National Community Centers of Excellence in Women's Health

Program Evaluation Executive Summary

May 2004

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1.0 INTRODUCTION

This executive summary provides a synopsis of the National Community Centers of Excellence in Women's Health (CCOE) program evaluation, sponsored by the Department of Health and Human Services (DHHS) Office on Women's Health (OWH). The CCOE program is an initiative to implement a unique, interdisciplinary, community-based model to provide services to underserved women, a historically marginalized population. The CCOE model also addresses the historical disparities in health care that have long placed women's wellness at risk. The executive summary is organized as follows:

- Section 1 introduces the content and organization of the Executive Summary;
- Section 2 provides an overview of the CCOE program and the populations it serves;
- Section 3 provides a description of the evaluation methodology;
- Section 4 summarizes the evaluation results including impact of the CCOE program, client perspectives on the program, core component scores, and best practices and lessons learned; and
- Section 5 discusses next steps for the CCOE program and provides recommendations to be taken into account for future evaluation efforts.

This is an abridged version of the full CCOE program evaluation report. For more information about the CCOE program evaluation, please contact OWH.

2.0 CCOE PROGRAM BACKGROUND

In September 2000, the OWH implemented the CCOE program in partnership with the DHHS Office of Minority Health (OMH) and the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC) Office of Minority and Special Populations. The CCOE program uses an integrative approach that links existing activities and resources, rather than creating new ones, with a community-focused organization as the nucleus for operationalizing the new model to deliver comprehensive services to women. (Federal Register, Volume 66, Number 14). The overarching vision of the CCOE program is to develop an integrated, innovative, community-based, comprehensive, and multidisciplinary care delivery system that extends quality services to women of all ages and racial and ethnic groups. Figure 2.1 depicts the CCOE model. OWH has developed eight goals for the CCOE program to support this vision and six program core components as the means of accomplishing these goals. Table 2.1 shows the eight CCOE program goals and six core components and the relationship between them. Each of the core components addresses one or more programmatic goals. Each CCOE serves as a hub or nucleus for providing services to the community, building upon community partnerships and existing activities and resources to implement the CCOE core components and achieve program goals.

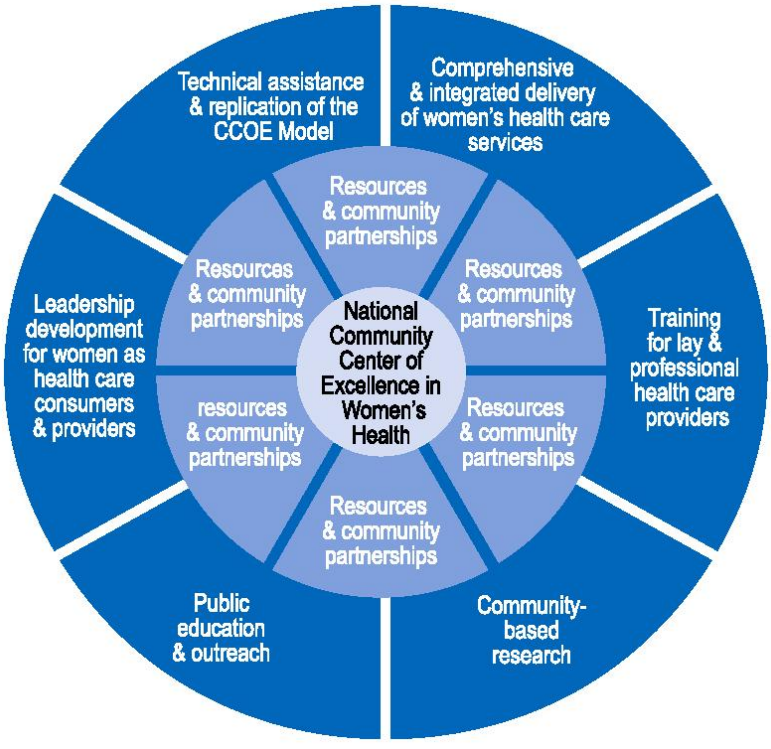
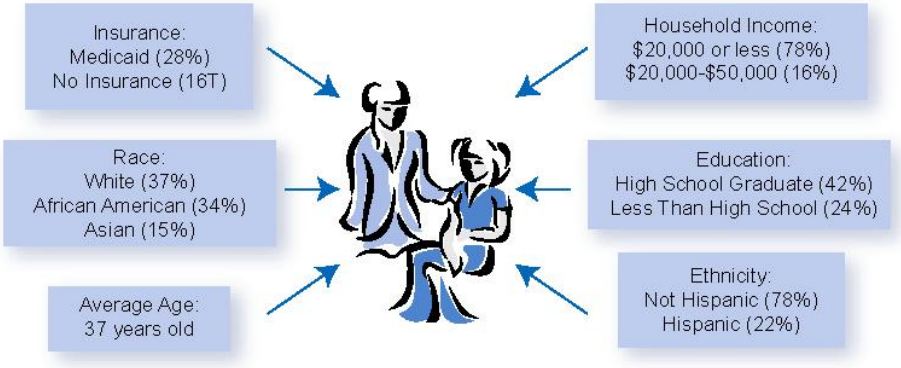


