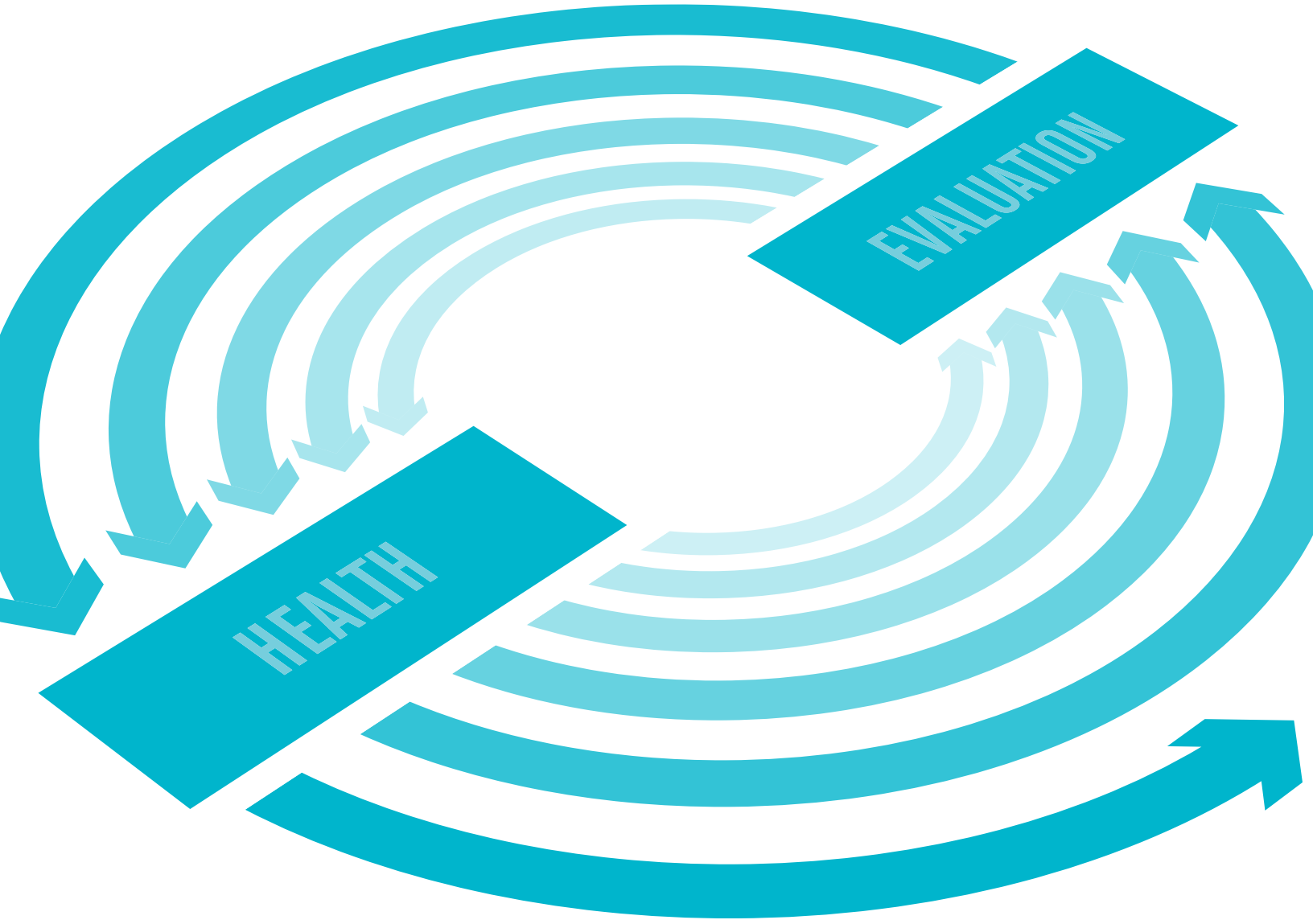
CASEBOOK ON

EVALUATION FOR LEARNING

IN CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION



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Casebook on Evaluation for Learning in Chronic Disease Prevention and Health Promotion

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FOREWORD

Evaluations are done for many reasons. When they include a learning and improvement component, they set the stage for evaluation to be its very best. This Casebook offers exciting and inspirational examples of how six initiatives, using a range of evaluation approaches and methods, were able to incorporate a learning and improvement agenda. They show that learning and improvement can transcend both process and outcome evaluation; can be incorporated into a variety of data collection methods; and can lead to a host of benefits that extend beyond accountability or program development.

I encourage you to explore the ideas and approaches in these cases and to reach out to others to share your own insights and learning. In reading this Casebook you will learn how to incorporate real-time learning into your evaluation practice, and you might see the practices you currently use reflected in these cases. The cases show that it is possible to include evaluation for learning in any evaluation. If you want your evaluations to be used and useful, this Casebook will be a valuable resource.

Marla Steinberg, Ph.D.
Director of Evaluation
The Capture Project

INTRODUCTION

When we apply learning we improve. When we bring the evidence-based nature and critical thinking of evaluation to the process of learning and improvement, we help individuals and organizations tackling public health challenges to generate useful insights that can inform programs and policies.

There is growing enthusiasm for evaluation that is done to support evaluation used for learning and improvement. This Casebook was born in response to the encouraging signs of an expanded role for evaluation beyond pure evaluation for accountability.

Evaluation for learning is primarily improvement oriented. It involves a systematic and collaborative cycle of inquiry and feedback related to the context, design, implementation, and outcomes of policies and programs.

Evaluation for learning and improvement is meant to complement, not replace, the accountability role of evaluation. In a way, evaluation for learning and improvement represents the highest form of accountability – accountability to ourselves to do better in our work as programmers, funders, policy-makers, researchers, or any of the many roles that contribute to the public health field.

This *Casebook on Evaluation for Learning* presents six descriptive narratives of specific examples that illustrate the successful use of evaluation findings to inform programs and practices in chronic disease prevention and health promotion. Increasingly there are examples of individuals and organizations bringing an openness and curiosity to their work. The intent of this Casebook is to demonstrate the potential of evaluation for learning and improvement, and to share ideas and inspiration to people interested in evaluation in this way.

The Casebook's objectives are to:

1. Increase awareness and understanding of the value of evaluation for learning

2. Highlight different strategies and approaches that enhance the use of evaluation findings

3. Illustrate lessons learned from a diversity of contexts

4. Demonstrate the impact of chronic disease prevention and health promotion in informing policy, program or practice changes

5. Facilitate ongoing knowledge translation including uptake and adoption of chronic disease prevention and health promotion evaluation by connecting audiences to the work of others and to each other

Cases were identified through a request for submissions soliciting examples from a diversity of organizations that have successfully used chronic disease prevention and health promotion evaluation findings to enhance their learning and practice.

As part of the pan-Canadian Vibrant Communities initiative, Vibrant Communities Saint John is a case illustrating how a learning agenda and evaluation processes can stimulate collaboration on local strategies. As an intermediary organization, they have used evaluation to support a network of community partners in gathering and sharing data to enhance learning and improvement.

The Cardiovascular Health Awareness Program is a standardized cardiovascular health promotion and disease prevention program. This case illustrates an initiative that balanced rigorous testing of standardized features

with the adaptation of some program elements in response to ongoing learning. The evaluation was designed to support the needs of community-based health promotion organizations and their local partners as well as the coordination of an overall initiative.

Minding Our Bodies a multi-year pilot project led by the Canadian Mental Health Association of Ontario in partnership with mental health service providers and other organizations to highlight the connection between healthy lifestyle activities and mental health. In this case, evaluation is used to help expand, promote, and sustain programs. CMHA engaged external evaluators as partners with internal evaluators for improved program learning.

Spark Together for Healthy Kids™ is a major initiative of the Heart and Stroke Foundation of Ontario. The organization's board and staff looked to evaluation to help them gain confidence and to support their learning in this initiative that represented a new way of thinking and working. Their process of evidence-informed critical thinking and continuous improvement fed interim results into program decisions, strategy, and plans for evaluation.

The Wood Buffalo Primary Care Network in Fort McMurray, Alberta, is a formal agreement between local family physicians working with extended healthcare professionals to provide comprehensive primary healthcare programs and services to the community. They created a system that provided clinician leads and program coordinators with information needed to consistently improve their programs in order to provide relevant and current information to assist in organizational decision-making. They embedded evaluation activities into the natural course of program operations, and built a simple and practical system that enables multiple users of common information.

Sip Smart! is an educational program to help elementary school students in grades 4, 5, and 6 make healthy drink choices. It is an example of using multiple levels of external and internal evaluation effectively to contribute to program credibility, use, and growth. Created in B.C and adapted in other Canadian jurisdictions, including Quebec, it provides an example of how program and evaluation resources help disseminate a program across communities.

Each of these cases is unique – they demonstrate different evaluation approaches responding to different needs in different conditions. The cases also reveal to us some general lessons about evaluation for learning and improvement – the importance of:

- Planning evaluation from the beginning of the initiative
- Involving stakeholders in shaping the evaluation
- Having data that are useful and available
- Bringing people together for shared learning and reflection
- Creating a culture that enables evaluation for learning

A culture of evaluation for learning and improvement in chronic disease prevention and health promotion can contribute to better outcomes. We hope that this resource is beneficial to you in your work.

REFLECTIVE QUESTIONS

1. What do the experiences of the organizations highlighted in the cases tell us about different possible uses of evaluation for learning and improvement?

2. What do these cases tell us about the role of relationships, partnerships, and knowledge exchange in supporting evaluation for learning and improvement?

3. What conditions and factors helped to facilitate the process of evaluation for learning and improvement?

4. How do these cases highlight different ways of thinking about evidence and findings?

5. Which lessons stand out the most, and how might you apply them in your own work?

VIBRANT COMMUNITIES SAINT JOHN (VCSJ)

THIS IS A CASE ABOUT

A national initiative in which a learning agenda is central to the program

A community that uses evaluation processes to stimulate collaboration on local strategies

An intermediary organization that supports a network of community partners in gathering and sharing data to enhance learning and improvement

SAINT JOHN IS A PART OF VIBRANT COMMUNITIES, a pan-Canadian initiative that started in 2001 in which 13 communities have experimented with mobilizing local poverty-reduction efforts by building on local assets, collaborating across sectors, and thinking comprehensively about poverty.

Vibrant Communities Saint John (VCSJ) emerged in 2002 out of existing poverty-reduction work being pursued in the community by a local business network, a social planning council, the municipality, and an organization promoting the voice of low-income women. Over time, many other partners have engaged with VCSJ, including the local Community Health Centre.

