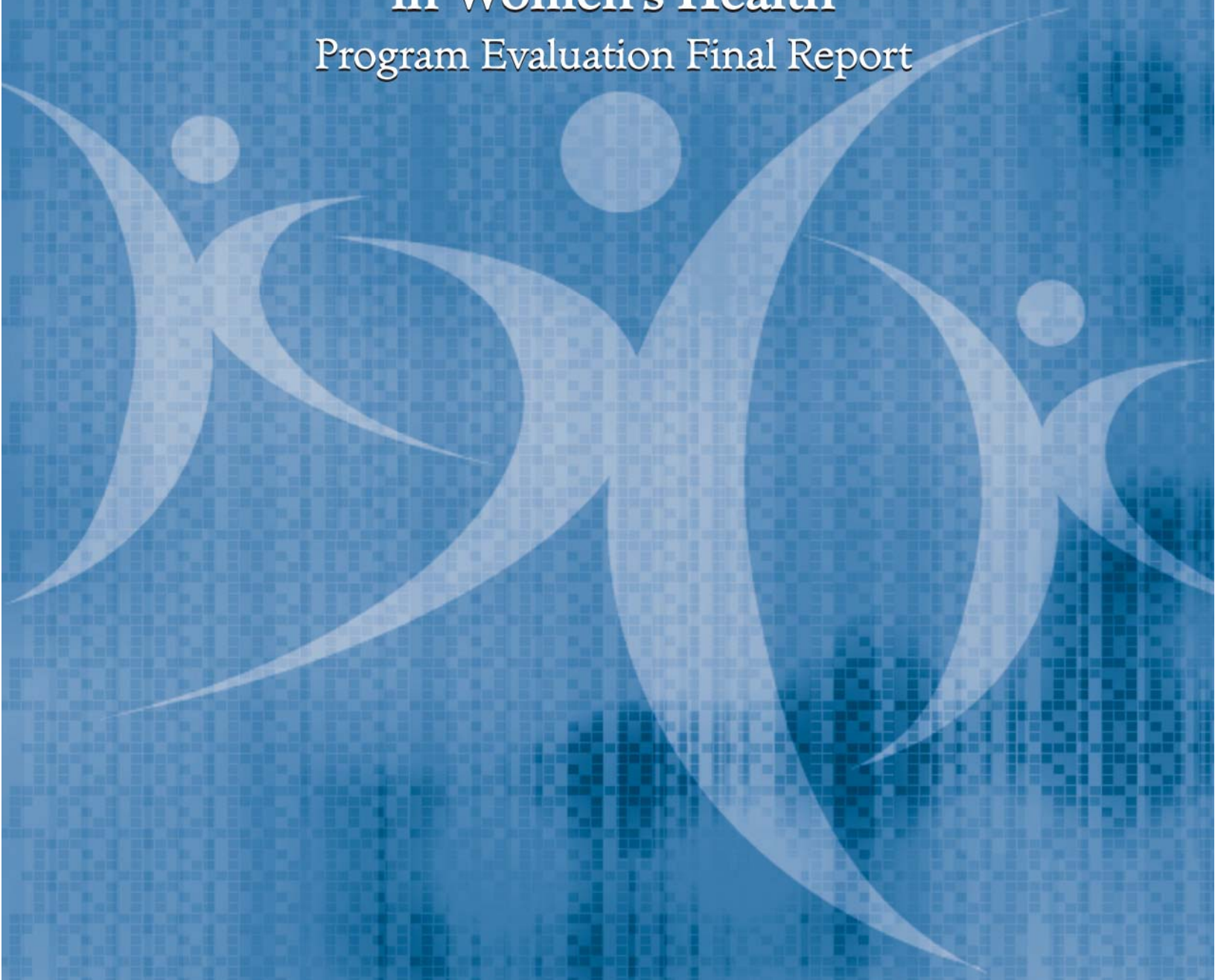
National Community Centers of Excellence in Women's Health

Program Evaluation Final Report



U.S. Department of Health and Human Services
Office on Women's Health

National Community Centers of Excellence in Women's Health

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ABSTRACT

In September 2000, the Department of Health and Human Services (DHHS) Office on Women's Health (OWH) implemented the National Community Centers of Excellence in Women's Health (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 (formerly the Office of Minority and Women's Health). The intent of the CCOE program is to integrate, coordinate, and strengthen linkages between programs and activities that already exist in the community to improve service delivery to underserved women. The coordination of these activities should reduce fragmentation in women's health services. Community-based organizations serve as the hub for the implementation of this new model of care. (Federal Register, Volume 66, Number 14). Currently, 12 CCOEs serve underserved communities across the United States in locations ranging from densely populated urban settings to very rural and isolated communities.

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 program goals and making an impact on women's health in the targeted catchment areas. OWH identified the following six core CCOE program components as the means for accomplishing these goals:

1. Comprehensive and integrated delivery of women's health care services
2. Training for lay and professional health care providers
3. Community-based research
4. Public education and outreach
5. Leadership development for women as health care consumers and providers
6. Technical assistance and replication of the CCOE model

The evaluation measured the extent to which the CCOE program goals were being achieved by evaluating the extent to which the six core CCOE program components were being accomplished and integrated.

The evaluation methodology approved by OWH included five data collection instruments (DCI) that that were used to obtain feedback from different CCOE stakeholders, including CCOE leadership and staff, partners, and clients. The data collection approach allowed both quantitative and qualitative information to be obtained from multiple sources, each with a different experience and knowledge of the CCOE program. It included the use of Internet-based surveys, site visits, interviews, focus groups, and self-reported data submitted to OWH by the CCOEs.

A total of 1,636 CCOE clients, most between the ages of 18 to 45, responded to the participant survey. Twenty percent of these clients received services from the CCOE eight or more times (n=640) within the past year. Most received health care services. CCOE clients responding to the survey reported having access to general health care services, in addition to women-centric services such as gynecological care (94 percent, n=1217). CCOE clients were highly satisfied with the overall quality of care provided by the CCOE and with how well their care was coordinated. Almost all CCOE clients (98 percent) would recommend the CCOE to family or friends (n=1515).

Overall, the CCOE program is meeting the goals and objectives set forth by OWH. This is demonstrated through increased enrollment and participation in the CCOE program, a multitude of individual CCOE client success stories, heightened client awareness of the importance of health care, integrated partnerships with community organizations, success at empowering women, and positive client perceptions of care.

Additionally, the CCOE program continues to demonstrate its impact on women through the successful development of the CCOE core components. The CCOE program is achieving its program goals for each of its core components. The CCOE program is exceeding 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.

The evaluation team identified three areas that the OWH should consider when planning the future of the CCOE program.

- First, OWH should consider the amount of time and effort required to get the core components up and running and, keeping this in mind, explore options to improve the level of integration among the core components and the speed with which integration is accomplished.
- Second, OWH should consider how the CCOE program has evolved during its first three years of existence and how it continues to evolve as the CCOEs and OWH gain a better sense of what works well when implementing the CCOE model and what does not. Within this context, the OWH should continue building on what it has learned from the existing CCOEs and refine the CCOE program guidance and requirements to improve the program's impact on women's health and well-being and to ensure the efficiency and continuity of the program.
- Third, although searching for other funding sources is the first approach many of the CCOEs are taking to try to sustain their program after OWH funding ends, the OWH should be aware that not all CCOEs have been successful in finding additional funding. If they have not already done so, CCOEs should consider exploring more nontraditional methods to achieve sustainability. For example, the institutionalization of services and staff positions. Additionally, succession planning and institutionalization of knowledge are practices all CCOEs should implement to prepare for the future.

1.0 BACKGROUND

1.1 CCOE Program Background

The Department of Health and Human Services (DHHS) Office on Women's Health (OWH) implemented the National Community Centers of Excellence in Women's Health (CCOE) program in September 2000 in partnership with the DHHS Office of Minority Health (OMH) and the Office of Minority and Special Populations (formerly the Office of Minority and Women's Health) in the Bureau of Primary Health Care, Health Resources and Services Administration (HRSA). The concept for the CCOE program is based on the National Centers of Excellence in Women's Health (CoE) program. The CoEs have been functioning in academic health centers since 1996.

Similar to the CoE program, the CCOE program uses an integrative approach that focuses on linking existing activities and resources, rather than creating new ones, with a community-based organization as the nucleus of operation for the new model. (Federal Register, Volume 66, Number 14) The intent of the CCOE program is to integrate, coordinate, and strengthen linkages between programs and activities that are already under way in the community to improve service delivery to underserved women. This should reduce fragmentation in women's health services and activities.

The overarching vision of the CCOE program is to develop an integrated and innovative community-based multidisciplinary, comprehensive care delivery system that extends quality services to women of all ages and racial and ethnic groups. The term "women's health care" also embraces the challenges of overcoming cultural and economic barriers to good health for all women through education and the provision of health care to disadvantaged women. *Healthy People 2010*, developed by the Office of the Surgeon General, is a set of health objectives for the nation to achieve during the first decade of the 21st century. It notes that most successful community health initiatives involve multiple disciplines and interventions, linking community strengths and resources so that the whole is indeed greater than the sum of its parts. The CCOE program links community resources that address women's health to increase awareness and knowledge and to advance women's health efforts more efficiently. (Federal Register, Volume 66, Number 14) The CCOE program's emphasis on the needs of underserved women also supports the national effort to eliminate health disparities due to age, gender, race and ethnicity, education, income, disability, or rural location — one of *Healthy People 2010* goals.

The CCOE program links community resources that address women's health activities and disciplines used to increase awareness and knowledge and to advance women's health efforts more efficiently.

(Federal Register, Vol. 66, No. 14)

Initially, the OWH developed the following eight goals for the CCOE program to support this vision:

1. Reduce the fragmentation of services and access barriers that women encounter using a framework that coordinates and integrates comprehensive health services with research, training, education, and leadership activities in the community to advance women's health.
2. Create healthier communities with a more integrated and coordinated women's health delivery system targeted to underserved women.
3. Empower underserved women as health care consumers and decision makers.

4. Increase the women's health knowledge base using community-based research that involves the community in identifying research areas that address the health needs and responds to issues of concern to underserved women.
5. Increase the number of health professionals trained to work with underserved communities and increase their leadership and advocacy skills.
6. Increase the number of young women who pursue health careers and increase the leadership skills and opportunities for women in the community.
7. Spread the successes, through technical assistance, of model women's health program strategies and latest innovations to communities across the country, and through replication of the CCOE model in another community or organization.
8. Eliminate health disparities for women who are underserved due to age, gender, race and ethnicity, education, income, disability, or living in rural localities. (Federal Register, Volume 66, Number 14)

To achieve these goals, the CCOE program is segmented into the following six core components:

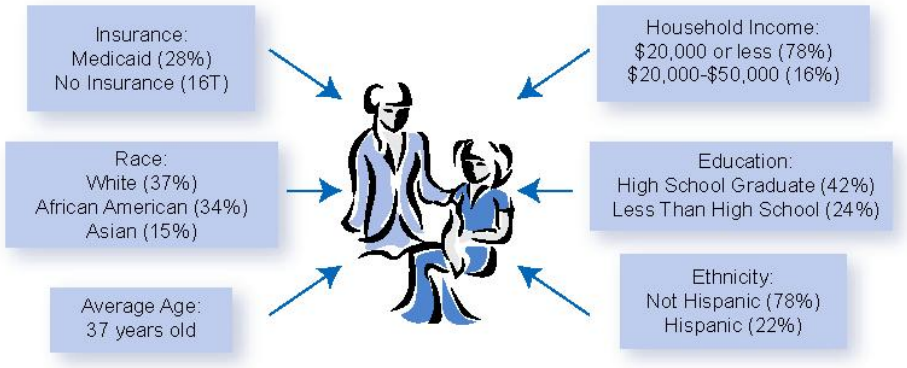
1. Comprehensive and integrated delivery of women's health care services
2. Training for lay and professional health care providers
3. Community-based research
4. Public education and outreach
5. Leadership development for women as health care consumers and providers
6. Technical assistance and replication of the CCOE model.

Figure 1.1 depicts the CCOE model. Each CCOE serves as a hub or nucleus for providing services to the community. They build upon community partnerships, existing resources, and activities already offered by community organizations to implement the CCOE core components to achieve program goals.

The CCOE program is one of several DHHS-sponsored safety net programs providing services to underserved individuals. These individuals fall between the gap of government-sponsored and employer-sponsored health care programs. They often need assistance to pay for health care services. They live in areas that have a shortage of health professionals and health care organizations that provide services at an affordable cost. The CCOE program provides services to women, a historically marginalized population. The interdisciplinary approach to women's health that the CCOE model uses also addresses the historical disparities in health care that have long placed women's wellness at risk.

Figure 1.1 CCOE Model

Figure 1.2 shows several key characteristics of the CCOE client population. The average[1] CCOE client has an annual household income of less than $20,000, which is slightly above the 2004 federal poverty line.[2] They have either Medicaid insurance or no insurance. High school is the highest level of education attained by the majority of CCOE clients. The average CCOE woman is African American or white, and approximately 22 percent of the CCOE client population is Hispanic. The CCOEs must be able to meet the needs of women at every stage of their life. Therefore, they must provide programs that target adolescents, women of reproductive age, as well as geriatric populations. While the average age of CCOE client who responded to the Participant Survey is 27, the age of respondents ranged from as young 14 years of age to as old as 100 years of age.



The 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 1.2 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 Centers, such as the Northeastern Vermont Area Health Education Center (AHEC), located in the Northeast Kingdom in St. Johnsbury, Vermont, to urban Centers, as exemplified by the St. Barnabas Hospital and Healthcare System in New York (Bronx), New York. The populations served by the CCOEs differ greatly as well. They range from ethnically diverse to ethnically uniform communities, and from communities with wide variation in socioeconomic status (SES) to communities with uniformly low SES.

Additionally, the number and sophistication of community partner resources available to each CCOE varies 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 also differ across each CCOE. Many CCOEs use allied health professionals as their primary providers because of the shortage of traditional primary care providers in their communities. The result of these differences is that each CCOE has implemented a unique paradigm and blend of services to fit the needs of its community and to address each of the core components of the CCOE model. The common thread among all of the CCOEs is their support of the OWH CCOE vision and eight programmatic goals, their implementation of the six core program components, and their integration of the six program components.

[1] The average was taken across the demographic questions from the CCOE Participant survey for all CCOE women who completed the survey (1,636) regardless of their specific CCOE affiliation. Therefore, those CCOEs with a high number of participants will influence the average profile to a greater extent.

[2] The 2004 Federal poverty threshold for a family of four is $18,850. (Federal Register, Volume 69, Number 30, February 13, 2004, pp. 7336-7338.)

Figure 1.3 shows the location of the CCOEs throughout the United States. Table 1.1 lists the CCOEs according to the year they were funded and provides a profile of each CCOE. Each CCOEs receives $150,000 (total cost) per year for up to 5 years. The OWH plans to fund a critical mass of CCOEs throughout the United States.

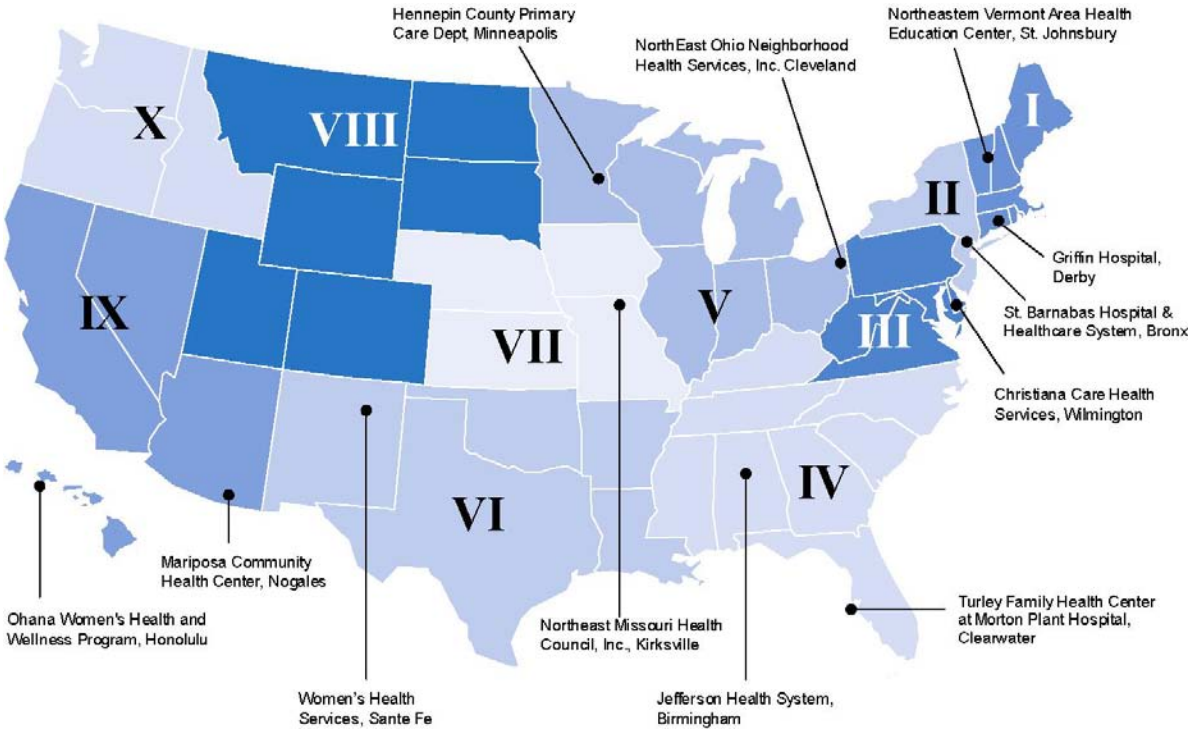
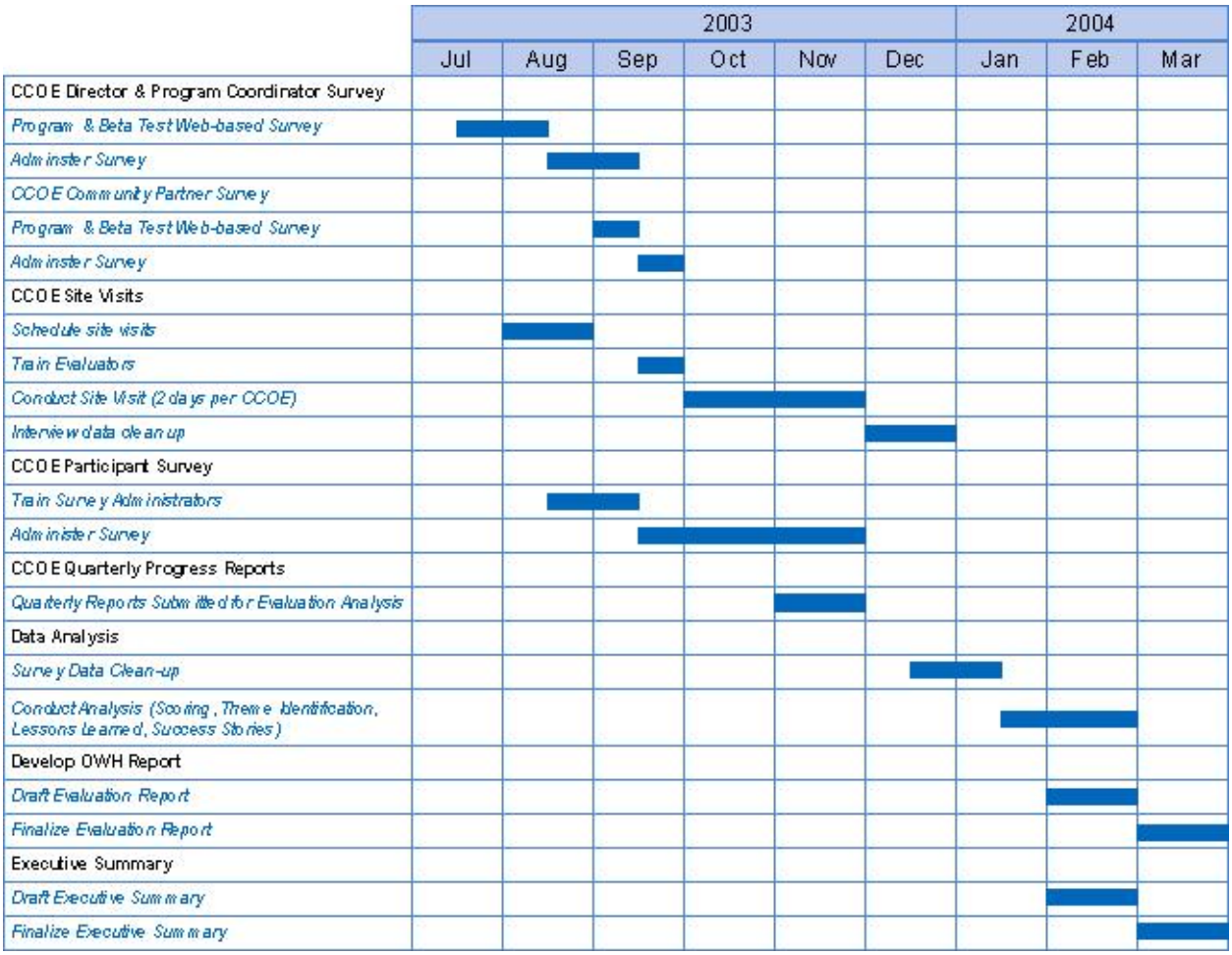


Figure 1.3 National Community Centers of Excellence in Women's Health

1.2 History of the CCOE Program Evaluation

In the spring of 2001, OWH sought to gain a better understanding of how complex programs housed in community-based organizations were evaluated. The OWH funded an external contractor to: 1) review the evaluation literature, 2) identify approaches used to evaluate programs housed in and managed by community-based organizations, 3) recommend a strategy for the evaluation of the CCOE program, and 4) discuss the strengths and weaknesses of the evaluation methodology as it related to the CCOE program.

Table 1.1 National Community Centers of Excellence in Women's Health Profile



Using this information and the CoE 2002 internal evaluation as a foundation, the evaluation team[3] developed an evaluation plan, methodology, data collection instruments (DCI) (i.e., surveys and focus group protocols), and an analysis plan for the evaluation of the CCOE program [4]. The evaluation plan defined the goals of the CCOE program evaluation and linked them to specific research questions around which the evaluation was ultimately framed. The plan also identified potential data sources and proposed methods for gathering and analyzing data. These preliminary ideas were then finalized in the evaluation methodology. As part of the evaluation methodology, the evaluation team developed DCIs and a corresponding analysis plan for the data to be collected. The DCIs were developed based on the research questions. They were informed in part by the DCIs used in the OWH CoE internal evaluation.