Figure 2.1 CCOE Model

Table 2.1 Relationship Between CCOE Goals and Core Components

Eight CCOE Program Goals	Six Core CCOE Program Components					
	Integrated Delivery of Women's Health Care Services	Training	Community-Based Research	Public Education & Outreach	Leadership Development for Women as Health Care Consumers/Providers	Technical Assistance/ Replication of CCOE Model
Reduce fragmentation of services and access barriers that women encounter, integrate comprehensive health services with other key components	✓					
Create healthier communities	✓			✓	✓	✓
Empower underserved women as health care consumers and decision makers				✓	✓	
Increase women's health knowledge base using community-based research			✓			
Increase the number of health professionals trained to work with underserved communities and increase their leadership and advocacy skills		✓		✓	✓	
Increase the number of young women who pursue health careers and increase leadership skills for women in the community		✓		✓	✓	
Spread success, through technical assistance, of model women's health program strategies				✓		✓
Eliminate health disparities for underserved women	✓	✓	✓	✓	✓	✓

The CCOE program is one of several DHHS-sponsored safety net programs aimed at providing services to underserved individuals. The populations served by the CCOEs differ greatly, ranging from ethnically diverse communities to ethnically uniform, and from communities with widely varied socioeconomic status (SES) to communities with uniformly low SES. The majority of the individuals in these communities fall between the gap of government-sponsored and employer-sponsored health care. They often need assistance to pay for health care services, and they live in areas that have both a shortage of health professionals and a shortage of health care organizations that provide affordable services. Figure 2.2 shows several key characteristics of the overall CCOE program client population.



All percentages presented in this graphic do not add up to a 100%. Only the most prevalent data are presented for each category of information.

Figure 2.2 The Typical CCOE Client

The CCOE program builds on community strengths, links community resources, and responds to women's health issues identified by the community. As such, each CCOE is structured around its own particular community's health needs, resources, geographic area, and community demographics. Currently 12 CCOEs exist. Each is located in disparate environments, ranging from rural to urban. In addition, the number and sophistication of community partner resources available to each CCOE vary from a few limited choices to multiple, long-standing organizations with considerable resources of their own. The available funding, preexisting infrastructure, and number and type of providers differ at each CCOE. Many CCOEs use allied health professionals as their primary care providers because of the shortage of traditional medical providers in their communities. As a result of these differences, each CCOE has implemented a unique structure and mix of services in each of the core components to fit its community. The common thread among all of the CCOEs is their support of the OWH CCOE vision and eight programmatic goals, and their implementation of the six core program components. Table 2.2 lists the CCOEs according to the year they were funded and also provides a profile of each CCOE.

Table 2.2 National Community Centers of Excellence in Women's Health Profile

	National Community Centers of Excellence	Federal Region	Location	Organization Type	Primary CCOE Client Languages
Year 1 (2000)	Mariposa Community Health Center, Nogales, AZ	Region IX	Rural	Community Health Center	English, Spanish
	Northeast Missouri Health Council, Inc., Kirksville, MO	Region VII	Rural	Community Health Center	English, Spanish
	St. Barnabas Hospital and Health Care System, New York, NY	Region II	Urban	Hospital	English, Spanish
Year 2 (2001)	Hennepin County Department of Primary Care, Minneapolis, MN	Region V	Urban	Community Health Center	English, Hmong, Laotian, Spanish
	NorthEast Ohio Neighborhood Health Services, Inc., Cleveland, OH	Region V	Urban	Community Health Center	English
	Northeastern Vermont Area Health Education Center (AHEC), St. Johnsbury, VT	Region I	Rural	Area Health Education Center	English
	Women's Health Services, Santa Fe, NM	Region VI	Urban	Community-Based Organization	English, Spanish
Year 3 (2003)	Christiana Care Health Services, Wilmington, DE	Region III	Urban	Hospital	English, Spanish
	Griffin Hospital, Derby, CT	Region I	Suburban	Hospital	English, Polish, Spanish
	Jefferson Health System, Birmingham, AL	Region IV	Urban	Hospital	English, Spanish
	Kokua Kalihi Valley Comprehensive Family Services-Ohana Women's Health and Wellness Program, Honolulu, HI	Region IX	Urban	Community Health Center	Chinese, Chuukese, English, Laotian, Marshallese, Phonpeian, Samoan, Tagalog, Thai, Ilocano, Vietnamese, Visayan
	Turley Family Health Center at Morton Plant Hospital, Clearwater, FL	Region IV	Suburban	Hospital	English, Spanish

3.0 CCOE EVALUATION METHODOLOGY

In the summer of 2003, an external evaluation of the CCOE program was undertaken to assess whether and to what extent the CCOE program as a whole was meeting the eight program goals set forth by OWH and the impact of the program on women's health care in the targeted catchment areas. The evaluation measured the extent to which the CCOE program goals had been achieved by evaluating the extent to which the six core CCOE program components had been accomplished.

Table 3.1 CCOE Program Evaluation Research Questions

Six Core Components	(Core Component) Research Question
Integrated Delivery of Women's Health Care Services	Has the CCOE program improved comprehensive health service delivery within the targeted communities?
Training for Lay and Professional Health Care Providers	How has the CCOE impacted the training of lay and professional health care providers within the targeted community?
Community-based Research	What is the impact of the CCOE program on community-based research?
Public Education and Outreach	What is the impact of the CCOE program on public education and outreach?
Leadership Development for Women as Health Care Consumers/Providers	What is the impact of the CCOE program on leadership development among women?
Technical Assistance/ Replication of CCOE Model	Has the CCOE program replicated successful models and strategies?
Program Requirements[1]	Overarching Program Requirements

These components also provided a mechanism to measure how well the CCOE program was integrating existing community health resources that supported and affected women's health, a fundamental element of the CCOE model. Research questions were developed around each of the six core components. (See Table 3.1).

