

Learning As We Grow

Evaluation Highlights from National Asthma Control Program Grantees



Learning As We Grow

ACKNOWLEDGEMENTS

The CDC's National Asthma Control Program extends its gratitude to the state partners who shared their evaluation experiences for this report. We know that, in many cases, the evaluations "took a village" and involved a broad group of stakeholders, including multiple people from the asthma program team who contributed to the quality of the evaluations with their different perspectives and disciplines. We wish to thank everyone involved for their efforts and commitment to these evaluations.

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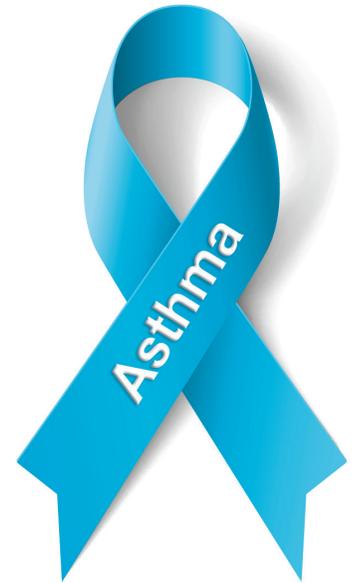


Learning As We Grow

“Evaluation is hard, especially when the intent is to produce findings that can be put to immediate use. I’m so happy to see this award process focus on use of findings. I think it will increase the visibility and importance of a practical evaluation approach beyond just the evaluation community.”

Tom Chapel
Chief Evaluation Officer,
Centers for Disease
Control and Prevention

Asthma is a major health concern. Almost 26 million people have asthma in the United States, and the costs to society are estimated to be over \$56 billion annually. Asthma is controllable, and since 1999, the National Asthma Control Program (NACP), in the Centers for Disease Control and Prevention’s (CDC) Air Pollution and Respiratory Health Branch (APRHB), has been working with national and state-level partners to promote strategies and programs that will reduce this burden and help persons with asthma lead healthy, productive lives.



For the past 15 years, the NACP has funded selected states to address asthma from a public health perspective. NACP has supported states to develop state-specific asthma surveillance systems; partnerships for coordinated efforts to address state asthma goals and objectives; and interventions to control asthma among persons living with asthma. As evaluation is an essential function of public health, NACP has always acknowledged its importance and in the 2009 funding cycle, the NACP launched an unprecedented strategy aiming to build and advance evaluation capacity among its funded grantees. By including evaluation among the many charges to state programs and requiring a half-time evaluator, the 2009 funding cycle particularly highlighted evaluation as an explicit priority. Please see <http://www.cdc.gov/asthma/nacp.htm> for additional information.

Throughout the 5-year grant period, a team of Evaluation Technical Advisors (ETAs) within NACP worked together with evaluators in funded state programs to strengthen and expand evaluation capacity among states and their partners. As ETAs, our role was to provide strategic evaluation guidance to our state partners in planning and implementing high quality evaluations, striving to assure that evaluation findings were useful to stakeholders and used for making programmatic decisions and improvements. This focus on the need for evaluations to generate useful information for programs is one of the critical founda-

Evaluation Highlights from National Asthma Control Program Grantees

tions of the asthma-focused evaluation framework and series, *Learning and Growing through Evaluation* (http://www.cdc.gov/asthma/program_eval/default.htm). Similarly, at the state level asthma program evaluators used the *Learning and Growing through Evaluation* framework to guide their work with key stakeholders in planning and implementing at least one evaluation of each of three core program components: partnerships, surveillance, interventions. Many states went beyond the minimum requirements and conducted more evaluations, especially of their many interventions. The vast majority of the evaluations generated findings that were useful to programs, whether for improving their operations, restructuring activities or approaches, or guiding decisions to expand or, in some cases, halt programs. Without exception, our states and their partners learned immensely from the planning, implementation, analysis, and dissemination processes and, perhaps most importantly, they recognized the importance of engaging stakeholders throughout the evaluations.

To highlight the importance of good evaluation and to recognize states for their achievements, the NACP Evaluation Award program was created. Starting in 2013, and repeated in 2014, state asthma programs nominated evaluations that demonstrated valuable use of findings. These nominated evaluations underwent a standardized review process that included both internal (within NACP) and external (outside NACP) reviewers. This compendium showcases the awarded evaluations that exemplify the value and utility of evaluation. Also included are summaries of high quality evaluations that, although not nominated for an award, deserve recognition for their merit. On the following pages you will read stories written by state asthma programs illustrating how the asthma programs evaluated their work and used their findings to improve and enhance their efforts to better serve persons with asthma. The stories are grouped into sections by the type of initiative they were evaluating (partnerships, surveillance, interventions).

The NACP is honored to present these state achievements in evaluation and hopes as you read this document you will begin to appreciate the commitment that asthma programs have shown to achieving the best for persons and communities most in need. The stories in this compendium will hopefully serve to inspire more evaluation and program innovation.

“This award reflects the enormous payoff that’s resulted from the capacity building efforts of our branch and state evaluators. We’ve moved away from a culture of merely collecting data to one of routinely using evaluation results to inform the decisions we make about our programs.”

Paul Garbe
Branch Chief, Air Pollution
and Respiratory Health

We wanted to identify whether the campaign was implemented as planned in school districts throughout the state.

The “No Idling” campaign is an intervention focused on persuading parents and school bus drivers to not idle their vehicles while waiting to pick up or drop off schoolchildren. It is intended to reduce the environmental triggers of asthma by improving the outdoor air quality (AQ) near children and those with compromised lung function. Idling produces excessive vehicle exhaust, releasing airborne particulate matter (PM), which can cause nasal, throat, respiratory, and eye problems, and can be a harmful trigger to people with asthma. No Idling is primarily a promotional campaign consisting of signs posted in school pick up/drop-off zones, pamphlets, and awareness promotion for idling as a health risk. It is managed by the larger Alabama Asthma Program (AAP), and is a joint effort by the Alabama Department of Public Health (ADPH), Alabama State Department of Education (ALSDE), and Alabama Department of Environmental Management (ADEM).





WHAT WE DID

We evaluated the extent of implementation of “No Idling” in Alabama schools and among school bus drivers. We wanted to identify whether the campaign was implemented as planned in school districts throughout the state. The evaluation included a process evaluation of the components of the No Idling campaign and descriptive statistics. We collected data from multiple sources according to a mixed methods design. The methods included telephone surveys of representatives of the 132 public school districts in the state, observations and photographs of posted No Idling signs at schools by ADPH staff and members of the AAP Facebook page, and a pencil-and-paper survey of bus drivers. The baseline assessments were taken from the ALSDE Department of Transportation’s listing of school districts in the state that were sent signs.



WHAT WE LEARNED

Our initial findings from the survey showed: 107 (81 percent) of Alabama public school districts’ representatives acknowledged receiving the No Idling signs, and 95 (72 percent), stated that the No Idling signs were posted on all school campuses. However, our photographic data collection showed that the survey data were not always correct regarding individual school participation. Complicating data gathering efforts was the fact that another campaign to reduce air pollution from car and bus idling was also initiated in one of the larger school districts. To help resolve some data conflicts, we surveyed 3,995 bus drivers. Although many bus drivers may serve the same schools, findings indicate almost three-quarters of schools had posted the signs. Almost 92% of the bus drivers had received information about the No Idling program and generally understood its benefits; however less than half reported that they had taken the No Idling pledge.



Our evaluation stakeholders concluded that the implementation of the program was inconsistent, and attempts to match child health outcome data, i.e., measure the outcomes of the program, would be unreliable. Stakeholders concluded that the lack of direct contact with local school personnel and their engagement was a barrier to both implementation and evaluation. Their input would have provided better insight into how best to promote No Idling in their local schools and communities.

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The Childhood Rural Asthma Project evaluation measured progress towards intervention implementation (i.e., development of assessment tools, delivery of asthma education, and distribution of toolkits) and effectiveness in reducing asthma symptoms and improving overall quality of life for children with asthma.

In 2008-2010, the Hawaii State Asthma Control Program (HSACP) partnered with the Hawaii Primary Care Association (HPCA) and three community health centers (CHC) to build CHC capacity to effectively identify, treat, and educate pediatric asthma sufferers and educate their families in rural Hawaii. The three CHCs (Koolauloa Community Health and Wellness Center and Waianae Coast Community Health Center on Oahu and West Hawaii Community Health Center on the island of Hawaii) were selected based on high prevalence of asthma, particularly among Native Hawaiian and uninsured residents, and on community readiness and available resources. The Childhood Rural Asthma (CRA) Project trained outreach workers to conduct a home visit intervention to reduce exposure to known allergens and to educate children and their families. The three CHCs enrolled 86 patients with current physician-diagnosed asthma who received the home visit intervention.



CRA Project stakeholders, including representatives from the HSACP, HPCA, and three CHCs



WHAT WE DID

The Childhood Rural Asthma Project evaluation measured progress towards intervention implementation (i.e., development of assessment tools, delivery of asthma education, and distribution of toolkits) and effectiveness in reducing asthma symptoms and improving overall quality of life for children with asthma. The planning and implementation of project activities was an on-going learning experience in community-focused program planning and implementation. Monthly narrative reports, bimonthly face-to-face and/or phone conference meetings with all project stakeholders, and frequent communications by other media sources were used to evaluate the progress of the project and ensure timely implementation of all project activities, including data collection. During these work group meetings, stakeholders discussed and addressed concerns, barriers, challenges and any changes required during the implementation of proposed activities (both programmatic and evaluation). Program evaluation tools included the Asthma Control Test, patient medical history, environmental home assessment, and educational program and in-home intervention assessment questionnaires. These tools were selected to provide information on the various outcome indicators, such as asthma triggers, symptoms, and knowledge. Data were collected via clinic visits, initial and follow-up home visits, and phone interviews. The schedule was arranged so all necessary information could be collected without overwhelming participants and CHC staff.



WHAT WE LEARNED

Due to the successful implementation of culturally tailored and standardized asthma education curriculum, and the in-home environmental asthma control intervention, the number of daily asthma symptoms, missed school days, use of asthma medications, and physician visits were significantly reduced among our study participants. Moreover, the educational and in-home environmental interventions proved to be effective in improving individual asthma control and self-management, as well as overall quality of life for children with asthma.



HOW WE GREW

The successful implementation of project activities was largely due to a fruitful, collaborative partnership between local community health organizations and the state health department. The direct involvement and active participation of community health workers at CHCs were especially crucial. The identified barriers served as learning opportunities to improve the practices and activities conducted at CHCs, including patient recruitment, purchase of equipment and tools for the in-home environmental intervention, patient scheduling, and conduct of home visits and phone interviews. Participants found the evaluation questionnaires and forms easy to understand and complete. Cultural and language barriers were successfully addressed by CHCs through the use of interpreters and/or speakers of the native language (such as Spanish and Tongan). The project directly addressed the needs of local communities and families with asthmatic children by delivering tailored asthma self-management resources, which were very highly evaluated, easy to understand, and well-accepted by children and family members.

The successful implementation of project activities was largely due to a fruitful, collaborative partnership between local community health organizations and the state health department.

The goal of the evaluation was to determine if Asthma Friendly Schools is an effective and efficient way to address the needs of students with asthma.

The Louisiana Asthma Friendly Schools (AFS) is a multicomponent, school-based asthma intervention run by the Louisiana Department of Health and Hospitals' Louisiana Asthma Management Program (LAMP) in collaboration with the Louisiana Asthma Surveillance Coalition. AFS focuses on training school staff to provide appropriate care for students with asthma and improve indoor air quality. Training for coaches and physical educational staff, including use of the Coach's Asthma Play Card, is also included as part of the intervention.

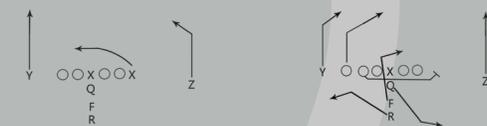


COACH'S ASTHMA PLAY CARD

Green Zone Prepare the players. No asthma attacking student.

You have ALL of these:

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleep through the night



1. Identify your students with asthma and be familiar with their individual Asthma Action Plans.
2. Make sure rescue/reliever inhalers are easily accessible for all and students directed to use them before exercise do so.
3. Adjust exercise for poor air quality, high pollen levels, sprayed/mowed fields, and weather extremes.

Yellow Zone Use rescue inhaler. Asthma defense is on the attack.

You have ANY of these:

- Cough
- Mild Wheeze
- Tight Chest
- Waking at night due to asthma



1. Recognize coughing as well as wheezing as a sign of poor asthma control.
2. Stop the player who is having trouble breathing; check their plan, have them use their inhaler, and permit resting with supervision. Don't let them "tough it out" or leave them alone!
3. Communicate with school nurse and the family if a player has asthma symptoms with physical activity.

Red Zone Seek emergency help. Asthma in all out blitz.