The DCIs were pilot tested with the CCOEs to ensure that the questions were easy to understand and solicited the intended information. The pilot test was also used to identify ways to improve how the questions were asked and to determine how long it would take to complete the surveys. Once the DCIs were finalized, the evaluation team developed and submitted a clearance package to the Office of

[3] Booz Allen Hamilton Inc. conducted the CCOE Evaluation in conjunction with OWH.

[4] For more information or to obtain a copy of the CCOE Evaluation Plan, Methodology, DCIs, and Analysis Plan please contact OWH.

Management and Budget (OMB) to gain the approval o the federal government to conduct the evaluation and to solicit input from the public[5]. These tasks took place between the fall of 2001 and the summer of 2002.

The evaluation team began collecting data in August 2003 after obtaining OMB clearance on all DCIs. Data were collected from August through December 2003. The results of the data analyses are included in this evaluation report.

In reading this report, the reader will learn and understand:

- How the CCOE program evaluation was **designed and implemented**, including a description of the research question structure used to guide the evaluation efforts, the methodology and analysis, key study limitations, and the methods used to mitigate them.
- Evaluation results, including a discussion of the **overall impact** of the CCOE program on women's health, perceptions of the CCOE program from the perspective of CCOE clients, and results for each of the **six core component** of the CCOE program, and results for compliance with general program requirements.
- Key CCOE program **success** areas and best practices, as well as **opportunities for improvement** and lessons learned.
- Next steps for the CCOE program, including a discussion of assessing **impact and effectiveness** of the program in the future, and lessons learned from the current evaluation effort.

[5] OMB clearance is required when the Federal Government seeks to collect data from more than nine individuals from the general public, per the Paperwork Reduction Act (5 CFR 1320).

2.0 EVALUATION METHODOLOGY

2.1 CCOE Evaluation Research Questions, Framework, and Scoring

2.1.1 Evaluation Research Questions

The primary goal of the CCOE program evaluation was to assess whether and to what extent the CCOE program, as a whole, was meeting the eight program goals set forth by OWH. The evaluation focused on measuring the extent to which the CCOE program achieved its goals by evaluating how and to what extent it implemented the six core CCOE program components. The six core components also provided a mechanism to measure how well the CCOE program was integrating existing community resources that supported and impacted women's health, a foundational element to the CCOE model and another key area of interest to OWH. Additionally, the evaluation assessed the extent to which other overarching program requirements had been fulfilled, such as the requirement to have a physically identifiable clinical care center and to integrate the six program components. Table 2.1 depicts the relationship between the eight CCOE program goals and the six core components. The six core components are "linked" to each of the eight program goals. Core components of the CCOE program address one or more programmatic goals.

Table 2.1 Relationship Between CCOE Goals and Core Components

	Six Core CCOE Program Components					
Eight CCOE Program Goals	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	✓	✓	✓	✓	✓	✓

2.1.2 Evaluation Framework

The evaluation team developed a framework to measure and evaluate the national CCOE program and its impact on the delivery of care to women in its communities. The evaluation framework consists of four levels, shown in Figure 2.1. Each level of this framework supports the overall program evaluation goals.

At the base, or first level, are the survey questions. These are the questions in the DCIs that were used in the evaluation. Each survey question captures data for one or more research subquestions, thus, supporting the next highest level of information (the second level in Figure 2.1). The research subquestions were developed based on the requirements associated with each core component and areas of interest to OWH. They serve as a way to group multiple survey questions into larger, broader questions that supply additional detail and context to how and to what extent each of the six core components are being addressed and their level of integration with other core components. The research subquestions are then grouped into one of the six core components (the third level in Figure 2.1). Table 2.2 lists each of these core components, which subsequently support the CCOE's eight program goals (the fourth level in Figure 2.1). The CCOE Evaluation Analysis Plan outlines the entire CCOE evaluation framework, including the linkages from the survey questions up to the research questions and goals. This plan also served as the basis for the analysis and scoring of the data collected during the evaluation.

Figure 2.1 CCOE Evaluation Framework

Table 2.2 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[6]	Overarching program requirements

2.1.3 Evaluation Scoring

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 visual coding scheme to make results easy to interpret. Each core component received one of three ratings: three, two, or one circle. The number of circles is

[6] 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 such as signage, leveraging of additonal dollars, etc.

associated with a maximum 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**.

The scoring process was completed using a two-phased approach: 1) analysis of the survey data using an analysis template and 2) scoring of the research and research subquestions using a scoring template. First, survey data for each CCOE was entered into an analysis template that was developed based on the CCOE Evaluation Analysis Plan. The analysis template displayed each research question, all associated sub research questions, and corresponding survey questions (from one or more DCIs) that "answered" the research subquestion. Each survey question was linked to one or more research subquestions and thus to a particular research question. Figure 2.2 shows an excerpt of the analysis template structure for the research question, "Has the CCOE program replicated successful models and strategies?" Replicated_1 is the code for the research subquestion, "Is the CCOE maintaining a sustained interaction with another community?" The codes for the individual survey questions, the actual survey questions, and their responses are listed to the right of each research subquestion.

Research Question: Has the CCOE replicated successful models and strategies?				
Replicated_1	Is the CCOE maintaining a sustained interaction with another community?	DR_TA_35	Does your CCOE provide on-going technical assistance to another community (so as to help the community replicate the CCOE model)?	Yes
		DR_LD_35A	If yes, how long (in months) has this relationship existed? If you have more than one on-going relationship, list the length of time your relationship with each community has existed.	3 months
		CP_TA_23	During the last year, have you provided or assisted the CCOE in providing other communities and/or organizations with information on how to replicate the CCOE model?	Yes

Figure 2.2 Excerpt from the Analysis Template

The evaluation team reviewed the survey data for each research subquestion using this template. A rating of three, two, or one circle was assigned to the research subquestions based on how well they were being fulfilled. All of the CCOEs were rated on the same research subquestion before the evaluation team progressed to the next research subquestion. Therefore, each CCOE had its own three, two, or one circle score for each research subquestion, as shown in the excerpt of the survey question scoring sheet in Figure 2.3.

		CCOE#1	CCOE#2	CCOE#3	CCOE#4	CCOE#5	CCOE#6	CCOE#7	CCOE#8	CCOE#9	CCOE#10	CCOE#11	CCOE#12
Replicated_1	Is the CCOE maintaining a sustained interaction with another community?	●●●	●●●	●●●	●●●	●●●	●●●	●●	●●●	●●	●●	●●●	●●●

Figure 2.3 Excerpt of Survey Question Scoring Sheet

Next, the results for each CCOE were entered into a scoring template, a tool used to score the research questions and research subquestions. All three-circle scores were assigned full points with the research subquestion, while two-circle scores were assigned half as many points, and one-circle scores were assigned no points[7]. The research question score (i.e., the core component score) was then calculated by adding the number of points per research question. Full performance on each research question was equivalent to 100 points.

Subsequently, a mean score was averaged across all 12 CCOEs to determine the CCOE research questions and research subquestion scores. Figure 2.4 illustrates the format used to calculate the average research question and subquestion scores across all 12 CCOEs. The scores for the research questions and research subquestions are presented in Section 3.3 of this document.

RESEARCH QUESTION (100 pts per research question)	Research Question Score	SUBQUESTION (# of points=100/# of sub question)	Subquestion Score
Integrated Delivery of Women's Health Care Services	75.52	(12.5 pts per subquestion) Subquestion #1	10.42
		Sub question #2	7.29
		Sub question #3	10.42
		Sub question #4	11.46
		Sub question #5	10.94
		Sub question #6	12.50
		Sub question #7	6.25
		Sub question #8	6.25
Training for Lay and Professional Health Care Providers	84.38	(25.0 pts per question) Subquestion #1	20.83
		Sub question #2	22.92
		Sub question #3	22.92
		Sub question #4	17.71
Community-based Research	72.50	(20.0 pts) Subquestion #1	17.50
		Sub question #2	20.00
		Sub question #3	16.67
		Sub question #4	8.33
		Sub question #5	10.00
Public Education and Outreach	82.79	(11.1 pts) Sub question #1	11.10
		Sub question #2	11.10
		Sub question #3	9.71
		Sub question #4	11.10
		Sub question #5	8.33
		Sub question #6	9.71
		Sub question #7	7.86
		Sub question #8	11.10
		Sub question #9	2.78
Leadership Development for Women as Health Care Consumers/Providers	58.33	(12.5 pts) Sub question #1	6.77
		Sub question #2	8.33
		Sub question #3	6.25
		Sub question #4	7.81
		Sub question #5	8.33
		Sub question #6	6.25
		Sub question #7	8.33
		Sub question #8	6.25
Technical Assistance/ Replication of CCOE Model	65.83	(10.0 pts) Sub question #1	7.50
		Sub question #2	10.00
		Sub question #3	7.08
		Sub question #4	4.58
		Sub question #5	4.58
		Sub question #6	8.33
		Sub question #7	8.33
		Sub question #8	2.92
		Sub question #9	7.08
		Sub question #10	5.42
Program Requirements	87.50	(25.0 pts) Sub question #1	21.88
		Sub question #2	21.88
		Sub question #3	18.75
		Sub question #4	25.00
GRAND TOTAL	526.85		526.85

Figure 2.4 Excerpt from Scoring Template

[7] The actual score or number of points assigned per research subquestion differed based on the number of research subquestion per research question. The calculation used to determine the point value was to divide the number of research subquestions by 100 points. Figure 2.4 lists the number of points possible per research subquestion in the third column.

2.2 Overview of Data Collection Methodology

The OWH evaluation methodology included multiple phases and methods of data collection that built upon one another. A strong combination of qualitative and quantitative data gleaned from multiple sources provided a solid basis for the evaluation team to analyze and interpret results. These data sources then informed the final report, where findings were summarized. Figure 2.5 provides an overview of the CCOE data collection and analysis methodology timeline.

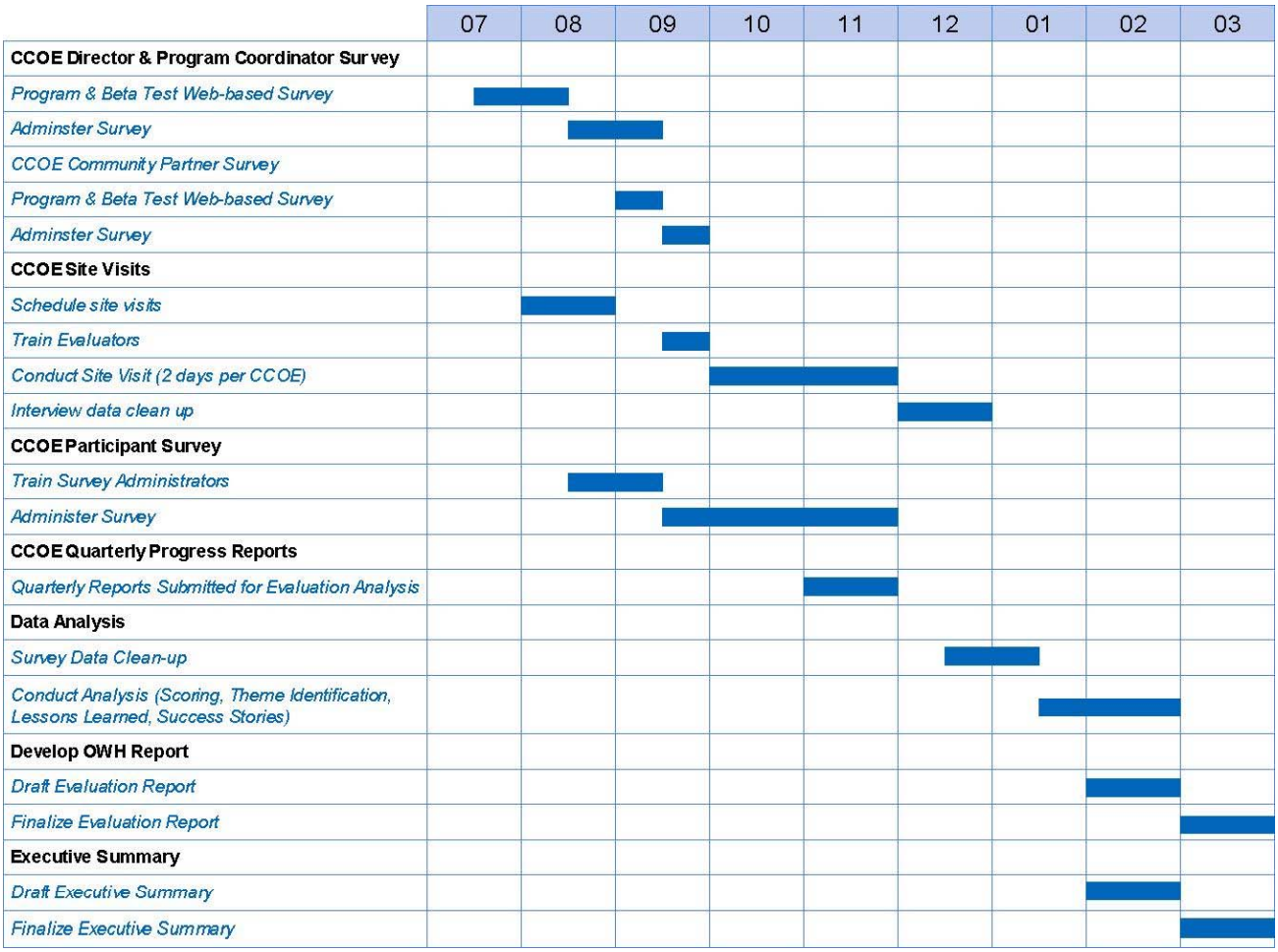


Figure 2.5 Evaluation Timeline

A key element of the data collection effort was to obtain input from multiple sources; each source had a different experience and knowledge of the CCOE. The five data collection initiatives are described in Table 2.3.

Together, all the data collection efforts aided in providing a comprehensive 360-degree snapshot of CCOE activities in each CCOE component area, and the CCOE's progress in meeting its program goals.

Table 2.3 CCOE Evaluation Data Collection Initiatives

DCI	DESCRIPTION	COLLECTION METHOD
CCOE Director and Program Coordinator Survey	The CCOE Center Director and Program Coordinator Survey provided essential information on the services and activities the CCOE offers and the extent to which they integrate with their community partners.	Internet-based survey
CCOE Community Partner Survey	All CCOE community partners were invited to provide feedback about their relationship and integration with the CCOE and the services they provide to CCOE clients. They also provided additional utilization information for the services and activities they provide in conjunction with the CCOE.	Internet-based survey
CCOE Site Visits	Evaluators gathered data about day-to-day operations of each CCOE through interviews with CCOE leadership and staff. They also obtained copies of distributed literature (e.g., smoking cessation tips, how to eat healthy), visited and interviewed a sample of partners, and observed ongoing CCOE activities. Information gathered during the site visits allowed for further refinement, validation, and understanding of survey data gathered during other phases of the CCOE evaluation and provided information on day-to-day operations and processes used at the CCOE.	Onsite focus groups and individual interviews
CCOE Participant Survey	CCOE clients provided feedback on their experiences at the CCOE related to access, quality of care, and interaction with the CCOE, and general information about the services they received. A Survey Participant Training Guide was used to train onsite survey administrators.	Paper (in-person) survey
CCOE Quarterly Progress Reports and Other Submitted Documents	Data submitted in the CCOE quarterly reports was used to assess the type and amount of services offered by the CCOE related to each of the six core components. The reports also included information about the number and type of CCOE services used by CCOE clients. Other information provided to OWH as part of the CCOE program's reporting requirements were reviewed to provide additional detail on CCOE services and activities. This information included interim and ad-hoc reports, as well as the original grants submitted to OWH. All of this data was self-reported by each CCOE to OWH.	Microsoft Excel Reports and Word Reports

2.3 Data Collection and Analysis

2.3.1 CCOE Director and Program Coordinator Survey

Each CCOE's leadership completed the CCOE Director and Program Coordinator Survey. This Internet-based survey provided many benefits for this evaluation effort. It was a cost-effective mechanism for gathering information because responses were automatically entered into an electronic database. It also reduced the time and level of effort needed to analyze responses and produce results. The CCOE Director and Program Coordinator Survey was administered to all 12 CCOEs. Each CCOE was asked to complete a survey because each CCOE's input was considered integral to conducting a meaningful evaluation. Information from each CCOE was important because each CCOE serves a very different client population and employs different approaches to implementing the CCOE core components.

In August 2003, each CCOE was sent an e-mail invitation asking them to complete the survey. The e-mail included detailed instructions on how to complete the survey and a link to the Internet survey site. The CCOEs had about one month to gather the requested information and to submit the completed survey. The survey had a 100 percent response rate.

The CCOE Director and Program Coordinator survey included quantitative and qualitative survey questions related to each of the six core components, including CCOE operations, structure, and partners. The data requested included:

- A description of the CCOE structure
- A description of CCOE activities and services
- Information related to each of the core components
- A list of partners, including a description of the type of services offered and contact information.

During data analysis, the evaluation first assessed data quality (i.e., checking for missing data, extreme outliers, and data that did not fit expectations) and then determined frequencies and mean scores on all quantitative data. Responses, where applicable, were compared with similar questions on the CCOE Community Partner Survey and other surveys (with different target audiences) used in the CCOE evaluation. Qualitative data, such as descriptions of best practices or improvement ideas, were reviewed and aggregated based on key themes and research questions.

2.3.2 CCOE Community Partner Survey

An Internet-based survey was also used for the CCOE community partners. Using data provided by each CCOE (i.e., contact name, address, and e-mail address), the evaluation team developed a list of all CCOE community partners. Because of the ease of administration available with an Internet-based survey and the minimal cost implications with adding additional respondents, all CCOE partners were asked to complete the survey.

In September 2003, the evaluation team e-mailed the 119 current[8] CCOE community partners identified by the CCOEs and asked them to complete the CCOE Community Partner Survey. As with the CCOE Director and Program Coordinator Survey, the e-mail included detailed instructions on how to fill out the survey and an electronic link to the Internet site. A few of the CCOE partners did not have e-mail and Internet access. A letter was mailed or faxed to these partners along with a paper survey and instructions for completing and returning it. Each CCOE Program Coordinator was responsible for communicating the importance of the survey and the program evaluation to its partners prior to the arrival of the survey. The partners had about one month to gather the requested information and submit the completed survey. Throughout this time, the evaluation team was available to answer any questions. The CCOE Community Partner Survey had more than a 65 percent response rate.

As mentioned previously, the CCOE Community Partner Survey requested additional information about CCOE-related services to help provide a comprehensive picture of CCOE program services and activities. The survey data was primarily qualitative, but some quantitative data was also collected. The data requested included:

- Descriptions of partner activities and services, including client service utilization/ participation statistics
- Types of communication channels that exist between the CCOE and partner organization
- Levels of integration with the CCOE and other partners.

The majority of the survey results were qualitative data such as descriptions of partner services and activities. These data were reviewed and aggregated based on key themes. Quantitative data were analyzed by conducting descriptive statistics and frequencies (percentages of responses). Data were aggregated by CCOE and averaged (for quantitative data) when there was more than one partner response. Data for all community partners were analyzed in conjunction with data gathered from the CCOE Director and Program Coordinator survey to determine the extent to which the partners are integrated with the CCOE and to help the evaluation team understand the full spectrum of activities and services related to each CCOE core component.

[8] The CCOE leadership provided this information in September 2003.

2.3.3 CCOE Site Visits

Site visits were made to all 12 of the CCOEs because of the unique characteristics and practices of each.

A two-person team of evaluators went to each CCOE. Site visits were made to all 12 of the CCOEs because of the unique characteristics and practices of each CCOE. Additional information from each CCOE was deemed necessary to clarify data gathered through the CCOE Director and Program Coordinator Survey and because the number of CCOEs was too small to use a psychometrically sound sampling strategy. Each site visit team attended a training session on how to structure and conduct the site visits. At the training, they received instruction on sound interviewing techniques to ensure data was gathered in a consistent manner and to minimize interviewer biases.

The CCOE site visits occurred during October and November 2003. Each site visit took about two days. The length of the site visit was dependent on the number of CCOE partners visited. Each site visit team facilitated multiple interviews and focus groups with CCOE staff and with a sample of CCOE community partners. Focus groups typically consisted of no more than six to eight CCOE or partner staff. Focus group participants were selected to ensure a representative sample of the various staff roles at each organization. However, selection was limited to who was working at the time of the site visit and the availability of staff to meet with the site visit team.

In choosing partner facilities to visit, the evaluation team considered the number and type of community partners affiliated with each CCOE. Then each CCOE Program Coordinator was given a list of recommended partners to participate in the site visit. The CCOE Program Coordinator scheduled each partner interview based on partner availability. As with the CCOE staff focus groups, staff at the partner sites were chosen to minimize disruptions in service at the partner facility. An effort was made to ensure that a representative sample of employees in various roles were invited to participate in the focus groups.

The site visits enabled an objective assessment of the CCOEs. The purpose of the site visits was to gain further insight into the day-to-day operations and procedures of the CCOEs and to clarify data submitted from the CCOE Director and Program Coordinator survey and the CCOE Community Partner Survey. Part of the site visit team's purpose was to independently confirm that the CCOE was in compliance with general OWH requirements (e.g., ensuring CCOE signs were posted). The evaluation team obtained copies of distributed literature (e.g., brochures), observed any CCOE activities taking place during the site visit, and gathered information directly from CCOE staff. They also took advantage of the opportunity to observe facility characteristics that could affect CCOE operations such as facility space, location, and accessibility of the CCOE. Key data collected during the site visit included information on:

- Record-keeping systems
- Information technology infrastructure
- Governance structure (e.g., advisory board)
- Accessibility of CCOE facilities
- Staff perspectives on the quality and types of services offered, success factors, barriers, and key lessons learned.

All the site visit data was qualitative. Data from the site visits was compared to similar questions on other DCIs. Data was then validated by each site visit evaluator and cleaned to ensure the data was grammatically correct and could be easily understood. A thematic analysis was performed to

determine overall themes and trends related to the CCOE core components or other topics. This data served as a key source for lessons learned, success stories, and opportunities for improvement for the CCOE program.

2.3.4 CCOE Participant Survey

The CCOE evaluation included an anonymous point-of-service pen and paper participant survey that was administered by trained CCOE staff at each CCOE's main clinical care facility and other sites, as appropriate. Satellite or alternate locations were surveyed to take advantage of relatively high client volumes at those locations. The surveys were administered from September to December 2003. The overall CCOE participant survey strategy for this DCI was determined during individual conference calls with each CCOE.[9] In August 2003, CCOE Participant Survey Administrators – at least one per CCOE – participated in a training session with the evaluation team. During the training, they received instruction and a Participant Survey Administration Training Guide. The training provided instructions on:

- Selecting and sampling clients
- Administering the survey, typical questions asked, and ensuring confidentiality
- Maintaining records of survey respondents
- Storing (in a secure locked location) and sending completed surveys to the evaluation team.

