Oklahoma

Best Practices in Program Evaluation

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Where did we come from?

- No formal evaluation strategy
- Minimal staff time dedicated to the process
- Activities seemed to work, so they continued

- Workplan/grant management in separate office
- Workplan was not “SMART”
Where did we go?

- Hired Program Evaluator
- Workplan and grant management moved in-house
**Where did we go?**

- **Developed planning team (Engaged stakeholders)**  
  - Tied planning and evaluation together

- **Started broad Evaluation model**

<table>
<thead>
<tr>
<th>Stakeholder Name</th>
<th>Stakeholder Category</th>
<th>Role in Evaluation</th>
</tr>
</thead>
</table>
| Jeff Hackler     | Secondary            | • Utilize evaluation results for grant funding/planning  
                     |                      | • Utilize evaluation findings to determine program gaps/needs |
| Rod Hargrave     | Secondary            | • Assist with data collection  
                     |                      | • Implement change based on findings |
| Corie Kaiser     | Primary              | • Implement change based on evaluation findings  
                     |                      | • Assist in evaluation planning and data collection  
                     |                      | • Review evaluation plans/instruments |
| Pete Walton      | Primary              | • Oversight of evaluation  
                     |                      | • Develop evaluation plans  
                     |                      | • Develop evaluation instruments  
                     |                      | • Collect and analyze data  
                     |                      | • Recommend change based on findings |
| Denna Wheeler    | Secondary            | • Provide technical assistance for evaluation planning implementation |
Where did we go?

• **Evaluation Plan**
  - Stakeholder roles
  - What is being evaluated
  - Evaluation design
  - Data collection methods
    - Quantitative & Qualitative
  - Indicators and standards
  - Who is responsible
  - How results will be used

• **CDC Toolkit & Flex Program Eval Toolkit**

• **Align Work plan Evaluation Plan**

http://www.ruralcenter.org/sites/default/files/Flex%20Program%20Evaluation%20Toolkit_0.pdf

http://www.cdc.gov/asthma/program_eval/guide.htm
Oklahoma Flex Program Evaluation Logic Model

**Inputs**
- OORH Staff
- Flex Coordinator
- Flex Funding
- OFMQ Staff
- OHA Staff
- Consultants
- OORH Staff
- Cooperative Extension Staff
- Flex Coordinator
- Flex Funding
- OSU Center for Rural Health Staff
- OSU Telemedicine Staff Consultants
- OORH Staff
- Flex Coordinator
- Flex Funding
- Consultant

**Outputs Activities Participation**

**QI Activities**
1. Add CAHs to Multistate Learning Community
2. HCAHPS Participation
3. OHA Training Webinars
4. Competitive QI demonstration projects
5. MBGIP Participation
6. Support CAH participation in OFMQ Projects

**O/F/I Activities**
1. Add CAHs to Multistate Learning Community
2. OHA Training Webinars
3. Competitive O/F/I demonstration projects
4. Joint Rural Health Conference
5. Financial analyses for CAHs
6. Assist with CAH marketing and public relations efforts

**Community Engagement**
1. Provide Community Health Needs Assessment
2. Develop telemedicine networks
3. EMS budget studies
4. CALS training

**Convert to CAH Status**
1. Provide financial analyses for conversion option
2. Rural EMS improvement plan

**Outcomes-impact**

**Short**
- CAH staff actively participate in QI activities
- Feedback and satisfaction survey results
- # of CAHs that participate in QI projects

**Medium**
- CAH staff actively participate in operational and financial improvement projects
- Feedback and satisfaction survey goals
- # of CAHs that participate in O/F/I projects

**Long**
- CAH staff adopt a culture of continuous evaluation of processes and going QI activities
- Patient outcomes and satisfaction improve and CAH staff contribute to ongoing QI activities
- The financial health and stability of the CAH improves as processes are improved and new more efficient practices adopted
- Communities gain knowledge about the economic impact of local healthcare
- Community members understand how their healthcare choices impact the economic health of the community
- The community works together to ensure the economic health of the local healthcare system.

**PIMS-Process Measures (Some outcome measures)**

**Outcomes/Impacts**

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From PIMS to Evaluation Questions

- **PIMS=Process measures**
  - # of CAHs participating
  - # of personnel participating
  - Total dollars spent
  - # of CAHs that complete CHNA

- **Left side of logic model**

- **Outcomes/Impacts**
  - Improved health
  - Habit change
  - Adoption of culture of excellence

- **Right side of logic model**

- If we weren’t part of the process, we weren’t part of the outcome
Examples from Oklahoma