ABOUT THE EVALUATION

From its inception, the Vibrant Communities initiative has focused on learning and change. As a result, *evaluating learning and improvement* has been a core part of the agenda of the initiative as a whole and of each of the 13 VC communities individually.

VCSJ's challenge in evaluating its progress and effectiveness was to find a way to harmonize the evaluation interests and priorities of this diverse set of stakeholders. Its aim was to find the right balance between measures that tracked progress on a variety of aspirational poverty-reduction targets and learning about key principles and objectives. The evaluation generated: lessons about the local adaptation of the Vibrant Communities concept; insights into specific program and policy initiatives; and a deeper perspective on collaboration between partners.

The main strategies for evaluation were as follows:

- Tap into supports provided by the national VC initiative: access to a community coach, use of evaluation tools generated by the national partners (see below) or other VC communities, and participation in a learning community that focused on evaluation in complex, community-wide initiatives
- Draw on a variety of evaluation supports to meet the diverse needs and different stages of the initiative (these supports would turn out to include VCSJ staff, partner agencies, local consultants, academics from local universities , and coaches from the national initiative)
- Engage in overall evaluation activity as well as specific evaluation initiatives within the larger initiative
- Link evaluation activity closely to ongoing communications with internal stakeholders and with the broader community

EVALUATION DESIGN

This case study demonstrates the use of a cross-scale evaluation, in which local and national assessment processes, with different purposes, overlap and are complementary.

At the national level, all participating communities agreed to track and analyze common measures and report them semi-annually to the Vibrant Communities national partners: the Tamarack Institute, the J.W. McConnell Family Foundation, and the Caledon Institute for Social Policy. The above activity contributed to a national pool of data that could be used to understand the overall initiative and the way the VC approach was playing out in different cities.

At the local level, VCSJ aimed to direct its evaluation effort to local areas of interest. This kind of complementary local evaluation was common across most of the cities participating in Vibrant Communities.

HOW THEY DID IT: IMPLEMENTATION

VCSJ's evaluation tended to fluctuate from year to year, depending on immediate priorities and its stage of development. Its evaluation efforts have included a survey process led by residents in a low-income neighbourhood, evaluations of specific community programs, a review of the state of the collaboration between the stakeholders, identification of improvements, and the tracking of common measures across programs that were operating on a common issue.

One major evaluation process was designed to fulfill a joint local and national objective. An annual reflection

session pulled VCSJ stakeholders together to review progress and share learning. Then, with support from the Caledon Institute, VCSJ revised its Framework of Change, a document outlining its theory of change and local priorities. This process fed into the national partners' interest in monitoring the evolution of each VC community while encouraging, at the local VC level, a systematic process of reflecting on, and when appropriate adjusting, the framework for change to reflect learning and evaluative feedback.

VCSJ engaged with individual or sub-groups of partners on specific evaluation initiatives. Such engagements were expected to contribute to overall VCSJ learning and provide more detailed attention to specific areas of interest. The Community Health Centre, for example, has worked with VCSJ on the issue of delivering programs in specific neighbourhoods, collaborated with other partners in a teen pregnancy coalition, and incorporated overall evaluation findings from VCSJ into its own planning cycle.

The evaluation approach has been a mix of consistent measurement over time, adjustments to evaluation approaches as needs have changed, and the adoption of emergent opportunities that support new learning.

For Vibrant Communities Saint John, evaluation is closely integrated with its other activities. The facilitation of learning and improvement is a core part of its mandate as an intermediary organization focused on stewarding a network, convening partners, and conducting research on poverty and poverty reduction. Every VCSJ staff meeting includes time for the review of evaluation questions. Though members of staff often feel pressured to use this time for other things, they see this review as part of a continuous learning loop that has been a key part of VCSJ's success.

Early in its mandate, VCSJ invested in local research that led to a report entitled Poverty and Plenty: A Statistical Snapshot of the Quality of Life in Greater Saint John. One of the report's primary findings was that poverty is highly concentrated in neighbourhoods in which the housing stock is generally old and in poor condition, access to government services is difficult, and overall economic opportunity is limited. VCSJ began to shift its focus to these neighbourhoods, and over time this approach gained momentum and support.

For example, the Community Health Centre takes these targets as guidance in determining where it might fit into the bigger picture. When gaps in neighbourhood access to health services were identified, the centre began shaping its programs to respond. The centre is now using the process and results of evaluation to guide program implementation in these neighbourhoods by conducting an annual analysis based on the Laverick model for measuring community capacity.

Over time the community's poverty-reduction targets have evolved in response to new learning and changes in overall strategy. These targets received a major update in 2010. The targets include specific objectives related to increased participation in community programming, increased community capacity, expanded engagement with stakeholders, improved outcomes for specific populations, and the meeting of research objectives.

"WE WERE VISITED ANNUALLY BY FEDERAL PUBLIC SERVANTS PARTICIPATING IN A LEADERSHIP DEVELOPMENT PROGRAM CALLED DIREXION. THIS PRESENTED AN OPPORTUNITY FOR A POWERFUL LEARNING EXPERIENCE AS WE HAVE 20 PEOPLE UNFAMILIAR WITH OUR CONTEXT COMING AND ASKING QUESTIONS ABOUT WHAT WE DO. THE RESULT IS A CONVERSATION ABOUT OUR OUTCOMES AND PROCESS THAT WE MIGHT NOT OTHERWISE HAVE, AND THAT ITSELF CREATES MOMENTUM IN OUR COMMUNITY."

– WENDY MACDERMOTT, VIBRANT COMMUNITIES SAINT JOHN

"I'VE BEEN TWEETING OUR EVALUATION AS WE LEARN NEW THINGS."

– WENDY MACDERMOTT, VIBRANT COMMUNITIES SAINT JOHN

The Community Health Centre is a highly engaged partner in VCSJ. Based on its decision to focus on priority neighbourhoods, the centre has been investigating how to establish neighbourhood-based programs and teams. Clinical services are being introduced in priority neighbourhoods; the centre is also working with other government and non-government service delivery agencies to co-locate wellness programming in these neighbourhoods.

The design and implementation of these programs have benefited from the cooperative efforts of Public Health, the Community Health Centre, Mental Health, and VCSJ. These organizations have shared data and learning and have coordinated several community meetings in which residents and health professionals come together to review progress and voice concerns. The most recent check-in combined a survey and a community meeting that resulted in a better understanding of how some broader health promotion issues – such as access to healthy food and access to infant care – could be linked to initiatives that address the priorities of residents, including garbage collection and mold.

These targets are now a main driver of measurement activity. The burden of data collection has shifted from Vibrant Communities to partner agencies in the community. VCSJ has begun to play the role of facilitating agreements concerning what to measure and how. It is prompting agencies when it is time for them to collect information and managing the aggregation of the information. The increased number of agencies involved has influenced VCSJ to focus more on communications. VCSJ provides information to partners in small, digestible pieces. Partners think this approach makes evaluation far more accessible and practical for their learning.

THE BENEFITS OF EVALUATION

AN AID TO BUILDING A COMMUNITY STRATEGY

As the network of partners from across sectors began to shape its work with a neighbourhood lens, evaluation processes looked at questions of what was emerging in these neighbourhoods. What kinds of activity showed promise? How was this work best supported? This learning, which was actively communicated to local partners, encouraged involvement with and buy-in to a poverty-reduction agenda.

AN AID TO INFORMATION SHARING AND BUILDING AN OUTCOMES FOCUS

One of the early barriers to evaluation was the challenge of working in a network in which positive effects are often the result of multiple interventions, involve multiple organizations, and are affected by overall contextual changes. VCSJ was collecting data from partners on participation and outcomes targets, and initially there was some tension about who should take the credit. Sticking with evaluation over a longer term has enabled people and organizations to build trust and see themselves as part of a larger system.

For example, a group of child-serving organizations is now having a conversation about how they could collectively redesign the community's child and youth supports. This means everyone is examining what they do best and considering whether they should do things differently given the overall child and youth outcomes they are seeking. Sharing information and starting to work with some common measures have led these organizations to productive conversations that at one time would have been inconceivable.

VCSJ recognizes that cooperation by organizations with a common interest is just the beginning. However, it is encouraged by the prospects of this kind of thinking and gratified that its orientation to evaluation helped lay some of the groundwork for this to happen. The Community Health Centre is now interested in a similar approach and is reaching out to local police and recreation groups to explore building a common measurement framework.

AN AID TO FINE-TUNING PROGRAMS

Teen pregnancy is a significant issue for Saint John, which has one of the highest overall rates in the country. An analysis of health zone data indicated positive progress overall on this issue. Working with Vibrant Communities, the Community Health Centre found that incidence was growing in urban parts of the health region. As a result it has shifted its efforts from some broader public awareness campaigns to more highly targeted health promotion activity in these specific areas.

LESSONS LEARNED

1. Package evaluation information in a variety of ways. Different audiences respond to different things. VCSJ has found value in reporting information and findings in smaller, digestible pieces as opposed to relying on large reports. It has used stories to complement quantitative data and has experimented with visual techniques for presenting information efficiently and clearly. Some VC partners are even using social media to share progress and lessons

2. Evaluation processes can be a way for VCSJ to engage further with a diverse group of local partners; such process can help this network move forward together as an initiative progresses and new learning shapes its overall direction

3. Achieving perfect evaluation is impossible in a diverse, community context. It is important to recognize limitations and move forward anyway

THE CARDIOVASCULAR HEALTH AWARENESS PROGRAM

THIS IS A CASE ABOUT

An initiative that balanced rigorous testing of standardized features with the adaptation of some program elements in response to ongoing learning

An evaluation that supports the needs of community-based health promotion organizations and their local partners as well as the coordination of an overall initiative

THE CARDIOVASCULAR HEALTH AWARENESS PROGRAM (CHAP) is a standardized cardiovascular health promotion and disease prevention program. Implemented in 20 mid-sized communities in Ontario in 2006, the program helps at-risk people become more aware of their cardiovascular risk, link with a range of community and health care supports, and acquire self-management skills. CHAP sought established health promotion organizations to lead the program locally.

Volunteers helped participants measure their blood pressure with an automated blood pressure measuring device. They also conducted a risk factor assessment and educational sessions. Blood pressure readings and other cardiovascular risk factor data were sent to participants' family physician and pharmacist.

ABOUT THE EVALUATION

The primary purpose of the CHAP program evaluation was to determine the uptake, effectiveness, cost-effectiveness, and sustainability of the CHAP model. Program proponents recognized the need to give communities as much latitude as possible in their implementation and evaluation efforts while protecting the program's integrity. CHAP's evaluation challenge was finding the right balance between testing the intervention, making learning immediately accessible to support improvements to the program, and adopting an approach to evaluation that could make evaluation an integral part of the operation of the program.