Your asthma is bad:

- Medicine is not helping within 10 to 20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Trouble walking
- Trouble talking



1. Call for help! If student in distress, having difficulty talking, blue lips, nose flaring, inhaler not helping or not available - dial 911 and stay with the student.

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WHAT WE DID

The goal of the evaluation was to determine if Asthma Friendly Schools is an effective and efficient way to address the needs of students with asthma. The first phase of the evaluation was to determine if the overall intervention was effective and practical for schools to implement. The second phase focused on determining the effectiveness and cost efficiency of the online training curriculum.

The evaluation focused on the various school-based activities, such as training school staff, assessing indoor air quality (IAQ), and increasing the number of asthma action plans for students with asthma. To affirm and highlight successes, the Louisiana Asthma Surveillance Coalition reviews a school's progress and awards the designation "Asthma Friendly School." The program began with in-person trainings for all school staff in four areas of the state with a high burden of asthma. Two years ago, AFS became an online training program.



WHAT WE LEARNED

During the first phase of the evaluation, key findings showed that indoor air quality improved in the participating schools. In addition, asthma awareness among school staff increased, and the number of school days missed by students with asthma decreased. The process of being designated an "Asthma Friendly School" served to raise overall awareness about asthma in schools throughout the state and increased demand for asthma services.



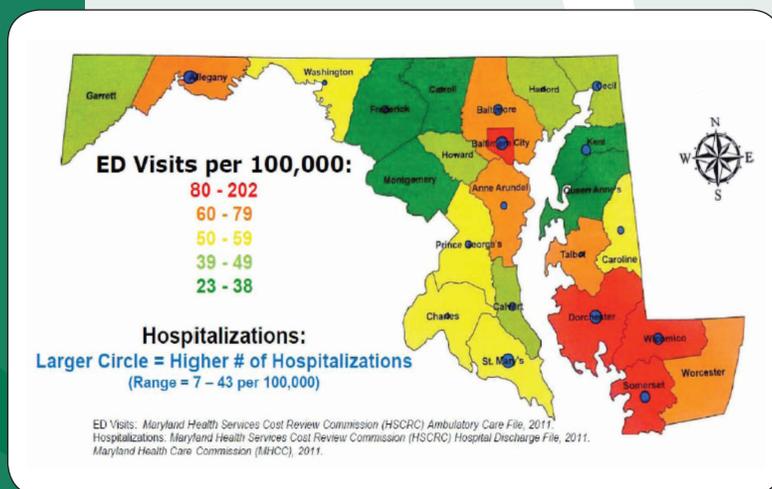
HOW WE GREW

Louisiana Asthma Management Program used the findings from the pre-post knowledge survey to make rapid refinements to the curriculum and retrain trainers. Faced with budget reductions that severely limited in-person trainings, LAMP used the evaluation findings to develop an online training curriculum that could be accessed by a broader audience. The second phase evaluation of this online training showed that it reaches a much wider audience than was possible through in-person trainings; indeed, well over 95% of school staff successfully completed the online training and showed a significant increase in knowledge. By 2013, over 2,300 school staff had received AFS training.

Louisiana Asthma Management Program used the findings from the pre-post knowledge survey to make rapid refinements to the curriculum and retrain trainers.

We integrated evaluation and intervention planning from earliest stages of intervention development.

In 2012, the Maryland Asthma Control Program (MACP) evaluated their Rx for Asthma intervention, an on-line training for community pharmacists offered in collaboration with the University of Maryland School of Pharmacy Center for Innovative Pharmacy Solutions. The intervention trains pharmacists to provide asthma management education in the pharmacy setting to people with asthma and their caregivers. The training focuses on general asthma knowledge (e.g., pathophysiology, medications) as well as communication and counseling skills. Participating pharmacists were recruited from areas in the state with the greatest burden of asthma, and they received continuing education credits. The evaluation documented the intervention's successes and provided information for improvement.





WHAT WE DID

We integrated evaluation and intervention planning from earliest stages of intervention development. This specific evaluation focused on whether the pilot intervention was successful in recruiting community pharmacists who are in high-burden areas and training them to effectively provide on-site education. The pilot, which used in-person training, also produced important information for refining the on-line course.

A key component was an extensive assessment of stakeholder needs and interests from which a list of fifteen groups that might have an interest in the evaluation and its findings was compiled. The stakeholder assessment also identified evaluation questions. Data collection methods included pre- and post-tests to assess knowledge gain as well as practice change (with follow up at one month and six months); an informal discussion group with a subset of participants; and semi-structured interviews with pharmacists who reported few changes in their practice post-training. Stakeholder engagement was ongoing throughout the evaluation, supporting broader dissemination and use of the evaluation findings.



WHAT WE LEARNED

First and foremost, we learned from the evaluation that the intervention had met all its goals and exceeded some by as much as 70%. Almost half of the trained pharmacists taking the post-test at six months reported an increase in education encounters, and 84% were in areas with a high asthma burden. The program also gained important insight into a critical teaching element. We learned that pharmacists gained valuable knowledge from the opportunity to physically manipulate medication-delivery devices. From the “low-adopting” pharmacists, the program learned about additional benefits beyond an increase in the number of education encounters. These pharmacists reported that, even though they didn’t provide more education, the quality of their communication and counseling had improved.



HOW WE GREW

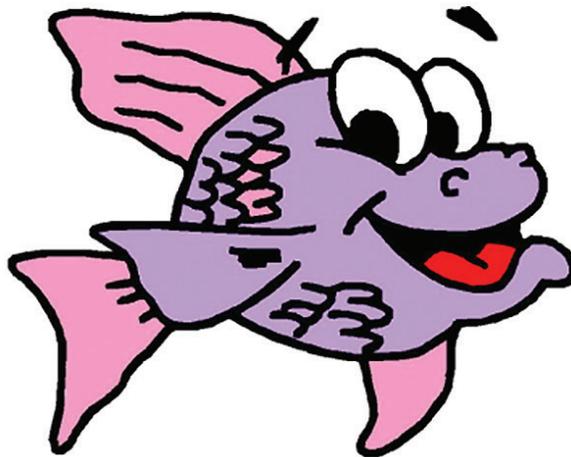
Based on the finding that pharmacists gain valuable knowledge from manipulating medication delivery devices, the program altered its original plan of using only video demonstrations in the on-line training to also ship devices to participants. In the future, evaluation findings will be used to educate community pharmacists, pharmacies, primary care providers, policy makers, people with asthma, and other community members about the importance of asthma self-management counseling.

First and foremost, we learned from the evaluation that the intervention had met all its goals and exceeded some by as much as 70%.

The evaluation included a wide variety of data collection methods, and much of the data were derived from the program's routine administrative data, thereby limiting the need for additional data collection resources.

The Massachusetts Asthma Prevention and Control Program (APCP) conducted an evaluation of its Asthma Disparities Initiative (ADI), which integrates evidenced-based asthma self-management education delivered by a community health worker (CHW) with community education, mobilization, and advocacy promoted by an asthma coalition to address the social determinants of asthma.

Pioneer Valley Asthma Coalition



www.pvasthmacoalition.org



WHAT WE DID

We wanted to test a “hybrid” approach that pairs clinics with coalitions and bridges them with community health workers to see if it could be adequately implemented. We had a particular interest in using positive evaluation findings to highlight the value of community health workers to potential insurers and other funders. Similarly, we wanted to demonstrate that coalitions could influence important local policies that have the potential to reduce asthma disparities.

The evaluation included a wide variety of data collection methods, and much of the data were derived from the program’s routine administrative data, thereby limiting the need for additional data collection resources. Methods included abstraction of grant reports, encounter forms, and environmental action forms; key informant interviews (both in person and telephone); and a literature review. Stakeholder engagement in designing the evaluation also increased understanding about the ADI among high-level health officials. Grantees were also included on the evaluation planning team, and they found the monthly evaluation calls so useful, with such rich information sharing, that they requested to continue the calls even after the evaluation was completed.



WHAT WE LEARNED

Ultimately, the evaluation findings demonstrated that the stakeholders felt the ADI model of working with CHWs was able to support improved health for the participants with asthma and also was able to influence important community-level changes, such as strengthened community leadership and the identification of asthma champions. It also identified policy changes and improved clinical networks in the two communities implementing the ADI.



HOW WE GREW

During the course of the two-year evaluation, the evaluator continuously fed information from the evaluation back to the program, refining the approach in real time. One of the most useful lessons came not from the evaluations findings, but from the evaluation process. We saw just how productive it can be to engage a variety of people in the evaluation while maintaining a focus on generating information they could all use. Program staff also saw how useful it was to carry that approach throughout the evaluation as the stakeholder- and utilization-driven framework unified the many activities that comprised the evaluation. While the two communities had quite different experiences with the ADI, both were left with increased capacity to implement asthma initiatives.

During the course of the two-year evaluation, the evaluator continuously fed information from the evaluation back to the program, refining the approach in real time.

Michigan Department of Community Health Asthma Prevention & Control Program coordinated an evaluation to assess the effectiveness of three Managing Asthma through Case Management in Homes (MATCH) programs in Michigan: the Asthma Network of West Michigan, Hurley Medical Center, and St. Joseph Mercy Health System.

The Asthma Network of West Michigan (ANWM), a multi-organizational coalition that contracts with health plans for asthma case management services, initiated the Managing Asthma through Case Management in Homes (MATCH) intervention. Enrollment in a MATCH program includes at least 6 home visits by a Certified Asthma Educator (AE-C) case manager over a period of at least 5 months. During home visits, the AE-C case managers:

- *Provide asthma education, emphasizing prevention and daily management*
- *Assess asthma triggers, document the participant's asthma symptoms and severity, and discuss social circumstances relevant to managing asthma*
- *Create or update an asthma action plan guiding patients to use asthma medications and respond to worsening asthma appropriately*
- *Facilitate discussions with primary care providers, schools, or workplaces*

Since its inception in 1994, the MATCH model has been replicated across Michigan and currently serves as the foundation for 4 programs reaching 6 high-burden counties.





WHAT WE DID

Michigan Department of Community Health Asthma Prevention & Control Program coordinated an evaluation to assess the effectiveness of three Managing Asthma through Case Management in Homes (MATCH) programs in Michigan: the Asthma Network of West Michigan, Hurley Medical Center, and St. Joseph Mercy Health System. This evaluation included MATCH participants enrolled between 2009 and 2011. Questionnaires were completed for each participant at the time of enrollment, during program participation, and six months after discharge from the program. Questions covered demographics, asthma healthcare utilization, medication use, and symptoms during the past 6 months. Participants were also given the Asthma Control Test™ (ACT), Mini-Asthma Quality of Life Questionnaire (MiniAQLQ), Mini-Paediatric Asthma Quality of Life Questionnaire (Mini-PAQLQ), and Paediatric Asthma Caregiver's Quality of Life Questionnaire (PACQLQ).

- The percent of participants with at least one asthma-related inpatient hospitalization dropped from 45% at enrollment to 8% after participating in MATCH.
- The proportion of participants reporting at least one Emergency Department visit in the last six months dropped from 87% at the time of enrollment to 34% at the time of discharge.
- The proportion of children who missed one or more schooldays in the last six months due to asthma dropped from 76% at the time of enrollment to 46% at the time of discharge.
- The average number of inpatient hospitalizations and ED visits in the past 6 months decreased significantly.
- The average number of workdays missed due to asthma decreased from 3.75 days at the time of enrollment to 0.82 days at the time of discharge for program completers.



HOW WE GREW

The sustained improvement of asthma outcomes after MATCH enrollment showed promising implications for long-term health, and greatly enhanced promotion capability for MATCH replication throughout Michigan. Findings were disseminated among partners and used to encourage resource development and implementation of new programs. An infographic with the results from this evaluation was shared with policy-makers, Michigan stakeholders, potential partners, and local coalitions considering the development of new programs using the MATCH model. Since this evaluation began in 2009, the MATCH model was implemented by Capital Area Asthma Management Program (Ingham County) and the Wayne Children's Healthcare Access Program (Wayne County), with plans to expand MATCH to more Michigan regions in 2014-2019.



WHAT WE LEARNED

The success of the MATCH program across three communities validated the 1996 pilot findings, demonstrating that the MATCH model of asthma case management improves asthma control and quality of life and reduces the frequency of severe events related to asthma. Of 184 participants initially enrolled, 132 were considered program completers with at least 6 home visits or 5 months in the program, and 89 of the program completers completed a survey six months after being discharged from MATCH. The following comparisons were made for program completers:

The sustained improvement of asthma outcomes after MATCH enrollment showed promising implications for long-term health, and greatly enhanced promotion capability for MATCH replication throughout Michigan.

This project was a partnership with local public health departments in five jurisdictions with a secondary goal of increasing the number of local public health staff trained to provide in-home asthma education and medical management and to conduct environmental assessments for asthma triggers and provide allergen-mitigating products.