The training sessions were conducted to reduce or eliminate any bias introduced by variations in survey administration across the CCOEs and to avoid improper survey administration. The training was particularly important because the sampled populations included clients with low-literacy levels, clients whose primary language was not English, and clients whose culture might impact participation and the quality of responses received.

The survey was designed for completion within 15 minutes. Several CCOEs offered the survey in Spanish because a large percentage of their client population spoke Spanish as their primary language. At CCOEs where it was necessary and appropriate, and where sufficient staff were available, survey administrators answered questions regarding the survey and translated it from English to Spanish. The respondent universe included all individuals 18 years of age or older who were considered clients of the CCOE program. Every CCOE client had an equal probability of selection and the administrators asked the appropriate questions to ensure that no clients were resampled during the participant survey data collection period. Participation was voluntary. Any client could decline to participate without penalization. Each CCOE was asked to give the survey to all CCOE clients who used CCOE services from September through December 2003.[10] Therefore, the number of clients completing surveys at each CCOE differed based on weekly client volume.

The evaluation team worked closely with the survey administrator at each CCOE to ensure that survey administration proceeded smoothly, to monitor data quality, to answer questions as needed, and to

[9] A customized survey strategy was developed for each CCOE based on the number of facilities through which each CCOE offered services.

[10] Initially, the evaluation team planned to institute a customized sampling schema at each CCOE based on patient volume estimates. However, while working with the CCOE Participant Survey Administrators to develop the initial survey strategy for each site, it became apparent that the variability in CCOE client volumes at the clinical care sites prohibited development of effective sampling plans.

monitor the number of completed surveys. Completed surveys were submitted to the evaluation team monthly. They were reviewed to determine if there were any problems with data collection. When necessary, feedback and additional guidance was provided to the survey administrators. Data from the surveys were transferred into a database where analysis was conducted monthly.

A majority of the CCOEs had relatively high numbers of women who completed the CCOE Participant Survey. However, three CCOEs had a relatively low number of women who completed the survey. Each of these CCOEs had fewer than 20 CCOE women complete the CCOE Participant Survey during the 4-month survey administration period. Possible reasons for low client responses may have been a lack of dedicated resources for administering the survey, low client volume (fewer number of visits by the CCOE women), the survey not being administered at a clinical care site (women attending doctor's appointments may have been more likely to complete a survey), or competing priorities (e.g., one of these CCOEs had two other organizations conducting surveys within the CCOE parent organization at the same time and in the general vicinity of the CCOE).

The purpose of this data collection effort was twofold. Gathering information from the client population allowed a profile of the population to be developed. Additionally, along with the data provided by the CCOEs themselves, the survey provided an understanding of the clients' perceptions of the services offered or coordinated through the CCOE. Data gathered from the participant survey helped to indicate the CCOE's impact in its surrounding community. The data requested included the following:

- General opinions on the CCOE program and services, including perceptions on access, quality of care and interaction with the CCOE
- Service utilization
- Perceptions of the CCOE client-focused core components (i.e., all the core components except for technical assistance)
- Client and/or community demographics.

The survey data was mostly quantitative with few qualitative or open-ended questions. For each question, excluding open-ended questions, descriptive statistics and frequencies were generated to ensure data quality and to aggregate the data for each CCOE. Any data quality issues, such as extreme outliers, were resolved before analysis. All questions with the response categories "Yes," "To Some Extent," or "No" were coded numerically and then averaged.

2.3.5 CCOE Quarterly Reports and Other Reporting Requirements

The CCOE Quarterly Reports were not a formal part of the program evaluation; however, they provided integral data for the national evaluation effort. The evaluation was designed to minimize the data reporting requirements for the CCOEs so that existing data was used whenever possible. The quarterly reports submitted by each CCOE provided in aggregate annually, summarized service utilization levels and described the number and type of events the CCOE was involved in (e.g., community research, training, and outreach events). The data used in this evaluation was from the 2003 fiscal year (October 2002 through September 2003).

In addition to the CCOE Quarterly Reports, other information provided to OWH as part of the CCOE program's reporting requirements was also reviewed to provide further detail about various aspects of the program. This information included the original CCOE grant applications, the fiscal year 2003 How To Manuals, and any other interim and ad-hoc reports provided to OWH by the CCOEs.

The CCOE Quarterly Progress Reports and other information reported to OWH were quantitative with few qualitative descriptions, such as the type of event, class, or research conducted. All of this data was self-reported by each CCOE to OWH. This data was used to evaluate each CCOE against the evaluation research questions and subquestions.

2.4 Methodology Limitations

There were several limitations inherent in this evaluation, from the beginning stages of data collection to the final stages of data analysis. A majority of these limitations result from the unique nature of the CCOE program and the variations in implementation of the CCOE core components at each site. These limitations were acknowledged at the beginning of the study. Thus, the evaluation was designed to mitigate these limitations to the fullest extent possible, given the cost and resource constraints for conducting the evaluation. Standardization of the data collection procedures and analysis was the most effective way to aggregate multiple data sources and types of data while mitigating the inherent limitations of the study. Table 2.4 summarizes each evaluation limitation and the strategy developed to mitigate the effects of each limitation.

Table 2.4 Evaluation Limitations and Mitigation Strategies

Evaluation Limitation	Mitigation Strategy
Each CCOE had *limited resources* to support the data collection effort, particularly the participant survey.	• Someone at each CCOE was responsible for either responding to or administering each phase of the data collection process as appropriate. The participant survey administrators received training on how to administer the participant surveys to ensure standardization. • All CCOEs were given an opportunity to obtain funding to help defray the cost of supporting the data collection effort, in particular, to administer the participant survey.
Each CCOE had a unique client population, different number and types of partnerships, and different levels of sophistication with data collection techniques.	• The CCOEs had the freedom to grow and tailor their services to their population as long as they met OWH requirements, including the implementation of each of the six core components. Thus, structuring the evaluation around the core components and the requirements associated with them helped to address the variances due to multiple CCOE implementation approaches. • In addition, the evaluation focused on how CCOEs grew and integrated services after receiving CCOE status. • Standardized data collection instruments and administration techniques helped ensure CCOEs provided data in a consistent format and style.
No *comparable populations* were identified at the time of the CCOE evaluation that the CCOEs could be assessed against. The CCOEs vary widely in their geographic environments, target client populations, and available resources. For these reasons, finding a comparison group against which to assess the CCOEs and/or choosing to assess the CCOEs against each other was not considered a feasible option for this evaluation effort.	• The intent of this evaluation was not to compare CCOEs, instead it was to establish baseline CCOE performance. Therefore, this limitation was not an overwhelming factor in this evaluation. • Not having a comparison group limits the ability of the CCOE program to gauge performance and impact relative to other organizations operating in a similar environment or to the population at large (depending on the comparison group). These comparisons typically can help the CCOE in planning and development. • A comparison study will be conducted starting in FY 2004 to address this study limitation.

Evaluation Limitation	Mitigation Strategy
Bias toward answering the CCOE participant survey or agreeing to participate in the survey could have occurred as a result of how the survey was administered. Different individuals at each of the CCOEs administered the participant survey. The survey itself was administered in person.	• Survey administrator training was provided to each individual administering the CCOE survey at each site. Part of the training included training on ensuring the client felt comfortable taking the survey and was aware that they could decline participation and would not face any negative consequences. • Survey administrator training was conducted to reduce any bias introduced by variations in survey administration. This was particularly important because the populations being sampled include clients with low-literacy levels, where languages other than English are commonly used, and whose cultural beliefsmight impact participation.
Some CCOEs *did not have 400 clients* who completed the CCOE Participant Survey, thus reducing the ability to allow for a statistically significant analysis of the survey responses for future evaluations.	• There are two reasons why a CCOE had fewer than 400 participant survey responses. The first reason is that some CCOEs did not have enough CCOE clients enrolled in the CCOE program to allow for 400 survey responses. • In such instances, the data is considered representative of the CCOE's client population because all CCOE women were asked to complete the survey. In these cases, the survey responses still reflect meaningful results in the individual CCOE report.[11] • The second reason a CCOE had fewer than 400 responses is because of a low patient volume during the 4-month survey administration. This effect could only be mitigated by extending the data collection period. • This step was not taken in an effort to minimize additional evaluation costs, burden on the CCOE, and to remain on schedule to produce the final evaluation report. • Having fewer than 400 surveys per CCOE impacts the strength of the conclusions that can be drawn during future program evaluations. For example, it may be difficult to determine if the CCOE experienced statistically significant growth during the next evaluation if there are not enough survey responses to allow significance testing to be completed.[12]
The CCOE Participant Survey was not translated into all the languages spoken by the CCOE client population due to the costs associated with doing so. This resulted in missed opportunities to survey CCOE women whose primary language was one other than Spanish or English.	• This limitation was mitigated in part by offering the survey in Spanish. Spanish was identified as the second most common language spoken by clients of the CCOE program. Additionally, several CCOEs have predominantly Spanish speaking populations.
There may be *potential inaccuracies and omissions* in self-reported data from survey instruments, CCOE quarterly progress reports, and other reporting required by OWH. Such inaccuracies would allow for a misrepresentation of the CCOE's performance.	• The data collection instruments provided multiple opportunities to validate CCOE activities. Similar information from different data collection instruments can be verified because there are multiple data collection methods (e.g., questions about CCOE referrals are asked on more than one data collection instrument). Additionally, the site visits allowed the opportunity for corroboration and validation of self-reported information.

[11] Client responses for each CCOE were aggregated for the CCOE Evaluation Report, and thus, a low number of client responses will not affect the overall report as compared with the individual CCOE reports.

[12] Most significance testing will be conducted during future evaluations to determine if the CCOE's progress and growth in the community is statistically significant. Because the focus of this evaluation is to gather baseline data, there is not a strong need to use significance testing in this evaluation.

3.0 CCOE PROGRAM EVALUATION RESULTS

3.1 Overall Impact of the CCOE Program

Results from the CCOE evaluation helped baseline the extent to which the CCOE program is meeting its goals. These results provide a snapshot of the entire CCOE program and the impact it is making on the 12 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. Although this evaluation does not assess health status changes in women who participate in the CCOE program, there is substantial evidence that the CCOE program is positively impacting the community and clients it serve. This impact is noticeable in several ways, each of which is discussed below.

Impacts:

- Increased enrollment and participation in the CCOE program.
- Documented individual success stories.
- Heightened awareness of the importance of health care.
- Integrated partnerships with community organizations.
- Empowered the whole woman.
- Improved client's perception of care.
- Reached women through multiple CCOE core components.

- **Increased enrollment and participation in the CCOE program.** The CCOEs helps women 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, CCOEs are able to make women in their community aware of the services available to them. At St. Barnabas Hospital and Healthcare System, peer educators, who function as community health workers (CHW), provide outreach in the community and case management. They call CCOE clients to remind them of their appointments and actively follow up with them to ensure that they keep their appointments. This extra care and concern, delivered in a culturally competent manner, helps ensure that women fully use the CCOE and its resources. Christiana Care Health Services leverages its hospital's Women's Health Mobile Screening Van and a bilingual staff member to increase awareness of the CCOE in underserved Spanish-speaking communities. The CCOE also partners with churches in the Spanish-speaking community. After Sunday services, free screenings are offered for osteoporosis and breast cancer, with the CCOE's bilingual staff member providing translation services. These mobile screenings provide increased opportunities for underserved women to receive health care, and they make women aware of the CCOE and the community services available to them.

- **Documented individual success stories.** In all the CCOEs, there are success stories that demonstrate the power of the CCOE's ability to link women to critically needed services and to information they would normally be unable to access. At the Northeast Missouri Health Council CCOE, a woman with breast cancer was given medical care after a partner organization (a safe house) learned that her husband had denied her medical care. The partner organization was able to identify this need and refer the woman to the CCOE for care because they knew to ask, during the patient intake process, not only about the woman's emotional state but also about her physical state. At the NorthEast Ohio Neighborhood Health Services CCOE, a woman was connected with housing and food resources after she came seeking information on medical services. She had been incarcerated for about 10 years, and upon leaving prison, did not have the money necessary to have her prescriptions refilled. After the

CCOE determined that the woman needed more than basic health care, she was connected with programs that began providing her with clothing, food, and job counseling services.

- **Heightened awareness of the importance of health care.** The 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 steps they can take to mange their own health better. At Ohana Women's Health and Wellness Program, CCOE women are given a "passport" that they use to track basic health care data, such as blood pressure and cholesterol. The passport, personalized with a small Polaroid photo of the woman and color-coded by age group, is helpful to physicians and other care providers in understanding the woman's medical history, especially if language is a communication barrier. CCOE women at Mariposa Community Health Center also receive a passport. Their passports are also color-coded by age group. Each passport provides specific age-appropriate health tips that help the client work in partnership with her health care providers to ensure that she receives the health care she needs and deserves.

- **Integrated partnerships with community organizations.** The CCOEs have worked hard to build good working relationships with community partners who share the same goal of improving health outcomes for women in their communities. The CCOEs have removed barriers that previously prevented diverse organizations from working together. At Turley Family Health Center, diverse partners are joined through the CCOE. As a result, the CCOE and its partners have increased awareness in the community and now are providing a wide range of resources to CCOE women, including access to car seats, lead poisoning screening, and transportation to the CCOE or its partners. Even the police department is involved in helping to locate potential CCOE women and giving information to them in a non-threatening manner (which is key for undocumented women).

- **Empowered 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. At Mariposa Community Health Center, promotoras or CHWs are trained to lead a series of empowerment classes for CCOE clients. The CCOE has found that women in its community first need to develop strong self-esteem before they can truly take ownership of their own health care. The classes teach women skills that enable and empower them to become stewards of their own health and that of their families. The classes focus on providing a woman with everything she needs to know to stay healthy. Discussion and instruction are offered in the following areas: goal setting, finding a job, budgeting and personal banking, and women's health needs.

  Women in one underserved community served by the CCOE at Griffin Hospital, have agreed to let a facilitator, a CCOE staff member, proactively address health topics during their arts and craft classes. Women in the group were already using their craft time to discuss topics of concern related to spiritual, physical, and emotional health. The CCOE facilitator uses naturally occurring conversations as an avenue for pursuing discussions on how women can improve their own spiritual, physical, and emotional health.

- **Improved client's perception of care.** On the CCOE Participant Survey, CCOE clients were asked, what they thought about the services they were receiving at the CCOE. Overall, CCOE clients are very happy with the services they receive. Examples of feedback provided by women include:

  > *"They are doing very well. This is a very comfortable place to bring your health care needs and concerns. I really enjoy all the staff."*
  >
  > *"The CCOE is well coordinated and [staff members] are very professional in the care for their patients."*

  Survey data also provides insights into CCOE client perceptions of care, based on the respondent's demographic profile. For example, women who do not have insurance are more satisfied with their care than those with some form of insurance. A possible explanation for this difference is that these women are unlikely to have the same expectations of the health care visit and thus do not have the same standard for comparison. Section 3.2 discusses client perceptions of care in more detail.

- **Reached women through multiple CCOE core components.** Overall, all the CCOEs are demonstrating an impact on CCOE women and communities through multiple components. In each core component, activities are occurring to address women's health from multiple perspectives, thus demonstrating integration. At St. Barnabas Hospital and Healthcare System and Mariposa Community Health Center, peer educators and promotoras are recruited from volunteers and attendees at CCOE education events. These women are then trained on specific health topics and issues, effective outreach, patient confidentiality, and counseling techniques. After completion of their training, they provide outreach and education to women in the catchment areas. Multiple examples of the integration of education and outreach and leadership training, or community-based research and education and outreach, are seen in many of the CCOE programs.

  The CCOE program has not been in existence long enough to determine its impact on women's health status. The entire evaluation process needs to be repeated in 5 years to assess the impact of the program. Repeating the evaluation will allow the OWH to further determine the impact the CCOEs are having in their communities by comparing this data to the baseline established by this evaluation. A future evaluation will allow the OWH to see the progress made toward goal achievement and the impact of the program on the communities the CCOEs serve.

3.2 Client Perceptions of the CCOE Program

The results from the CCOE Participant Survey are presented in this section. They include feedback about the clients' perceptions of their experience with the CCOE program. Information topics such as access, quality of care, interaction with the CCOE, and general information about the services they are receiving was obtained. A total of 1,636 CCOE clients, a majority of whom were between 18 to 45 years of age (as shown in Figure 3.1), responded to the CCOE Participant Survey. Twenty percent of the clients went to the CCOE eight or more times (n=640) in the past year. (See Figure 3.2). Over a third (39 percent) of the CCOE clients heard about the CCOE program through friends or from a

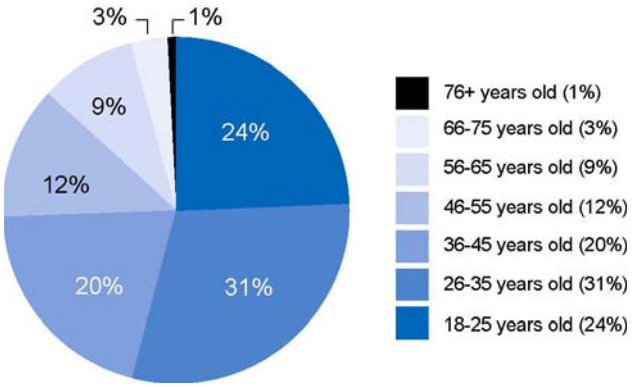


Figure 3.1 Age Range of CCOE Clients

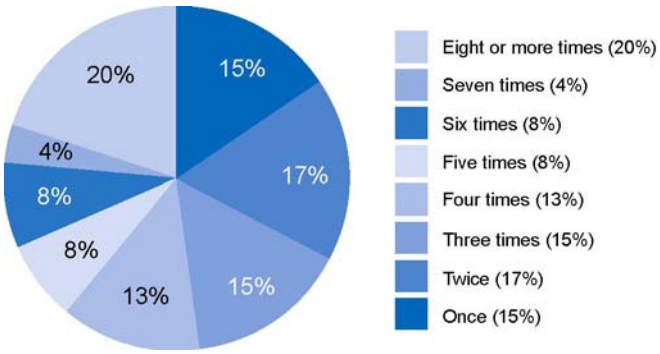


Figure 3.2 Percent of CCOE Visits

family member. Almost half of the clients heard about the CCOE program through other means such as their health care provider or a CCOE staff member (46 percent, n=1,485).

Overall, clients are satisfied with the services they receive at the CCOE. Almost all CCOE clients (98 percent) would recommend the CCOE to family or friends (n=1,515). Additionally, clients believe that they are being treated with respect (97 percent, n=1,607) and that the CCOE staff is courteous (94 percent, n=1,586). During visits for services, they are able to speak to someone in their native language (95 percent, n=1589).

A majority of CCOE clients (78 percent, 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 (84 percent, n=424). CCOE clients without insurance (63 percent, n=209) and those between the ages of 18 and 25 are slightly less likely to have a regular provider (70 percent, n=340).

Overall, clients believe they can trust the health professionals at the CCOE (91 percent, n=1,576). Regardless of income or age, women report they are able to access the CCOE easily (88 percent, n=1,567). It is slightly more difficult, however, for women who self-reported that they are in poor or very poor health to access the CCOE (70 percent, n=102). Eighty-one percent of clients agree that they can rely on the CCOE to obtain health care information (n=1,574).

Additionally, clients indicated on the Participant Survey the services they received through the CCOE network in the last six months. The top three services used by the CCOE women are health care services (71%, n=1,154), referral services (41%, n=667), and printed health information (36%, n=581). CCOE clients are least likely to seek out the CCOE for support groups, to use a women's health resource center, or for transportation assistance. Figure 3.3 shows the services CCOE clients receive.

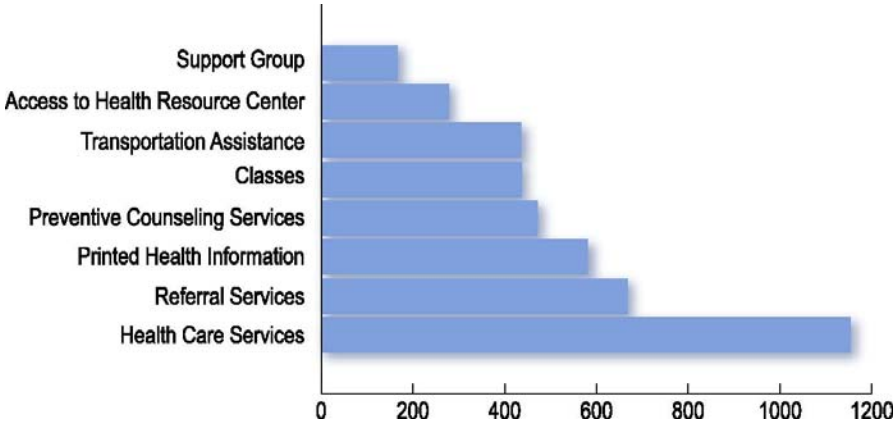


Figure 3.3 Services Received at the CCOE

Clients have the most interaction with the CCOE through its health care or clinical care component (n=1,365). Figure 3.4 shows the number of clients reached through four of the client-centric CCOE core components: leadership development, community-based research, education and outreach, and health care services delivery. Additional information on client perceptions of these core components is discussed below.

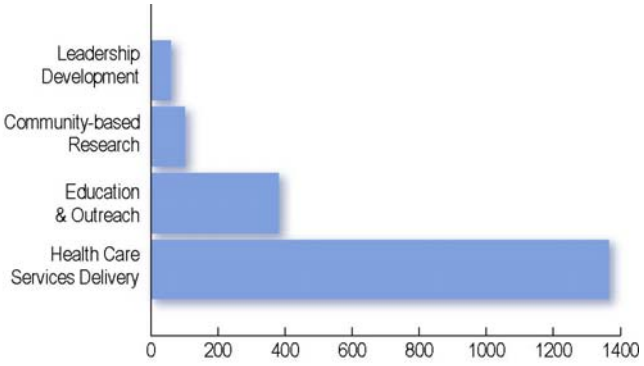


Figure 3.4 Client Involvement with CCOE Core Components

3.2.1 Perceptions of Health Care Services Delivery

As shown in Figure 3.5, the top three reasons for health care visits by CCOE clients are: follow-up care (28 percent), routine exams (27 percent), and prenatal or postpartum exams (26 percent) (n=1,365). Clients report that the CCOE provides them with women-specific services such as gynecological care, in addition to general health care services (94 percent, n=1,217). Additionally, clients are very satisfied with the overall quality of care the CCOE provides and with how well their care is coordinated. However, 50 percent (n=1,289) of CCOE clients indicated that they have to provide the same information (i.e., name, address, telephone number) more than once. This indicates that record keeping is not always centralized at the CCOEs and that records are not always shared among CCOE providers. It may also be indicative of CCOEs still learning how to share information with their partners and while adhering to the requirements and restrictions of the Health Insurance Portability and Accountability Act (HIPAA).