The key features of the evaluation were as follows:

- Randomly select the 20 participating communities and 19 comparison communities
- Provide a standardized implementation guide and a downloadable set of resources and templates based on a pilot of CHAP in two communities
- Provide centralized support and a peer learning group to assist with implementation, learning and improvement, and local adaptation

EVALUATION DESIGN

The evaluation relied on population-based administrative data to capture the impacts of the interventions. Evaluators used:

- Hospital discharge abstracts
- Physician service claims
- Prescription drug claims

These were used to measure change in hospital admissions for community members 65 and older with a primary discharge diagnosis of:

- Acute myocardial infarction
- Congestive heart failure
- Stroke

Routinely collecting data from the health authority, as opposed to collecting primary health data, decreased the cost of evaluation.

The evaluation process added context to the administrative data. First, thirteen weeks into the program, each community was asked to report on its successes and challenges in using a standardized template. Second, follow-up interviews were conducted with each community to understand these successes and challenges more deeply. And third, all of the communities were convened to collaboratively describe important aspects of the program's evaluation and add perspective on areas where there were remaining questions.

This evaluation of the implementation process looked at several elements, including the success of different advertising and invitation strategies, event attendance, participant consent, completion of assessments, and the feedback loop to family physicians, pharmacists, and participants.

The qualitative data gathered by this more nuanced evaluation process informed ongoing learning and quality improvement for participating communities as well as for CHAP overall.

To accelerate the learning and make iterative improvements accessible to communities in real-time, participating organizations took part in a learning community to share experiences, ideas, and lessons learned in terms of what was working and not working.

HOW THEY DID IT: IMPLEMENTATION

CHAP's centralized support of the evaluation process started with a launch meeting in which local program coordinators met with one another and the two regional CHAP coordinators. This learning community was supported with weekly teleconferences with peer communities, monthly newsletters, an online forum, and site visits. CHAP coordinators surfaced issues of interest for the group to consider. Many times the coordinators received a call from a community on an issue, made note that it might be an area of common concern, and brought it forward to all of the communities.

As CHAP was rolled out, the experiences and questions of the first communities to implement generated some immediate lessons for those still to implement. CHAP central provided several changes and clarifications to all participating communities, for example, clarifying the role of the on-call nurse.

Data collected from each community were reviewed as part of the comparison of the randomly selected CHAP communities with 19 other mid-sized communities that were not part of CHAP. Data were broken down by community and each community was able to access its information, thereby gaining a perspective on who was participating and what the risk-profile patterns were.

In the risk-assessment sessions, community health nurses provided a documented assessment of high-risk participants and pharmacists reported their assessment of the drug therapy and patient adherence. Local coordinators faxed this information to a service that transferred it into a database.

Participating communities were responsible for the security and quality of their data.

Overall, the evaluation initiative and CHAP were highly successful, with a very high uptake of assessment results, a high level of participation by pharmacies and physicians, and positive outcomes in all 20 of the test sites.

"BEING ACTIVE WITH COMMUNITIES IN TRACKING PARTICIPATION AND COMMUNITY-LEVEL DATA, IN A WAY THAT RESEMBLED THE INTENDED LONG-TERM OPERATION, GAVE US ACCESS TO EXCELLENT INFORMATION AND LAID THE FOUNDATION ON WHICH COMMUNITIES COULD BASE DECISIONS ABOUT EXISTING AND NEW INITIATIVES."

– LARRY CHAMBERS, ÉLISABETH-BRUYÈRE RESEARCH INSTITUTE

"THE EVALUATION DATA [WERE] VERY VALUABLE IN STRENGTHENING OUR VOLUNTEER ENGAGEMENT AND CONFIRMING AN APPROACH THAT WE WERE INTERESTED IN USING TO ADDRESS OTHER HEALTH ISSUES."

– KAREN ROOSEN, PEMBROKE REGIONAL HOSPITAL

Pembroke was one of the 20 communities participating in the CHAP program. Led locally by the Pembroke Regional Hospital, this site was greatly aided by the peer exchange aspect of the evaluation process. Leaders learned about innovative strategies and partnerships in communities that were incorporating CHAP into wellness programs within a family health team setting. More specifically, leaders gained access to data from another community that, like Pembroke, was conducting community screening for diabetes, as well as to participant resources in that community that could be standardized for Pembroke. As a result, Pembroke is shifting its diabetes education program to a more integrated service delivery model. Meanwhile, the Pembroke Regional Hospital, with its experience in developing a local network, was a resource to peer communities wishing to engage their local community.

THE BENEFITS OF EVALUATION

AN AID TO REFINING PROGRAM ELEMENTS

The evaluation gave CHAP an insight into the key factors of program success across all sites. Lessons and confirmation emerged regarding the engagement of local opinion leaders --particularly physician and pharmacy personnel -- the need to support volunteer-led activities, and the transfer of responsibility to communities.

AN AID TO MAKING THE CASE FOR THE PROGRAM

Stratford Meals on Wheels and Neighbourly Services led the implementation of CHAP in Stratford. This community was strongly interested in and supportive of CHAP. The program lessons and evaluation findings of CHAP helped the city make the case for funding to support the expansion of CHAP across Perth County. With the support of dollars from the Health System Improvement Plan, more partners are now involved and there are 25 CHAP sessions per month in Perth County.

AN AID TO NEW PROGRAM DEVELOPMENT

CHAP principles are being applied to a glucose-screening program in Pembroke. Participant data from the CHAP program have revealed that high-risk seniors are not the only population that needs attention. New programs are being spearheaded to address cardiovascular risks in younger populations. The fact that doctors are following through and prescribing confirmed, for the Pembroke program, the importance of evaluation and of the communication loop back to the physician. Pembroke Regional Hospital is now adding this feature to some other programs that were facing challenges.

AN AID TO IMPROVING CENTRALIZED SUPPORTS

The research evaluation team used the evaluation to learn how to provide better central support to communities delivering the program.

AN AID TO VOLUNTEER ENGAGEMENT

Evaluation data supported ongoing communication with program volunteers and were used to share the success of the program with the volunteers and give them feedback on how valuable they were to program success. Seeing the positive outcomes was an inspiration to volunteers.

LESSONS LEARNED

1. Having a central group to coordinate the efforts across communities was helpful in sharing learning, providing updates, and developing standard resources

2. The sharing of learning was facilitated by emphasizing transparency, promoting collaboration across communities, and creating a culture that placed a high value on evaluation activities

3. Preparing a guide that is clear on essential program components but that allows local level flexibility enables local leaders to shape their program within the context

of their community. These adaptations feed into broader learning that can inform the participating communities as a whole

4. The data-management system was successful because it allowed local communities to input and correct their own data. This is not sustainable in some communities because of limited funding, so a cheaper yet still effective data management system would be optimal

MINDING OUR BODIES

THIS IS A CASE ABOUT

Engaging external evaluators as partners with internal evaluators for improved program learning

Using evaluation to help expand, promote, and sustain programs

Incorporating multiple levels of evaluation by making optimal use of internal evaluations

MINDING OUR BODIES (MOB) is an Ontario-wide program to improve awareness of the relationship between healthy lifestyles and mental health. MOB is a multi-year pilot project led by the Canadian Mental Health Association of Ontario in partnership with mental health service providers and other organizations with a shared interest in chronic disease prevention and management. MOB's aim is to highlight the connection between healthy lifestyle activities (healthy eating and physical activity) and mental health and to build organizational capacity to incorporate this thinking into mental health support and recovery programming.

MOB helped service providers work with community partners to build on this connection in delivering healthy lifestyle programs. The key challenge of the MOB program was to encourage self-evaluation on the part of partner programs regarding how well healthy lifestyle components figure into programming and contribute to the support and recovery of mental health service users.

ABOUT THE EVALUATION

The objective of evaluation for MOB was not only to help the organization shape and understand the rollout of the overall program, but also to evaluate the success of initiatives undertaken by the pilot sites. MOB wanted the evaluation to (a) clarify how project partners wanted to be engaged and supported throughout the program and (b) support the refinement of program elements, partnership building, and engagement in self-evaluation. Objectives included:

- Establish a partnership with an external research team to work closely with MOB project leaders in the development and implementation of an evaluation approach as well as building MOB's internal capacity for evaluation
- Make use of, and provide support for, internal evaluations being conducted by pilot sites (service providers), in addition to having evaluators conduct external case study evaluations of each site
- Engage the help and advice of evaluators at the level of the planning committee, as well as at the pilot site level (through assistance with local evaluation development and design)
- Employ a participatory approach in which pilot sites and the MOB project team have the capacity to react to and act on evaluation outcomes
- Approach evaluation as a self-study and a self-reflective exercise and as a tool for constantly re-evaluating whether goals are being met and evaluation information is being used in the program development process

EVALUATION DESIGN

Minding Our Bodies was delivered in two overlapping phases. The first phase, focusing on the connection between physical activity and mental health, was initiated in 2008. The second phase, promoting healthy eating and food security for people with mental illness, was initiated in 2009.

- Six pilot sites took part in each phase
- MOB received two project grants from the Ontario Ministry of Health Promotion and Sport, which included funding to conduct a formal evaluation
- An evaluation consultant was hired in 2008 to evaluate phase one
- In 2010, researchers from the York Institute for Health Research (YIHR) began working closely with the MOB project team to develop a new evaluation approach based on MOB's program goals

Each site conducted internal evaluations. These were based on direct outcomes observed by program leaders at the pilot sites and on data collected by the pilot sites

using their own materials. The evaluations were followed up by external evaluations by YIHR. The final evaluation incorporates the internal pilot site evaluations and the external evaluation data into a case study for each site, and an evaluation of the MOB program as a whole.

The evaluation process was designed as an evolving self-reflection process for both MOB and the service providers. As the director responsible for the program at the Canadian Mental Health Association noted, "The evaluation was a rolling process. Evaluators were engaged with us from the beginning rather than acting as outside observers. They helped us focus on the right things as the program evolved."

HOW THEY DID IT: IMPLEMENTATION

In addition to the evaluation of the overall MOB program, researchers from the York Institute for Health Research used a number of ways to gather information from pilot sites, including:

- Site visits
- Documentation materials
- Interviews and surveys conducted with staff
- Focus groups with staff and participants

Participating organizations took part in a training day. They were given a program toolkit and access to an evaluation toolkit. They proceeded to (1) plan and implement strategies and partnerships for incorporating healthy living strategies into their programs and (2) evaluate participant experiences. Pilot sites were given latitude in terms of how they planned their programs and conducted their own evaluations. In general, these internal process- and outcome-based evaluations involved gathering participant data in terms of:

- "Did we reach who we intended to reach?"
- "How many of them did we reach?"
- "Did the program work for them?"

