



ADDRESSING ASTHMA FROM A PUBLIC HEALTH PERSPECTIVE

A REPORT ON THE EVALUATION OF THE MAINE
ASTHMA PREVENTION & CONTROL PROGRAM

September 1, 2006-August 31, 2009

AUGUST 2009

Prepared for:
Maine Asthma Prevention and Control Program
Division of Chronic Disease
Maine Center for Disease Control and Prevention
Department of Health and Human Services

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I. Background Information

The Maine Department of Health and Human Services (DHHS), Maine Center for Disease Control and Prevention (ME-CDC), contracted with the Maine Center for Public Health (MCPH) to evaluate the Maine Asthma Prevention and Control Program (referred to as the Maine Asthma Program or MAP). The goal of the independent evaluation was to complete a rigorous assessment of the effectiveness of MAP partnerships revitalized or built during the 2008/09 grant year. The purpose of the evaluation is to provide data for making decisions or judgments about the program based on what is working well, what could work better, and lessons learned from partnership activities during the grant year.

A. Asthma in Maine

Asthma in Maine is significantly higher than the national average. For example, in 2005 Maine's lifetime asthma prevalence in adults was 15% compared to 12.5% in U.S. populations. Also, from 2000-05 the asthma prevalence in Maine was significantly higher than the national rate, and during that time 9-10% of Maine adults reported having asthma currently, compared to 7-8% nationally.

Additionally, we know that too many Maine people have a diagnosis of asthma. This fact is compounded by the fact that too many Maine people are suffering with poorly controlled asthma. We know those on MaineCare have higher rates of asthma and we know disparate populations in the state experience unusually high rates of asthma. And finally, the National Survey of Children's Health reports that 14.6% of Maine children have had asthma at some point in their life, and 10.7% had asthma at the time of the survey.¹

B. Maine Asthma Prevention and Control Program

The Division of Chronic Disease at the ME-CDC houses the Maine Asthma Prevention and Control Program, which is funded by the Federal Centers for Disease Control and Prevention (Cooperative Agreement#EH06-604cont09). The program was established by the legislature in 2002 for the purpose of providing leadership for, and coordination of, asthma prevention and intervention activities statewide. The program includes a staff of two and has access to epidemiological consultation for assistance regarding the surveillance component of the program. MAP also contracts with the Maine Center for Public Health to provide the evaluation component of the program.

¹ *The Burden of Asthma in Maine*, 2008. The Maine Asthma Program, Maine Center for Disease Control.

The MAP is responsible for helping to facilitate the implementation of the Maine Asthma Plan and for bringing together resources to address asthma throughout the state. The overarching goals of the Maine Statewide Asthma Plan, established to directly affect Maine's asthma burden as identified in the 2008 MAP report, *The Burden of Asthma in Maine*, are as follows:

- To decrease hospital admissions and emergency department visits for people with asthma.
- To increase the proportion of people with current asthma who report that they have received self-management education.
- To reduce asthma disparities among affected populations.

The goals of Maine's Asthma Plan are set within the context of the Healthy Maine 2010 Asthma Objectives that include:

1. Reduce the number of school and workdays missed due to asthma.
2. Reduce the number of emergency department visits due to asthma.
3. Reduce the number of hospitalizations due to asthma.
4. Increase the proportion of persons with asthma who receive formal education.
5. Establish a surveillance system for tracking asthma.

In addition to its focus on the above state-wide goals, the MAP has several other activities that are designed to collectively lead to accomplishing the program's long-term program-specific goals. These program-specific goals are intended to be achieved based on the cooperative efforts of governmental and nongovernmental stakeholders, providers, health systems, and others who are committed to decreasing the burden of asthma in Maine. While this evaluation focuses primarily on the efforts and activities of the state MAP, it is important to recognize the contributions of others working in this area to achieve the same overarching goals.

Over the past year MAP has made tremendous strides at rebuilding Maine's Asthma Council and program integrity across the state. MAP staff provided support and resources to the revitalization of both the state-sponsored asthma programs, and MAP's major partnership — the Maine Asthma Council. The key tenant of MAP's work is the building of coalitions and partnerships to address the burden of asthma in Maine, as identified above. In 2008-09 MAP has worked hard to build those key partnerships and thus, it is those partnerships that this independent evaluation assessed.

C. Overview of Report

The state Asthma Plan is seen as a collaboration to decrease the severity of asthma and improve the quality of life for the people of Maine. It serves as the roadmap for the work MAP and its asthma partners undertaken in any given year. The major portion of this report (the

Evaluation Results section) addresses three key partnerships that have been front and center for MAP during the 2008/09 grant year: First, the Maine Asthma Council, a coalition for which MAP is the convening partner for the council and provides support to the council and its workgroups; second, the Asthma Learning Collaboratives initiative, a partnership with Maine Primary Care Association and the Federally Qualified Health Centers in Maine; and lastly, the Asthma Healthy Homes (AHH!) initiative, a partnership with the Houlton Band of Maliseet Indians (HBMI).

