South Phoenix Healthy Start Evaluation Report

May 2015

LeCroy & Milligan
ASSOCIATES, INC.

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Submitted to:
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Acknowledgments:
The evaluation team is thankful for South Phoenix Healthy Start Program Director Lisa Derrick and staff members Rosalind Akins, LaKesha Crump, and Betty Harroun, for their support and guidance with this evaluation. We also thank everyone who participated in the Theory of Change Mapping process for their insight and feedback. The evaluation team includes Michele Schmidt, MPA, Michele Scanze, MPH, Jenny McCullough-Cosgrove, MSW, and Michel Lahti, PhD.

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Founded in 1991, LeCroy & Milligan Associates, Inc. is a consulting firm specializing in social services and education program evaluation and training that is comprehensive, research-driven and useful. Our goal is to provide effective program evaluation and training that enables stakeholders to document outcomes, provide accountability, and engage in continuous program improvement. With central offices located in Tucson, Arizona, LeCroy & Milligan Associates has worked at the local, state and national level with a broad spectrum of social services, criminal justice, education and behavioral health programs.

Suggested Citation:
LeCroy & Milligan Associates, Inc. (2015). *South Phoenix Healthy Start Evaluation Report*. Tucson, AZ: Author.

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Introduction

The Federal Healthy Start Initiative was created by the White House Task Force to Reduce Infant Mortality in 1989 to address the nation's declining international ranking in infant mortality. The Maricopa County Department of Public Health has operated the **South Phoenix Healthy Start (SPHS) program** since 2002. SPHS is a federally funded, community based infant mortality reduction program, with the mission of increasing the number of infants that live and remain healthy past one year of age. SPHS serves families in the urban communities of South Phoenix and Maryvale, working primarily with African American families in these communities to increase positive birth outcomes and maternal and infant health through a number of interventions with mothers, fathers, and their infants. Through direct services and community partnerships, SPHS provides families with:

- Perinatal case management services;
- Health education events and learning opportunities;
- Screening and referral; and
- Interconceptional continuity of care.

SPHS links women and families to community resources for services such as: job and educational assistance and training; nutrition assistance (e.g., WIC); smoking and other substance abuse cessation interventions; immunizations; food, housing, and transportation; child care; and counseling services. Exhibit 1 displays the Healthy Start Logic Model. Additionally, SPHS facilitates the Community Action Network (CAN), a community consortium of nearly 100 members that mobilizes key stakeholders in the South Phoenix with a goal of strengthening the target communities' capacity to provide services to families that will increase health, well-being, resilience, and sense of personal success.

LeCroy & Milligan Associates was contracted by SPHS to provide evaluation services from January 2015 to May 2015. This evaluation has two components: (1) a program evaluation that examines child and family level outcomes, and (2) a collective impact evaluation that examines the outcomes of partnership work at the community level. This report presents a summary of evaluation activities performed during this time frame, including: four Theory of Change (TOC) Maps developed to inform the project's work and future evaluation activities, and the results of a Coordination and Collaboration Survey completed by CAN members. Based on the TOC Maps and survey results, the evaluation team has made recommendations for process and impact evaluation outcome measures, as well as suggested indicators for the CAN.

Exhibit 1. Healthy Start Program Logic Model

Evaluation Design and Methods

The evaluation of the SPHS program has two components:

1) A **program evaluation**, with **process** and **outcome** components that examine child and family level outcomes, and
2) A **collective impact evaluation** that examines the outcomes of partnership work at the community level.

The evaluation team utilized a participatory approach for both the program and collective impact evaluations (Weiss, 1998). This type of approach involves key stakeholders in the evaluation process, including program staff, program participants, and any other funders and key decision makers. The benefits of participatory evaluation include recognizing local insight, gaining stakeholder buy-in, and empowering participants to engage in the evaluation of their program. Additionally, evaluation results will be presented to interested program participants using a method that is meaningful to participants, to promote data utilization and use of data-driven decision-making.

South Phoenix Healthy Start Program Evaluation

The evaluation of the SPHS program is designed to be implemented in phases that will gradually build the program's evaluation capacity. This evaluation is based on a Five-Tiered Approach to Evaluation (Jacobs, 1988), which is incremental and developmental in nature. The tiers build on each other in order to increase evaluation capacity, however the tiers can occur simultaneously (see Appendix A for a table outlining the Five-Tiered Approach to Evaluation). The first three tiers include elements of **process evaluation** (examining program implementation), while the final two tiers include elements of an **outcome evaluation** (examining the impact or end result of the program on service recipients) (Weiss, 1998).

In the past five months of this contract, the evaluation team examined Tiers 1 and 2 of this evaluation framework. Future evaluation work that will take place from June 2015 through December 2015 will begin to address the additional Tiers (see the section of this report, Recommended Evaluation Plan). Use of Jacob's Five-Tiered Approach allows for the SPHS program to enhance their evaluation capacity in order to measure program outcomes in later stages of the evaluation, which will take place in subsequent years of grant funding. By synthesizing information from the process and outcome components, the evaluators and program staff will be able to determine the replicability of specific program components, as well as the sustainability of the program.

Tier 1: Program Definition

The initial tier of this evaluation defined the SPHS program, including all of its core services: outreach and recruitment, case management, health education, screening and referral, and interconceptional continuity of care. This phase of evaluation ensured that all program staff, stakeholders, and the evaluation team have a collective understanding of the program's core services, target population, vision, mission, objectives, and goals. Exhibit 2 shows the evaluation questions, data sources, and analytic methods used for Tier 1. The major components of program definition includes:

- Describing the population being served (overall and for each core service);
- Assessing the target population in zip codes served;
- Creating a Theory of Change (TOC) Map;
- Refining the program logic model, including identifying key indicators for outcomes; and
- Reviewing of current literature related to core program services.

Exhibit 2. Tier 1 Evaluation Questions, Data Sources, and Analytic Methods

Evaluation Question	Data Source	Analytic Methods
What are the characteristics of the families receiving various SPHS services?	Client demographic data	Descriptive
What are the targeted populations for inclusion in the program?	US Census	Descriptive
What are the goals, objectives, and related indicators of SPHS program?	Program staff in collaboration with evaluation team TOC Map	Qualitative TOC Map
How can current literature inform the implementation of SPHS?	Scholarly journals	Literature Review

Theory of Change Mapping

The evaluation team engaged key stakeholders (e.g., the Project Director, Staff, key stakeholders, grant partners) in a two-part Theory of Change (TOC) mapping session, held on 3/30/2015 and 4/6/2015. This mapping process utilizes the TOC approach to help identify important inputs and immediate, intermediate, and long term outcomes (Anderson, 2005). The end product of these sessions is the three Theory of Change Maps for SPHS program presented in this report, which define and illustrate the assumptions, interventions, and short- and long-term outcomes of this project; mapping out the theory of how and why this project is expected to address these outcomes. The TOC Maps illustrate the conceptual linkages between the identified problems and potential solutions. The evaluation team will then operationalize the projects Theory of Change Map into a Logic Model that identifies the inputs, interventions, direct outputs, desired goals, and measureable short and longer-term outcomes. The evaluation plan for this project will be based on both the Theory of Change Map and the Logic Model. The evaluation team will continuously test and refine the assumptions and linkages between project activities, outputs, and outcomes, as part of our continuous monitoring and improvement efforts.

Tier 2: Monitoring and Service Delivery

This second tier of this program evaluation examined the implementation of the program as it was defined during the first tier. This tier established client flow through the program, as well as how information is documented and how data are collected from program participants. The major components of evaluating monitoring and service delivery include:

- Documenting how clients enter and exit the program;
- Examine what services are being delivered to which clients;
- Examine how services are being delivered to clients;
- Document data collection processes and what data are being collected; and
- Examine the flow of client data from referral to intake to close.

Data was collected for Tier 2 by the evaluation team through discussion and consultation with program staff and review of program level data. Exhibit 3 shows the evaluation questions, data sources, and analytic methods used for Tier 2.

Exhibit 3. Tier 2 Evaluation Questions, Data Sources, and Analytic Methods

Evaluation Question	Data source	Analytic Methods
How do clients enter and exit the program?	Program data, program staff	Descriptive, flow chart
What are the patterns of service delivery? (Including timing, frequency, format, purpose, and attendance)	Program data	Descriptive, flow chart
Are services being implemented consistently by various providers with different clients?	Program staff	Qualitative/ Quantitative
To what extent are clients following through with services and referrals?	Program data	Descriptive
What data are collected?	Program staff	Qualitative
How are data entered and stored?	Program staff	Qualitative
Who enters data and when?	Program staff	Qualitative

Collective Impact Evaluation

Concurrently, in order to best evaluate the various partnerships that make up the CAN, the evaluation team is utilizing a **collective impact** evaluative approach that examines outcomes at the community level (Kania & Kramer, 2011; Parkhurst & Preskill, 2014; Phillips & Splansky Juster, 2014; Preskill, Parkhurst, & Splansky Juster, 2014). Collective impact occurs when a group of stakeholders come together with a common agenda to address a complex social issue, such as the disproportionate rate of poor birth outcomes in the South Phoenix and Maryvale African American communities. A collective impact approach offers flexibility for emergence in a long-term and often unpredictable process of problem-solving based on the five core conditions of collaborative impact: (1) a common agenda, (2) shared measurement, (3) mutually reinforcing activities, (4) backbone infrastructure, and (5) continuous communication. The collective impact evaluation seeks to determine how the CAN is functioning in relation to these five core conditions. This evaluation approach is unique in that it is a responsive and flexible method for assessing the functioning of often complex relationships, which will support development, learning, and sustainability of the CAN.

Evaluating outcomes of collaborative impact is a complex and long-term endeavor. Therefore, similar to the program evaluation, the foundation for the collaborative impact evaluation must be established by first assessing the developmental stage of the CAN and building upon a strong organizational backbone to increase the capacity for an assessment of the impact of the CAN. The goal of the first stage of collaborative impact evaluation is to define what exists. As an initial activity, the evaluation team prepared and delivered a presentation to the CAN on 1/28/2015 regarding collective impact and collective impact evaluation. The results of this presentation and discussion are presented in this report. Subsequently, the evaluation team attended monthly CAN meetings in February, March, and April 2015 and administered the Coordination and Collaboration Survey on paper to meeting attendees on 4/29/2015. The results of this survey are presented in this report. Additionally, the evaluation team facilitated a TOC Mapping session on 4/29/2015, documenting how the program will address the grant outcome of achieving collective impact. This TOC Map is also presented in this report.

Coordination and Collaboration Survey

To assess the baseline partnership of the CAN, the evaluation team administered the Coordination and Collaboration Survey instrument developed by LeCroy & Milligan Associates in 2013, which we have used to evaluate numerous collaboratives throughout Arizona. This instrument was adapted from instruments described below. This survey monitors a coalition's stage of development by assessing the extent to which essential coordination components are present and functioning, and the quality of interactions among coalition members. The survey is comprised of 106 items.

- 10 items that capture information on respondent's agency, position, and participation in the CAN;
- 28 items adapted from the Wilder Collaboration Factors Inventory (CFI) (Mattessich, Murray-Close, & Monsey, 2001);
- 61 items adapted from the Partnership Self-Assessment Tool (PSAT) (Center for the Advancement of Collaborative Strategies in Health, 2006);
- 24 questions that capture information about benefits, drawbacks and satisfaction level; and
- One open-ended item for members to provide additional comments.

Wilder Collaboration Factors Inventory. The Wilder CFI instrument is a tool used to assess the elements of effective collaboration organized within 15 factors, using a 5-point Likert scale ranging from strongly disagree (1) to strongly agree (5) (Mattessich, Murray-Close, & Monsey, 2001). Examples of factors include: shared vision, unique purpose, development of clear roles and policy guidelines, and mutual respect, understanding and trust. These

factors were identified by the inventory's authors through a systematic review of empirical studies of collaboration and were grouped into six categories:

1. *Environment*: the extent to which the community has a history of collaboration and whether the community views collaboration as a legitimate effort.
2. *Membership characteristics*: the degree to which there is mutual respect and trust among members.
3. *Process and structure*: the presence of clearly understood roles, rights and responsibilities of members that lead to a feeling of ownership that collaboration members feel about the work.
4. *Communication*: the existence of fully developed and utilized lines of communications resulting in high interaction between individuals.
5. *Purpose*: having a shared vision, with clearly articulated goals and strategies, that is affirmed by each member. The mission, purpose and delivery system of the collaborative is distinctive from those of participating organizations.
6. *Resources:* the extent to which the collaboration has sufficient financial, human and in-kind resources to achieve its goals.

A study by the RAND Corporation that utilized the Wilder CFI showed that the factors have a moderate to high internal consistency, with a range of Cronbach Alpha scores for each factor from .50 to .93 (Pitkin Derose, Beatty & Jackson, 2004). A reliability analysis performed with the survey data collected for this study demonstrates a high internal consistency of the Wilder CFI scale, with a Cronbach Alpha score of .93 achieved. The assessment of these survey items was performed according to Wilder CFI guidelines, which recommend averaging across respondent ratings for items within a given success factor. Factor scores were interpreted in the following way:

- 4.0-5.0 – The CAN shows strength and probably does not need special attention;
- 3.0-3.9 – The CAN may require attention to this area; and
- 1.0-2.9 – This area is of concern for the CAN and should be addressed.

Partnership Self-Assessment Tool (PSAT). The PSAT survey items assess additional factors of the coordination components that influence the success of collaborations, such as administration and management, sufficiency of resources, and decision-making, the benefits and drawbacks of partnering, and satisfaction with the coalition. These quantitative measures gathered categorical data using a five-point Likert scale or a Yes/No format. The PSAT instrument was designed to help coalitions understand and assess how well their collaborative process is working and identify specific areas of focus for

improving the collaborative (Center for the Advancement of Collaborative Strategies in Health, 2006; Weiss, Miller Anderson & Lasker, 2002).

The authors of this tool recommend that the PSAT be used by an alliance that has been in existence for at least six months; is comprised of people and organizations that continually work together to develop and modify strategies to achieve their goals; has begun to take action to implement its plans; and has at least five active members. CAN meets all of these criteria. This section of the survey was scored according to the PSAT author's guidelines, which recommend averaging across respondent ratings for items within each of the six areas. Scores were interpreted in the following way:

- 4.5-5.0 – **Target Zone**: the coalition currently excels in this area and needs to focus attention on maintaining a high score;
- 4.0-4.4 – **Headway Zone**: the coalition is doing pretty well in this area but has potential to progress even further;
- 3.0-3.9 – **Work Zone**: more effort is needed in this area to maximize the coalition's collaborative potential; and the factor may require attention; and
- 1.0-2.9 – **Danger Zone**: this area is in need of a lot of improvement.

Survey Data Analysis

Quantitative survey data were analyzed using the Statistical Package of the Social Sciences (SPSS 22). Analysis of quantitative data depends on variable and sample characteristics and included descriptive statistics, including frequency distributions of categorical variables and measures of central tendencies for continuous variables. Guiding questions for this study include:

- To what extent do members feel elements of effective collaboration are present in the CAN? What is the average respondent rating for items within the 15 success factors?
- How do members rate the CAN in terms of synergy; leadership; efficiency; administration and management; non-financial resources; financial and other capital resources; and decision making? What is the average respondent rating for each of the six areas? What is the frequency distribution of ratings for items within each of the six areas?
- To what extent are members satisfied with the CAN? What is the frequency distribution of ratings for satisfaction items?

Results

Tier 1: Program Definition

The initial tier of this evaluation defined the SPHS program, including all of its core services: outreach and recruitment, case management, health education, screening and referral, and interconceptional continuity of care. This phase of evaluation ensured that all program staff, stakeholders, and the evaluation team have a collective understanding of the program's core services, target population, vision, mission, objectives, and goals. The key evaluation questions related to program definition include:

- What are the characteristics of the families receiving various SPHS services?
- What are the targeted populations for inclusion in the program?
- Using the Theory of Change Mapping, what are the goals, objectives, and related indicators of SPHS program?
- How can current literature inform the implementation of SPHS?

Describing the Population Served

Since implementation of Healthy Start 3.0, from November 1, 2014 through April 30, 2015, SPHS served over 485 pregnant and interconceptional women. This number includes carry over from families with children under the age of 2. The average age of participants was 22 years and participants' ages ranged from 15 years to 58 years. Additionally, 48 fathers participated in home visitation services. Of those served:

- 22% of participants were pregnant teens;
- 23% of participants were interconception/parenting teens;
- 17% of participants had health insurance at the time of enrollment.

Exhibit 4 displays demographics of pregnant and interceonceptional participants.

Exhibit 4. Select Characteristics of Pregnant and Interconception SPHS Participants

Type of Participant	% African American	% Hispanic	% Residing in South Phoenix (including Laveen)	% Residing in Maryvale	% Residing in Central Phoenix
Pregnant	46%	41%	44%	29%	20%
Interconception	47%	42%	33%	30%	37%

A total of 43 SPHS women gave birth, with a 33% Cesarean section rate; these births included two sets of twins. Over half of these births (56%, 24) were supported by doulas. Of these births:

- 14% of babies had a low birth weight;
- 2% had a very low birth weight;
- 12% were premature;
- There were no infant deaths;
- 56% of mothers giving birth were at the highest level of multiple risk factors at time of birth.

Assessing the Target Population in Zip Codes Served

Since 2002, the SPHS program has served families in the urban communities of South Phoenix and Maryvale (South Phoenix region). SPHS works primarily with African American families in these communities.

Single mothers with children under the age of 6 years made up 25.9% of households in this area. The median income for a single female with children under the age of 18 was $25,764 for Phoenix. The city had a 5.6% unemployment rate in 2013 (Office of Employment & Population Statistics, 2015). The areas of the South Phoenix region are generally areas of high poverty, with 2010 Census data reporting that 35.0% of children living in poverty in the South Phoenix region (U.S. Department of Commerce, 2015). 2010 Census data estimates 52,303 of the region were children.

Children living in poverty are at high risk for not having their basic needs met, like food and health care, as well as being exposed to higher rates of violence and crime (South Phoenix Regional Partnership Council, 2014). Exhibit 5 demonstrates the high proportion of Black or African American residents in the area of focus for SPHS. The South Phoenix region averages 10.9% of its residents identifying as Black or African American, more than twice the average of 5.0% for Maricopa County as a whole. It can be inferred that the rates of negative infant and mother birth outcomes may be higher within the South Phoenix region than the County-wide data indicates.

Exhibit 5. Percentage of African American Households by Zip Code or Location

Zip Code	Black or African American (%)
85037	7.9
85031	5.2
85033	5.1
85035	5.8
85041	14.3
85040	20.6
85042	17.3
Average South Phoenix Region	10.9
Average Maricopa County	5.0

(U.S. Department of Commerce, 2015)

County level data from the Arizona Department of Health Services indicates the infant mortality rate for Maricopa County has decreased for the most recent three years on record from 5.9 deaths per 1,000 live births in 2011 to 5.3 deaths per 1,000 live births in 2013 (Arizona Department of Health Services, 2015). However, when examining the infant mortality rate in Maricopa County by race and ethnicity in that time period, Black or African American babies had 13.4 deaths per 1,000 live births.