Next, research subquestions were developed to define how each core component would be measured. The research subquestions were developed based on the requirements associated with each core component and areas of interest to OWH, such as integration of the core components. For example, the level of integration between each core component was measured by developing a research subquestion for each core component. These research questions and subquestions, in turn, provided the basis for the survey questions used in the evaluation data collection instruments (DCI). This evaluation framework is shown in Figure 3.1. Each level of this framework supported the overall program evaluation goals.

Figure 3.1 CCOE Evaluation Framework

A scoring process was used to assign a numerical score to each of the core component areas and research questions. These scores provide a way to quantify the extent to which the CCOE program is fulfilling each of the core components and, thus, program goals. In addition to calculating the quantitative scores, the evaluation team used a visually-coded scheme to make results easy to interpret.

[1] Program requirements are not considered a core component but are included as a study research question to address non-component related requirements for the CCOE program.

Each core component received a rating of three, two, or one circle. Each of these ratings is associated with a score range with a total possible score of 100 points. The following guidelines are used to interpret the core component scores:

- A ●●● rating indicates that the CCOE exceeded the goals or requirements for the core component. This rating corresponds to a **score of 75 to 100**.
- A ●● rating indicates that the CCOE met the goals or requirements for the core component. This rating corresponds to a **score of 51 to 74**.
- A ● rating indicates the CCOE only partially met or did not meet goals or requirements for the core component. This rating corresponds to a **score of 50 or below**.

OWH's evaluation methodology included five DCIs[2] that targeted feedback from different CCOE stakeholders. This data collection approach enabled both quantitative and qualitative information to be obtained from multiple sources, each with a different experience and knowledge of the CCOE program. The method of data collection included Internet-based surveys, site visits, interviews, focus groups, and self-reported data provided to OWH by the CCOEs. The DCIs are:

1. CCOE Director and Program Coordinator Survey
2. CCOE Community Partner Survey
3. CCOE Patient Survey
4. CCOE Site Visit Protocol
5. CCOE Quarterly Reports to OWH and Other Required Reporting.

The data from the five DCIs were collected during a 5-month time frame (August–December, 2003). All CCOEs and a majority of their partners and clients took part in the evaluation.

[2] For more information or to obtain copies of the CCOE Evaluation DCIs, the evaluation methodology, and other planning tools developed to support the evaluation effort, please contact OWH.

4.0 SUMMARY OF CCOE EVALUATION RESULTS

4.1 CCOE Program Impact

The results from the CCOE evaluation baseline the extent to which the CCOE program is meeting its goals. The results provide a snapshot of the entire CCOE program and the impact it is making on the twelve communities it serves at *one specific point in time*. This impact is documented through qualitative and quantitative data that captures what is happening in the CCOE communities. While this evaluation did not assess health status changes in CCOE women who participated in the CCOE program, there was substantive evidence that the CCOE program is currently impacting the community and CCOE clients it is serving. The impact was noticeable in a variety of ways, each of which is discussed below:

Impacts:

- Enrollment and participation in the CCOE program.
- Individual success stories.
- Heightened awareness of the importance of health care.
- Integrated partnerships with community organizations.
- Empowering the whole woman.
- Client's perception of care.
- Impacted women through multiple CCOE core components.

- **Enrollment and participation in the CCOE program.** The CCOE programs help women to locate and receive health care services and information. Education, outreach, training, and leadership development opportunities provide points of contact between CCOE staff, community partners, and potential clients. Through these interactions, the CCOEs are able to make women in their community aware of the services available to them, and women are then able to find the care and services they need.

- **Individual success stories.** In all of the CCOEs, there are success stories that demonstrate the power of the CCOE's ability to link women to critically needed services and information that they would otherwise not be able to access.

- **Heightened awareness of the importance of health care.** CCOEs take many steps to increase women's awareness of the importance of health care. Many programs develop tips, tricks, or take-home tools that make women more aware of how they can take steps to manage their own health.

- **Integrated partnerships with community organizations.** CCOEs have worked hard to build good working relationships with community partners who share the same goals of improving health outcomes for women in their communities. CCOEs have broken down barriers that previously prevented diverse organizations from working together.

- **Empowering the whole woman.** Many CCOEs report that before they can adequately address their client's health care needs, they need to address the woman as a whole. Self-confidence and self-assurance are often needed before women can find the courage to seek health services.

- **Client's perception of care.** On the CCOE Participant Survey, CCOE clients were asked, what they thought about the services they received at the CCOE. Overall, CCOE clients are very happy with the services they receive.

- **Women affected by multiple CCOE core components.** Overall, services offered in each of the CCOE core components demonstrate an impact on CCOE women and communities. In each core component, activities that address women's health from multiple angles and perspectives are taking place. Therefore, components of the CCOE program appear to be well integrated.

4.2 Client Perceptions of the CCOE Program

CCOE clients, at each of the CCOEs, were invited to complete the CCOE Participant Survey. The results of this survey reflect the clients' perceptions of their experience at the CCOE. A total of 1,636 CCOE clients, mostly between the ages of 18 and 45, responded to the survey. Figure 4.1 and Figure 4.2 provide detailed information on the age range of clients and percent of visits. Twenty percent of the clients have been to the CCOE eight times or more (n=640)[3]. More than one-third (39%) of the CCOE clients have heard about the CCOE program from friends or a family member, while almost half of the clients have heard about the CCOE program through other means such as their health care provider or CCOE staff member (46%) (n=1,485).

