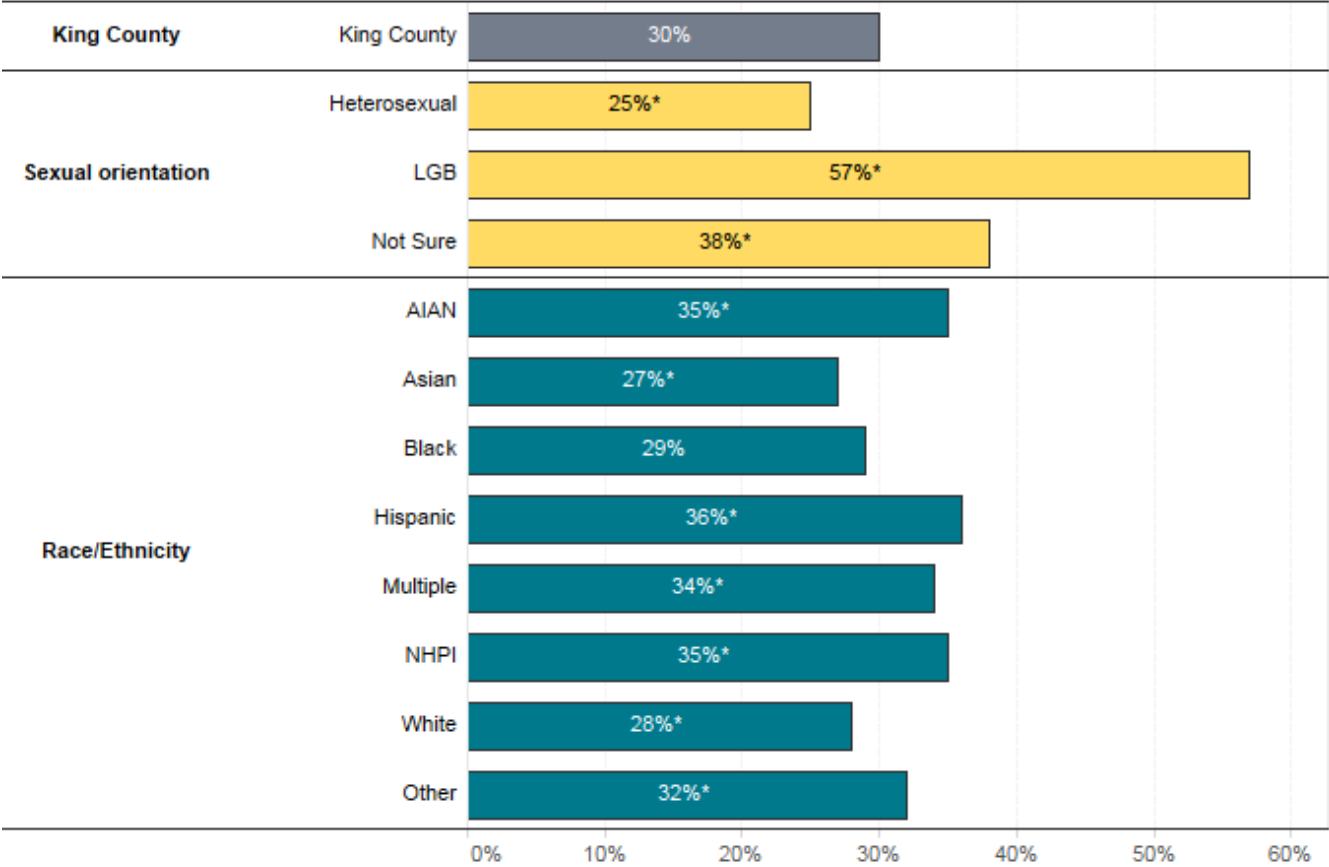
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AIAN = American Indian/Alaska Native
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Inequities & sexual orientation: youth depression

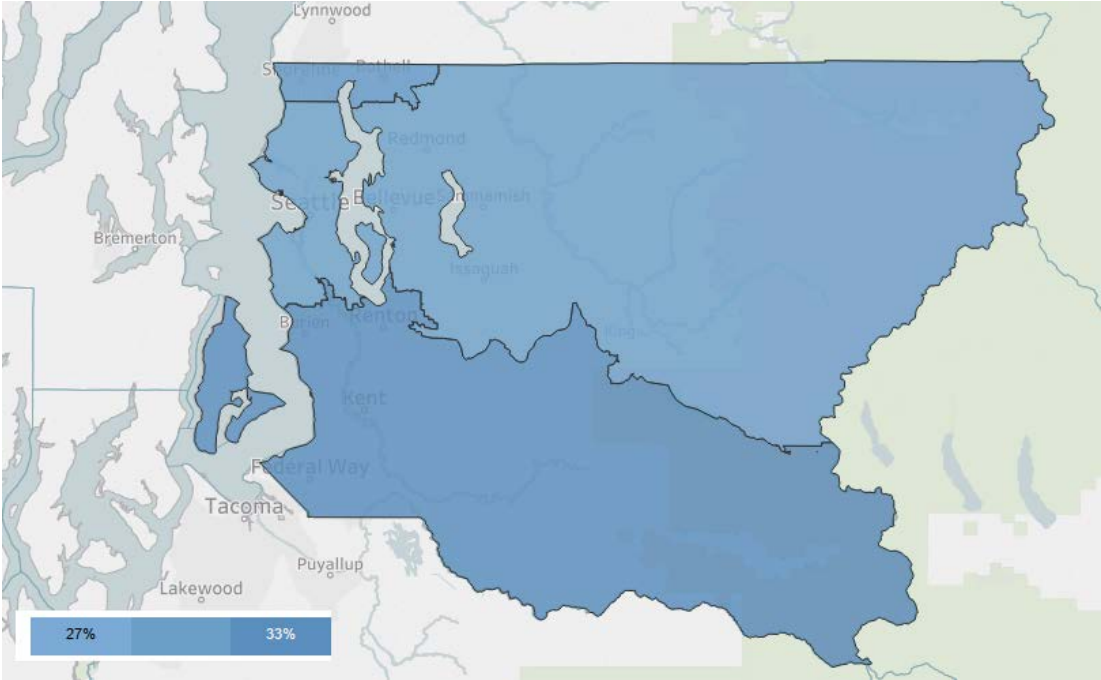
Depression prevalence (8th, 10th, 12th grade), King County (average: 2014 & 2016)



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LGB = Lesbian, gay, or bisexual

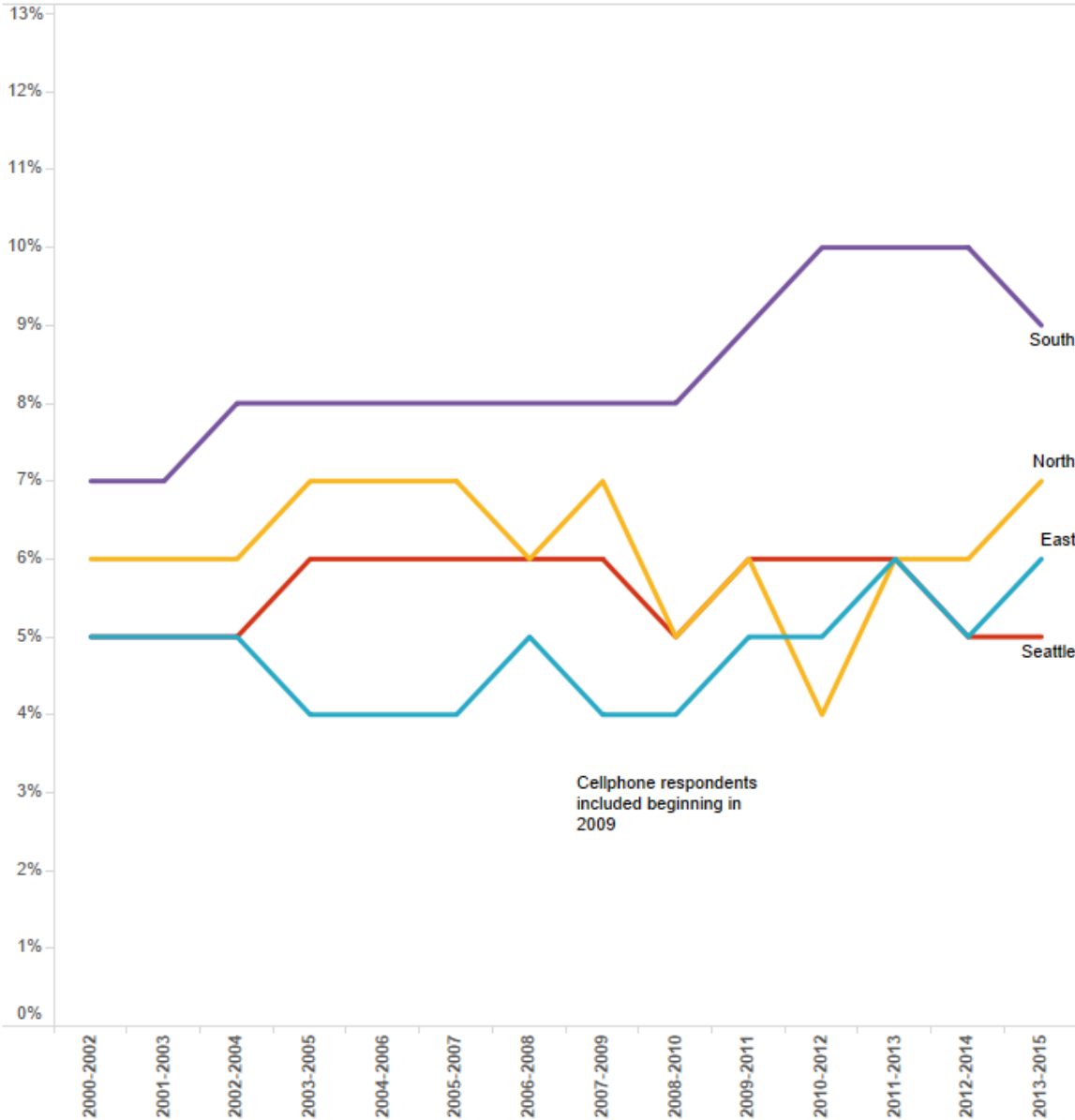
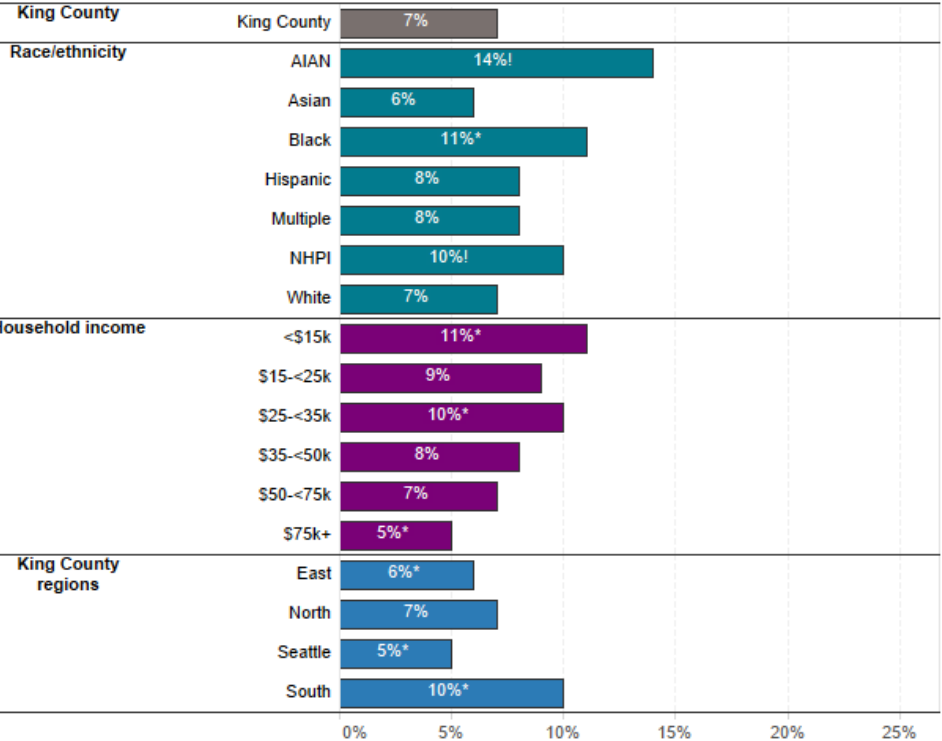
Since 2004, youth rates of depressive feelings have *increased* in King County overall
Double the rate of depressive feelings in youth who identify as LGB compared to heterosexual youth



Inequities & place: diabetes prevalence

Diabetes prevalence has been rising for King County overall since 2000, *inequities by neighborhood poverty and region are apparent*

Diabetes prevalence (adults), King County (average: 2011-2015)



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Communities Count

Social & Health Indicators Across King County

TOPICS

Arts & Culture • Community • Education • Environment • Families • Food • Health • Housing
Income • Population • Public Safety • Transportation

- Narrative to help understand the data
- Data dives into community
- Training on how to use the site

How are guns stored in King County homes?