Both external and internal evaluation results were compiled by the research team into a case study about each pilot site. The sites were then provided with the results of their case study reports and given the opportunity to contribute their feedback.

Evaluators were accessible to pilot program leaders throughout the process, and several of the sites engaged the evaluation team to help them come up with their own evaluation tools and for advice along the way. For example, in the case of one site, Mood Disorders Association of Ontario, the researchers and program leaders co-developed the evaluation survey, which in this case included pre- and post-test surveys, based on participants' goals. Interviews with leaders of the overall MOB program were conducted at the beginning, midpoint, and endpoint of the program. This became a reflective process. Evaluators had given feedback to leaders after the midpoint interview. As a result, when evaluators asked them, in the final interview, about their incorporation of information from the feedback, these leaders rethought how they were incorporating information into their plan.

"THE PARTICIPANT FOCUS GROUPS [CONDUCTED AS PART OF THE EXTERNAL EVALUATION] WERE VERY VALUABLE. THEY ALLOWED US TO HEAR STORIES AND GET QUOTES FROM PARTICIPANTS ABOUT WHAT BEHAVIOUR HAD ACTUALLY TAKEN PLACE . . . ABOUT THE FOOD CHOICES THEY WERE MAKING, AND HOW THE PROGRAM AFFECTED THEIR DECISION MAKING EVERY DAY. WE WOULD NOT HAVE BEEN ABLE TO GATHER THIS DEPTH OF INFORMATION WITH OUR QUESTIONNAIRES ALONE."

KIM UMBACH, MOOD DISORDERS ASSOCIATION OF ONTARIO

The Mood, Food and Movement program of the Mood Disorders Association of Ontario (MDAO) was one of six pilot programs in phase two. Delivered through a series of facilitated group sessions, the program was designed to engage participants, depending on their personal priorities, in understanding the benefits to mood of such factors as:

- Weight loss
- Better control of metabolic complications
- Improved cardiovascular function
- Better sleep patterns
- Improved mood
- Improved muscle tone and flexibility
- Increased confidence and skill related to food preparation
- Social interaction and support

The MDAO case illustrates how the overall MOB evaluation process is highly beneficial and complementary to the internal evaluation processes of individual pilots. MDAO found the evaluation process helpful because it:

- Reduced the burden of evaluation without compromising benefits. The fact that external evaluators were also gathering and compiling material on their project allowed MDAO to focus on delivery
- Provided a non-biased view of the program. Having an outside evaluator added a non-biased perspective, giving greater value to the feedback that managers received from their in-house facilitators
- Provided it with some externally generated evidence of program success, of benefit to the organization in its search for program funding
- Aided self-learning and program development. MDAO's perspective was broadened by the case study's comparison of pilot sites. And the organization's programming decisions were influenced by the case study's concrete information about factors influencing program success. These decisions include extending the length of the program and continuing to include peer supporters as program facilitators
- Helped it shape future evaluation and funding approaches

THE BENEFITS OF EVALUATION

MOB has already begun to realize several benefits as a result of its evaluation process.

AN AID IN REFINING ITS ASSUMPTIONS

The evaluation caused MOB to reflect on its assumptions and program goals concerning the lifestyle activities that contribute to mental health. For example, while MOB always understood social inclusion to be an important factor in promoting mental health, the evaluation indicated that in some cases social inclusion may be even more important than physical activity and healthy eating. MOB's evaluation supported the insight that social inclusion may to some extent even be the means by which physical activity and healthy eating programs contribute to mental health. Programs requiring a commitment of time in a group setting (e.g., an eight-week session) seemed to be more successful than those using a drop-in model. In the focus group sessions, participants noted the important impact on mental health of connection to other people.

AN AID TO FUNDING THE NEXT PHASE OF THE PROGRAM

The evaluation has become a key document in MOB's demonstration, for funders, of the program's effectiveness. It is thus a key element in the application by MOB, along with its partners, to the Ontario Ministry of Health Promotion and Sport for funding support for a third phase of the project, which would expand the program's reach and add a train-the-trainer component.

AN AID TO STRENGTHENING RELATIONSHIPS

The evaluation has helped MOB shape how it would approach the third phase of the project. For example, recommendations have emerged from the evaluation for MOB to establish long-term relationships with the pilot sites and provide increased support for organizations with less evaluation experience. MOB is therefore including in its planned third phase a specific evaluation working group to look at ways to establish these ongoing support relationships.

LESSONS LEARNED

1. External and internal evaluations can be complementary. Organizations can benefit from simultaneous internal and external evaluation, especially where support is provided by the external parties. In the case of MDAO and others, the whole is greater than the sum of the parts when it comes to internal and external evaluation where their own data provide feedback that is then enriched by the evaluators' case studies

2. Projects benefit when evaluators work alongside them cooperatively, giving guidance throughout the process. Involving pilots directly in the gathering of evaluation data for their site ensured that they were engaged in the process; pilots viewed it as a beneficial exercise as opposed to a top-down assessment of their work/approach

3. While allowing multiple sites to develop their own internal evaluation models has benefits, it also imposes some limitations on the overall study. For example, not all participants gathered pre- and post-test data. There is a risk that goals could be reframed to reflect outcomes

4. The invitation to use evaluation from the beginning as a tool for pilots to learn about their approach helped pilots see evaluation not as intimidating but as an open and supportive process

SPARK TOGETHER FOR HEALTHY KIDS

THIS IS A CASE ABOUT

An organization's use of evaluation to help it develop a new kind of initiative that takes a population approach

A process of evidence-informed critical thinking and continuous improvement

An organization that feeds interim results into its program decisions, strategy, and plans for evaluation

A productive collaboration between a health charity with internal evaluation capacity and a university-based research centre

SPARK TOGETHER FOR HEALTHY KIDS™ (SPARK) is a major initiative of the Heart and Stroke Foundation of Ontario (HSFO). This multi-year childhood obesity prevention initiative aims to improve children's access to healthy foods and physical activity. Spark is a bold, innovative project that departs from HSFO's traditional focus on cardiovascular and cerebrovascular health research, although health research remains core to the organization overall. Spark emphasizes advocacy, catalyzing a "social movement," and substantial outreach and engagement through public awareness campaigns and a community grants program.

ABOUT THE EVALUATION

Given that Spark is a significant investment,[1] has a high profile within HSFO, and carries some risks as a new approach, HSFO's board and staff needed confidence to support what sometimes felt like "leaps of faith" and needed to manage expectations about outcomes. They looked to evaluation to help them gain this confidence and to support their learning about this new way of thinking and working.

To do this several evaluation strategies were used:

- Incorporate evaluation from the beginning of the initiative and find an approach to evaluation that matched the complex nature of the initiative
- Use developmental evaluation primarily to (a) inform ongoing development and refinement of the strategy for Spark and (b) examine early markers of progress that are plausibly linked to longer-term changes in healthy eating and physical activity environments, the healthy eating and physical activity patterns of children, and childhood obesity
- Engage the Propel Centre for Population Health Impact to partner with HSFO to design and lead the evaluation process
- Align the evaluation with four decision filters used by the HSFO board: mission impact, stakeholder response, the leadership role of HSFO, and proven capacity for implementation

EVALUATION DESIGN

Spark uses developmental evaluation to support continuous learning that informs ongoing adaptation in the initiative. Developmental evaluation is an evaluation approach geared to social innovation; it helps innovators use evaluative thinking to respond to emergent and dynamic realities in complex environments and initiatives.

Propel's role in the initiative differs from that of a typical client-consultant relationship. Propel's mandate is to accelerate the generation and use of relevant evidence to improve population-level initiatives. In addition, Propel has a Youth Health program that focuses on creating health-promoting environments. As a result, Spark helps both Propel and HSFO achieve their individual mandates and goals. Under these circumstances, Propel is as much a partner in Spark as a provider of evaluation expertise. Propel and Spark share an interest in using evaluation tools to make Spark as effective as possible.

Innovative initiatives are often characterized by several uncertainties, based primarily on the fact that while there may be high aspirations for a big idea, specific thinking about an initiative's strategies and goals is still evolving. Spark's evaluation activity therefore focused during its initial two years on clarifying intentions, assumptions, and outcomes and ultimately on helping everyone involved understand, more deeply, what they were trying to do. Evaluation also focused on assisting decision making regarding continuation of and modifications to Spark. The link to decision making was made explicit with the evaluation questions. The questions, which were consistent with the HSFO decision filters noted above, included:

1. What are Spark's contributions to the HSFO mission, specifically with regard to proximal markers or progress toward creating healthy food and physical activity environments for children in Ontario?

2. How does Spark benefit stakeholders (notably, the public, government, Heart and Stroke staff, volunteers, partners, sponsors)?

3. To what extent is the Heart and Stroke Foundation's leadership role acknowledged and accepted among stakeholders (both internal and external to HSFO)?

4. Does HSFO demonstrate sufficient capacity to sustain and grow Spark?

5. What are barriers to the sustainability and growth of Spark and how can they be addressed?

HOW THEY DID IT: IMPLEMENTATION

The developmental evaluation process began with a very deliberate engagement between Propel and HSFO. Propel conducted a series of interviews with HSFO senior management and facilitated highly interactive workshops with Spark staff. The purpose of these initial meetings was to clarify tasks and roles, appreciate Spark's organizational context, and understand as deeply as possible what HSFO was trying to accomplish. This last objective went beyond a mere understanding of the mechanics of the intervention, leading to the exploration of such questions as:

- How is Spark different from HSFO's traditional practice?
- Where is it as an organization in its thinking about and use of evaluation?
- What kinds of decisions need to be made about Spark? By whom? When?
- What are people's expectations regarding evaluation?
- What form and language are they are used to, given the organization's history with evaluation?

An interim evaluation report was prepared in May 2010. This coincided with a major review point in Spark in which the HSFO board was scheduled to make decisions about the program's ongoing development. Evaluation activity has not focused solely on the preparation of this report. Regular meetings between the Spark program team and the evaluators explored and jointly interpreted findings. This regular interaction provided a space in which to: probe how the initiative was unfolding; surface and explore assumptions about their thinking; and review progress markers.