The Minnesota Department of Health (MDH) Asthma Program has conducted two successful home visit demonstration projects: in-home asthma education and home environment assessment. MDH was awarded funding from the federal Housing and Urban Development (HUD) Agency to augment CDC funding to support a third asthma home-visit demonstration project to focus on children (ages 4 to <18) who have been diagnosed with asthma and who live in Section 8 multifamily housing, a recognized high risk population. This project was a partnership with local public health departments in five jurisdictions with a secondary goal of increasing the number of local public health staff trained to provide in-home asthma education and medical management and to conduct environmental assessments for asthma triggers and provide allergen-mitigating products. The direct care objectives of the program are three-fold:

- 1. Reducing or eliminating environmental triggers of asthma in the home;*
- 2. Improving health outcomes for children with asthma; and*
- 3. Improving asthma management skills through in-home education.*

The MDH Asthma Program provided training, technical support, and program evaluation.





WHAT WE DID

For this pilot project, a minimum target of 40 children was set for each of the five local public agencies, a target that seemed reasonable and achievable based on the number of Section 8 public housing units identified within the geographic area served by each agency. The external evaluator collected information about the progress of the recruitment, such as frequency of enrollment and location. Project implementation discussions were convened monthly with the evaluator, local coordinator and the MDH Asthma Program coordinating staff. Information included the number of participants recruited and their location.



WHAT WE LEARNED

The initial monitoring calls demonstrated that because of the lack of formative evaluation of the strategy, it was not determined until the implementation that some of the buildings did not allow any door-to-door promotions.

Other important lessons learned included:

- Multiple strategies for recruiting and enrolling participants need to be identified and tested in the target community.
- Identifying a target audience by address is difficult for non-local public health agency staff such as physicians and staff at clinic offices and school health offices
- The estimate of target enrollment numbers must also incorporate an estimate for the potential refusal rate.
- There is an ongoing need to be flexible with recruiting strategies.
- The Minnesota Department of Health is valuable as a larger informational and resource connection.
- Staff transitions during the course of a grant program are inevitable.

The initial monitoring calls demonstrated that because of the lack of formative evaluation of the strategy, it was not determined until the implementation that some of the buildings did not allow any door-to-door promotions.

Program planners built evaluation into every aspect of the Early Childhood Asthma Initiative to assure it met the needs of the many participants and key data were collected as part of implementation.

In Missouri, surveillance data showed that children ages 1 to 4 have the highest number of emergency (ER) visits and hospitalizations than any of the other age groups. To help these families, the Missouri Asthma Prevention and Control Program (MAPCP), a unit within Missouri Department of Health and Senior Services, developed the Early Childhood Asthma Initiative (ECAI) with the support of key partners. This initiative focuses on preschool children with current asthma and their families as well as caregivers employed by licensed childcare facilities. Environmental specialists from local public health agencies (LPHAs) provide air quality assessments in childcare facilities, make recommendations for improvement and re-visit to evaluate change. LPHAs also provide child care health consultants (i.e., nurses) to deliver asthma self-management education to parents/caregivers of young children with asthma. The child care health consultants also help develop localized strategic plans for linking childcare facilities and local, state, and national resources for asthma care improvement.





WHAT WE DID

The evaluation was conducted to assess the statewide implementation of the initiative and to provide information about how the program could be improved. Program planners built evaluation into every aspect of the Early Childhood Asthma Initiative to assure it met the needs of the many participants and key data were collected as part of implementation. The flexibility of the evaluation design was especially important because each LPHA could tailor their participation based on resources (e.g., staff, licensed childcare facilities) and community needs. In order to obtain feedback from LPHAs, webinars were held weekly for the first few months, and then monthly as implementation ramped up. Ongoing open and frequent dialogue is crucial to rapid quality improvement and the overall success of an initiative like ECAI that requires statewide deployment. Performance monitoring was built into the fiscal tracking system (i.e., documentation necessary to approve payments to the LPHAs), which provided information in “near real-time” to help target evaluations and program changes as needed. At the level of participants, pre-post tests assessed knowledge gains, and telephone interviews with families and childcare staff measured how care and environmental improvements were implemented.



WHAT WE LEARNED

Overall, sixty-seven ECAI contracts covering 71 counties were awarded to LPHAs in 2010. The participating counties distributed educational materials to licensed childcare facilities in those counties not participating in the project to achieve true statewide reach.

A total of 152 LPHA staff received the asthma trigger identification and reduction training and conducted a total of 904 initial environmental assessments. A total of 106 participants completed one or more of the three ECAI training courses and participants’ knowledge scores significantly increased pre- to post-test for all courses. Using a random sample of 113 child care facilities, the evaluation team conducted telephone follow-up calls which revealed 45% had made changes to improve the environment. The parent-caregiver assessments showed children had significant declines in asthma severity, days of disruption in routines, nights of being awakened by asthma symptoms and days of albuterol use, and increased daily inhaled corticosteroids and written asthma plans.



HOW WE GREW

Early in the evaluation, as a result of the webinars, MAPCP staff learned that caregivers in licensed child care facilities are required to have annual continuing education. State staff coordinated the process to have the environmental assessments and education consults pre-approved as part of this continuing education requirement. This led to an increased number of child care facilities requesting ECAI services. The internet-based evaluation and fiscal management system simplified administrative tasks and allowed the program to meet increased workload while maintaining quality without additional personnel for program management.

Fifty three local public health agencies submitted an asthma strategy plan to the state health department which described their proposed efforts, aligned with the state plan, to link childcare facilities with local, state, and national resources for asthma care improvement.

The internet-based evaluation and fiscal management system simplified administrative tasks and allowed the program to meet increased workload while maintaining quality without additional personnel for program management.

The evaluation was conducted to guide program development and improvement and to assess the program's effectiveness.

Teaming Up for Asthma Control (TUAC) is a work force development intervention to improve asthma control by (1) increasing asthma monitoring by an asthma-trained school nurse, (2) promoting asthma literacy using culturally appropriate material and messages, and (3) enhancing self-care behaviors among students (kindergarten to 6th grade) with persistent asthma and their families.





WHAT WE DID

The evaluation was conducted to guide program development and improvement and to assess the program's effectiveness. The evaluation assessed the impact of TUAC on student wellbeing, lung function, inhaled corticosteroid (ICS) adherence, use of quick relief medications for managing asthma symptoms, health care costs and service utilization, including emergency visits and hospitalizations. The evaluation also examined school nurse and parent perceptions of program effectiveness. A multistage evaluation was implemented with substantial input from project stakeholders. Process evaluation coincided with the program development and rollout. Focus groups were conducted with participating families. Outcome data was contributed by 54 school nurses from urban and rural districts who completed asthma assessments and provided self-care education for 178 children. Independent field evaluators were used to measure change in school nurse skills and validate quantitative and qualitative results. Medical and pharmacy claims data was obtained from Medicaid, with the consent of participating families, to measure key outcomes.



WHAT WE LEARNED

At the beginning of the evaluation planning process, stakeholders identified a need to update the widely used and respected *Missouri School Asthma Manual* (MSAM). School nurse interest and engagement in TUAC was made possible by releasing the updated manual in conjunction with TUAC rollout. Approximately 3 out of 4 participating students initially met the criteria for "not well" or "very poorly" controlled asthma, demonstrating appropriate enrollment by school nurses. Overwhelmingly both nurses (87%) and parents (93%) who participated in the first phase recommended TUAC to others. Most clinical outcomes were favorable and significant. Lung function (as measured by FEV1) improved a 14.5% over baseline. Access to ICS in the homes of participating students increased as did their inhalation

technique for the metered dose inhaler, yet ICS access (76%) and adherence of participating students remained below optimal levels, as measured by pharmacy claims data. Student-reported impairment decreased and six psychosocial indicators improved. Student-reported exposure to secondhand tobacco smoke also decreased.

A substantial time lapse between student assessment and data analysis was observed during the first phase of the evaluation. Such a delay impeded rapid response to intervene with students who were experiencing a high level of impairment and risk. In response, the project team began building a secure web-based application to collect and analyze health assessment data from school nurses and link it to health care centers. A formative evaluation associated with building the web-based application revealed the term "asthma assessment" lacked meaning to most family members and other stakeholders; as a result, the more acceptable and non-threatening term "asthma check-up" is now used in communications with school nurses, parents, students and health care providers.

The formal evaluation process and rich, informal communication with school nurses, in particular, helped build local champions for TUAC. Evaluation provided multiple critical insights which made possible a successful deployment for the intervention.



HOW WE GREW

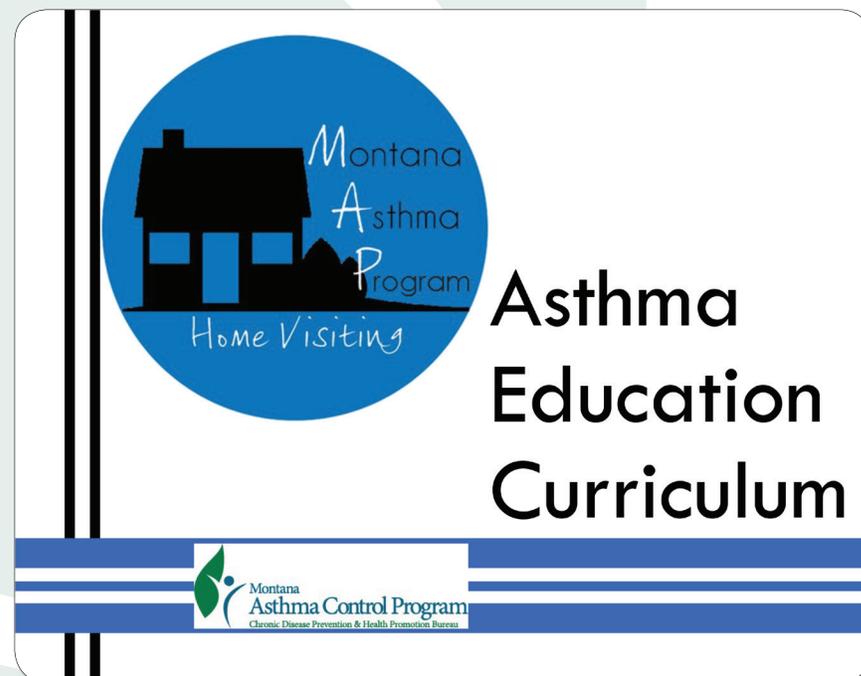
The evaluation is on-going with a particular focus on measurement of cost-savings. To date, TUAC has trained 501 school nurses from 112 school districts resulting in 1617 documented student asthma check-ups. The TUAC evaluation shows the importance of having multiple stages in an evaluation and using findings from each stage to improve the program. It also shows that building in evaluation to the program's overall operations can be effective. The evaluation process contributed to substantial improvements in program quality and also revealed practical steps for improving asthma outcomes, which have been translated to other projects.

Teaming Up for
Asthma Control's
evaluation shows
the importance of
having multiple stages
in an evaluation and
using findings from
each stage to improve
the program.



A comprehensive evaluation of the Montana Asthma Home Visiting Program was conducted to assess and improve program operations and determine if the program was effective and should be replicated.

The Montana Asthma Home Visiting Program (MAP) is a multi-component, multi-trigger program for families with children with uncontrolled asthma. The program provides six contacts with a registered nurse to each family over the course of 12 months. The Montana Asthma Control Program (MACP) developed the MAP based on recommendations from The Community Guide and other evidence-based programs. The program was initiated in 2010 in three pilot sites around the state.





WHAT WE DID

A comprehensive evaluation of the Montana Asthma Home Visiting Program was conducted to assess and improve program operations and determine if the program was effective and should be replicated. Guided by evaluation advisory group members, the evaluation measured MAP's effectiveness and return on investment. Streamlined into the service protocol, data for this evaluation included demographic data on participants; participant report data about asthma symptoms and knowledge and self-efficacy towards asthma; and observed inhaler technique. The MACP evaluator also interviewed each of the MAP home visiting nurses about program implementation and barriers, and to document program costs, nurses recorded information about time spent on each visit, and travel times.



WHAT WE LEARNED

This evaluation showed that Montana Asthma Home Visiting Program nurses were satisfied, but offered suggestions for improvement. Nurses explained that the first visit was too long to hold a child's attention for the entire time, and that families often had needs other than asthma that they would like nurses to help them address. Further, the nurses mentioned that recruitment of participants was challenging and taking time from serving their current clients. Based on these suggestions, the program was revised to allow an option to split the first visit, and conduct part of it in the home-visiting nurse's office before visiting the home. Nurses also now have a list of resources, such as weatherization assistance and legal services to offer families. To address recruitment of participants, the state program has taken a larger role in marketing the program through short public service announcements and advertising. Also, home-visiting nurses have worked to establish a referral process from local health care providers and school nurses, creating new linkages.



HOW WE GREW

The evaluation also showed that children of color are more likely to not finish the program. Further evaluation is planned to determine what issues lead to families leaving the program, and what program revisions can be made regarding length of the program, the content, and any cultural components.