In the same time period for Maricopa County, infant birth weight stayed relatively stable at 7.0% of babies born in 2011 with low birth weight (LBW), 6.8% born in 2012, and 6.9% in 2013. Black or African American babies LBW rate of 11% was almost double the overall average County rate of 6.9%. Preterm births (PTB), births with less than 37 weeks of completed gestation, has continued to decrease for the County at 9.6% in 2011, 9.4% in 2012, and 9.2% in 2013. The percentage of Maricopa County mothers who received prenatal care rose from 85.7% in 2011 to 86.2% in 2012, but then fell to 84.7% in 2013. When examining the rates of Arizona as a State by race and ethnicity, Black or African American mothers fell behind White mothers' 87.6% rate of receiving early prenatal care at 78.3%.

Creating Theory of Change (TOC) Maps

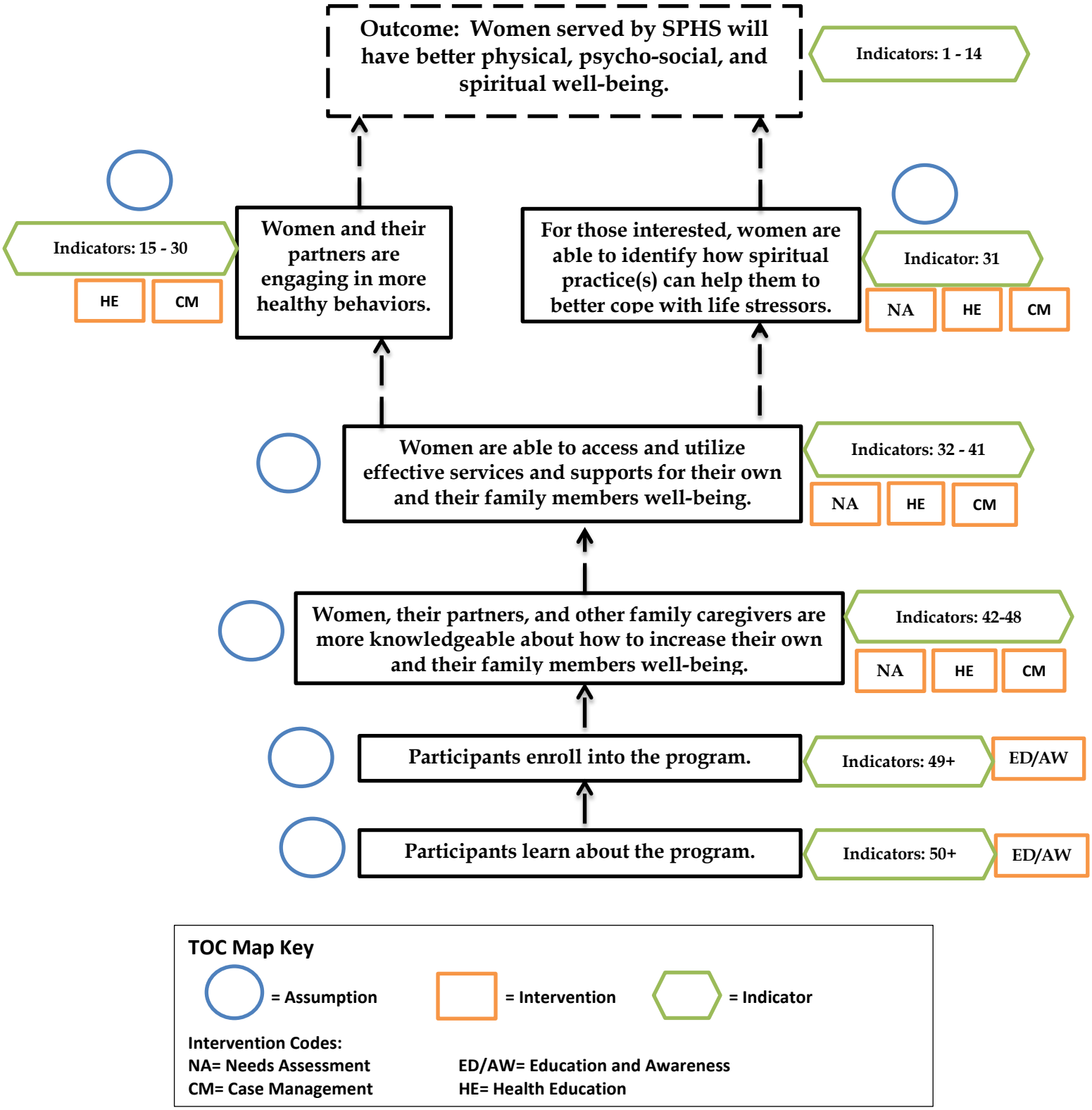
The evaluation team engaged key stakeholders (e.g., the Project Director, staff, key stakeholders, and grant partners) in a two-part Theory of Change (TOC) mapping session, held on 3/30/2015 and 4/6/2015. This mapping process utilizes the TOC approach to help identify important inputs and immediate, intermediate, and long-term outcomes (Anderson, 2005). The end products of these sessions are four Theory of Change Maps that document how SPHS will achieve the four program outcomes, including:

1) Improving women's health;
2) Promoting quality services;
3) Strengthening family resilience; and
4) Achieving collective impact.

The fifth program outcome is to increase accountability through quality improvement, performance monitoring, and evaluation, which is addressed through the use of an evaluation team comprised of external (LeCroy & Milligan Associates) and internal evaluators (see the section Recommendation Evaluation Strategies in this report).

The four TOC Maps presented in this report define and illustrate the assumptions, interventions, and short- and long-term outcomes of this project (see Exhibits 6-9). This process maps out the theory of how and why this project is expected to address each outcome. The TOC Maps illustrate the conceptual linkages between the identified problems and potential solutions.

Improving Women's Health TOC Map



TOC Map Key

= Assumption = Intervention = Indicator

Intervention Codes:

NA= Needs Assessment
CM= Case Management
ED/AW= Education and Awareness
HE= Health Education

Exhibit 6. Assumptions, Interventions, and Indicators for SPHS Improving Women's Health TOC Map

Assumptions
TBD

Interventions
Needs Assessment (NA)-SPHS staff assess the needs of clients at intake to the program.
Case Management (CM)- Case Management provides one on one outreach to SPHS participants. Case Management supports participants to develop and achieve both short and long term goals relating to maternal and child support and healthy lifestyles.
Health Education (HE)-Health Education is delivered through community classes. These classes provide education on breastfeeding, prenatal care and nutrition.
Education & Awareness Sessions (ED/AW)-

Indicators
Outcome: Women served by HS will have better physical, psycho-social and spiritual well-being.
1. To reduce the proportion of all live deliveries with very low birth weight. 2. To reduce the number of all live deliveries with low birth weight. 3. To reduce the number of infant deaths. 4. To reduce the number of neonatal deaths. 5. To reduce the number of post-neonatal deaths. 6. To reduce the number of perinatal deaths. 7. Reduce the proportion of HS pregnancies conceived within 18 months of a previous birth to 30%. 8. Reduce the proportion of HS participants with elective delivery before 39 weeks to 10%. 9. (For those interested), increase the number of women reporting positive effects of a spiritual practice in their lives. 10. To reduce the number of women with significant risk factors associated with chronic illnesses such as; diabetes, obesity, high blood pressure and heart disease. 11. Increase abstinence from cigarette smoking among HS pregnant women to 90 %. (To reduce the number of women reporting the use / abuse of tobacco, alcohol and or other drugs). 12. To increase the number of women reporting positive psycho-social well-being. 13. Increase the proportion of HS participants that read daily to a HS child between the ages of 0-24 months to 50%. 14. Increase the number of women with a partner / spouse that report a positive, nurturing relationship.
Outcome: Women and their partners are engaging in more healthy behaviors.
15. To increase the number of children in the State who have a medical home. 16. To increase the percentage of women participating in MCHB-funded projects who have an ongoing source of primary and preventive care services for women. 17. To increase early entry into prenatal care. 18. Decrease smoking during pregnancy. 19. To increase the percent of program participant mothers who breastfeed their infants at 6 months of age. 20. Increase the proportion of HS participants who have a documented reproductive life plan to 90%.

Indicators
21. Increase the proportion of HS participants who engage in safe sleep behaviors to 80%. 22. Increase the proportion of HS infants who are ever breastfed to 82 %. 23. Increase the proportion of HS infants who breastfed at 6 months to 61%. 24. Increase proportion of well child visits (including immunization) for HS participants' children between ages 0-24 months to 90%. 25. Increase the proportion of HS grantees that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) during pregnancy to 90%. 26. Increase the proportion of HS grantees that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) with child 0-24 months to 80%. 27. Increase the amount of quality time mothers and fathers spend with their family. 28. Increase the number of women who are regularly exercising. 29. Increase the number of mothers and fathers who promote an active lifestyle for their family. 30. Increase the number of fathers and mothers who report better nutritional choices for their family diet.
Outcome: For those interested, women are able to identify how spiritual practice(s) can help them to better cope with life stressors.
31. 90% of women who express an interest in enhancing their spiritual practices report a regular spiritual practice; e.g., participating in a women's support group helps one to feel not alone and supported by others, or re-engaging with activities at a church, synagogue or mosque, etc.
Outcome: Women are able to access and utilize effective services and supports for their own and their family members well-being.
32. SPHS demonstrates an increase in services/programs for women and their families that have integrated cultural and linguistic competence into their policies, guidelines, contracts and training. 33. Increase the percentage of completed referrals for women in need of services. 34. To improve health providers' appropriate screening for risk factors of women participants. 35. Increase the proportion of HS participants with health insurance to 90%. 36. Increase the proportion of HS participants who receive a postpartum visit to 80%. 37. Increase the proportion of women, infants, and children participating in HS who have a medical home to 80%. 38. Increase proportion of well child visits (including immunization) for HS participants' children between ages 0-24 months to 90%. 39. Increase the proportion of HS participants who receive perinatal depression screening and referral to 100%. 40. Increase the proportion of HS participants who receive follow up services for perinatal depression to 90%. 41. Increase the proportion of HS participants who receive intimate partner violence screening to 100%.
Outcome: Women, their partners, and other family caregivers are more knowledgeable about how to increase their own and their family members well-being.
42. (Number and Percent) Increase their knowledge about importance of breast feeding. 43. (Number and Percent) Increase their knowledge about risk factors associated with chronic diseases; e.g., diabetes, obesity, high blood pressure, heart disease, etc. 44. (Number and Percent) Increase their knowledge about parenting skills. 45. (Number and Percent) Increase their knowledge about safe sleeping behaviors. 46. (Number and Percent) Increase their knowledge about nutrition and diet. 47. (Number and Percent) Increase their knowledge about importance of primary care provider and medical home. 48. (Number and Percent) Increase their knowledge about…

Indicators
Outcome: Participants enroll in the program.
49. Increase the proportion of eligible women and families who enroll into the HS program.
Outcome: Participants learn about the program.
50. Increase the number of outreach activities to eligible women and families.

Improving Family Resiliency TOC Map

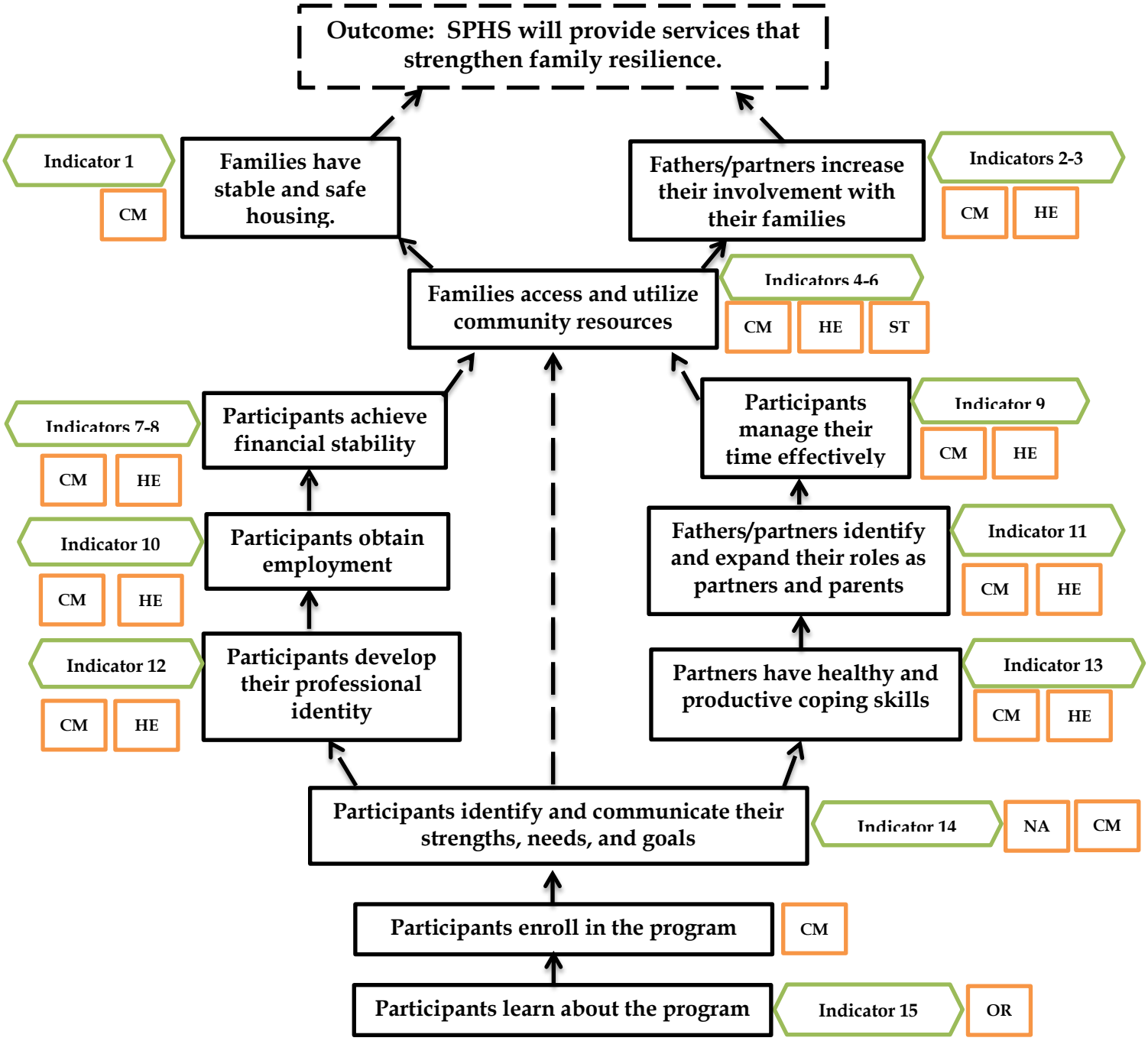


Exhibit 7. Assumptions, Interventions, and Indicators Key for Strengthening Family Resiliency TOC Map

Assumptions
TBD

Interventions
Needs Assessment (NA)-SPHS staff assess the needs of clients at intake to the program.
Case Management (CM)- Case Management provides one on one outreach to SPHS participants. Case Management supports participants to develop and achieve both short and long term goals relating to maternal and child support and healthy lifestyles.
Health Education (HE)-Health Education is delivered through community classes. These classes provide education on breastfeeding, prenatal care and nutrition.
Staff Training (ST)-Staff training is delivered on a monthly basis to all SPHS staff. This trainings have the purpose of ensuring that all community health workers and educators are providing consistent and accurate information to the participants.
Outreach (OR)-SPHS staff conduct outreach efforts to ensure that eligible community members are aware of the program.

Indicators
1. **Families have stable housing:** Increase the proportion of SPHS participants that have stable housing to 50% within 6 months of program enrollment. (new)
2. **Fathers/partners increase involvement:** Increase the proportion of SPHS participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) during pregnancy to 90%.
3. **Fathers/partners increase involvement:** Increase the proportion of SPHS participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) with child 0-24 months to 80%.
4. **Access and utilize community resources:** Increase the percentage of completed referrals for women participating in MCHB-funded programs in need of services.
5. **Access and utilize community resources:** Develop infrastructure that supports comprehensive and integrated services.
6. **Access and utilize community resources:** Increase the proportion of SPHS participants who receive follow up services for perinatal depression to 90%.
7. **Financial stability:** Increase the proportion of SPHS participants with health insurance to 90%.
8. **Financial stability:** Reduce the proportion of SPHS pregnancies conceived within 18 months of a previous birth to 30%.
9. **Manage time effectively:**
10. **Obtain employment/income:** Increase proportion of SPHS families that have regular, stable, sufficient income to XX%. (new)
11. **Roles as partners and parents:** Increase proportion of HS fathers/partners with goals regarding being a parent and partner to XX%. (new)

Indicators
12. **Develop their professional identity:** Increase proportion of SPHS participants with education and work related goals to XX%. (new)
13. **Partners have healthy and productive coping skills:** Increase the proportion of SPHS participants who receive intimate partner violence screening to 100%.
14. **Participants identify and communicate their needs and goals:** Increase the proportion of SPHS participants who receive perinatal depression screening and referral to 100%.
15. **Participants learn about SPHS through outreach strategies:** To increase family/youth/consumer participation in MCHB programs.