Posted on March 31, 2018

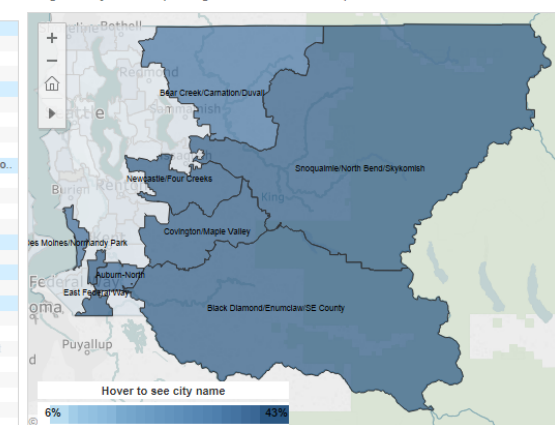
Across all of King County, more than 1 in 5 adults reported keeping a gun in or around their homes, including in a car or other motor vehicle. But where they lived made a big difference: Keeping a gun at home was least likely in Seattle neighborhoods (14%) and most likely in rural areas in east and south King County, with the highest rate (43%) in Covington / Maple Valley and Newcastle / Four Creeks.

Firearms stored in home, King County (average: 2012, 2013, & 2015)

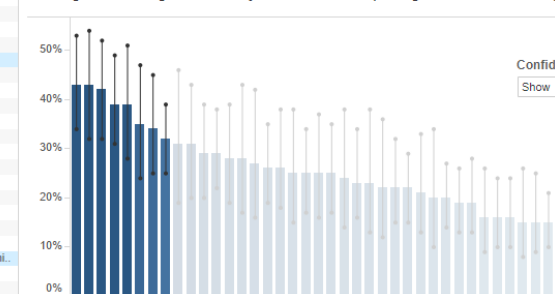
Click to highlight a city/neighborhood

Auburn-North*
Auburn-South
Ballard
Beacon/Glenn/S. Park*
Bear Creek/Carnation/Duvall*
Bellevue-Central
Bellevue-NE
Bellevue-South
Bellevue-West
Black Diamond/Enumclaw/SE Co.
Bothell/Woodinville
Burien
Capitol Hill/E. Lake*
Central Seattle*
Covington/Maple Valley*
Delridge
Des Moines/Normandy Park*
Downtown
East Federal Way*
Fairwood
Fed Way-Central/Military Rd
Fed Way-Dash Point/Woodmont
Fremont/Greenlake*
Issaquah
Kenmore/LFP
Kent-East
Kent-SE
Kent-West
Kirkland
Kirkland North
Mercer Isle/Pt. Cities
NE Seattle
Newcastle/Four Creeks*
North Highline *
North Seattle*
NIW Seattle*
QA/Magnolia*
Redmond
Renton-East
Renton-North
Renton-South
Sammamish
SE Seattle
SeaTac/Tukwila
Shoreline
Snoqualmie/North Bend/Skykomish
Vashon Island
West Seattle

King County overall, (average: 2012, 2013, & 2015): 23%



Ranking of cities/neighborhoods by firearms in home (average: 2012, 2013, & 2015)



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Source: Behavioral Risk Factor Surveillance System

PH

To help gun owners protect their children and neighbors against accidental shooting, access by children, firearm suicides, and firearm theft, Public Health - Seattle & King County is partnering with firearms retailers, elected and tribal leaders, local hospitals, and law enforcement on the **LOK-IT-UP** safe storage initiative.

The same survey that asked about keeping guns around the home also asked how those guns were stored. In 2015 —

- 43% of respondents with guns at home (about 150,000 people) said they stored at least one gun unlocked

Evaluation of Policy Change: ACA and ACH

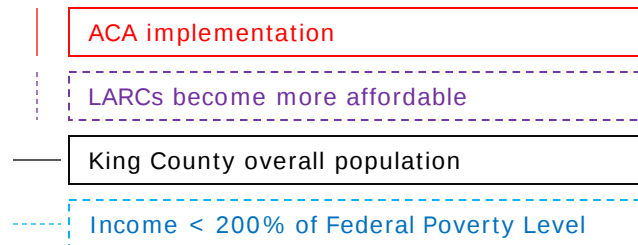
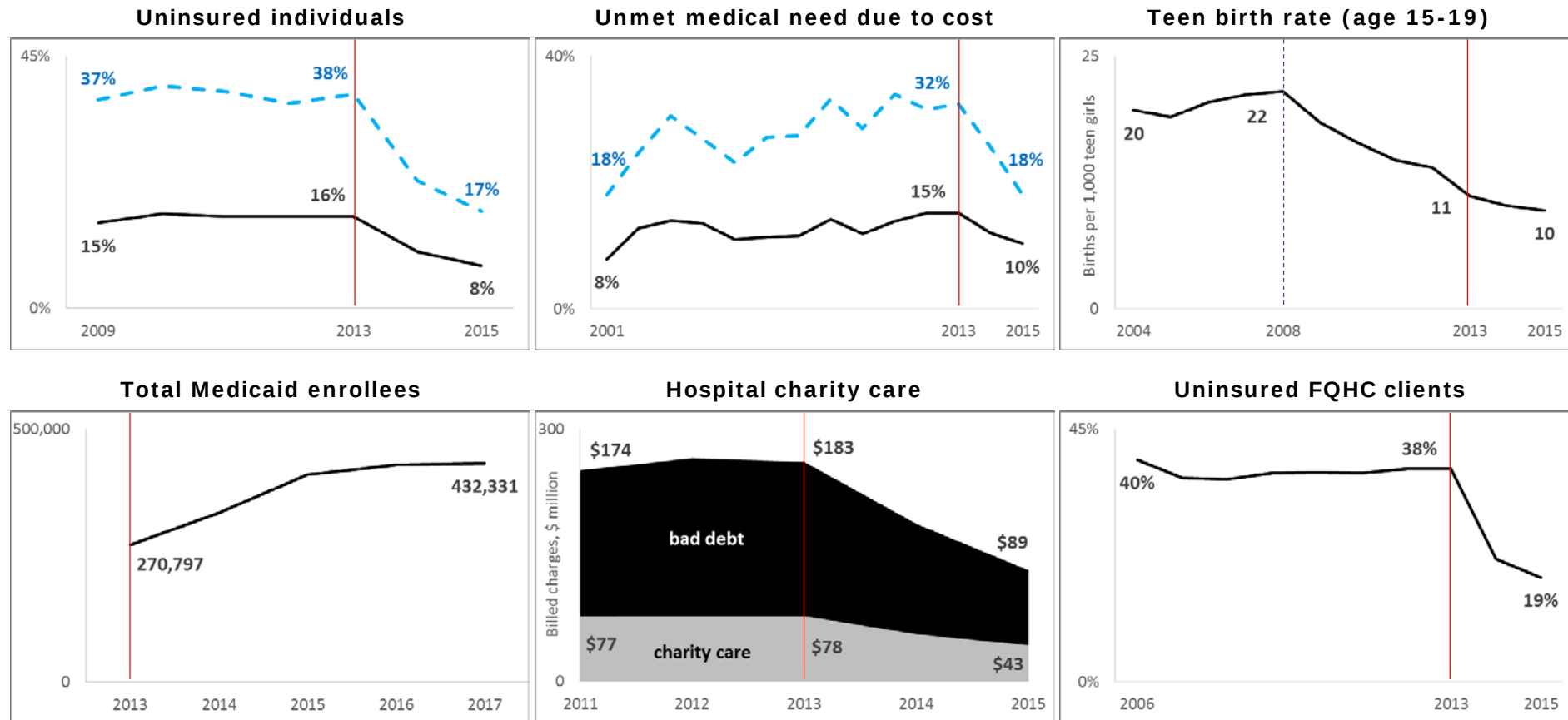
Other monitoring and evaluation work: examples and lessons learned

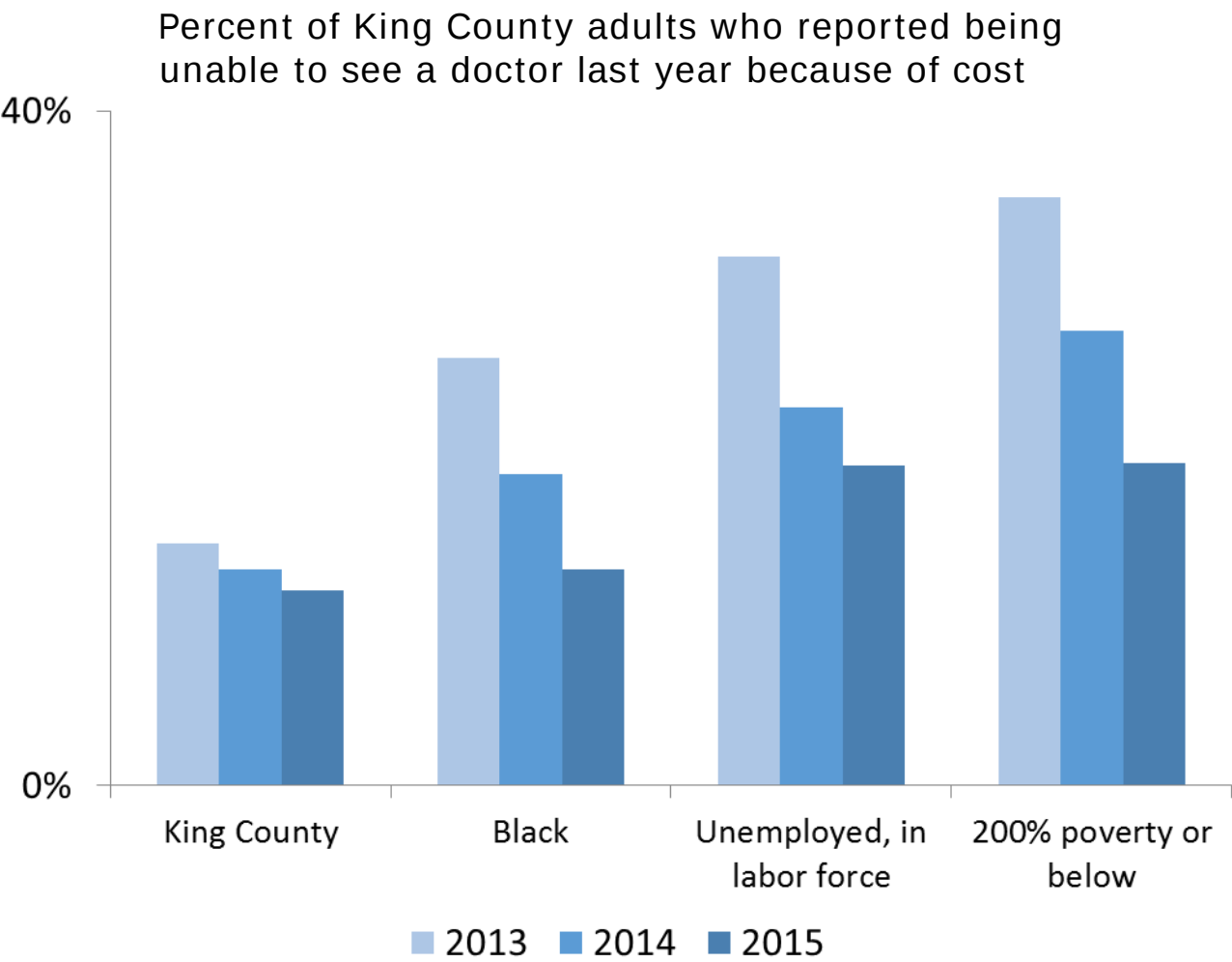
Evaluation framework to monitor ACA impacts KC: beyond traditional public health datasets

Topic area	Indicator areas	Illustrative indicators	Data sources	Data availability
Access to care	- Coverage - Unmet need - Affordability	- Uninsurance - Not seeking care d/t cost - Enrollment	- ACS - BRFSS - HBE - CHARS	Good/Fair
Utilization of care	Percent using any care	- Visits per capita - Routine checkup past year - Avoidable hospitalizations	- BRFSS - CHARS - DCHS	Good
Quality of care	- Evidence-based health care practices - Health outcomes	Clinical Process Measures (e.g. Heart Failure Care)	ProviderOne	In process
Patient experience	Satisfaction with health care received	Satisfaction with health care received	- BRFSS - CAHPS	Some
Health system capacity	- Plan network adequacy - Health provider capacity	- Per capita supply of HCPs - Accepting new patients	- OIC - Safety net providers - Mystery shopper	Poor
Costs	Total costs of health care per capita	Estimated price of inpatient care	CHARS	Poor
Population health	- Preventive services - Immunizations - Health status	- Late/no prenatal care - Child immunization rate - Fair/poor health status	- Vital stats - BRFSS	Good