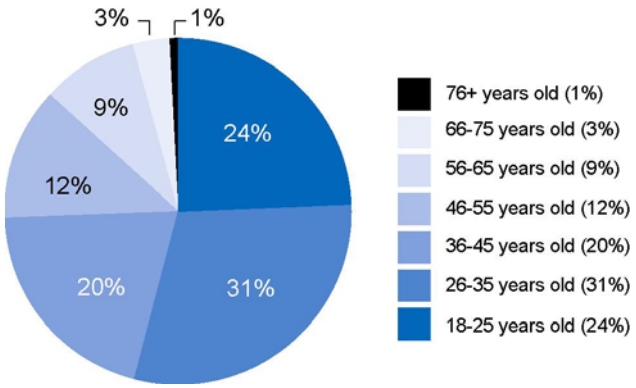


Figure 4.1 Age Range of CCOE Clients

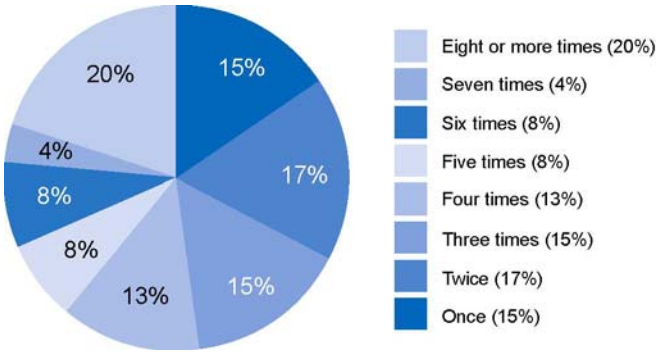


Figure 4.2 Percent of CCOE Visits

Overall, CCOE clients are satisfied with CCOE services. The CCOE clients believe they can trust the health professionals at the CCOE (91%, n=1,576), although CCOE clients of Hispanic ethnicity trust health professionals slightly less (88%, n=241). CCOE clients believe they are treated with respect at the CCOE (97%, n=1,607), they are able to speak to someone in their native language (95%, n=1,589), and the CCOE staff are courteous (94%, n=1,586). Clients report that the CCOE is easy to access (88%, n=1,567), regardless of women's income or age. It is slightly more difficult for women who self-reported that they are in "poor" or "very poor" health to access the CCOE (70%, n=102) than it is for their healthy counterparts. Almost all (98%) of CCOE clients would recommend the CCOE to family or friends (n=1,515).

[3] N= the number of CCOE clients who provided data for this survey question.

CCOE clients have the most interaction with the CCOE through its health care services core component (n=1,365). The top three reasons for health care visits for CCOE clients are follow-up care (28%), routine exams (27%), and prenatal or postpartum exams (26%) [n=1,365]. The CCOE provides gynecological and general health care to 93 percent of their clients. In addition, CCOE clients are highly satisfied with the overall quality of care provided by the CCOE and with how well their care is coordinated. However, 40 percent of CCOE clients indicated that they have to provide the same information more than once. Figure 4.3 presents the service provided at the CCOE.

A majority of CCOE clients (78%, n=1,566) have a regular provider at the CCOE. The CCOE clients who have been to the CCOE three times or more are slightly more likely to have a regular provider at the CCOE (84%, n=424). CCOE clients without insurance are less likely to have a regular provider (63%, n=209), and the 18–25 age group is also slightly less likely to have a regular provider (70%, n=340).

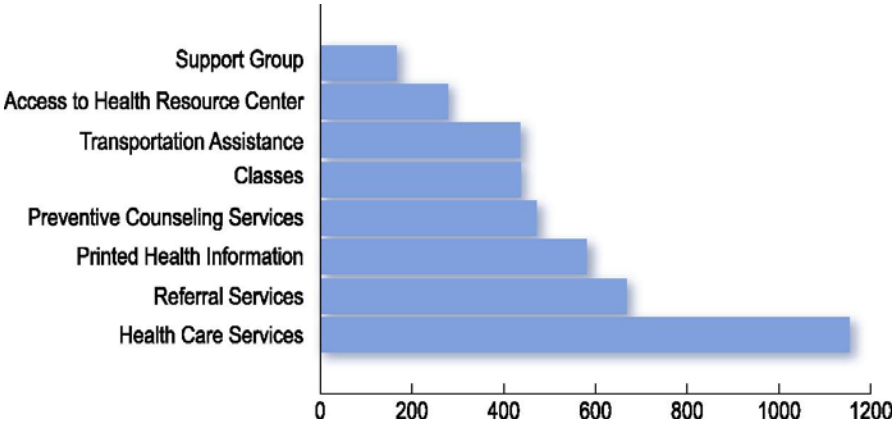


Figure 4.3 Services Received at the CCOE

4.3 Core Component and Overarching Program Requirements

Overall the CCOE program is meeting the goals and objectives set forth by OWH. However, individual CCOEs vary in how well they are performing against each of the individual core components. Table 4.1 summarizes how the CCOE program, as a whole, is performing against each of the CCOE core components.

A total of 100 points was assigned to each component. The CCOEs scored between 58 - 84 points in each of the six core components. The CCOE program is achieving its program goals for all of its components. They exceeded the goals or requirements for the comprehensive and integrated delivery of women's health care services, training for lay and professional health care providers, public education and outreach, and other program requirements. They are meeting the goals and requirements for the community-based research, leadership development for women as health care consumers and providers, and technical assistance and replication of the CCOE model.

These scores take into consideration subtleties that are a part of each of these core components. Subtleties are addressed through research questions and their associated subresearch questions that address different aspects

Table 4.1 CCOE Program Core Component Performance

CCOE Core Components	Score	
Comprehensive and integrated women's health care services delivery	76	●●●
Training for lay and professional health care providers	84	●●●
Community-based research	73	●●
Public education and outreach	83	●●●
Leadership development for women	58	●●
Technical assistance (TA) to support replication of successful models and strategies	66	●●
Other Program Requirements	86	●●●

of the core components. Each score, except for other program requirements, considers the level of integration between the core components and other components.