Program Quality TOC Map

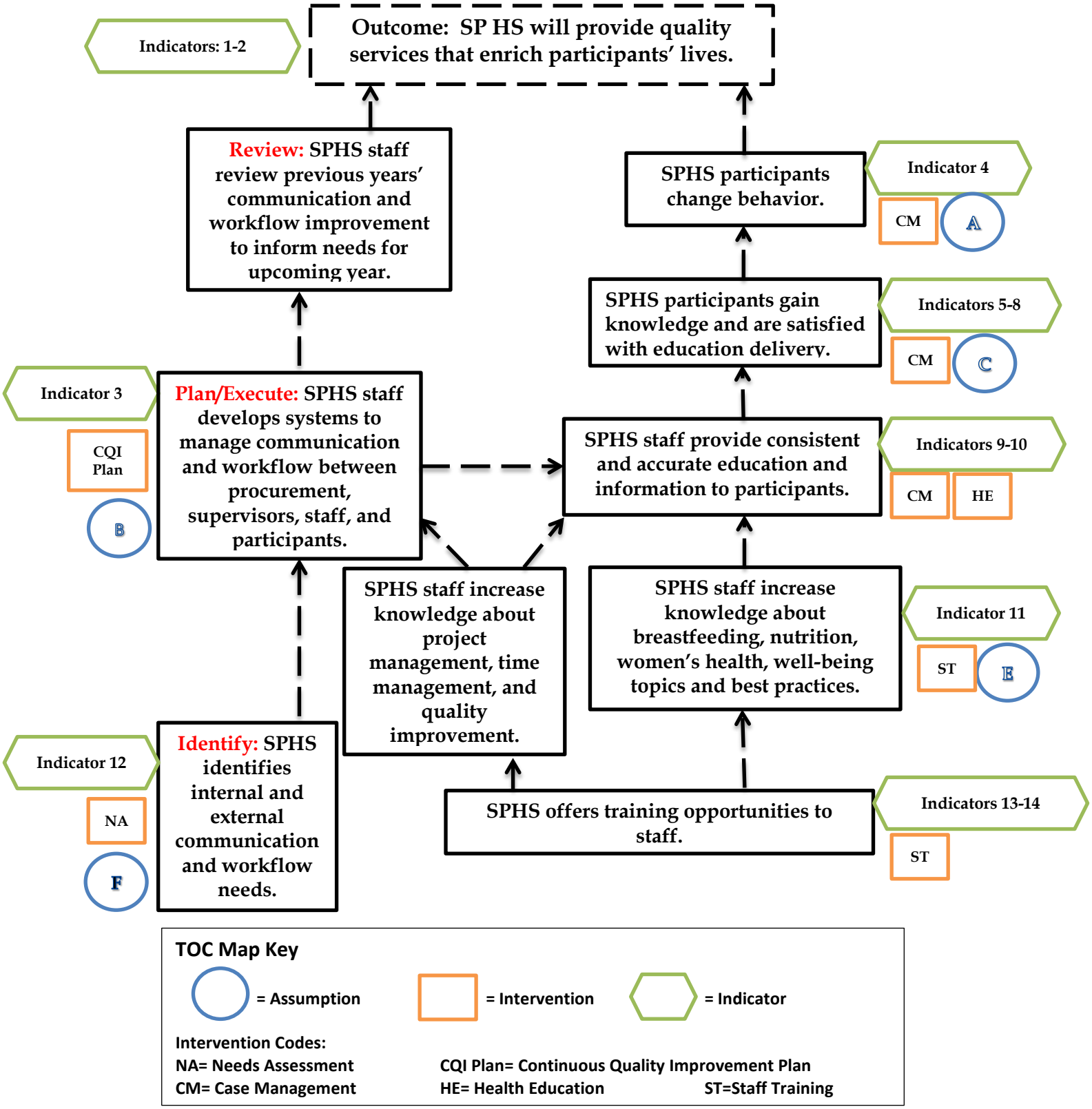


Exhibit 8. Assumptions, Interventions, and Indicators Key for SPHS Program Quality TOC Map

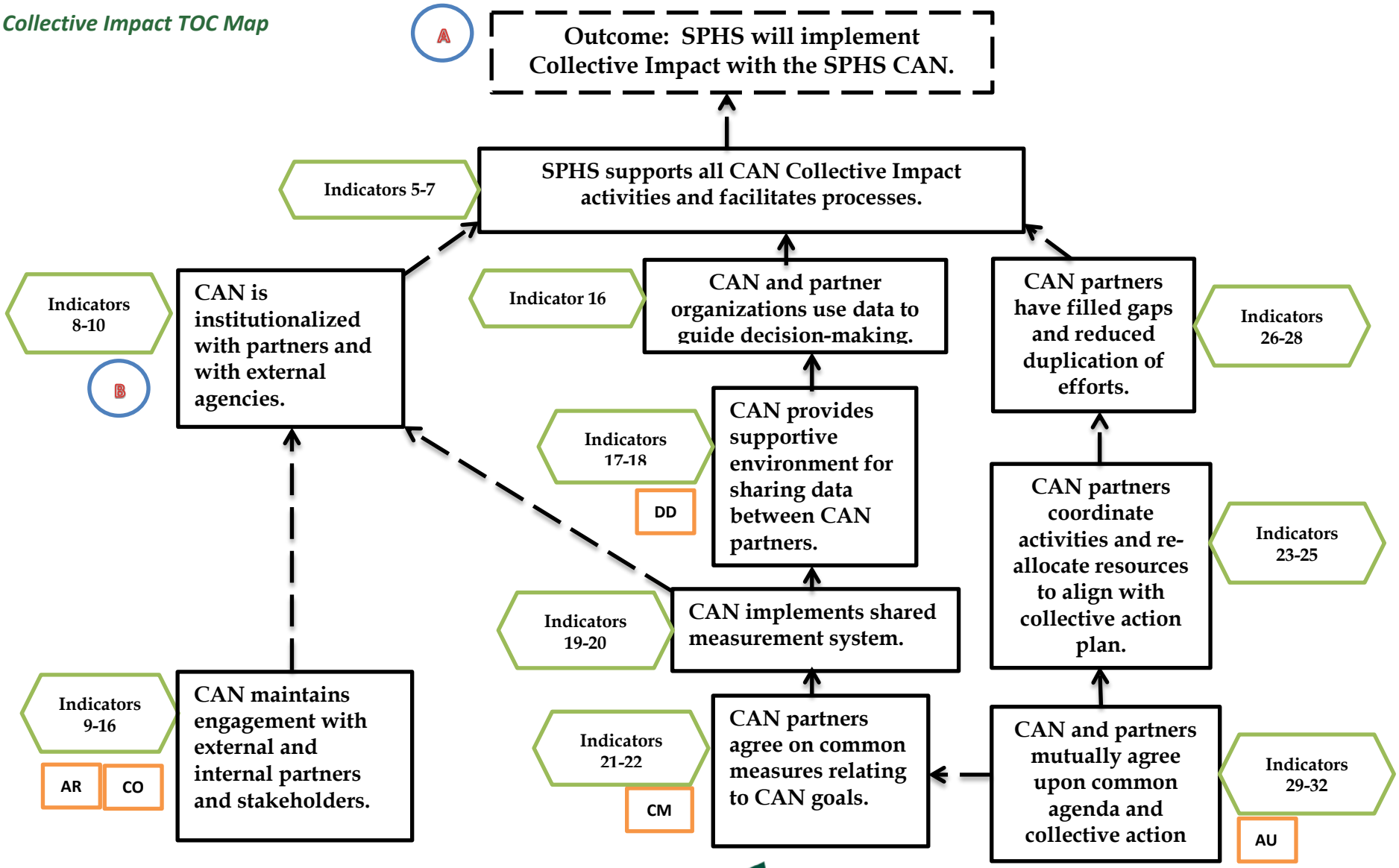
Assumptions
A. SPHS participants track their progress in achieving their goals; and have support and access to services to implement behavior change resulting from their gain in knowledge.
B. All SPHS staff are involved in developing and implementing improved communication systems.
C. All SPHS staff attend supervision, case manager support and other identified activities to increase and communication and improve workflow.
D. SPHS activities are culturally relevant for their participants to understand and interpret the education.
E. SPHS target audience is able to access and participate in SPHS activities.
F. All SPHS staff find value in improving SPHS internal and external communication and workflow.

Interventions
Needs Assessment (NA)- A communication needs assessment is completed every annually to identify changes that need to be made for internal communication.
Case Management (CM)- Case Management provides one on one outreach to SP HS participants. Case Management supports participants to develop and achieve both short and long term goals relating to maternal and child support and healthy lifestyles.
Health Education (HE)-Health Education is delivered through community classes. These classes provide education on breastfeeding, prenatal care and nutrition.
Staff Training (ST)-Staff training is delivered on a monthly basis to all SP HS staff. This trainings have the purpose of ensuring that all community health workers and educators are providing consistent and accurate information to the participants in addition to providing education on home visiting best practices. These best practices may be
Continuous Quality Improvement Plan (CQI Plan)- SP HS develops and implements a CQI Plan that identifies systems change for improving internal communication and workflow between procurement, supervisors and all SP HS staff. The CQI Plan may establish best practices from other home visiting organizations, such as Healthy Families. One example mentioned in the small group Theory of Change activity was that SP HS may create and utilize participant satisfaction surveys (indicator #7) as a means for direction communication between the participant and SP HS supervisors on successes and challenges of service delivery.

Indicators
1. 50% of SP HS participants have met their long and short term goals.
2. 100% of SP HS staff report consistent internal and external messaging, as described in the Communication Plan.
3. 75% of SP HS newsletters, email updates and management meetings follow guidelines set forth in communication plan.
4. 50% of SP HS participants demonstrate behavior change and progress in their long and short term goals.
5. 40% of Community Health Workers' participants attend Health Education classes.
6. 60% of SP HS CM and HE participants demonstrate a gain in knowledge in a pre/post-test (for HE) and a gain in knowledge at interim time points (for CM).

Indicators
7. 75% of SP HS CM and HE participants indicate satisfaction with SP HS services.
8. 75% of SP HS CM and HE participants are aware of community resources providing transportation, food, childcare and healthcare needs.
9. 75% of Health Education classes and Case Management appointments adhere to fidelity or best practices.
10. 75% of Health Education classes and Case Management appointments adhere to common messaging identified in Communication Plan.
11. 75% of SP HS staff attending staff training indicate an increase in knowledge in staff training pre/post-tests.
12. 100% of SP HS staff participate in interviews/respond to surveys to identify internal and external communication needs on an annual basis.
13. One staff training opportunities are provided to SP HS staff on monthly basis.
14. Averages of 65% of SP HS staff attend staff training opportunities.

Collective Impact TOC Map



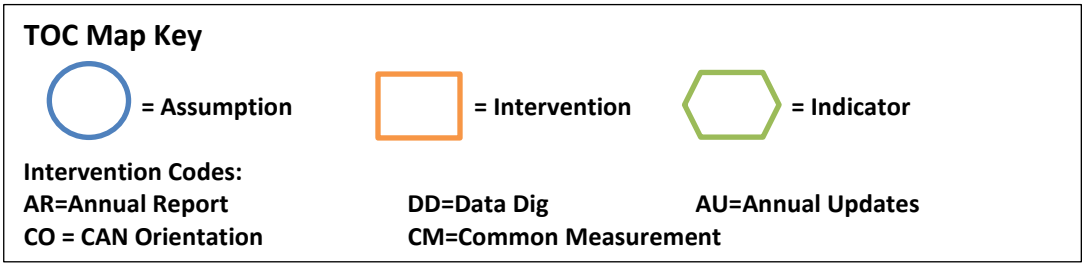


Exhibit 9. Assumptions, Interventions, and Indicators Key for HS Improving Women's Health Map

Assumptions
A. Maricopa County and Arizona's political environment supports CAN's work.
B. CAN partner organizations will prioritize CAN's common agenda.

Interventions
Annual Report (AR)- CAN produces an annual report about the status of maternal and child health in South Phoenix.
CAN Orientation (CO)-SPHS develops CAN Orientation to orient new and old CAN members to its history and collective impact initiative.
Data Digs (DD)- CAN hosts DDs periodically to provide opportunity for CAN partners and external agencies to increase capacity for understanding quantitative and qualitative data.
Common Measurement (CM)- CAN partners identify data that they currently collect that is similar or the same measurement. Partners then identify what information they might need to collectively start collecting in order to measure progress in their goal, that they are not currently collecting. For example, this may be a question that each organization agrees to collect on a survey.
Annual Updates (AU)- CAN's common agenda and collective action plan is annually updated to better understand successes and barriers for implementing the action plan and whether activities are still relevant.

Indicators
1. CAN demonstrates progress towards mutually agreed upon goals.
2. CAN partners ask for support (financial and other resources) from SP HS.
3. CAN has the potential to become a 501c(3).
4. CAN partners share common messages and resources.
5. CAN partners agree or strongly agree that SP HS: maintains coherence of Collective Impact effort, helps coordinate management, supports fundraising and outreach and supports work groups.
6. SP HS ensures community members are engaged in the Collective Impact activities.
7. SP HS seeks out alignment with other initiatives in South Phoenix.
8. Staff turnover with CAN partners does not impact the organizations present at CAN meetings.
9. Other community organizations are reaching out to include CAN in their events, interventions, and programs.
10. CAN partners communicate and coordinate efforts regularly (with and independent of the backbone agency).

Indicators
11. CAN partners feel the AR is useful and informative.
12. Structures and processes are in place to engage CAN members.
13. CAN working groups hold regular meetings and members actively participate.
14. Structures and processes are in place to engage CAN external stakeholders.
15. CAN engages external stakeholders in regular meetings and integrates their feedback into the overall strategy.
16. CAN partners report regularly using data from the shared measurement system for their own organizations' purposes and are confident of its quality.
17. CAN partners feel more comfortable with data and associated terminology.
18. CAN regularly analyzes and interpret data, synthesizes findings and refines plans as a collective.
19. CAN has informal and formal data sharing agreements are in place.
20. Shared measurement system is in place and CAN partners are trained on how to use it.
21. CAN partners identify common measures that can provide timely evidence of progress (or lack thereof) toward CAN's common agenda.
22. CAN partners understand the value of identifying common measures.
23. Working groups are established to coordinate activities in alignment with the plan of action.
24. CAN partners understand the roles of other working groups and how these support the common agenda.
25. CAN partners identify and implement new strategies or activities to address gaps or duplication.
26. Collective plan of action clearly specifies the activities that different partners have committed to implementing.
27. Partners' individual activities are changing to better align with the plan of action.
28. Funders of partner organizations align their resource to support the plan of action.
29. All CAN partners feel ownership of CAN's common agenda and collective plan of action.
30. CAN partners had the opportunity to provide input into the development of the common agenda and collective plan of action.
31. Community members had the opportunity to provide input into the development of the common agenda and collective plan of action.
32. CAN partners are aware of the community agenda and collective plan of action.

Refining the SPHS Program Logic Model

Once the TOC Maps are finalized, the evaluation team will work with the Project Director, the internal evaluator, and other project staff to operationalize the TOC Maps into a program specific Logic Model.

Literature Review of Core Program Services

This literature review describes the core services of SPHS within the context of peer-reviewed and professional literature.

Home Visitation

Home visitation is a key intervention method used by SPHS, which research shows can have significant impact in preventing maltreatment for both universal and targeted intervention strategies. Prenatal and early home-visitation programs by nurses and paraprofessionals have consistently shown significant improvements for immediate and long-term outcomes for children and parents, especially when combined with other services such as parental support and connection to services (Brooks-Gunn, 1998; CCAH, 1994; Cicchetti, 2005; El-Mohandes, 2003; Gomby, 2005; MacMillan, 2008; Mikton, 2009; Olds, 1990). The benefits of home-visitation programming exceeds the intervention cost due to preventing emergency hospital visits, hospitalizations, child protective services involvement, and foster care services (CCAH, 1998; Gomby, 2005). Promising home-visitation programs are Healthy Start, Healthy Families America, the Nurse-Family Partnership, PURPLE, Early Start, and the Triple-P program (Barth, 2009; MacMillan, 2008; Olds, 1986; Olds, 2014).

Doula Care

In addition to home visitation, the intervention of doula care (the emotional, social, educational, and physical care for a person from pregnancy to the postnatal period) has increasingly shown to be beneficial for women and their families during pregnancy. Unlike nurses and doctors, Doulas stay with mothers for the entirety of labor, in order to create an environment tailored to the mother's needs and advocate for services in accordance with the mother's wishes (Chapple, Gilliland, Li, Shier, & Wright, 2013; Gentry, Nolte, Gonzalez, Pearson, & Ivey, 2010; Gruber, Cupito, & Dobson, 2013; Kozhimannil, Hardeman, Attanasio, Blauer-Peterson, & O'Brien, 2013). Multiple studies have shown that this uninterrupted customized service and advocacy practice is associated with positive outcomes relating to pregnancy, labor, the birthing process, postpartum emotional status, and neonatal and post-neonatal infant health (Chapple, 2013; Gentry, 2010; Gruber, 2013; Kozhimannil, 2013).

The impact of doula services has also been associated with decreased costs for low-risk deliveries, and has a greater impact for adolescent mothers and, "women who were socially disadvantaged, low income, unmarried, primiparous, giving birth in a hospital without a companion, or had experienced language/cultural barriers," (Gruber, 2013, p.50; Chapple, 2013; Gentry, 2010; Kozhimannil, 2013). It is important to note that despite the emerging body of evidence, Doula services have been criticized as an under-researched aspect of pregnancy and birthing services, attributed to inconsistent and poorly-developed methodological designs (Chapple, 2013; Steel, Frawley, Adams, & Diezel, 2013).

Education

Similar to the knowledge imparted from doula services, the influence of providing education to pregnant women on pregnancy, birth, and postnatal care has been shown to reduce rates of infant mortality, especially among African-Americans (Moehling & Thomasson, 2014). Notable education efforts aimed at reducing infant mortality rates have been the Sheppard-Towner Act of 1921 and the Back-to-Sleep campaign of 1994, both of which have been associated with reductions (19-21% and 50%, respectively) in rate of infant mortality (Ramirez & Malloy, 2013; Moehling, 2014). Research on the Back-to-Sleep campaign has shown that aside from providing education to pregnant and new mothers, staff must consistently demonstrate and inform parents of a singular message to achieve the best results (Harris, 2014; Moon, Kington, Oden, Iglesias, & Hauck, 2007). It is interesting to note in contrast to the effects of the Sheppard-Towner Act, Moon (2007) posited that a lack of uniform and informed education among physicians (via the Back-to-Sleep program) and cultural differences between medical personnel and African-American parents may explain the higher rate of infant mortality within this community. Harris (2007) also states that the current body of research has shown that the best opportunity to disseminate education is at birth, thus nurses, pediatricians, and physicians must stay appraised of the current body of research to best inform pregnant and new mothers. Please see Appendix B for more information on curriculum used by maternal and infant health programs.

Tier 2: Monitoring and Service Delivery

This second tier of this program evaluation examined the implementation of the program as it was defined during the first tier. This tier established client flow through the program, as well as how information is documented and how data are collected from program participants. The major components of evaluating monitoring and service delivery include:

- How do clients enter and exit the program?
- What are the patterns of service delivery? (Including timing, frequency, format, purpose, and attendance)
- Are services being implemented consistently by various providers with different clients?
- To what extent are clients following through with services and referrals?
- What data are collected?
- How are data entered and stored?
- Who enters data and when?

Client Flow from Referral to Intake to Close

Exhibit 10 depicts the 10 stages of a participant's path through SPHS, from program entry to the child's 2nd birthday.

Exhibit 10. Participant's Path through the South Phoenix Healthy Start Program

Service Delivery

Through direct services and community partnerships, SPHS provides families with:

- Perinatal case management services;
- Health education events and learning opportunities;
- Screening and referral; and
- Interconceptional continuity of care.

SPHS links women and families to community resources for services such as: job and educational assistance and training; nutrition assistance (e.g., WIC); smoking and other substance abuse cessation interventions; immunizations; food, housing, and transportation; child care; and counseling services.

Health Education, Prevention, and Health Promotion Services

The **preconception health** curriculum resources used is from the CDC's Preconception Health and Health Care Toolkit and resources from the website. The **prenatal curriculum** used is Partners for a Healthy Baby developed through Florida State University and Healthy Steps Enhancement PrePare program materials. The **postpartum/infant development** curriculum used is the Beginnings Guide developed by Linda Wollensen, RN MA and Dr. Sandra Smith, MPH. The standardized **parenting curriculum** used is the Triple P – Positive Parenting Program. **Fathers and male partner caretakers** will receive Men's Health Network and Library education modules. All participants' male partners/father of baby will receive individual and small group health education sessions outlined by evidence-based, standardized curriculum.

Individual prenatal and postpartum/infant health education are conducted during scheduled home visits. Supplemental or optional small group education sessions are held at various community based locations to meet the geographic or specific population needs i.e. at high schools for students, jails for incarcerated women, federally qualified health care centers and local health system clinics, family resource centers. Exhibit 11 outlines the topics covered during health education, the curriculum or materials used, staffing, and frequency. Please see Appendix B for more information about key maternal and infant health curricula.