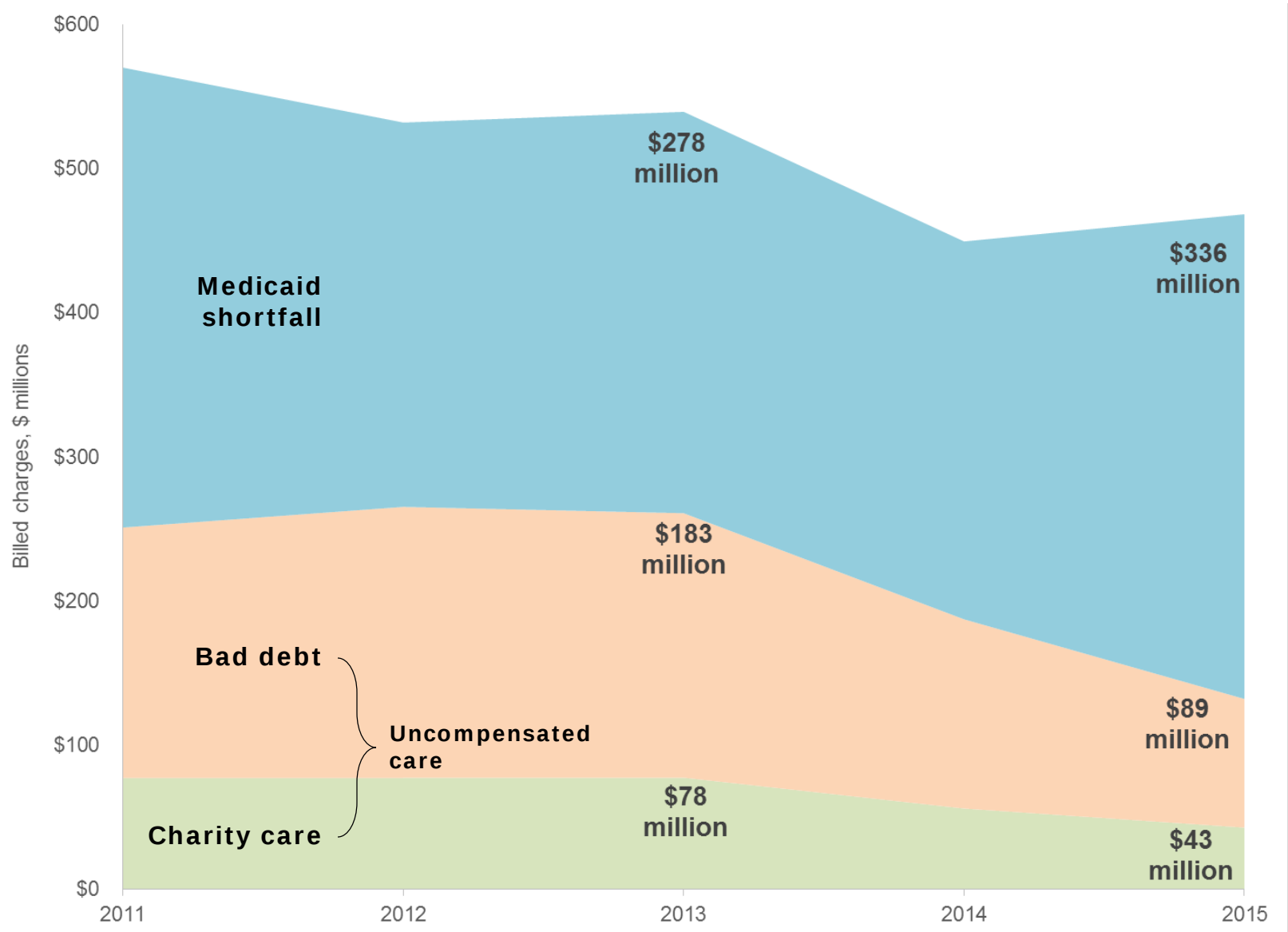
ACS, American Community Survey; BRFSS, Behavioral Risk Factor Surveillance Survey; AMA, American Medical Association; OIC, Office of the Insurance Commissioner; HBE, Health Benefit Exchange; HCP, Health care provider; DCHS, Department of Community and Human Services; JHS, Jail Health Services; HRSA, Health Resources & Services Administration; NPPES, National Plan and Provider Enumeration System; CHARS, Comprehensive Hospital Abstract Reporting System; MCO, Managed Care Organization.

Monitoring ACA-related gains and vulnerabilities of King County safety net providers and clients





Data source: Behavioral Risk Factor Surveillance System

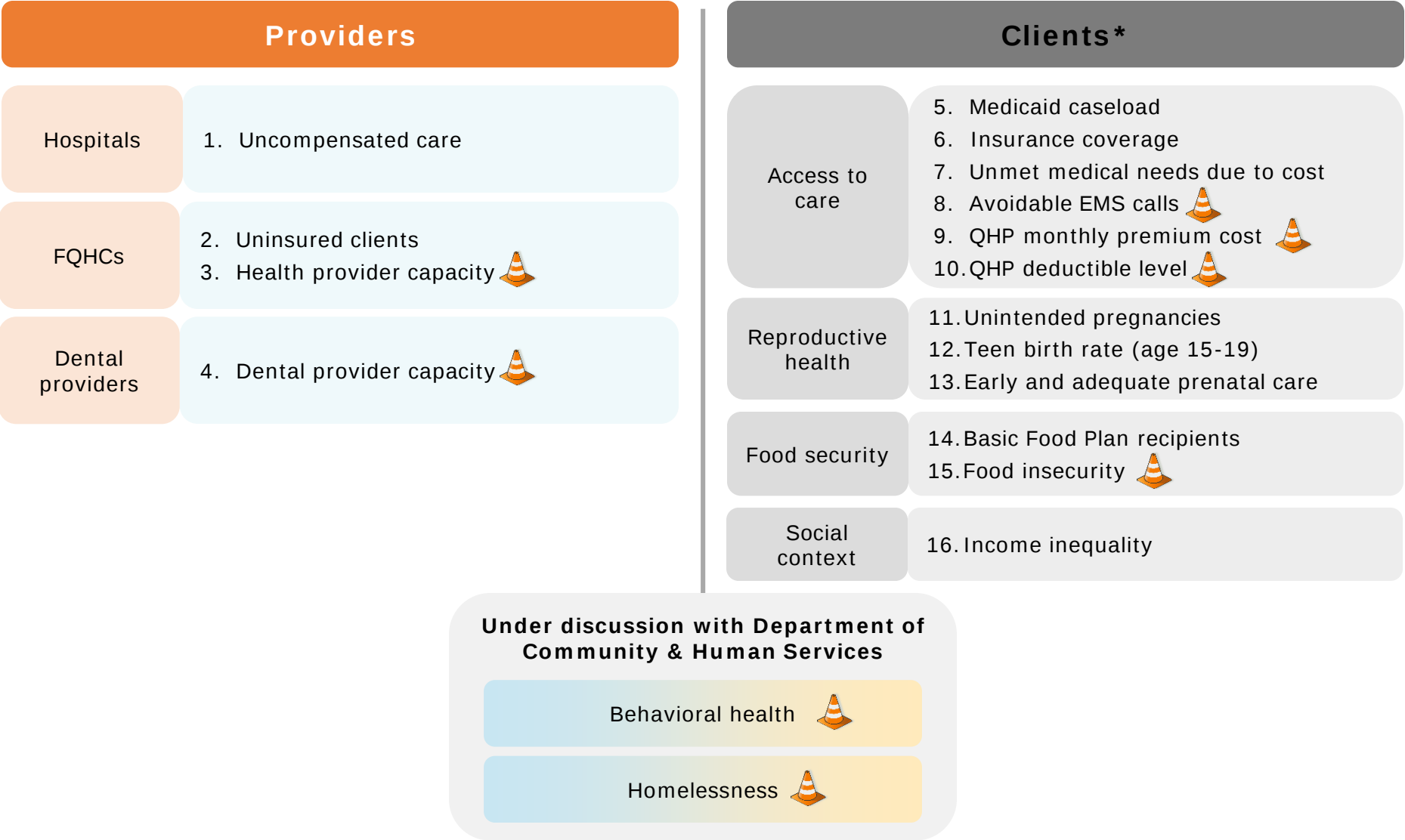


Data source: WA State Department of Health, Year End Financial Reports, Washington State Hospital Association

Continued plans for evaluation

- Healthcare utilization comparisons between the newly insured vs continually insured
- Return on investment for cost of care
- Health outcomes after continuous insurance: improve?
 - Looking across costly or chronic conditions: are they better managed?
- What is happening with QHP costs?
- Opportunity to see who moves on and off Medicaid rolls to private insurance using a statewide APCD

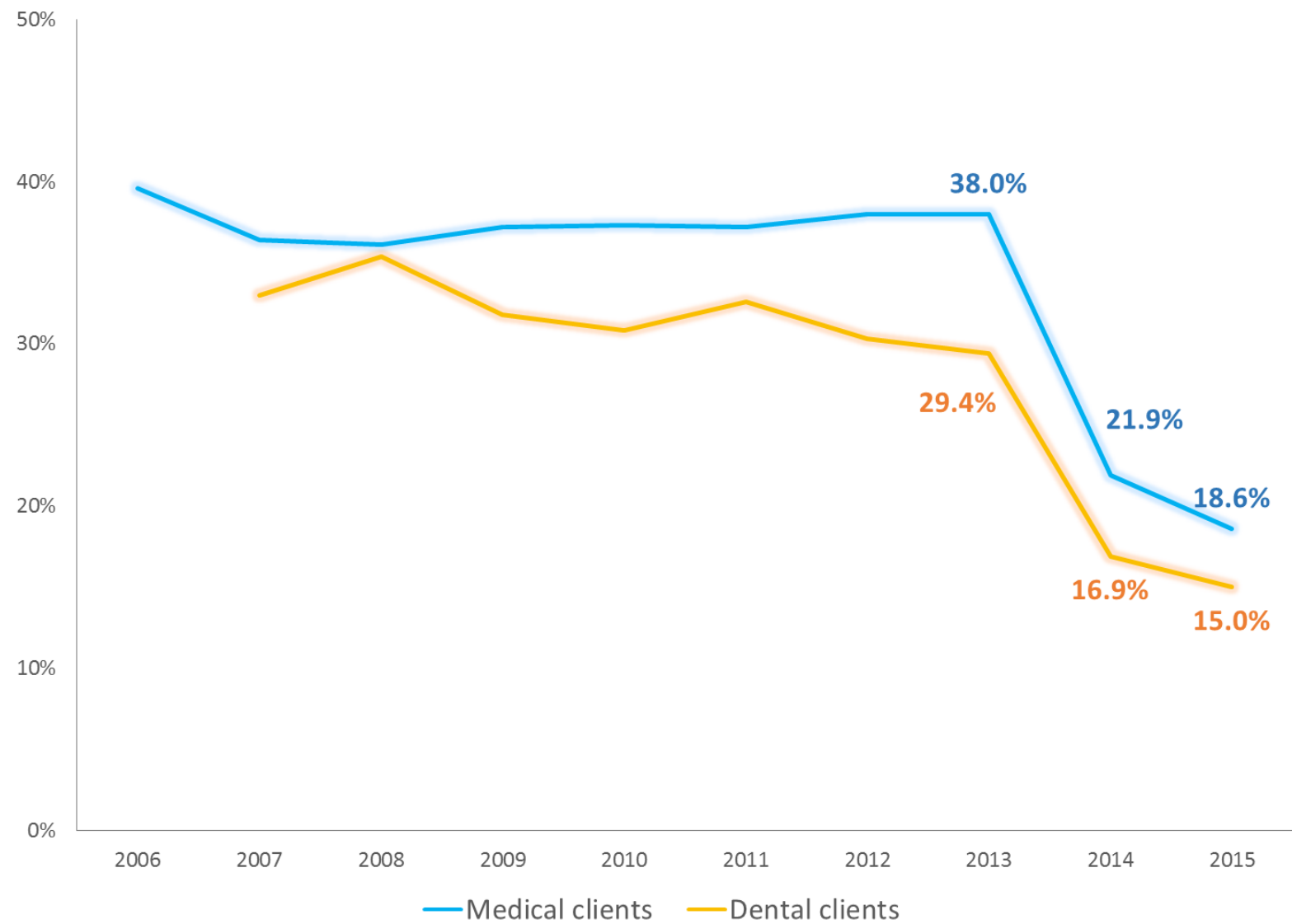
Evaluating specific populations in ACA: King County health safety net providers and clients



*All client-level indicators will be presented by available demographics where possible, including immigration status. 🚧 = availability of data to be determined.
FQHC = Federally Qualified Health Center, EMS = Emergency Medical Services, QHP = Qualified Health Program.