- Evaluation Questions
- Data we collect
- Reports
- Recommendations
<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Indicator</th>
<th>Standards (success)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was a state plan developed and disseminated?</td>
<td>State plan completed and distributed to partners</td>
<td>One state plan developed and two methods of dissemination</td>
</tr>
<tr>
<td>What is the quality of the state plan?</td>
<td>Score of state plan using the “State Plan Index” (modified)</td>
<td>All components within the Index Summary receive at least a score of 3. (Scored by 3 individuals not involved in planning or development)</td>
</tr>
<tr>
<td>Did the OORH provide useful assistance to the CAH throughout the process?</td>
<td>% of CAH staff that respond favorably</td>
<td>90%</td>
</tr>
<tr>
<td>Are community members engaged and satisfied with the presentations?</td>
<td>% of community members that respond favorably</td>
<td>80%</td>
</tr>
<tr>
<td>Did the CAH create an action plan?</td>
<td>Implementation strategy developed</td>
<td>100%</td>
</tr>
<tr>
<td>What impacts did the process have?</td>
<td>Success story</td>
<td>25% of CAHs have submitted a success story</td>
</tr>
<tr>
<td></td>
<td>6 month follow-up visit</td>
<td>All CAHs have implemented at least one item from action plan</td>
</tr>
<tr>
<td>Did the OORH provide useful technical assistance?</td>
<td>% of CAH staff that respond favorably</td>
<td>90%</td>
</tr>
<tr>
<td>To what extent do participants increase knowledge based on training?</td>
<td>% of individuals showing an increase in knowledge based on training</td>
<td>Significant difference in test means. (t-tests)</td>
</tr>
<tr>
<td>Evaluation Question</td>
<td>Indicator</td>
<td>Standards</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Did CAHs utilize these resources?</td>
<td>% of CAHs that indicate they utilize data/info from the OORH</td>
<td>No standards (first year only)</td>
</tr>
<tr>
<td>What type of information is most useful for CAHs to know?</td>
<td>Feedback from CAHs</td>
<td>No Standards</td>
</tr>
<tr>
<td>Was the training effective? (&gt;3 hour training sessions only)</td>
<td>% of individuals showing an increase in knowledge based on training</td>
<td>90%</td>
</tr>
<tr>
<td>Do participants feel that the conference was beneficial?</td>
<td>% of individuals that feel the conference has met immediate needs</td>
<td>85%</td>
</tr>
<tr>
<td>Did hospitals reach QA targets? (SQSS)</td>
<td>Hospitals reporting % improvement</td>
<td>Specific to activity (In this case a 5% improvement)</td>
</tr>
<tr>
<td>Are CAHs satisfied with service providers we contract with?</td>
<td>% of CAH staff that report satisfaction</td>
<td>85%</td>
</tr>
<tr>
<td>What changes has the hospital and community seen due to the assistance of the OORH?</td>
<td>No criteria-Case Study</td>
<td>No Standards</td>
</tr>
<tr>
<td>What challenges and concerns do CAH’s see in the coming year?</td>
<td>Feedback from CAHs</td>
<td>No standards</td>
</tr>
</tbody>
</table>
From eval questions to data collection/analysis
## From eval questions to data collection/analysis

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Number of Measures</th>
<th>Total Number of Measures Improved</th>
<th>Total Number of Measures Declined</th>
<th>Percentage Improved</th>
<th>Percentage Declined</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2011</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>X Memorial Hospital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>X Regional Medical Center</td>
<td>506</td>
<td>7</td>
<td>3</td>
<td>1%</td>
<td>1%</td>
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<tr>
<td>X General Hospital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>X Hospital &amp; Physician Group</td>
<td>45</td>
<td>1</td>
<td>9</td>
<td>2%</td>
<td>20%</td>
</tr>
<tr>
<td>X Hospital</td>
<td>120</td>
<td>11</td>
<td>5</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>X Municipal Hospital</td>
<td>997</td>
<td>262</td>
<td>73</td>
<td>26%</td>
<td>7%</td>
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<tr>
<td></td>
<td>1668</td>
<td>281</td>
<td>90</td>
<td></td>
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<td><strong>2012</strong></td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>X Memorial Hospital</td>
<td>142</td>
<td>30</td>
<td>19</td>
<td>21%</td>
<td>13%</td>
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<tr>
<td>X Regional Medical Center</td>
<td>806</td>
<td>10</td>
<td>7</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>X General Hospital</td>
<td>28</td>
<td>0</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>X Hospital &amp; Physician Group</td>
<td>126</td>
<td>10</td>
<td>1</td>
<td>8%</td>
<td>1%</td>
</tr>
<tr>
<td>X Hospital</td>
<td>369</td>
<td>35</td>
<td>16</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>X Municipal Hospital</td>
<td>1921</td>
<td>88</td>
<td>126</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>3392</td>
<td>173</td>
<td>169</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2013</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Memorial Hospital</td>
<td>659</td>
<td>53</td>
<td>13</td>
<td>8%</td>
<td>2%</td>
</tr>
<tr>
<td>X Regional Medical Center</td>
<td>983</td>
<td>94</td>
<td>20</td>
<td>10%</td>
<td>2%</td>
</tr>
<tr>
<td>X General Hospital</td>
<td>207</td>
<td>105</td>
<td>19</td>
<td>51%</td>
<td>9%</td>
</tr>
<tr>
<td>X Hospital &amp; Physician Group</td>
<td>485</td>
<td>21</td>
<td>10</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>X Hospital</td>
<td>666</td>
<td>42</td>
<td>15</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>X Municipal Hospital</td>
<td>2050</td>
<td>167</td>
<td>43</td>
<td>8%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>5050</td>
<td>482</td>
<td>120</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
From eval questions to data collection/analysis

- Why was there a drop in FY12?