Exhibit 11. SPHS Health Education Topics, Curriculum/Materials, Facilitator, and Frequency

Health Education Topics	Curriculum/Materials	Facilitated by	Frequency
Maternal Care			
Preconception Health and Reproductive Life Planning; including Family Planning	March of Dimes NC Preconception Health Campaign Activities	SPHS RNs; CHWs Health Educators	Quarterly community groups; third trimester; first postpartum visit
Fetal Alcohol Syndrome	CDC/ACOG Drinking and Reproductive Health Toolkit	Contracted certified childbirth educator and	Bi-annual community groups; preconception counseling session; postpartum
Prenatal Care	Partners for a Healthy Baby/Healthy Steps PrePare	Dancing for Birth Instructor	After and during prenatal provider visits; Centering beginning 2nd trimester in clinical satellites
Postpartum Care /Well Woman Oral Health Child Birth Education and Prenatal Fitness	Beginnings Guides A.T. Still School of Dentistry and Oral Health Perinatal Oral Health Toolkit Lamaze and Dancing for Birth	Contracted local representative of Arizona Postpartum Wellness Coalition	After postpartum provider visit
Perinatal Mood Disorders Breastfeeding	Postpartum Support International Toolkit	SPHS RN's CHWs certified as Lactation Counselors	Preconception counseling session, prenatal or postpartum visit
Infant Care			
Newborn Care Well Child Health and Immunizations Infant Development; Physical, Social/Emotional, Language and Learning, Cognition	Beginnings Guides	SPHS RN, CHW	Third trimester; within first two weeks of birth and subsequent visits following immunization schedule
Infant Nutrition and Baby food Making	WIC curriculum	CHW	Monthly during home visits
Safe Sleep Environment Infant/Toddler Home Safety Car Seat Safety	SUIDS/SIDS Training; AAP: Healthy Child Care America: HCCA Back to Sleep Campaign	Health Educators	Quarterly community groups; third trimester; during first postpartum visit and monthly

Health Education Topics	Curriculum/Materials	Facilitated by	Frequency
Scald Prevention	Maricopa Health Foundation Scald Prevention book and flashcards	CHW's Phoenix Children's Hospital/Injury Prevention	Third trimester; within first two weeks of birth and subsequent visits following immunization schedule
Infant/Child Oral Health	A.T. Still School of Dentistry and Oral Health Infant Oral Health Toolkit	CHW Health Educators Community Mobilizers	Third trimester; within first two weeks of birth and subsequent visits following immunization schedule
Family Care and Parenting			
Folic Acid	March of Dimes	SPHS RN CHW	Quarterly community groups; preconception counseling session; third trimester; first postpartum visit
Reproductive Health, HIV, STD's and Family Planning	ARHP Curricula Organizer for Reproductive Health Education (CORE)	SPHS RN CHW	
Self-Breast Exam	National Breast Cancer Foundation	SPHS RN	
Healthy Weight	Healthy Weight Matters	SPHS RN	
Smoking Cessation	Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) Program	SPHS RN SPHS Social Worker	
Managing Chronic Disease Sickle Cell Awareness	CDC materials: Preventing and Managing Chronic Disease to Improve the Health of Women and Infants	SPHS RN SPHS Social Worker	Monthly community based seminars and discussion groups. Quarterly community groups; preconception counseling session; first trimester
Bonding and Attachment Infant Mental Health and Adverse Childhood Experiences	Infant Toddler Mental Health Coalition of Arizona Curriculum	Infant Toddler Mental Health Coalition of Arizona; ACE Coalition reps	
Positive Parenting	Triple P	Certified Triple P Trainers/SPHS staff	
Reading to Your Baby	Little Reader Curriculum	CHW	

Health Education Topics	Curriculum/Materials	Facilitated by	Frequency
Healthy Relationships/ Prevalence of IPV and PPMD	Arizona Coalition To End Sexual and Domestic Violence	Staff/group facilitators	Quarterly community groups; on-going support groups
Life Skills			
Preparing a Budget Financial Planning Skills	Arizona Saves Financial Toolkit	Arizona Saves; local credit unions and financial institutions	Quarterly community based groups
Job Readiness Skills Continuing Your Education	Maricopa County Workforce Connection and Maricopa Skill Center curricula	Local workforce development agencies; community colleges and universities	Quarterly community based groups
Male Specific			
Male Health	Men's Health Library Men's Health Consulting's Health MENtor	RN's; CHW's Health Educator	Preconception counseling, during perinatal home visits
Father Identity Development	Fathers Matters Fathers Mentoring Fathers	Contracted male involvement and education agency	Quarterly community based groups
Court and Custody	Maricopa County Courts and Child Support Modules	DES Child Support, Family Law Attorneys	Quarterly community based groups
Financial Stability	Maricopa Workforce Connections modules	Local workforce development and local banking and financial institutions	Quarterly community based groups

Data Collection and Reporting Processes

SPHS has several data gathering and reporting applications. This section provides a summary of these applications, the application development history, and the opportunities for future data/reporting projects. Exhibit 12 presents a summary of the applications used by SPHS for data collection and reporting, the purpose, and the platform.

Exhibit 12. Data Collection and Reporting Applications, Purposes, and Platforms

Application	Purpose	Platform/comments
SPHS "web" case management	Collect client data. Document client progress using notes. Collect data for grantor reports.	Backend: SQL Server; front-end development in C# using Visual Studio (IDE). Accessed through the County intranet.
Healthy Start Reports	Provide reports: dataviews (spreadsheet format) and formatted reports.	Access 2010; "standalone" format (data and app in one file). Data refreshed from SQL Server daily.
Dashboard	Define services, goals and objectives and the progress towards these goals.	Public Health app. Third-party County contractor. Accessed through the internet.
Weekly Reporting	Provide client data to Case Managers in an Excel format.	MS Excel 2010.

Application Development History

SPHS's Information Management Analyst (IMA) developed the program's first relational database around nine years ago, using MS Access 2003. At the time the IMA used "replication" to allow for multiple users. In 2007, the application was redeveloped and the "replication" process was dropped. The application was split between a back-end (data) and front-end (user interface application) which were linked. This resulted in a more stable platform. However, MS Access does not work with the network structure at SPHS. This platform was adequate when there were only 4 to 5 users. When SPHS staff increased and the network (analog and digital) increased, Access was no longer a viable platform (the network connection includes both phone and data traffic). In early 2013, SPHS obtained funding for the development of a SQL Server based application. The IMA used the current database design, which reduced development costs. However, the IMA did not include a reports function within the application. The SQL Server platform has been very stable. The primary identified issues are the cost and delay time involved in making changes to the application.

When the new web application became available, SPHS developed a reporting application, Healthy Start Reports, which uses MS Access 2010. Even though Access does not work well at SPHS, this application is designed to be a "standalone" program with only single-

user access. The application (front-end) and the data (back-end) are in one file. The user copies the file from the network to their local (C :) drive and runs the application from the local drive. Access works fine from the local drive. The data in the application file on the network is refreshed manually by the IMA.

Data Collection and Entry

All staff members have access to the "web" application. They open the application and enter client data as needed. A few users are allowed to add a new client – which is in accordance with SPHS business rules. Case Managers also add notes, data about health topics discussed with the clients, a Woman's Health Questionnaire, Edinburgh data, goals, and appointments. Baby records associated with the client record are also added. Within the baby record, staff enter the baby demographic data, doula data, and ASQ data.

Reporting

Healthy Start Reports. The data for the Healthy Start Reporting application is refreshed daily from SQL Server, which is performed manually by the IMA. Key reports and data views include:

- Client data
- Grantor reporting: FTF and HRSA
- Missing data reports to aide in data review and data scrub activities

Monthly Spreadsheets. The SPHS Manager needs a data summary in order to complete the grantor reports for First Things First (FTF) and HRSA. Some of the data comes from the database and some data is not in the database. At the beginning of each month the IMA creates a dataview in the Healthy Start Reports application and exports this data to Excel spreadsheets. A spreadsheet is created for each Case Manager with data from SQL Server. It also has areas for the Case Manager to enter other data needed for the grantor reports. The IMA tallies the data from all of the spreadsheets. The tally is sent to the SPHS Manager who uses the data for the HRSA and FTF reports.

Weekly Case Manager Spreadsheets. On the network there are three Excel reports: Case Manager Weekly Report; Weekly Baby Data Report; and Client Contact List. The data in these reports are updated at the beginning of each week. The IMA runs three dataviews in the Healthy Start Reports application and exports the data to the Excel spreadsheets. The data for each Case Manager are on a separate worksheet tab. These reports are done for the convenience of the Case Managers who are not familiar with the Healthy Start Reports application and are more familiar with Excel.

Opportunities

Data Gathering/Reporting. At the beginning of this application development (9 years ago) the data gathering closely reflected the needs of the reporting requirements. As SPHS progressed, using Access, we could easily and inexpensively make changes and remain congruent. However as the Access platform became a problem due to an increased number of users and higher network traffic, more data gathering was done by hand or in other logs and documents.

The web application had been helpful in creating a stable platform for data gathering. However, it is costly in time and money to make updates when SPHS program reporting requirements change. In an attempt to narrow this expanding gap between the data gathering and reporting, the IMA has moved to using Excel reports to gather more data.

A strategy needs to be developed to allow a more nimble data gathering process that is more responsive to the needs of management and the grantors. After developing a strategy, one of the first projects should be an evaluation on how to update the web application to better meet the needs of management.

Data Gathering/Goals and Objectives. Last year Maricopa County Department of Public Health introduced the "Dashboard". This application documents the services, goals, and objectives for each program. The goals are measurable. The program staff enters data about the progress of each activity which measures the progress towards attaining the goal.

For Healthy Start the services, goals and objectives were defined. However, we found these did not match the data we gather in the web app. A decision needs to be made about whether to change the goals and objectives to meet the data gathering app (which is design is 9 years old) or fund an update the web app to meet the goals and objectives defined in the "Dashboard".

Along with a strategy to deal with the data gathering and reporting congruency SPHS also needs a strategy for the congruency between the data gathering and our goals and objectives.

Training. There are several training opportunities that need to be considered.

- New staff data entry orientation and training (how to use the web app)
- Written user documentation (consider using OneNote)
- Short data workshops on specific topics
- How to use your data for decision making activities

Collective Impact Evaluation

In January 2015, LeCroy & Milligan Associates discussed Collective Impact at the CAN meeting. Participants completed a group activity regarding the CAN's goals, assets, and measures, with the key results shown below.

The CAN members were asked what they think the CAN is working towards. A total of 14 groups and individuals responded to this question, with each person identifying one or more focus areas. Exhibit 13 shows the focus areas identified by respondents, ordered by the percentage of respondents from highest to lowest. The two most frequently given focus areas were improving maternal and child health outcomes (50%, 7) and creating partnerships/collaborations (43%, 6).

Exhibit 13. CAN Focus Areas

Focus Area	Number of Responses	%
Improve Maternal and Child Health (birth outcomes, infant mortality, maternal health)	7	50%
Create Partnerships/Collaborations	6	43%
Reach Community	3	21%
Decrease Disparities	2	14%
Target population is African Americans	2	14%
Decrease tobacco use	1	7%

(N=14)

CAN members are motivated to attend CAN meetings by seeing improvements in birth outcomes, and learning from CAN about healthy habits. Exhibit 14 shows a summary of the strengths/assets and challenges of the CAN, as identified by attending members.

Exhibit 14. Strengths, Assets, and Challenges of the CAN

Strengths and assets of the CAN	Challenges that the CAN must overcome
• Maricopa County Partnership/CAN; • Demonstrating progress made with families; • Providing community classes; • Having access to trained staff; • Forming formal partnerships; • Strong communication and outreach efforts; and • Ability to work with individual families.	• E-cigarettes; • Institutional racism; • Political will; • Mistrust in the community; • Lack of affordable healthcare; • Lack of funding; • Information sharing; and • Identifying community needs.

CAN members also provided information on the current data collected by the CAN, which are used to inform the CAN's outcome measures, and potential data collection strategies the CAN membership would consider adopting for enhanced outcome measurements. A summary of these measures are shown in Exhibit 15.

Exhibit 15. Current and Potential Data Collection for CAN Outcome Measures

Current data collected	Potential data to collect
Program level data	Identify location of where need is located
Information on outreach efforts	Shared data
Qualitative data	Participant stories of wrap around
Demographic data	Participant progress (ex. pre/posttest)
Information on the coalition (CAN)	Data on healthy relationships and families
Success stories	Long-term outcomes
Program exit survey	

Coordination and Collaboration Survey Findings

This section presents the findings of the Coordination and Collaboration Survey of the SPHS CAN. This survey was distributed in hard-copy at the April 2015 CAN meeting and through an online survey collector (Survey Monkey) in May 2015. A total of 30 members completed the survey (22 of whom completed it at the CAN meeting).

Participation and Roles of Survey Respondents

CAN membership includes individuals who have been a part of this consortium for both short- and long-term. The range of membership time spans from a new member to 12.5 years, with an average membership duration of 3 years, and median of 2.3 years. About 24% (5) of respondents have been a part of the CAN for one year or less; 52% (11) have been with the CAN for 1 to 3 years; and 24% (5) have been a part of the CAN for 4 or more years. Respondents have attended between one (this was their first meeting) and 120 CAN meetings, with an average of 16.5 meetings and median of 10 meetings.

Exhibit 16 shows the positions or titles represented by survey respondents. Respondents have worked at their position for a wide range of time, from one month to 12.5 years, an average of four years and median of 2.5 years (N=26).

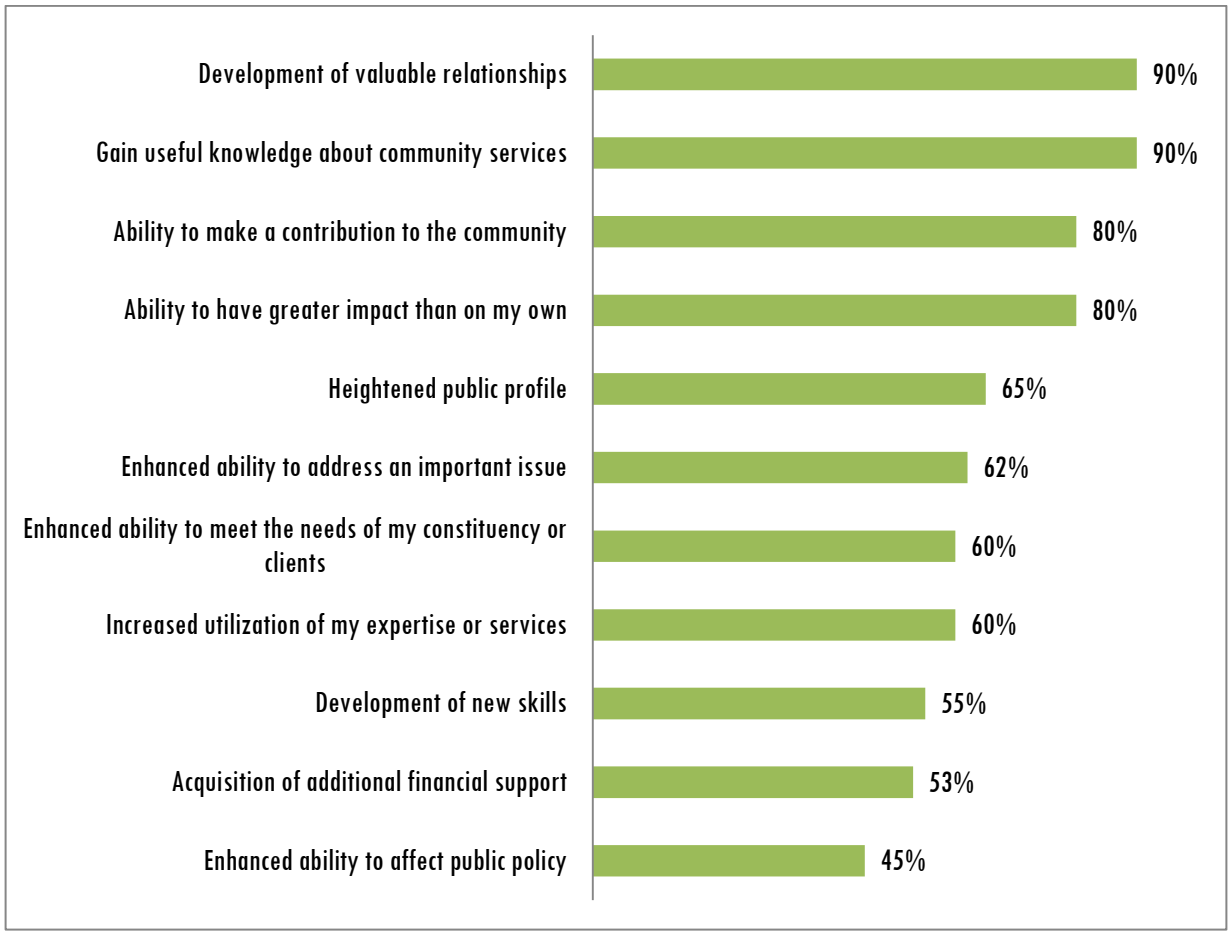
Exhibit 16. Positions/Titles Represented by Survey Respondents

Position/Title	N
Community Health Worker	9
City of Phoenix, Housing Department, Supportive Services Program Coordinator	2
Registered Nurse/Supervisor	2
Administrative Assistant	1
Care Coordinator	1
Case Manager	1
Community Experience Partner	1
Development Director	1
Education and Prevention Administrator	1
Executive Director	1
Health Net Access / Community Outreach and Education	1
Maricopa County Outreach Specialist/WIC Educator	1
Maternal and Child Health Coordinator	1
Outreach Specialist	1
Pediatric Care Coordinator	1
Program Director	1
Community Development Manager	1
Social Worker/Supervisor	1
Not Reported	2
Total N	**30**

Benefits of Participating in the CAN

Exhibit 17 shows a summary of the benefits respondents have received as a result of CAN membership (note: the number of people who responded to this set of questions varies from 19 to 21). A strong majority of 90% (18) of survey respondents feel they benefit from the CAN by **developing valuable relationships with colleagues** and **gaining useful knowledge about community services, programs, or people**. Additionally, 80% (16) feel they benefit by having an enhanced ability to make a contribution to the community and having a greater impact by working as a collaborative rather than as individual agencies. The three areas that the lowest percentage of members rated as a benefit to participation include: the development of new skills (55%, 11); acquisition of additional financial support (53%, 10); and enhanced ability to affect public policy (45%, 9).