This evaluation showed that Montana Asthma Home Visiting Program nurses were satisfied, but offered suggestions for improvement.

The purpose of the evaluation was to solicit recommendations for improving the program, identifying curriculum topics that were missing or extraneous, and identifying ways data reporting could be improved.

In 2011 and 2012, the New Mexico Department of Health Asthma Control Program (NMACP) partnered with Nor-Lea General Hospital (NLGH) in Lovington, NM to support implementation of an asthma self-management education program based in the Cardio-Pulmonary Rehabilitation Unit of NLGH. On a weekly basis, a certified asthma educator (AE-C) provided asthma self-management education to NLGH patients identified and referred by NLGH physicians. Initial patient visits lasted 90 minutes; follow-up visits were scheduled 2-4 weeks after the initial visit and lasted for 30-60 minutes depending on patient need. Additional visits were scheduled as 3-month follow-ups or as needed.

Summary of the NAEPP's EPR-3: Guidelines for the Diagnosis and Management of Asthma

Consider the Diagnosis of ASTHMA if:

- Patient has **RECURRENT** episodes of cough, wheeze, shortness of breath, or chest tightness.
- Symptoms occur or worsen at night, awakening the patient.
- Symptoms occur or worsen in the presence of factors known to precipitate asthma.
- Alternative diagnoses have been considered such as GERD (a common co-morbidity), airway anomaly, foreign body, cystic fibrosis, vocal cord dysfunction, TB, or COPD. If diagnosis is in doubt, consider consulting an asthma specialist.

Confirm the Diagnosis of ASTHMA if:

- Spirometry demonstrates **obstruction** and **reversibility** by an increase in FEV₁ of $\geq 12\%$ after bronchodilator (in all adults and children 5 years of age or older).

Assess Asthma Severity: Any of the following indicate PERSISTENT ASTHMA

- Daytime symptoms > 2 days per week **OR**
- Awakens at night from asthma ≥ 2 X per month (age 0-4 years: ≥ 1 X per month) **OR**
- Limitation of activities, despite pretreatment for EIB **OR**
- Short-acting beta₂-agonist (SABA) use for symptom control > 2 days per week (not prevention of EIB) **OR**
- Two or more bursts oral corticosteroids in 1 year (age 0-4 years: ≥ 2 bursts oral corticosteroids in 6 months*) **OR**
- Age ≥ 5 years: FEV₁ $< 80\%$ predicted **OR** FEV₁/FVC ratio $<$ predicted normal range for age (see below)

*NOTE: For children age 0-4 years who had 4 or more episodes of wheezing during the previous year lasting > 1 day, check risk factors for persistent asthma. Risk factors include either (1) one of the following: parental history of asthma, a physician diagnosis of atopic dermatitis, or evidence of sensitization to aeroallergens; or (2) two of the following: evidence of sensitization to foods, $\geq 4\%$ peripheral blood eosinophilia, or wheezing apart from colds.

Treatment for Persistent Asthma:
Daily Inhaled Corticosteroids (Step 2 or higher)
Follow the Stepwise Approach

Assess response within 2-6 weeks

Is Asthma Well Controlled?

1. Daytime symptoms ≤ 2 days per week **AND**
2. Awakens at night from asthma ≤ 1 X per month (age ≤ 4 years: ≤ 2 X per month) **AND**
3. No limitation of activities **AND**
4. SABA use for symptom control (not prevention of EIB) ≤ 2 days per week **AND**
5. ≤ 1 burst oral corticosteroids per year **AND**
6. FEV₁ $\geq 80\%$ predicted
7. FEV₁/FVC $\geq 80\%$ or $\geq 75\%$

YES → Consider step down if well controlled for 3 consecutive months. Reassess every 3 to 6 months.

NO → Step up therapy. Reassess in 2-6 weeks. Continue to step up until well controlled.

Quick Tips for All Patients with Asthma

- **Planned Asthma Visits:** Every 1-6 months
- **Environmental Control:** Identify and avoid exposures such as tobacco smoke, pollens, molds, animal dander, cockroaches, and dust mites (Allergy testing recommended for anyone with persistent asthma who is exposed to perennial indoor allergens)
- **Flu Vaccines:** Recommended annually
- **Saquinavir (Not During Exercise/Heat):** At diagnosis every 1-2 years starting at age 5 years
- **Asthma Control:** Use tools such as ACCQ, ACT, or assess asthma control
- **Asthma Education:** Review correct inhaled medicine technique at every visit
- **Asthma Action Plan:** At diagnosis; review and update
- **SABA** (e.g. inhaled albuterol): 1) for quick relief use needed (see step 1); 2) pretreat with 2 puffs for event bronchospasm (EIB) 5 minutes before exercise
- **Inhaled Corticosteroids (ICS):** Preferred therapy for persistent asthma
- **Oral Corticosteroids:** Consider burst for acute exacerbation
- **Valved Inhaler Chamber (VIC) or Spacer:** Place with all metered dose inhalers (MDI)
- **Mask:** Recommend for use with VICs or spacers for age < 5 years and anyone unable to use correct technique

Indications for asthma specialist consultation include: As averse to therapy; asthma is not well controlled within 3-6 months; life-threatening asthma exacerbation; hospitalization for ≥ 2 bursts oral corticosteroids in 1 year; requires higher level Stepwise Approach; need additional therapy; or death of a family member.

NEW MEXICO ASTHMA ACTION PLAN FOR SCHOOLS

School District: _____ School Name: _____ Date: _____
 School Hours / Health Act: _____ School Phone # / FAX # _____

PARENT/GUARDIAN: Please complete the information in the top sections and sign consent at bottom of the page.

Student Name _____	Date of Birth _____	Student # _____
Health Care Provider Name/Title _____	Provider's Office Phone / FAX # _____	
Parent/Guardian _____	Parent's Phone #s _____	
Emergency Contact _____	Contact Phone #s _____	

Triggers to Medication: _____

Asthma Triggers Identified (Things that make your asthma worse): _____
 (Exercise / Colds / Smoke (tobacco, fire, incense) / Pollen / Dust / Strong Odors / Mold/moisture / Stress/Emotions / Pests (rodents, cockroaches) / Season: Fall, Winter, Spring, Summer / Animals / Other (food allergies): _____)

Date of student's last visit to medical provider: _____ Date of Last Flu Shot: _____ Inhaler in hand: _____
 With Student / In Classroom / Health Office / Other _____

HEALTH CARE PROVIDER: Please complete Severity Level, Zone Information and Medical Order Below

Asthma Severity: Intermittent or Persistent Mild Moderate Severe

Green Zone: Go! Take Control Medications EVERY DAY

You have ALL of these: _____
 • Breathing is easy _____
 • No cough or wheeze _____
 • Cans work and play _____
 • No symptoms at night _____

Peak flow (optional): _____
 Greater than \geq _____ (More than 80% of Personal Best)

Personal best peak flow: _____

You have ANY of these: _____
 • Cough or mild wheeze _____
 • Tight chest _____
 • First signs of a cold _____
 • Problems sleeping, playing or working _____
 • Peak flow (optional): _____
 Less than $<$ _____ (Less than 80% of Personal Best)

Yellow Zone: Caution! Continue CONTROL Medication & ADD RESCUE Medication-

DO NOT LEAVE STUDENT ALONE! Call Parent/Guardian when rescue medication is given.

You have ANY of these: _____
 • Fast-acting inhaled _____
 OR _____
 • Fast-acting inhaled _____
 OR _____
 • Fast-acting inhaled _____

Peak flow (optional): _____
 Less than $<$ _____ (Less than 80% of Personal Best)

Red Zone: EMERGENCY! Continue CONTROL Medication & ADD RESCUE Medication and GET HELP!

You have ANY of these: _____
 • Cough, talk, eat, or walk well _____
 • Medication is not helping _____
 • Getting worse, not better _____
 • Breathing hard & fast _____
 • Blue lips & fingernails _____

Peak flow (optional): _____
 Less than $<$ _____ (Less than 50% of Personal Best)

DO NOT LEAVE STUDENT ALONE! → Call for emergency 911 and start treatment _____
 Administer Oxygen _____ puffs MDI with spacer & every 20 minutes until paramedics arrive

HEALTH CARE PROVIDER ORDER AND SCHOOL MEDICATION CONSENT | Parent/Guardian: _____
 I approve of this asthma action plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary. I assume full responsibility for providing the school with the prescribed medications and delivery and monitoring devices. I give my permission for the school to share the above information with school staff that need to know and permission for my child to participate in any asthma educational learning opportunities at school.

Student is to notify designated school health personnel after using inhaler at school. _____
 Student needs supervision or assistance when using inhaler. _____
 Student is unable to carry his/her inhaler while at school. _____

SIGNATURE/TITLE _____ DATE _____ SCHOOL NURSE: _____ DATE _____
Signature must be in blue ink. Medication(s) must be in original container with expiration date. School Nurse must be present at the time of signing. This form is valid for 12 months. If the student's asthma severity changes, this form must be updated. © 2012 American Lung Association. All rights reserved.

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WHAT WE DID

The purpose of the evaluation was to solicit recommendations for improving the program, identifying curriculum topics that were missing or extraneous, and identifying ways data reporting could be improved. Program findings were written for and shared with multiple audiences through meetings, reports, presentations, and fact sheets. Information about the program was also made available on the NMACP website.

Pre and posttests measured changes in knowledge, asthma control, and healthcare utilization among patients. Because data were collected for each patient visit, different data points could be used to compare improvements. To ensure that patient education was effective and data were collected properly from patients and caregivers who prefer to speak Spanish, translation was provided.



WHAT WE LEARNED

As a result of the findings, NMACP and its partners took a number of actions to improve the program and to inform policy. Most importantly, we found that only 20% of claims for self-management education by the AE-C were reimbursed by insurance companies.



HOW WE GREW

After learning about this low rate of reimbursement, the NMACP and the statewide asthma coalition, the New Mexico Council on Asthma, reached out to health insurance companies regarding improving asthma education reimbursement rates for non-physicians. This effort led to multiple health insurance companies reconsidering their reimbursement policies for asthma self-management education provided by non-physicians.

Evaluation processes also resulted in program improvement. During the first six months of data collection, the data collection tools did not capture the total number of patients referred and scheduled for asthma education who did not complete a scheduled visit, although this measure was of interest to NLGH staff. Subsequent improvements to the data collection tools included recording who did not show up for their scheduled visit with the asthma educator and measuring the quality of life after participating in asthma self-management education, a variable of interest for all the original program stakeholders.



As a result of the findings, NMACP and its partners took a number of actions to improve the program and to inform policy.

The evaluation occurred in multiple phases and focused on increasing the evaluative capacity of Integrated Educational Interventions (IEI), examining the cultural relevance and appropriateness of assessment tools for IEI participants, and improving methods of measuring longitudinal outcomes.

Integrated Educational Interventions (IEI) for Asthma Management, developed by the Texas A&M University School of Public Health, educates both children and parents about how to reduce household triggers through separate but simultaneous 90-minute educational sessions, as well as follow up home visits and telephone calls made by a Promotora (Community Health Worker).





WHAT WE DID

The University of North Texas Health Science Center was contracted to work collaboratively with Texas Asthma Control Program and IEI stakeholders to establish a pilot evaluation project in 2013 and 2014. The evaluation occurred in multiple phases and focused on increasing the evaluative capacity of Integrated Educational Interventions (IEI), examining the cultural relevance and appropriateness of assessment tools for IEI participants, and improving methods of measuring longitudinal outcomes. The first phase was a pilot evaluation and involved a review of existing methods of measuring program outputs and outcomes, shadowing a Promotora on two home visits, and interviewing a Promotora. The second phase of the evaluation included: a) examining data associated with a subset of participants who had completed baseline, 3 month and 6 month follow-up assessments, b) meeting with stakeholders to determine ways to consolidate the number of assessment items and improve assessment of behavioral change; and c) creating a revised pre/post assessment that measures both knowledge and behavioral change. The third phase of evaluation included such activities as:

- 1) examining full baseline, 3, 6 and 9 month follow-up results;
- 2) meeting with stakeholders to consider future improvements; and
- 3) producing dissemination materials regarding the results of the evaluation.



WHAT WE LEARNED

Evaluation lessons learned fell into three main themes: 1) cultural appropriateness, 2) balancing assessment and intervention, and 3) capturing changes. For example, the observational and interview data showed some problematic items in the tools used.



HOW WE GREW

After reviewing these tools as a team, the original quality of life assessment was exchanged for a standardized tool available in English and Spanish that assesses quality of life dimensions specific to asthma, as well as symptom frequency and health care utilization (i.e., Children's Health Survey for Asthma from the American Academy of Pediatrics). The evaluation team worked with the Promotora and other IEI staff members to create and use alternative sentence structures or clarifying statements while maintaining the integrity of the data collection instrument.



Evaluation lessons learned fell into three main themes: 1) cultural appropriateness, 2) balancing assessment and intervention, and 3) capturing changes.