Comprehensive and integrated women's health care services delivery

Overall, the CCOE program exceeds the goals of delivering comprehensive and integrated health services to the targeted CCOE communities. The overall average component score for **Comprehensive and Integrated Women's Health Care Services Delivery** is **76** out of 100 points. This score indicates that the CCOE program is impacting local communities by improving access to and integrating health care services. CCOEs impact communities and improve the comprehensive, interdisciplinary health services available to women by removing or lessening barriers between health care providers and community partners, by making women and communities more aware of the services available to them, and by focusing on providing comprehensive, interdisciplinary health care to all women.

Training for lay and professional health care providers

Overall, the CCOEs exceed the goals for impacting the training of lay and professional health care providers within the targeted communities. The overall average component score for **Training for Lay and Professional Health Care Providers** is **84** out of 100 points. This score indicates that the CCOE program is impacting the training available to lay and professional health care providers within CCOE communities by providing training on topics of importance and relevance to their communities, by focusing on the multiple points of contact individuals may have with health care providers, and by incorporating training with the overall CCOE mission and goals.

Community-based research

Overall, the CCOE program meets the community-based research goals, although there are opportunities to enhance community research activities in CCOE communities. The CCOE program has provided a focus and a reason for the CCOEs to identify health issues that should be investigated to better understand and provide care to their participants and their community. The overall average component score for **Community-Based Research** was **73** out of 100 points. CCOEs are conducting community-based research, both independently and with the help of partners and outside organizations, and they are using this research to improve the health care provided to women in their communities. Based on research results, CCOEs are making decisions about what programs and services they need to focus on or provide.

Public education and outreach

Overall, the CCOE program exceeds the goals and requirements for the educational and outreach component. CCOEs are impacting local communities by educating women about topics important to them and in a manner that encourages women to improve their health care. The overall average component score for **Education and Outreach** is **82** out of 100 points. This score indicates that the CCOE program is exceeding the education and outreach goals of the CCOE program. All CCOEs have high average scores for this component. The research subquestions for this component include the educational events and activities sponsored by the CCOE program, the educational materials used by the program, the amount of community input solicited by the CCOE program, and the level of integration of the education and outreach core component with other components. The research

subquestions do not differentiate between educational activities and materials versus outreach activities; however, the two topics are summarized separately in the full report.

Leadership development for women

Overall the CCOE program meets the goals and requirements for the leadership development component, but there is an opportunity to further expand activities within this core component. The average component score for **Leadership Development** is **58** out of 100 points for the CCOE program. The research subquestions that feed into this score include the leadership approach of the CCOE, the number and type of opportunities for women and girls to take leadership roles, the number and type of opportunities that encourage women and girls to enter the health field, and the level of integration of the leadership development core component with other components.

Technical assistance to support replication of successful models and strategies

Overall, the CCOE program is fulfilling the activities included in the technical assistance and replication core component. All CCOEs performed one or more of the technical assistance activities; however, only one performed all of the activities described in the technical assistance and replication table. Only two CCOEs have made noticeable progress with their replication site. The overall average component score for **Technical Assistance and Replication** is **66** out of 100 points. The research subquestions impacting this score include activities performed to support a replication site, the number and type of technical assistance activities performed by the CCOE, the development or dissemination of technical assistance (reference) materials, and the level of integration of the technical assistance and replication core component with other components.

Program Requirements

Overall, the CCOE program successfully exceeds the CCOE program requirements. The overall average component score for **Program Requirements** is **86** out of 100 points. The research subquestions for this component include how well have services met the needs of culturally diverse CCOE women, is the CCOE's advisory board well rounded, does the CCOE have methods to improve or expand the awareness of the program to the public, and do funds provided by OWH contribute to a positive outcome for the program. All CCOEs complied with OWH requirements during the evaluation. The CCOEs also complied with other program requirements, such as submitting quarterly and yearly progress reports, participating in the national evaluation, and conducting a local evaluation.

4.4 CCOE Program Best Practices and Lessons Learned

Variances in the environment, existing infrastructure and resources, populations served, and strategies used at each individual CCOE results in each CCOE having its own unique set of strengths and weaknesses. However, across the CCOE program, there are several areas where many of the CCOEs have had similar successes, faced similar obstacles, and where the resulting best practices and lessons learned are applicable to the CCOE program as a whole. These results may serve best as a tool to inform and shape future CCOE planning.

4.4.1 Success Areas and Best Practices

The three types of personnel most commonly referenced as critical to the success of the CCOE program include the CCOE Center Director, CCOE Program Coordinator, and, where implemented, community health workers.

Key CCOE Program Personnel: Center Director

The CCOE Center Directors, in most cases, have been instrumental in obtaining the CCOE grant. They are often physicians and/or are already serving in leadership capacities within the CCOEs' parent organizations. They leverage their existing leadership role and connections within the medical and social services communities to build the partnerships that form the basis of the CCOE program at each site. The most effective CCOE Center Directors serve as advocates for the CCOE program within their parent institutions and within the community and help set the strategic direction for their CCOE program.

Key CCOE Program Personnel: Program Coordinator

Successful CCOE Program Coordinators have many common attributes. These include a commitment and connection to their community, strong leadership skills, the ability to coordinate and bring multiple organizations with varying goals and objectives together toward a common goal, and strong communication skills. Because these individuals are responsible for day-to-day administration of the CCOE, they are often seen as the face of the CCOE program by the community partners.