Exhibit 17. Benefits of Participating in the SPHS CAN

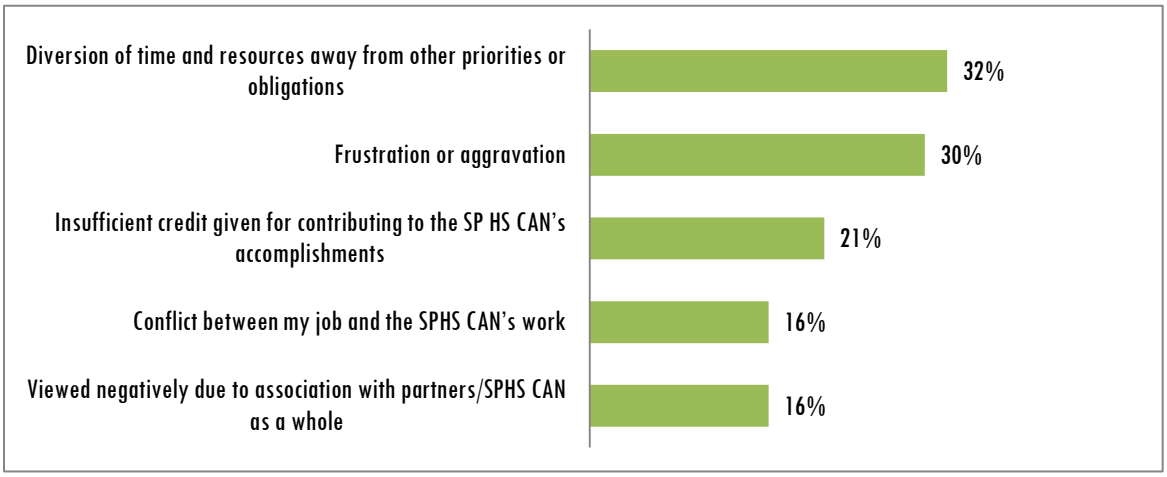


(N varies from 19 to 21)

Drawbacks of Participation in the SPHS CAN

Exhibit 18 shows a summary of the drawbacks that respondents have experienced as a result of SPHS CAN membership (note: the number of people who responded to this set of questions varies from 19 to 20). The most common drawbacks reported by respondents is the diversion of time and resources away from other priorities or obligations (32%, 6) and feeling frustrated or aggravated (30%, 6). Additionally a few respondents, 21% (4), feel that insufficient credit has been given for their contributions to the CAN and 16% (3) each have experienced a conflict between their job and the CAN's work and feel they are viewed negatively due to association with the CAN.

Exhibit 18. Drawbacks of Participating in the SPHS CAN

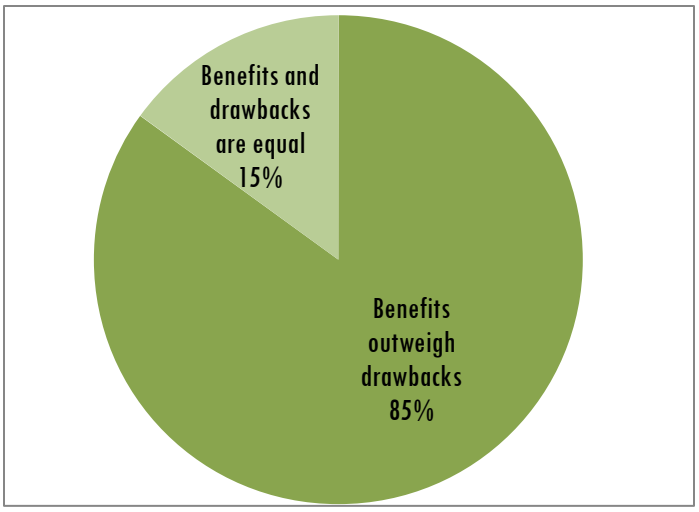


(N varies from 19 to 20)

Benefits versus Drawbacks of Participation

As shown in Exhibit 19, the majority of survey respondents (85%, 17) feel that benefits gained from participating in the SPHS CAN outweigh any drawbacks; 15% (3) rated the benefits and drawbacks as equal (N=20; 10 people did not answer this question).

Exhibit 19. Benefits versus Drawbacks of Participating in the SPHS CAN



Factors that Foster Successful Collaboration of the CAN

The quality of inter-professional collaboration that takes place within an alliance has a profound effect on overall performance. Woodland and Hutton (2012) recommend that strategic alliances periodically self-evaluate according to "success factors." These success factors build stakeholder capacity for effective and efficient collaboration, which are the building blocks of overall performance. The Wilder CFI instrument was adapted for this study to assess the elements of effective collaboration organized within 15 factors (Mattessich, Murray-Close, & Monsey, 2001). Success factor scores were interpreted according to the developer's guidelines:

1.0-2.9 – The success factor is of concern and should be addressed
3.0-3.9 – The success factor may require attention
4.0-5.0 – The success factor shows strength and does not need special attention

Exhibit 20 shows survey respondent ratings for the 15 success factors, determined by averaging scores for each item within each factor. A positive finding is that none of the success factors received scores in the 1.0-2.9 range, indicating that members do not feel strongly that the success factors are of concern and should be addressed. Members rated 11 of the 15 success factors as strengths of the MCR Alliance that do not need special attention, with average ratings ranging from 3.4 to 4.0.

Strengths of the CAN. The area of "mutual trust and respect" achieved the highest average rating of 4.0, indicating that this factor is a strength of the CAN and does not need special attention. The 14 remaining success factors fell within the 3.4-3.9 range, suggesting that these factors may require attention. Within this grouping, areas that scored the highest average rating of 3.9 include:

- Shared vision
- Flexibility
- Adaptability
- Appropriate cross section of members
- Ability to compromise

Exhibit 20. Success Factor Summary Statistics

Guideline	Success Factor	Mean Rating	Std. D	Min. Rating	Max. Rating	N
Success factors show strength and do not need special attention	Mutual respect, understanding, and trust	4.0	.798	2.0	5.0	30
Success factors may require attention	Shared vision	3.9	.712	2.0	5.0	28
	Flexibility	3.9	.733	1.5	5.0	29
	Adaptability	3.9	.672	2.0	5.0	28
	Appropriate cross section of members	3.9	.926	2.0	5.0	30
	Ability to compromise	3.9	.776	2.0	5.0	30
	Unique purpose	3.8	.681	2.5	5.0	28
	Members share a stake in both process and outcome	3.8	.869	2.0	5.0	30
	Favorable political and social climate	3.8	.838	1.0	5.0	30
	Established informal relationships and communication links	3.8	.751	2.0	5.0	28
	Concrete goals and objectives	3.8	1.110	1.0	5.0	28
	Seen as a legitimate leader in the community	3.6	.773	2.0	5.0	30
	Appropriate pace of development	3.5	.776	2.5	5.0	28
	Development of clear roles and policy guidelines	3.5	.948	1.5	5.0	28
	Multiple layers of participation	3.4	.845	2.0	5.0	30

Opportunities for Improvement. The four areas that received the lowest average rating, ranging from 3.6 to 3.4, include:

- Seen as a legitimate leader in the community
- Appropriate pace of development
- Development of clear roles and policy guidelines
- Multiple layers of participation

Exhibit 21 depicts the survey items that comprise the factor of "Seen as a legitimate leader in the community," which received an average rating of 3.6 out of 5.0. Of the two items measured for this success factor, the item that brought down the average rating overall was "Leaders in the community who are not part of this SPHS CAN seem hopeful about what this Collaborative can accomplish." While 47% (14) of survey respondents agreed or strongly agreed that community leaders who are not part of the CAN seem hopeful about what this collaborative can accomplish, 47% (14) were neutral in opinion and 7% (2) disagreed. For the second item that makes up this success factor, 14% (4) disagreed and 17% (5) were neutral regarding "Others (in the community) who are not a part of the SPHS CAN would generally agree that the organizations involved in the SPHS CAN are the 'right' organizations to do this work. These findings suggest that many CAN members are not aware of how this collaborative is perceived by other leaders in the community.

Exhibit 21. Survey Items Measuring the Success Factor: Seen as a Legitimate Leader in the Community

Seen as a legitimate leader in the community	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n
Leaders in the community who are not part of this SPHS CAN seem hopeful about what this Collaborative can accomplish.	0%	7% (2)	**47% (14)**	37% (11)	10% (3)	30
Others (in the community) who are not a part of the SPHS CAN would generally agree that the organizations involved in the SPHS CAN are the "right" organizations to do this work.	0%	**14% (4)**	17% (5)	48% (14)	21% (6)	29

Exhibit 22 shows the survey items that comprise the factor of "Appropriate pace of development," which received an average rating of 3.5 out of 5.0. While 47% (13) of survey respondents agreed or strongly agreed that "the CAN has tried to take on the right amount of work at the right pace," a high proportion of respondents have a neutral opinion (43%,

12) and a few disagree (11%, 3). Likewise, over a third of members are neutral and 11% (3) disagree that "The SPHS CAN is currently able to keep up with the work necessary to coordinate all of the people, organizations, and activities involved." These findings suggest that many members are ambiguous as to whether or not the CAN is operating at an appropriate pace of development.

Exhibit 22. Survey Items Measuring the Success Factor: Appropriate Pace of Development

Appropriate pace of development	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n
The SPHS CAN has tried to take on the right amount of work at the right pace.	0%	11% (3)	**43% (12)**	36% (10)	11% (3)	28
The SPHS CAN is currently able to keep up with the work necessary to coordinate all of the people, organizations, and activities involved.	0%	11% (3)	**36% (10)**	39% (11)	14% (4)	28

Exhibit 23 shows the two items that comprise the success factor of "Development of clear roles and policy guidelines," which received an average rating of 3.5 out of 5.0. Half or slightly more than half disagreed or were neutral in opinion to each of the items shown in Exhibit 23. While half of respondents agreed that CAN members have a clear sense of their roles and responsibilities, but 36% (10) were neutral, 11% (3) disagreed, and 4% (1) strongly disagreed with that statement. Almost a third (32%, 9) of survey respondents were neutral with whether there was a clear process for decision making, and 21% (6) disagreed that a clear process exists.

Exhibit 23. Survey Items Measuring the Success Factor: Development of Clear Roles and Policy Guidelines

Development of clear roles and policy guideline	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n
People in the SPHS CAN have a clear sense of their roles and responsibilities.	4% (1)	**11% (3)**	36% (10)	29% (8)	21% (6)	28
There is a clear process for making decisions among the SPHS CAN.	0%	**21% (6)**	32% (9)	29% (8)	18% (5)	28

Exhibit 24 shows the survey items that comprise the factor of "Multiple layers of participation," which received the lowest average rating of 3.4 out of 5.0. For both items, half or more than half of respondents reported neutral or disagreeing opinions regarding the types of people participating in the CAN and its impact on decision-making and organizational representation.

Exhibit 24. Survey Items Measuring the Success Factor: Multiple Layers of Participation Success Factor

Multiple layers of participation	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n
When the SPHS CAN makes major decisions, there is always enough time for members to take information back to their organizations to confer about what the decision should be.	3% (1)	**20% (6)**	**27% (8)**	40% (12)	10% (3)	30
Each person who participates in decisions of the SPHS CAN can speak for the entire organization they represent.	0%	**13% (4)**	**40% (12)**	33% (10)	13% (4)	30

Partnership Self-Assessment of Collaboration

Exhibit 25 summarizes the Alliance members' perceptions about seven aspects of partnership measured on the PSAT instrument: 1) levels of efficiency; 2) quality of leadership; 3) how well administrative and managerial tasks are handled; 4) level of synergy among members; availability of 5) financial and 6) non-financial resources; and 7) decision-making capacity (Center for the Advancement of Collaborative Strategies in Health, 2006; Weiss, Miller Anderson & Lasker, 2002). Following the authors' recommendations, guidelines for interpreting scores include:

4.5-5.0 – **Target Zone**: currently excels
4.0-4.4 – **Headway Zone**: doing pretty well; potential to progress
3.0-3.9 – **Work Zone**: more effort is needed to maximize potential
1.0-2.9 – **Danger Zone**: this area is in need of a lot of improvement

Exhibit 25 shows the PSAT average ratings for the seven aspects of partnership. It should be noted that people who opted out of answering these questions or indicated that they "don't know" were excluded from mean computations. All areas measured were rated by members as within the guideline of the "work zone," indicating that more effort is needed within the CAN to maximize the partnership's potential. The two areas of partnership that received the highest average ratings include: financial and other capital resources and non-

financial resources. However, it should be noted that half of survey participants (n=15) did not respond to the questions regarding financial and other capital resources, which indicates that many members are not aware of the CAN's status regarding money, space, and equipment and goods.

Exhibit 25. Self-Assessment of Collaborative Processes

Guideline	Partnership Aspect	Mean Rating	Std. D	Min. Rating	Max. Rating	N
Work Zone: more effort is needed to maximize potential	Financial and Other Capital Resources	3.9	.831	2.7	5.0	15
	Non-Financial Resources	3.9	.840	2.0	5.0	24
	Synergy	3.8	.912	1.6	5.0	26
	Efficiency	3.7	1.052	2.0	5.0	24
	Leadership	3.7	.926	1.6	5.0	27
	Administration and Management	3.4	1.075	1.5	5.0	25
	Decision-Making	3.4	1.393	1.0	5.0	20

The two areas that received the lowest average rating of 3.4 out of 5.0 include "administration and management" and "decision-making." The survey items comprising each area are shown in Exhibits 25 and 26, respectively. While respondents who indicated they "don't know" were excluded from average computations shown above, for the purposes of further examining the data, the "don't know" response category is shown as part of the total percentage in the tables below.

Exhibit 26 shows members' effectiveness ratings for the SPHS CAN's administrative and management activities. Within each row, noteworthy findings that demonstrate areas of strength, opportunities for improvement, or member ambiguity are in bold and underlined font. Three **strengths of the CAN's administrative and management**, which received a high percentage of **"excellent" ratings** include:

- Minimizing barriers to participation in meetings and activities;
- Applying for an managing grant funds; and
- Preparing materials that inform partners and help them make timely decisions.

Five areas that received a high proportion of "**don't know" ratings**, and suggest **opportunities for which the CAN leadership may clarify and/or increase transparency** to members include:

- Applying for and managing grant funds;
- Performing administrative duties;
- Coordinating communication with people and organizations outside the SPHS CAN;
- Providing orientation to new partners as they join the SPHS CAN; and
- Evaluating the progress and impact of the SPHS CAN.

Finally, four areas that received a higher percentage of "**poor" or "fair" ratings**, and suggest **opportunities for improvement** include:

- Coordinating communication among partners.
- Providing SPHS program-level updates to the SPHS CAN.
- Evaluating the progress and impact of the SPHS CAN; and
- Providing orientation to new partners as they join the SPHS CAN.

Exhibit 26. Effectiveness Ratings for the SPHS CAN's Administrative and Management Activities

Administration and Management	Poor	Fair	Good	Very Good	Excellent	Don't Know	n
Minimizing barriers to participation in the SPHS CAN's meetings and activities (e.g., holding at convenient places and times).	4% (1)	4% (1)	36% (9)	8% (2)	**40% (10)**	8% (2)	25
Applying for and managing grants and funds.	0%	12% (3)	23% (6)	8% (2)	**27% (7)**	**31% (8)**	26
Preparing materials that inform partners and help them make timely decisions.	4% (1)	23% (6)	19% (5)	12% (3)	**23% (6)**	19% (5)	26
Organizing SPHS CAN activities, including meetings and projects.	4% (1)	15% (4)	**35% (9)**	23% (6)	19% (5)	4% (1)	26
Performing administrative duties.	4% (1)	12% (3)	23% (6)	15% (4)	19% (5)	**27% (7)**	26
Coordinating communication among partners.	4% (1)	**19% (5)**	27% (7)	23% (6)	15% (4)	12% (3)	26
Providing SPHS program-level updates to the SPHS CAN.	4% (1)	**27% (7)**	31% (8)	15% (4)	15% (4)	8% (2)	26
Evaluating the progress and impact of the SPHS CAN.	**15% (4)**	8% (2)	23% (6)	15% (4)	15% (4)	**23% (6)**	26
Coordinating communication with people and organizations outside the SPHS CAN.	0%	19% (5)	31% (8)	8% (2)	15% (4)	**27% (7)**	26
Providing orientation to new partners as they join the SPHS CAN.	**19% (5)**	12% (3)	23% (6)	8% (2)	15% (4)	**23% (6)**	26

Exhibit 27 shows member ratings regarding decision-making. Almost a third of respondents said the survey items on decision-making were "not applicable" to them, suggesting that they don't participate in the decision-making of the CAN. Of those who do participate, **56% (14) said they support the decision made by the SPHS CAN "most of the time" to "always."** Three people in total rated their support level as "sometimes" to "never" supporting the decisions of the CAN.

Regarding the decision-making process, **40% (10) combined said they "never" or "rarely" feel left out of making decisions.** However **16% (4) feel they are "sometimes" and 12% (3) feel they are "always" left out of the decision-making process**. A similar split was observed for those who elect to not participate in the CAN's decision-making process; 26% (9) "never" or "rarely" opt out, while 12% "sometimes" and 24% (6) opt out "most of the time" to "always."

Exhibit 27. Survey Items Measuring Decision-Making

Decision-Making	Never	Rarely	Sometimes	Most of the Time	Always	Not Applicable	n
Support the decisions made by the SPHS CAN?	4% (1)	4% (1)	4% (1)	**16% (4)**	**40% (10)**	**32% (8)**	25
Feel that you have been left out of the decision-making process?	**16% (4)**	**24% (6)**	16% (4)	0%	12% (3)	**32% (8)**	25
Elect not to participate in the decision-making process of the SPHS CAN?	**20% (5)**	**16% (4)**	12% (3)	4% (1)	**20% (5)**	**28% (7)**	25

Satisfaction with the SPHS CAN

Exhibit 28 shows members' satisfaction ratings given for the SPHS CAN. **Overall, the majority of respondents (65% to 79%) are "mostly" to "very satisfied" with the five areas measured.** Members are most satisfied with the way the people and organizations in the SPHS work together, with 79% (18) reporting feeling "mostly" to "very satisfied." Furthermore, almost three-quarters of members (74%, 17) are "mostly" to "very satisfied" with their role and their influence in the SPHS CAN. Two areas where a few people expressed lower levels of satisfaction are the CAN's plans for achieving its goals and the way the CAN is implementing those plans.

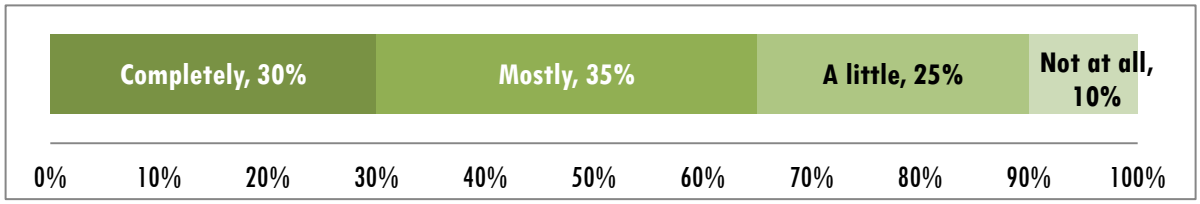
Exhibit 28. Members' Satisfaction Ratings of the SPHS CAN

Please indicate how satisfied you are with:	Not Satisfied	A little	Somewhat	Mostly	Very Satisfied	No Opinion	n
The way the people and organizations in the SPHS CAN work together.	0%	0%	9% (2)	**35% (8)**	**44% (10)**	13% (3)	23
Your role in the SPHS CAN.	0%	0%	9% (2)	**35% (8)**	**39% (9)**	17% (4)	23
Your influence in the SPHS CAN.	4% (1)	0%	4% (1)	**39% (9)**	**35% (8)**	17% (4)	23
The SPHS CAN's plans for achieving its goals.	4% (1)	0%	9% (2)	**35% (8)**	**35% (8)**	17% (4)	23
The way the SPHS CAN is implementing its plans.	4% (1)	0%	**13% (3)**	**30% (7)**	**35% (8)**	17% (4)	23

Evaluating the Collective Impact of SPHS CAN

Respondents gave mixed reviews regarding their understanding of the collective impact model. Exhibit 29 shows that while 65% (13) mostly to completely understand this model, 35% (7) a little to no understanding of this model.

