Session Title: Assessing Change in Health Program Participants: Useful Tools and Lessons Learned

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M: Thank you. I want to also thank my co-presenters. Some notes before we start: None of us are assessment experts. We believe we have to show the good, the benefits of what we do. We are not professional assessors. We’ll be sharing from our perspective some lessons learned. Two, if you have any questions this morning just ask as they come up. And lastly, the material you have on your table are handouts we created a week ago and we’ve had a few updates in our slides.

So why is this important? Assessment has a lot to do with the planning and outcomes and changes we want to make in a community. Results are often what grant providers are looking for. So if you can show your plan for assessment and conduct it, grant providers like to see that. When you write your plan don’t include grandiose ideas—be realistic. Our objectives for today, just to highlight some points: partnership principles are crucial. We will share with you some lessons learned. We’ll tell you about our projects, what we planned to do, what we achieved.

Clarifying terms, we talk about measurement, assessment, evaluation. Measurement is really the narrowest description, so it’s applying a standard scale or device. It’s the ruler. Assessment is the middle ground—information is obtained relative to some known objective or goal. Food logs, or sleep logs, could be assessment. Evaluation is the most broad—it’s a process that determines value of a program. Example: taking a blood pressure measurement could be assessment of a patient, and a summary of assessment of several patients could be part of a community health evaluation.

Now, these [indicating slide] are four principles of 10 that are listed on the website: CCPH Principles of Campus-Community Partnerships. So what do these have to do with assessment? These point to obligations on the part of assessors. So assessors need to be prepared and communicate often. Be intentionally focused on what you’re measuring and trying to assess.

Second, respect. Make sure your tools are geared toward the literacy levels of your subjects. Research assistants need to be trained and prepared to go out and assess.

Third, build upon identified strengths. These communities have enormous challenges, but if I were to go in thinking that community isn’t strong, I’d be wrong. Be sure your assessments show that there are those strengths and resources there.

Finally, assessments should balance power. Show fairness, and give credit.

S: I’m going to speak about a tool we used with the faith community gym project. The partners are listed on the slide. Our objectives are on the slide. Members of New Birth Church were trained in health
advocacy. These advocates then presented a nutrition health curriculum for youth. Second, youth participated in a physical activity program. Third, we increased health career awareness.

I was in charge of the 2nd objective—how to make exercise and running more palatable for youth? We had to make sure the youth would participate. We needed key partner buy-in. And we had to figure out how we would test and measure cardiovascular fitness in the youth. I’m an exercise physiologist. We can measure exertion on a treadmill with gas analysis, and we can also ask about their perception of effort. With our gym project, though, we needed to have measures we can use out in the field—like the 12 minute run, or how fast can you walk a mile. We got together and thought, well, we have middle and high school students, boys and girls, somebody is going to be last. How can we conduct this assessment without making someone embarrassed about being last? We used perceived physical exertion. As an individual works harder, their perception of working hard goes up. The OMNI scale is for children—as a person has more effort their perception of effort is increased. It’s not a fatigue scale, it’s perception of effort with physical activity.

So, we wanted to make sure we had key partner buy in. Our steering committee was on board. We also talked to clinicians. Bob Robertson, one of the developers of the OMNI scale said this had good merit in the lab, and you really could use it in the field. We previewed it with our health advocates so they knew what we were measuring. We trained our trainers to make sure they knew how to use it, and we previewed it with our youth. We devised a program we hope was fun. Whatever measurement you have, you have to make sure kids actually show up and are there. We played games, we stretched, and then we did progressive run-walk sessions. By the end we were doing 4 minutes of running and one minute of walking. Assessors were positioned around the gym and would ask youth during the running portion at intervals where they were at on the scale of perceived exertion. We didn’t want to do it every week. The youth would be tired of it. We did it weeks 1, 5, and 10. We decided to also measure week 7 to make sure the youth were familiar with it. Here’s our chart (slide). We want to know 2 things: could our youth work hard enough to have increased work load? Based on our results as an individual reaches 5 on the scale you start to see improvement. We saw that our youth were reaching 5. The other thing, we wanted to see whether from week 1 to week 10 there was improvement. We can see that in week 1 when they were running 1 minute walking 1 minute youth perceived they were working harder than they were running for 4 minutes and walking for 1 minute. That’s a success.

Lessons learned: key partner buy in. This is what drove it, having our steering committee on board. Talking with our partners and saying that we don’t want any youth to finish last. We want to make exercise palatable. Explore practical adaptation from the lab and dialogue with clinicians. Pilot the measurement tool when possible. Measure the small stuff. Kids were asking fewer times to go get a drink of water—they weren’t looking for excuses to get out of work.

J: My name is Tina Johnson. I’m coming from a different side of assessment. I’m a Research Assistant at the VA working in community based research. I’m coming from the POWER program. The purpose is to compare the effectiveness of peer delivered health education and support with professionally delivered seminars. Hypertension is a leading cause of morbidity and mortality. Many veterans have suboptimal
blood pressure control. Evidence suggests that community and peer support can improve these outcomes.