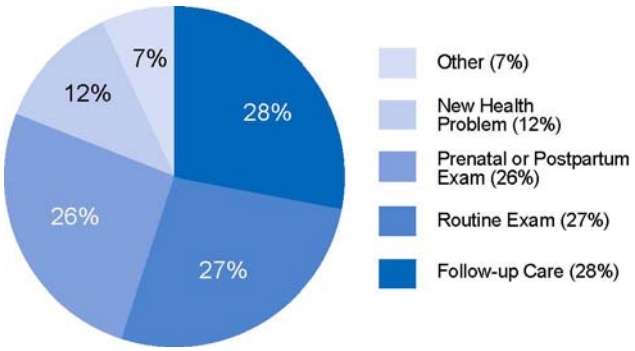


Figure 3.5 Reason for Health Care Visit

The CCOE program also received high ratings for providing help to CCOE clients in scheduling additional health care visits (91 percent, n=1,237). This help is often provided through a referral, which a majority of CCOE clients reported using (86 percent, n=788). CCOE clients indicated that it is easy to get a referral (92 percent, n=931). Over a third of CCOE clients (35 percent) received a referral in one business day or less, while 42 percent of CCOE clients have a referral within two to three business days (n=766). Table 3.1 shows the CCOE Participant Survey questions that provided this information.

Table 3.1 Reason for Health Care Visit

Survey Question	% Agree	# of Clients
Does the CCOE provide you the chance to get both gynecological and general health care?	94%	1,217
Were you satisfied with the overall quality of care you received?	93%	1,304
Were you satisfied with the overall coordination of your care?	91%	1,271
Did you have to provide the same information (e.g., name, address, phone) more than once?	50%	1,289
Did you receive help with scheduling your next visit?	91%	1,237
Was it easy to get a referral for a health care service?	92%	931
Did you use the referral?	86%	788

3.2.2 Perceptions of Community-Based Research

Fewer CCOE women have participated in research studies compared to those who received services through the health care services component. For the community-based research component, 101 CCOE clients reported participating in a community-based research study. A high percentage of CCOE clients indicated that the purpose of the research study was explained to them (91 percent, n=96) and that the study was explained in an understandable manner (91 percent, n=92). Slightly fewer CCOE clients (86 percent, n=91) have indicated that it was convenient for them to participate in the research study. Table 3.2 shows the CCOE Participant Survey questions that provided this information.

Table 3.2 CCOE Participant Survey – Community-Based Research

Survey Question	% Agree	# of Clients
Was the **purpose** of the research study explained to you?	91%	96
Were the procedures of the research study explained to you in an **understandable manner**?	91%	92
Was it **convenient to participate** in the research study?	86%	91

3.2.3 Perceptions of Leadership Development

For the leadership development component, 60 CCOE clients indicated that they participated in a training event at the CCOE in the last six months. Almost all CCOE clients (93 percent, n=54) agreed that it was easy to sign up for leadership and skills training and that they were satisfied with the training they received (91 percent, n=55). Over three fourths (77 percent, n=51) of CCOE clients believe that leadership opportunities are available to them through the leadership program. Fewer (62 percent, n=42) have a mentor that provides them with career advice. Although, the purpose of the leadership and skills training was not job placement, approximately 40 percent (n=45) of the CCOE clients have earned a job in the health care field after completing the training. Table 3.3 shows the CCOE Participant Survey questions that provided this information.

Table 3.3 CCOE Participant Survey – Leadership Development

Survey Question	% Agree	# of Clients
Was it **easy to sign up** for the leadership and skills training?	93%	54
Did you get a **job in health care** after you finished the leadership and skills training?	40%	45
Do you have a **mentor** who provides you with career advice?	62%	42
Are **leadership opportunities** available to you through the CCOE program?	77%	51
Were you **satisfied** with the leadership and skills training you received?	91%	55

3.2.4 Perceptions of Education and Outreach

For the education and outreach core component, 381 CCOE clients indicated that they participated in a CCOE-sponsored event or class in the last six months. According to the CCOE clients, the events were culturally competent and respectful of different cultures (97 percent, n=363) and were provided in the CCOE clients' primary language (96 percent, n=369). CCOE clients were also able to learn new information during their event or class (98 percent, n=364). However, slightly fewer women indicated that they changed their behavior or habits following the event (89 percent, n=342). The CCOE clients highly agree that the information they are given is helpful (99 percent, n=372), including healthy living topics (98 percent, n=366), and that this information is easy to read (95 percent, n=370). Almost all CCOE clients (92 percent, n=362) are being asked for suggestions for topics on educational sessions or classes and 96 percent (n=339) received help finding resources related to women's health. Table 4.6 shows the CCOE Participant Survey questions that provided this information.

Table 3.4 CCOE Participant Survey – Classes, Events, and Information

Survey Question	% Agree	# of Clients
Were you asked for **suggestions about topics** for educational sessions or classes?	92%	362
Was the most recent event or class presented in your primary **language**?	96%	369
Was the most recent event or class presented in a manner that was **respectful** of different cultures?	97%	363
Did you **learn new information** during your most recent event or class?	98%	364
Did you **change your habits or behavior** (e.g., quit or reduce smoking) because of information you learned from an event, class, or information you received?	89%	342
Did you receive help with finding information **resources in women's health**?	96%	339
Was information about **healthy living** (such as diet and exercise) available to you?	98%	366
Was the information you received **helpful**?	99%	372
Was the information you received **easy to read**?	95%	370

3.3 Results for Each Core Component and Other Program Requirements

The CCOE program evaluation analyzes how well the CCOE program, as a whole, is achieving each of the six core components, and thus, the program goals. The core components include:

1. Comprehensive and integrated delivery of women's health care services
2. Training for lay and professional health care providers
3. Community-based research
4. Public education and outreach
5. Leadership development for women as health care consumers and providers
6. Technical assistance and replication of the CCOE model

As Section 2.1.3 discusses, the scoring process for this evaluation involves assigning a numerical score to each of the core component areas/research questions. Scoring CCOEs on their performance provides a way to quantify how well each CCOE is meeting each of the core components. A visual coding scheme of 3-circle, 2-circle, and 1-circle ratings has been implemented to make these results easy to interpret. Each rating is associated with a score range out of a total possible score of 100 points. To interpret the core component score, use the following guidelines:

- A ●●● rating indicates that the CCOE is exceeding the goals or requirements for the core component. This rating corresponds to a score of 75 to 100.
- A ●● rating indicates that the CCOE is meeting the goals or requirements for the core component. This rating corresponds to a score of 51 to 74.
- A ● rating indicates that the CCOE is only partially meeting or does not meet goals or requirements for the core component. This rating corresponds to a score of 50 or below.

In addition to assessing achievement of the core components, the evaluation also assesses the extent to which other program requirements are being fulfilled. These program requirements are not considered a core component. However, as with the core components, a research question and associated subquestions were developed to address non-component related requirements for the CCOE program.

Program requirements have been assessed and scored using the same process used to assess the core components. Results of this scoring effort are included in this section.

Table 3.5 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 ●●●

Individual CCOEs vary in how well they are performing against each of the individual core components and program requirements. Table 3.5 summarizes how the CCOEs, overall, are performing against each of the CCOE core components. Each score, except for "other program requirements" such as signage, leveraging additional dollars, etc., considers the level of integration between the core components and other components.

A total of 100 points was assigned to each component. The CCOEs scored between 58 to 84 points in each of the six core components. The CCOE program is achieving its programmatic goals for all of its components. The CCOEs are exceeding the goals or requirements for the following components: 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 components.

These scores consider subtleties that help to fulfill each of the core components/program goals. Subtleties are addressed through research questions and their associated research subquestions. The core components/research questions are discussed in greater detail and supplemented with qualitative examples in the following portions of Section 3.0. Examples provided throughout this section illustrate the conclusions drawn from this study. The CCOEs highlighted as examples are not the only CCOEs demonstrating the described characteristics; they are cited because they serve as good examples of the types of activities the CCOEs are implementing to support the core components and the goals of the CCOE program.

Each of the following core component subsections provides:

- A description of the core component being discussed
- A brief description of the research questions and subquestions associated with the core component as well as the overall score received for the core component
- A table summarizing the scores for the research questions and subquestions associated with the core component
- A discussion of the findings and conclusions associated with each of the research subquestions
- A discussion of opportunities for improvement for the CCOE program as they relate to the core component.

3.3.1 Comprehensive and Integrated Women's Health Care Services Delivery

In a previous report on how to improve women's health in community settings, the author said that to address women's health issues, it was important for different specialists and physicians to work together in the interest of clients. It was suggested that, "at a minimum, physicians could explore the resources available to their clients and become familiar with them and who provided them. By establishing a connection with other professionals in their community, physicians could work together to ensure their patients receive the best preventive care and treatment available." (ORC Macro, April 2001.)

The health care services delivery core component, more than any other, assesses ways in which CCOEs are working to bring together those members of their community who are committed to creating a comprehensive women's health care delivery system that is easily accessible to underserved women. The research subquestions associated with this core component, and the program goal the component links with, focused on whether services were women-centered, women-focused, women-relevant, and women-friendly. CCOEs were assessed on how well they are providing acute, chronic, and preventive care, and how well they have incorporated both primary and specialty services, including mental and dental health services, patient education, health promotion, and enabling services.

Overall, the CCOE program is exceeding the goals of delivering comprehensive and integrated health services in 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, as shown in Table 3.6. This score indicates that the CCOE program is impacting local communities by improving access to and integrating health care services. CCOEs are impacting communities and improving 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, regardless of their ability to pay.

The research subquestions for this core component consider the strategic aspects of the CCOE program, including improvement in access to health care services, the range of care offered, whether or not continuous care is offered by the CCOE and its partners, how well these services are being integrated and coordinated, and whether or not there is a sustainable framework for providing CCOE services. This score also considers administrative aspects of the program, including whether the CCOE is physically identifiable with appropriate space and signage, and if CCOEs can identify and track the women and the costs of services delivered to them.

The research subquestions did not differentiate between those factors that are more strategic in ensuring increased access to and integration of women's health care services and those that are more operational in nature (e.g., the number of services offered). However, these distinct components are discussed separately in the findings and conclusions below.

Table 3.6 Comprehensive and Integrated Delivery of Women's Health Care Services Core Component Scores

Research Question:	Has the CCOE program improved comprehensive health service delivery within the targeted communities?	Component Score: 76	
Research Subquestion		**%**	**Score**
Does the service delivery network provide **continuous care through the range of services** offered and the referral system?		88%	11/12.5 ●●●
How is health care service delivery **integrated** with the other components of the CCOE program?		50%	6.25/12.5 ●
Does the service network successfully **integrate and coordinate** care with community partners?		58%	7/12.5 ●●
Does the CCOE program offer a **full range of care** including, but not limited to: acute, chronic, and preventive care, both primary and specialty services (including mental and dental health services, patient education, health promotion, enabling and ancillary services)?		83%	10/12.5 ●●●
Does the service delivery network demonstrate **improvement in access to health care services** for the targeted community?		92%	11.5/12.5 ●●●
Does the clinical care center have a schedule and procedures for **identifying and counting women** served by the CCOEs **and tracking the cost of services** delivered through the program?		50%	6.25/12.5 ●
Is a **physically identifiable** clinical care center with **permanent signage** and the **appropriate space** and **operational hour** allocation available?		100%	12.5/12.5 ●●●
Is a **sustainable framework** in place for providing CCOE services?		83%	10/12.5 ●●●

Findings and Conclusions

Does the service delivery network provide continuous care through the range of services offered and the referral system?

The CCOEs, their community partners, and their clients indicated that the CCOEs, and the programs they offer, are increasing the accessibility of health care services for women in their community. In most cases, women find accessing the full range of services easier as a result of the CCOE network. The CCOE program also makes it easier for women to navigate the network of health care resources in their community. The CCOEs have worked hand in hand with their advisory boards and consortium of community partners to identify the range of services offered in their communities and to incorporate those services into their networks. They have served as a magnet for health care providers and others who have an interest in women's health. They are bringing these entities together to discuss the needs of the community, how they can address those needs, and how they can work together to provide the full range of health care services needed. CCOEs and their partners are communicating with one another about the resources available to meet these needs, and they are leveraging their different networks and resources to communicate this information to the public. By removing barriers to communication and serving as a catalyst for coordinating resources, CCOEs are increasing the integration and accessibility of services within their communities.

How is health care service delivery integrated with the other components of the CCOE program? Does the service network successfully integrate and coordinate care with community partners?

In addition to coordinating access to a full range of health care services, the CCOEs, with their partners, have spent time and effort to ensure that health care delivery is integrated with other components of the CCOE program. Most clients' main point of access to the CCOE is through clinical care. The CCOEs are leveraging this point of entry to make women aware of the training and education opportunities they offer. When the first point of contact with a woman is not through a clinical care center, the CCOEs and their partners are using these other points of contact (e.g., a

domestic violence shelter, an AHEC, a social service organization) to make women aware of the health care and ancillary services offered through the CCOE network.

The CCOEs are using a variety of innovative and creative ways to integrate health care delivery with other core components. Usually, training, research, leadership development, and educational and outreach opportunities include and extend beyond, traditional health topics. Mariposa Community Health Center and St. Barnabas Hospital and Healthcare System are using their promotoras and peer educators as a key point of integration in their delivery of health services. These women are trained on a variety of topics related to health care, nutrition, leadership, lay counseling, and group facilitation. These promotoras and peer educators are meeting with women about their health care needs, conducting education and outreach activities, and in some cases, serving as case managers. Mariposa Community Health Center, through one of its partners, has a program where medical students are conducting home health visits with promotoras. As one of the administrators at this partner site conveyed, this is one of the first and purest exposures to public health that most of these medical students receive. Griffin Hospital is providing mentoring and leadership training in group facilitation techniques to one of its own staff members. This person is leveraging those skills in her community and has facilitated a group that uses arts and crafts as a way to create a comfortable forum for discussing spiritual, physical, and emotional health. Women's Health Services has collaborated with the Institute of American Indian Arts (IAIA) and the Indian Health Service (IHS) to develop and provide a "niche service" for Native American students at the IAIA. These organizations are providing a weekly student clinic at the college. Women's Health Services provides the medical services, and IHS provides labs and prescriptions for the clinic.

Does the CCOE program offer a full range of care including, but not limited to: acute, chronic, and preventive care, both primary and specialty services (including mental and dental health services, patient education, health promotion, enabling and ancillary services)?

All CCOEs are providing access to preventive services and some specialty health care services. The critical distinguishing factor among CCOEs, however, is the provision of behavioral health, dental, and/or vision care. Eight of the 12 CCOEs offer behavioral health care or access to behavioral health care through partnerships. Many CCOEs reported a significant need for dental services. Northeast Missouri Health Council and Ohana Women's Health and Wellness Program are providing access to dental care, while NorthEast Ohio Neighborhood Health Services and Christiana Care Health Services, through its partners, are securing space and staff to provide dental care in the future. Many clients visiting these sites have reported very lengthy waits for appointments. These wait times may be expected, however, as there is currently a nationwide shortage of dentists in the United States. Most CCOEs reported being aware of this issue and reported taking steps to address dental needs in their communities. No CCOEs reported that they provide vision care.

To increase access to health care, it is critical that CCOEs provide enabling services such as translation, transportation, and childcare. Many CCOEs have a great need for translation services. Only one CCOE, Northeastern Vermont AHEC, did not have a great need for translation services. In contrast, several CCOEs, including St. Barnabas Hospital and Healthcare System, Mariposa Community Health Center, and Ohana Women's Health and Wellness Program, report having very significant needs for translation services. Each of these CCOEs is doing a very good job of meeting the demand for translation services in their communities and has multiple staff available to speak the predominate or multitude of languages spoken. However, a few CCOEs are having difficulty meeting translation service needs. Hennepin County Department of Primary Care has many new, rapidly

growing and changing immigrant populations. Despite its efforts, the CCOE is having a difficult time meeting the translation needs of their community. Although the CCOE is working hard to address the increasing translation needs of its community, its limited resources and staff are insufficient to keep pace with the speed of the changes occurring in this community.

Does the service delivery network demonstrate improvement in access to health care services for the targeted community?

For women served by the CCOEs, lack of transportation is the single largest barrier to accessing services. The CCOEs and their partners report that in their communities, public transportation is available but inadequate, expensive, or inconvenient. For example, Derby, Connecticut, where Griffin Hospital is located, has limited public transportation. What transportation exists is expensive. Mariposa Community Health Center did make transportation available to CCOE clients but found that women came to expect this service, even if they did not truly need it. This eventually taxed Mariposa Community Health Center's resources. Jefferson Health System CCOE reported that transportation is not an issue. However, feedback from CCOE clients indicated that transportation to this CCOE is difficult and/or inaccessible.

Transportation difficulties can result from any one or combination of factors, the causes of which the evaluation team can only speculate about. Difficulties with public transportation can be due to a variety of reasons, such as an individual's perceptions about public transportation, an individual's preference not to use public transportation, inaccessibility of the transportation, long wait times, and/or the strength or weakness of the local transit program.

Another key component to helping women access health care is to provide childcare. Most CCOEs report they are providing childcare in some form or another. In spite of this, however, CCOEs and their partners have identified multiple instances where women missed appointments because they needed to provide care for a child and were either unaware of child care services at the CCOE or their alternative childcare providers cancelled at the last minute. Some CCOEs and their partners are providing childcare in more formal ways than others. One Christiana Care Health Services CCOE partner, who does not officially provide childcare, indicated that she and all of her staff have served, at one point or another, as impromptu babysitters for CCOE clients. In contrast, Ohana Women's Health and Wellness Program offers a formal childcare program that is a distinct and separate service. This CCOE has a fully staffed daycare with designated space, where children over the age of four can play while their caregivers are receiving health care services.

Does the clinical care center have a schedule and procedures for identifying and counting women served by the CCOEs and tracking the cost of services delivered through the program?

All CCOEs have a process for tracking CCOE clients. All CCOEs also reported that they are continuously looking for ways to improve and refine their tracking systems. Most are in various stages of formalizing and/or automating their tracking systems. Most CCOEs are using a combination of manual chart tracking methods, electronic records management, billing systems, and their own custom databases or MS Excel spreadsheets to track CCOE women. Jefferson Health System tracks CCOE women within its hospital using the hospital's information technology (IT) systems. Jefferson Health System is also working on ways to track women when they receive or are given referrals to community partners. Mariposa Community Health Center is transitioning from one database to another. Griffin Hospital is leveraging its Valley Access Management System (VAMS)—which had been in use since 2000, before its CCOE designation—to track its clients. Griffin Hospital uses an intake form to collect

information about its clients and uses this system to electronically send and confirm referrals with most partner organizations. For additional information on the lessons learned by CCOEs during their development of effective tracking systems, refer to Section 4.2.4.

Although it is not a tracking system, one CCOE partner has identified benefits to tracking client information manually by color-coding client files. This CCOE reviews these files to provide quarterly data for OWH, and by doing so, is, by default, providing better care to its clients. In her review of files to count the number of different types of services provided, the Registered Nurse (RN) conducting the review found clients who had not followed up on medications or who needed to return for follow-up assessments. The RN has subsequently been able to coordinate with physicians and administrative staffs to either bring these women in for follow-up visits or to discuss, by phone, the next steps they need to take.

Most CCOEs do not track the costs of services provided to CCOE women. If and when the costs of providing services to CCOE women are tracked, they most often are tracked through insurance payments. No CCOE has reported using cost information to analyze operations or track the services being provided. Because many CCOE women are uninsured, the accuracy of tracked costs is limited. Tracking costs is a part of the CCOE program evaluation, because costs provide a measure of services offered. Without this information, CCOEs cannot capture in-kind contributions or know how much money they can recover through a sliding fee scale.

Is a physically identifiable clinical care center with permanent signage and the appropriate space and operational hour allocation available?

All CCOEs have signage to indicate their status as a CCOE and the location of their clinical care center. Turley Family Health Center and Christiana Care Health Services are CCOEs operating in large hospital systems, and each of these CCOEs has signs in multiple locations to either indicate its facility's status as a CCOE or to make the CCOE easier to find. All CCOEs have space that is designated for the CCOE and CCOE purposes.

Is a sustainable framework in place for providing CCOE services?

When sustainability was discussed with the CCOEs, discussions focused on three main topics: funding, leadership, and documentation of policies and procedures. These were identified as the three key ingredients for CCOE sustainability. Funding is key to retaining staff and continuing programs, leadership is critical for establishing a vision and setting priorities for the CCOE program, and documentation of policies and procedures is critical to ensuring that CCOEs can replicate themselves at their current location or somewhere else. In general, CCOEs affiliated with large hospital systems or created from long-standing programs indicate that they have a larger pool of resources, both financial and otherwise, to sustain their activities post-CCOE designation. They have stronger networks within their community and larger amounts of leadership and support from individuals with access to substantial funds.

Opportunities for Improvement

Although the CCOEs are having a significant and highly positive impact on improving comprehensive and integrated women's health care services delivery, there are additional opportunities for the CCOE programs to improve. One key issue facing OWH and the CCOE programs is that of sustainability. Similar to many young and new organizations, the CCOEs have very energetic and charismatic leaders. In almost every CCOE, CCOE staff and community partners have identified the Program

Coordinator as the most critical player responsible for the success of the CCOE program. These leaders have been critical in obtaining support and buy-in from the community for the CCOE mission, goals, and programs. If, and when, these individuals choose to leave the CCOEs for other opportunities, the CCOEs will need to have a succession plan for ensuring that programs continue and that the reputations of the CCOEs are sustainable. Another key component of stability is funding. CCOEs, after they lose their CCOE designation, will need to ensure program impact and results are sufficient to warrant current and, if possible, additional funding levels. (See Section 6 for additional information on this topic.)

There are opportunities to refine the processes and systems being used to track CCOE clients and the costs of providing services. Currently, there is no one single definition of who a CCOE client is. Each individual CCOE determines who is considered a CCOE client, and the definition of a client is determined as much by the operations at each individual CCOE as it is by program goals and targeted populations. CCOEs generally are taking two approaches to defining who is a CCOE client. Some CCOEs define their clients as everyone seen in their facility, while other CCOEs identify and enroll a specific subset of their population as CCOE clients. The resources each CCOE has available largely determines the approach taken by each CCOE. Depending on resources available to them, some CCOEs have established caps on the number of women for whom they can manage care and the number of women to whom they can provide services.

Finally, there is an opportunity to make women in targeted communities more aware of the ancillary services that make receiving health care easier. Communicating to communities that translation services, transportation, and childcare services are available may help to encourage women to seek health care or information on health services from the CCOE.