Key CCOE Program Personnel: Community Health Worker (CHW)

CCOE program staff and partners view the CCOE's use of CHWs to be another innovative success at the sites where they were used. CHWs are lay advocates or advisors who educate and lead individuals and groups in their communities to attain increased health and well-being. They act as bridges between the community and the providers of clinical health care services. CHWs help women in the community to feel more comfortable about coming to the CCOE to receive care, to take part in CCOE activities, to be more receptive to the advice and information provided to them by the CCOE, and they also add a personal touch to the CCOE that make it more welcoming and friendly.

Women trained as CHWs receive the benefits of training and experiences that provide them a tangible skill set that they can leverage in other areas of their lives and use to further their own career and leadership development. Many said that the training they receive helps them understand the importance of healthy lifestyles and preventive behaviors in their own day-to-day living.

Community Partnerships: Building Strong Partnerships Early

Because partnering to provide comprehensive, multidisciplinary, and integrated health care services to the community is an integral part of the CCOE model, the earlier these working relationships are established, the sooner the CCOE can begin realizing an impact on its surrounding community. There are several examples of methods used by various CCOEs to build strong partnerships early.

The first and most common practice among the CCOEs is to capitalize on previously existing relationships between the CCOE's parent organization and the partner groups to create partnerships specifically for the CCOE program. The benefit of this practice is that the relationship between leadership and key staff is often already established, which means that there is already a common understanding of the capabilities and goals of both organizations and a level of trust. This helped the CCOE get off to a faster start. Another critical practice articulated and practiced by several CCOEs is the inclusion of partners in the development of CCOE activities, either informally or through their

Advisory Boards. This serves to make partners feel more a part of the CCOE program and to take ownership of the ideas and services offered through the CCOE, thus improving their level of participation and the overall implementation of CCOE activities and services to the community.

Community Partnerships: Formalization of Partnerships

Use of memoranda of understanding (MOU) with partner organizations is inconsistent across the CCOEs. Several CCOE staff and partners without MOUs believe they do not need such formalized partnerships and, instead, rely heavily on personal relationships to conduct joint activities. CCOEs that have MOUs believe they are necessary to develop a shared understanding of the goals and responsibilities associated with the partnership or to add specificity to contracting relationships. Use of MOUs occurs most often when the parent organization of the CCOE is a large entity such as a hospital system or health department, most likely as a requirement of the parent organization.

Without strong working partnerships and integration among partner organizations, the CCOE program is limited in its ability to provide a full range of critical services and to reach out to the community.

While MOUs are not necessary for a successful partnership, they may be beneficial. Reliance on personal relationships alone can lead to setbacks and deterioration of partnerships when staff turnover at either the CCOE or the partner organization occurs. When MOUs are not used, the most successful partnership models are those in which partnerships remain strong in spite of staff turnover, as a result of partners' investments in and commitment to the mission, vision, and goals of the CCOE. Since an organization's long-term commitment to the CCOE may not be clear when they first become a partner, the use of a MOU is a best practice that can help avoid setbacks by clearly defining the relationship and commitments of both parties.

Community Partnerships: Communication Among Partners

The formality, form, and frequency of communication among partner groups and CCOEs vary across all of the sites. Regardless of the approach used, the common theme that emerged during the site visits was that ongoing, consistent communication is critical in making sure that CCOE activities remain a focus for the CCOE partners. Partners that articulated that infrequent or minimal communication occurs also displayed a "disconnect" or lack of understanding of the CCOE program, its goals and objectives, and of ongoing activities. Partners that have a strong working relationship with their CCOEs identified factors such as their participation in their advisory board, strong interactive program coordinators, and the most important factor—excellent communication—as the reasons why the relationship is so successful.

Coordinating activities across multiple organizations can be challenging. Some CCOEs are exploring strategies such as sending regular updates, newsletters, or meeting minutes via e-mail or postal mail to CCOE partners to ensure that they are all kept aware of ongoing activities and meetings. Regardless of the approach used, frequent and meaningful communications with partners is a key to success for several CCOEs and should be a customized best practice employed by each CCOE.

Community Partnerships: Common Mission and Commitment to Community

The most common element mentioned by the CCOE staff and partners as critical to the success of the CCOE is a commitment to the community. Several CCOEs stated that their partnerships (and the resulting services or activities offered in conjunction with these partners) are strongest with organizations that have both a mission and staff members with a commitment to helping women in the community. These organizations are often more active in their partnership with the CCOE, most likely

because of the opportunity to have an increased impact in the community through their partnership with the CCOE.

Equally important is a commitment to impacting the community through one or more of the CCOE components. Finding organizations that have both missions and staff commitment in line with CCOE objectives is not an easy task. However, looking for both of these characteristics when building partnerships is a best practice currently used by several CCOEs, which should be kept in mind for future CCOE partnership development efforts. Without them, partnerships that may seem to be perfect fits on paper can be just the opposite in reality.

Finding organizations that have both missions and staff commitment in line with CCOE objectives is not an easy task. However looking for both of these characteristics when building partnerships is a best practice currently used by several CCOEs, which should be kept in mind for future CCOE partnership development efforts.

Characteristics of a Effective CCOE Advisory Board

All of the CCOEs have an advisory board as part of their organizational structure; however, the structure of the boards, frequency of meetings, and their intended use vary. No specific model or format stands out as better than the rest. However, several successful practices were articulated throughout the site visits that can be considered best practices for managing an advisory board. These include having regularly scheduled advisory board meetings and making sure all members of the advisory board are aware of the schedule, time, and place of these meetings; clearly articulating the mission, goals, and objectives of both the CCOE and of the advisory board and having meeting agendas so that all members are clear on the purpose of the meeting; and using a portion of the meeting to allow networking among partner organizations and/or to allow an individual partner organization to showcase its services.