The Propel team brought a range of information into these meetings:

- A distillation of the best of the literature on concepts relevant to Spark to understand: What does social change mean? How do you define sustainability? What does a leadership role look like when working with partnerships? How can advocacy outcomes be measured?
- Results from interviews and focus groups with Spark field staff (health promoters and fundraisers), Spark grant recipients, Spark partners, and HSFO senior management to gather feedback on such questions as: How was Spark beneficial for us? Did it support or enhance fundraising activities? What supports have we received and what other supports would be helpful?
- Public and partner perceptions of childhood obesity and of HSFO as a leader in addressing this issue

"THE CLOSE RELATIONSHIP BETWEEN THE EVALUATION AND PROGRAM TEAMS MEANT WE WERE ABLE TO USE ACTIVITIES FOR MULTIPLE PURPOSES. WE WERE ABLE TO GET PROGRAM NEEDS AND EVALUATION NEEDS FROM THE SAME ACTIVITY."

– MARY LEWIS, HEART AND STROKE FOUNDATION OF ONTARIO

1. ALTHOUGH SPARK IS A MAJOR INVESTMENT, WITH CORRESPONDING LEVELS OF EVALUATION RESOURCES, THE LESSONS FROM HSFO'S APPROACH TO EVALUATION FIT PROJECTS AND EVALUATION RESOURCES OF DIFFERENT SIZES.

From its inception, a feature of Spark is a grants program that makes investments of $5,000 and $25,000 to community organizations to advocate for increased access and opportunities for physical activity and healthy eating for children [s1] . Early feedback from the developmental evaluation prompted changes to promotion and communication of the grants, funding criteria, application process, reporting expectations, and supporting resources. Based on the learnings about the degree to which the grants were making a contribution, the grants program is now very central to the overall initiative. HSFO has a much better understanding of what to expect from the different granting levels within a year's timeframe and has adjusted its expectations and communications accordingly to provide greater clarity and support to applicants and grantees. HSFO has introduced capacity-building and communications activities to support and inform interested stakeholders in the area of advocacy, which has improved both the quantity and quality of grant applications and grant projects. Additional resources are now dedicated to support applicants and grantees and include peer exchanges and shared learning at the local and provincial levels through application reviews, webinars, video stories, workshops, PR, and social media.

THE BENEFITS OF EVALUATION

HSFO has already begun to realize several benefits from developmental evaluation.

AN AID TO CREDIBILITY

Spark's evaluation processes and Propel's involvement in those processes are serving to increase HSFO's:

- Confidence in moving forward with Spark
- Bridging of a strong history in evidence-based scientific research and a strong desire to be leading edge in the complex realm of catalyzing social change
- Development, now in progress, of an organization-wide evaluation plan

AN AID TO COMMUNICATING ABOUT THE INITIATIVE

Developmental evaluation is helping HSFO staff and volunteers build a common understanding of Spark as well as realistic and meaningful expectations regarding outcomes. The evaluation has helped clarify expectations of what can be accomplished and in what time frame.

AN AID TO CLARIFYING THINKING

Developmental evaluation has helped the program team develop their ideas, frame their thinking, and make the theory underlying the program more explicit. Ongoing interactions between the program and evaluation teams have generated a shared language, building a bridge between different views within HSFO concerning what they were trying to do with Spark. Input from discussions with staff and volunteers has helped shape the initiative.

AN AID TO PROGRAM ADAPTATION

Evaluation has supported the program team in its efforts to tailor activities that best meet the initiative's intent and what is emerging from the stakeholders involved.

LESSONS LEARNED

1. Understand organizational needs and culture so you can frame evaluation purpose, questions, and findings in a way that is most useful in supporting organizational effectiveness

2. Avoid evaluation jargon. Spark uses concepts such as complexity, social innovation, and developmental evaluation. These help advance thinking about the initiative; the evaluation team found, however, that communications were more effective when more accessible language was used

3. Select your evaluator carefully. Propel brought content expertise in complex population approaches, experience in working on complex issues (including obesity), a relevant mandate and focus on Youth Health, and a familiarity with working in highly emergent initiatives. The result was a good match with what HSFO was seeking, resulting in a productive and trusting relationship that encouraged openness and critical thinking

4. Be ready to invest time and effort in the evaluation. HSFO personnel rolled up their sleeves and participated fully in every step of the evaluation. As a result, the evaluation process could be tailored to the HSFO context and adapted based on changes to the program

5. Be clear — with yourself and with others — about your mandate. HSFO and Propel's clarity about clear about their roles and their boundaries moved the collaboration forward

6. Don't focus goals too early. There was much internal pressure at the beginning to define Spark. The team working on the program resisted this, which they now see as a benefit because it created space for them to take ideas much further than how they were initially conceived

"WHEN WE FIRST MET WITH THE [HSFO] MISSION COMMITTEE, THEY WERE USED TO WORKING WITH HEALTH OUTCOME QUESTIONS SUCH AS: HOW MANY LIVES DID THIS INTERVENTION SAVE? BY HOW MANY PERCENTAGE POINTS DID THIS INTERVENTION REDUCE BLOOD PRESSURE MEASUREMENTS? THEY TRANSFERRED THIS THINKING TO SPARK AND ASKED, WHAT IS THE SINGLE INDICATOR OF SUCCESS THAT WILL TELL US HOW SPARK IS DOING? THIS WAS AN IMPORTANT OPPORTUNITY TO REINFORCE THE DIFFERENCE BETWEEN LINEAR CAUSE-AND-EFFECT RELATIONSHIPS AND A PROCESS OF CHANGE INVOLVING A COMPLEX, INTERDEPENDENT SET OF VARIABLES AND PLAYERS. THIS DISCUSSION HOPEFULLY CONTRIBUTED TO A SHIFT IN MINDSET TOWARD VALUING A COMPLEX INTERVENTION IN A COMPLEX ENVIRONMENT AND IMPLICATIONS FOR EVALUATION."

— DR. BARB RILEY, PROPEL CENTRE FOR POPULATION HEALTH IMPACT

THE WOOD BUFFALO PRIMARY CARE NETWORK

THIS IS A CASE ABOUT

Linking health promotion and disease prevention in a primary care setting

Embedding evaluation activities into the natural course of program operations

Building a simple and practical system that enables multiple users of common information

Involving patients in program development by regularly soliciting their feedback

THE WOOD BUFFALO PRIMARY CARE NETWORK (WBPCN) in Fort McMurray, Alberta, represents a formal agreement between local family physicians working with a team of interdisciplinary (IDT) professionals to provide comprehensive primary healthcare programs and services to the community. Physicians refer patients to various programs at the WBPCN centralized clinic where the IDT, consisting of nurses, dietitians, exercise specialists, mental health therapists, pharmacists, and other clinicians, design and deliver programs in eight different areas of chronic disease management and annual screenings. These programs include adult weight management, diabetes, family practice nursing, geriatric care, palliative care, heart health, women's health, and secondary stroke prevention.

ABOUT THE EVALUATION

With ongoing growth and development of WBPCN programs, an evaluation system was required to deliver enhanced methods of data collection and reporting to facilitate better decisions regarding patient care and program design and delivery.

Recently, the WBPCN administrative team, with full support of the governance committee, has come together to lead and support its physicians, clinicians, and administrators in meeting this need.

- In 2009, WBPCN evaluation measurement began meeting the reporting requirements of local and provincial governing bodies. Basic program data were gathered twice annually and reported to WBPCN senior managers, meeting WBPCN's accountability requirements. However, a need was identified for an iterative tool that would improve day-to-day primary care programming and decision-making
- When the program and evaluation manager took up his work at WBPCN in July 2010, he brought lessons from his military experience in a Canadian Forces Health Services Centre. Within that healthcare organization, systems had been developed and proven highly effective in generating informed decisions and strategic direction regarding health-care delivery improvements
- The team needed a system that provided clinician leads and program coordinators with up-to-date and accurate information to consistently improve their programs. The primary purpose of this system was to provide relevant and current information to assist in organizational decision making. The secondary purpose became meeting mandated reporting requirements
- To make this system usable, a change in the organization's philosophy had to be established. Stakeholders needed to understand the real value of program-specific evaluation and take ownership of the information

EVALUATION DESIGN

The WBPCN administrative team and clinicians began meeting to develop the evaluation process. The journey to an upgraded evaluation system started with taking the baseline measures being used for reporting purposes and establishing a more "real-time" method of generating updates for these measures. To be usable in this regard, the information needed to be time sensitive; the team therefore set out to establish a system whereby the information being measured could be regularly updated with minimal effort.

With the clinicians' support, this group implemented time-sensitive tracking mechanisms and expanded upon the measurement of three different kinds of data:

- Biophysical: individual patient health measurement information, such as blood pressure or body mass index, to be tracked over time
- Program use: information about patients' participation patterns
- Patient perspectives: whether patients would refer a friend; whether classes included sufficient time for questions; what patients thought about the facility, the program's approach, and session length

HOW THEY DID IT: IMPLEMENTATION

Some clinicians initially saw this new approach as taking time away from patient care. "It's not in our job description to enter data" was a commonly heard response. The evaluation team secured the clinicians' buy-in by framing the information as patient care improvement, rather than as an administrative reporting task. The team sealed the deal by showing the clinicians, and allowing them to take ownership of, the positive benefits to their program and their patients.

Also aiding the implementation process was the evaluation team's decision to develop the new evaluation process slowly. The program & evaluation manager says it was vital "to keep it simple and to keep everyone involved, while not taking clinicians away from their patients."

The role of the coordinators was key; they helped oversee the inputting of data, which saved time and enhanced its integrity. They worked closely with the clinicians to reveal the valuable tradeoff involved with entering much of the data themselves. While it took them away from their programs and patients for short periods of time, it also engaged them in analyzing and understanding important patient performance-related information. Entering data also gave them reason to review other statistics and aggregate charts, which kept them current in the evaluation process.

The coordinators helped make the training "stick" by showing the practical relevance of the data to be captured and giving examples of how the data could be applied. All of the team members were involved at some point throughout the entire process. The assumption was that the more team members know and see, the more they will want to improve.

Early challenges in data-entry training and ensuring accuracy did not stall implementation of the new process.

All clinicians entered data within the electronic medical records (EMR) system through the charting process. Based on this data input, the organization's information technology (IT) person was able to extract and filter the raw data into usable form for the evaluation system. Once the information was available, the program coordinators interpreted it and used it to generate appropriate program measures.

Throughout the implementation process, the program & evaluation manager provided support and coaching to the program coordinators to ensure maintenance of the authenticity of the evaluation purpose. He and the program coordinators worked closely and held themselves accountable for progress through weekly meetings in which they discussed problems and issues, set new goals, and celebrated accomplishments. Constructive conversations and updates during these meetings often led to innovations; for example, formatting the tracking templates to easily facilitate time-frame comparisons. The program & evaluation manager also made sure the information was used in team meetings, to praise and to recognize clinicians who were making use of the data. When forwarding information to others in the facility, such as senior administrators or physicians, he copied the clinician who had generated the data as a way of recognizing the efforts and demonstrating the usefulness of their work.