Overall this report provides data and results from the process evaluation of the partnership activities of MAP. This information is not intended to be used to assess the impact of the State Program or its statewide partners. This report does not directly reflect outcomes of the program, but rather, it reflects the process of program implementation, i.e. how activities and initiatives were implemented. So, while positive program implementation might often result in the fruition of program outcomes, that is not a given. A good process does not always produce the anticipated outcomes. However, every process provides lessons and as a process evaluation, this report can provide valuable data that can help to guide and direct future program implementation and partnership activities.

This evaluation report is designed to inform Program staff and other stakeholders about the progress, achievements, gaps, and limitations of MAP's partnerships, to date, based on the three predetermined activities listed above. This evaluation report should be viewed as a learning opportunity and one of several tools utilized to identify priorities, allocate resources, make programmatic decisions, and strengthen the collective efforts of those seeking to decrease the burden of asthma in Maine.

The Report is divided into four sections, including:

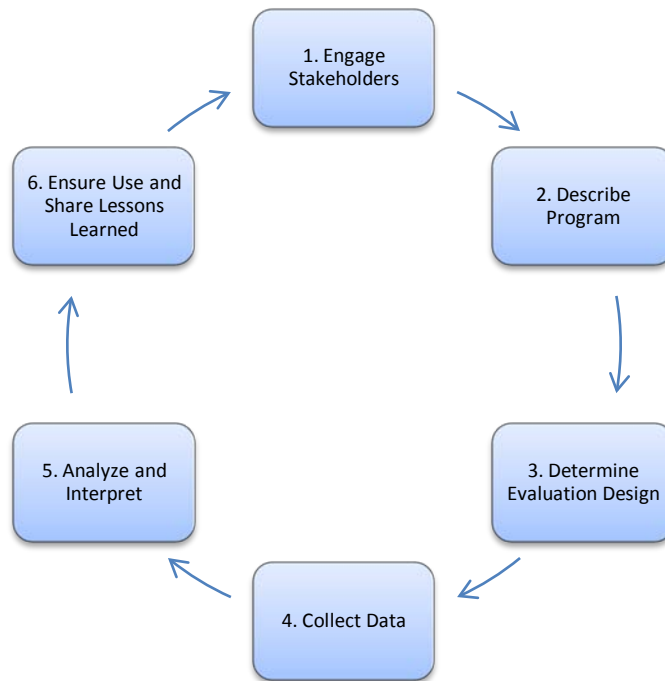
- I. Background Information, which speaks to the burden of asthma in Maine and the state's response through establishing the MAP.
- II. Evaluation Design, which reviews what is being evaluated and how. This section includes a description of the process evaluation undertaken, why the design was chosen, and how the design directed the evaluation efforts that result in this report.
- III. Process Evaluation Results, which provides the findings from the three MAP activities evaluated in 2008/09 — the Maine Asthma Council, the Learning Collaboratives Initiative, and the AHH! Initiative.
- IV. Evaluation Conclusion and Next Steps, which presents the evaluation agenda for the next grant year, including the development of a 5-year evaluation plan which will begin taking place in September, 2009.

II. Evaluation Design

A. Evaluation Framework

The MCPH evaluation follows the recommendations of the Center for Disease Control and Prevention's Framework for Program Evaluation in Public Health² which lays out six distinct steps in the evaluation process. These steps are depicted below in Figure 1.

Figure 1: CDC Evaluation Framework: Steps in the Evaluation Process.



The CDC framework supports and encourages the use of a participatory³ approach to conducting evaluation that encourages dialogue and critical reflection. Additionally, a participatory evaluation approach involves all who have a stake in program outcomes and who ultimately can take action and effect change based on those outcomes. Thus, in the CDC framework, stakeholders remain engaged throughout the six steps which occur in an iterative sequence rather than a linear one.

Based on this framework, the MCPH Lead Evaluator worked with MAP stakeholders to design a process evaluation to assess MAP's key partnerships. The overall program evaluation includes an outcome component, predominantly completed by the program's epidemiology team through the MAP surveillance activities, which resulted in separate reports, such as *The Burden of*

² Framework for Program Evaluation in Public Health. MMWR, September 17, 1999 Volume 48, RR11, pages 1-40.

³ Minkler M and Wallerstein N. (2008) Community-Based Participatory research for Health: From Process to Outcomes, 2nd Edition, Jossey-Bass, San Francisco, CA.