Both partners and CCOE staff believe these practices strengthen the quality of the advisory board meetings and, as a result, also strengthen the working relationship among the community partner organizations and the CCOEs.

4.4.2 Opportunities for Improvement and Lessons Learned

Building an Internal Understanding of the CCOE

One lesson learned by several of the CCOEs is the importance of building awareness and understanding of the CCOE, not only in the community and with partners but also within the CCOE's clinical care center. Services will be underutilized until knowledge of the CCOE, its services, and how it can be leveraged become a recognized and relied-upon part of the body of resources available within the CCOEs' clinical care center. Some CCOEs discovered that their physicians and staff are aware of the CCOE but do not always remember to refer women for CCOE services.

Several CCOEs recognize that they have to make an effort to build awareness, understanding, and a reliance on the CCOE within their parent organizations and develop strategies to improve awareness of the CCOE among the physicians and staff at the institutions housing their clinical care center. These CCOEs increased enrollment and referrals as a result of their efforts.

Competing Priorities with Parent Institutions

Many of the CCOEs are part of large, well-established institutions such as hospital systems. These CCOEs gained the support of their parent organizations and established agreements with them to

support the CCOE when submitting their proposals to become a CCOE. While these CCOEs have benefited from having resources such as information technology systems and (in some cases) extra funding available to them through their parent institution, the staff at these CCOEs cited several frustrations as well. The frustrations centered around two main issues: the amount of bureaucracy and red tape that the CCOEs must navigate through to make progress or accomplish tasks in these large institutions, and the problems that arise when there are differences between the CCOE and parent organization's values and priorities. Both of these issues can be obstacles for the CCOEs in terms of getting approval for certain activities, requisitioning supplies and resources, and sometimes limit their partnering choices and methods for implementing components of their program.

One suggestion voiced by several CCOE staff was to better define the CCOE's relationship with the parent organization. This can occur through development of formal guidelines or procedures to support day-to-day operations such as requisitioning supplies, hiring CCOE staff, or establishing partnerships to support CCOE efforts. Another suggestion was to designate an individual to serve as a liaison with the parent organization so that clear and direct channels of communication are available to expedite decisions and approvals. In most cases, the CCOE Center Director serves this role.

Succession Planning/Institutionalizing Knowledge

Because community-based organizations and small programs such as the CCOE are often limited in resources and infrastructure support, they tend to rely heavily on their personnel to make their programs a success. One of the pitfalls of this reliance is the loss of institutional knowledge when a staff member transitions to a new role or leaves the program. This has happened several times in the 3-year history of the CCOE program, and in several cases, has had serious negative repercussions for the individual CCOE. The importance of documenting knowledge and sharing it among partners and staff is a key lesson learned for the CCOEs.

Dynamic, committed individuals can compensate for some of the resources the organization may lack. One of the pitfalls of this reliance is the loss of institutional knowledge that occurs when a staff member transitions to a new role or leaves the program.

Tracking CCOE Clients: Variability in CCOE Client Identification

While the CCOEs can identify the majority of their clients, one of the challenges they face is effectively and consistently identifying their entire client base. Many of the women who are formally enrolled in the CCOE program are not always identified when receiving services or attending CCOE activities.

In some cases, it is because of the difficulty of asking CCOE patients to identify themselves at venues such as seminars, health fairs, or other large events. In other instances, it is because CCOE staff and partners do not always consistently ask whether the woman is a CCOE client. In many cases, it is because the women themselves do not want to be identified or are difficult to track. They may provide false names, inaccurate contact information, or just fail to respond to CCOE attempts to follow up with them. This often happens with victims of abuse who want their search for care or support to remain unknown. This is also common with immigrant and undocumented populations. Often these groups are distrustful of organized institutions because of inherent cultural biases or fear of authority because of questionable legal status or are uncomfortable because of language barriers. Virtually all of the CCOEs serving these population groups have expressed difficulties in identifying and tracking individuals from these populations.

No solution can completely solve the problem of identification of CCOE women. Developing program-wide guidelines and finding customized strategies to deal with these issues should be a consideration for the future.

Tracking CCOE Clients: Tracking Systems

All of the CCOEs implemented mechanisms to identify their CCOE clients and to track their referrals and participation in CCOE activities. However, accurate and consistent identification of CCOE women can be challenging as described above.

Many of the CCOEs implemented tracking solutions within their clinical care facilities but have problems accurately tracking receipt of services outside of these facilities. Developing tracking solutions that are easily implementable in such disparate locations is not easily achievable. Another issue with tracking outside of the CCOE clinical care facility is that partner organizations often have their own record keeping and tracking systems that are not compatible with the solution the CCOE has in place. This is a problem both when that solution is manual and when it is automated, and results in difficulty in managing and tracking referrals and sharing relevant data among providers. Sharing patient information among providers is also difficult because of the need to obtain a release from the CCOE client to share information with other organization as required by the recent Health Insurance Portability and Accountability Act (HIPAA) regulations.

Several CCOE staff stated that they lack sufficient resources to research and implement a comprehensive solution. Others said that they would like to see additional and more specific guidance from OWH on what information needs to be tracked and why this information is important so they can tailor their tracking systems accordingly. Developing a customized and adequate tracking solution is yet another area for improvement for the CCOE program—one that the CCOEs continue to address on an individual basis and make improvements upon as specific problems are uncovered and addressed.