3.3.2 Training for Lay and Professional Health Care Providers

Training for lay and professional health care providers includes health care professionals, students, medical residents, and allied health care workers. Training is provided in the form of in-service training, continuing education, workshops, demonstrations, courses, and internship opportunities.

Overall, the CCOEs are exceeding the goals for impacting the training of lay and professional health care providers within the targeted communities. As shown in Table 3.7, 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.

The research subquestions that populate this score consider whether training topics are focused on improving health services for women, if training is focused on both lay and professional health care providers, if existing community resources are being leveraged, and how training activities are being integrated with other components.

Table 3.7 Training of Lay and Professional Health Care Provider Core Component Scores

Research Question:	How has the CCOE program impacted the training of lay and professional health care providers within the targeted communities?	Component Score: 84

Research Subquestion	%	Score	
Are training activities provided on **topics aimed at improving health services** for women?	83%	21/25	●●●
Are training activities targeted towards a spectrum of **lay and professional health care providers**, including any special provider groups?	92%	22/25	●●●
How are training activities **integrated with the other components** of the CCOE program?	71%	18/25	●●
Do training activities **leverage existing community resources**?	92%	23/25	●●●

Findings and Conclusions

Are training activities provided on topics aimed at improving health services for women?

The CCOEs collectively have a very lengthy and diverse list of training programs focused on improving women's health. The topics CCOEs offer cover a broad range of health care concerns. A sample of the types of training being offered include:

- Pursuing a career as a health professional
- Domestic violence
- Nutrition
- Depression
- Heart disease
- Uterine and breast cancer
- Oral health/smoking cessation
- Substance abuse
- Diabetes
- Nursing skills

Training aimed at improving health services for women is taking many forms. At the Northeastern Vermont AHEC, the most successful provider education programs have resulted from collaborative planning efforts between the CCOE/AHEC and other community organizations and institutions. The Northeastern Vermont AHEC is authorized to award CME/CEU credits for nine different professional entities, and it is administering credits for each of the programs offered. It offers training and education programs for both lay and professional providers, on topics ranging from diabetes to domestic violence to heart disease. The CCOE planned and sponsored a six-session "Community Health Advisor Women's Health Lunch and Learn Series" with the Community Health Advisor Network (CHAN) at the University of Mississippi. The topics included Adolescent Angst, Helping Women Find Their Intrinsic Motivation, Women and Addiction, Eating for Healthy Living, Domestic & Sexual Violence: Asking the Right Questions, and Women and Diabetes. A physician presented the topics, and the target audience included physicians, nurse practitioners, and physician assistants. At Griffin Hospital, the Griffin Residency Program/Faculty Practice obtained two grants to facilitate and train residents and faculty in women's health. It will develop a comprehensive curriculum in women's health, and a faculty member will be responsible for developing/coordinating a total of 6 months of new rotations, focusing on topics such as women's health, HIV/AIDS, and genetics. Residents will be trained on how to provide culturally competent preventive primary care for underserved and vulnerable populations. One of the 2 to 4 week rotation blocks for internal medication will be at the Griffin Hospital CCOE and will train residents on all aspects of Women's Health.

Are training activities targeted towards a spectrum of lay and professional health care providers, including any special provider groups?

Training courses are offered for a variety of audiences, with a variety of objectives and goals. Courses are offered to lay and professional health care providers to increase their awareness of medical issues and conditions, to train them on how to recognize symptoms, and to make them aware of where to find additional resources for clients. Depending on the subject of the training and the experience and specialties of CCOE staff and partners, different individuals or groups are responsible for designing and offering training. In some cases, lay health professionals provide training to health professionals (i.e., signs of domestic violence); in other cases, health professionals provide training to lay health providers (i.e., breast screening techniques).

Several CCOEs have developed training curriculums for use in training health care providers. Women's Health Services has developed a curriculum for a women's health "research" elective designed for fourth year medical students, as well as second and third year internal medicine, family practice, or obstetrics and gynecology residents. These training curriculums allow students and residents to pursue a women's health focus and help further develop the American College of Women's Health Physicians' women's health residency curriculum. Women's Health Services is also working with the University of New Mexico to acknowledge and design a sex and gender approach to medicine. Together, they are publishing a curriculum for fourth year medical students that focuses on and addresses medical needs and differences in genders. Christiana Care Health Services has partnered with the University of Delaware School of Nursing to develop a curriculum to train nurses to train patients on how to become advocates for their own health. Nursing interns with the CCOE use this curriculum with the community patients with whom they come into contact.

How are training activities integrated with the other components of the CCOE program?

The question of whether or not training activities are being integrated with other components of the CCOE program can be answered on two levels: how well activities are integrating with partners and partner activities and how well activities are integrating with other core components of the CCOE program. There are several examples that demonstrate how CCOEs are helping to bridge the link between their staff and other health care providers in the community.

The Turley Family Health Center CCOE has partnerships with Morton Plant Hospital System. The CCOE is one of the few places where residents and interns can obtain primary care experience in a community-based primary care setting. These residents not only attend internal training programs for professional health care providers, they also receive some of their medical training from the CCOE. Mariposa Community Health Center has established a way for medical residents and public health specialists to receive some of their training through the CCOE program. Medical residents and students of public health have conducted home health visits and outreach activities with the CCOE promotoras, providing them with hands on community public health experience.

In answer to the second question of how well training activities are being integrated with other core components of the CCOE program, it is apparent that training for lay and professional health providers is integrated more strongly with some of the CCOE components than others. Training activities are very closely integrated with education and outreach activities, and in some cases, they are integrated more fully with community-based research. As CCOE staff and their partners are trained and gain skills in certain areas, they are leveraging this knowledge in their education and outreach activities. Hennepin County Department of Primary Care has conducted research on racism in its community and

how it affects the care women receive. They used the results of this research to create a training program on how to provide culturally competent care. The Northeastern Vermont AHEC has provided training for its CHWs, who in turn, are providing case management and counseling to community members.

In some cases, training activities are supporting leadership development activities. For example, Mariposa Community Health Center has offered CPR training to young women interested in becoming health care professionals or interested in health care. The skills these young women obtained have both increased their leadership skills and provided them with a lay health skill. Mariposa Community Health Center and St. Barnabas Hospital and Healthcare System provide training for community members through the promotoras and peer educator programs. These programs are focused on educating local women on health care topics and providing them with a knowledge base they can use to reach out to empower other women to actively maintain their health and to seek health care when needed. At the Mariposa Community Health Center, selected women received training on how to work as promotoras. These women subsequently went on to provide outreach, education, and training to other women in the community. At St. Barnabas Hospital and Healthcare System, women underwent a rigorous peer educator training that enabled them to provide outreach, education, and case management to women in the community. Every one of these women has become a recognized leader in her community.

Do training activities leverage existing community resources?

Many CCOEs are leveraging partner relationships and other existing community resources to offer training to their professional and lay health care providers on topics related to the partners' area of expertise. Mariposa Community Health Center, Christiana Care Health Services, Ohana Women's Health and Wellness Program, and Hennepin County Department of Primary Care are all using this approach. The Mariposa Community Health Center is leveraging its relationship with a partner and a recently designated National Center of Excellence in Women's Health (CoE) at the University of Arizona, Tucson, to provide training to health care providers on uterine and breast cancer. Christiana Care Health Services is offering training on folic acid by joining together physicians associated with the CCOE and one of its community partners, the March of Dimes. Christiana Care Health Services has also partnered with the University of Delaware School of Nursing and their nursing student interns to develop a training curriculum to train clients to become advocates for their own health. The next step is for the interns to work with the School of Nursing to develop a training curriculum to train health care providers on how to respond to clients who act as their own advocates. Together with the State of Hawaii Department of Health Tobacco Control Unit, the Ohana Women's Health and Wellness Program trained its CHWs in tobacco cessation and intervention skills so they could conduct interventions when they met women in need of these services.

Opportunities for Improvement

The CCOEs have developed a significant number of quality training programs targeting both lay and professional health care providers. Some of these programs address health care topics and needs identified by the community, as defined by community partners. Most training programs, however, are offered by the CCOE without inquiry into community needs. There may be opportunities for more CCOEs to seek feedback from those they serve. Opportunities also may exist to expand the formats used for providing training. Of the training programs that CCOEs are participating in or offering, most

use traditional didactic approaches. There may be creative, interactive ways to provide training that involves role-playing or technology.

Training needs also may be met by partnering with academic institutions, whether a graduate school or a community college, to develop training curriculums and leverage recent research findings. Mariposa Community Health Center, Christiana Care Health Services, and St. Barnabas Hospital and Healthcare System are partnering with academic health centers to develop training materials and curricula. These partnerships have evolved into creative, innovative training programs that integrate and fulfill many different aspects of the core components and CCOE program goals. Christiana Care Health Services' partnerships with academic health centers have resulted in the integration of nursing students with curricula development and the provision of public health services. Several of the CCOEs are located near CoEs or other academic health centers. The CCOEs may wish to investigate opportunities to partner with these organizations to develop and to provide training for health professionals.

3.3.3 Community-Based Research

The community-based research component of the CCOE program is intended to bring CCOE community members into the research process in a truly participatory manner. The program seeks to maximize the exchange of knowledge between the CCOE and its community and partners, and to provide a forum for implementing research findings. Ideally, community members work together with the CCOE to develop research issues, inform the research objectives, shape the research process, and bring research results back to the community. OWH guidance suggests that scientific integrity in research methods be maintained, while incorporating the skills, knowledge, and strengths of the participants and beneficiaries of the research. Results of the research should be implemented and communicated to the community.

Overall, the CCOE program is meeting the community-based research goals, although there are opportunities to enhance community research activities in CCOE communities. As Table 3.8 shows, the average component score for **Community-Based Research** is **73** out of 100 points. This indicates that the CCOEs are conducting community-based research, both independently and with the help of partners and outside organizations. They are also using the research results to improve the health care provided to women in their communities. Based on research results, the CCOEs are making decisions about what programs and services they need to focus on or provide.

This score indicates that the CCOE program is impacting community-based research and is increasing the amount of research being done in communities. The research subquestions that populate this score consider who is involved in conducting the research, the focus of the research, whether these efforts are an expansion of previous efforts or new activities, how the results will be used to improve women's health, and how the activities integrate with other CCOE components.

Table 3.8 Community-Based Research Core Component Scores

Research Question:	What is the impact of the CCOE program on community-based research?	Component Score: 73	
Research Subquestion	**%**	**Score**	
Are the research activities focused on improving women's health?	100%	20/20	●●●
Are community resources (e.g., partners, advisory boards, other organizations) involved in the research development process?	88%	18/20	●●●
Are these activities expansions of previous efforts or new activities?	83%	17/20	●●●
How are research results used to improve women's health?	42%	8/20	●
How are research activities integrated with the other components of the CCOE program (used in improving patient care, program operations, referrals, etc.)?	50%	10/20	●

Findings and Conclusions

Are the research activities focused on improving women's health?

All the research activities the CCOEs sponsor are focused on gaining knowledge and information that can be used to improve women's health. Community research activities are geared toward gaining a better understanding of the health needs of a local community or gaining a deeper understanding of a specific health issue within that community.

Are community resources (e.g., partners, advisory boards, other organizations) involved in the research development process?

Nine of the 12 CCOEs have relied on multiple resources to conduct community-based research. Three CCOEs—Jefferson Health System, Northeast Missouri Health Council, and St. Barnabas Hospital and Healthcare System—have collaborated with one resource outside of the CCOE staff to conduct community-based research. Seven of the CCOEs have leveraged partner organizations to conduct community-based research, and of those seven, two have collaborated with only community partner organizations to conduct research. Seven of the CCOEs have leveraged advisory boards to conduct their community research. One of those CCOEs has used the advisory board as their sole resource in conducting research.

The CCOEs have relied on the insight, guidance, and resources of these organizations to support and assist their research. Advisory boards have offered insight—from their perspective—into what are the most pressing health issues in their communities. Working together with such organizations, CCOEs have been able to identify public health issues that warrant a closer look and investigation. In many cases, partners have provided the CCOE with the resources necessary to conduct research activities, such as providing access to target populations, research expertise or skills, or streamlined distribution methods. Mariposa Community Health Center is leveraging its relationship with one if its partners—a recently designated CoE, the University of Arizona, Tucson—to conduct its community research.

Are these activities expansions of previous efforts or new activities? How are research results used to improve women's health? How are research activities integrated with the other components of the CCOE program (used in improving patient care, program operations, referrals, etc.)?

Some CCOEs are conducting new research efforts, while others are expanding on previous research efforts. Griffin Hospital is collecting and storing data from its intake forms to serve as the basis for a long-term epidemiological study. Beginning in 2000, Griffin Hospital began collecting data on the demographics, health, social capital, and food security of women in its community. This data has been stored in the Valley Access Management System (VAMS). Griffin Hospital hopes that within another year or so, there will be enough data to conduct a study on the health profile and needs of women in its community. Some of the data collected will provide key links to understanding heart health, diabetes, and obesity. Griffin Hospital plans to use its community-based research results to determine how to provide better health care to its community.

Christiana Care Health Services began a new community-based research project shortly after receiving its CCOE award. They asked women of all ages and ethnic backgrounds to identify their major health concerns. These concerns, along with basic demographic information, were gathered, allowing the CCOE to examine local women's greatest health concerns and needs. Because the study collected demographic information, the CCOE has been able to assess the greatest health care concerns of women in the community by age, ethnic backgrounds, and socioeconomic status. It anticipates using this information to plan its programs and activities.

Hennepin County Department of Primary Care initiated a new research effort with the College of St. Catherine's to study how race influenced the care women received. Through a series of focus groups, data were gathered on the impact of race on care, on how racial background affected preferences for treatment, and on how race affected provider interaction. The results of this study were used to produce a report that was distributed to providers. The Hennepin County Department of Primary Care is now in the process of creating a video to educate providers on how to provide culturally competent care. The results of this research effort are feeding back into the CCOE's health services delivery and training activities.

The University of Alabama School of Public Health is conducting a study on the use of CHWs to serve women's health needs and the impact CHWs are having on improving access to care. The populations it is investigating are the same populations served by the Jefferson Health System CCOE. The two organizations have partnered, with the University of Alabama School of Public Health providing health outreach and case management, and the CCOE identifying the clients to participate in the study. These community-based research efforts are benefiting the health services, education, and outreach activities being provided to CCOE women.

Opportunities for Improvement

There are several opportunities for improvement in the CCOE community-based research efforts. One CCOE has conducted research that does not specifically focus on the needs of the local community. It is looking to contribute to the wider body of knowledge on women's health and hopes to later apply the findings from the research to its CCOE clinical practices and program offerings. Although these efforts are good and noteworthy, they do not have a clear link to the OWH requirements for conducting community-based research. Other CCOEs appear to be hesitant to begin conducting research. They are worried that they do not have the time, resources, and/or skills necessary to conduct a

methodologically rigorous research project. The OWH and the CCOEs need to work together to further define the requirements of the community-based research core component. There may be a variety of creative ways for CCOEs to conduct valuable research in their communities, and these approaches may not require CCOEs to invest large resources in conducting a strict, methodologically rigorous research study.

3.3.4 Education and Outreach

The purpose of education and outreach is to help women become more knowledgeable about their health and be empowered to make sound health care decisions. Education and outreach activities address concerns and issues that the community identifies and are developed in partnership with the community. The activities and materials, therefore, are culturally competent, age appropriate, and focus on preventing and reducing illnesses or injuries.

Overall the CCOE program is exceeding the goals for impacting educational and outreach activities. 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. As Table 3.9 shows, 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 the CCOE program sponsors, the educational materials the program uses, the amount of community input the CCOE program solicits, 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 this section.

Table 3.9 Education and Outreach Core Component Scores

Research Question: What is the impact of the CCOE program on public education and outreach? Component Score: 82 out of 100

Research Subquestion	%	Score	
Are the educational materials and activities appropriate to the **age** of the targeted audience?	100%	11/11	●●●
Are the educational materials and activities appropriate to the **culture/ethnicity** of the targeted audience?	100%	11/11	●●●
Are the educational materials and activities appropriate to the **gender** of the targeted audience?	91%	10/11	●●●
Are the educational materials and activities appropriate for the **literacy level** of the targeted audience?	100%	11/11	●●●
Do the educational materials and activities address issues that are **relevant to the community**?	73%	8/11	●●
Do the educational materials and activities address issues that are amenable to recipient **behavioral modification**?	91%	10/11	●●●
Is the selection of educational topics based on **community input** or feedback?	73%	8/11	●●
Does the CCOE use non-CCOE community resources in the **production or dissemination** of educational materials?	100%	11/11	●●●
How are public education and outreach activities **integrated** with the other components of the CCOE program?	27%	3/11	●

Findings and Conclusions

Are the educational materials and activities appropriate to the age of the targeted audience?

All of the CCOE programs have education and outreach events appropriate for a wide age range of clients. The NorthEast Ohio Neighborhood Health Services CCOE offers activities for elderly women, high school students, adult women, and incarcerated women. This subquestion also considers if the educational topics are appropriate for the age of the women attending the event.

Although data from the CCOE Director and Program Coordinator and CCOE Community Partner surveys does not directly support scoring this subquestion, it does provide some context to determine if educational materials are meeting audience needs. Using a large font in educational materials is often necessary to accommodate women or men with vision difficulties. Five of the CCOEs responded that they do offer educational materials in a large font, while three CCOEs neither agreed nor disagreed. Partners affiliated with nine of the CCOEs have indicated that educational materials are provided in a large font to CCOE clients.

Are the educational materials and activities appropriate to the culture/ethnicity of the targeted audience?

All of the CCOEs are providing appropriate materials to CCOE clients of different cultures or ethnicities. This is an especially meaningful subquestion because many CCOEs service clients from many different cultures. These clients have differing views about how to manage their health and about health care in general. If the CCOE did not respect these cultural differences, clients would be less likely to come to the CCOE for classes or health care services. St. Barnabas Hospital and Healthcare System and Ohana Women's Health and Wellness Program are two examples of CCOEs with outreach programs that are exhibiting a high degree of cultural competence. Ohana Women's Health and Wellness Program is demonstrating respect for different religious and cultural beliefs when it presents materials related to reproductive health. For example, it is inappropriate for some health topics to be discussed in places of worship in the Laotian community. Therefore, CHWs at the CCOE educate local women by going door-to-door. The CHWs are bi-or multi-lingual, speak to women in their native language, and encourage them to come to the CCOE. St. Barnabas Hospital and Healthcare System uses peer educators who promote health care issues in the community and encourage women to use CCOE services. Because the peer educators are from the community, local women are more likely to identify with them and listen to what they have to say.

Additionally, 11 of the CCOEs indicated that educational materials are available in languages other than English. Community partners at eight of the CCOEs also agreed that the CCOE is offering materials in languages other than English. Partners at the remaining three CCOEs indicated that they neither agreed nor disagreed, which most likely indicates that they are not certain, or did not provide a response.

Are the educational materials and activities appropriate to the gender of the targeted audience?

Nine of the CCOEs are providing women-specific education and outreach events. While the other three CCOEs are offering a wide range of educational and outreach activities, their activities tend to include health topics that are applicable to both men and women. Events are also attended by both genders. Most educational activities[13] (and materials) sponsored by the CCOEs are targeted to females

[13] Some educational activities include both men and women and target health issues relevant to both sexes.

of different ages. The topics of these educational activities focus on the needs of the community, such as diabetes, weight loss, breast cancer, and preventive health care. Northeastern Vermont AHEC, Mariposa Community Health Center, and the Turley Family Health Center, each have strong examples of women-specific programs. One event in particular sponsored by Northeastern Vermont AHEC, Jump Start Your Health, has reached about 110 women. It included a report on cardiovascular health, information about a local women's health resources guide developed by the CCOE, a heart healthy cookbook, and exercises. Women also received free vouchers for a cholesterol screening, blood pressure screening, and body composition analysis. This was a highly successful event for rural Vermont, especially when one considers how difficult it is to bring women together when they are geographically dispersed and transportation is a barrier.

Are the educational materials and activities appropriate for the literacy level of the targeted audience?

All of the CCOEs are offering educational materials and activities appropriate to the reading level of their CCOE clients. All but one CCOE agree that they are providing educational materials that can be easily read by CCOE clients. Community partners at 11 CCOEs agree that materials are at the appropriate reading level. CCOE clients at 11of the CCOEs agree that the information they are receiving is easy to read[14].

Do the educational materials and activities address issues that are relevant to the community?

Half of the CCOEs are doing an especially good job of addressing issues relevant to the community according to CCOE Center Directors and Program Coordinators, CCOE Community Partners, and CCOE clients. All CCOE Center Directors and Program Coordinators report that the educational materials distributed by the CCOEs are addressing important issues in the community, while CCOE Community Partners affiliated with 10 of the CCOEs report that the educational materials are addressing important community issues. However, fewer CCOEs are seeking input from the CCOE clients on educational activities or materials. Input from CCOE clients allows CCOEs to further tailor their education and outreach to meet the needs of the community.

Do the educational materials and activities address issues that are amenable to recipient behavioral modification?

Ten of the CCOEs have educational materials and activities that fully address issues amenable to recipient behavioral modification. For example, a partner affiliated with the Hennepin County Department of Primary Care has a program called Take Off Pounds Sensibly (TOPS). Through this program, women learn about weight management and get the support they need to lose weight. Another example of a successful event that targets behavioral modification is provided by the Northeastern Vermont AHEC CCOE. This CCOE, in conjunction with the Department of Health and a local health care organization, held a 4-week educational series about fitness, stress, nutrition, and heart disease. Each week the series included a presentation, dinner, "interactive" activities, and free items related to the topic covered. Local health care providers also conducted screenings for blood pressure, iron, blood sugar, and body composition.

CCOE Center Directors and Program Coordinators and CCOE Community Partners at 11 CCOEs indicate that the materials distributed by the CCOE are geared toward prevention. CCOE clients at

[14] For one CCOE, no participant survey responses were received for this question.

half of the CCOEs strongly agree that information about healthy living is available to them. CCOE clients at five of the CCOEs also strongly agree that they learn new information at their recent event or class.

Is the selection of educational topics based on community input or feedback?

Five of the CCOEs regularly or systematically select educational topics based on community feedback, while seven are doing so to a lesser extent. These seven CCOEs have solicited input from 20 to 25 percent of their clients or other members of the community (other than partners). According to the CCOE Director and Program Coordinator Survey, three CCOE programs have solicited more than 90 percent of their topics for educational and outreach events from the community. These programs include Mariposa Community Health Center, Turley Family Health Center and Ohana Women's Health and Wellness Program. These CCOEs also hold more education and outreach events compared to the other CCOEs. On average, most CCOE clients at Mariposa Community Health Center and the Ohana Women's Health and Wellness Program reported that they are being asked for suggestions about topics for educational sessions or classes.