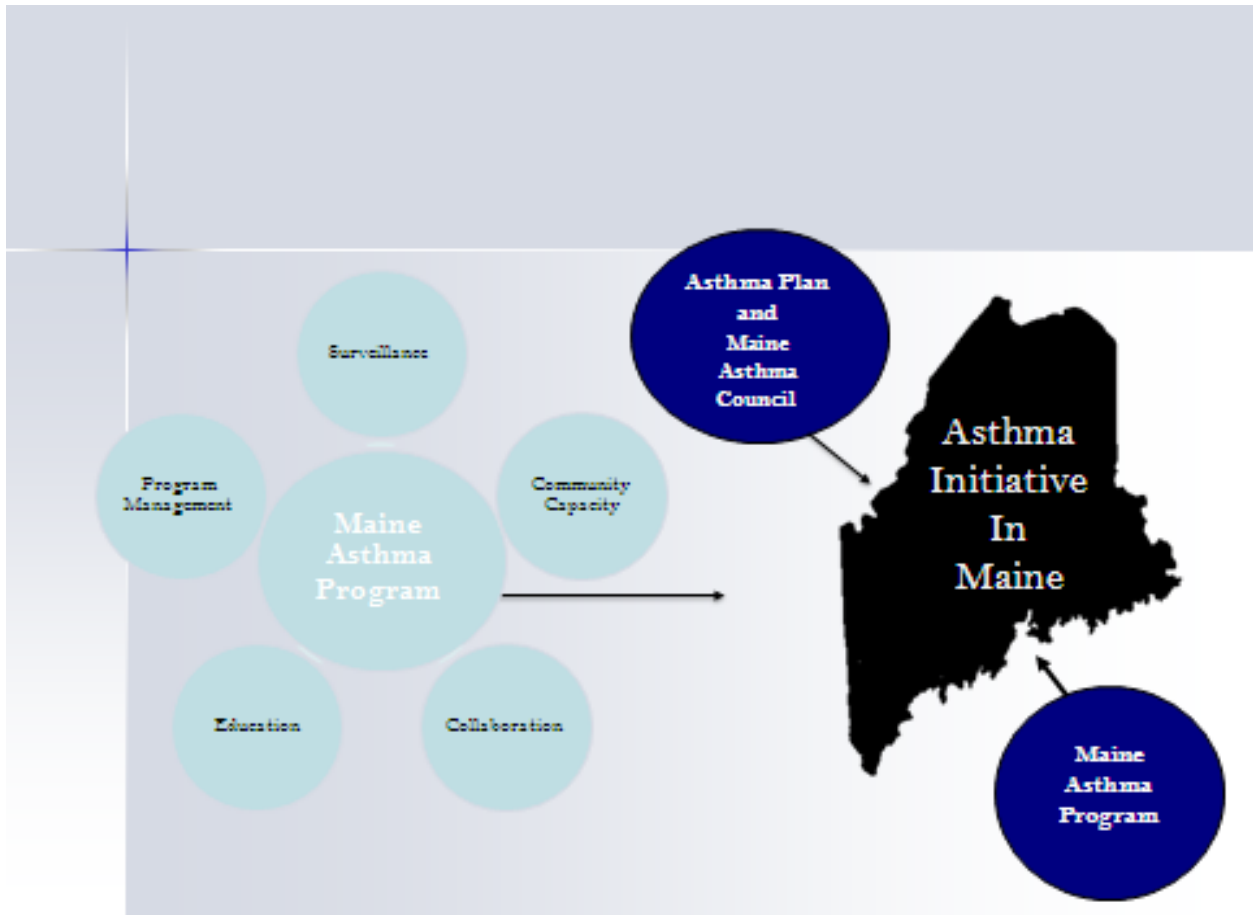
Asthma in Maine, 2008 Maine. This evaluation report focuses on the process component of the overall MAP evaluation efforts and places emphasis on activities and potential contextual factors that have the ability to influence the program, its efforts, and the intended outcomes.

The original objective in the 2008/09 work plan was to conduct an assessment of the effectiveness of interventions. The activities identified to complete the assessment were to conduct and assess the process of three interventions through first identifying which three interventions, then conducting assessments, and finally, offering feedback on lessons learned. This report represents the completion of the process evaluation objective of the work plan.

B. MAP Overall Evaluation

While the emphasis of this evaluation focuses on the partnerships, and the activities that result from those partnerships, process evaluation is just one component of MAP's overall evaluation activities. As Figure 2 below depicts, the overall MAP evaluation activities intend to capture the work done not only by the MAP, but also when possible, the work undertaken, and the impact of that work, through the efforts of the broad range of asthma partners committed to decreasing the burden of asthma in Maine.

Figure 2: What is being Evaluated



C. MAP Process Evaluation

The process component of MAP evaluation focuses on the implementation of activities and strategies designed to bring about changes that are directly linked to program goals. Process evaluation examines the extent to which program implementation is successful and the degree to which the program is doing what it set out to do. As many program managers know, the implementation process can often be challenging due to contextual issues, organizational dynamics, and programmatic uncertainties. That said, the process evaluation can provide valuable information to assist MAP with adjusting and or redesigning activities over the course of program implementation. For example, in the next section of the report the lessons learned from the Learning Collaboratives initiative informed the implementation of the partnership with the HBMI around the AHH! Initiative.