5.0 DISCUSSION

5.1 Future of the CCOE Program

The CCOEs continue to make strides in achieving program goals. Each year, the CCOEs continue to increase their reach to women in their communities, expand and improve their partnerships and service offerings, and to positively impact women's health and well-being. While conducting the CCOE evaluation and analyzing data, several topics worthy of further consideration were identified. These topics are all particularly relevant to the future of the CCOE program and are discussed below.

In the future, OWH and the CCOE applicants should consider the amount of time and effort required to implement the core components. Keeping these factors in mind, they should explore options to improve the level of integration among the core components and the time required to accomplish the integration.

CCOE Model Integration

The CCOEs, often in conjunction with one or several partner organizations, are focused on developing the services needed to fulfill each core component. Some have been better at implementing their health care services delivery component, and others have been better with developing their training and education programs. Similarly, each individual CCOE has made varying degrees of progress in integrating the services and activities offered through each core component of the CCOE model. Education and outreach, training, and leadership development are the three core components that are naturally integrated. The CCOEs' offerings in these three areas reflect that ease of integration. Community-based research and technical assistance are not as naturally integrated and have experienced a lesser degree of integration with the rest of the core components.

Implementation of all six core components within the first year of the program can be a very daunting task, especially when the limited funding and resources available to many of the CCOEs are considered. In the future, OWH and the CCOE applicants should consider the amount of time and effort required to implement the core components. Keeping these factors in mind, they should explore options to improve the level of integration among the core components and the time required to accomplish the integration.

CCOE Program Evolution

The CCOE program is a pilot-initiative that is implementing a unique model to address women's health care in a community-based setting. All three of these factors imply a certain degree of experimentation. Pilot-initiatives function under limited funding until the concept they are implementing has been shown to be successful. They often serve as guides to future efforts. Implementation of a unique model often requires trial and error until successful practices have been identified. Community-based initiatives often have limited funding, infrastructure, and resources, and, as a result, are reliant on local leadership, partnerships, and ingenuity to develop creative approaches to accomplish goals. As a result of these three factors, the CCOE program has evolved in its first 3 years of existence and continues to do so as both the CCOEs and OWH gain a better sense of what works well and what does not when implementing the CCOE model. Each year, the CCOE program announcement to solicit new grants has been refined based on lessons learned. Thus, while each cohort of CCOEs is implementing the same basic CCOE model, they have each responded to an announcement that has varied in emphasis and language and thus have implemented their programs

slightly differently as a result. The CCOE program will continue to build upon lessons learned and refine program guidance and requirements to improve the program's impact on women's health and well-being and to ensure the continuity of quality programs that deliver efficient and effective care.

Funding and Sustainability

Several CCOEs were asked about their plans for sustainability to gain insight into their sustainability strategy. Information from the CCOE How To Manuals provided additional information on this topic. Sustainability of the CCOE program is an important topic to consider when discussing the future of the CCOE program because there is a limit to OWH's support of the program. The majority of the CCOEs have had varying degrees of success in leveraging funding and support for their efforts. In several instances, the CCOE has a strong indication that it can expect to continue leveraging funds and support from these institutions after the CCOE grant has ended.

> How activities and services are institutionalized will determine whether the CCOE model of integrated and comprehensive health care service delivery survives.

However, this is not the case across the board. Some CCOEs are still in the planning stages of trying to determine how to sustain their programs after the CCOE grant ends. Other CCOEs have expanded their definition of sustainability beyond simply looking for additional funding. These programs are working to institutionalize their efforts past the life of their grants. In these cases, the CCOEs plan to integrate several of the services offered through the CCOE into the service offered by their parent organization and/or partners. Succession planning and institutionalizing knowledge is another key method to help ensure sustainability. To avoid loss of knowledge resulting from staff turnover, CCOEs should document processes, resource information, and other critical information.

5.2 Future Evaluation Efforts

The CCOE evaluation established a baseline of performance for the CCOE program, and as such, has provided a snapshot of CCOE activities and performance. Future evaluation efforts should use the data and findings from this evaluation as a comparison point so that progression toward program goals can be assessed over time.

Future CCOE evaluation efforts should consider using comparison populations to evaluate CCOE performance. Comparing CCOE client perceptions of their own health and of their experiences in receiving health care and other services from the CCOE to a comparable population's perceptions of these same points of interest can provide powerful data that can help OWH demonstrate the impact the CCOE program is making on women's health and on women's lives. The unique characteristics of each individual CCOE population make this a difficult task. Since the intent of this evaluation effort was to establish a baseline of CCOE performance, it was not considered a significant limitation for this study. However, OWH is planning to conduct a comparison study to identify populations that are comparable to the CCOE client populations so that a comparison client group can be incorporated into future CCOE evaluation efforts.

Future evaluation efforts should also consider assessing the CCOEs on a cohort-by-cohort basis so that when the evaluation is conducted, each CCOE being assessed is at a similar point in development. This will allow OWH to tailor evaluation research subquestions and survey instruments to the specific guidance provided to that particular cohort of CCOEs. Still taking into account the unique approach to implementing the CCOE model that each CCOE is taking, it will also allow some level of comparison among the CCOEs within an individual cohort.

Using a weighted scoring methodology is one additional approach that a future CCOE program evaluation should consider. The current scoring process assigned equal weight to each of the CCOE research subquestions for a given core component. OWH might consider whether the requirements associated with each core component are of equal value or whether weight should be assigned to the requirements based on a more complex algorithm. Based on their assessment, the research subquestions in the evaluation framework can be weighted accordingly and, thus, the overall quality of assessment for the CCOE evaluation can be improved upon.