Overall, CCOEs differ in the amount of input they receive from the community for education and outreach topics. The amount of input ranges from 20 percent to 90 percent. The CCOEs also use additional resources from the community to select educational topics, such as local health concerns and issues, national health concerns and issues (e.g., Healthy People 2010, CDC warnings), input from the CCOE women, partner input, CCOE staff input, polling the local community, and funding availability. The CCOEs, according to the CCOE Director and Program Coordinator Survey, are using between four and seven of these community resources to select education and outreach topics.

Does the CCOE use non-CCOE community resources in the production or dissemination of educational materials?

All CCOEs report that they are collaborating with partners and other non-CCOE community resources to conduct education and outreach program and activities. However, only nine CCOEs listed organizations that have provided money or in-kind donations to the CCOE. Christiana Care Health Services is an example of a CCOE that is effectively leveraging its local resources. It received a $1,250 donation from a local organization called The Christmas Shop. The donation was used for educational materials and participation incentives. The CCOEs that have strong partner relationships for education and outreach tend to hold more annual events and produce them on a larger scale. Leveraging partner and non-partner relationships allows the CCOEs to offer more materials, brochures, and giveaways.

How are public education and outreach activities integrated with the other components of the CCOE program?

Five CCOEs are demonstrating a strong integration between the education and outreach component and two or more other core components. Most of these CCOEs are integrated with health care services, leadership development, and training. One CCOE, Christiana Care Health Services, has conducted a needs assessment and is using the data to inform its education and outreach efforts. The remainder of the CCOEs are integrating education and outreach with other core components to a lesser extent and often are linking education and outreach to only one component. An example of integration is using a mobile mammography van to raise awareness about breast cancer (education and outreach) and then performing mammograms or issuing referrals for follow-up care (health care). Another

example is provided by the Hennepin County Department of Primary Care, where CCOE clients are asked what materials they would like to receive when they sign up to join the CCOE program, typically during their health care visit.

Opportunities for Improvement

The evaluation did not determine if health outcomes are affected by the education and outreach that the CCOEs are performing. As a baseline evaluation, it is inappropriate and too soon to determine if there are CCOE client health status changes that may be attributed to the CCOE program. Some CCOEs indicated that women enroll in the CCOE program as a result of attending one of their outreach or educational activities. There is an opportunity to assess the impact of education and outreach events by tracking how many women enroll in the CCOE as a result of participating in an event. This may be achieved by including a question during the enrollment process about how the client learned about the CCOE. Because many of the CCOEs have cited anecdotally that an event improves awareness of the CCOE, performance metrics can be used to set such goals as increasing the number of enrolled women or the number of women who are diagnosed in early stages of a disease as result of education and outreach activities.

With the education and outreach core component, the CCOEs have less control over the educational materials being offered. CCOEs rely on other organizations, such as OWH, local health departments, or AHECs to supply their educational materials and brochures. Therefore, the CCOEs do not have much control over the literacy level or languages of brochures and materials. Many of the CCOEs serve diverse populations, including immigrants, who speak languages other than English. However, several of the CCOEs have noted that brochures are not available in all the languages their CCOE clients speak. The Ohana Women's Health and Wellness Center has attempted to overcome this limitation by contacting another country to see if the government is willing to provide educational brochures. While this practice may not be feasible or necessary for other CCOEs, it may be possible to obtain materials from other states or non-profit groups or to partner with community organizations that can translate popular materials.

3.3.5 Leadership Development

Encouraging women and minorities to enter into and remain in the health professions operationally defines leadership development. In addition to developing policies and procedures to attract and retain women and minorities, women should be promoted as community leaders and within health fields. Examples of leadership development activities include the following: offering mentoring, leadership skills and training development; providing opportunities for women to assist with planning; and exposing young women to health care careers.

Overall, the CCOE program is meeting the goals for impacting leadership development but has an opportunity to further expand activities within this core component. As shown in Table 3.10, the average component score for **Leadership Development** is **58** out of 100 points for the CCOE program. The research subquestions that populate 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.

The focus of the leadership development at each CCOE differs. For example, some CCOEs have a well-developed leadership program and health professions program for young girls while other CCOEs are focused on empowering women by teaching them life skills or hiring women from the community to take a leadership role at the CCOE. The CCOEs tend to focus on one or two areas of leadership development and few have conducted activities to address all the research subquestions listed above. Regardless of the approach being used for leadership development, the goal is for the women or girls to become empowered through knowledge and education to take responsibility for their health care and to help open doors for them to pursue health care careers, if they are so inclined.

Table 3.10 Leadership Development for Women as Health Care Consumers and Providers Core Component Scores

Research Question: What is the impact of the CCOE program on leadership development among women? Component Score: 58 out of 100

Research Subquestion	%	Score	
Is a structured, comprehensive, long-term approach utilized for conducting leadership activities for young girls/women in the community?	56%	7/12.5	●●
Do CCOE activities support promotion of women and minorities into positions of leadership?	64%	8/12.5	●●
Are CCOE activities supporting promotion and retention of women and minorities in the health professions?	48%	6/12.5	●
Are mentoring initiatives in place to interest young women in careers in health care?	64%	8/12.5	●●
Are leadership training and skills development opportunities available for women in the community?	64%	8/12.5	●●
Is the CCOE providing opportunities for women to take leadership roles?	48%	6/12.5	●
Are leadership activities targeting young women/girls provided?	64%	8/12.5	●●
Are leadership development activities integrated with other components of the CCOE program?	48%	6/12.5	●

Findings and Conclusions

Is a structured, comprehensive, long-term approach utilized for conducting leadership activities for young girls/women in the community?

Only two CCOEs report having a mission or long-term goal for conducting leadership activities for women and young girls in the community. In the CCOE Director and Program Coordinator Survey, nine CCOE programs did not report that they had a mission or goal for their leadership development activities; however, each has ongoing leadership development activities. The goal of the leadership development component as cited by Griffin Hospital is to train leaders at the "grass roots" level. This CCOE has hired a leadership development consultant and created a community tailored document for addressing leadership development. Another CCOE also has gone a step beyond by developing a long-term goal; it has indicated that it will try to measure the number and quality of its leadership development programs over time to inform and improve efforts.

Do CCOE activities support promotion of women and minorities into positions of leadership?

Five of the 12 CCOEs report examples of activities that are promoting or empowering women into positions of leadership. However, the evaluation team is unable to determine to what extent these activities are impacting minorities. Examples of CCOEs supporting the entry of women into positions of leadership are at Christiana Care Health Services and Mariposa Community Health Center. Christiana Care Health Services has developed a training curriculum with the University of Delaware to train nursing student to be health care advocates. Once the nursing students are trained, they are

responsible for transferring the information they learn to their patients (including CCOE clients). The University of Delaware also works with nursing students to develop a curriculum to help train patients to serve as advocates for their own health care. Mariposa Community Health Center has promoted women into leadership positions yearly by recruiting volunteers to do outreach, training them during a 2-day orientation titled, "What is a Promotora?", offering additional training opportunities (e.g., diabetes workshops or cardio-pulmonary resuscitation [CPR] certification), and encouraging them to further their education by providing career mentoring. About 20 volunteers "graduate" each year; four former volunteers are now employed as promotoras at the CCOE.

Are CCOE activities supporting promotion and retention of women and minorities in the health professions?

Four of the 12 CCOEs report examples of activities that are supporting the promotion and retention of women in health professions. However, the evaluation team is unable to determine to what extent these activities are impacting minorities. The CCOEs that have CHW programs have developed an infrastructure to promote women from the community as lay health care providers on an ongoing basis. During the St. Barnabas Hospital and Healthcare System CCOE site visit, peer educators indicated that some of them (or past educators) have decided to return to school after becoming a peer educator and that some had entered a health care field after finishing school[15].

Are mentoring initiatives in place to interest young women in careers in health care?

Seven of the 12 CCOEs have mentoring initiatives in place to interest young women[16] in health care careers. An example of a mentoring initiative that targets young women is at NorthEastern Ohio Neighborhood Health Services. This CCOE has a year-round relationship with the local high school located across the street from the CCOE. The program places girls in health care internships at the CCOE clinics and encourages them to attend college or enter into a technical health field. The program is also integrated with its partner university, Case Western Reserve. The girls health internship program includes visits to the local university and meetings with health professionals who serve as mentors for the afternoon.

Are leadership training and skills development opportunities available for women in the community?

Four of the 12 CCOEs indicated that they are leveraging leadership training skills and skills development opportunities for women. The remainder of the CCOEs reported opportunities available in the community but did not indicate how the CCOE was leveraging these resources. Community partners of seven CCOEs are offering leadership programs or know of other local organizations that provide similar training.

Leadership activities often serve as a method to encourage women to take care of themselves and to take ownership of their health care. Women often make their family or job their first priority and put their families' needs before their own. Making sure the children are fed and clothed or that there is enough money to support the family's needs often takes precedence over personal health maintenance. In certain cultures, this prioritization is extreme and women may even be discouraged from focusing on their own health needs. It is important that women receive education and training in basic life skills

[15] Exact numbers of women entering into the health care field, other than as a lay provider, are not available.

[16] Young women include those 18 yeas old and younger for the purpose of this evaluation.

such as how to write a check or manage a household budget, in addition to training on preventive health care. Until women are empowered to better manage their many personal responsibilities, it is difficult for them to focus on or realize the importance of preventive health care for themselves. Turley Family Health Center seeks to empower women and girls as health care consumers and community leaders through its leadership development program. It offers educational sessions on leadership topics such as self-advocacy, parenting, money management, and empowering women as health consumers.

Women's Health Services is providing leadership development opportunities to a population of urban Native American women. Currently, there are gaps in the health and social services available to these women. They are from different tribes and they do not have a formal organization representing or advocating for their need for services. To assist these women achieve their goals, Women's Health Services has helped them organize a steering committee to begin to address their health care needs. Women's Health Services is hopeful that these efforts will evolve into a Native American Women's CCOE.

Is the CCOE providing opportunities for women to take leadership roles?

Three of the CCOEs are providing ongoing opportunities for women to take leadership roles through a structured CHW training program. The Mariposa Community Health Center and St. Barnabas Hospital and Healthcare System provide the most opportunities to women through their promotoras and peer educator programs. These women have become leaders in their community and are well respected. Half of the CCOEs provide leadership development opportunities for women but they are not accomplishing this by using a structured CHW training program. However, the women are still recognized as leaders in their community.

Are leadership activities targeting young women/girls provided?

Half of the CCOEs provide leadership activities targeted to young women. Examples of two CCOEs that fully meet this subquestion are Northeast Missouri Health Council, Inc. and Northeastern Vermont AHEC. The Northeast Missouri Health Council, Inc. has a tobacco control coalition that focuses on mentoring young women and educating them about tobacco control. When they complete the program, the girls educate other young women in their schools. The Northeastern Vermont AHEC provides a Medquest summer camp for young women who receive mentoring from health professionals at the local hospital. Students participating in this program job shadow four different professionals and attend workshops such as teen depression, stress management, death and dying, and healthy eating. The CCOE also partnered with a community organization to hold a conference called "Exploring Our Voices, A Day of Dialogue, Connection, and Celebration for Teen Girls and Their Allies" targeted to young girls.

Are leadership development activities integrated with other components of the CCOE program?

Three CCOEs are demonstrating integration with two or more core components, mostly by integrating health care services delivery, training, and education and outreach. This integration is illustrated particularly well through the CHW programs. CHWs are recruited from the community and are trained on health topics of interest to the community. As a result of their training, they often perform outreach in their community and provide case management services for clients attending health care visits. The St. Barnabas Hospital and Healthcare System CCOE have leveraged its partnership with

the University of Puerto Rico CoE to develop its peer educator training curriculum. This further demonstrates integration between a CCOE and a partner.

These are a few examples of the leadership development component being integrated with the other core components. Some CCOEs cited integration of the leadership development component with clinical health care services delivery and community-based research efforts but did not elaborate on how the components are integrated.

Opportunities for Improvement

One opportunity for improvement is for the CCOEs to track how many women or girls enter the health care field, remain in the health care field, or enter into leadership roles after being part of the CCOEs' leadership development programs. At the time of the evaluation, none of the CCOEs reported gathering these data. However, some of the CCOEs, such as the Northeastern Vermont AHEC, do track the number of young women who enroll in leadership programs. Tracking the number of young women who continue their education and/or enter into the health care field will provide data to support each CCOE's impact in the leadership development activities. During the CCOE site visits, several of the CCOEs discussed plans to incorporate tracking into their future efforts.

Additionally, some CCOEs may be able to further leverage leadership training and skills development opportunities in their local community. CCOEs should review the CCOE Community Partner Survey data from this evaluation[17] to identify suggestions offered by community partners. There may be organizations listed that the CCOE has not partnered with yet.

3.3.6 Technical Assistance and Replication

The goal of technical assistance is for the CCOE programs to share valuable lessons learned with other organizations seeking to replicate the unique service delivery model. Important lessons learned about establishing a CCOE infrastructure include tips on such topics as setting up strong partnerships within the local community; securing financial and non-financial (e.g., in-kind donations) support; and coordinating activities.

Overall, the CCOE program is fulfilling the activities included in the technical assistance and replication core component. All CCOEs have performed one or more of the technical assistance activities; however, only one has performed all the activities described in Table 3.11. 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. This is likely because the CCOEs are focusing on implementing their CCOE and developing the infrastructure (e.g., tracking systems) needed to meet the grant requirements. The research subquestions impacting this score include activities being performed to support a replication site, the number and type of technical assistance activities being 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.

This core component includes two main topic areas: 1) providing technical assistance (to other organizations) about the CCOE model and 2) replicating the CCOE model at a site other than the

[17] OWH will provide each CCOE with an MS Access database containing this data.

CCOE parent organization. When the evaluation methodology was developed, these two topics were included under a single core component. In the future, they may be separated into two components with additional detailed guidance provided on each. In addition, OWH developed further clarification of the replication site requirements based on lessons learned and feedback from the CCOEs. This guidance describes how the replication site should be chosen, what characteristics the site must have, and the timeline for phasing in the core components. OWH draft guidance states:

"To successfully implement the CCOE model, the replication site must have, at a minimum, a stable infrastructure and the commitment of the leadership. Below are additional characteristics/criteria of an eligible replication site:

a) must be a community-based organization.

b) must provide comprehensive primary care and have already demonstrated some evidence of commitment to women-focused, women-friendly care.

c) must have several CCOE components in place or at least there must be the ability to implement all components.

d) must not be an academic health center/academic institution.

e) must be financially viable with a strong funding base."

Replication is cited by most CCOEs as the hardest component to implement. Some of the barriers include limited funding resources, a limited timeline to replicate the model, and difficulty in gaining support from leaders at the replication site to fully implement the CCOE model. In fact, many CCOEs have changed replication sites more than once because a barrier could not be overcome. Only one CCOE has the same replication site identified in its grant application.

Table 3.11 Technical Assistance and Replication of the CCOE Model Core Component Scores

Research Question:	Has the CCOE replicated successful models and strategies?	Component Score: 66 out of 100	
Research Subquestion		**%**	**Score**
Has the CCOE contributed materials for a "How To" Manual?		100%	10/10 ●●●
Has the CCOE **developed and/or disseminated** any technical assistance materials that could improve the CCOE program?		30%	3/10 ●
Has the CCOE **intervened** with a professional organization to further the cause of women's health?		70%	7/10 ●●
Has the CCOE site-visited another organization to **provide "How To" training**?		50%	5/10 ●●
Has the CCOE hosted an **on site training** session?		50%	5/10 ●●
Has the CCOE participated in **any meetings** where the program or program elements were showcased?		80%	8/10 ●●●
Has the CCOE participated in any **national, regional, state, or local meetings** where the program or program elements were showcased?		80%	8/10 ●●●
Has the CCOE showcased any **lessons learned** at a non-OWH meeting?		70%	7/10 ●●
Is the CCOE maintaining a **sustained interaction** with another community?		80%	8/10 ●●●
How are technical assistance activities **integrated** with the other components of the CCOE program?		50%	5/10 ●●

Findings and Conclusions

Has the CCOE contributed materials for a "How To" Manual? Has the CCOE developed and/or disseminated any technical assistance materials that could improve the CCOE program?

All CCOEs submitted materials in December 2003, as required by OWH, for the "How To" Manual, thus fully meeting the requirements for this research subquestion. However, fewer (less than 25 percent) of the CCOEs report disseminating technical assistance materials about their CCOE program. This may be because many of the CCOE programs are still in development, and these CCOEs are still implementing their own program. Therefore, CCOEs are not in a position to offer guidance to outside organizations. Despite this challenge, one CCOE reports that it regularly updates the "How To" Manual and disseminates it to whoever is interested in learning about their CCOE model.

Has the CCOE intervened with a professional organization to further the cause of women's health?

Over half of the CCOEs have intervened with a professional organization to further women's health. Typically, the type of intervention the CCOEs are conducting is a presentation to a health professional community. For example, Jefferson Health System has spoken to members of the Healthy Start Community Program to promote the CCOE and its services for healthy living. The purpose of the seminar was to educate women about the CCOE and, ultimately, to encourage the women to use CCOE services. The Northeast Vermont AHEC has met with state officials from the Vermont Department of Health and Department of Corrections to discuss collaborating on a grant application to address the health needs of incarcerated women as they reenter the community. The goal of this partnership is to obtain grant funding and, possibly, develop a pilot CCOE program to improve the health of these women.

Has the CCOE site-visited another organization to provide "How To" training? Has the CCOE hosted an on site training session?

More than 40 percent of the CCOEs reported (in their quarterly reports) visiting another organization to provide training on the CCOE model. This training is often provided by telephone, e-mail, or in-person visits to the replication site. Women's Health Services has presented its CCOE program to a group of rural health care workers who, as a result, have accepted the CCOE model and started replicating it. The Ohana Women's Health and Wellness Center has met with its replication site, on the island of Kauai, to develop a timeline and action plan for implementing all of the core components except replication. Northeastern Missouri Health Council, Inc. consistently provides ongoing (in person) training to its replication site and its advisory board. The replication site is located in a nearby county.

None of the CCOE programs reported hosting an on-site training session at its CCOE to disseminate information about the CCOE model. However, the only difference between the second research subquestion and the first (listed above) is the location of the training. Given this slight difference, all CCOEs have been scored based on whether or not the CCOE site has visited another organization to provide training.

Has the CCOE participated in any meetings where the program or program elements were showcased? Has the CCOE participated in any national, regional, state, or local meetings where the program or program elements were showcased?

Nine CCOEs have participated in meetings at the national, regional, state, or local level to showcase CCOE program components. The St. Barnabas Hospital and Healthcare System is a good example of a CCOE that uses presentations to showcase the CCOE model to a wide audience. This CCOE successfully presented its model at the "Somos El Futuro" conference in New York City, which included attendees from more than 300 organizations and New York state legislators. The session reached more than 400 clients, and the CCOE was asked to make the presentation again next year. St. Barnabas Hospital and Healthcare System is leveraging its relationship with the local Region II office of the OWH to identify opportunities to reach large numbers of organizations and clients. The NorthEastern Ohio Neighborhood Health Services is another example of a CCOE that is successfully showcasing its program components. Its Center Director has presented the CCOE model to health care providers at community health centers and safety-net providers from across Ohio at the annual Ohio Primary Care Association meeting. The CCOE model was presented as one of three "model" programs in the state of Ohio.

Has the CCOE showcased any lessons learned at a non-OWH meeting?

Two thirds of the CCOEs presented information about the CCOE program at national, regional, state, or local meetings. The CCOEs did not specifically report discussing lessons learned at these meetings. However, the CCOEs fulfilled this requirement if a presentation was made about the CCOE program at a non-OWH meeting. As the CCOEs gain more experience with the CCOE model, each will be more equipped to share specific information about lessons learned instead of general CCOE program information.

Is the CCOE maintaining a sustained interaction with another community?

The second part of this core component is replicating the CCOE at another (non-CCOE affiliated) location. All CCOEs indicated that the requirement to replicate the CCOE program within one year of gaining the CCOE designation is extremely difficult to fulfill. In many cases, CCOEs have changed their replication site at least once, often because of a lack of commitment (e.g., resources, people, or dedication to the CCOE model) from the replication site. During the first year the CCOEs are focused on establishing their own processes and procedures and adapting to meeting OWH's requirements. All CCOEs are finding it difficult to provide guidance to another site while they are busy establishing their own programs.

None of the CCOEs had a fully operational replication site at the time of the evaluation and three CCOEs were in the midst of reestablishing their replication ties. Ohana Women's Health and Wellness Program and Northeast Missouri Health Council, Inc. are the furthest along in implementing the replication of their programs. Ohana Women's Health and Wellness Program partnered with a new health care organization on the island of Kauai. Despite the geographic distance, the CCOE has started a successful relationship by carefully selecting an organization that is readily embracing the CCOE concept. By communicating constantly with the replication site, the CCOE has ensured that there is a shared understanding of the CCOE goals. Northeast Missouri Health Council, Inc.'s replication site is in a health department in a nearby county. Like the Hawaii replication site, the replication site at Northeast Missouri Health Council, Inc. is fully dedicated to replicating the CCOE model and is

building its own partner relationships before implementing the remainder of the CCOE core components.

How are technical assistance activities integrated with the other components of the CCOE program?

The extent of the integration of the technical assistance core component with the other core components is measured using the CCOE Director and Program Coordinator Survey results. Integration with a replication site is assessed based on the amount and type of ongoing interaction and resources (e.g., technical assistance materials) the CCOE is providing and if partners are also part of the replication effort. Based on these comments, four CCOEs are integrated with their replication site and/or share resources with their partner organizations to promote replication. An example of integration is at the Northeastern Vermont AHEC. This CCOE has replicated a community health education program, worked with health care providers and the local hospital to develop a community health worker program, and plans to include the site in its community research project.

The length of time a CCOE has had a relationship with a replication site varies from just initiating the relationship to 16 months. Therefore, integration for this component is at its early stages and should prosper over time.

Opportunities for Improvement

The foremost opportunities for improving the technical assistance and replication efforts at existing CCOEs are to first review the updated replication guidance released by OWH and then develop a plan and timeline for any areas not currently being addressed. Future CCOE programs should carefully identify a site that is a good candidate for replication and develop a timeline for replicating the CCOE program. Based on lessons learned from current replication efforts, good replication candidates are located near the CCOE, already have an established relationship with the CCOE, and have a similar mission and goals.

Additionally, there is also an opportunity for improvement in the development and dissemination of technical materials about the CCOE program. Much of this knowledge is communicated orally, especially during presentations, which leaves an opportunity to document it and share it with others. Some CCOEs may currently be providing many technical assistance documents to others but did not report it as technical assistance. Therefore, the opportunity is twofold: document existing advice being shared with other organizations and report (in the quarterly reports) what materials are being shared (e.g., enrollment forms, tracking system information, educational curriculum).