Typically the process component of the evaluation process attempts to answer questions like:

- Which initial strategies or activities are being implemented?
 - Which of these strategies are successfully implemented and why?
 - Which of these strategies are not successfully implemented and why?
- Which initial strategies or activities are not being implemented and why?
 - Are there specific strategies or activities that have been revised or disregarded?
 - What are the potential barriers?
 - What can be done to overcome the barriers?
- What lessons have been learned from implementation?

A key feature of the process evaluation component is the assessment and understanding of the contextual factors (e.g., environmental, organizational, human, etc.) that either hinder or facilitate a program's success. The assessment of context provides important information that can be used for program replication and decision-making. This context portion of the process evaluation answers several broad questions agreed upon by stakeholders, such as:

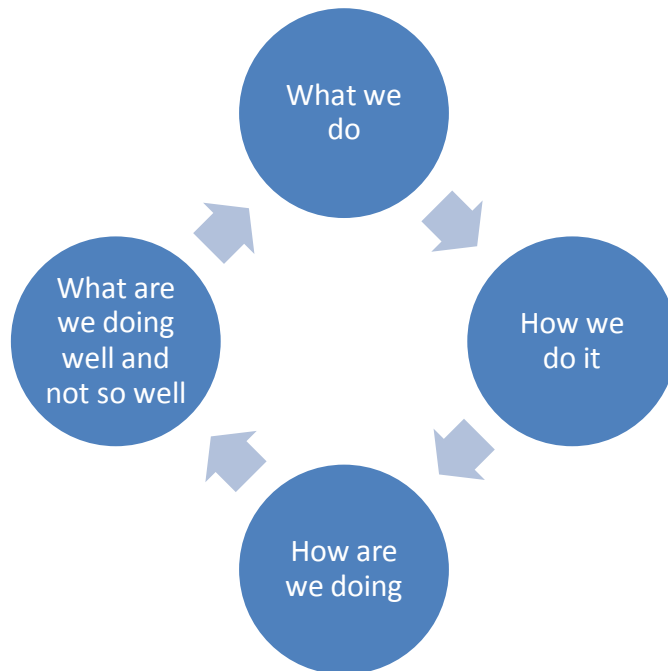
- What resources (e.g., funding, staffing, expertise, organizational support) are available and how are these resources used?
- What external factors (e.g., environment, social, economic, political) can be identified as having been strengths or barriers to the partnership/initiative?
- What internal factors can be identified as having been strengths or barriers to the partnership/initiative?
 - How does partnership functioning (e.g., partner involvement, leadership, efficiency, administration and management, sufficiency of resources) and partnership synergy influence the program's effectiveness?

Incorporating the contextual dynamics into the process component, MAP stakeholders developed the following set of evaluation questions specific to the work they are doing and the processes, the three key partnerships/initiatives, they wanted evaluated.

- What have we learned about partnerships?
- What lessons have we learned about creating new partnerships?
- How does partnership functioning influence program effectiveness?
- Which interventions have been successful and why?
- Which interventions have not been successful and why?
- What impact have the interventions had on their intended audience?
- Which initial strategies/activities were not implemented and why?
- What were the barriers to implementation? External and Internal?
- What evaluation information can we use to inform next year's program?
- What will we want to evaluate as we move forward into the next year?

In order to answer these questions it is critical to evaluate not what is being done and how, but also what is working and what can be done better to then inform what is done next. Figure 3 depicts this continuous feedback loop of evaluation informing program in a viable fashion.

Figure 3: Continuous Evaluation Feedback



III. Process Evaluation Results

A. MAINE ASTHMA COUNCIL: A Statewide Partnership

The Maine Asthma Council is a coalition of partners who are committed to addressing asthma in Maine. The Council provides the structure for partners to collaboratively address asthma priorities identified in the Maine Asthma Plan. The MAP serves as the convening organization for the Council. Working with the Program, the Council and its workgroups have responsibility for meeting the goals and objectives that are agreed upon in the plan.

The Council's partnership activities are evaluated annually. Under the previous co-operative agreement, the August 2006 Evaluation Report included an assessment of the Council membership and the MAP's collaborative activities. In August of 2007, the Council's Partnership Self-Assessment findings were reflected in a Report of Findings (Attachment 1) that indicated waning involvement of Council members and recommended clarifying and strengthening Council management, resources, and communication pathways. Due to a number of reasons, the Council took a hiatus until the spring of 2008, at which time the 2007 recommendations could be revisited and addressed.

In May of 2008, The MAP held its *Phoenix Event* with the primary purpose of celebrating the past and reactivating the coordination of asthma activities in Maine through the revitalization of Maine's Asthma Council. With the great success of the May event (See *May 2008 Evaluation Findings Report, Attachment 2*), the Council began to meet regularly beginning in the fall of 2008. Since September '08 the Council has met four times with excellent and ever expanding attendance. Council attendance has averaged twenty-one members with as many as thirty-four members attending one meeting. Three workgroups of the Council (Homes, Schools and Workplaces) also began to meet again regularly with an average attendance of eight members per workgroup meeting.