Exhibit 29. Members' Satisfaction Ratings of the SPHS CAN

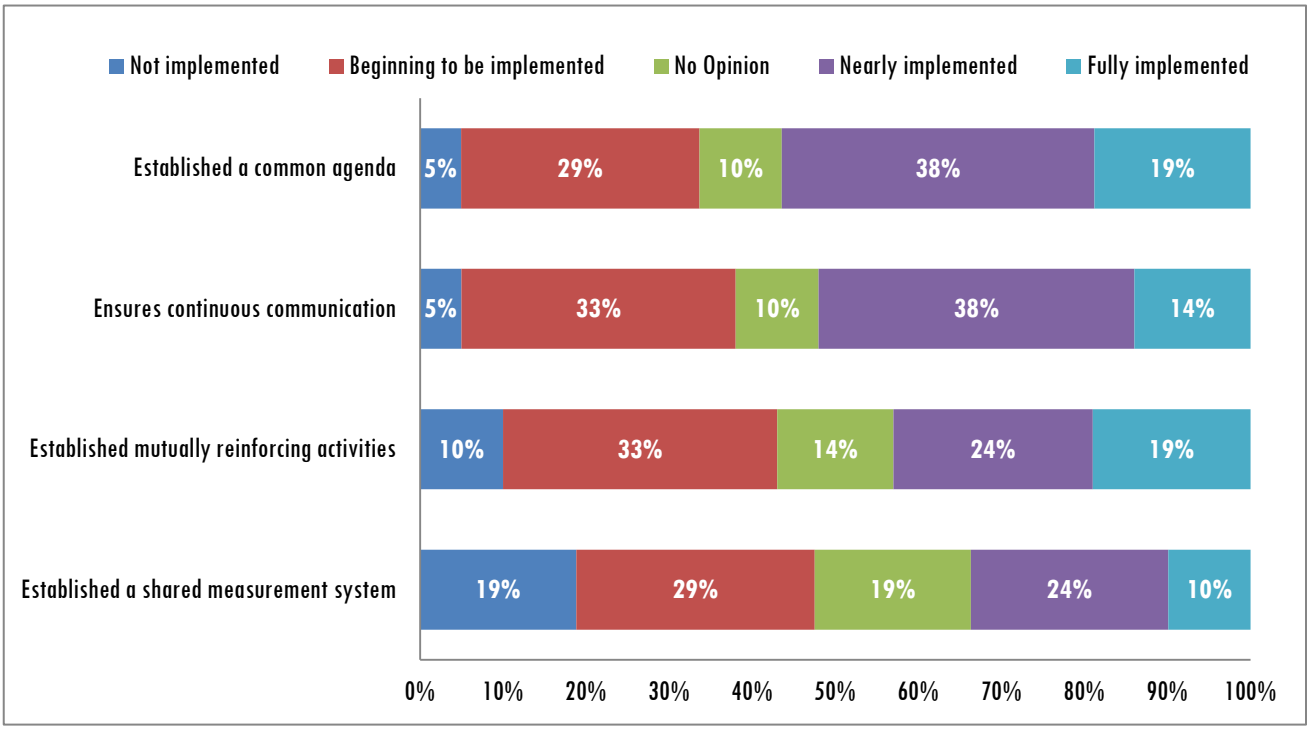


(N=20)

Respondents were asked to describe the extent to which four collective impact constructs are being implemented through the SPHS CAN, using a five-point scale from "not" implemented" to "fully implemented." Exhibit 30 shows that there is a split in opinion regarding the stage of the CAN's implementation for all constructs measured.

- Constructs that **over half of respondents feel are "nearly" to "fully" implemented are establishing a common agenda** (a shared vision for change, a common understanding of a particular problem, and a joint approach to solving the problem) (57%, 12) and **ensuring continuous communication** (across stakeholders to build trust and assure mutual objectives) (52%, 11).
- On the other hand, constructs that **over a half to nearly two thirds of respondents rated as "not implemented," "beginning to be implemented," or "no opinion"** include establishing **mutually reinforcing activities** (through a shared work plan) and having a **shared measurement system** (to ensure data is collected consistently across all SPHS CAN members and that data efforts remain aligned).

Exhibit 30. Extent that the SPHS CAN is Implementing Collective Impact Constructs

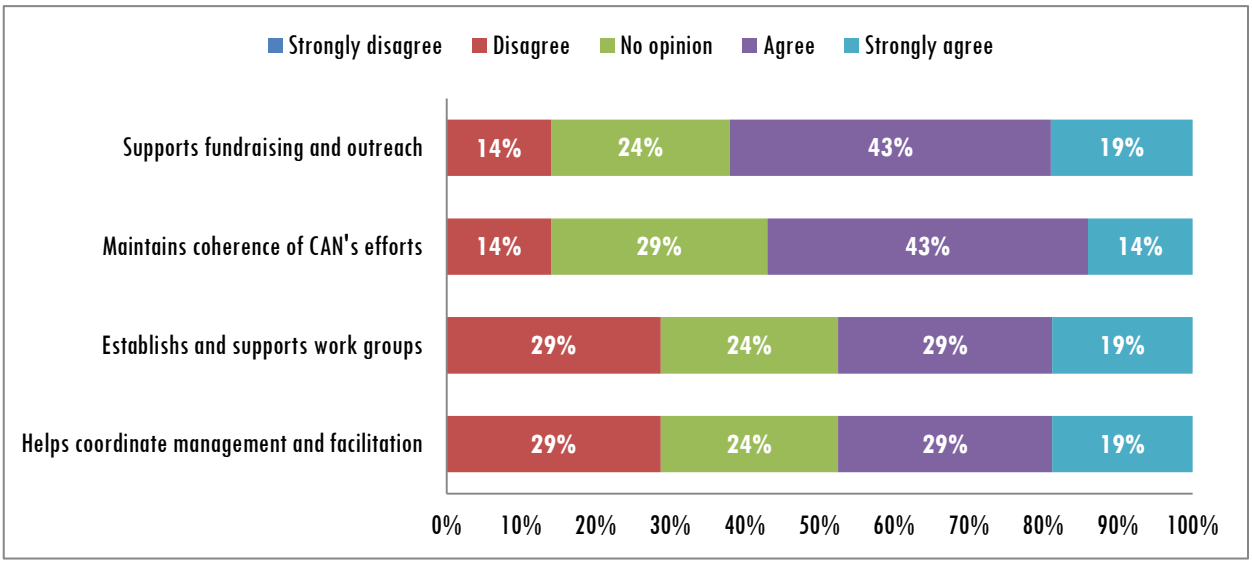


(N=21)

Evaluating the SPHS Program as the Backbone Organization of the CAN

Under the **collective impact framework**, the SPHS program as the backbone organization is responsible for strategic coordination, operations management, and implementation of the collaborative work of the CAN. Exhibit 31 shows members' agreement ratings on the extent to which the SPHS program has completed the four overarching backbone organization objectives (per the collective impact model). It should be noted that roughly a quarter of respondents (N ranges from 5 to 6) held "no opinion" regarding SPHS as a backbone organization of the CAN, which suggests an opportunity to improve members' knowledge and understanding of the SPHS program's role within the CAN.

Exhibit 31. Agreement that the SPHS Program Meets the Backbone Organization Objectives



(N=21)

- Nearly two-thirds of respondents (62%, 13) "agreed" or "strongly agreed" that the **SPHS program supports the fundraising and outreach efforts** of the CAN. Examples of this construct include: engaging with and/or facilitating community engagement with a broader audience, as appropriate; developing external communication materials and a comprehensive community engagement and communication plan; coordinating with other major initiatives in the community to minimize redundancies; and developing a plan for on-going funding.
- Over half (52%, 12) "agreed" or "strongly agreed" that the **SPHS program maintains the coherence of the CAN's efforts**. Examples of this construct include: encouraging sharing of best practices among the CAN members; coordinating activities currently underway; and monitoring and enabling easy dissemination of a common agenda.

- The two areas in which the highest percentage (29%, 6) of respondents "disagreed" is the **SPHS program's establishment and support of CAN work groups** and **helping to coordinate the management and facilitation** of the CAN. Examples of the work groups construct include: establishing work groups and work group goals; refining goals with work group co-chairs; and assisting co-chairs to develop meeting materials. Examples of the coordination and management construct include: following-up and managing next steps that come out of work group meetings, as necessary; and summarizing meeting notes and next steps. While a few people disagreed, a positive finding is that none of the survey respondents "strongly disagreed" that the SPHS program is meeting the backbone organization objectives.

Recommendations for Improving the SPHS CAN

Six members provided the following recommendations as ways to continue improving the SPHS CAN and the collective impact process.

- *"[It] would be good to have more medical professionals [represented] in the CAN."*
- *"The consortium [is] not fully engaged formally with [collective impact] activities [but] will be transforming and focusing more on collective impact."*
- *"I believe there should be more structure as to [CAN] activities, concerns, and plans to [address] those concerns. More connectedness from one month to the next. More structure."*
- *"I believe the hiring of the CAN coordinator has been a great decision and probably the solution to start the CAN moving in the right direction in the community."*
- *"I believe that South Phoenix Healthy Start is an excellent agency dedicated to their mission and always willing to work with other agencies. As a partner where they use [our facility] space, I see that their program, events, and meetings are always very well attended. I believe this program has a unique ability to work with their target population!"*
- *"I really enjoy attending this meeting and it is beneficial to my agency."*

Recommended Evaluation Strategies

The fifth program outcome of SPHS is to increase accountability through quality improvement, performance monitoring, and evaluation. This program outcome is addressed by employing an evaluation team comprised of external (LeCroy & Milligan Associates) and internal (a recently hired staff person) evaluators. LeCroy & Milligan Associates was recently awarded an extension of our evaluation contract for the time frame of 6/1/2015-12/31/2015. We recommend that the SPHS program and the internal evaluator consider this proposed evaluation plan, to ensure that the program documents progress in achieving the four program outcomes related to individual and community-level impacts:

1) Improving women's health;
2) Promoting quality services;
3) Strengthening family resilience; and
4) Achieving collective impact.

Appendix C shows a comprehensive list of required (per Healthy Start grant funding) and recommended (by the evaluation team and TOC Mapping process) evaluation measures for SPHS.

Process Evaluation

The evaluation team recommends that evaluation activities continue to monitor the data collected as part of Tiers 1 and 2, specifically client demographic data; the program's TOC Maps and logic model; client flow through the program, including referral sources, service delivery and utilization, and exit reasons. Periodic collection and review of these data elements will enable the external and internal evaluation team to monitor the extent that SPHS serves the target population, as intended, and will document any changes in program implementation or service utilization that may occur as the program grows.

Tier 3: Understanding and Refining

The third tier is the final step in preparing for evaluating objectives and outcomes. During this time, information from the previous two tiers of the evaluation will be synthesized collaboratively by the external and internal evaluation team. From the lessons learned during these first two tiers, recommendations will be made and implemented in Tier 3. As part of Tier 3, LeCroy & Milligan Associates proposes to work with the internal evaluator of SPHS to review data collection instruments, processes, and database systems at the onset of our continued contract. Exhibit 32 shows the evaluation questions, data sources, and

analytic methods for Tier 3. The major components of understanding and refining the program include:

- Refining data collection tools and processes;
- Determining program satisfaction and making appropriate recommendations; and
- Identifying other areas of program strengths and opportunities for improvement.

Exhibit 32. Tier 3 Evaluation Questions, Data Sources, and Analytic Methods.

Evaluation Question	Data Source	Analytic Methods
What data collection tools are necessary for evaluation?	Program materials	Qualitative
Are participants satisfied with program services and experiences?	Program participants	Qualitative, descriptive
What are other program areas of strength and opportunities for improvement?	Program staff in collaboration with the evaluation team	Qualitative

Outcome Evaluation

Tiers 4-5: Measuring Objectives and Outcomes

The final tiers of the program evaluation involve determining the best way to document program performance in relation to objectives or short- and long-term outcomes (Exhibit 32). The outcome evaluation will allow SPHS to monitor intended outcomes and examine the relationships between select variables; e.g., assessing the relationship between exposure to the program intervention (independent variable) and progress on outcome measures (dependent variables). Given the resources available for this evaluation, it is assumed that a quasi-experimental design will be implemented using multiple methods of data collection and analyses. The major components of measuring objectives and outcomes of the program include:

- Determining an evaluation design appropriate for the program, population, and indicators;
- Collecting relevant data;
- Analyzing data; and
- Reporting and disseminating evaluation findings, including recommendations, to program staff, stakeholders, and program participants.

Exhibit 33 presents a set of program evaluation questions that, if data is available and suitable for analyses, can help to explain the outcomes of SPHS services.

Exhibit 33. Tiers 4-5 Evaluation Questions, Data Sources, and Analytic Methods

Evaluation Question	Data Sources	Analytic Methods
(1) Is SPHS reaching the most vulnerable African American women in the service area?	County, local level health administrative data sets that collect information on: socio-demographics, prenatal care adequacy, smoking, drug use, pregnancy history, and birth outcomes. Other psychosocial and or chronic disease data as available. May require data linkage in order to capture the most relevant variables for the study.	Cross tabulation and comparison of risk characteristics of those served by SPHS and those not served by SPHS. May include a third comparison of those not served by SPHS and served by another similar type program.
(2a.) Do SPHS participants utilize more maternal and infant care health care than similar women and infants not served by SPHS? (2b.) Does participation in SPHS, accounting for program timing and dosage, reduce the risk for low birth weight and preterm birth, particularly among women who are at greatest risk for adverse outcomes?	County, local level health Medicaid / ACCESS administrative data sets that collect information on: socio-demographics, prenatal care adequacy, smoking, drug use, pregnancy history, and birth outcomes. Other psychosocial and or chronic disease data as available. May require data linkage in order to capture the most relevant variables for the study.	Data, including birth records, Medicaid claims, and monthly program participation, extracted from County / State Agency administrative data sets. Participants include pregnant women who had a Medicaid-insured singleton birth within a specific time period. The SPHS participants could be propensity score-matched with nonparticipants based on demographics, previous pregnancies, socioeconomic status, and chronic disease.
(3) Is SPHS achieving program objectives? (e.g., are parents receiving sufficient support to keep their families healthy and safe? Are parents demonstrating behavior changes indicating that the program has had its intended effect?)	Program staff, client data, may include: Risk Assessment Tool, Safety Checklist, Women's Health Questionnaire, and newly selected measures.	Quantitative/ Qualitative
(4) Is there a relationship between utilization of program services and select client outcomes?	Program staff, client data	Quantitative / Qualitative

Evaluation Question	Data Sources	Analytic Methods
(5) What changes do clients experience during program implementation, immediately after, and one year after completing the program?	Client data	Quantitative/ Qualitative
(6) How do SPHS mothers perceive the type of help they receive? • Are there any differences based on mother, family characteristics? • Are there any difference based on types of services provided / utilized?	Client Self Report/Interviews Data is collected within one month of program enrollment and then again at approximately 12 – 15 months after birth.	Qualitative Analyses
(7) What program level changes or improvements can be made based on the findings?	Program staff and Advisory Council in collaboration with the evaluation team	Quantitative/ Qualitative
(8) What program components are worthy of replication?	Client data	Quantitative/ Qualitative
(9) Is SPHS on track in its sustainability plan?	Program staff, client data	Quantitative/ qualitative

Collective Impact Evaluation

The next proposed stage of collaborative impact evaluation will help the CAN determine what action steps are necessary to carry out its work. Subsequently, a final stage is to determine the community-level impacts of the work of the CAN. The major components of evaluating collective impact in the beginning stages of the CAN include:

- Determining the stage of development of the CAN;
- Identifying the CAN's desired outcomes and associated indicators;
- Defining the scope and focus of the evaluation;
- Collecting relevant data; and
- Reporting findings and lessons learned, including recommendations.

Exhibit 34 on illustrates various suggested evaluation questions related to the five core conditions for collective impact.

Exhibit 34. Collective Impact Conditions and Suggested Evaluation Questions with Related Indicators

Collective Impact Core Condition and Definition	Suggested Evaluation Questions	Potential Indicators of Success
Common Agenda: A shared vision with common understanding of the issue(s) working in an agreed upon joint approach. The three strategies are realized as a collective effort.	To what extent do the Consortium partners have a shared vision for change?	▪ Members of the target population help shape the agenda ▪ Geographical boundaries and target populations are clear for all partners ▪ Partners use data to inform selection of strategies and actions
Backbone Infrastructure: Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies.	Has the Consortium established an effective backbone infrastructure and governance structure?	▪ A steering committee has been established that includes diverse members and perspectives from relevant sectors ▪ Backbone staff are respected by important partners and external stakeholders
	To what extent and in what ways does the backbone infrastructure provide the leadership, support, and guidance partners need to do their work as planned?	▪ The backbone infrastructure convenes partners and key external stakeholders to ensure alignment of activities and pursue new opportunities ▪ The steering committee regularly reviews data from the shared measurement system on progress toward goals and uses it to inform strategic decision-making
	To what extent and in what ways does the backbone infrastructure engage community members and other key stakeholders to ensure broad-based support for the Consortium?	▪ There is a perceived sense of urgency and a call to action among targeted audiences

Collective Impact Core Condition and Definition	Suggested Evaluation Questions	Potential Indicators of Success
Mutually Reinforcing Activities: Activities are differentiated amongst the partners and still coordinated through a mutually reinforcing plan of action.	To what extent and in what ways are Consortium partners' activities differentiated, while still coordinated through a mutually reinforcing plan of action?	▪ An action plan specifies activities that different partners have committed to implementing ▪ Working groups (or other collaborative structures) are established to coordinate activities in alignment with the plan of action
Shared Measurement: Collect data and measure results consistently across all partners in the effort. While acknowledging the need for and utilization of existing evaluation activities unique to some programming. Shared measurement results in new learning and new, more effective interventions for those served.	To what extent and in what ways are partners engaged in using the shared measurement system?	▪ Partners understand the value of the shared measurement system ▪ Partners understand how they will participate in the shared measurement system ▪ Partners agree to a data sharing agreement that supports ongoing collaboration
	To what extent and in what ways does the shared measurement system's design and implementation support learning?	▪ The system includes a common set of indicators and data collection methods that can provide timely evidence of progress toward the collective impact initiative's outcomes ▪ Partners share lessons learned and how these lessons inform their practice
Continuous Communication: Communicate to build trust and assure mutual objectives.	To what extent and in what ways does communication help to build trust, assure mutual objectives, and create common motivation?	▪ Regular meetings are held where members actively participate ▪ The Consortium engages external stakeholders in regular meetings and integrates their feedback into the overall strategy

Source: Kania & Kramer, 2011

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Appendix A. Five-Tiered Approach to Program Evaluation

Below is a summary of Five-Tiered Approach to Program Evaluation (Jacobs, 1988).