The purpose of the evaluation was to identify the strengths and weaknesses of the Vermont Asthma Learning Collaborative and its ability to promote and sustain adherence to National Heart Lung and Blood Institute guidelines in the primary care setting.

A major driving force to ongoing quality improvement for the Vermont Asthma Program has been the Asthma Learning Collaborative. Through a close partnership with the Vermont Blueprint for Health, Vermont's state-led initiative in promoting sustainable health care delivery reform, the Vermont Asthma Learning Collaborative (VALC) has completed three Learning Collaborative cycles with 21 primary care practices across the state. Quality improvement is inherent to the framework of the Learning Collaborative structure, and practices are encouraged to conduct Plan-Do-Study-Act (PDSA) cycles. Practices identify opportunities for improving processes and systems based on the National Heart Lung and Blood Institute (NHLBI) asthma guidelines, develop and implement strategies for change, collect and analyze data to study the impact of their changes, and act based on what is learned. Through this systematic approach, quality improvement strategies can be designed to enhance the effectiveness and efficiency of health care delivery in the primary care setting and help reach the ultimate goal of the Asthma Learning Collaborative, which is to reduce the burden of asthma in Vermont by improving diagnosis, management, and control of asthma.





WHAT WE DID

The purpose of the evaluation was to identify the strengths and weaknesses of the Vermont Asthma Learning Collaborative and its ability to promote and sustain adherence to National Heart Lung and Blood Institute guidelines in the primary care setting. Because the Learning Collaborative has become such a driving force in its ability to engage and communicate with primary care providers, a formal evaluation was necessary to address its impact, especially from the perspective of a participating medical provider.

The first Asthma Learning Collaborative was held in 2012, followed by one in 2013 and one in 2014. Beginning in May of 2013, the Asthma Program's evaluator worked with the Program to design a retrospective descriptive evaluation using both qualitative and quantitative data. The evaluation tracked six indicators: assessment of asthma control and severity, documentation of an Asthma Action Plan and tobacco use, and administration of spirometry. To get the patient perspective, we used a web-based survey, in-person discussion groups, and key informant interviews.



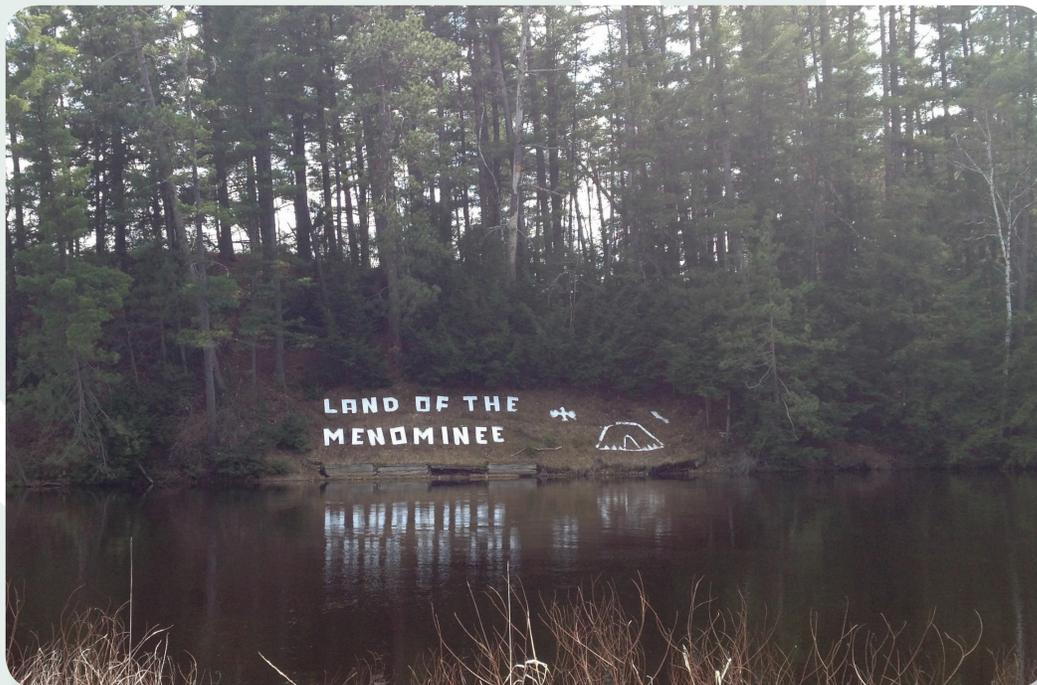
WHAT WE LEARNED

All data indicators increased significantly from baseline. In addition, all participating practices have made more effort to document asthma measures and modify their electronic health system to better align with NHLBI guidelines. Secrets to success include involving all staff members—physicians, other medical providers, and office staff—to help create open lines of communication. Findings also indicated that 71% of participants in the first two Learning Collaborative cycles were generally pleased with their experiences. Suggestions for improving the format included: 1) extending the time frame of the Collaborative cycle for 6-12 months beyond the 6-month learning session to allow for additional time to monitor data and realize systems changes; and 2) providing additional technical assistance with data collection practices and modifying patient flows in the office with limited time and staffing. Participants also noted that it was difficult to attend three in-person, full day learning sessions.

Findings also indicated that 71% of participants in the first two Learning Collaborative cycles were generally pleased with their experiences.

We conducted the evaluation to answer the overarching question about whether the program had not reached its objectives because the strategies were ineffective or the implementation was ineffective.

Native Americans in Wisconsin have a significantly higher asthma prevalence than white adults. Members of the Wisconsin Asthma Coalition (WAC) and the Wisconsin Asthma Control Program worked with the Menominee Tribal Health Center (MTHC) over several years to implement different interventions that they hoped would impact the asthma rates in Menominee County. The state's Strategic Evaluation Plan prioritized the MTHC evaluation to determine why asthma interventions in Menominee had not shown an effect on the community.





WHAT WE DID

Most recently, we evaluated the MTHC program that focused on a respiratory therapist educating students and adults with asthma on basic asthma strategies. We conducted the evaluation to answer the overarching question about whether the program had not reached its objectives because the strategies were ineffective or the implementation was ineffective. The program evaluator reviewed various documents including quantitative data from each training, patients' clinic health data, clinic staff and Healthy Homes referrals to the respiratory therapist, and the respiratory therapist's recommendations. Additionally, qualitative data were collected through key informant interviews with program staff at the state asthma program and the MTHC.



WHAT WE LEARNED

Although the site had undertaken many strategies to reduce asthma rates, the program evaluation showed that the strategies had not been implemented as initially proposed and thus had little impact. The multi-year evaluation identified many problems with the implementation of the interventions and showed that they were not meeting objectives. For example, use of curriculum was inconsistent, limited assessment tools were used, physician referrals were not made, and efforts to encourage clients to follow through with their appointments were not consistent. Unfortunately, some key stakeholders were not interested in getting input from the community and actively prevented collaboration.



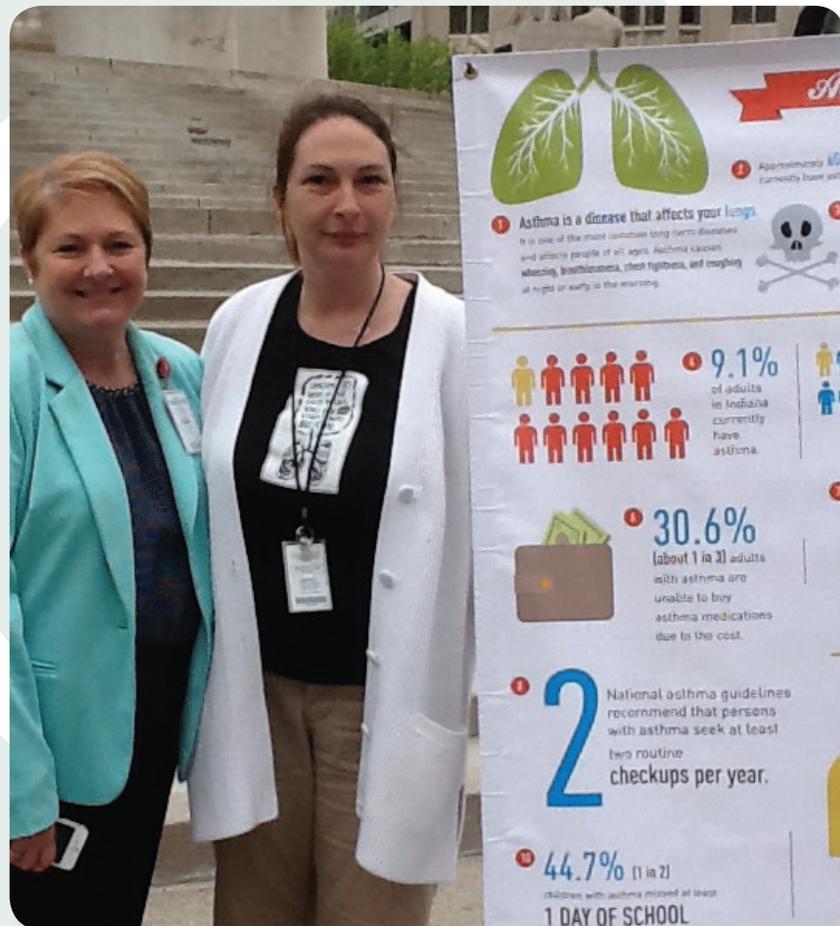
HOW WE GREW

As a result of these findings, the state asthma program and WAC Executive Committee (EC) recommended that set-aside funding for one of the sites be stopped. While the county continues to have high asthma rates, the EC recommended that the State Asthma Program pilot a program that would encourage input from community stakeholders. It is expected that greater engagement with the community in a more participatory fashion will contribute to a more successful program and evaluation. Similar collaboration is currently occurring with the La Courte Oreilles tribe in Sawyer County, WI and positive results are anticipated in the coming year.

It is expected that greater engagement with the community in a more participatory fashion will contribute to a more successful program and evaluation.

The evaluation was done to determine whether the data products were useful and accessible, solicit recommendations for improvement, learn about topics that were missing or extraneous, and identify ways the data reporting could be improved.

In 2009, the Indiana State Department of Health (ISDH), in collaboration with the Indiana Joint Asthma Coalition (InJAC) created a five-year Strategic Evaluation Plan which prioritized a surveillance evaluation, the scope of which was broadened during the development of the individual evaluation plan, to evaluate the usefulness and data communication power of the surveillance burden report and fact sheets.





WHAT WE DID

The evaluation was done to determine whether the data products were useful and accessible, solicit recommendations for improvement, learn about topics that were missing or extraneous, and identify ways the data reporting could be improved. We collected quantitative data from stakeholders via a widely disseminated survey. In addition, we collected qualitative data via focus groups and key informant interviews to gather more detailed feedback.



WHAT WE LEARNED

We learned that few people knew of or were using their surveillance data products. The results indicated only 12% of respondents had reviewed or used the burden report and only 20% had viewed the specified fact sheets. In addition, it was clear the current products were text-heavy and did not have enough charts or graphs.



HOW WE GREW

The findings from the evaluation prompted discussion among internal Indiana State Department of Health personnel (including the Chronic Disease Division Director, Evaluation Director, and Epidemiology Director) to determine the best course of action to meet needs of current data users. As a result of these findings and discussions, the decision was made for the Asthma Program to work with the ISDH in-house graphics designer to create materials that would be more appealing to a broader audience and to speak to the specific finding around products being too text-heavy. As a result of this work, an infographic model was created and pilot tested among community organizations, health care providers, local health departments, and other stakeholders. Preliminary feedback for this new format has been extremely positive. The infographic is now being used as the basis for the program's action campaign to link data to the public in a format that can be easily understood, with contact information for the Indiana State Family Helpline. The infographic can be viewed at the following website – https://secure.in.gov/isdh/files/13-Asthma_infographic_FINAL2.pdf.



The findings from the evaluation prompted discussion among internal Indiana State Department of Health personnel (including the Chronic Disease Division Director, Evaluation Director, and Epidemiology Director) to determine the best course of action to meet needs of current data users.

For more information visit:

http://www.in.gov/isdh/files/15-Asthma_infographic_11x17_FINAL2.pdf

The evaluation was designed to assess what kinds of information from the state surveillance system would be most useful and what types of surveillance products would have the greatest impact in the work of the affected asthma coalition members and other important stakeholders.

Since 2002, the New Jersey Department of Health has created informational products discussing facts about asthma in the state. The state utilizes information from a variety of sources:

- *Administrative data on all asthma-related deaths, hospitalizations, and emergency department visits*
- *Occupational health reporting of work-related asthma*
- *Surveillance survey data of asthma prevalence and comorbidities Behavioral Risk Factor Surveillance System (BRFSS) and more detailed information of adults and children with asthma via the asthma call-back survey (ACBS, since 2008). Information on adults with asthma was gathered via the adult asthma history module of the BRFSS.*

The number of data requests received along with informal feedback indicated that many users did not find some of their longer reports useful. In response, the department began to design shorter fact sheets focused on topics such as asthma in preschool-age children and adult asthma and other chronic health conditions.