We had survey and measurement instruments that had been pretested in POWER 1 (Pilot study). We taught representatives from each service organization what we wanted them to teach their participants, like using a pedometer, that sort of thing. And we had a control group where physicians, clinicians would come in and teach the same things.

The project goals were to encourage veterans and their organizations to be interested in the research, to be partners in the goals. We wanted these members to improve their self-management skills, to see if this then helped improve blood pressure control, and then we wanted to share results with the greater community.

We trained quarterly with experts on proper blood pressure taking with a handheld machine instead of those automatic ones. The handout shows a sample of the survey we put together and some of the pretested instruments we used to put together the survey. These are actual instruments we studied and used and how we applied them to the survey. We practiced these surveys on each other and with our PI. And we gave them at baseline, 6 months and 12 months. We wanted to make sure questions were clear and we’d get the data we wanted. We recently had a results party with participants, and here’s an example of how we displayed the results. We had farmers, housewives, blue collar workers, and we put these results in a clear and concise chart.

What we learned from the field is that you have to create a partnership. Make them interested in your goals. Make sure data is collected in a consistent and accurate manner. Have a well-trained staff. Make sure you know who your audience is and disseminate results accordingly.

M: The project I was PI for is elder community health upholders. My partners are listed, I won’t name them all. We had 9 churches, 5 community organizations, and others came in sideways and kind of joined us. Here are lists of our goals. We have training to make participants health leaders in their communities, and we’ve had pastoral training.

I’m going to talk about goal number 1: to work with health volunteers to improve knowledge and self-confidence in health project planning and coordination. We had pretests and posttests. With true pretests it can be hard to match the pretests and find those exact people to complete the posttest. Another problem is that there can be response bias. In the pretest, people might inflate their answers because they don’t really know. In the program they learn more about the topic, and their response in the posttest is more accurate, but it might not show any change. Retrospective pretest can be more useful in this case. For example, on the pretest you might ask about how often people eat foods rich in vitamin C. Well, if people don’t know about what foods have vitamin C they might think that they eat more than they truly do. By the posttest, they’ve learned about these foods and their answers might be more accurate, but it might look like they’re now eating fewer vitamin C rich foods.

Here I’ve tried to show some of our preliminary results. You see we line up the retrospective pretest averages with the posttest averages, and you can tell we’ve had some real gains. We think these
outcomes are really positive. Lessons we’ve learned: include all partners and start planning early. Use existing tools if you can, that have already been validated. If you’re using your own instruments, pretest them and pilot them to make sure the assessment is telling you what you want it to say in a way that’s meaningful. Finally, know when to get expert assistance. And all of us have used experts when we need them.

Question: How do you compensate your health care workers?

M: We tried to estimate the amount of time it would take to do this project and then tried to estimate a fair and reasonable compensation. For us, it may have been ~$100 per half year, to come to a few sessions. We talked with our volunteers about this. In later years it increased a bit because we asked more of our subjects. The benefit of working with church volunteers was that a lot of people were already working in the community. Come up with the value you think is reasonable and the grant can support, and then talk to your partners about it.

Question: Is the GYM program going to continue in the churches?

S: What we found was, the information we gathered from the GYM project, we’re taking what we learned and we’ll implement it at Agape and we’re also working with MPS. In a faith community, you really have to have that champion. Unless you have that person, it’s hard for us to come in and do it. But if you have that champion, we’ll give you the stuff. We’re looking for other grant funded opportunities to share our stuff.

Question: I think that raises issues about sustaining programs. One of the roles of a partner is to come in and make sure before you pull out, can you speak to that, the role of continuing the program beyond the research?

J: Our POWER program is going to move from blood pressure control to weight control using the same VSOs for Power. And I think one reason we were given that grant was because we’re using the same VSOs, the same people. So by the time we’re done we’re going to have super-vets.

S: Tomorrow night we’re presenting some of our results, and what we thought is we have some good results, but we need some volunteers also. It’d be great to be grant-funded all the time, but what we’re doing is being able to sustain some of these efforts, we’re trying.

M: I’d add that in our example the church moved out. We learn what we can, create the impacts we can.

Q: You’ve talked about engaging participants in measurement. Judy, how did you engage the kids in using the OMNI scale? And how did you avoid bias from frame of reference?

S: Right, we asked all the youth to rate their perceived exertion. That first night after running for one minute we had youth who said they were working at a 6, and I don’t doubt it! She was working as hard as she could. So, we educated the youth on the scale and gave them a frame of reference. What we did find is that there is probably some bias. You answer what someone else answered.
M: I want to thank again Tina and Judy and all of you. On limitations of statistics, which could also be said of assessment, Andrew Land said: “He uses statistics as a drunken man uses lampposts—for support rather than illumination.”