"WE NEEDED TO BE ABLE TO SHOW, WITH MEASURABLE INDICATORS, HOW THE PROGRAMS WERE WORKING WITH REAL-TIME ACCURACY."

– CHRIS MITCHELL, PROGRAM & EVALUATION MANAGER, WBPCN

The WBPCN's Adult Weight Management (AWM) program includes a year-long physician-monitored clinical program known as the Optifast 900 program. Participants begin with one three-hour session per week for 17 weeks and then take part in bi-weekly and monthly group sessions.

The Optifast 900 program is a good example of how all three levels of data (biophysical, program use, and participant perspectives) are used and how clinicians are involved. The AWM clinician program site lead and program coordinator track and enter health measurement data to provide an accurate reflection of the health status changes as patients progress through the program.

Data from the weight-loss and lifestyle modification program are used in a number of ways. For example, the program site and/or physician lead shows newly registered participants the results of those who previously faced the same challenge. As well, items like participation patterns are reviewed to determine if the program is being offered enough or too often, and if it is being offered at the right times.

Accurate data collection and analysis are not only helping the clinician program site and physician leads get a clear picture of their patients, they are also helping the patients themselves set realistic goals and expectations.

The program site lead closely monitors the satisfaction data to make changes to program design. Noted the AWM Program Site Lead Lydia Powers,"If I ever see the numbers under ninety percent, I pull out the surveys and see what is going on."

THE BENEFITS OF EVALUATION

Wood Buffalo Primary Care Network has already begun to realize several benefits from the new evaluation system.

AN AID TO MORE TARGETED PATIENT CARE AND PREVENTION

Now that data are regularly updated (e.g. weekly and reviewed biweekly) and are clearly displayed on a common drive to which all WBPCN staff have access, the entire WBPCN staff have a nearly real-time view of how patients and programs are faring and are able to react accordingly. If there is a sudden or unexpected change in the health status of a patient or group of patients, the clinician can investigate, against a broader range of information, whether the change is lifestyle related or evidence of something more serious.

The availability of evaluation data enables clinicians to proactively involve the patient's physician. For example, the geriatric and palliative program site lead (RN) noted weakness in the recorded grip strength test of a patient and determined, by looking at the patient's data chart, that this was a marked change. The RN then alerted the physician to investigate whether the patient had experienced a stroke, based on a number of warning signs.

AN AID TO HEALTHCARE COLLABORATION

Clinicians also draw on the evaluation information to get the other appropriate clinicians or physicians involved in a program. For example, participants in the Diabetes program are now referred to the exercise specialist because of the weight management problems common to that group.

Referrals from physicians to the various clinical programs have increased over the past year. The more frequent sharing of information keeps physicians up to date on the service availability contained within the programs. Program attendance rates have gone up as the data have illustrated positive changes in patients.

In addition, when coordinators share data patterns with clinicians, the latter are able to provide a ground-level perspective on the data they need and how to make that data more accurate and useful.

AN AID TO PROGRAM CUSTOMIZATION

Clinician program site leads and their respective IDT members review biophysical data to find health concerns or pathologies that are common to users across various programs. This guides them in shaping program content and possibly merging program elements for ideal efficiency.

Changes have been made to several programs as a result of the new evaluation approach. For example, WBPCN used to offer two classes on heart health. One focused on prevention and the other on helping those who had already experienced a heart event. Assessment of the evaluation data from the classes helped the program coordinator and site lead see how the patients in both classes could benefit from one another. It was one thing for a clinician, and quite another for an overweight heart attack survivor, to tell people how important it is to follow the dietary advice provided by the interdisciplinary team as part of a much-needed lifestyle modification. The two classes were merged, and the combined class turned out to be better attended.

Another example is smoking cessation. Not all clinicians were asking patients consistent questions about their smoking habits, causing the data to be incomplete. Once the question was asked consistently, it was noted that a significant number of juvenile diabetic patients were smoking and WBPCN began investigating possible approaches to meet the needs of this demographic.

AN AID TO MORALE

WBPCN's new approach to evaluation is contributing to high staff morale. It is confirming that they are in charge of something significant. Almost immediately, clinic staff began to appreciate having almost immediate access to relevant data and began to see the positive effect on patient care.

AN AID TO DECISION MAKING

WBPCN's approach to evaluation enables evidence-based decision making – whether the decisions have to do with programming, administrative and resource planning, or reporting to larger governing bodies and potential funders. The approach has an impact as well on the value physicians place on WBPCN as part of the healthcare system. The shared evaluation reports and updates enable them to connect their patients' results to the work being done

"THE NEW APPROACH REQUIRES SOME EFFORT, BUT THE INVESTMENT IS DEFINITELY WORTH IT. ALWAYS ENSURING PATIENT CONFIDENTIALITY IS MAINTAINED, WE CAN TELL YOU ANYTHING THAT IS HAPPENING WITH A PATIENT OR PROGRAM AT ANY GIVEN TIME."

– DESPINA SPORIDIS & TARRYN HOLDER, PROGRAM COORDINATORS, WBPCN)

at the centralized clinic. As a result, the physicians are more aware of the value associated with the added care patients receive through WBPCN services.

LESSONS LEARNED

1. Data should be recorded and tracked in a way that enables it to be effectively utilized — as Chris Mitchell, the Program & Evaluation Manager noted, "getting the right data to the right place at the right time so that they can be used the right way"

2. However worthwhile a database may be at enhancing decisions at every level of healthcare, inputting data remains labour intensive. A long-term objective is to become more efficient to the point that evaluation tracking can be done completely within the electronic medical record system

3 Building buy-in early, especially with clinicians, was the key to WBPCN's success

4. Make things automatic where possible — but do so in a way that saves effort over time

5. Keep it simple, useable, and relevant...don't spend time evaluating or tracking something that has no real purpose

SIP SMART!

THIS IS A CASE ABOUT

Using multiple levels of external and internal evaluation effectively

Employing evaluation to contribute to program credibility, use, and growth

Applying program and evaluation resources across jurisdictions.

SIP SMART! is an educational program to help elementary school students in grades 4, 5, and 6 make healthy drink choices. The program is a response to high rates of childhood obesity in Canada and the large role in this trend of sugar sweetened beverage (SSB) consumption. The end goal of the program is to reduce consumption of SSBs by affecting the decision-making processes of students through classroom learning modules.

Sip Smart! BC was led by two health organizations, the BC Pediatric Society and the Heart and Stroke Foundation of BC and Yukon, with provincial program funding from the BC Healthy Living Alliance (BCHLA). Evaluation was also supported by BCHLA.

In 2010, the Heart and Stroke Foundation of Québec (HSFQ) secured funding to contextualize Sip Smart! BC to Québec and began adapting the program, and renamed it simply "Sip Smart!" (Sois futé, bois santé! in French).

Priorities for the program were to:

- Make the program easy to understand and effective for students, teachers, and parents by making it fun and easy for all three parties to use
- Make it easy for teachers to refer to the resources provided

ABOUT THE EVALUATION

The objectives of the evaluation process in BC and Québec included:

- Using evaluation to improve effectiveness and ensure that program design and delivery were aligned with the program's goals
- Communicating the evidence of effectiveness so the program could grow beyond a pilot, continue to receive support, and be implemented in provincial schools
- Building sustainability into the program, given that the initial program in BC was a two-year multi-phase pilot only

EVALUATION DESIGN

Sip Smart! BC placed a high priority on evaluating the program from the beginning, before funding for a formal external evaluation had been established. Sip Smart! BC sought feedback from parents, teachers, facilitators, and students. This feedback established knowledge of usability — how well the program was received, how easy it was to deliver, etc. — and influenced changes to a great deal of the program's materials, content, and activities.

The key features of the evaluation design were to:

- Establish feedback and evaluation mechanisms early in the pilot process to ensure usability. Compare feedback against project goals
- Make changes to program activities based on feedback as the program is rolled out
- Establish funding for a formal, in-depth external evaluation process to demonstrate effectiveness to funders and organizations with the capacity to support implementation on a larger scale. (A summative evaluation of the program implementation and effects was conducted by the Social Research and Demonstration Corporation (SRDC)
- Provide teachers not only with facilitated sessions but also with materials for delivering program content themselves
- Reach out to potential champions and partners for feedback and foster the expansion of the program in

other regions, sharing evaluation tools for comparability and the adaptation and alignment of goals

For the pilot rollout, evaluation feedback was received through specific mechanisms:

- Feedback from facilitators on each program activity was collected
- Comments from teachers were gathered from all sessions (through questionnaires)
- Students were asked to write down what they thought about the program
- Students' drink-diaries were used to determine the feasibility of the evaluation instruments
- Project coordinators observed facilitators in session to ensure that the message and its delivery were aligned across all sessions

HOW THEY DID IT: THE BC IMPLEMENTATION

Program evaluation and feedback mechanisms prompted a number of changes to the program as the pilot launched. Changes were made as information was received. As the project manager noted, this allowed content to be revised and improved for each subsequent group.

For example, one of the findings from teachers as a result of the first pilot was that the program content was not suitable for all three age groups (grades 4, 5, 6).
→ As a result, the program was split into level one (grades 4 and 5) and level two (grade 6). The new, split material was worked into the second pilot

One of the findings from teachers and facilitators as a result of the second pilot was that the "drink diary" component of the program was too complicated for grade four students to follow.
→ As a result, the diary was simplified and was revised again a second time, with tools being added to lead students in how to fill out the diary

By the third (teacher) pilot rollout, few changes were made to content, since many of the issues had already been addressed and retested. Facilitator feedback did indicate that the program was running long and that fitting all of the content into three sessions was a challenge.
→ As a result, the program was split into five lessons, retaining all of the content but reducing the length of each lesson

Other feedback from the evaluation of the pilot led to changes to the program. For example:

- The school coordinator was able to see, based on observation of facilitated sessions, that some facilitators needed additional coaching
- Feedback from the teacher pilot, in which ten teachers used the materials for the delivery of the modules without a facilitator, indicated that the content layout could have been lighter and easier to follow; the pages were reorganized

HOW THEY DID IT: BC'S SUMMATIVE IMPLEMENTATION

After its initial pilot, Sip Smart! BC received funding for a summative evaluation, which was to answer a number of implementation questions and most importantly ask:

- Did the program impact the consumption of sugar sweetened beverages among students?
- Did it help students choose healthier options?
- Did it affect the students' awareness of healthy drinks?

The summative evaluation looked at how the program impacted the behaviour of students and how those outcomes could be measured. SRDC evaluators had been involved with Sip Smart! BC from its inception, learning what the program was trying to accomplish and what the program could learn from the evaluation process.