Falling uninsured rates among King County FQHC medical and dental clients

Uninsured FQHC clients



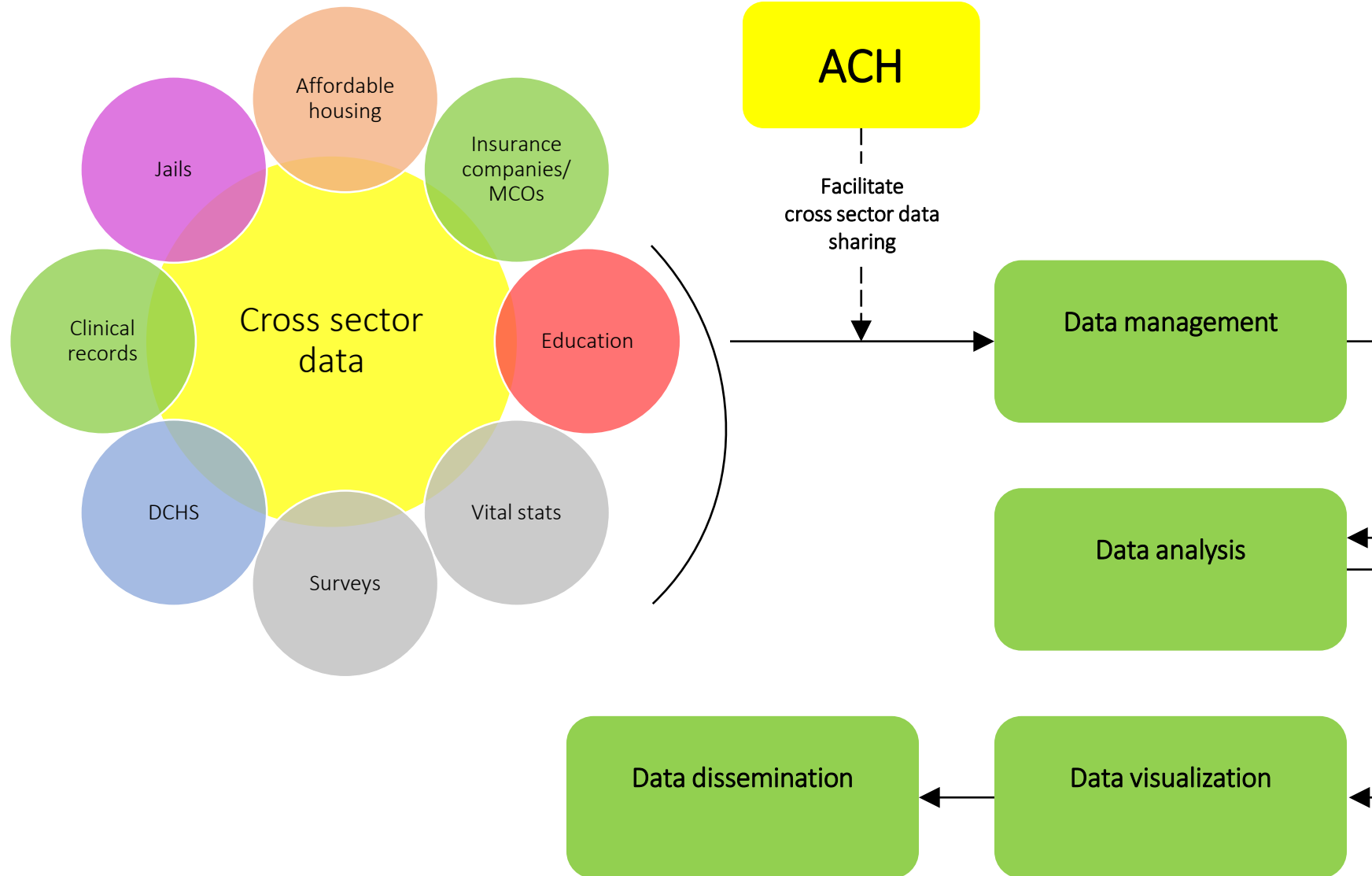
Data Source: Community Health Services Division, PHSKC. Data shown are for King County residents only, all ages included.

Who uses the health safety net in King County? A comparison of medical clients with the overall King County population in 2015

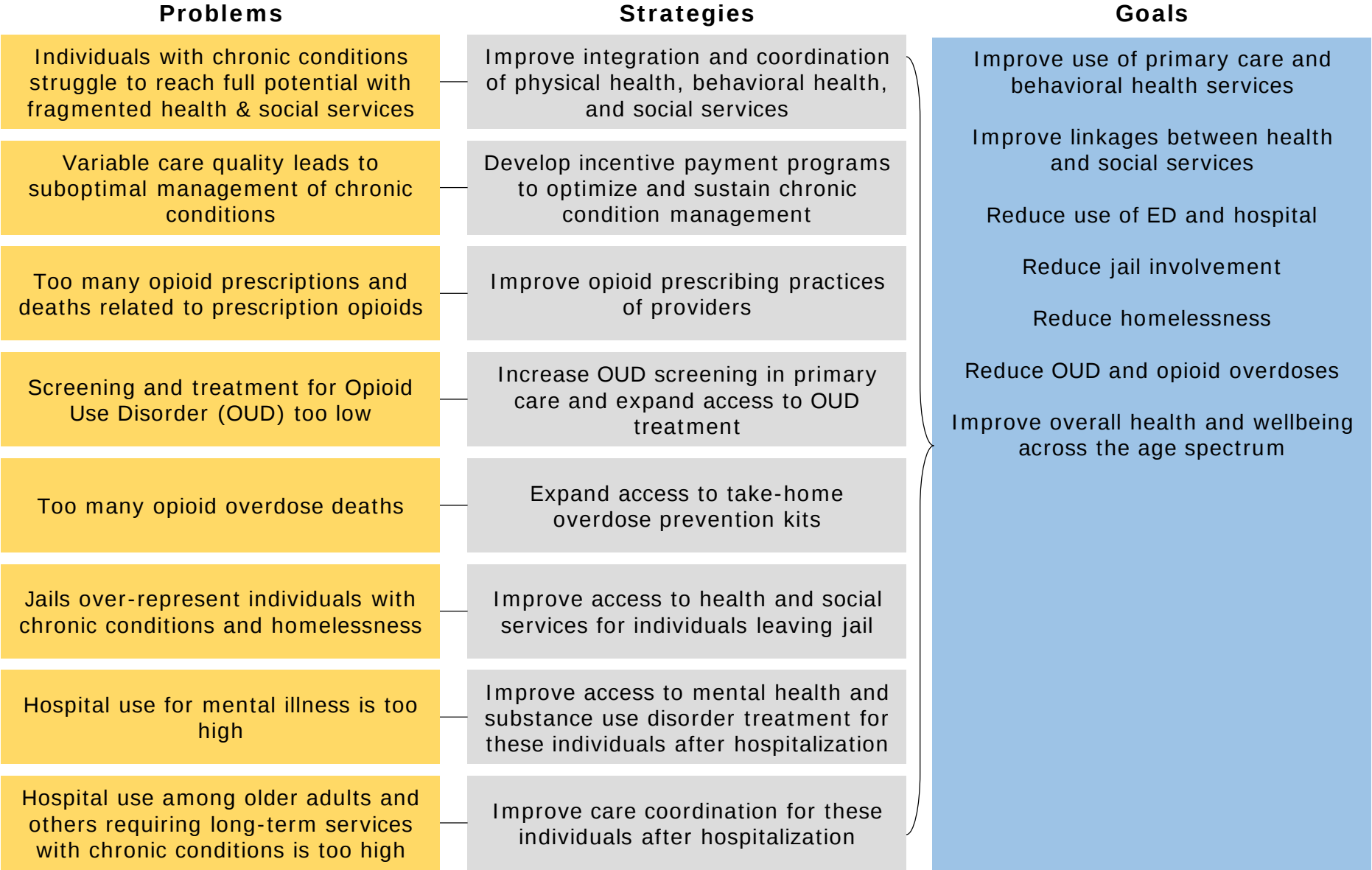


Data Source: Health safety net – Community Health Services Division, PHSKC; overall King County population – US Census Bureau, American Community Survey, 2015. Note that data include all FQHC medical clients in 2015, with exception of Public Health Centers for which homeless clients only are included.

Using Data and Cross-Sector Data Vision to Create Accountable Communities of Health



High level theory of change for the Medicaid transformation



Identifying hot and cold spots in the Medicaid population

Hot spots

- 1. Broad:** Members with heavy utilization of ED, hospital, and/or jail
- 2. Behavioral health:** Members with heavy utilization of ED and/or hospital for behavioral health concerns
- 3. Chronic disease:** Members with poorly managed chronic disease (P4P measures)

For each of these cohorts, estimate the following:

- a) # not using primary/preventive care
- b) # not using behavioral health services
- c) # who are homeless
- d) # eligible for but not enrolled in Health Home

By demographics:

- i. Adult (18+) vs. child (<18)
- ii. Gender
- iii. Race
- iv. Language/limited English proficiency status
- v. Sub-county region
- vi. Medicaid coverage group

Cold spots

- 4. Primary care:** Members with no primary/preventive care use in past year
- 5. Behavioral health:** Members with unmet mental health service need
- 6. Chronic disease:** Members with potentially undiagnosed chronic illness?

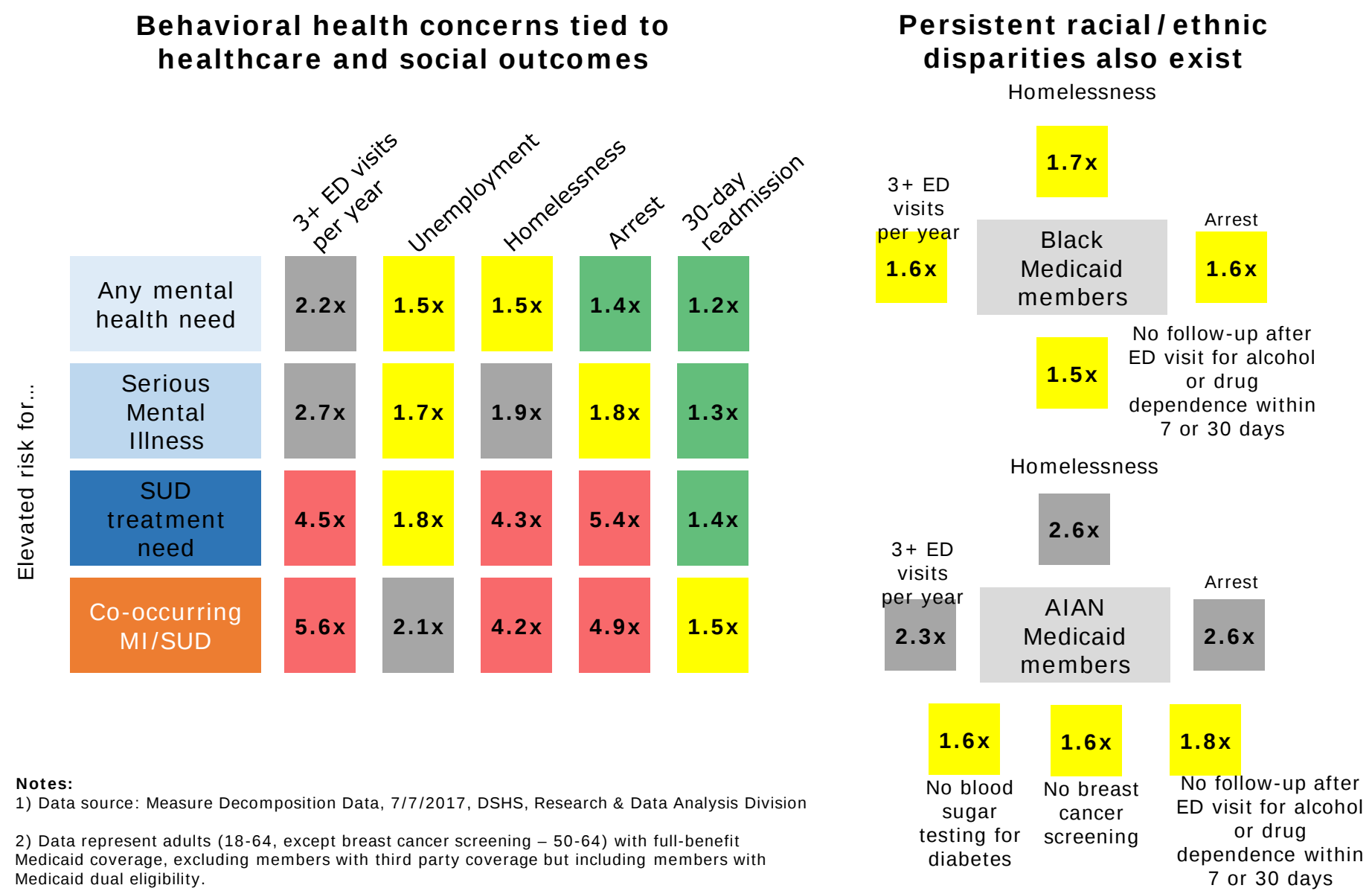
For each of these cohorts, estimate the following:

- e) # using primary/preventive care (except #4)
- f) # using behavioral health services (except #5)
- g) # who are homeless

By demographics:

- i. Adult (18+) vs. child (<18)
- ii. Gender
- iii. Race
- iv. Language/limited English proficiency status
- v. Sub-county region
- vi. Medicaid coverage group

Which Medicaid members have greatest opportunity for improvement?



Notes:
1) Data source: Measure Decomposition Data, 7/7/2017, DSHS, Research & Data Analysis Division
2) Data represent adults (18-64, except breast cancer screening – 50-64) with full-benefit Medicaid coverage, excluding members with third party coverage but including members with Medicaid dual eligibility.

Path of least resistance for performance-based initiatives not necessarily transformative change

Maximal overlap approach	Equity & social justice approach
Find the common denominator across all projects – Medicaid members with chronic disease & behavioral health concerns who may benefit from opioid dependence prevention/treatment and transitional care services	Identify Medicaid member subgroups with largest burden of <u>relative</u> health and social disparities – AI/AN, Black, mental illness & SUD treatment needs
Optimize efficiency, but may only be able to move interconnected P4P measures (e.g. may miss child P4P measures)	Grounded in justice, accountability to underserved populations, but may not be able to move region-level needle
Find providers who have established health or social service relationships with the largest number of Medicaid members <u>not</u> meeting performance measures	Identify the small subset of Medicaid members with the most complex health and social needs and thus the highest utilization and cost of health care services (e.g. 5% responsible for 50% of total cost of care)
May be well designed for shifting region-level needle, but not necessarily linked to transformative change	May blend elements of both performance and ESJ, given focus on members with maximal suffering and high, costly utilization of health services
May be worthwhile to consider a blended approach that includes both needle-moving, condition-specific clinical and social strategies (e.g. diabetes management) AND ESJ-grounded, system-level transformative change (e.g. centralized referral hub for clinical and social services to support improved care coordination)	

Designing for rigor

Logic models, reach and impact, oh my!