WHAT WE DID

Rutgers Center for State Health Policy (CSHP) coordinated an evaluation to assess asthma data surveillance needs in order to identify new surveillance outputs for development and an appropriate plan for dissemination. The evaluation was designed to assess what kinds of information from the state surveillance system would be most useful and what types of surveillance products would have the greatest impact for a variety of asthma stakeholders from the Pediatric/Adult Asthma Coalition of New Jersey (PACNJ) or others involved in health-related planning or communications with state or local agencies that these groups or individuals do.

Between April and July of 2013, CSHP conducted 15 telephone interviews averaging 40 minutes each with a variety of asthma stakeholders. Interviews covered the following topics:

- Awareness, use and perceived utility of existing Asthma Awareness and Education Program products, and ideas for their improvement
- Other sources for NJ asthma data and perceived utility of source
- Preferences for topics, length, form of products and method of notification about products

The interviews were content analyzed and feedback on findings was received from strategic partners at multiple levels.



WHAT WE LEARNED

Interviewees' views on suggested topics to pursue generally stemmed from how they wanted to use the data—that is, what did they want to do with the knowledge gained from a fact sheet or other presentation? There were three main themes reflected, with many interviewees touching on more than one of the themes: a) targeting populations or geographic areas in need of intervention, b) documenting the burden of asthma in terms of days missed from work/school, ED visits, etc., and c) assessing asthma control and the variables that affect it.

Interviewees' views on suggested topics to pursue generally stemmed from how they wanted to use the data—that is, what did they want to do with the knowledge gained from a fact sheet or other presentation?

The program relies on surveillance data for developing, monitoring and evaluating policies and programmatic interventions. Thus, the New York State Surveillance and Program Evaluation Team deemed evaluation of this comprehensive asthma surveillance system a priority.

Members of the Asthma Surveillance and Evaluation team at the New York State (NYS) Asthma Program engaged the NYS Asthma Evaluation Steering Committee to conduct an evaluation of the NYS asthma surveillance system. The program relies on surveillance data for developing, monitoring and evaluating policies and programmatic interventions. Thus, the New York State Surveillance and Program Evaluation Team deemed evaluation of this comprehensive asthma surveillance system a priority.





WHAT WE DID

The goal of the first phase of this surveillance evaluation, which included administration of a survey of asthma partners, was to assess how the available NYS asthma surveillance data are accessed and used by asthma partners. The goal of phase two, which included administration of a survey of data owners in states adjacent to New York, was to determine if gaps exist in population coverage for surveillance datasets. Phase three is being conducted to determine how well the surveillance system measures the burden of asthma and trends over time and includes a review of the asthma surveillance system by non-asthma personnel to assess if the surveillance data were meeting needs in a timely manner. The first two phases have been completed; the third phase is nearing completion.



WHAT WE LEARNED

The evaluation indicated that a high proportion of surveillance data users accessed and used the data, demonstrating the value of the NYSDOH public website for state asthma partners. The findings also indicated, however, the need to expand content areas, such as those related to asthma care processes, on the NYSDOH website and in NYSDOH asthma reports. The evaluation also indicated that the information in the Surveillance Summary Reports needed to be highlighted and made more visible and accessible to partners.



HOW WE GREW

As a result of the evaluation, a number of recommendations were made. To date, the program has utilized the evaluation results to improve the way the Asthma Surveillance and Evaluation Team disseminates asthma summary reports. Reports will now be shared in pdf format via email and web links and in shorter, more focused “briefs.” NYS will also make improvements to their website, making information more visible and readily accessible. Phase 2 findings confirmed that the NYS SPARCS inpatient surveillance dataset captures the majority of the state’s population.

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Asthma Surveillance
and Evaluation Team
disseminates asthma
summary reports.

The purpose of the evaluation was ultimately to identify how the surveillance system had improved since 2009, highlight what has worked, and identify ways to improve asthma surveillance in Oregon.

Since 1999, the Oregon Public Health Division (OPHD) has built and improved its comprehensive asthma surveillance system. This system is built from a number of data sources:

- *Asthma prevalence from the Behavioral Risk Factors Surveillance System (BRFSS) and the Oregon Healthy Teens survey of 8th and 11th graders*
- *Asthma specific content from the BRFSS Asthma Callback Surveys (adult and child)*
- *Asthma-related deaths and hospital discharges*
- *Asthma-related claims from Medicaid and the Children's Health Insurance Program from the Medicaid Management Information System (MMIS)*
- *Asthma-related claims from Medicare Managed Care and most commercial health insurance plans in Oregon from the All-Payers All-Claims data system (APAC)*

Collection, analysis, and reporting of asthma data are integrated within the Health Promotion and Chronic Disease Prevention (HPCDP) section of OPHD and rely on relationships with the owners of each data source. Therefore, any improvement to asthma surveillance requires working within an inter-related network of leveraged staff, relationships, and technology.





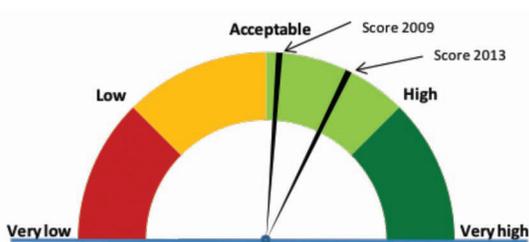
WHAT WE DID

In 2009, the Oregon Asthma Program (OAP) evaluated its surveillance system. In 2013, the OAP reassessed its surveillance system to: (1) determine if improvement had occurred based on the findings from the 2009 evaluation, and (2) recommend additional actions to improve asthma surveillance in Oregon. This new evaluation was guided by an Evaluation Team that provided guidance during development of the evaluation plan, helped craft evaluation questions, suggested analysis methods, and conducted outreach to stakeholders. The purpose of the evaluation was ultimately to identify how the surveillance system had improved since 2009, highlight what has worked, and identify ways to improve asthma surveillance in Oregon. Between August and December of 2013, OAP staff conducted semi-structured interviews with data owners and key HPCDP staff. Attributes of a public health surveillance system were assessed to score changes since the 2009 evaluation.



WHAT WE LEARNED

From the interviews and discussions, we found that the OAP surveillance system had improved since 2009. The most improved attributes of the asthma surveillance system were timeliness of data provided by data owners, acceptability of asthma data, and stability of the data sources. We also found that improvements in the BRFSS and the addition of the APAC data system were the most influential changes to the asthma surveillance system. Overall, the Oregon surveillance system score (ranked from 1=very low to 5=very high) improved from an acceptable score in 2009 (3.1) to half-way to a high score in 2013 (3.5).



The most improved attributes of the asthma surveillance system were timeliness of data provided by data owners, acceptability of asthma data, and stability of the data sources.



HOW WE GREW

Regarding recommendations for improvement, we identified three main themes:

- 1.** Better documentation on the processes used to collect, clean, analyze and store data; both from the data owners and by HPCDP staff.
- 2.** Increased training opportunities for HPCDP staff, particularly from data owners.
- 3.** Timelier communications with data owners.

We developed specific and actionable short term and long-term recommendations that provide the OAP a roadmap for continued growth and improvement of asthma surveillance in Oregon.

In preparation for a new edition of their burden report, the program wanted to identify effective elements of their previous burden report.

The Utah Asthma Program (UAP) Burden Report is a frequently downloaded document. The content and dissemination methods had changed little over the years, and it had never been evaluated. To ensure that the program was including information most relevant to stakeholders and delivering it to them in an effective manner, the program conducted an evaluation of the burden report's content and dissemination, timed just prior to the creation of the 2012 version. The timing allowed for all content recommendations to be implemented. Following a recommendation from the evaluation, the burden report was released in conjunction with the publication of the new state asthma plan, resulting in increased media coverage for both.

Asthma in Utah Burden Report 2012





WHAT WE DID

In preparation for a new edition of the UAP Burden Report, the program wanted to identify effective elements of the previous burden report and learn about new approaches to sharing asthma data. The evaluation followed a sequential mixed methods design including document review, an online questionnaire, and key informant interviews. Epidemiologists from several different programs in the Bureau of Health Promotion participated in the evaluation, which elevated the profile of the program's evaluation efforts and improved collaboration efforts in the Bureau.



WHAT WE LEARNED

The evaluation identified additional data elements that asthma stakeholders would find useful in a burden report, as well as formatting changes that could improve usability and comprehension. Suggestions included presenting data with GIS maps and maintaining consistent color coding throughout the report for population segments. User recommendations for disseminating the data included posting the report in sections on the website and limiting the report's distribution in hard copy.



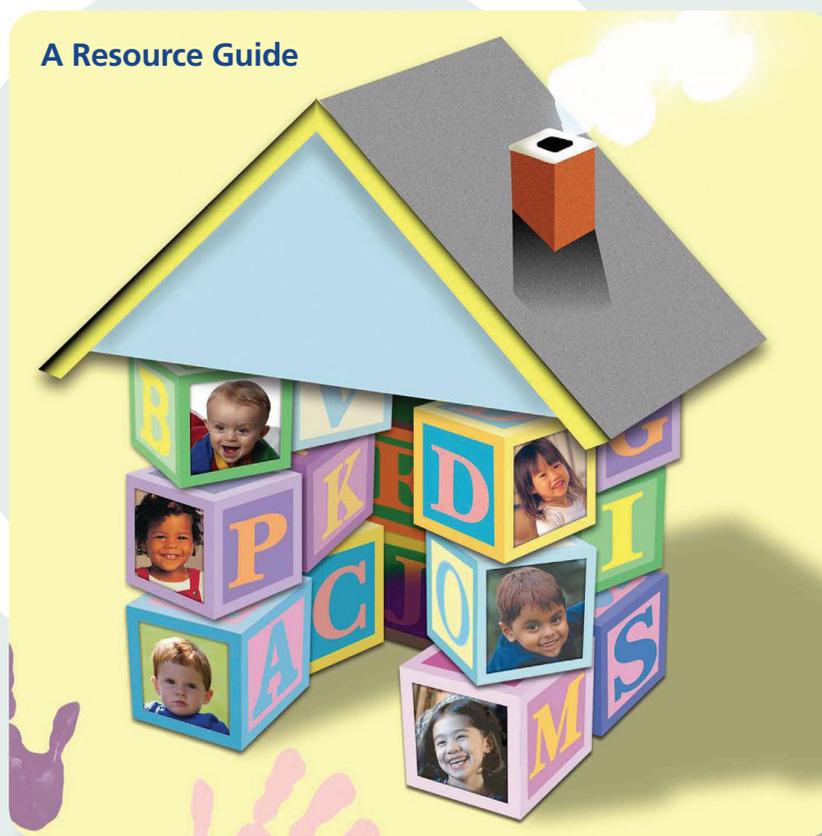
HOW WE GREW

In addition to the direct benefits of the evaluation, the program also saw positive side effects or, in evaluation terms, "process use" of the evaluation. Because the evaluator consistently focused on using the evaluation's results, program staff became excited and energized about the evaluation and its potential to support their work. When presenting the results of the evaluation to the Utah Asthma Task Force, the evaluator included a mini-evaluation training, increasing the members' overall understanding of evaluation as well as their familiarity with the burden report evaluation. Finally, many of the key informants were epidemiologists in other programs within the Bureau of Health Promotion. Their participation raised the profile of the strong evaluation work being done by the UAP, and so it became a resource to other programs within the Bureau.

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The evaluation was undertaken to describe the manual development process and to identify barriers to the manual's completion.

The DPH Asthma Program and some of its key partners had been working to revise an asthma management resource manual for day care facilities; however, the manual development process was taking much longer than anticipated. The Connecticut Asthma Program (CAP) decided to conduct an evaluation of the day care manual process and to assess the working relationships between the CAP, Department of Public Health (DPH) Day Care Licensing Program (DCLP), and Asthma Advisory Council (AAC).





WHAT WE DID

The evaluation was undertaken to describe the manual development process and to identify barriers to the manual's completion. We interviewed each of the major players in the process to obtain their perspective about the day care manual revision context, components, chronology, and the relationships between the persons involved in it. The evaluator reviewed program documents and primary documents (e.g., e-mail, CD-ROM) that were referenced by key informants during interviews. Using the information gathered from the data collected, the evaluator created a manual development timeline, which illustrated the many delays in the manual revision process.



WHAT WE LEARNED

This partnership evaluation yielded significant findings that shed light not only on the manual revision process and its progress, but also regarding how the CAP can work more effectively with internal and external partners. The findings have helped the CAP to better frame its goals and plans for working with partners. The evaluation showed that during the manual revision process, roles and responsibilities were unclear, communication mechanisms did not operate properly, and deadlines were routinely missed.