In order to assure that the Council's meetings continue to be relevant, meaningful to attendees, and effective in coordinating asthma efforts in Maine, the MAP requested its independent evaluator to conduct a semi-annual Council Satisfaction Survey. As a result, from February 25th to March 11th the 2009 Maine Asthma Council Satisfaction Survey was electronically administered (Attachment 3 is the non-electronic version of the survey questions). The findings from that survey are summarized below.

Maine Asthma Council Satisfaction Survey

1. Response Rate and Participant Characteristics

The electronic survey was sent to all members of the Maine Asthma Council as well as to asthma partners in Maine who are poised to become members. Membership in the Council is open, voluntary, and continuously growing. Thus, the survey was administered to not only

attendees at Council meetings over the past six months, but also to Asthma Council Workgroup members (the Council has three active workgroups that meet regularly), and to electronically connected only members — members who receive minutes and e-mailings from the MAP but don't actively attend meetings of the Council or its Workgroups.

Survey response was excellent with forty-one completed responses and one partially completed response. These forty-two respondents represent a response rate of 74% of the fifty-seven members currently involved in some format (actively or electronically) with council activities. All responses were anonymous and came directly to the MAP evaluator for compilation and analysis.

Participants represented a variety of sectors with over a third (35%) coming from the non-profit/advocacy sector. Another 27.5% of respondents were from state/local/tribal government settings (e.g., state/local/tribal Public Health Department or other department). Only 15% of respondents were from a healthcare system (including hospitals and physicians). These sector representation results are shown in Table #1.

Table 1: Sector Representation of Respondents (n=40)

Sector Represented	Percentage (#) of Respondents
Non-profit/advocacy	35% (14)
Hospital/physician/healthcare system	15% (6)
State/Municipal/Tribal Department/government	15% (6)
State Public Health Department	12.5% (5)
Healthy Maine Partnership	12.5% (5)
School Health	7.5% (3)
Other (consultant)	2.5% (1)

The other respondent characteristic captured in the survey was the self-identified level of involvement in asthma-related issues. Respondents were asked to rate themselves on a 5-point scale (1 being “Not at all involved,” 3 being “Somewhat involved,” and 5 being “Very involved”) in relation to the question: “How involved in asthma-related issues would you say you are?” Ninety-five percent of respondents answered this question (2 or 5% of the 42 chose not to answer this question). Of those respondents, 87.5% (35) indicated they were at least

somewhat involved in asthma-related issues. Table #2 provides a summary of the responses that characterize respondents’ level of involvement in asthma-related issues.

Table 2: Respondents’ Perceived Level of Involvement in Asthma Issues (n=40)

LEVEL OF INVOLVEMENT	PERCENTAGE (#) OF RESPONDENTS
(1) Not at all Involved	2.5% (1)
(2)	10% (4)
(3) Somewhat Involved	40% (16)
(4)	22.5% (9)
(5) Very Involved	25% (10)

2. Survey Results

The key components of the survey included:

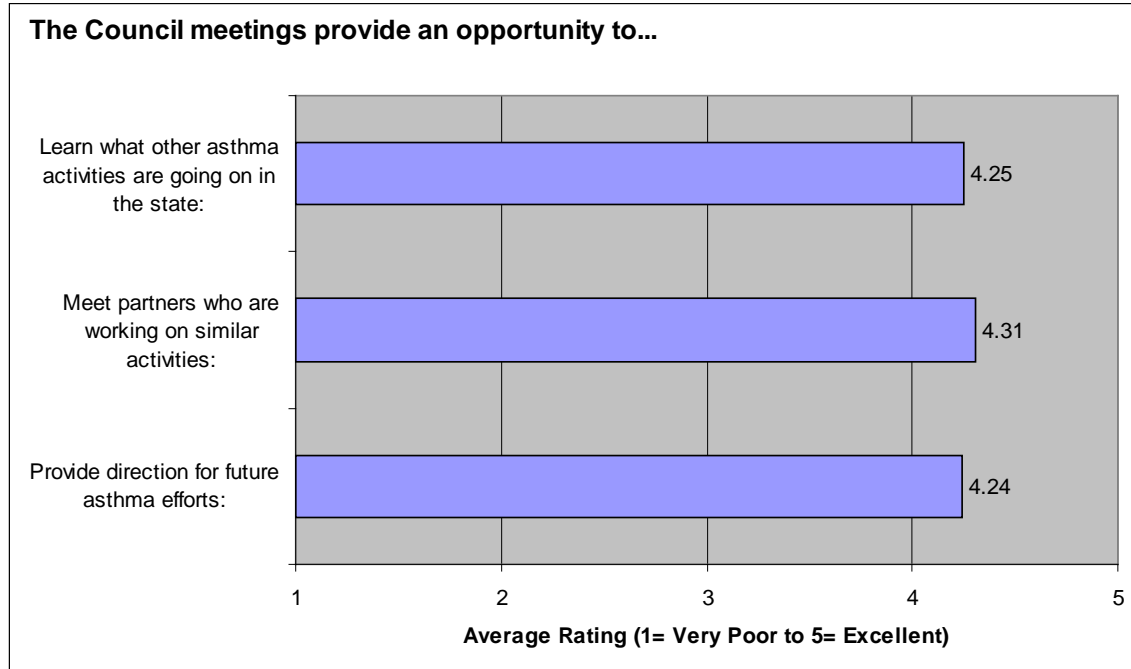
- The identification of the relevance and usefulness of Council activities for its membership;
- The identification of new and or enhanced content areas or growth directions for the Council’s work moving forward; and
- The preferred communication vehicle for membership partners to continue their involvement with Council and or Workgroup(s) activities.