SQSS Quality Assurance Measures

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Number of Measures Improved</th>
<th>Total Number of Measures Declined</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY11</td>
<td>281</td>
<td>90</td>
</tr>
<tr>
<td>FY12</td>
<td>173</td>
<td>169</td>
</tr>
<tr>
<td>FY13</td>
<td>482</td>
<td>120</td>
</tr>
</tbody>
</table>

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From eval questions to data collection/analysis

FY13 Quality Assurance Measures

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Total Number of Measures Improved</th>
<th>Total Number of Measures Declined</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Memorial Hospital (659 Measures)</td>
<td>53</td>
<td>13</td>
</tr>
<tr>
<td>X Regional Medical Center (983 Measures)</td>
<td>94</td>
<td>20</td>
</tr>
<tr>
<td>X General Hospital (207 Measures)</td>
<td>105</td>
<td>19</td>
</tr>
<tr>
<td>X Hospital &amp; Physician Group (485 measures)</td>
<td>21</td>
<td>10</td>
</tr>
<tr>
<td>X Hospital (666 Measures)</td>
<td>42</td>
<td>15</td>
</tr>
<tr>
<td>X Municipal Hospital (2050 Measures)</td>
<td>167</td>
<td>43</td>
</tr>
</tbody>
</table>

Hospital Name and total # of measures tracked

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From data collection/analysis to use

- Why are hospitals succeeding?
  - Community sharing
  - Best practices
  - Lessons learned

- Why are hospitals lagging?
  - Turnover?
  - Trained to use system?
  - Not Improving?
## Moving from QA to QI

- Is there a level of performance that is not good enough to protect our patients or our hospital?
- Is there a new standard, new evidence or a new regulation that we must achieve compliance with?
- Is there an opportunity to make some aspect of the organization that is OK better, so to strengthen its financial, operational or reputational health?
- Is there an opportunity to strengthen some aspect of how we deliver care that would allow us to better compete in an increasingly competitive market?
- Does our participation in some outside project suggest that there is an opportunity for us to improve our level of performance?

<table>
<thead>
<tr>
<th>VTE-IP Assessment and discharge education</th>
<th>Mar-12</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>Dec-12</th>
<th>Jan-13</th>
<th>Feb-13</th>
<th>Mar-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>77.90%</td>
<td>91.70%</td>
<td>83.80%</td>
<td>59.60%</td>
<td>85.70%</td>
<td>90.00%</td>
<td>87.80%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOB-IP-3 All patients reporting tobacco use within the last 30 days will be provided or offered tobacco treatment at discharge</th>
<th>Mar-12</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>Dec-12</th>
<th>Jan-13</th>
<th>Feb-13</th>
<th>Mar-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>51.00%</td>
<td>57.30%</td>
<td>66.00%</td>
<td>79.00%</td>
<td>80.00%</td>
<td>82.00%</td>
<td>83.00%</td>
<td>88.00%</td>
<td>66.70%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
From eval questions to data collection/analysis

- **CHNA Participant Surveys**
  - Post survey only
  - Survey fatigue

- **FY13; 100% of respondents (n=54)** said that the information “Dramatically improved” or “Improved” their opinion on local healthcare in their community

- **FY13; 100% of hospital administrators (n=9)** responded that they “Strongly agree” that they learned things they did not know about the community from the CHNA process

- **Success Stories**
From eval questions to data collection/analysis?

- FY13; CHNA Project Impacts
  - Weight management clinic
  - Mammography on site
  - Patient transport services provided
  - OB/GYN visits 2x’s/month
  - Surgeon sharing across counties
  - Prenatal classes
  - Numerous providers added
  - Numerous educational programs added
Now what?

- Monthly stakeholder meetings
- Increased awareness by everyone in the office of need for evaluation
- Over 600 surveys completed this year

- Expand into impacts
- Expand stakeholder group (external stakeholders)
- Recommendations for program improvement and program development
What recommendations came from program evaluation activities?

- Financial Assessment Program
  - CAHFIR/iVantage/Apps

- ↑ QI initiatives

- Some things don’t work;
  - Webinars
  - Financial Assessment Program

- Board development-30% CEO turnover

- MBQIP site visits/discharge instructions/learning session

- ↑ communication with CAHs (site visits, newsletter)

- Work with consultants to provide eval data to YOU
Things to take away

- Ensure goals are consistent with need
- Just because we help with QI (or anything) doesn’t mean WE had an impact
- Begin with the end in mind

- This is not research; don’t generalize across programs/counties/states
- Include external stakeholders
- It’s OK to start small
For Additional Information

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2012-2014

Stacey Knapp, D.O.
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Endowed Rural Health Professor (Clinton)
2010-2012

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