The evaluators worked closely with the project manager and the program's school coordinators, who were also involved in gathering data for the formal evaluation and in selecting sites. This integrated approach helped make the evaluation more responsive, and made evaluation possible on a limited budget.

The SRDC's evaluation also looked at the implementation of the study, by using the information gathered by Sip Smart! BC.

SRDC also collected, through pre- and post-tests, outcomes measures in terms of (1) students' awareness and knowledge of sugar sweetened beverages and (2) consumption of sugar sweetened beverages to determine program outcomes.

Twenty schools were involved in the evaluation, with two grade four classes in each school involved in the

program (a participating group and a comparison group).
Information was gathered through: project data; interviews; initial, midpoint, and follow-up questionnaires; and evaluator observations.

FINDINGS: DID IT WORK?

The evaluation demonstrated that the program was implemented successfully, and affected the students' preferences, and knowledge of sugar sweetened beverages. It also showed that the program affected the consumption of sugar sweetened beverages in the short-term but not in the longer term.

A key outcome of the program was the gathering of data that showed evidence of change in behaviours. As the project manager noted, the program evaluation enabled Sip Smart! BC to be seen as successful and evidence-based.

After the six-month follow-up of students, evaluators noted that that the students' knowledge was diminishing, and the decrease in the consumption of sugar sweetened beverages observed during the program did not persist. The recommendation was made that the program be lengthened, consistent with the decision that had already been made at the program level. A recommendation from the subsequent process evaluation was to increase the level of support and follow-up with teachers.

EVALUATION WAS KEY

Sip Smart! BC is currently delivered through Action Schools, which delivers provincially endorsed educational materials and programs to public schools in British Columbia. The province's Ministry of Health assisted Sip Smart! BC with the printing and distribution of program materials to Action Schools. *According to the project manager, the ministry would not have endorsed Sip Smart! BC as a program in the Action Schools! BC suite of offerings without evidence of success and endorsement as seen in the evaluation material.* Sip Smart! BC owes its continued existence in large part to the formal and informal evaluations undertaken throughout the development period.

HOW THEY DID IT: THE QUÉBEC IMPLEMENTATION

In March 2010, Heart and Stroke Foundation of Québec secured funding from the Canadian Partnership Against Cancer and the Public Health Agency of Canada to contextualize the Sip Smart! program from BC to Québec. The program appealed initially because of: the high consumption of sugary drinks in Québec; the program's clear organization and appealing activities, content, and illustrations; and the program's success in BC.

A Sip Smart! (Sois futé, bois santé!) pilot was run by Québec in the fall of 2010 to see if further adaptations made sense. The expanded implementation, to begin in the fall of 2011, will include an implementation evaluation similar to the BC evaluation.

The BC program and its evaluation figured very strongly in the development

IT IS FASCINATING TO GET THE OPPORTUNITY TO ADAPT THE PROGRAM FOR DIFFERENT PROVINCES. FOR EXAMPLE, FOR THE QUÉBEC PROVINCE, CHANGES ACCORDING TO BEVERAGES AVAILABLE IN QUÉBEC WERE ESSENTIAL TO ASSURE THE SUCCESS OF THE PROGRAM. USING AN EXISTING RESOURCE AND ADAPTING IT TO OUR REALITY IS REMARKABLE AND INCREASE THE OVERALL SUCCESS OF THE PROGRAM!

– EMMANUELLE DUMOULIN, HEART AND STROKE FOUNDATION OF QUEBEC

of the Québec program. Québec convened a committee of educators, school board representatives, nutritionists, and dental hygienists to look at the BC program and evaluation and recommend changes that would make sense for Québec.

WHAT CHANGED?

1. The Québec program adapted the name in French, modified the logo and illustrations, and simplified one of the program activities

2. Sip Smart! in Québec is applying several key lessons from the BC evaluation

- Notably, they focused on the BC evaluation's findings that teachers lacked time to effectively teach the program and as a result emphasized teacher supports and training sessions for teachers
- They also used questions from the BC evaluation regarding the ease of use and applicability of the material, as well as whether it was simply and clearly communicated to all parties and was user friendly for the children

THE BENEFITS OF EVALUATION

Approaching evaluation in both an iterative and a formal way and demonstrating program success have resulted in a number of benefits for the Sip Smart! BC and Sip Smart! Québec programs. *The ultimate benefit of evaluation*, notes the Project Manager, *is having a program that meets the needs of the learner and that will be used again and again.*

AN AID TO CREDIBILITY AND SUSTAINABILITY

The most important benefit of the evaluation approach Sip Smart! BC is its significant contribution to the credibility of the program, allowing it to be supported and endorsed by the provincial health ministries. The evaluation process also contributed to the program's appeal as a model to be replicated by other health promotion organizations and applied in other jurisdictions. The BC Project Manager noted that the use of Sip Smart! BC in Québec and also in the Northwest Territories adds to the credibility and profile of its own program, as well as to the evaluation evidence.

AN AID TO CLASSROOM SUCCESS

Both levels of evaluation contributed to the potential of the program to work for teachers and students at the classroom level, increasing the likelihood that the program will sustain itself over the long term and have wider impact.

AN AID TO COMMUNICATION OF PROGRAM RESULTS

The evaluation approach served to communicate program benefits to participants, and the evaluation results have since been used to communicate and promote program success. While formal evaluation added to credibility and focused on receiving impact-based results, gathering project data likely contributed to buy-in at the teacher, parent, student, and community level.

LESSONS LEARNED

1. Incorporate evaluation and feedback into the program as it evolves and be prepared to make changes to the model, based on project goals

2. Be receptive to feedback even if it is negative and adapt tools to the users' constraints

3. Be prepared to constantly re-evaluate the alignment of program approach with program goals. (For example, external evaluators advised against using the Body Mass Index as a measure of outcome because it was not realistic for the short time line of the program)

4. Be committed to evaluation as a means of iteratively developing the program

5. Be prepared to put the effort into properly conducting and securing funding for evaluation

6. Foster partnerships so the program can gain momentum beyond its immediate borders

CONTACT INFORMATION

Please contact the following organizations for more information on the cases.

VIBRANT COMMUNITIES SAINT JOHN

Vibrant Communities Saint John and its partners have been coordinating efforts to reduce poverty in Saint John since 2004. Its mandate is to weave together the numerous community and government efforts aimed at poverty reduction and community revitalization.

CONTACT: Wendy MacDermott, Coordinator
EMAIL: wendy.vibrantsj@nb.aibn.com

For more information about Vibrant Communities Saint John, visit facebook.com/VibrantSJ or http://tamarackcommunity.ca/g2s28.html

CARDIOVASCULAR HEALTH AWARENESS PROGRAM

The three main organizations involved in CHAP are the Department of Family Medicine, McMaster University, Élisabeth-Bruyère Research Institute, and the Department of Family Practice University of British Columbia. The program was delivered in collaboration with the Canadian Stroke Network, Ontario Ministry of Health and Long Term Care, the Institute for Clinical Evaluative Sciences, FigP software Inc, and Blood Pressure Canada (now part of Hypertension Canada).

CONTACT: Lisa Dolovic, Research Director & Associate Professor, Department of Family Medicine, McMaster University
EMAIL: ldolovic@mcmaster.ca

For more information about CHAP, visit http://www.chapprogram.ca/

MINDING OUR BODIES

Founded in 1952, the Canadian Mental Health Association, Ontario Division (CMHA Ontario) is a non-profit, charitable organization committed to improving the lives of people with mental illness and their families and to promoting mental health for all. Minding Our Bodies is a multi-year project (2008-2013) to increase capacity within the community mental health system in Ontario to promote physical activity and healthy eating for people with serious mental illness.

CONTACT: Scott Mitchell, Director, Knowledge Transfer
E-MAIL: smitchell@ontario.cmha.ca

For more information about Minding Our Bodies, visit www.mindingourbodies.ca.

SPARK TOGETHER FOR HEALTHY KIDS

The Heart and Stroke Foundation, a volunteer-based health charity, leads in eliminating heart disease and stroke and reducing their impact through the advancement of research and its application, the promotion of healthy living, and advocacy.

CONTACT: Sharon Brodovsky, Sr. Mgr, Spark Together for Healthy Kids
EMAIL: sbrodovsky@hsf.on.ca

For more information about Spark Together for Healthy Kids, visit www.heartandstroke.ca/spark

The Propel Centre for Population Health Impact is a partnership between the Canadian Cancer Society and the University of Waterloo. Propel is a collaborative enterprise that conducts solution-oriented research,

evaluation, and knowledge exchange to accelerate improvements in the health of populations.

CONTACT: Barbara Riley, Co-Director
EMAIL: briley@uwaterloo.ca

For more information about Propel, visit
http://propel.uwaterloo.ca

SIP SMART!

Sip Smart! BC is led by the BC Pediatric Society and the Heart and Stroke Foundation of BC & Yukon. The BC Pediatric Society is a professional association holding a vision that all B.C. infants, children, adolescents and their families will attain optimal physical, mental and social health. The Heart and Stroke Foundation of BC & Yukon, a volunteer-based organization, leads in eliminating heart disease and stroke and reducing their impact through the advancement of research and its application, the promotion of healthy living, and advocacy.

CONTACT: Pat Zellinsky, B.HEc., M.Ed., PMP, Project Manager, Sugar Sweetened Beverages Initiative
EMAIL: patssb@gmail.com

For information about Sip Smart! BC, visit
http://www.bcpeds.ca/sipsmart/

SIP SMART! QUEBEC (SOIS FUTÉ, BOIS SANTÉ!)

Sip Smart! Quebec is led by the Heart and Stroke Foundation of Quebec. Sip Smart! program is an interactive classroom-based program that aims to raise awareness among school children in grades 4, 5 and 6 of the negative health effects associated with the consumption of sugary drinks. The program will also provide students with the knowledge and skills they need to make healthy drink choices.

CONTACT: Emmanuelle Dumoulin, Chargée de projet Prévention/Promotion de la santé
EMAIL: emmanuelle.dumoulin@fmcoeur.qc.ca

For information about Sip Smart! Quebec, visit
http://www.heartandstroke.qc.ca

WOOD BUFFALO PRIMARY CARE NETWORK

The Wood Buffalo Primary Care Network in Fort McMurray, Alberta, represents a formal agreement between local family physicians working with a team of interdisciplinary professionals to provide comprehensive primary healthcare programs and services to the community.