The survey contained two questions meant to determine the relevance and usefulness of Council activities, and two questions focused on new or enhanced content areas or directions for future Council activities. The last question on the survey provided communication options for continued involvement with the activities of the Council and its workgroup(s).

➤ Relevance and Usefulness

In terms of relevance the survey asked membership to rate the relevance of Council meetings in reference to the opportunities meetings provide in three distinct areas — networking, knowledge of other asthma activities, and direction for future asthma efforts. A five point scale was utilized (1 being very poor and 5 being excellent) for each of the three areas. All three areas averaged well above 4 points for the total respondents (39 or 93% of respondents answered this question and 3 or 7% skipped it). Figure #2 reflects the responses addressing the relevance of Council meetings for its membership.

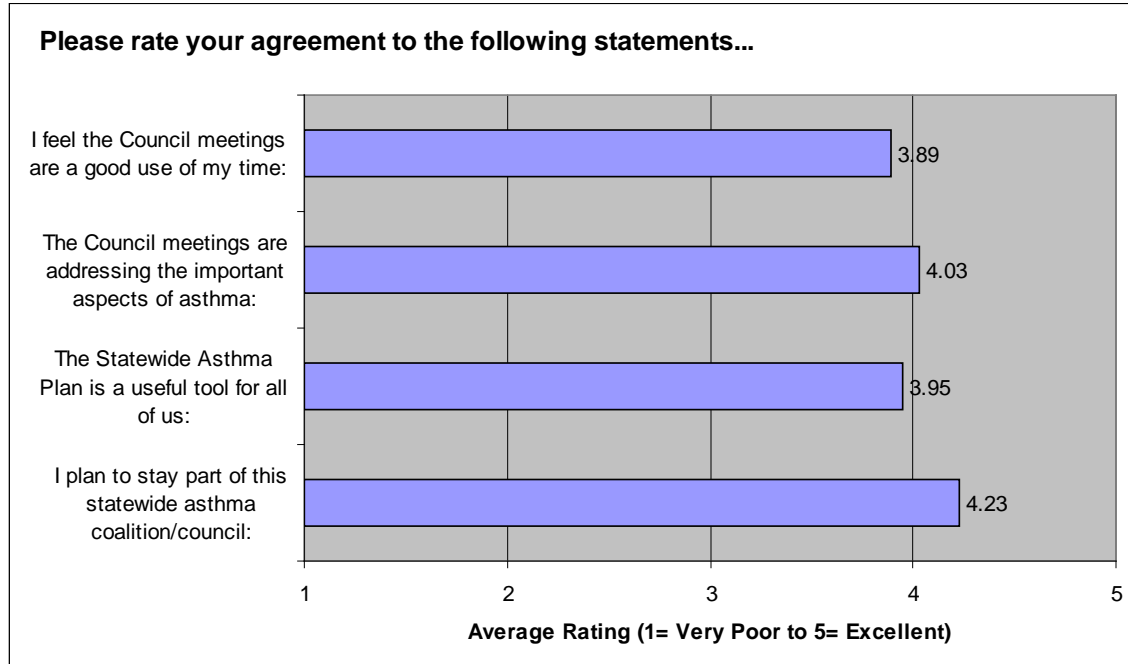
Figure 4: Average Respondent Ratings of Council Meetings (n=39)



In reference to usefulness, the survey used the same 5-point scale (1= very poor and 5 = excellent) to determine the perceptions of members in four areas — Council meetings as good use of their time, meetings addressing important issues, Asthma Plan as useful tool, and desire to stay involved with Council. For the overall question 95% or 40 respondents answered the question and only 2 (5%) chose not to answer the question. However, some respondents did not answer all four sections of the question so not all identified areas received the same number of responses; thus, response averages for each section of the question were calculated based on total responses to that specific section.