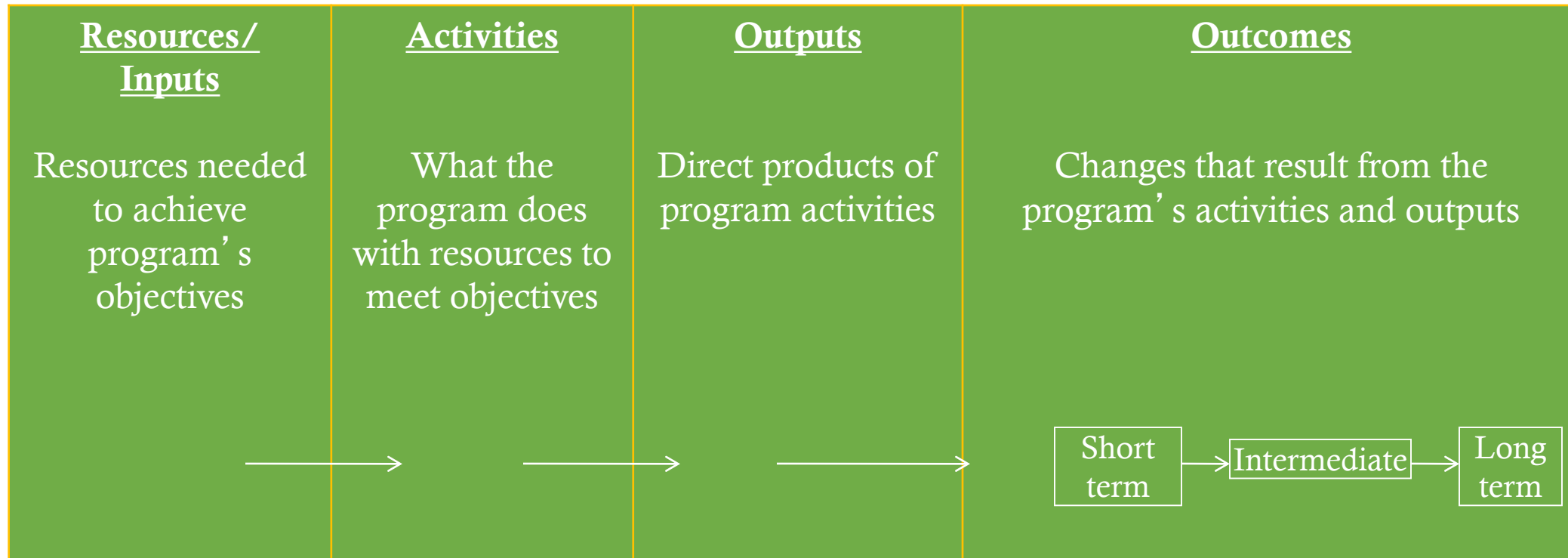


Good Evaluations Start with Good Data

- Plan early for scientific rigor
 - Develop evaluation plan
 - Identify data gaps
 - Literature search
- Detailed data plan (collection and/or analysis)
 - Determine data needed (administrative, survey, secondary, observational)
 - Data quality
 - Continue to monitor data and shift if necessary
- Analysis plan needs to match the evaluation questions
- **Don't forget to write up the results for dissemination!**



Common Logic Model Components



Assumptions: The underlying assumptions that influence the program's design, implementation or goals

External Factors/Context: Description of environment in which program takes place

Obesity Prevention Efforts: Generic Logic Model

8-10

EVALUATING OBESITY PREVENTION EFFORTS

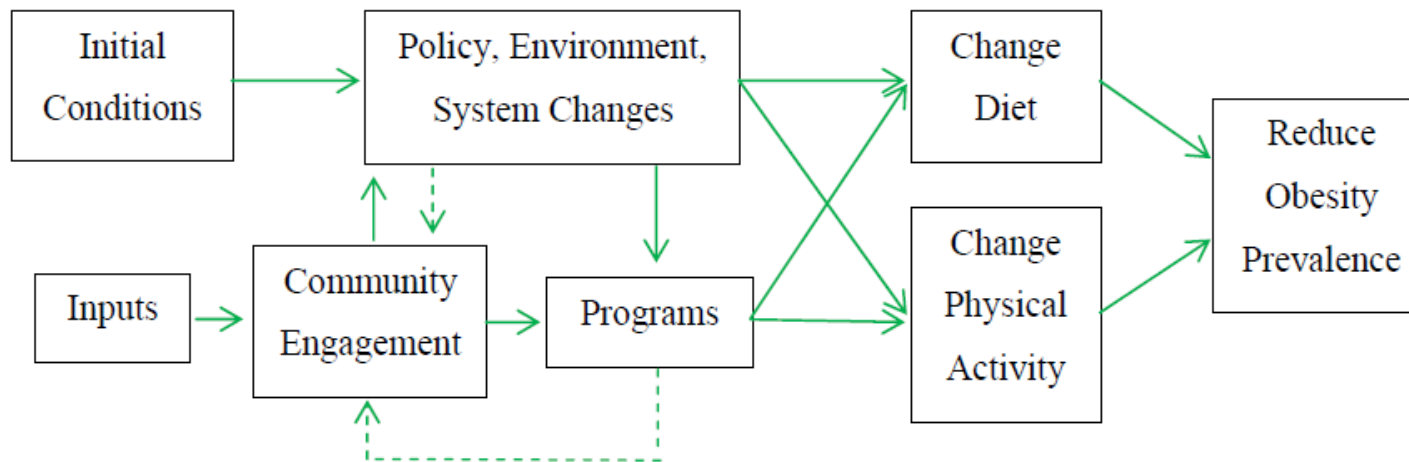
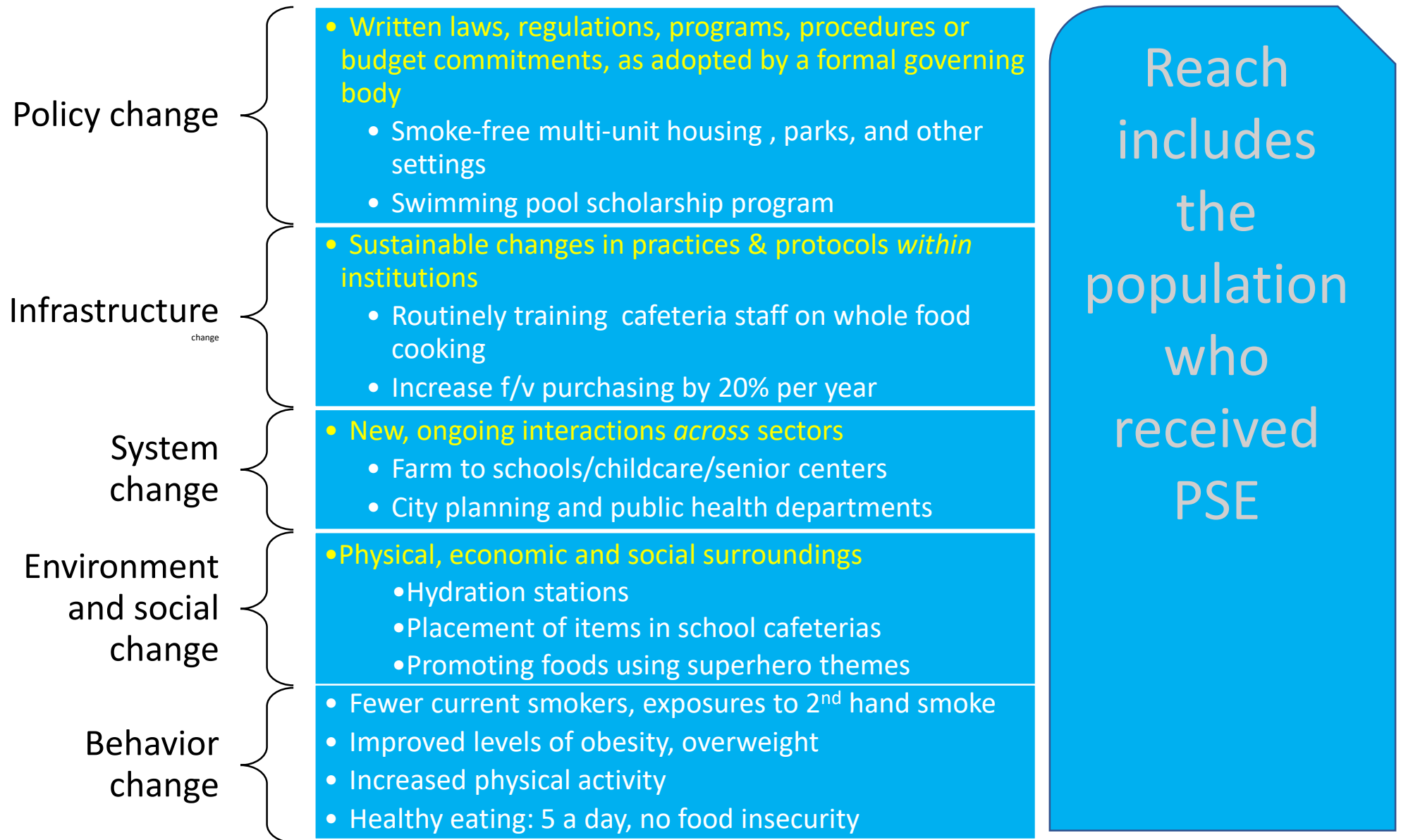


FIGURE 8-1 Generic **logic model** or theory of change for community obesity prevention. Not all interventions will include programs, policies, and environmental changes or systems changes. Not all interventions will focus on both diet and physical activity. Dashed lines indicate potential for interventions to increase community engagement over time.

Components of policy, systems and environment change: measuring reach



Reach: the extent to which a program attracts its intended audience

- People
- Organizations
- Communities
- Largely based on the intervention's scope.

Reach Formula

$$\frac{\text{Actual number of people or entities served}}{\text{Potential number of people or entities served}} = \text{Percentage Reached}$$

Impact

- Impact is the effect that interventions have on people, organizations, or systems to influence health.
- Key considerations:
 - Measurable: Impact is concrete, meaningful to stakeholders, and speaks to the value of your program.
 - Realistic level of change: How an intervention helps achieve public health goals.
 - Consider using short-term change for chronic disease risk factors
- Refer to Vickie's slide deck for examples of how to apply the evidence base to calculate impact on reach

Sample Data Collection Plan: Process Evaluation

Data Collection Matrix				
PERFORMANCE MONITORING and PROCESS EVALUATION: Implementation/Outputs				
What do we want to know...	As evidenced by...		Accessed where and by whom...	At what time point...
Evaluation Questions	Indicator	Data Source	Data Collection (Person Responsible)	Time Frame
<i>Evaluation questions should be developed based on literature review and identified gaps in evidence base to extent possible</i>	<i>What type of data we'll need</i>	<i>Where we'll get the data</i>	<i>How we will get the data (initials)</i>	<i>When we will collect the data</i>
Implementation Science: Identify strategies to promote the integration of evidence into policy and program decisions				
1) How much of what kind of support (training, TA) was used? What things were perceived to be helpful?	- Topics - Counts or time - Staff description of helpful topics	a) Training agendas b) Attendee logs c) TA tracking sheet d) Staff interviews	a) Collected from DJ/MP/DO b) Collected from DO and MP c) Conducted with key district and school key staff by EQ	a) Post training b) Quarterly c) Spring 2014
2) What facilitators and barriers arose during implementation? (What needed to be purchased? (How) was support - admin, teachers, students - present and useful?)	- TA topics noted - Staff descriptions of facilitators and barriers	a) TA tracking sheets b) Staff interviews	a) Collected from DO and MP b) Conducted with key district and school staff by EQ	a) Quarterly b) Spring 2014
Implementation Science: Comparisons of multiple evidence-based interventions				
3) What did schools choose to focus on and why?	- Selected objectives and action items - Topics receiving most attention	a) Schools' plans b) TA tracking sheet c) Staff interviews	a) Plans reviewed (EQ) b) Collected from MP and DO c) Interviews conducted with key district and school key staff (EQ)	a) Fall 2013 b) Quarterly c) Spring 2014
Implementation Science: Appropriate adaptation of interventions according to population and setting				
4) Were there differences between middle and high schools?	[analysis question, see Q2 and Q3]			
5) Were there differences based on school resources (e.g., cafeteria layout, food service skills)?	[analysis question, see Q2 and Q3]			
Other				
6) What media messages were used, at what dose and to whom?	Staff description	a) Staff interviews	a) Interviews conducted with key district and school key staff (EQ)	a) Spring 2014