Further guidance from OWH on how many (and to what extent) technical assistance activities per research subquestion are required annually will provide clarification to the CCOEs and assist them in future evaluations. For this core component, the CCOEs are considered fulfilling an activity if it is performed once during the fiscal year and is related to the research subquestion topic. Many research subquestions are very similar; thus further clarification is also needed on whether or not one activity being provided by the CCOEs can fulfill more than one technical assistance research subquestion.

3.3.7 Other Program Requirements

Contingent upon award of the CCOE grant, each CCOE has to meet a number of requirements to maintain its CCOE designation. These program requirements include providing services in a culturally competent manner, involving the community in an advisory board, promoting the CCOE in the community, and using OWH funds to obtain a positive outcome for the CCOE program. These program requirements are of interest to OWH but are not affiliated with a specific core component. These activities have been analyzed using the same evaluation framework applied to the core components and the results of that analysis are included in this section of the report.

Overall, the CCOE program is exceeding the CCOE program requirements. As shown in Table 3.12, the overall average component score for Program Requirements is 86 out of 100 points. The research subquestions for this component include how well services are meeting the needs of culturally diverse CCOE women, if the CCOE's advisory board is well rounded, if the CCOE has methods to improve or expand the awareness of the CCOE program to the public, and if funds provided by OWH are contributing to a positive outcome for the program. All CCOEs are complying with OWH requirements. The CCOEs are also complying with other program requirements not listed in Table 3.12, such as submitting quarterly and yearly progress reports, participating in the national CCOE evaluation, conducting a local evaluation, and having appropriate signage.

Table 3.12 Other CCOE Program Requirement Scores

Research Question: Overarching Program Requirements		Component Score: 86 out of 100	
Research Subquestion	**%**	**Score**	
Are services women-centered, and culturally and linguistically appropriate?	88%	22/25	●●●
Is a CCOE advisory board that includes representatives from the community partners in place?	88%	22/25	●●●
Are mechanisms in place to create an awareness of the CCOE's existence and services to the community?	76%	19/25	●●●
Does the distribution of funds among CCOE staff contribute to a positive outcome for the program?	100%	25/25	●●●

Findings and Conclusions

Are services women-centered, and culturally, and linguistically appropriate?

The score for this research subquestion takes into account CCOE client satisfaction with health care services, whether CCOE providers speak to their clients in a language other than English, and if female providers are available at the CCOE. Analysis of data indicates that the CCOE program provides women-centered, culturally and linguistically appropriate services to CCOE clients. CCOE clients, across all CCOEs, are highly satisfied with their CCOE experience. All CCOEs have a large number of female clinicians who provide care and see women in separate exam rooms. This is especially important because more than 40 percent of CCOE clients reported on the CCOE Participant Survey that they prefer to see a female health care provider.

Additionally, half of the CCOEs report that staff are available who speak one or more languages of their client population. This capability is vital to the CCOEs; most (all but three) CCOE programs serve women who speak in languages other than English. For example, the staff at the Ohana

Women's Health and Wellness Center speaks 17 of the different languages and dialects spoken in their community. If translation services were not available, many of the women who speak these languages or dialects would not access the CCOE because language would be a barrier.

Providing linguistically appropriate services also helps the CCOEs ensure that the interactions with the women are respectful of their culture, a starting point for ensuring overall cultural competence for the care of minority women. At the Ohana Women's Health and Wellness Program, CHWs are from the local community and understand cultural sensitivities. For example, Micronesian women do not gather in groups very often and if they do it is considered inappropriate to disseminate reproductive health information. Understanding this, the CCOE can focus its outreach efforts in a more appropriate manner, such as going door-to-door to visit these women.

Is a CCOE advisory board that includes representatives from the community partners in place?

Ten of the 12 CCOEs are meeting or exceeding the requirement to have a formal advisory board that includes community partners. All advisory boards consist of partners from the community and occasionally include women from the community. Only one CCOE does not have its own advisory board. Instead, it incorporates CCOE advisory board meetings into its parent organization's board meetings. Another CCOE has community members on its board, but the board does not have regularly scheduled meetings, and some of the members are unsure of how often the board meets.

CCOEs that involve community partners in their advisory board are experiencing a higher level of integration with their partners (as indicated by the partners during the site visits). More referrals are being sent between the CCOE and its partners, more joint activities are being identified and fulfilled that share common goals, and a shared understanding of the mission and goals of the CCOE program is being achieved.

Are mechanisms in place to create an awareness of the CCOE's existence and services to the community?

The scoring process for this research subquestion considers the number and type of community awareness activities the CCOE performs and the methods being used to promote the CCOE to women. The CCOEs are using several mechanisms to increase community awareness of their services. For the most part, the CCOEs are conducting community awareness through outreach events. Other approaches being used to create awareness include sponsorship of events in partnership with organizations to promote the CCOE program to the community and advertisements (e.g., local newspaper, radio station, and television).

An example of a community awareness effort many CCOEs are using is visits to local beauty salons to talk with women about their health concerns. The CCOEs also rely on their partner organizations and the women who enroll in the CCOE program to help communicate an awareness of the CCOE to the remainder of the targeted community. In fact, more than 40 percent of clients at five of the 12 CCOEs have reported hearing about the CCOE through friends.

Does the distribution of funds among CCOE staff contribute to a positive outcome for the program?

A positive outcome is being achieved, as determined during the site visits, by using OWH funds to cover the salaries of the Program Coordinator, Administrative Assistant, and in part, the Center Director positions. These individuals are integral to the success of the CCOE program. The CCOEs

rely heavily on these individuals to ensure that the CCOE program is being integrated within its partners and in promoting the CCOE program to its parent organization, the community, and health professionals. The Program Coordinator position is essential to the success of the CCOE program and is often the "glue" that holds the program and the partners together. This position ensures that the CCOE program submits the required data to OWH, that partners participate in the program, and that the core components are effectively addressed. From the site visits, it is clear that funding for the Program Coordinator position directly supports the CCOE in its integration with its partner organizations. Additional information describing these positions is located in Section 4.1.1. Additionally, some CCOEs indicated that a positive outcome occurred after they formally defined their relationships with partner organizations or replication sites. Memorandums of Understanding (MOU) are a common tool for documenting agreements between the CCOE and its partner organizations, thus reinforcing the partner's commitment to the CCOE program.

Opportunities for Improvement

Almost all of the CCOEs are providing services that are women-centered and culturally and linguistically appropriate. However, some CCOEs did not indicate in their quarterly reports that they offer many programs and outreach activities or services in a language other than English. This could be an opportunity to reach additional CCOE women by providing services in languages other than English. This will be especially important as community awareness efforts increase, which, in turn, may increase the diversity of the CCOE clients.

None of the CCOEs reported having by-laws for their advisory boards. While this is not a requirement of OWH or addressed in the research subquestion in Table 4.14, it does present an opportunity for the CCOEs to formalize their advisory board and clearly define their role as it relates to the CCOE. This action would contribute to promoting the sustainability of the organization and further ensure that current and new community partners and other advisory board participants understand how the advisory board functions.

As mentioned above, CCOEs with community partners involved in their advisory boards indicated they are experiencing a satisfactory degree of integration, especially when it refers to joint activities, referrals, and ensuring a shared understanding of CCOE mission and goals. Working to increase community partner involvement in advisory board activities, in conjunction with formalizing their advisory board activities and its role in the CCOE, is another opportunity for improvement for the CCOE program.

While all of the CCOEs promote education and outreach events, there is an opportunity for them to further increase awareness and understanding of their purpose and services by using a more structured approach. A more structured approach to promoting efforts can include developing a formal strategy and plan for increasing the awareness of CCOE services. Some community partners indicated during the CCOE site visits that it takes time to fully comprehend what the CCOE program is and how they fit into its structure. At CCOEs where the partnerships are not as integrated, there is an opportunity to increase partner awareness and interaction with the CCOE by having regularly scheduled (e.g., monthly) advisory board meetings and reviewing the mission and core components and their status at each meeting. (Additional suggestions to improve understanding of the CCOE among providers and partners are provided in Section 5 of the report.)

The CCOEs can also promote themselves more in the community. For example, they can leverage local political figures to help promote their goals. This is a strategy the St. Barnabas Hospital and Healthcare System is using. The St. Barnabas Hospital and Healthcare System established a relationship with a local Assemblyman who is helping to promote the CCOE to the community. He has also provided funding to expand the CCOE program to the Latino community.

4.0 CCOE PROGRAM BEST PRACTICES AND LESSONS LEARNED

As the evaluation results in Section 3.0 show, there are many examples of innovations, successes, areas for improvement, and lessons learned from the first 3 years of the CCOE program. Variances in the environment, existing infrastructure and resources, populations served, and strategies used at each individual CCOE have resulted 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 experienced similar successes, faced similar obstacles, and where the resulting best practices and lessons learned are applicable to the CCOE program as a whole.

Section 3.0 discusses overall themes about successes and lessons learned, as they relate to specific CCOE components. A majority of the observations documented in this section are compiled from the qualitative data gathered during the CCOE evaluation site visits. Where relevant data has been captured in the survey instruments and submitted to OWH by the CCOEs to fulfill their reporting requirements, that data has also been used to inform the discussion below. The information that follows may serve as a tool to help educate and shape future CCOE planning initiatives.

4.1 Successes and Best Practices

4.1.1 CCOE Program Personnel

All the CCOEs voiced the importance of strong leadership and quality personnel in making the CCOE program a success. Community-based organizations, because they are often limited in resources and the infrastructure supporting them, tend to rely heavily on their personnel to make their programs a success. The relatively modest amount of OWH funding makes this especially true for the CCOE program. The three types of personnel most commonly referenced as critical to the success of the CCOE program are the CCOE Center Director, CCOE Program Coordinator, and, where implemented, community health workers. The CCOE staff and their partners identified "best practice" characteristics that made these roles particularly successful and added value to the CCOE program.

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

CCOE 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 a leadership capacity within the CCOE's parent organization. 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. The most effective CCOE Center Directors serve as advocates for the CCOE program within their parent institutions and within the community, helping to set the strategic direction for their CCOE program.

Although there are many dynamic and committed Center Directors, the Center Director of the CCOE at Jefferson Health System provides a good example of the characteristics described above. This individual is a respected physician and leader at Cooper Green Hospital, where the CCOE is housed. He was instrumental in obtaining the CCOE grant and obtaining hospital buy-in to support the CCOE within its facility and under its umbrella of services. He has leveraged his existing relations within the

community and established several partnerships critical to the CCOE program. These partners include the University of Alabama, the Alabama Department of Public Health, and several other organizations in the surrounding community. Both partners and CCOE staff have pointed to his dedication and advocacy as the primary reason for the CCOE program's progress.

CCOE Program Coordinator

Successful CCOE Program Coordinators have many common attributes including a commitment and connection to their community, strong leadership skills, the ability to coordinate and bring multiple organizations with varying goals and objectives together to address a common goal, and strong communication skills. Because Program Coordinators are responsible for the day-to-day administration of the CCOE, community partners often view them as the face of the CCOE program.

> Community Partners often view Program Coordinators as the face of the CCOE program.

Although there are many strong Program Coordinators, the CCOE at Turley Family Health Center serves as a good example of the difference a strong Program Coordinator makes. The current Program Coordinator is lauded by both the staff at the CCOE and the majority of the CCOE community partners as integral to the CCOE program. This is particularly noteworthy because before her assumption of the Program Coordinator role, the interviewed staff and partners all believed that the CCOE was not as effective in integrating the community partners into the implementation of programs and initiatives for the women in the surrounding community. They attribute this change to the current Program Coordinator's initiative and drive.

Community Health Workers

The concept of a Community Health Worker (CHW) or promotora is common within community-based health care organizations. CHWs are lay advocates or advisors who educate and lead individuals and groups in their communities to attain increased health and well-being. They receive training in health and wellness topics, and in some cases, in topics that will increase their leadership and communication skills. They act as bridges between the community and the providers of health care services. CHWs increase access to health care by providing outreach and cultural linkages between their communities and health care providers. They reduce the costs of health care by providing education, disease screening, and detection services that promote health and prevent disease. They improve the quality of care by enabling better communication between the patient and the health care provider. (Global Health Action; http://www.globalhealthaction.org/chw.html)

At the CCOE programs where they are used, CHWs are viewed as an innovative success. Both CCOE program staff and partners share this view. They note that CHWs help women in the community feel more comfortable about coming to the CCOE to receive care and to take part in CCOE activities. Clients are more receptive to the advice and information provided to them by the CHWs, and the CHWs add a personal touch to the CCOE that make it more welcoming and friendly. In addition, women trained as CHWs receive the benefits of training and experiences that provide them with a tangible skill set they can leverage in other areas of their lives and use to further their own career and leadership development. In many cases, the CHWs state that the training they receive helped them understand the importance of healthy lifestyles and preventive behaviors in their own day-to-day living.

At the Mariposa Community Health Center, promotoras are women from the community trained to be effective outreach workers and case managers by the CCOE program. Peer educators at the St.

Barnabas Hospital and Healthcare System serve in the same capacity for the Puerto Rican and African American communities. The Ohana Women's Health and Wellness Program uses its staff to conduct door-to-door outreach to the Laotian, Philippine, and Micronesian communities. In Northeastern Vermont AHEC, the CHWs are essential in coordinating care and facilitating access to services for the CCOE clients. In all four of these cases, the methods of outreach and case management vary depending on what works best for the community. The commonality, however, is that the women trained as CHWs have strong ties to the community and, as such, leverage their understanding and familiarity of the culture, language and resources of the community and work with women one-on-one to bring them into the CCOE network of services and help manage their care.

4.1.2 Community Partnerships

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.

The CCOEs display several strengths in building and maintaining their community partnerships. These strengths are documented and can serve as best practices that can be leveraged to improve current CCOE operations at sites where they are not implemented. Ideas presented in this section should be kept in mind during future development efforts. Community partnerships are critical to the success of the CCOE program and are a core part of the CCOE model. 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. Common themes regarding best practices and successful CCOE partnerships are described below.

Building Strong Partnerships Early

Several of the interviewed staff and partners emphasized the importance of building partnerships with other organizations early in the development of the CCOE program. Because partnering to provide comprehensive, multidisciplinary services to the community are 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.

The CCOEs use a variety of methods 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 benefits of this practice are that relationships between the CCOE, partner leadership, and key staff are often already established and there is a level of trust, so there is already a common understanding of the capabilities and goals of both organizations. This previously established relationship helps the CCOE to begin its operations sooner. Another critical practice several CCOEs use is to include partners in the development of CCOE activities, either informally or through their advisory boards. This makes partners feel more a part of the CCOE program and helps them take ownership of the ideas and services the CCOE offers, thus improving their level of participation and the overall implementation of CCOE activities and services to the community.

Formalizing Partnerships

Use of Memorandums of Understanding (MOU) with partner organizations is inconsistent across the CCOEs. Several CCOE staff and partners without MOUs believe they do not need formalized partnerships and instead, rely heavily on personal relationships to conduct joint activities. Other CCOEs have MOUs and believe that they are necessary to develop a shared understanding of the goals

and responsibilities associated with the partnership. 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 MOUs are established to fulfill a requirement of the parent organization. Although it appears that MOUs are not necessary for a successful partnership, reliance on personal relationships can lead to setbacks and deterioration of partnerships when staff turnover occurs at either the CCOE or the partner organization. MOUs can help clearly define the relationship and commitments of both parties. For these reasons, MOUs are a best practice that can help avoid setbacks in CCOE/partner organization relationships.

Communicating Among Partners

The formality, form, and frequency of communication among partner groups and the CCOEs vary across all the sites. In some cases, communication occurs daily, weekly, or monthly. In others cases, it happens on a strictly as-needed basis. Some CCOEs use conference calls, telephones, and e-mail as their main means of communication, while others rely more on face-to-face meetings. Regardless of the approach used, the common theme that has emerged from the site visits is that ongoing, consistent communication is critical to ensure that CCOE activities remain a focus of the CCOE partners. Partners who report that infrequent or minimal communication occurs with the CCOE also display a "disconnect" or lack of understanding of the CCOE program, its goals and objectives, and of ongoing activities.

Several CCOEs have a high level of communication with their partners, and their partners appear to understand the individual CCOE's goals and objectives. However, this is not the case across all the CCOEs. Partners who believe they have a strong working relationship with their CCOE point to factors such as their participation in advisory board meetings, strong and interactive Program Coordinators, and the most important factor – excellent communication – as the reasons why the relationship is so successful. The CCOE staff echo similar sentiments – NorthEast Ohio Neighborhood Health Services, Inc. staff members believe that, "coordination, collaboration, communication" are the three activities necessary for successful partnering.

Partners who believe they have a strong working relationship with their CCOEs point to factors such as their participation in advisory boards, strong and interactive Program Coordinators, and as 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 out regular updates, newsletters, or meeting minutes via e-mail or postal mail to CCOE partners to ensure that they are aware of ongoing activities and meetings. Although this approach may not be a fit for everyone, it is a solution that can be easily implemented and that may help improve the level of communication among all the partner organizations involved with the CCOE program. Regardless of the approach used, frequent and meaningful communications with partners is a key to success for several CCOEs, and it should be a best practice employed by all CCOEs.

Committing to a Common Mission and the Community

The most common element CCOE staff and partners mention 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 those partners) are strongest with organizations that have both a mission and staff who are committed to helping women in the community. Such 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 partnership with the CCOE. As with the Program Coordinator role, this common commitment is viewed as a key element to success.

Griffin Hospital and Turley Family Health Center have especially strong partnerships. Interviewed staff said that partner commitment to the community and to the CCOE concept were the major reasons the partnerships were working so well.

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

Equally important is a commitment to impacting the community through one or more of the CCOE core components. Finding organizations that have both missions and staff commitment in line with the CCOE's objectives is not an easy task. However, looking for both of these characteristics when establishing partnerships is a best practice used by several CCOEs that should be kept in mind for future CCOE partnership development efforts.

Without similar goals, partnerships appear to be perfect fits on paper can be, in reality, just the opposite. For example, Women's Health Services is facing challenges arising from incompatible partnerships. Several of the initial partnerships formed by the CCOE are not effective because of differences in the specific goals and objectives of the organizations, even though the organizations have a community focus. The CCOE has been unable to instill ownership of the CCOE program within these organizations. For the past year, the CCOE has been working to establish several new partnerships with organizations that have compatible missions and offer services that can be leveraged in the delivery of one or more of the CCOE core components. Women's Health Services is achieving success using this new approach.

4.1.3 CCOE Advisory Board

Having a CCOE advisory board composed of CCOE partners and community representatives is an OWH requirement for each CCOE program. All 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 others.

However, during the site visits, several successful practices were identified that could be considered best practices for managing an advisory board. These include: having regularly scheduled advisory board meetings and ensuring 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; 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 such 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.

Where these practices are not implemented, partners often appear disconnected from the CCOE. They voice confusion over the purpose of the CCOE and often do not know a great deal about current CCOE or partner organization initiatives and services.

Many of the CCOEs, including Turley Family Health Center, Christiana Care Health Services, Griffin Hospital, NorthEast Ohio Neighborhood Health Services, Inc., and Northeast Missouri Health Council,

Inc. have incorporated many of the practices discussed above. Both their staff and their partner organizations attest to the quality of the advisory board meetings. These CCOEs demonstrate a cohesiveness that they attribute, in part, to their participation in their respective advisory boards.

The Northeast Missouri Health Council serves as a particularly good example. Its board meets monthly and has a formal agenda that always includes a review of CCOE goals and objectives to remind all those involved of why they are there. Their partners all understand the goal of the CCOE program and how they fit within the CCOE. All the interviewed partners were aware of the advisory board meeting schedule and consistently attend meetings. They believe the meetings serve as a good opportunity to network with other organizations, discuss ongoing issues within the community, and plan initiatives to address them.

4.2 Opportunities for Improvement and Lessons Learned

Whenever a new program is implemented, there are challenges along the way to success. In many cases, hindsight shows best approaches that should have been used and approaches that should have been avoided. The section below summarizes the major program-level lessons learned during the first three years of the CCOE program.

A significant lesson learned by several of the CCOE programs was the importance of building awareness and understanding of the CCOE not only in the community and with their partners, but also at the CCOE's clinical care center.

4.2.1 Building an Internal Understanding of the CCOE

Section 3.0, Education and Outreach, discusses the various community outreach methods the CCOEs used to build awareness of the CCOE program and its services and to bring women into their networks of care. A significant lesson learned by several of the CCOE programs was the importance of building awareness and understanding of the CCOE not only in the community and with their partners, but also at the CCOE's clinical care center.

Services will be fragmented and underutilized until knowledge of the CCOE, its services, and how it can be leveraged, is a recognized and relied on part of the body of resources available within the CCOE's clinical care center. For example, some CCOEs discovered that their physicians and staff are aware of the CCOE but do not always remember to refer women to services provided by the CCOE.

Hennepin County Department of Primary Care and the Northeastern Vermont AHEC have successfully addressed this issue. Both organizations realized they needed to employ strategies to improve awareness of the CCOE among the physicians and staff at the institutions housing their clinical care center. To address this issue, staff at the Hennepin County Department of Primary Care began holding sessions with faculty and staff at their clinical care facility to ensure that they are all aware of the CCOE's existence and the services it offers. The Northeastern Vermont AHEC has a medical advisor whose role is, in part, to promote the CCOE to other clinicians. The Northeastern Vermont AHEC also spends many hours performing outreach to educate clinicians about CCOE services and related issues. Both organizations are seeing increased enrollment and referrals as a result of their efforts.

In both of these examples, the CCOE recognized that it had to make an effort to build awareness, understanding, and a reliance on the CCOE within its parent organization. Failing to address this issue internally can result in slow progression toward meeting program goals, and it can significantly change the impact the CCOE program has on its respective communities.

4.2.2 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 prior to the submission of their proposals. While these CCOEs have benefited from having resources, such as information technology (IT) systems and (in some cases) extra funding, available to them through their parent institution, the staff at these CCOEs identified several frustrations as well. The frustrations center around two main issues: the amount of bureaucracy and red tape that the CCOEs must navigate to make progress or accomplish tasks in these large institutions, and the problems that arise because of differences between the CCOE and the parent organization's values and priorities. These issues can cause delays in obtaining approval for certain activities, requisitioning supplies, and accessing resources. These issues can also limit their partnering choices and methods for implementing components of their program. For example, one CCOE faced difficulty obtaining hospital privileges for midwives so they could provide services at the CCOE. It was not until the hospital ran into a problem with a shortage of physicians and changed its policy that the CCOE was able to provide this service to its clients.