CONTACT: Jill Sporidis, Executive Director
EMAIL: jill.sporidis@albertahealthservices.ca

CONTACT: Chris Mitchell, Program & Evaluation Manager
EMAIL: chris.mitchell@albertahealthservices.ca

For more information about WBPCN, visit
www.wbpcn.ca

GLOSSARY

ADOPTION AND UPTAKE

The acceptance by a profession or organization of knowledge disseminated. This includes organizational policies and practices, as well as the decision to adopt an innovation. Uptake refers to the utilization and implementation of knowledge in practice which includes several types of use: direct/instrumental, conceptual/ enlightening, symbolic/political and process.
Sources: adapted from: Organization for Economic Co-operation and Development: Knowledge Management in the Learning Society, 2000, p. 40; and Pelz, D.C. 1978. Some Expanded Perspectives on Use of Social Science in Public Policy. In Major Social Issues: A Multidisciplinary View, eds. J.M. Yinger and S.J. Cutler, 346-57. New York: Free Press.

CAPACITY BUILDING

Increasing an individual, organizational or systemic ability to effectively plan, implement, evaluate and sustain public health promotion and protection efforts. Improved capacity is understood to lead to better decisions informed by multiple sources of data and information and to enhanced practice.
Source: Goodman RM, Speers MA, McLeroy K, Fawcett S, Kegler M, Parker E, Smith SR, Sterling TD, Wallerstein N. Identifying and defining the dimensions of community capacity to provide a basis for measurement. Health Education and Behaviour. 1998; 25(3): 258-278.

CONTEXT

The settings, circumstances, conditions and factors influencing the way in which knowledge is developed, shared, adapted and implemented. This may include consideration of processes, structures, resources and environments, as well as interactions between researchers, policymakers, practitioners, the public and media.
Sources: adapted from McCormack, B., Kitson, A., Harvey, G., Rycroft-Malone, J., Titchen, A., Seers, K. 2002. Getting evidence into practice: the meaning of 'context'. Journal of Advanced Nursing. 38(1): 94-104.

DEVELOPMENTAL EVALUATION

Helps social innovators to explore possibilities for addressing major problems and needs, identify and develop innovative approaches and solutions, and support adaptation in complex, uncertain, and dynamic conditions. Developmental evaluators document what actions in innovators engage in, the short-term results and consequences of those actions, and their connections to the larger vision of the innovators. Developmental evaluation can also help to determine when and if an innovation is ready for formative evaluation as a pilot intervention.
Source: Cabaj, Mark. Developmental Evaluation: The Experience and Reflections of Early Adopters. 2011. Waterloo, Ontario: University of Waterloo. Gamble, Jamie A. A. 2008. A Developmental Evaluation Primer. Montreal, Quebec: The J.W. McConnell Family Foundation. Patton, Michael Quinn. Developmental Evaluation. 2011. New York: The Guilford Press.

DISSEMINATION

An active and strategically planned process whereby new or existing knowledge, interventions or practices are communicated to targeted groups in a way that encourages them to factor the implications into their work. Dissemination goes well beyond simply making research available through the traditional vehicles of journal publication and academic conference presentations. Examples of dissemination vehicles include best practices documents, electronic listservs, presentations, policy forums, websites, training workshops, journal publications, and pilot studies or trial use of an intervention.
Sources: adapted from Kiefer, L., Frank J., Di Ruggiero, E., Dobbins, M., Manuel, D., Gully, P., Mowat, D. 2005. Fostering Evidence-based Decision-making in Canada. Canadian Journal of Public Health. May-June: 11-119; and Canadian Health Services Research Foundation (http://www.chsrf.ca/keys/glossary_e.php).

EVALUATION

In the context of the Knowledge Cycle, it entails systematically determining the impact of the exchange and use of knowledge on desired outcomes. This includes assessment of knowledge exchange processes, outcomes, and context as well as assessment of improved health, practitioner, and/or system outcomes.

Examples of evaluation topics: perceptions of stakeholders and participants, reach and participation rates, competency, communication and interaction change, rate of knowledge uptake, nature of decision- making changes (research, policy and practice), behavioural change, health system outcomes and cost-benefit issues.

Source: adapted from KT Clearinghouse (http://ktclearinghouse.ca/home)

EVALUATION CULTURE

A positive evaluation culture exists when leadership supports the capacity to engage in evaluative activities to foster continuous learning through feedback and results and then acts on evaluation findings.
Adapted from: http://www.oecd.org/dataoecd/11/56/1902965.pdf - Retrieved 16Aug11

EVALUATION FOR LEARNING AND IMPROVEMENT

Evaluation for learning is primarily improvement oriented. It involves a systematic and collaborative cycle of inquiry and feedback related to the context, design, implementation and outcomes of population health policies and programs.

EVALUATION FRAMEWORK

The Evaluation Framework summarizes and connects all of the elements needed to complete an Evaluation Plan, including the Evaluation Questions, Indicators, Evaluation Design, Data Collection Methods & Tools and Methods of Data Analysis.
Adapted from: http://teip.hhrc.net/docs/tools/e._Program_Evaluation_Tool/TEIP_Program_Evaluation_Tool_Complete-Package.pdf - Retrieved 16Aug11

EVALUATION PLAN

A written document describing the overall approach or design that will be used to guide an evaluation. It includes what will be done, how it will be done, who will do it, when it will be done, why the evaluation is being conducted, and how the findings will likely be used.
http://www.cdc.gov/getsmart/program-planner/Glossary-Eval-Res.html - Retrieved 16Aug11

EVIDENCE

Information that is systematically obtained such as analyzed data, published research findings (qualitative or quantitative), results of evaluations, prior experience, and expert opinions, any or all of which may be used to reach conclusions on which decisions are based.

Source: adapted from Last J, editor. A dictionary of public health. New York: Oxford University Press; 2007

EVIDENCE INFORMED PRACTICE

Practice that is attentive to evidence, including research, experiential knowledge of the organization, cultural context, and educational, symbolic/political and process uses, and that uses knowledge syntheses of summarized findings to inform practice, decision-making and implementation.
Source: adapted from Avis, J. 2002. Really useful knowledge? Evdence-informed practice, research for the real world. Post 16 Educator (8): 22-24.

FORMATIVE EVALUATION

Formative evaluations are used to improve the design and delivery of an intervention once its implementation begins. Formative evaluation questions tend to be similar regardless of whether the intervention being evaluated is in its early or mature phases of implementation: Are things going to plan? What are the beneficiaries of the intervention saying about the program? What are the strengths and weaknesses of the model? Where and how might we adjust the design or implementation of the intervention in order for better performance?
Sources: Cronbach, L.J. & Associates. 1980. Toward Reform of Program Evaluation. San Francisco, CA: Jossey-Boss.; Scriven, M. 1991. Evaluation Thesaurus. Fourth Edition. Newbury Park, CA: Sage Publications.

KNOWLEDGE

A fluid mix of framed experience, values, contextual information, evidence interpretation and expert insight that provides a framework for decision making, evaluating and incorporating new experiences and information. It may be explicit or tacit, and individual or collective. In organizations, it often becomes embedded not only in documents or repositories, but also in organizational routines, processes, practices, and norms.
Source: adapted from Davenport, T.H. & Prusak, L. Working Knowledge: How Organizations Manage What They Know, Harvard Business School Press, 1998 and European Committee for Standardization, 2004.

KNOWLEDGE CREATION

A process that results in the generation or collection of new knowledge. Knowledge creation is not limited to research activities, but also results from evaluation of prac- tice or policy and the collection and sharing of tacit knowledge in order for it to become explicit knowledge. Examples include performing basic or applied research, attaining expert consensus, and gathering and documenting evidence.
Source: adapted from Stuhlman Management Consultants, Chicago, IL. http://home.earthlink.net/~ddstuhlman/defin1.htm

KNOWLEDGE TRANSLATION

A process by which relevant evidence is made available and accessible for practice, planning, and policy-making in formats that suit user needs. Examples include preparing a policy brief/report, synthesizing research findings into accessible and practical formats, detailing practice and policy implications, and repackaging/ tailoring information for various audiences.
Source: adapted from UBC Centre for Health and Environment Research http://www.cher.ubc.ca/research/knowledge transfer.asp

NEEDS ASSESSMENT

The process of identifying the learning and practice needs of policy makers, practitioners, and researchers engaged in health pro- motion and chronic disease prevention in Canada. This is most often accomplished through subjective survey methods and informal feedback methods, such as meetings and conversations, though the process may also include objective measures.
Source: adapted from St. Michael's Hospital Glossary - Joint Program in Knowledge Translation http://www.stmichaelshospital.com/research/ ktglossary.php

PRACTICE-BASED LEARNING

A systematic and collaborative cycle of inquiry and feedback related to the context, design, implementation and outcomes of population health policies and programs that produce evidence relevant to the application setting and which is primarily improvement and learning-oriented.
Sources: adapted from Potter MA, Quill BE, Aglipay GS, et al. 2006. Demonstrating excellence in practice- based research for public health. Public Health Reports 121(1), A1-A16 and Green LW, Glasgow R. 2006. Evaluating the relevance, generalization, and applicability of research: Issues in external valida tion and translation methodology. Evaluation & the Health Professions 29 (1), 126-153.

REFLECTIVE PRACTICE

The process of learning through and from experience towards gaining new insights of self and / or practice *(Mezirow, 1991)*

SUMMATIVE EVALUATION

Summative evaluation of a program (or other evaluand) is conducted after completion of the program (for ongoing programs that means after stabilization) and for the benefit of some external audience or decision-maker (for example, funding agency, oversight office, historian, or future possible users). The decision it services are most often decisions between these options: export or generalize, increase site support, continue site support, continue with conditions (probationary status), continue with modifications, or discontinue.
Source: Scriven, M. 1991. Evaluation Thesaurus. Fourth Edition. Newbury Park, CA: Sage Publications.

TACIT KNOWLEDGE

In contrast to codified or documented knowledge (i.e. knowledge gained through formal teaching and learning processes) tacit knowledge is gained informally through experience. It is seldom documented and is difficult to transmit from person to person as one may not be fully aware of one's tacit knowledge.
Adapted from: Fleming, P. (2006) Reflection – A neglected art in health promotion Health Education Research: Vol.22 no.5 2007 p. 658-664

HOW THE CASES WERE DEVELOPED

The Public Health Agency of Canada requested submissions of possible case examples to include in this casebook. This was distributed through various networks, bulletins and contacts. Numerous examples were submitted providing a rich set of possible case examples. A committee consisting of staff from the Chronic Disease Interventions Division of the Public Health Agency of Canada and external colleagues reviewed these submissions and made final selections to reflect a diversity of situations and organizations.

Jamie Gamble and Heather McTiernan of Imprint Consulting prepared the cases in consultation with the organizations involved. Jamie and Heather interviewed 3-4 key informants from each case example, prepared drafts that were then refined based on input from the committee and the organizations in the cases.