Once again the average ratings for each identified area hovered around 4.0 and are broken out individually in Figure #3 below. Within this question there is a significant finding for the fourth component — planning to stay involved with the council. For this component of the question 97.5% of respondents identified a score of medium (3) or above. Also of interest is that when one looks at the all four components to the question combined, out of a possible 150 responses only 3 scores were recorded at less than medium (3) (i.e. 147 of 150 responses were 3,4, or 5). And finally, it is important to remember that for most Council members, asthma is just one of many job responsibilities, or not the major focus of the work they do. As noted in the previous two sections (sector and involvement with asthma issues), Council members are often only tangentially dealing with asthma concerns and thus may not find much of the Council meeting agendas pertinent to their daily work.

Figure 5: Average Respondent Ratings of Council Activities (n=40)



➤ **New/Enhanced Content Areas & Directions**

In an open-ended question, the survey asked respondents to identify “content areas or alternative directions” that they felt the Council or its Workgroups could be addressing or taking. Well over a third of the respondents (15) choose to answer this question and among the areas/directions identified were the following:

- “I would like to see the council remain engaged with environmental health issues associated with asthma, in particular, pest and pesticide-related asthma issues such as the role of each.”
- “Indoor air quality and its affect on asthma”
- “Asthma assessment with spirometry is still the major obstacle in providing care”
- “Asthma self management”
- “Assistance in the development of asthma educators”
- “The workgroups are essential. Hopefully, more environmental monitoring issues such as funding concerns should be a topic...Need additional resources to increase monitoring efforts.”
- “I would love to see more clinical involvement, but generally clinical people are working”
- “Stronger linkage to those who are advocating for access to health care”

In a second open-ended question the survey asked respondents to share any suggestions they might have for enhancing the Council meetings or expanding Council membership. This question also got a good number of responses (14) and included some of the following suggestions:

- More clinical focus – both in content (for example as speakers) and in members
- Partner with and engage more tribal health providers
- Shorter meetings - possibly held more frequently
- Improved phone technology for those calling in
- Alternate locations for meetings – “move around the state”
- Clarify Council role as advisory or project-oriented, as forum for reporting out or for debate/discussion
- Continue to highlight evidence-based practice methods and validated tools

➤ Overall Satisfaction with Council

Within the context of the questions posed about enhancing/expanding the council, there were a number of responses which affirmed the current work of the Council. Many qualitative comments reflected the positive experiences of Council or Workgroup participants. Some of those remarks are as follows:

- “They [council meetings] are a vast improvement from the past...”
- “Keep doing what doing as it seems to be working well”
- “... others in my Department have been [active participants] and have found the Council very useful and informative”
- “So far, so good! The Council (and the Program) has covered a lot of territory in just 15 months. The scope of activities appear to be appropriate given the time frame needed to accomplish them”
- “I like the energy of the effort”
- “I serve on the school health subcommittee and feel it is an awesome connection to my work as a school nurse.”

➤ Preferred Communication Patterns

The final question in the survey asked respondents to identify the ways that they would prefer to stay involved with the Maine Asthma Council. Respondents were given six options and asked to check all that apply. Forty-one of the respondents choose to answer this question by checking at least one option for involvement. Table #3 reflects the percentage of response for each involvement option.

Table 3: Responses for Preferred Involvement (n=41)

Involvement Option	Percentage of Responses
Attend Council Meetings	68.3%
Attend Council Workgroup meetings	63.4%
Receive E-mail Updates	87.8%
Receive Council or Workgroup meeting minutes	78.0%
None at this time	0%
Other — Both of these responses referenced occasional attendance at meetings	4.9%

3. Recommendations

As the above summary results indicate, the revitalization of the Maine Asthma Council is, in the words of its members, a “vast improvement” and “seems to be working well.” Through this survey three quarters of the membership report that meetings are relevant — 91.3% rated relevancy at above average, and the other 8.7% rated it as average. They also find the Council useful to their work — 97.2% rated “Council meetings are a good use of my time” at average or above. Additionally, they have a clear desire to stay involved — 97.5% recorded a positive response to the question on staying part of the Council/Workgroup.

Networking and building partnerships are seen as key features of the Council and its workgroups. The good response rate affirms that the membership is involved and satisfied with the Council’s work, and are actively interested in extending and enhancing that work. Many thoughtful suggestions were made to expand the reach and content of the Council that are worth further discussion by staff and or membership.

Council membership appears to be pleased with the range of communication patterns that are being offered to keep them connected to the work of the Council/Workgroups, even if they are unable to attend in person. The failure of electronic connections to meetings was the only drawback identified and is one that should be addressed. And while some meeting logistics were identified as difficult, both the geography of the state and Asthma funding levels may limit what changes can be made. Again, it is clear from the data that the concerns raised come from members’ desire for continued (or stronger) involvement with the work being done through the MAP and the Council.