HOW WE GREW

The lessons learned from the evaluation were incorporated into an action plan that is currently being implemented. The CAP has made improvements in documenting meetings and monitoring the progress of projects. Through active engagement in the evaluation process, Connecticut Asthma Program staff and partners have come to understand: what program evaluation entails, that evaluation is a shared effort, the fundamental value of evaluation, and that implementing actions based on evaluation findings can improve program performance.

Through active engagement in the evaluation process, Connecticut Asthma Program staff and partners have come to understand: what program evaluation entails, that evaluation is a shared effort, the fundamental value of evaluation, and that implementing actions based on evaluation findings can improve program performance.

Evaluation tools and methods were created to assess the success of the coalition's initial operations and promote its continued achievement of core goals.

The Florida Asthma Coalition (FAC) began operations in 2009 with the goal of improving asthma management in the state of Florida and thus improving quality of life for Floridians with asthma. The FAC is a collaborative volunteer group of health care and public health professionals, business and government agency personnel, and community activists. The coalition is designed to (1) provide a common vision for individuals, organizations, and communities in the state of Florida to address the burden of asthma, and (2) facilitate the implementation of the 2004-2014 Florida State Asthma Plan.





WHAT WE DID

This evaluation was designed to provide information for increasing the effectiveness of the FAC. Evaluation tools and methods were created to assess the success of the coalition's initial operations and promote its continued achievement of core goals. The evaluation of the FAC began in 2011 and continued until 2014. The Evaluation team engaged members of the FAC in the planning and implementation of the evaluation, beginning at the annual meeting and continuing through workgroup and steering committees. We collected data through surveys, semi-structured interviews, observation, document review of meeting minutes, the coalition roster, participation records, the coalition's 2012 and 2013 Operational Plans, the State Asthma Plan, and other documents identified during the process. The team provided evaluation updates frequently to cultivate interest in evaluation and to encourage use of evaluation findings. The ongoing evaluation work within the FAC became well known to FAC membership, and FAC membership assisted with advancing the evaluation work.



WHAT WE LEARNED

Findings indicated the need for greater attention to the following coalition areas:

- member collaboration across all projects,
- participation in intervention planning and implementation,
- promotion of guidance documents,
- creation of stronger linkages between FAC members and other surveillance data users,
- development of coalition infrastructure that promotes sustainability,
- community awareness of coalition activities,
- and outreach to lawmakers and advocacy groups.



HOW WE GREW

Evaluators worked with FAP staff to develop an evaluation capacity building plan for the FAC that evolved from year to year as new findings became available. This plan eventually included 10 different strategies for developing evaluation capacity and improving member engagement in evaluation activities. These strategies included:

1. Maintaining evaluation resources on the FAC website
2. Discussing online evaluation content during workgroup and All Members meetings
3. Presenting information about using evaluation to promote financial sustainability
4. Conducting short evaluation surveys after all FAC summits and workgroup meetings
5. Distributing sample evaluation reports and journal articles to FAC members
6. Promoting the development of evaluation success stories from members
7. Participating in local asthma coalition meetings throughout Florida to share evaluation items
8. Collecting data to demonstrate return on investment from asthma management course
9. Establishing a workgroup to share evaluation results with legislators and policy advocates
10. Providing additional resources to help FAC leaders implement evaluation findings

Evaluation findings are continually being used to refine the structure of the FAC to support activities planned for the new project cycle.

Evaluation findings were used to improve functioning of the coalition, thereby supporting the state health department efforts to address asthma burden in Florida.

We conducted this evaluation to improve the structure and management of Georgia Asthma Advisory Council (GAAC).

The Georgia Asthma Advisory Coalition (GAAC) was organized to build capacity statewide to address the burden of asthma through a coordinated effort, implementing GA's strategic asthma plan. The GAAC supports GACP by providing assistance, expertise and guidance on a variety of asthma-related topics for a broad range of audiences. Guided by the utilization-oriented framework, Learning and Growing through Evaluation and the CDC Evaluation Framework, Georgia Asthma Control Program (GACP) implemented partnership evaluation activities that resulted in findings that have helped drive improvements in organization, composition and management.





WHAT WE DID

We conducted this evaluation to improve the structure and management of Georgia Asthma Advisory Council (GAAC). The Georgia Asthma Control Program engaged a diverse evaluation team comprised of partners, including program staff, epidemiologist, health educators, School Wellness Liaison, local level boards of personnel, and academia. During the planning for this partnership evaluation, we also engaged the larger GAAC body for input and feedback on the plan. Through a survey administered both in person at the August 2012 GAAC meeting and via Survey Monkey for persons not attending the meeting, information was collected regarding the function, communication, participation, representation, and leadership of the coalition.



WHAT WE LEARNED

We discovered that many of the GAAC members thought GAAC functions and activities aligned with that of a small advisory board as opposed to a larger coalition which the name suggests.



HOW WE GREW

As a result, the structure of the body was reorganized to form an advisory board of those who would be instrumental in delegating and driving the work in the Asthma Strategic Plan. This board was renamed to become the Georgia Asthma Advisory Board (GAAB). A Memorandum of Understanding (MOU) was established with the Georgia Asthma Coalition (GAC), an existing partner of GACP, to facilitate a broader range of stakeholders, thereby expanding the reach and resources for statewide asthma management efforts and enhancing the sustainability and visibility of the body. Also, as a part of this restructure, the roles and responsibilities of members were documented and a formal process developed for monitoring the work of the body through the leadership of the workgroup chair, including work plan monitoring and quarterly status reporting. The evaluation efforts have all been well received by current partners. GACP plans to continue conducting periodic evaluation of partnerships, expanding to new partners through the relationship with GAAC.

As a result, the structure of the body was reorganized to form an advisory board of those who would be instrumental in delegating and driving the work in the Asthma Strategic Plan.

The Illinois Asthma Partnership (IAP) saw the evaluation as an opportunity to engage and reengage IAP members while setting direction for the future.

The mission of the Illinois Asthma Partnership (IAP) is to improve the quality of life for people with asthma and those who care for them. The overall goal is to reduce morbidity and mortality from asthma through system changes and collaboration with state asthma partners. During its 12 year history, IAP's structure and operations changed dramatically. Attendance at meetings, the roster for the Listserv, and the number of initiatives have waxed and waned. By 2011, there was a sense that IAP needed to assess how to keep current partners active and reengage partners who were no longer active.





WHAT WE DID

The purpose of the evaluation was to solicit feedback about the environment and structure of the IAP, as there was anecdotal evidence suggesting that the partnership needed to be reinvigorated. The Illinois Asthma Partnership (IAP) saw the evaluation as an opportunity to engage and reengage IAP members while setting direction for the future.

The Illinois Asthma Program Partnership Evaluation was a qualitative assessment. We conducted interviews with members of the IAP and held a group discussion to implement a strategic planning method to evaluate projects and groups. As part of this discussion the team conducted a SWOT analysis to assess the environment in which the Illinois Asthma Partnership and its members operate.



WHAT WE LEARNED

The key evaluation findings included a charge to leadership to recruit and retain a diverse membership, increase the presence of the IAP among the community and its own members, and to ease member burden for participation by developing tools and resources for grantees and partners to utilize.



HOW WE GREW

We categorized findings into five overarching themes for program improvement, and an action plan was created based on those themes: objectives/goals; resources; communication and media; membership; and leadership. For example, for the first theme, the action plan calls for changes in how progress on objectives is reported, including the development of IAP factsheets to highlight goals and progress toward meeting them and regular reporting on goals and objectives during biannual meetings. We assigned key personnel and partners to the activities identified in the action plan and included progress reports on implementing evaluation recommendations as a standing agenda item to the executive committee's monthly calls. Additionally, the evaluation provided data for revisions to the state asthma plan.

We categorized findings into five overarching themes for program improvement, and an action plan was created based on those themes: objectives/goals; resources; communication and media; membership; and leadership.

In addition to obtaining the perspectives of the Kentucky Asthma Partnerships members on the coalition's membership and functioning, we wanted to assess KAP's impact on the asthma program pilot sites and health care providers and to learn how the partnership could assist in the future and grow through development and recruitment.

The Kentucky Department for Public Health (KDPH) established the Kentucky Asthma Partnership (KAP) in 2003 to increase asthma awareness in the state. In 2009 the state received CDC funding for comprehensive asthma management programming. As a part of their strategic evaluation plan, KDPH prioritized an evaluation of the Kentucky Asthma Partnership (KAP), a statewide coalition of public and private partners working to address asthma management issues in the state. The coalition includes nearly 150 members representing about 90 organizations.





WHAT WE DID

In order to fully understand the perspectives of KAP members, we conducted a formal interview process. We used key informant interviews and reviewed relevant documents. These interviews aided the KAP in assessing its impact on the asthma program pilot sites and health care providers and in learning how the partnership could assist in the future and grow through development and recruitment. In addition to obtaining the perspectives of the Kentucky Asthma Partnership's members on the coalition's membership and functioning, we wanted to assess KAP's impact on the asthma program pilot sites and health care providers and to learn how the partnership could assist in the future and grow through development and recruitment.



WHAT WE LEARNED

This partnership evaluation yielded significant findings on how the KAP could work more effectively with partners to improve asthma control among Kentuckians. As a result of the evaluation, KDPH learned more about the impact of the KAP and the dynamic between the KAP, the pilot sites and other providers across the state. The results indicate that the interviewees:

- Are extremely passionate for asthma work.
- Believe the KAP is very responsive to their needs and provides opportunities for communication and networking as well as resources and education.
- Have concerns about the high turnover rates of the KDPH staff and those in KAP leadership roles.
- Believe the KAP isn't visible in the pilot site communities.
- See the need for the definition of roles and increased engagement from the KAP members.
- Want to see a decrease in asthma-related ER and doctor visits. However, the KAP members and the pilot sites have different plans to reach this outcome.

Based on the evaluation, the KAP leadership took steps to encourage a more targeted and thoughtful discussion between leaders and members, including the pilot sites and providers.



HOW WE GREW

Based on the evaluation, the KAP leadership took steps to encourage a more targeted and thoughtful discussion between leaders and members, including the pilot sites and providers. In late 2013 and early 2014, KAP engaged in strategic planning to develop clear goals and objectives for the future, including 501(c)(3) tax-exempt status and increased presence and credibility of the KAP. An evaluation tool was also created to assess progress in meeting these goals and objectives. In addition, new communication strategies were employed, more member input was sought regarding meeting format, frequency, etc. and roles of leadership and members were clarified. A meeting survey will be fielded at each meeting to provide continuous feedback to further refine and improve the KAP.

The evaluation was conducted to assess the Asthma Coalition of Mississippi's commitment and effectiveness in achieving the goals of the State Asthma Plan and determine its productivity and sustainability.

The Asthma Coalition of Mississippi (ACM) is a statewide partnership that strives to lessen the burden of asthma among Mississippians by promoting education, prevention, and management of asthma throughout the state. It is comprised of nine regional coalitions. The evaluation team included Asthma program staff, the American Lung Association in Mississippi, the ACM lead team, and interested coalition members. The Mississippi State Department of Health agreed with their partners from the American Lung Association in Mississippi and members of the ACM that it was important to evaluate the coalition's effectiveness toward achieving the overall goals of the State Asthma Plan.





WHAT WE DID

The evaluation was conducted to assess the Asthma Coalition of Mississippi's commitment and effectiveness in achieving the goals of the State Asthma Plan and determine its productivity and sustainability. Using a team-based approach, the Mississippi State Department of Health engaged partners in evaluating their Asthma Coalition of Mississippi (ACM), administering an electronic survey sent to coalition members and reviewing relevant documents, such as the State Asthma Plan and associated logs and minutes. The survey, which collected both quantitative and qualitative data, assessed members' satisfaction and perceptions of the coalition's functions and effectiveness.



WHAT WE LEARNED

The ACM Lead and evaluation team determined that the results were relevant, timely, and met the needs of stakeholders. Among the findings was the need for more engaged participation among current coalition members and increased representation of under-represented, important groups within the coalition, such as persons with asthma, doctors, and caregivers.



HOW WE GREW

The evaluation team prioritized membership concerns and developed a list of recommendations and an action plan that included structural and procedural activities to enhance membership diversity and meeting effectiveness. We also plan to modify the existing work plan to detail activities that have been conducted and advertise the coalition more broadly through a variety of methods. Some of the action steps have already been implemented.

The evaluation team prioritized membership concerns and developed a list of recommendations and an action plan.

The goal of the evaluation was to assess the level of engagement among several entities that work toward reducing the burden of asthma in New Jersey.

The Asthma Awareness and Education Program (AAEP) of the Chronic Disease Prevention and Control Services, Division of Family Health Services, New Jersey Department of Health and Senior Services, has coordinated a statewide asthma outreach program since 2001. The AAEP has collaborated with organizations and agencies to address the burden of asthma. The State Asthma Partnership (SAP) is an affiliation of diverse organizations and individuals who work with AAEP in education, intervention, advocacy, and outreach to reduce asthma's impact in New Jersey.