Tier	Purpose	Tasks
Tier 1: Program Definition	Document need for a particular program in a community Use literature to justify planned program relative to community needs and assets Define planned program	Work with stakeholders to assess community needs and assets Review pertinent literature base Describe program vision, mission, goals, objectives, and characteristics
Tier 2: Monitoring and Service Delivery (Accountability)	Examine if program serves those it was intended to in the manner proposed	Identify stakeholders Document program participants, activities, and how services are delivered
Tier 3: Understanding and Refining	Improve program by providing information to program staff, participants, and other stakeholders	Gather program satisfaction data Examine the fit between data collected in Tiers 1 and 2 Examine process data and identify lessons learned Identify program strengths and weaknesses Revisit literature
Tier 4: Progress Toward Objectives (Measuring Objectives and Outcomes)	Document program effectiveness and short-term outcomes	Sort objectives by short-term outcomes and long-term outcomes Select short-term outcome indicators and identify measures Decide on design issues and data analysis Report findings
Tier 5: Program Long-Term Outcomes (Measuring Objectives and Outcomes)	Demonstrate long-term improvements in quality of life of children, youth, families, and communities Demonstrate program sustainability Suggest program models worthy of replication	Plan to document long-term outcomes Provide evidence of program sustainability Identify program components worthy of replication Distribute findings of long-term outcomes

Appendix B. Maternal and Infant Health Curricula

The following is a compendium of key curricula utilized by maternal and infant/child health programs like SPHS.

Beginnings Guides
Beginnings Guides are designed to complement counseling during office and home visits for prenatal and parent education and family support. The Guides are both teaching & learning materials for promoting health literacy, reflective function, and other essential life skills for parents (see http://www.beginningsguides.com/default.html)

The following text is excerpt from "*Beginnings Guides and Healthy Start Goals*" (Smith, 2014).

Beginnings Pregnancy Guide translates the science of prenatal care into actionable understandable guidance for a healthy pregnancy. It puts into print the health promotion content of prenatal care as defined by the US Public Health Service Expert Panel on the Content of Prenatal Care. These guidelines are currently in force and endorsed by the ACOG and AAFP, although it is widely recognized that the typical prenatal visit does not allow time for delivering that component of care and policies recommend collaboration with home visiting programs like Healthy Start to bring this content to mothers. Focus is on key health behavior messages that research links directly to outcomes, particularly to reduced risk of low birth weight.

In continuous use nationally since 1989 and now in its 9th (2014) edition, *Beginnings Pregnancy Guide* is particularly suited to a Medicaid population. Readability testing shows a fourth grade reading level in English, third grade in Spanish. In addition, the latest research on health literacy, typology and graphics, adult learning, reading science and materials design are integrated with each update to make the materials attractive, engaging, interactive and memorable. Cover art by Laurel Burch leads even disinterested mothers to pick up the materials and leads them into the learning. The booklets are richly illustrated throughout showing a diversity of ethnicities.

Staged learning Content is presented in six booklets so that the information is immediately applicable and not overwhelming. Testing with mothers shows that the information is easy to read and apply independently by half of those with 6-8 years education and 80% of those with 9-12 years. All benefit by review and discussion with a service provider. Beginnings Guides earns high satisfaction ratings from both under-educated and college-educated mothers.

The *Beginnings Pregnancy* and *Parents Guides* are both teaching & learning materials for promoting health literacy, reflective function, and other essential life skills for parents. They are a companion to the Life Skills Progression instrument approved for documenting progress to MIECHV benchmarks. The crosswalk below indicates where the *Beginnings Guides* address topics of particular interest to Healthy Start programs.

Crosswalk of Beginnings Guide Pages with Healthy Start Topics

Healthy Start Program Topics	*Beginnings Pregnancy Guide* Pages	*Beginnings Parents Guide* Pages
ACEs, Prevent abuse, neglect	4, 20, 37, 42, 44, 50, 56, 68, 76, 81, 82, 93-94	1, 2, 6-9, 11, 12, 13-14, 31,40-41, 44, 56, 60, 66, 72, 78, 81, 84-87, 102- 103, 106-108, 113-115, 122, 124-125, 130-131, 138-139,142-143, 146, 150-151, 158, 162-163, 165, 183-185, 186-187
Attachment	1, 13, 28, 37, 46, 47, 87, 91	1, 2, 3, 5, 10, 37-38, 39, 178-179, 195
Resilience: Strengthen protective factors	2-3, 11, 22, 37, 42, 58, 62, 76, 80, 81	66
Resilience: Reduce risk factors	20, 32, 44, 55, 56, 82	21-26, 60, 70, 88, 106, 123, 136, 156, 176, 196
Promote use/reduce need for mental/behavioral health services	17, 30-31,37, 40, 42, 43	13,42, 73, 105, 163
Promote father involvement	38, 41, 63, 70, 71, 82, 84, 93	2, 16, 33, 39, 47, 53, 92, 122, 123, 133, 139, 146, 158, 164, 172, 185, 190
Reduce toxic stress		15, 31,43, 73-75, 98-101, 126-127, 152, 166-167, 191
Build socio-emotional skills Promote social connections	10-11, 12, 30-31, 39, 42, 50-51, 53, 70-71	2, 19-20, 103, 105, 174-175
Knowledge of child development	6-7, 8, 21, 23, 33, 34, 35, 39, 45-46, 57-58, 60, 61, 69	4,5, 6-9, 10-14, 18-19, 27, 29, 30, 37,-38, 39, 40-41, 52-53, 56, 58, 59, 61-65, 67, 82, 83, 89, 112, 117-121, 132-133, 137, 140-141, 154, 157, 159-161, 168-171, 172-173, 177-182, 188, 190
Promote health	13-17, 18-20, 23, 24-25, 26,27-29, 36, 38, 47-50, 54-55, 64, 66, 67,77-79, 85, 86-90, 92, 95,96	3, 28-29, 33-34, 36,45-47, 48-49,50—53, 54-55, 56-59, 68-71, 76-77, 79, 80, 91-97, 104, 108-110, 111-112, 128, 129, 130-131, 134-135, 144-145, 147-149, 153, 189, 192-194
Concrete supports	www.BeginningsGuides.com/pregnancyresources	www.BeginningsGuides.com/parentingresources

(Source: Smith, 2014)

Healthy Child Care America (HCCA)

The Healthy Child Care America (HCCA) Child Care & Health Partnership is coordinated by the American Academy of Pediatrics (AAP) Early Education and Child Care Initiatives and is partly funded by the Office of Child Care (OCC), Administration for Children and Families (ACF), and the Maternal and Child Health Bureau, HRSA, US Department of Health & Human Services. The HCCA Child Care & Health Partnership is a collaborative effort of health professionals and child care providers working to improve the early education and health and safety of children in out-of-home child care. This includes increasing access to preventive health services, safe physical environments, and a medical home for all children. The program also strives to increase pediatrician participation and effectiveness in providing high-quality care and promoting early education and children's health and well-being (see http://www.healthychildcare.org/about.html#1). HCCA goals include:

- To promote the healthy development and school readiness of children in early education and child care by strengthening partnerships between health and child care professionals;
- To provide information and support necessary to strengthen children's access to health services;
- To promote the cognitive, social and physical development of children in early education and child care;
- To provide technical assistance regarding health and safety for health professionals and the early childhood community;
- To enhance the quality of early education and child care with health and safety resources; and
- To support the needs of health professionals interested in promoting healthy and sage early education and child care programs.

HCCA Safe Sleep Campaign seeks to (see http://www.healthychildcare.org/sids.html):

- Promote the back to sleep message in child care programs;
- Raise awareness and change practices in child care settings;
- Disseminate information on national child care recommendations/standards related to SIDS risk reduction; and
- Support states to enhance existing and establish new child care regulations.

Infant Toddler Mental Health Coalition of Arizona

The Infant/Toddler Mental Health Coalition of Arizona (ITMHCA) is a voluntary 501c(3) organization that was established in 1995, which promotes the understanding that infancy is a critically important period in psychosocial development (see http://www.itmhca.org/). Therefore, equally critical is the collaboration of professionals from local, state, and nonprofit community-based organizations to work toward policy and social change for the benefit of Arizona's youngest children and their families. ITMHCA provides infant mental health and child development training and offers a professional endorsement to individuals from a variety of disciplines who work with infants and toddlers. A bi-annual Institute brings high-quality infant/toddler mental health speakers and workshops to the Southwest.

North Carolina Preconception Strategic Health Plan

Preconception health is a national priority that focuses on improving birth outcomes, reducing the risk of infant mortality, and transforming the health of women before, during, between, and beyond pregnancy. North Carolina has been a leader in preconception health and continues to drive innovation nationwide. In collaboration with maternal and child health experts across the state, the Division of Public Health developed a strategic plan to address preconception health issues. The North Carolina Strategic Plan examines how energy and resources can best be invested to improve the health of women and children and offers new strategies to achieve this vision (North Carolina Public Health, 2013) (see http://www.schs.state.nc.us/data/preconception/)

Mission:

- Improved health of men and women of reproductive age and improved health of infants.
- Reduced and ultimately eliminated racial/ethnic health disparities in women's health and birth outcomes.
- Every man and woman has a reproductive life plan and enters pregnancy in optimal health.

Short- & Mid-term Outcomes Include:

- Increased awareness about reproductive life planning and the benefits of being healthy before pregnancy, including healthy weight.
- Increased awareness of services available supporting women before, during and after pregnancy and collaboration among partners providing these services.
- Increased self-efficacy regarding preparing for pregnancy and/or avoiding pregnancy.
- Increased awareness of access and health insurance issues and barriers to services.
- Increased community outreach worker and health care provider awareness of preconception health.

- Increased development and use of tools and resources to improve quality preconception care.
- Increased dialogue between women and their partners and healthcare providers regarding pregnancy preparedness.
- Increased knowledge of factors that promote healthy physical and social environments and economical barriers to these environments.
- Increased awareness of economic barriers that impede healthy living.
- Increased awareness of health disparities among racial/ethnic groups particularly those affecting women's health and infant birth outcomes.

Short- & Mid-term outcomes: Individual level

- Increase in positive health behaviors in women such as healthy weight, reproductive life planning, and folic acid consumption.
- Increased utilization of primary care and family planning services by women of childbearing age.
- Decrease in negative health behaviors in women of childbearing age that hinder preconception health such as tobacco use, alcohol misuse and illicit drug use.
- Increased support for women living with chronic conditions in managing their conditions, and planning and preparing for pregnancy.
- Increased support for pregnancy preparedness in interactions with the health care system.

Short- & Mid-term Outcomes: Systems Level

- Eliminating barriers to access to care though health insurance expansion for women of childbearing age, especially those at highest risk for poor pregnancy outcomes and those with chronic medical conditions.
- Increased partnerships and collaborations for greater effectiveness and efficiency in providing services and removing barriers to these services.
- Model systems approach to racial/ethnic minority health improvement an health disparities reduction.
- Education, health care, business and government systems implement policies that support pregnancy preparedness before conception.

Public Health Impact

- Reduction in risk behaviors and chronic health conditions for men and women of reproductive age.
- Improved health of women of childbearing age.
- Reduction in unintended pregnancy.
- Increased percentage of women with birth interval >12 months.
- Reduction in maternal and morbidity and mortality.
- Reduction in premature births.

- Reduction in birth defects.
- Reduction in low birth weight births.
- Decrease in teen childbearing rate.
- Policies, practices, and places that support the health of men and women throughout every stage of life and promote elimination of racial/ethnic health disparities.

North Carolina Public Health Programs

The March of Dimes North Carolina Preconception Health Campaign has hosted many webinars for health care professionals. They are focused on improving the health of women prior to pregnancy. If you were unable to join us, the following topics were aimed at developing your knowledge and skill set around preconception health:

- Reproductive Life Planning: Simple strategies to help your patients plan ahead
- Healthy Weight Matters: Young Women and the Reproductive Health Consequences of Obesity
- Young Women & Tobacco: Using the 5As to Help Women Quit
- Folic Acid & Multivitamins: Preventing Neural Tube Birth Defects in North Carolina
- The Circle of Care for Women: The Role of Early and Effective Utilization of Prenatal Care
- The Affordable Care Act: Services that Support Women of Childbearing Age

Safe to Sleep Public Education Campaign

The Safe to Sleep® campaign offers a variety of outreach and educational materials to help share safe infant sleep messages with different audiences, particularly the prevention of sudden infant death syndrome (SIDS). (See http://www.mchlibrary.info/suid-sids/SafeSleep/campaigns.html).

Triple P

The Triple P – *Positive Parenting Program* is one of the most effective evidence-based parenting programs in the world, backed up by more than 30 years of ongoing research. Triple P gives parents simple and practical strategies to help them confidently manage their children's behavior, prevent problems developing and build strong, healthy relationships. Triple P is currently used in 25 countries and has been shown to work across cultures, socio-economic groups and in many different kinds of family structures (see http://www.triplep.net/glo-en/home/). The Triple P system aims to:

- Put evidence-based parenting into the hands of parents across the world;
- Normalize the concept of parenting programs so parents feel comfortable asking for help;
- Deliver the exact amount of support a parent needs – enough but not too much;

- Give parents the confidence and skills to be self-sufficient -- to manage problems independently; and
- Provide communities with population-level early intervention to prevent child abuse, mental illness and anti-social behavior.

The following is excerpt from Sanders, 2008, page 507.

A central goal of Triple P is the development of an individual's capacity for self-regulation. This principle applies to all program participants, from parents to service providers and researchers. Self-regulation is a process whereby individuals are taught skills to change their own behavior and become independent problem solvers in a broader social environment that supports parenting and family relationships (Karoly, 1993). The self-regulation model draws heavily on Bandura's cognitive social learning theory (1977, 1986). In the case of parents who are learning to change their parenting practices, self-regulation is operationalized to include the following five aspects:

- Promoting self-sufficiency of parents so that they may feel confident in their abilities to parent with minimal or no additional support;
- Increasing parental self-efficacy so that the parent believes he or she can overcome a problem in parenting when it arises;
- Using self-management tools so that parents may change parenting practices for the better. This involves self-assessment of performance, setting goals, and choosing child management techniques;
- Promoting personal agency meaning that parents must learn to "own" the improvements in their family situation; and
- Promoting problem solving so that parents can learn how to "define problems, formulate opinions, develop a parenting plan, execute the plan, evaluate the outcome, and revise the plan as required.

Women, Infants and Children (WIC)

WIC saves lives and improves the health of nutritionally at-risk women, infants and children. The results of studies conducted by FNS and other non-government entities prove that WIC is one of the nation's most successful and cost-effective nutrition intervention programs. Since its beginning in 1974, the WIC Program has earned the reputation of being one of the most successful Federally-funded nutrition programs in the United States. Collective findings of studies, reviews and reports demonstrate that the WIC Program is cost effective in protecting or improving the health/nutritional status of low-income women, infants and children. (See http://www.fns.usda.gov/wic/about-wic-how-wic-helps#Other for more information and related resources). Studies show that WIC impacts the following maternal and infant health outcomes:

- Improved birth outcomes and savings in health care costs;
- Improved diet and diet-related outcomes;
- Improved infant feeding practices;
- Improved immunization rates and use of regular sources of health care;
- Improved cognitive development;
- Improved preconceptional nutritional status;
- Increased likelihood of children having a regular provider of medical care; and
- Improved growth rates.

Appendix C. List of Required and Suggested Evaluation Measures for SPHS

The following table provides a list of required and suggested evaluation measures for SPHS to consider. This matrix presents the indicator sources (e.g., HS Benchmarks, HS Performance Measures; TOC Indicators), goal, measure, and data source.

Indicator Source	Goal	Measure	Data Source
1. Performance measures/ HS Theory of Change indicators	To increase family/youth/consumer participation in MCHB programs.	The degree to which MCHB-funded programs ensure family/youth/consumer participation in program and policy activities.	HRSA-provided grantee completed data collection form.
2. Performance measures	To increase the number of MCHB-funded programs that have integrated cultural and linguistic competence into their policies, guidelines, contracts and training.	The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts and training.	HRSA-provided grantee completed data collection form.
3. Performance measures	To increase the number of MCHB programs that incorporate the findings and recommendations from Mortality/Morbidity Review processes in their planning and program development (e.g., needs assessment, quality improvement, and/or capacity building).	The degree to which States and communities use "morbidity/mortality" review processes in MCH needs assessment, quality improvement, and/or data capacity building.	HRSA-provided data collection form completed by MCHB Program Directors.

Indicator Source	Goal	Measure	Data Source
4. Performance measures/ HS Theory of Change indicators	To increase the number of children in the State who have a medical home.	The percentage of children age 0 to 18 participating in MCHB-funded programs who receive coordinated, ongoing, comprehensive care within a medical home.	Numerator: The number of children participating in MCHB funded projects age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home during the reporting period. Denominator: The number of children participating in MCHB funded projects age 0 to 18 during the reporting period.
5. Performance measures/ HS Theory of Change indicators	To increase the percentage of women participating in MCHB-funded projects who have an ongoing source of primary and preventive care services for women.	The percentage of women participating in MCHB-funded programs who have an ongoing source of primary and preventive care services for women.	Numerator: The number of women participating in MCHB-funded projects who have received an ongoing source of primary and preventive care services during the reporting period. Denominator: The number of women participating in MCHB-funded projects during the reporting period.
6. Performance measures/ HS Theory of Change indicators	Increase the percentage of completed referrals for women participating in MCHB-funded programs in need of services.	The percentage of women participating in MCHB-funded programs who have a completed referral among those that receive a referral.	Numerator: Unduplicated number of women program participants who have at least one completed health or supportive service referral Denominator: Unduplicated number of women program participants who receive at least one referral for health and other supportive services

Indicator Source	Goal	Measure	Data Source
7. Performance measures/ HS Theory of Change indicators	To improve health providers' appropriate screening for risk factors of women participants in MCHB-funded programs.	The degree to which MCHB-funded programs facilitate health providers' screening of women participants for risk factors.	HRSA-provided grantee completed data collection form.
8. Performance measures/ HS Theory of Change indicators	To develop infrastructure that supports comprehensive and integrated services.	The degree to which MCHB-supported initiatives contribute to the implementation of the 10 MCH Essential Services and Core Public Health Program Functions of assessment, policy development and assurance.	HRSA-provided grantee completed data collection form.
9. Performance measures/ HS Theory of Change indicators	To develop infrastructure that supports comprehensive and integrated systems of care for maternal and child health at the local and/or state level.	The degree to which MCHB grantees are planning and implementing strategies to sustain their programs once initial MCHB funding ends.	HRSA-provided grantee completed data collection form.
10. Performance measures/ HS Theory of Change indicators	To increase the number of States having comprehensive systems for women's health services.	The degree to which States and communities have implemented comprehensive systems for women's health services.	HRSA-provided State MCH Directors data collection form.
11. Performance measures/ HS Theory of Change indicators	To increase early entry into prenatal care.	The percentage of pregnant participants in MCHB funded programs receiving prenatal care beginning in the first trimester.	Numerator: Number of program participants with reported first prenatal visit during the first trimester. Denominator: Number of program participants who are pregnant at any time during the reporting period.

Indicator Source	Goal	Measure	Data Source
12. Performance measures/ HS Theory of Change indicators	Increase the percentage of completed referrals for women participating in MCHB-funded programs in need of services.	The percentage of completed referrals among women in MCHB-funded programs.	Numerator: Number of referrals among women to health and other supportive services made by MCHB-funded programs that are completed Denominator: Number of referrals among women to health and other supportive services made by MCHB-funded programs
13. Performance measures/ HS Theory of Change indicators	Decrease smoking during pregnancy.	The percentage of women participating in MCHB-funded programs who smoke in the last three months of pregnancy.	Numerator: Number of MCHB-funded program participants who smoked during the last three months of pregnancy. Denominator: Number of MCHB-funded program participants who are pregnant at any time during the reporting period.
14. Performance measures/ HS Theory of Change indicators	To increase the prevalence of medical homes within the systems that serve MCH populations.	The degree to which grantees have assisted in achieving a medical home for the MCH populations that they serve.	HRSA-provided grantee completed data collection form.
15. Performance measures/ HS Theory of Change indicators	To reduce the proportion of all live deliveries with very low birth weight.	Percent of very low birth weight infants among all live births to program participants.	Numerator: Number of live births (single and multiple) with birth weight less than 1,500 grams in the calendar year among program participants. Denominator: Total number of live births (single and multiple) in the calendar year among program participants.