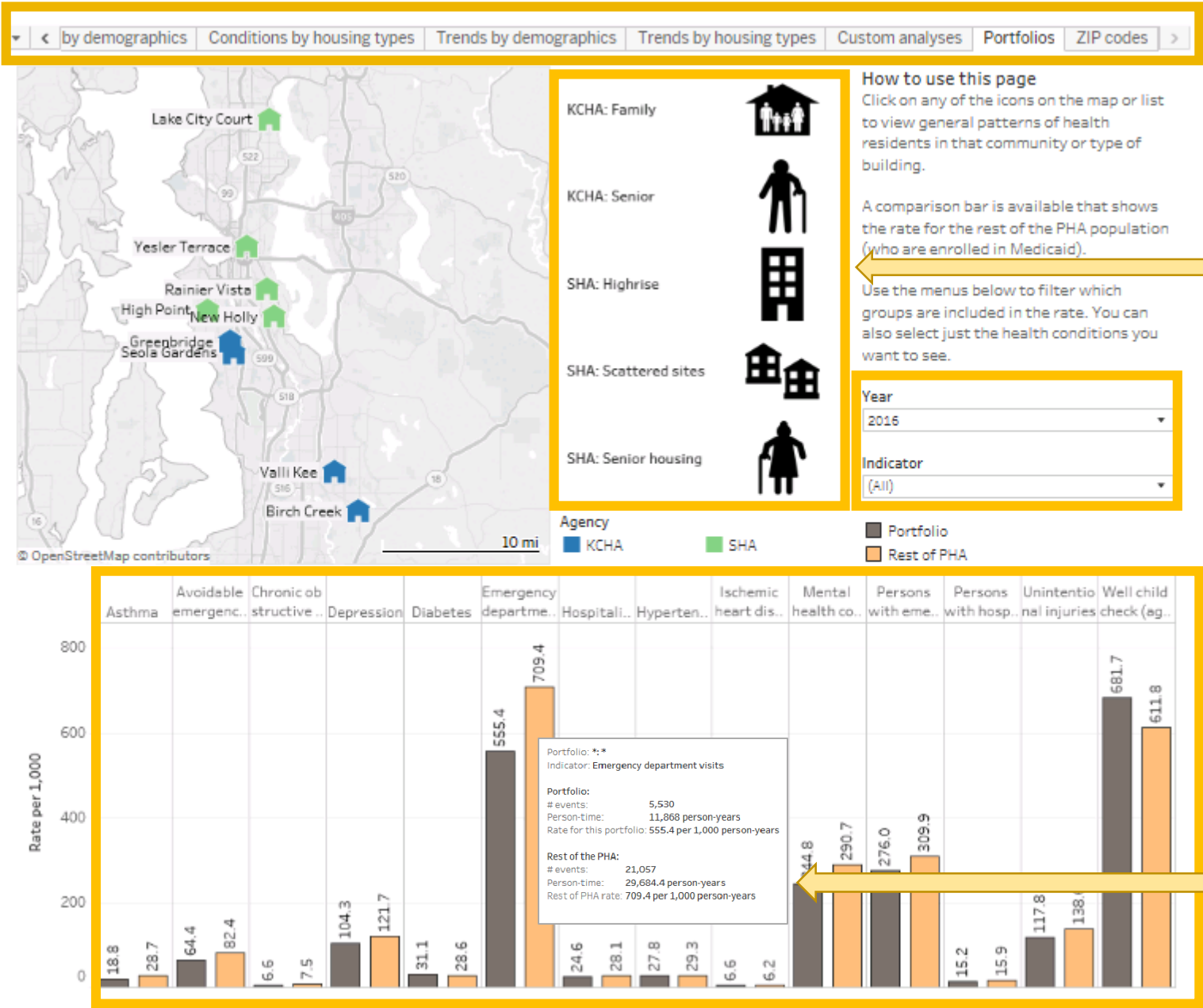
Sample Evaluation Plan

Evaluation Plan Summary: Behavioral Economics					
CPPW Evaluation Lead:			Date: May 2, 2013		
Logic Model					
PPO 2 (Healthy Eating): By September 29, 2014, increase the number of Intervention Area residents who are exposed to healthy eating opportunities from unknown to 325,393. AMO 2.4: By September 29, 2014, increase the number of students exposed to improved school nutrition environments by using behavioral economic strategies to increase student consumption of high nutrition quality foods from 0 to 9,000.					
Reach: Defined by the number of students in schools using (any?) BE principles OR the number of students who buy lunch in schools using (any?) BE principles (OUTPUT)					
Context or conditions: (situation in which the effort will take place; factors that may affect outcomes)					
- Some key details will be determined upon selection of funded district and schools (e.g., # of schools, current cafeteria practices, data collection logistics). - BE action steps and objectives will be selected by schools in the spring; these will then affect the outcomes of focus.					
Overarching Evaluation Question: To what extent can the evidence-based BE principles and strategies be effectively translated into effective school practices?					
Because we have these resources...	...we are able to do these activities...	...producing these results....	...and these increases in knowledge, skills, capacity...	... and these changes in practices, policies, systems and environments...	...resulting in behavior change or population-level outcomes...
Resources	Implementation Activities	Outputs	Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes
CTG funding 1 funded school district Up to 6 participating middle and high schools Evidence-based <i>Smarter Lunchroom Movement (SLM)</i> training and TA materials Sample marketing materials? Leading expert (trainer and TA provider) from the Cornell Center for Behavioral Economics for Child Nutrition Programs PHSKC lead/TA provider (expertise in BE, school nutrition, public health) CPHN TA provider (expertise in BE, school nutrition, public health)	District/schools participate in training on BE principles, objectives and action items (minimal training on marketing) District/schools engage with TA providers on BE principles, objectives and action items; media education initiative development and implementation Schools create BE plans for their cafeterias; they: - Identify specific SLM objectives from menu of 4 - Identify SLM BE action items to address each objective Schools implement BE plans District/schools implement media education initiative(s) District/schools develop and disseminate project products	#/amount of training conducted #/type of staff trained Amount of TA provided #/type of BE TA topics #/type of media TA topics # of schools with plans # objectives selected (by school, by district) # action items selected (by school, by district) #/% action items implemented (by school, by district) #/type/intensity of messages (by school, by district) # students exposed to media messages #/type of products developed and disseminated	Increased understanding of BE principles, objectives and action items among Nutrition Directors and school cafeteria staff	Increased application of BE principles and action items in school cafeterias	Increased student selection of fruit Increased student selection of vegetables Increased student selection of white milk Increased student selection of targeted entrée Increased student selection of reimbursable meals

Challenges and cross-sector considerations

Health & housing data dashboard

- Public Housing Authority (PHA) residents are **more likely to receive care for chronic conditions** than the non-PHA Medicaid population
- PHA children are **more likely to receive a well-child check** than non-PHA Medicaid children



Users can click through tabs to see **different dashboards**

Users can click to filter by **housing type**

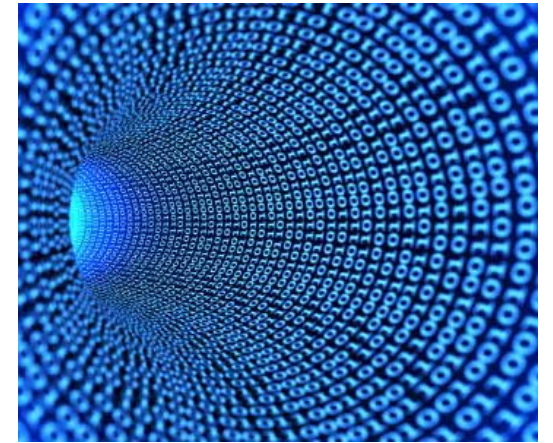
Users can select **different years** (2012 through 2016) and

different health indicators to see how rates change

Users can hover over data points to **see more information**

Challenges and Opportunities

- Increasing complexity of data
- More data available than ever before
- Public Health Accreditation
- Aging and chronic disease have long term trajectories
- Increasingly savvy consumers want more granular data, faster
- Getting social determinants of health data
- Cost of primary data collection
- “Collective impact” for community transformation
- Integration of epidemiology, quality improvement, decision and data science
- Transformation opportunities to leverage data integration and linkage
- Creating the “workforce of tomorrow” by increasing skills and facility with data



Healthy Community Action Plan

Health and housing partnership

Bring health and financial literacy programming to residents.



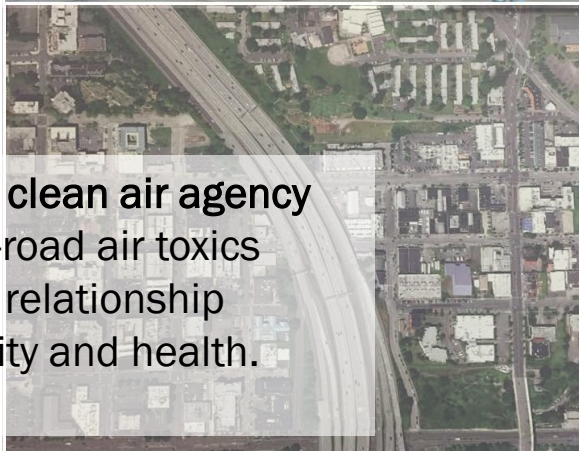
Neighborhood and City Parks & Rec

Activate neighborhood parks.



Support regional clean air agency

Conducting near-road air toxics study to quantify relationship between air quality and health.



Influence City government

Shifting City of Seattle toward providing more culturally appropriate responses to public safety, sanitation, and homelessness.



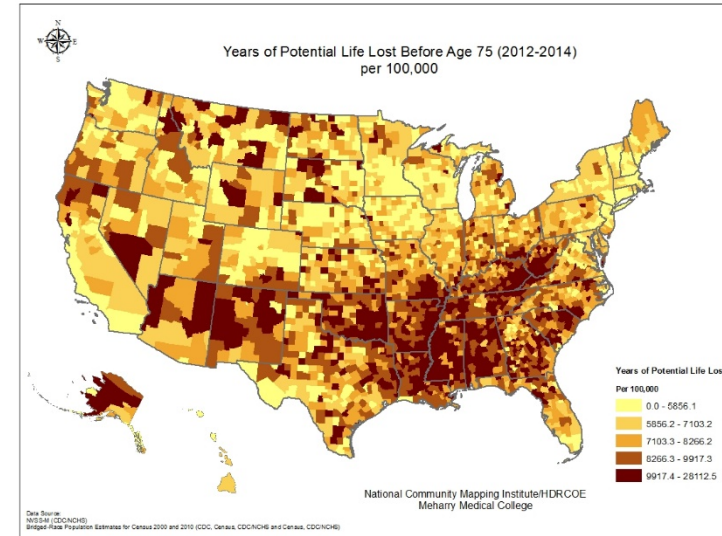
Other local health monitoring or evaluation

Economic Evaluation Methods

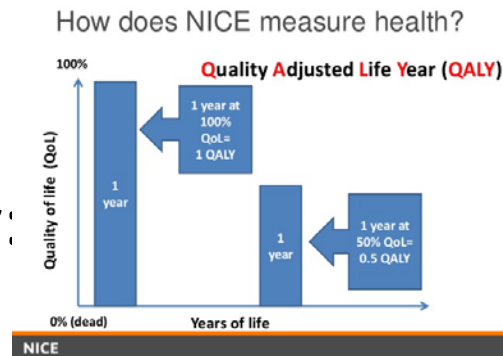
- Cost-benefit analysis accounts for outputs



Cost effectiveness:



- Cost utility:



Using Health Equity as a Focus

[Home](#)[About Us](#)[Creating Health Equity](#)[2018 Program](#)[Resources](#)[Contact Us](#)

Bay Area Regional Health Inequities Initiative

Search | 



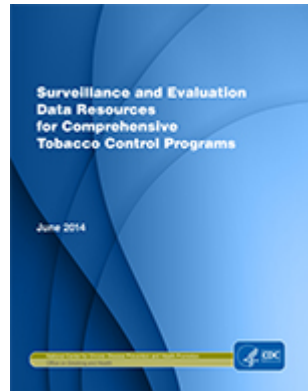
The Bay Area Regional Health Inequities Initiative (BARHII) is a coalition of the San Francisco Bay Area's eleven public health departments committed to advancing health equity. The regional collaboration includes public health directors, health officers, senior managers and staff from Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano and Sonoma counties, and the City of Berkeley.



Networks



- All-In for Community Health <https://allin.healthdoers.org/>
- American Evaluation Association <https://www.eval.org/>
- [A compilation of information
https://phpartners.org/health_stats.html](https://phpartners.org/health_stats.html)
- [Program specific:
https://www.cdc.gov/tobacco/stateandcommunity/tobacco_control_programs/surveillance_evaluation/surveillance_manual/index.htm](https://www.cdc.gov/tobacco/stateandcommunity/tobacco_control_programs/surveillance_evaluation/surveillance_manual/index.htm)
- Guiding Principles for Evaluators:
<http://www.eval.org/p/cm/ld/fid=51>
- Consider looking outside US (Public Health England, for example)

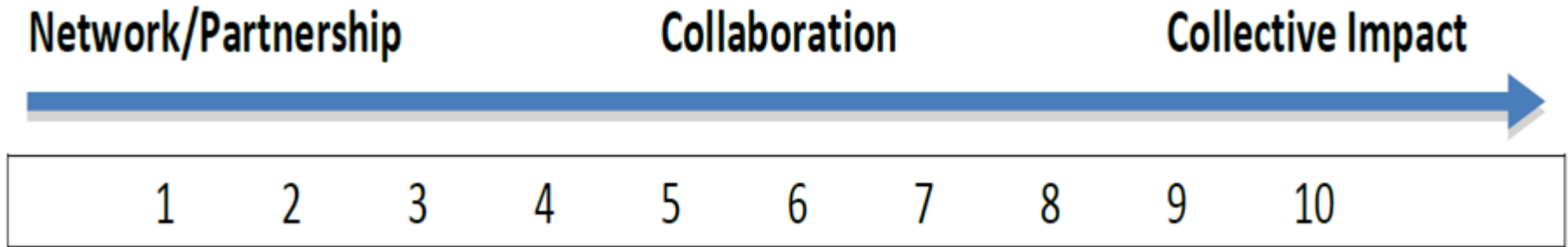


Collective Impact: Engaging Community for Results

Results based-thinking/accountability

- How much did we do?
- How well did we do it?
- Is any one better off?