WHAT WE DID

In 2010, AAEP contracted with the Institute for Families at the Rutgers University School of Social Work to evaluate the effectiveness of its partnership. The goal for the evaluation was to assess the level of engagement among several entities that work toward reducing the burden of asthma in New Jersey. The evaluation team collected online surveys. They emailed the assessment to 120 individuals who were asked to assess the partnership on a) mission, vision, and goals; b) collaboration; c) activities; d) leadership; e) communication, f) outcomes, and g) strengths and weaknesses. Quantitative analysis was conducted using frequencies, measures of central tendency, and dispersion. We presented findings in order to capture the extent to which respondents agreed or disagreed with survey items. The team used content analysis to analyze the qualitative data.



WHAT WE LEARNED

A number of important themes emerged from the SAP assessment. Participants generally felt positive about the SAP, its role in their work, and its role in the field of asthma in New Jersey. One important finding that emerged from the study, particularly through responses to open-ended questions, was that many respondents were more familiar with the sub-units of the SAP, such as the Pediatric/Adult Asthma Coalition of New Jersey, rather than the SAP as its own entity. This finding has prompted the Asthma Awareness and Education Program to work to engage the overall SAP on a more regular basis



Participants generally felt positive about the State Asthma Partnership (SAP), its role in their work, and its role in the field of asthma in New Jersey.



HOW WE GREW

Specific insights gained as a result of this evaluation include:

- The first recommendation is to establish a unique identity for the SAP so people in the field are familiar with what it is and how its partners are interconnected.
- The second recommendation is to conduct annual state-wide meetings such as symposia or summits, with the goals of sharing information and facilitating partner networking.
- The third recommendation is to increase the amount and type of communication to SAP and non-SAP people and organizations via a quarterly newsletter, a Facebook page, and an interactive website.
- The fourth recommendation is to seek opportunities to grow the SAP through a wide array of non-profit, government, education, and health institutions that offer venues to display and distribute SAP marketing materials.

The evaluation was undertaken to assess progress toward achieving the goals and objectives laid out in the State Plan as well as to assess Asthma Alliance of North Carolina member satisfaction.

The leadership of the North Carolina Asthma Program (NCAP) and the Asthma Alliance of North Carolina (AANC) was highly interested in the opportunity to evaluate the progress made towards achieving the goals and objectives of the State Plan. We decided to evaluate our collaborative work, given the increasingly limited resources for statewide asthma work and overall satisfaction of the membership. The Asthma Alliance of North Carolina (AANC) is a partnership of local and state government agencies, academic institutions, local asthma coalitions, non-profits and private industry working collaboratively to address asthma in North Carolina. The AANC is led by two co-chairs and has three main committees that form the backbone of the Alliance.

Children and Asthma
IN NORTH CAROLINA

What is Asthma?

- Asthma is a chronic (long-term) lung disease that inflames and narrows the airways.¹
- Common signs and symptoms of asthma may include wheezing (a whistling sound when you breathe), chest tightness, shortness of breath, and coughing.
- For people with asthma, contact with allergens or asthma triggers (like pollen, mold, animal dander, dust mites), secondhand tobacco smoke, air pollution, occupational hazards, exercise, and airway infections may make asthma symptoms worse. When asthma symptoms get intense and/or when there are additional symptoms, an asthma attack may occur.
- Severe asthma attacks may require emergency care, and they can cause death.

Why is asthma an important health issue for children?

- Asthma is the leading chronic health condition reported by North Carolina public schools. Asthma accounted for 35.0% of all chronic health conditions, affecting 101,599 students in the 2010-2011 school year.²

Asthma accounted for **35.0%** of all chronic health conditions

- Children are more likely to be hospitalized for asthma: in North Carolina asthma hospitalization rate was 10,000 population for children to 9.2 per 10,000 for adults.³
- In 2011, children with asthma age of 5 had the highest hospitalization rate of any other age group in Carolina (24.1 hospitalization population).³

Managing Asthma Triggers in Residential Units:
A GUIDE FOR OWNERS AND PROPERTY MANAGERS

What is Asthma?

Asthma is a common chronic disease that affects the lungs. It often causes wheezing, shortness of breath, chest tightness, and coughing at night or early in the morning. These symptoms are known as an asthma attack. An asthma attack happens when you are exposed to things like dust mites and secondhand smoke. These are called asthma triggers.

Asthma Is a Serious Health Issue¹

- Asthma is a leading cause of hospitalizations for North Carolina children.
- A higher percentage of people with lower incomes have asthma.
- Women in North Carolina are almost twice as likely to have asthma as men.
- The number of people with asthma is on the rise.

Common Asthma Triggers

- Dust Mites** are tiny bugs you can't see. They live in sheets, blankets, pillows, mattresses, box springs and stuffed toys.
- Mold and Mildew** grow on wet surfaces like shower curtains, bathtubs, sinks and tiles. They can look like a dark stain.
- Secondhand Smoke** comes from burning cigarettes, pipes, or cigars. It's also smoke breathed out by someone who is smoking. It can stay on walls and other surfaces for a long time.
- Cockroaches** leave droppings which can trigger an asthma attack. When they die, their body parts are also triggers.
- Pets** lick their fur and leave behind an asthma trigger from their saliva called "dander".
- Chemical Irritants** are found in many products with strong smells, like household cleaners, paints and air fresheners.
- Nitrogen Dioxide** is an odorless gas that can come from using appliances that burn fuels like gas, wood or kerosene.



WHAT WE DID

The evaluation was undertaken to assess progress toward achieving the goals and objectives laid out in the State Plan as well as to assess Asthma Alliance of North Carolina member satisfaction. Prior to beginning the partnership evaluation, the North Carolina evaluator conducted a membership assessment of the AANC to identify the main stakeholders and partners and their roles in the NCAP and AANC. Ensuring the evaluation team was diverse and representative of the AANC membership, the evaluator actively engaged key members from the AANC committees, individuals who occupied leadership roles, NCAP program staff and AANC members who had been members for over 5 years for a historical perspective. The partnership evaluation involved a document review to measure the level of completion of the NCAP Plan and implementation of a survey to assess AANC members' satisfaction.



WHAT WE LEARNED

The survey findings indicated that the majority of the goals in the plan had only been partially met over the past 5 years. However, organization and leadership of the NCAP and AANC were rated highly. The document review revealed that not only were the objectives in the Plan not measurable, tasks did not identify the responsible parties. The further revelation of inconsistent documentation of meetings and activities served as a timely impetus for action that included development of a template for monitoring and documenting progress.



HOW WE GREW

We plan to use this template to monitor and periodically evaluate the 2013-2018 State Plan. Use of the evaluation results will also ensure that the new State Plan includes SMART goals and objectives, identification of responsible parties, and a State Plan Index for closer monitoring of progress. In addition, the results of the evaluation have been used to engage new partners, such as school health professionals and local health departments, thereby increasing collaborations. This evaluation serves as a prime example of how an evaluation stimulated stakeholders to improve monitoring of progress on the State Plan and strengthened collaborations with partners.

Use of the evaluation results will also ensure that the new State Plan includes SMART goals and objectives, identification of responsible parties, and a State Plan Index for closer monitoring of progress.

Because of the Ohio Asthma Coalition's important role, the Ohio Department of Health Asthma Program Evaluation Planning Team prioritized a partnership evaluation to assess the coalition's strengths and weaknesses, particularly with respect to its membership composition and participation.

The Ohio Asthma Coalition (OAC) is the key external partner of the Ohio Department of Health Asthma Program (ODHAP). Though the coalition was well established, having been formed in 2003, its evaluation efforts over the years had been limited. Ideally, the OAC should be a self-sustaining organization that can collaborate with but not depend heavily on ODHAP. An evaluation, particularly one that is participatory and focused on generating practical and immediately useful information, can help provide a roadmap to that sort of relationship.





WHAT WE DID

Because of the Ohio Asthma Coalition's important role, the Ohio Department of Health Asthma Program Evaluation Planning Team prioritized a partnership evaluation to assess the coalition's strengths and weaknesses, particularly with respect to its membership composition and participation. An external evaluator conducted member satisfaction and other member surveys, meeting observations, and document reviews. Coalition members were involved in all stages of the evaluation, from planning and implementation to action planning and follow up. ODHAP was able to partner with OAC to get ongoing and systematic feedback about the changes they were making to strengthen the coalition. The evaluation began in Year 2 of the funding cycle and has been ongoing since. While the coalition leadership's initial response to the evaluation was somewhat ambivalent, the current steering committee members are now eager and active evaluation participants and have used the evaluation findings to improve many aspects of the coalition.



WHAT WE LEARNED

Several of the findings pointed to a coalition that had stagnated since its creation. For example, OAC informational and recruitment materials and its member roster were out of date, and the group had added few members in the more recent years. Findings also indicated that the OAC's structure and processes to orient and integrate new members were inadequate, and its operational functions were inconsistently implemented. Finally, the findings suggested that some members felt that ODHAP was running, rather than supporting, the coalition.



HOW WE GREW

Working with OAC members and ODHAP staff, the evaluator created an action plan based on 10 key evaluation findings. The action plan addressed all these findings, and many recommendations have been implemented, from updating member lists and informational materials to revising the by-laws and formalizing a meeting schedule. The evaluator is tracking the status of the recommended actions as well the results of the changes made. Most importantly, the coalition's leadership has become engaged in the evaluation and has come to see it as a tool for initiating and sustaining important discussions about how the members characterize and carry out their work, both as individual members and as a collective.

Most importantly, the coalition's leadership has become engaged in the evaluation and has come to see it as a tool for initiating and sustaining important discussions about how the members characterize and carry out their work, both as individual members and as a collective.



The purpose of the overall evaluation was to understand why the workgroups had become less active over time and to obtain feedback from the members to ultimately address the reasons for the decline.

The Pennsylvania Asthma Partnership (PAP) is a diverse, multi-disciplinary partnership of agencies, organizations and individuals in the Commonwealth concerned with asthma and committed to the sharing of mutual expertise and resources in addressing and reducing the burden of asthma in Pennsylvania. Key asthma stakeholders from across the Commonwealth comprise the membership of the PAP. PAP provides guidance and recommendations around the implementation and on-going development of the most recent Pennsylvania Asthma Strategic Plan. Over the past five years of the Asthma Control Program (ACP) funding, the Pennsylvania Asthma Partnership (PAP) has been continually evaluated to determine if its structure and function are assisting Pennsylvania in reaching its goals and objectives for Asthma control.





WHAT WE DID

Through a strategic evaluative process, the PAP was determined to be one of the top three priorities for evaluation of the Asthma Control Program and thus was included in the 5-year strategic evaluation plan. The following areas of the PAP were selected as the focus of the evaluation: the structure of the PAP; whether the PAP was functioning effectively; whether the PAP was helping to control Asthma in the Commonwealth; and whether the programs and tasks were helping to reach the overall goals and objectives of the PAP.

Over five years of the funding, the workgroup structures changed from the original five workgroups to three after two years. In part this was a result of inactivity of the workgroups. The workgroups were not meeting on a regular basis, chairs of the workgroups had changed or the positions were vacant, new members to the PAP identified that they were not sure of their roles and responsibilities as members, and overall, the participation in the workgroups and PAP had declined. The purpose of the overall evaluation was to determine why this was happening and to obtain feedback from the members to ultimately address the barriers.

During each year of the grant, the PAP participants were surveyed semi-annually. Also annually, each spring, the entire PAP was evaluated at an in-person full partnership meeting. This was a paper and pencil survey that was administered only to the members present at the meeting. The purpose of the in-person meeting evaluation was to collect information from the most active members around their perceptions of how the PAP was functioning, how active they were in the PAP, whether the PAP was reaching its goals and objectives, if the PAP had the right mix of members to accomplish tasks and meet goals, if the PAP was having an effect on asthma overall in the Commonwealth, if PAP was providing leadership in Asthma for PA and to gauge the level of interaction amongst members. This evaluation was conducted in each of the five years of CDC funding.



WHAT WE LEARNED

The findings of the overall evaluation uncovered three areas that needed to be addressed by the PAP: (1) Participation rates were low; (2) the members did not understand their roles and responsibilities; and (3) there were barriers to completing tasks and reaching goals.



HOW WE GREW

These findings were presented at the full PAP meeting in the spring 2013. As a part of the presentation, we held a participatory discussion to obtain feedback from the members, which we used to create an action plan to address these areas. Based on the feedback, the PAP decided to restructure in a way that created regional representation across the state. The action plan outlined a phasing out of the original workgroup structure and introduction of three regional groups, the Eastern (Philadelphia) region, the Central (Harrisburg) region and the Western (Pittsburgh) region. Regular monitoring and meeting evaluations will continue to be conducted in the coming years to ensure the new approach is working well and meets the needs of the PAP and its members.

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FOR MORE INFORMATION CONTACT:

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