Indicator Source	Goal	Measure	Data Source
16. Performance measures/ HS Theory of Change indicators	To reduce the number of all live deliveries with low birth weight.	The percent of live single births weighing less than 2,500 grams among all singleton births to program participants.	Numerator: Number of live singleton births less than 2,500 grams to program participants. Denominator: Live single births among program participants.
17. Performance measures/ HS Theory of Change indicators	To reduce the number of infant deaths.	The infant mortality rate per 1,000 live births.	Numerator: Number of deaths to infants from birth through 364 days of age to program participants. Denominator: Number of live births among program participants.
18. Performance measures/ HS Theory of Change indicators	To reduce the number of neonatal deaths	The neonatal mortality rate per 1,000 live births.	Numerator: Number of deaths to infants under 28 days born to program participants. Denominator: Number of live births to program participants.
19. Performance measures/ HS Theory of Change indicators	To reduce the number of post-neonatal deaths.	The post-neonatal mortality rate per 1,000 live births.	Numerator: Number of deaths to infants 28 through 364 days of age born to program participants. Denominator: Number of live births to program participants.

Indicator Source	Goal	Measure	Data Source
20. Performance measures/ HS Theory of Change indicators	To reduce the number of perinatal deaths.	The perinatal mortality rate per 1,000 live births plus fetal deaths.	Numerator: Number of fetal deaths > 28 weeks gestation plus deaths occurring under 7 days to program participants. Denominator: Live births plus fetal deaths among program participants.
21. Performance measures/ HS Theory of Change indicators	To increase the percent of program participant mothers who breastfeed their infants at 6 months of age.	The percent of program participant mothers who breastfeed their infants at 6 months of age.	Numerator: Number of program participant mothers who indicate that breast milk is at least one of the types of food their infant is fed at 6 months of age. Denominator: Number of program participant mothers with infants at 6 months of age.
22. Performance measures/ HS Theory of Change indicators	Increase the proportion of HS participants with health insurance to 90%.	The proportion of HS participants with health insurance.	Numerator: Number of HS participants with health insurance . Denominator: Number of total HS Participants .
23. HS Benchmarks	Increase the proportion of HS participants who have a documented reproductive life plan to 90%.	The proportion of HS participants who have a documented reproductive life plan.	Numerator: Number of HS participants with reproductive life plans . Denominator: Number of total HS Participants of childbearing age.
24. Performance measures/ HS Theory of Change indicators	Increase the proportion of HS participants who receive a postpartum visit to 80%.	The proportion of HS participants who receive a postpartum visit.	Numerator: Number of HS postpartum participants who received postpartum visits. Denominator: Total number of HS participants who gave birth.
25. Performance measures/ HS Theory of Change indicators	Increase the proportion of women, infants, and children participating in HS who have a medical home to	The proportion of women, infants, and children participating in HS who have a medical home.	Numerator: Number of women, infants, and children of HS participants in medical homes.

Indicator Source	Goal	Measure	Data Source
	80%.		Denominator: Number of women, infants, children in the HS program.
26. Performance measures/ HS Theory of Change indicators	Increase proportion of well woman visits among HS participants to 80%.	The proportion of well woman visits among HS participants.	Numerator: Number of HS participants who received a well woman visits. Denominator number of total HS female participants.
27. Performance measures/ HS Theory of Change indicators	Increase the proportion of HS participants who engage in safe sleep behaviors to 80%.	The proportion of HS participants who engage in safe sleep behaviors.	Numerator: Number of HS participants who engage in safe sleep behaviors for their infants. Denominator: Total number of HS participants with infants (0-24 months).
28. Performance measures/ HS Theory of Change indicators	Increase the proportion of HS infants who are ever breastfed to 82 %.	The proportion of HS infants who are ever breastfed.	Numerator: Number of HS participants' infants who were ever breastfed. Denominator: Total number of HS infants (0-24 months).
29. Performance measures/ HS Theory of Change indicators	Increase the proportion of HS infants who breastfed at 6 months to 61%.	The proportion of HS infants who breastfed at 6 months.	Numerator: Number of HS participants' infants who were breastfed at 6 months. Denominator: Total number of HS infants (0-24 months).
30. Performance measures/ HS Theory of Change indicators	Increase the proportion of abstinence from cigarette smoking among HS pregnant women to 90 %.	The proportion of abstinence from cigarette smoking among HS pregnant women.	Numerator: Number of HS participants who abstained from smoking cigarettes during pregnancy. Denominator: Total number of HS pregnant participants.

Indicator Source	Goal	Measure	Data Source
31. Performance measures/ HS Theory of Change indicators	Reduce the proportion of HS pregnancies conceived within 18 months of a previous birth to 30%.	The proportion of HS pregnancies conceived within 18 months of a previous birth.	Numerator: Number HS participants who conceived within 18 months of previous birth. Denominator: Total number of HS participants who have conceived with a prior birth.
32. Performance measures/ HS Theory of Change indicators	Increase the proportion of well child visits (including immunization) for HS participants' children between ages 0-24 months to 90%.	The proportion of well child visits (including immunization) for HS participants' children between ages 0-24 months.	Numerator: Number of HS children (0-24 months) who receive well child visits. Denominator: Total number of children in the HS program.
33. Performance measures/ HS Theory of Change indicators	Reduce the proportion of HS participants with elective delivery before 39 weeks to 10%.	The proportion of HS participants with elective delivery before 39 weeks.	Numerator: Number of HS participants with elective delivery before 39 weeks. Denominator: Total number of birth among HS participants (exclude medically indicated deliveries).
34. Performance measures/ HS Theory of Change indicators	Increase the proportion of HS participants who receive perinatal depression screening and referral to 100%.	The proportion of HS participants who receive perinatal depression screening and referral.	Numerator: Number of HS participants who receive perinatal depression screening and referral. Denominator: HS participants were eligible for perinatal depression screening and referrals.
35. Performance measures/ HS Theory of Change indicators	Increase the proportion of HS participants who receive follow up services for perinatal depression to 90%.	The proportion of HS participants who receive follow up services for perinatal depression.	Numerator: Number of HS participants who received follow up services for perinatal depression screening. Denominator: Total number of total HS participants identified as needing follow up services.

Indicator Source	Goal	Measure	Data Source
36. Performance measures/ HS Theory of Change indicators	Increase the proportion of HS participants who receive intimate partner violence screening to 100%.	The proportion of HS participants who receive intimate partner violence screening.	Numerator: Number of HS participants who received intimate partner violence screening. Denominator: Total number of HS participants.
37. Performance measures/ HS Theory of Change indicators	Increase the proportion of HS grantees that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) during pregnancy to 90%.	The proportion of HS grantees that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) during pregnancy.	Numerator: Number of fathers and/or partners engaged in activities (e.g., attend appointments, classes, infant/child care) with HS participants during pregnancy. Denominator: Total number of fathers and/ or partners.
38. Performance measures/ HS Theory of Change indicators	Increase the proportion of HS grantees that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) with child 0-24 months to 80%.	The proportion of HS grantees that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) with child 0-24 months.	Numerator: Number of fathers and/or partners engaged in activities (e.g., attend appointments, classes, infant/child care) with child 0-24 months HS participants. Denominator: Number of total fathers and/or partners
39. Performance measures/ HS Theory of Change indicators	Increase the proportion of HS participants that read daily to a HS child between the ages of 0-24 months to 50%.	The proportion of HS participants that read daily to a HS child between the ages of 0-24 months.	Numerator: Number of HS participants involved in reading to their children between ages 0-24 months. Denominator: Total number of HS participants with children between ages 0-24 months.
40. HS Benchmarks	Increase the proportion of HS grantees with a fully implemented CAN to 100%.	The proportion of HS grantees with a fully implemented CAN.	Numerator: Number of HS grantees with CAN. Denominator: Total number of HS grantees.

Indicator Source	Goal	Measure	Data Source
41. HS Benchmarks	Increase the proportion of HS grantees with at least 25% HS participant membership on their CAN membership to 100%.	The proportion of HS grantees with at least 25% HS participant membership on their CAN membership.	Numerator: Number of total HS participants in CAN. Denominator: Total number of CAN membership.
42. HS Benchmarks	Increase the proportion of HS grantees who establish a quality improvement and performance monitoring process to 100%.	The proportion of HS grantees who establish a quality improvement and performance monitoring process.	Refer to methodology section of FOA.
43. HS Benchmarks	For Level 3, increase the proportion of HS grantees that have a fully implemented CollN process to 90%.	The proportion of HS grantees that have a fully implemented CollN process.	Refer to methodology section of FOA.
44. HS Theory of Change indicators	Families have stable housing: Increase the proportion of HS participants that have stable housing to 50% within 6 months of program enrollment.	The proportion of HS participants that have stable housing within 6 months of program enrollment.	HS program data.
45. HS Theory of Change indicators	50% of SP HS participants have met their long and short term goals.	The percentage of HS participants that met their long and short term goals in a program year.	HS program data.
46. HS Theory of Change indicators	100% of SP HS staff report consistent internal and external messaging, as described in the Communication Plan.	The percentage of SP HS staff that report consistent internal and external messaging, as described in the Communication Pla	HS program data.
47. HS Theory of Change indicators	75% of SP HS newsletters, email updates and management meetings follow guidelines set forth in communication plan.	The percentage of SP HS newsletters, email updates and management meetings follow guidelines set forth in communication plan	HS program data.

Indicator Source	Goal	Measure	Data Source
48. HS Theory of Change indicators	50% of SP HS participants demonstrate behavior change and progress in their long and short term goals.	The percentage of SP HS participants demonstrate behavior change and progress in their long and short term goals.	HS program data.
49. HS Theory of Change indicators	40% of Community Health Workers' participants attend Health Education classes.	The percentage of Community Health Workers' participants that attend Health Education classes	HS program data.
50. HS Theory of Change indicators	60% of SP HS CM and HE participants demonstrate a gain in knowledge in a pre/post-test (for HE) and a gain in knowledge at interim time points (for CM).	The percentage of SP HS CM and HE participants that demonstrate a gain in knowledge in a pre/post-test (for HE) and a gain in knowledge at interim time points (for CM).	HS program data.
51. HS Theory of Change indicators	75% of SP HS CM and HE participants indicate satisfaction with SP HS services.	The percentage of SP HS CM and HE participants that indicate satisfaction with SP HS services.	HS program data.
52. HS Theory of Change indicators	75% of SP HS CM and HE participants are aware of community resources providing transportation, food, childcare and healthcare needs.	The percentage of SP HS CM and HE participants that report being aware of community resources providing transportation, food, childcare and healthcare needs.	HS program data.
53. HS Theory of Change indicators	75% of Health Education classes and Case Management appointments adhere to fidelity or best practices.	The percentage of Health Education classes and Case Management appointments that adhere to fidelity or best practices.	HS program data.
54. HS Theory of Change indicators	75% of Health Education classes and Case Management appointments adhere to common messaging identified in Communication Plan.	The percentage of Health Education classes and Case Management appointments that adhere to common messaging identified in Communication Plan	HS program data.

Indicator Source	Goal	Measure	Data Source
55. HS Theory of Change indicators	75% of SP HS staff attending staff training indicate an increase in knowledge in staff training pre/post-tests.	The percentage of SP HS staff attending staff training that indicate an increase in knowledge in staff training pre/post-tests.	HS program data.
56. HS Theory of Change indicators	100% of SP HS staff participate in interviews/respond to surveys to identify internal and external communication needs on an annual basis.	The percentage of SP HS staff that participate in interviews/respond to surveys to identify internal and external communication needs on an annual basis.	HS program data.
57. HS Theory of Change indicators	One staff training opportunities are provided to SP HS staff on monthly basis.	Number of staff training opportunities provided to SP HS staff on monthly basis.	HS program data.
58. HS Theory of Change indicators	Averages of 65% of SP HS staff attend staff training opportunities.	The percentage of SP HS staff that attend staff training opportunities.	HS program data.
59. HS Theory of Change indicators	CAN demonstrates progress towards mutually agreed upon goals.	The percentage of respondents that report CAN demonstrates progress towards mutually agreed upon goals.	Collaboration level survey.
60. HS Theory of Change indicators	CAN partners ask for support (financial and other resources) from SP HS.	The percentage of respondents that report asking for support (financial and other resources) from SP HS.	Collaboration level survey.
61. HS Theory of Change indicators	CAN has the potential to become a 501c(3).	The percentage of respondents that report CAN has the potential to become a 501c(3).	Collaboration level survey.
62. HS Theory of Change indicators	CAN partners share common messages and resources.	The percentage of respondents that report CAN partners share common messages and resources.	Collaboration level survey.

Indicator Source	Goal	Measure	Data Source
63. HS Theory of Change indicators	CAN partners agree or strongly agree that SP HS: maintains coherence of Collective Impact effort, helps coordinate management, supports fundraising and outreach and supports work groups.	The percentage of respondents that report CAN partners agree or strongly agree that SP HS: maintains coherence of Collective Impact effort, helps coordinate management, supports fundraising and outreach and supports work groups.	Collaboration level survey.
64. HS Theory of Change indicators	SP HS ensures community members are engaged in the Collective Impact activities.	The percentage of respondents that report SP HS ensures community members are engaged in the Collective Impact activities.	Collaboration level survey.
65. HS Theory of Change indicators	SP HS seeks out alignment with other initiatives in South Phoenix.	The percentage of respondents that report SP HS seeks out alignment with other initiatives in South Phoenix.	Collaboration level survey.
66. HS Theory of Change indicators	Staff turnover with CAN partners does not impact the organizations present at CAN meetings.	The percentage of respondents that report staff turnover with CAN partners does not impact the organizations present at CAN meetings.	Collaboration level survey.
67. HS Theory of Change indicators	Other community organizations are reaching out to include CAN in their events, interventions, and programs.	The percentage of respondents that report community organizations are reaching out to include CAN in their events, interventions, and programs.	Collaboration level survey.
68. HS Theory of Change indicators	CAN partners communicate and coordinate efforts regularly (with and independent of the backbone agency).	The percentage of respondents that report CAN partners communicate and coordinate efforts regularly (with and independent of the backbone agency).	Collaboration level survey.
69. HS Theory of Change indicators	CAN partners feel the AR is useful and informative.	The percentage of respondents that report CAN partners feel the AR is useful and informative.	Collaboration level survey.
70. HS Theory of Change	Structures and processes are in	The percentage of respondents that	Collaboration level survey.

Indicator Source	Goal	Measure	Data Source
indicators	place to engage CAN members.	report structures and processes are in place to engage CAN members.	
71. HS Theory of Change indicators	CAN working groups hold regular meetings and members actively participate.	The percentage of respondents that report CAN working groups hold regular meetings and members actively participate.	Collaboration level survey.
72. HS Theory of Change indicators	Structures and processes are in place to engage CAN external stakeholders.	The percentage of respondents that report there are structures and processes are in place to engage CAN external stakeholders.	Collaboration level survey.
73. HS Theory of Change indicators	CAN engages external stakeholders in regular meetings and integrates their feedback into the overall strategy.	The percentage of respondents that report CAN engages external stakeholders in regular meetings and integrates their feedback into the overall strategy.	Collaboration level survey.
74. HS Theory of Change indicators	CAN partners report regularly using data from the shared measurement system for their own organizations' purposes and are confident of its quality.	The percentage of respondents that report CAN partners report regularly using data from the shared measurement system for their own organizations' purposes and are confident of its quality.	Collaboration level survey.
75. HS Theory of Change indicators	CAN partners feel more comfortable with data and associated terminology.	The percentage of respondents that report CAN partners feel comfortable with data and associated terminology.	Collaboration level survey.
76. HS Theory of Change indicators	CAN regularly analyzes and interpret data, synthesizes findings and refines plans as a collective.	The percentage of respondents that report CAN regularly analyzes and interpret data, synthesizes findings and refines plans as a collective.	Collaboration level survey.
77. HS Theory of Change indicators	CAN has informal and formal data sharing agreements are in place.	Number of informal and formal data sharing agreements are in place.	CAN data.

Indicator Source	Goal	Measure	Data Source
78. HS Theory of Change indicators	Shared measurement system is in place and CAN partners are trained on how to use it.	The percentage of CAN partners trained.	CAN data.
79. HS Theory of Change indicators	CAN partners identify common measures that can provide timely evidence of progress (or lack thereof) toward CAN's common agenda.	The percentage of respondents that report CAN partners have identified common measures that can provide timely evidence of progress (or lack thereof) toward CAN's common agenda.	Collaboration level survey.
80. HS Theory of Change indicators	CAN partners understand the value of identifying common measures.	The percentage of respondents that report CAN partners understand the value of identifying common measures.	Collaboration level survey.
81. HS Theory of Change indicators	Working groups are established to coordinate activities in alignment with the plan of action.	Working groups are established.	CAN data.
82. HS Theory of Change indicators	CAN partners understand the roles of other working groups and how these support the common agenda.	The percentage of respondents that report CAN partners understand the roles of other working groups and how these support the common agenda.	Collaboration level survey.
83. HS Theory of Change indicators	CAN partners identify and implement new strategies or activities to address gaps or duplication.	The percentage of respondents that report CAN partners can identify and implement new strategies or activities to address gaps or duplication.	Collaboration level survey.
84. HS Theory of Change indicators	Collective plan of action clearly specifies the activities that different partners have committed to implementing.	Development of collective plan of action.	CAN data.

Indicator Source	Goal	Measure	Data Source
85. HS Theory of Change indicators	Partners' individual activities are changing to better align with the plan of action.	The percentage of respondents that report CAN partners' individual activities are changing to better align with the plan of action.	Collaboration level survey.
86. HS Theory of Change indicators	Funders of partner organizations align their resource to support the plan of action.	The percentage of respondents that report CAN funders of partner organizations align their resource to support the plan of action.	Collaboration level survey.
87. HS Theory of Change indicators	All CAN partners feel ownership of CAN's common agenda and collective plan of action.	The percentage of respondents that report CAN partners feel ownership of CAN's common agenda and collective plan of action.	Collaboration level survey.
88. HS Theory of Change indicators	CAN partners had the opportunity to provide input into the development of the common agenda and collective plan of action.	The percentage of respondents that report CAN partners had the opportunity to provide input into the development of the common agenda and collective plan of action.	Collaboration level survey.
89. HS Theory of Change indicators	Community members had the opportunity to provide input into the development of the common agenda and collective plan of action.	The percentage of respondents that report community members had the opportunity to provide input into the development of the common agenda and collective plan of action.	Collaboration level survey.
90. HS Theory of Change indicators	CAN partners are aware of the community agenda and collective plan of action.	The percentage of respondents that report CAN partners are aware of the community agenda and collective plan of action.	Collaboration level survey.
91. HS Theory of Change indicators	CAN demonstrates progress towards mutually agreed upon goals.	The percentage of respondents that report CAN demonstrates progress towards mutually agreed upon goals.	Collaboration level survey.