CI Readiness: Where are you now?



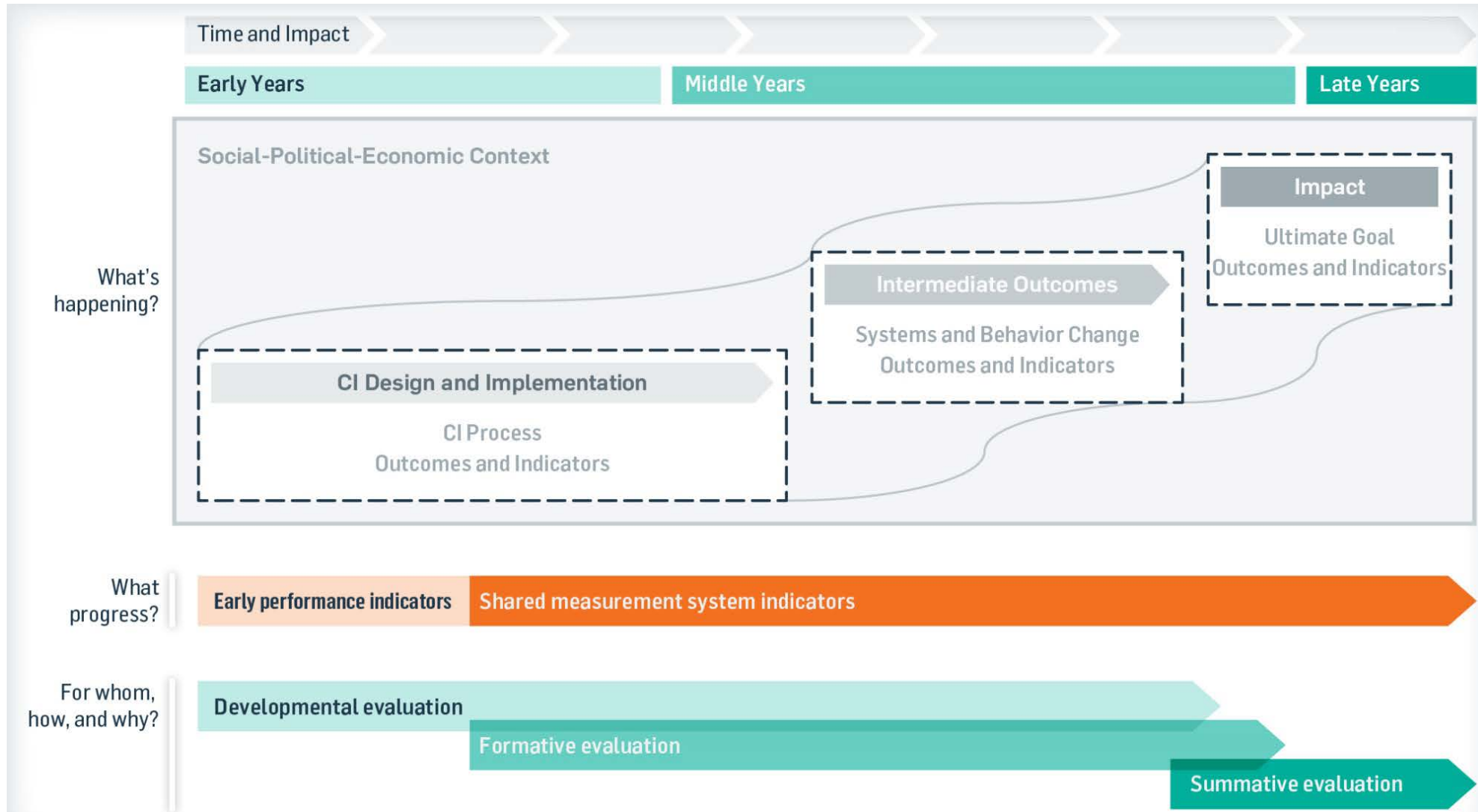
1-3 Information sharing,
networking, learning

4-7 Organizations working together
toward shared goals i.e. advocacy,
coalitions, joint fund raising, etc.

8-9 Assessing readiness,
identifying funding/resources for
CI; designing a structure for
backbone support (strategic
direction, dialogue between partners,
data collection and analysis, handling
communications, coordinating community
outreach, mobilizing Funders)

10 Launching
Collective
Impact initiative

Collective Impact Theory of Change



RBA in a Nutshell 2 – 3 – 7

2 Kinds of accountability

- Population- or Community-Level Quality of Life (Results & Indicators)
- Performance- or Program-Level (Performance Measures)

3 Kinds of performance measures

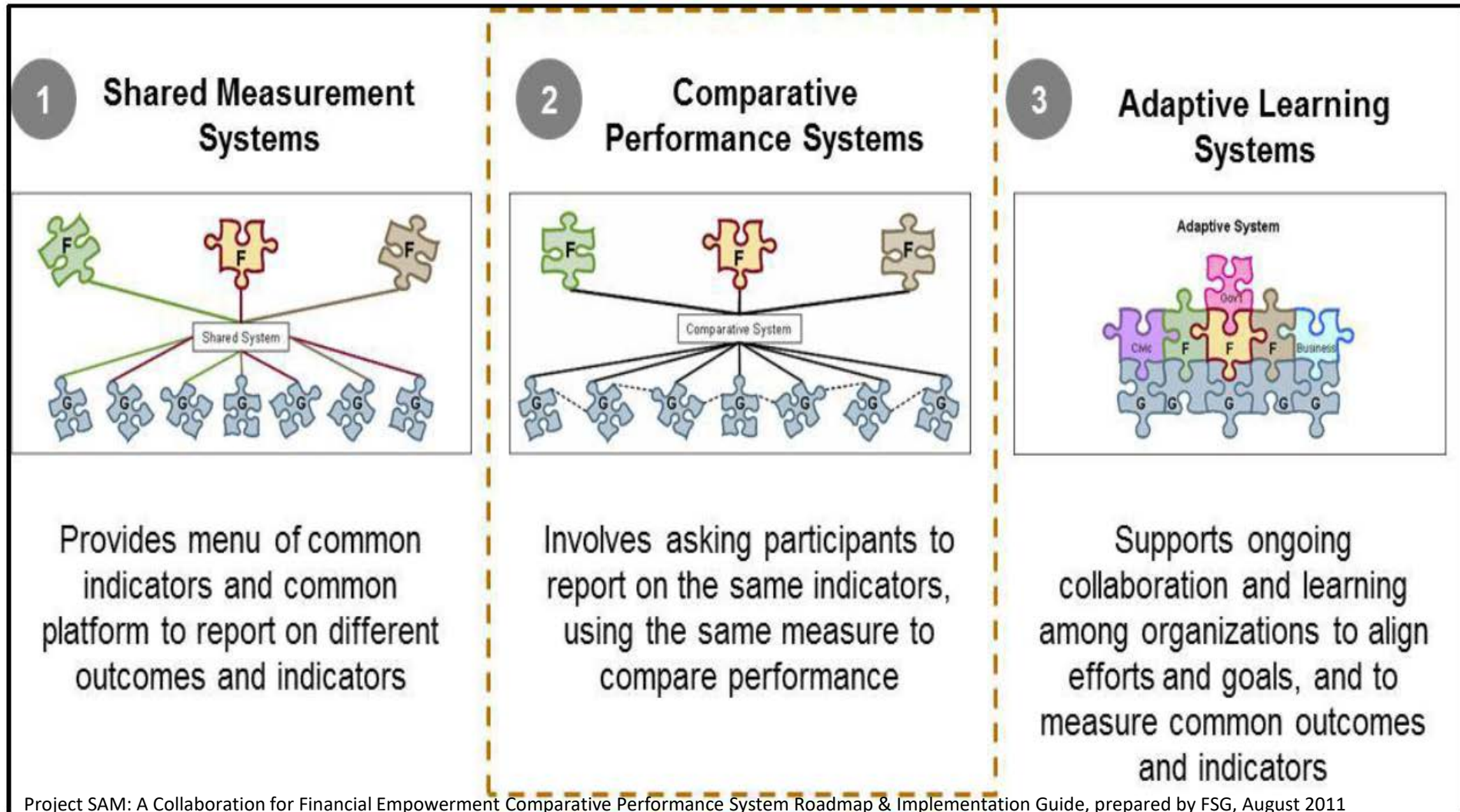
- How much did we do?
- How well did we do it?
- Is anyone better off?

7 Questions: from ends to means *“in less than an hour”*
(aka: Turning the Curve Thinking)

The 7 Population Accountability Questions

1. What are the quality of life conditions we want for the children, adults, and families who live in our community?
2. What would these conditions look like if we could see them?
3. How can we measure those conditions?
4. How are we doing on the most important of these measures?
5. Who are the partners that have a role to play in doing better?
6. What works, including no-cost and low-cost ideas?
7. What do we propose to do?

Developing Indicator and Measurement Systems



Examples from COO

Population

- Who is this about?

COO residents

Results

- Where do we want to end?

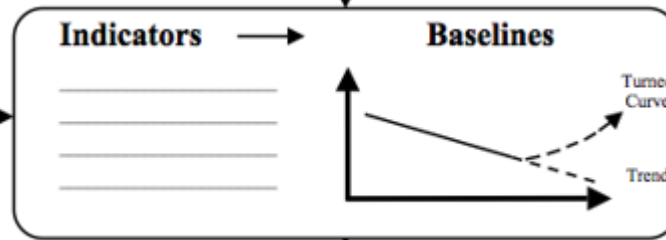
Health, housing, and economic equity

Experience

- How are we doing right now?

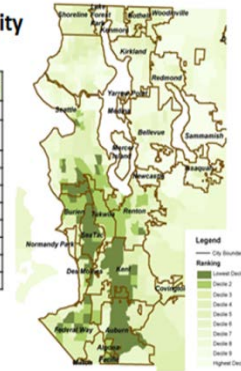
Story behind the numbers

- What's the story behind the baseline?



Communities of Opportunity

Population measures	Lowest 10% (dark green)	Highest 10% (light green)
Life expectancy	74	87
Adverse childhood experiences	20%	9%
Frequent mental distress	14%	4%
Smoking	20%	5%
Obesity	33%	14%
Diabetes	13%	5%
Preventable hospitalizations	1.0%	0.4%
Poor housing condition	8%	0%
Low-income, <200% poverty	54%	6%
Unemployment	13%	3%



Partners

- Who has a role to play in turning the curve?
- Who is impacted?
- Could there be unintended consequences?

Partners in Rainier Valley, White Center, SeaTac/Tukwila, government, states, NGO

What works

- What do we propose to do to turn the curve?
- What are our criteria for action?

Food Innovation Network; develop new affordable mixed-use housing; workforce development

Strategy and action plan

- How well did we do?
- How much did we do?
- Is any one better off?

Measure indicators; regular report outs; dashboard; community check-in

Selecting Program Level Measures

Communication Power

Does the indicator communicate to a broad range of audiences?