While there are limitations on what a CCOE can do to affect change within its parent organization, there are certain approaches it can take to make working within larger institutions easier. One recommendation made by several CCOE staff was to better define the CCOE's relationship with the parent organization. This can occur through the development of formal guidelines or procedures that outline day-to-day operations. Formal procedures could be developed for requisitioning supplies, hiring CCOE staff, or establishing partnerships within the parent organization to support CCOE efforts. Another recommendation is to designate an individual to act as a liaison to the parent organization so that clear and direct channels of communication are established to expedite decisions and approvals when needed. In most cases the CCOE Center Director serves in this role. These lessons learned should be kept in mind when planning future generations of CCOEs.

4.2.3 Succession Planning/Institutionalizing Knowledge

As discussed earlier, because they are often limited in resources and infrastructure support, community-based organizations and small programs such as the CCOE tend to rely heavily on their personnel to make their programs a success. 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. 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 CCOE program.

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.

As Section 3.0 discusses, the CCOE at Northeast Missouri Health Council, Inc. is an example where both the Center Director and Program Coordinator left the program, leaving the remaining CCOE staff to rebuild the program without the benefit of the expertise and leadership of these two critical staff members. Hennepin County Department of Primary Care faced a similar problem with turnover in its Center Director and Program Coordinator positions. At NorthEast Ohio Neighborhood Health Services, however, the previous Program Coordinator was promoted to another position within the parent organization and still works in the same building as the current Program

Coordinator. The current Program Coordinator has benefited from this arrangement because historical program knowledge can still be passed to her. Regardless, in all these cases, the CCOE would have benefited from a more formal succession planning effort.

Institutionalizing knowledge takes time and resources, both of which are in short supply at the CCOEs. However, without a formal process for succession planning, a loss of institutional knowledge can occur. For programs the size of the CCOEs, a loss of institutional knowledge can become a major deficiency. Many of the CCOEs realize this and are taking steps to address the issue. In the Northeastern Vermont AHEC, the community health workers are working to develop a resource book that lists all the resources in the community to which they commonly refer CCOE clients. This book also includes contact information and notes on shortcuts to obtain the resources and information necessary to help their clients. Christiana Care Health Services has developed a contact list with the names and phone numbers of partner organizations and other external community resource agencies. This list is displayed prominently at all of its sites. Although this is a simple idea, it is valuable in helping people find and connect with the right resources. Other CCOEs are researching strategies appropriate to their structure and resources. Regardless of the approach, documenting knowledge and sharing it among partners and staff is a key lesson learned for the CCOEs.

4.2.4 Tracking CCOE Clients

One of the most difficult tasks for the CCOEs is tracking the services received by their CCOE clients and using this information to improve case management and the overall coordination of care and services. Although the CCOEs have and continue to make progress in developing their tracking processes and tools, the problems they face can be summarized into two major categories: variability in the identification of CCOE clients and development of an effective tracking system.

One of the most difficult tasks for the CCOEs is tracking the services received by their CCOE clients and using this information to improve case management and the overall coordination of care and services.

Variability in Identification of CCOE Clients

Although the CCOEs can identify the majority of their clients, one of the challenges they face is effectively and consistently identifying their *entire* client base. The reasons for this are twofold.

The first is that CCOEs offer their services to all women regardless of whether or not they choose to enroll in the CCOE program. To do otherwise would be unethical, and for those CCOEs that are community health centers, it is a violation of their funding agreement with HRSA. Not all women who received CCOE services or took part in CCOE activities chose to formally enroll in the program; yet they still continue (and are welcome) to receive services and to participate in activities. This is not a problem in and of itself, however, it does result in variability in tracking CCOE clients across the CCOE program. For example, when counting CCOE clients at a lecture or training, should all participants be counted for tracking purposes or only those who have already been enrolled in the CCOE program? Several CCOEs have instituted a cap on the number of women they will formally enroll because they only have the resources to manage the care and delivery of services to a fixed number of women. Other CCOEs have not instituted a cap and have a much broader definition of who a CCOE client is, because case management has not been deemed as high of a priority as the provision of helpful services and activities. These differences also result in variability in the identification of CCOE women across the CCOE program.

Second, for several reasons, many of the women who formally enroll in the CCOE program are not always identified as CCOE clients when they receive services or attend CCOE activities. In some cases this is because of the difficulty of asking CCOE clients 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 or not 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 times, there are language barriers or these groups are distrustful of organized institutions because of inherent cultural biases and because of a fear of authority due to questionable legal status. Virtually all the CCOEs serving these population groups have stated that there are difficulties associated with identifying and tracking individuals from these populations.

Mariposa Community Health Center is located in Nogales, Arizona – a border community. It often provides care to women who have crossed over the border from Mexico. These women generally provide false contact and identifying information and, as a result, are hard to track. St. Barnabas Hospital and Healthcare System has similar problems identifying and tracking its Puerto Rican immigrant community in the Bronx.

The CCOEs have made strides in trying to implement consistent rules, effective processes, and tools to identify and track CCOE women. As a result, they are able to identify and track the majority of their client populations. One innovative solution has been implemented by the CCOEs at St. Barnabas Hospital and Healthcare System, the Mariposa Community Health Center, and the Ohana Women's Health and Wellness Program. These CCOEs provide their clients with identification cards or passports that the women carry with them. The CCOEs use the passports to track medical information. This gives the women a sense of ownership of their own health care; increasing the likelihood the women will carry the identification with them to their medical appointments. These CCOEs also successfully use CHWs or promotoras to help the women feel more comfortable about coming to the CCOE and taking part in activities. Making women more comfortable increases the likelihood that the women will return to the CCOE, whether for follow-up appointments or for new activities, thus making the women easier to track. The combination of these resources helps the CCOEs follow up with and track their clients.

No solution can completely solve the problem of variability in the identification of CCOE women across the CCOE program. When CCOEs provide services to underserved populations who are often ethnic minorities, immigrants, and individuals with low socioeconomic status and education levels, the problems with identification grow exponentially. Developing program-wide guidelines and customized strategies to address these issues should be a consideration for the future.

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Tracking Systems

All of the CCOEs have implemented procedures to record the identity of CCOE clients they serve and to track their referrals and participation in CCOE activities. The tools the CCOEs use to identify and track their clients range from manual systems to sophisticated automated ones. Several CCOEs use stickers and standardized note sheets on patient charts to identify CCOE clients and to track receipt of

services. Others have built homegrown databases. Others have had the luxury of sophisticated IT systems that are part of their parent organization's infrastructure. In many cases, these IT systems have been customized to flag CCOE women. In yet others, electronic medical record systems are in place to track detailed receipt of services and outcomes.

A majority of the CCOEs, however, have and continue to face several problems with their tracking systems. As previously mentioned, accurate and consistent identification of CCOE women is extremely challenging. As such, it is important to keep in mind that the content of these tracking systems is only as good as the data used to populate them.

Many of the CCOEs implemented tracking solutions within their clinical care facilities but have problems accurately tracking receipt of services outside of these facilities. CCOE services can be offered in partner facilities, churches, schools, and other locations. Developing tracking solutions that are easy to implement in such disparate locations is not easily achievable. The CCOEs that have tackled this issue generally keep track of CCOE clients involved in activities outside of their clinical care facility through a separate mechanism and then manually transfer that information to their recordkeeping systems. As discussed in the previous section, human error and/or biases can become a factor in these cases.

Another issue with tracking CCOE participation outside of the CCOE clinical care facility is that partner organizations often have their own recordkeeping 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 client information among providers is also difficult due to the need to obtain a release from the CCOE client to share any of her information. Sharing information between organizations is especially difficult due HIPAA regulations.

Additionally, currently only a few CCOEs have the ability to track the cost of their services. The CCOEs that have this ability are those that are housed in hospital systems or other large health care organizations. They have the benefit of preexisting IT systems that already track cost of service data. However, none of these CCOEs has segmented CCOE client cost information out of these large parent organization-wide systems yet. This is primarily because they are still concentrating on program development and have not fully explored the opportunities that having cost information available to them can provide. A limitation that all CCOEs face is tracking the cost of service across partners. As discussed above, sharing information across organizations is a difficult task given the myriad systems and procedures each organization uses.

Sharing information across organizations is a difficult task given the myriad systems and procedures each organization uses.

Several CCOE staff stated that they lack sufficient resources to research and implement a comprehensive solution. Others stated that they would like to see additional and more specific guidance from OWH on what information needs to be tracked and why that information is important. Such information will allow CCOEs to tailor their tracking systems accordingly. Many of the CCOEs funded in the first two years of the program believe that while guidance has been provided, it was provided too late for them to develop alternative tracking solutions or to alter their existing ones without committing significant additional resources and cost to the effort. A few CCOEs said they would like OWH to develop a tracking system and provide it to the CCOEs. Using an individual tool across all the CCOEs is only a feasible solution if a significant amount of funding and/or resources is put toward developing a customizable solution that meets federal, state, local, and organization-based

requirements, and if that tool can be tailored to meet the unique needs, environment, and structure of each CCOE. For instance, a hospital-based CCOE might have difficulty using a CCOE program-specific tracking system instead of its parent organization's system. Also, a CCOE program-specific tracking system would still run into the same customization and compatibility problems with partner institutions as it would with an individual CCOE-specific system.

Development of a customized and adequate tracking system is yet another area for improvement for the CCOE program – one that the CCOEs continue to address on an individual basis and improve as specific problems are discovered and addressed.

5.0 DISCUSSION AND NEXT STEPS

5.1 Future of the CCOE Program

The CCOE program leadership is continually exploring avenues to increase its reach to women in its communities, expand and improve its partnerships and service offerings, and integrate itself better into the community to continue positively impacting women's health and well-being in the future. In the process of conducting the CCOE evaluation and analyzing findings, several topics worth further consideration and comment have been identified that will be particularly relevant when discussing the future of the CCOE program. This section discusses these areas.

5.1.1 CCOE Model Development and Integration

The CCOEs are focused on developing their service offerings in each core component area, often in conjunction with one or several partner organizations. Some have been better at implementing their health services delivery component, whereas others have been better at developing their training and education programs. Similarly, each individual CCOE has made varying degrees of progress in integrating services and activities offered in each core component. Education and outreach, training, and leadership development are the three most naturally integrated core components. The strong development of the CCOEs' service offerings in these three areas reflects that ease of integration as well. The best example of this is the training and leadership development of local CHWs. The CHWs use their training to assist CCOEs in their outreach and education efforts and, in the cases where they are offering case management, in health services delivery as well. Community-based research and technical assistance are not as naturally integrated and, as a result, have experienced a lesser degree of integration with the remainder of the core components.

Implementation of all six core components within the first year of the program can be a very daunting task, especially given the limited funding and resources many of the CCOEs face. In the future, the CCOE program should consider the amount of time and effort required to ensure the core components are up and running and, keeping this in mind, explore options to improve the level of integration among the core components and the speed with which integration is accomplished. For instance, is it reasonable for the CCOEs to have all their core components in place by the end of the first year of their designation? Or should additional time be provided? For example, a staggered approach to the development of core components might allow staff to develop components more fully and better plan how they will be integrated with each other. The OWH is already tackling these questions and is considering lengthening the amount of time the CCOEs will have to replicate their program. However, there are still other opportunities that OWH could explore to help the CCOEs be more effective at implementing and integrating the CCOE model in the future.

In the future, the CCOE program should consider the amount of time and effort required to ensure the core components are up and running and, keeping this in mind, explore options to improve the level of integration among the core components and the speed with which integration is accomplished.

5.1.2 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, rely 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 three 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 in implementing the CCOE model. Each year, the CCOE program's announcement to solicit new grants has been refined based on lessons learned. Thus, although each cohort of CCOEs is implementing the same basic CCOE model, each has responded to an announcement that has varied in emphasis and language and, as a result, has implemented its programs slightly differently.

This report only discusses the evaluation findings at a program level. However, while the variations in findings among the CCOEs can be attributed to their individual strengths and weaknesses and the unique characteristics of CCOEs, they also can be attributed, in part, to the evolution in guidance, and the trial-and-error that occurs in trying to implement an innovative community-based program. The CCOE program will continue building on what it has learned and should continue refining the CCOE program guidance and requirements both to improve the program's impact on women's health and well-being and to ensure the continuity of the provision of high-quality services through the program.

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5.1.3 CCOE Funding and Sustainability

Several CCOEs were asked about their plans for sustainability to gain insight into their plans for continuing their program beyond the 5-year life of the OWH CCOE grant. 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 as there is currently a limit on how long the CCOEs can retain OWH funding and their CCOE designation.

The CCOEs have had varying degrees of success in leveraging funding and support for their efforts. They have received financial support from individuals in the community, their parent organizations (where applicable), other private sector companies, local businesses, research institutions, and also from federal, state, and local governments. This support includes monetary donations, awards, and grants; and in some cases, time, materials, and resources. Support is provided to either support the program as a whole or to fund specific services, projects, and activities. In several instances, the CCOEs have a strong indication that they can expect to continue leveraging funds and support from these institutions in the future – even after the CCOE grant ends.

This is not the case across the board. Some CCOEs are trying to determine how to sustain their programs after the CCOE grant ends. They are exploring options on how to generate income for the

CCOE program and/or searching for likely donations and funding opportunities to sustain them after the CCOE grant ends.

Other CCOEs have expanded their definition of sustainability to include activities beyond looking for additional funding. These organizations are working to institutionalize their efforts so they will continue past the life of the grant. In these cases, the CCOEs are planning to integrate several of the services offered through the CCOE program into the service offerings of their parent organization or partners. While this means that the CCOE as an organization may no longer exist, it does ensure that many, if not all, of the services it offers will continue to be provided to women in the community. The CCOEs developed many of their services in conjunction with their parent organizations or partners, so their services are already aligned with the mission and values of those organizations. In some cases, the services were already offered by the parent or partner organization and were adopted as part of the CCOE's integrated service offering. In those cases, the transition of responsibility and ownership of such services back to the parent or partner organization would not be highly disruptive. Additionally, by the time the CCOE grant ends, many of the partners will have worked with the CCOE for a number of years and thus will have already absorbed a portion of the CCOE's cost and incorporated the CCOE into their planning cycles. How these activities and services are institutionalized will determine whether the CCOE model of integrated and comprehensive health care service delivery survives.

A good example of a CCOE trying to establish its sustainability by institutionalizing its services is the Northeastern Vermont AHEC. This CCOE has already reached an agreement with one of its core partners, the Northeastern Vermont Regional Hospital, to fund the salaries of its CHWs. The CCOE is continuing to pay part of its CHW salary. After the CCOE funding ends, the hospital plans to continue funding the CHWs who will become a resource of the hospital. This transition will be easy for the hospital because the CHWs are already housed in clinic space within the hospital, have established working relationships with core staff and physicians, and already are providing services there. Because the CHWs are an integral part of coordinating and integrating health care and social services for CCOE women, a good portion of the CCOE model will continue to exist.

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

Other examples of CCOEs working to establish their sustainability through institutionalization include Turley Family Health Center and Ohana Women's Health and Wellness Program. Leadership at the Turley Family Health Center anticipates that its activities will be fully integrated into its parent organization's operations. In the case of Ohana Women's Health and Wellness Program, many of its services already were offered by the clinic it is housed within; and thus, transitioning back responsibility and ownership of many of its services from the CCOE to its parent organization will be easy. In these instances, the CCOE staff members are paid in part through their parent organization. Once CCOE funding is exhausted, unless the CCOE has an agreement with its parent organization to continue to maintain and fund CCOE activities, there may be a question as to whether the parent organization will continue supporting all six of the CCOE core components.

Succession planning and institutionalizing knowledge is another key method to help ensure sustainability. Community-based organizations and small programs such as the CCOE tend to rely on individuals as opposed to structured procedures to make their programs a success. To avoid loss of knowledge due to staff turnover, documentation of processes, resource information, and other critical information should occur.

Although searching for funding is the first approach many of the CCOEs are taking in their attempts to establish sustainability, not all CCOEs have made progress in finding it. Trying to achieve sustainability through institutionalization of services and staff positions is a nontraditional method that the CCOEs may consider exploring if they have not already done so. Additionally, succession planning and institutionalization of knowledge is a method all CCOEs should try to implement to be prepared for what the future may hold.

5.2 Assessing Impact and Effectiveness in the Future

5.2.1 Lessons Learned from Current Evaluation

Several lessons learned from conducting this evaluation effort should be considered in planning future evaluations of the CCOE program. They are described below.

An Internet-based survey tool proved to be a cost-effective mechanism for gathering information.

Use of an Internet-based survey tool proved to be effective for this evaluation effort. It was used for both the CCOE Director and Program Coordinator Survey and the CCOE Community Partner Survey. The evaluation team selected this approach when it was determined that the majority of respondents had Internet access. It proved to be a cost-effective mechanism for gathering information because responses were automatically entered into an electronic database, reducing both the time and level of effort needed to analyze responses and produce results. Because of the negligible cost and ease of administration of Internet-based surveys, it also allowed the evaluation team to administer the CCOE Community Partner Survey to the universe of CCOE community partners[18] instead of relying on a sampling scheme.

Use of surveys written in Spanish should be incorporated into future evaluation efforts.

Offering the CCOE Participant Survey in languages other than English was not part of the original survey methodology because of the time and cost associated with translation efforts. However, use of surveys written in Spanish was incorporated into the methodology once the Turley Family Health Center took the initiative to translate the survey for their Spanish-speaking population. The evaluation team distributed the translated surveys to all the CCOE Participant Survey Administrators. Each CCOE then used in-house personnel to translate Spanish responses back into English. Nine out of 12 of the CCOEs identified Spanish as one of the primary languages spoken by their client populations in part of their response to the CCOE Center Director and Program Coordinator Survey. This information leads the evaluation team to believe that offering a translated survey helped increase the representation of this significant population group's perspective in the evaluation results. Based on this lesson learned, use of surveys written in Spanish should be incorporated into future evaluation efforts. The evaluation team members should incorporate professional translation of the survey and the time associated with translation of responses into their project plan. They should also consider whether survey translation into languages other than English and Spanish is a feasible option given the resources available and the current composition of the CCOE program client community.

The evaluation team initially estimated that two months was sufficient time to analyze all the data collected during the course of the evaluation. However, this proved to be insufficient. It took about three months longer than originally anticipated to obtain OMB clearance on the data collection

[18] A small number of CCOE community partners did not have e-mail and Internet access. In these cases, a paper-based survey was used. Please see Section 2.3.2 of this report for more information.

instruments used in the evaluation. As a result, the evaluation administration period was also pushed back. Although the evaluation team was able to extend the delivery of the final evaluation report, delays in the evaluation timeline caused the evaluation team to resort to overlapping survey data cleanup, analysis, and drafting of the evaluation report to compensate for the time lost. (Please refer to the evaluation timeline presented in Figure 2.5 for additional information). Although all the necessary tasks were accomplished in the extended time frame, given the resource and time constraints that resulted because of delays to the schedule, it proved to be challenging to conduct analysis in conjunction with the other activities described above. Future evaluation efforts should factor in the dedicated resources and time needed to conduct data analysis, and evaluation team members should ensure they plan for delays in the timeline accordingly.

Initially, the evaluation team planned to use an MS Access database to store both qualitative and quantitative data from the surveys used in the evaluation. However, because of the 255-character limit on MS Access database cells, this software program proved to be insufficient for storing the qualitative responses to the surveys. Similarly, the evaluation team initially recorded and stored the site visit data in MS Excel. During data cleanup, the 255-character limitation on MS Excel cells made it difficult to clean and organize data within that software program and use it as a storage tool for the site visit data. As a result of both of these lessons learned, the evaluation team had to spend time transferring the qualitative data from both the surveys and the site visits to MS Word files for organized storage and to improve ease of data analysis.

The evaluation team also planned to use NUDIST, a qualitative analysis software tool, to analyze the qualitative data gathered during the CCOE evaluation. It is designed as a data-mining tool that can sift through large amounts of text, identify themes, and organize information by topic. This tool proved to be inappropriate for the CCOE evaluation because the qualitative data gathered was already organized topically. The site visit protocol questions and open-ended survey questions, the two major sources for qualitative data, addressed previously identified topics. Thus, responses received to these questions were already organized topically. This type of tool is more appropriate for larger, more complex studies where multiple, lengthy, qualitative texts, such as interview transcripts, need to be mined to identify themes.

Before a future CCOE evaluation begins, the CCOE program guidance's continued evolution should be considered so that it can be identified as an evaluation limitation, and strategies to address it can be developed.

As mentioned previously, in its efforts to improve the guidance provided to the CCOE program applicants, OWH has modified the program each year it has been announced. As with most new initiatives, improving the program is an evolutionary process and changes are to be expected. Although most of these changes have been refinements and slight modifications that left the basic CCOE model intact, in some cases, these changes did affect the evaluation effort. The evaluation subquestions for each core component were largely based on OWH requirements as described in the guidance provided during the first year of the program. As that guidance evolved, however, the evaluation framework, including the research subquestions, did not. This discrepancy could have implications for the evaluation results. This lesson learned was not established in time for a reassessment of the research subquestions or a refinement of the linked survey questions, if it had been proven necessary. An analysis of how the research subquestions compare to the latest set of OWH guidance should occur before using the current evaluation framework in a future CCOE evaluation. Another factor that could affect the results of this evaluation is the fact that the CCOEs developed their core components based on multiple sets of guidance. Even if these changes were slight modifications, they could impact results. They could also impact the comparability of data

gathered from this evaluation to that gathered in future evaluations. Before a future CCOE evaluation begins, the CCOE program guidance's continued evolution should be considered so that it can be identified as an evaluation limitation, and strategies to address it can be developed.

5.2.2 Future Evaluation Efforts

The CCOE evaluation established a baseline of performance for the CCOE program, and as such, it 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. The internal validity of any evaluation effort is increased by the use of two data points, and the data and findings from this evaluation provide a ready-to-use dataset that can be used as a second data point in a future evaluation of the CCOE program.

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.

Use of a comparison population is another potential second data point that future CCOE evaluation efforts should consider. Comparing CCOE clients' perceptions (data point one) of their own health and of their experiences in receiving health care and other services from the CCOE, to a comparable population's perceptions (data point two) 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. As Section 2.4 discusses, no comparison populations were identified during the time the current CCOE evaluation methodology was being developed. The unique characteristics of each individual CCOE population make doing so a difficult task. Because 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 with 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 subquestion and survey instruments to the specific guidance provided to that particular cohort of CCOEs. It will, while still accounting for the unique approach that each CCOE is taking to implementing the CCOE model, 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. This approach should be reconsidered. If a CCOE is performing extremely well in an area that populates one research subquestion and not addressing an area that populates another, should it be penalized for inadequate performance? The CCOE may be accomplishing the core component as adequately as it can, given the resources it has available within the community. OWH might consider whether or not the requirements associated with each core component are of equal value or if 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.