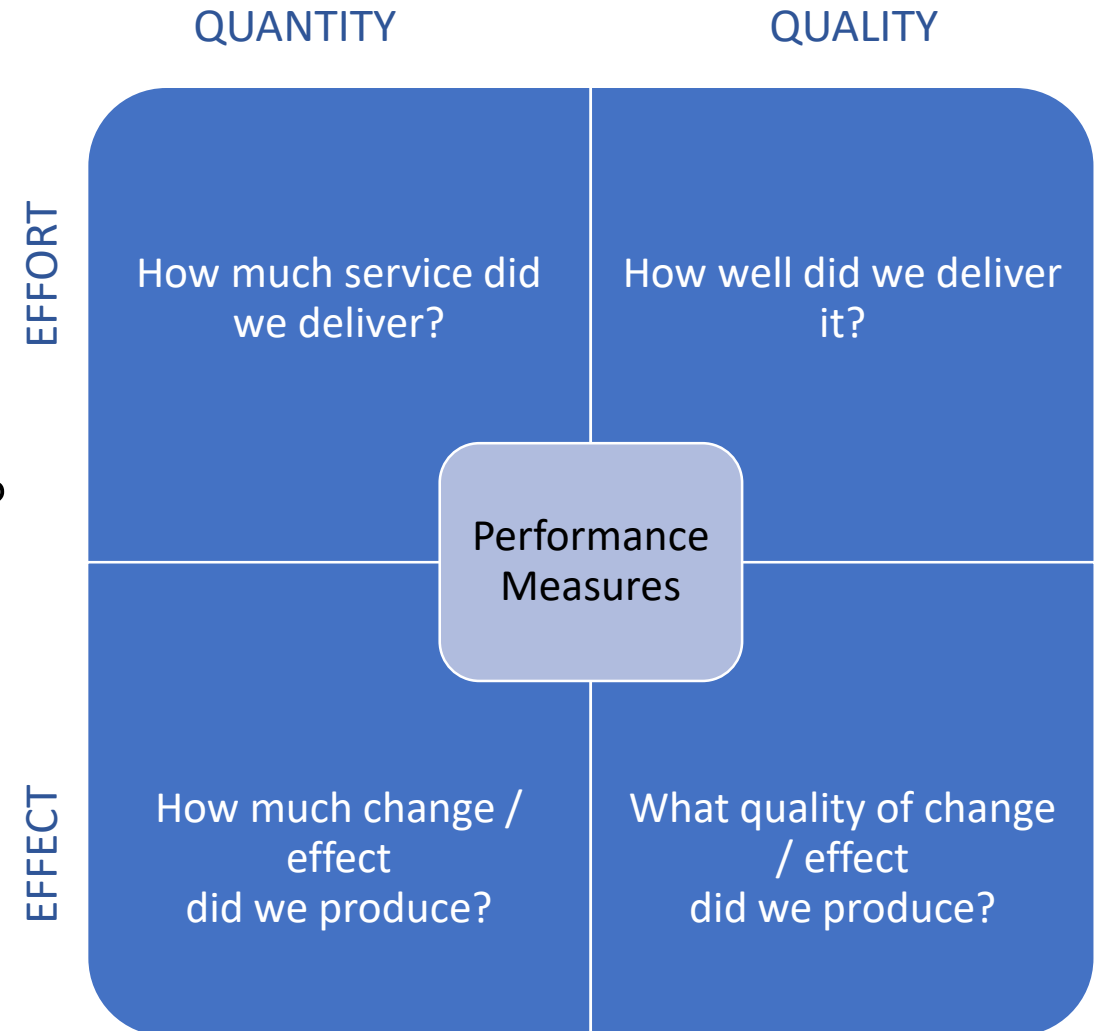
Proxy Power

Does the indicator say something of central importance about the result?

Does the indicator bring along the data **HERD**?

Data Power

Quality data available on a timely basis.



Criteria and types of indicators

Communication Power

Does the indicator communicate to a broad range of audiences?

Proxy Power

Does the indicator say something of central importance about the result?

Data Power

Quality data available on a timely basis.

Part 1: Primary Indicators

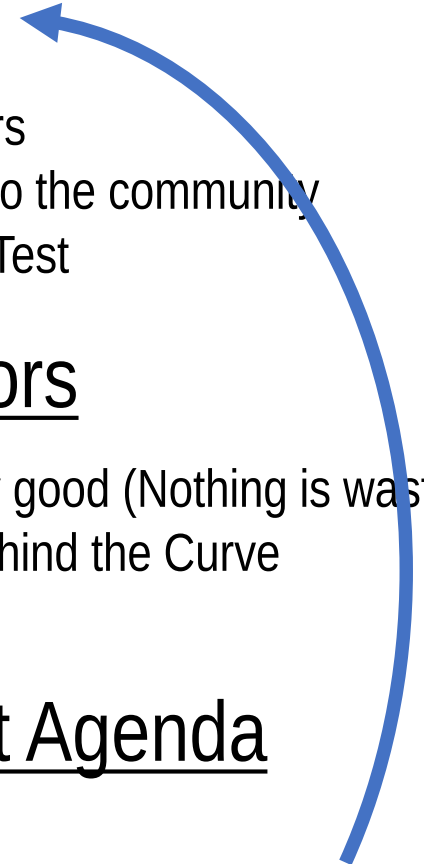
- 3 to 5 “Headline” Indicators
- What this result “means” to the community
- Meets the Public Square Test

Part 2: Secondary Indicators

- Everything else that’s any good (Nothing is wasted.)
- Used later in the Story behind the Curve

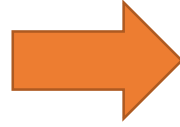
Part 3: Data Development Agenda

- New data
- Data in need of repair (quality, timeliness etc.)



Evaluating Collective Impact Requires a Mindset Shift for Many Funders and Practitioners

Typical Focus of Program Evaluation



Evaluating CI as a Complex Intervention

Assessing the impact of a **specific intervention**

Evaluating effects and impact according to a **predetermined set of outcomes**

Using logic models that imply cause and effect, and **linear** relationships

Providing findings **at the end** of the evaluation

Assessing **multiple parts of the system**, including its components and connections

Evaluating intended and unintended outcomes as they **emerge over time**

Evaluating **non-linear and non-directional relationships** between the intervention and its outcomes

Embedding **feedback and learning** through the evaluation

Continued monitoring and analysis of life expectancy

NOTE: these data are still under development and not considered final; please do not disseminate but consider as part of a discussion

Summary

Overarching Lessons Learned

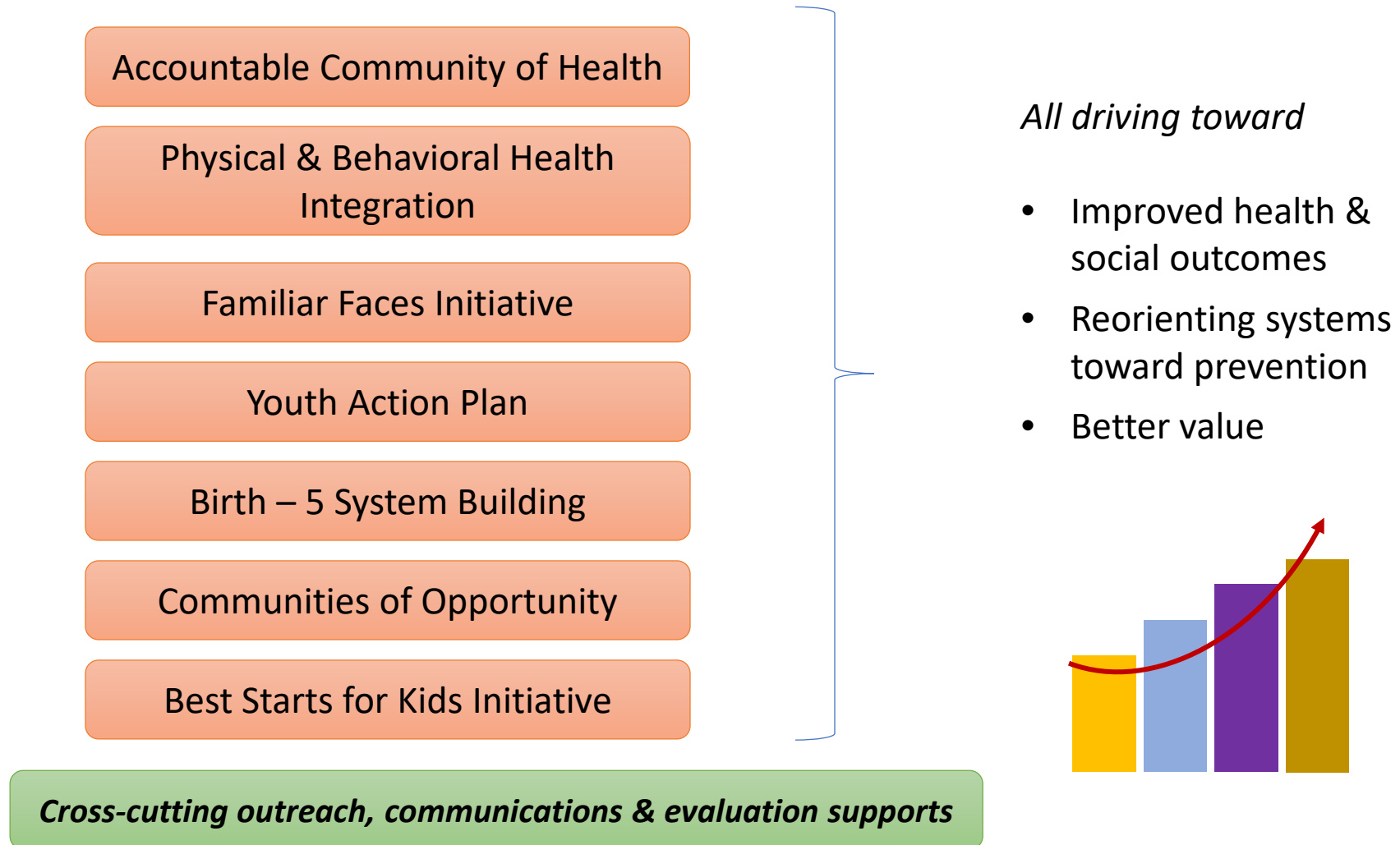
- Start small and grow evaluation function over time
- BEFORE getting to design and measurement, clarify:
 - What the intent of the program is and how it intends to achieve impacts and
 - The priority questions for *this* evaluation or monitoring effort
- Leverage resources from the profession of evaluation and colleagues in the field
- Always use a logic model or other plan to help you know where you start, where you want to go, how you are going to measure it, and how you are going to get there
- Include in budget; supplement funding with grants
- Remember that it is an on-going process. Revisit your plans in terms of M&E -- have different questions emerged? Are you getting *useful* information? Do you need to change your program or your plan?
- Community is vitally important



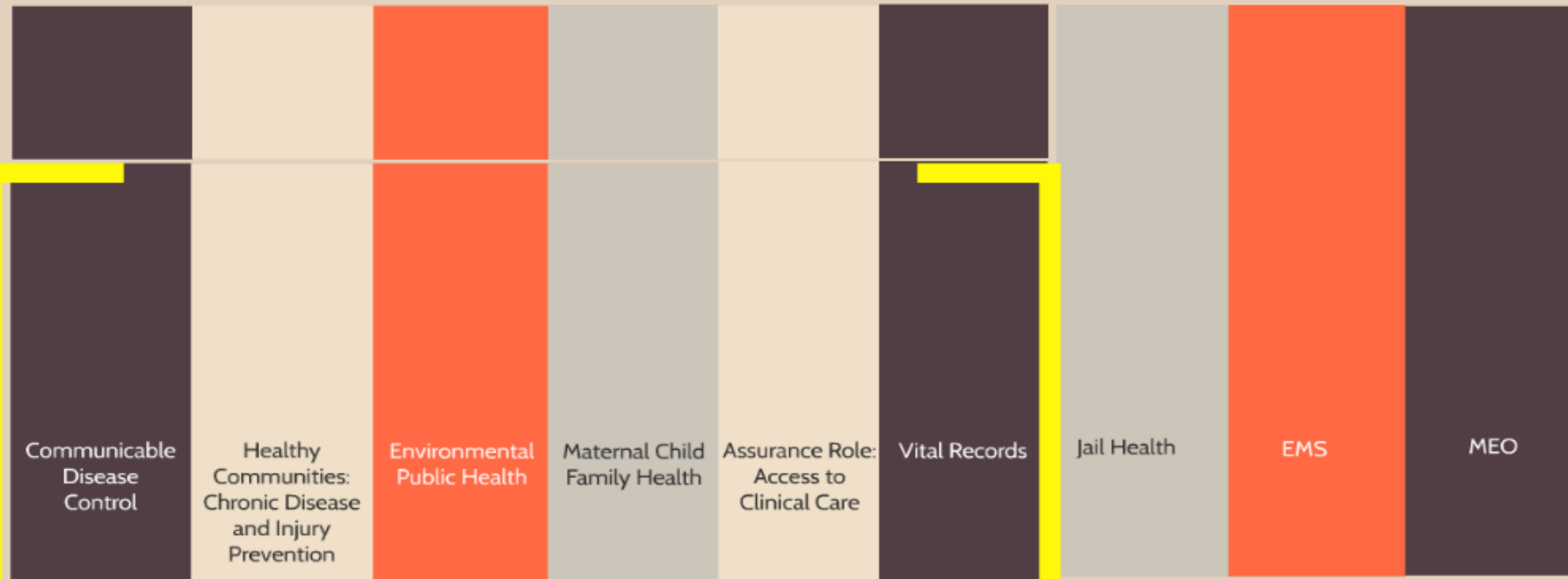
In summary – same as context setting

- No “right” or “wrong” questions; many different approaches
- All about the data
- Changes in knowledge, attitudes, beliefs, practices can take years to result in outcomes; hold the course and set expectations
- Fail forward faster
- Plan for evaluation and monitoring in budget
- In order to be Chief Health Strategist, requires knowing where you are, where you want to go and a plan of how to get there
- Relevant data partners
- Programs and services make sense for community
- Cross-sector rather than data siloes: how can data tell the story
- Don’t forget about the impact of qualitative data
- Collective impact with the community

Examples of transformation values and tools in action



Metro Foundational Public Health Services



Across all programs:

- Assessment (surveillance and epidemiology)
- Emergency preparedness and response (all hazards)
- Communications
- Policy development and support
- Community partnership development
- Business competencies

Wrap up and reminder for evaluation via the CSTE app

*We do really value your feedback and
use it to add to the next year's workshop!*

Questions?

If you want to join the SCALE project:

Amy Laurent amy.laurent@kingcounty.gov

Vickie Boothe veb6@cdc.gov

Hayleigh McCall hmcalls@cste.org

*Follow up items: participants will receive an electronic
version of the EHI calculation, a primer in creating a CT
map in MS Excel, and a link to the SEPHO tool for LE*



"HOW WOULD YOU RATE THIS MUGGING,
ON A SCALE FROM ONE TO TEN?"