Finally, while some respondents expressed a desire to expand the membership and scope to include more clinical expertise or perspective, that suggestion was accompanied with a caveat acknowledging that clinical work schedules may preclude greater participation. A more focused type of participation (such as a workgroup) for clinical respondents may be more relevant than the more general Council meetings. Therefore, it may be worth some future agenda time to clarify the most appropriate functions the Council meetings can serve — advisory, project oversight, reporting out, policy setting, etc. Membership could then be reviewed to identify gaps needing to be filled as the Council moves forward with its work.

4. Dissemination

Step #6 in the CDC Framework (Ensure Use and Share Lessons Learned) assures that evaluation results are shared with stakeholders to use for making program changes, adjustments or enhancements. The framework is adamant in terms of keeping stakeholders engaged throughout the evaluation process so that the circular process can be realized, i.e. step #6 leads back to step #1. To this end, the independent evaluator shared with the Maine Asthma Council, at its April 1st meeting, the results and recommendations from the Asthma Council Satisfaction Survey.

The council unanimously expressed the usefulness of the survey and assisted the evaluator in developing next steps for when and how the survey will be implemented again in the next year. Council membership provided thoughtful feedback on strengthening the tool and its administration. Additionally, membership supported the continued use of the survey as an appropriate vehicle for tracking the operation, process, and work of the Maine Asthma Council.

B. ASTHMA LEARNING COLLABORATIVES: A Partnership with Maine Primary Care Association & the Federally Qualified Health Centers

In the fall of 2008, the Maine Asthma Program (MAP) embarked on a partnership intervention with the Maine Primary Care Association (MPCA). The focus of the joint initiative was to develop an Asthma Learning Collaborative program in Federally Qualified Health Center (FQHC) catchment communities that have a high incidence of asthma in their population.

The goal of the initiative was to increase quality of life for people who have asthma by decreasing exacerbations for patients treated at FQHCs located in areas of Maine with a high burden of asthma. The objectives for the FQHCs participating in the initiative were identified as follows:

- A 10% decrease in ER admissions for patients diagnosed with asthma
- Understanding of asthma clinical guidelines by Primary Care Physicians
- Simple asthma plan embedded in medical records
- Implementation of best practice documented in charts

- A 10% decrease in school absenteeism for asthma patients who are children
- A 10% decrease in work absenteeism for parents of children with asthma
- Child patients with asthma will demonstrate consistently higher ACT scores
- A commitment by practices to see patients when they need to be seen

In order to realize the objectives for the initiative a project logic model (Attachment 4) and a process evaluation plan (Attachment 5) were developed for the Asthma Learning Collaborative initiative. The project logic model was driven by the project objectives and the activities needed to realize the project goal. The foundation for the process evaluation plan was a set of key evaluation questions that were developed and included the following:

- Has the Asthma Learning Collaborative interventions been successful, and why? If not successful, why not?
- What impact has the Asthma Learning Collaborative intervention had on the patients of FQHCs participating in the collaborative?
- What impact has the Asthma Learning Collaborative intervention had on the PCP practices and FQHCs that participated in the collaborative?
- Has the Asthma Learning Collaborative met its goal and objectives?

The central component of the initiative's work plan involved a MAP and MPCA partnership which would then extend out to three to five FQHCs located in areas of Maine that experience a high burden of asthma. Between the months of August 2008 and January 2009 a tremendous amount of time and energy was devoted by MAP staff to building the partnership with MPCA in order to get the initiative up and running at the FQHCs. Because MPCA works with FQHCs in other venues, one of the roles the MPCA staff was to play was to serve as the conduit for asthma education with primary care physicians. Thus, building bridges across MAP, MPCA, and FQHCs, while involving more work, had the potential of reaching further than either single partnership.

Among the roles that MAP would play in this initiative was to provide the resources and content expertise for the collaboratives themselves. Qualitative review of the extensive record of meetings and e-mail communications indicate that a clear set of expectations and timeframes were laid out at the beginning of the partnership building process. The initiative began with MAP funding MPCA to set up the Asthma Learning Collaboratives based on a successful Learning Collaboratives model utilized by MPCA in the past. The program was to include an initial large educational meeting for physicians and hospital staff, with follow-up collaborative meetings (virtual web sessions or physical meetings depending on each FQHC's needs) at three and six months after the full day educational meeting on best practice management guidelines for asthma patients.

Responses to MAP meetings and e-mails indicate that MPCA had a high level of interest in the project; however, it soon appeared that MPCA lacked the staff resources to complete their work. As a result the planning process proved to be a challenge and ultimately unsuccessful. Included in some of the steps taken, and activities and timeframes set out, are the following:

- Kick-off informational meeting for Collaborative members with national speaker set for October 28th;
- Memorandum of Agreements (MOA) to be established by MCPA before the meeting to secure that critical FQHC personnel will attend meeting;
- Oct. kick-off meeting canceled due to lack of commitment from FQHCs and re-scheduled for early December with assurances from MCPA that the MOAs with FQHCs will be in place;
- November 2008, FQHC MOA's continue to be a problem but unclear about root of problem, i.e. MCPA, FQHCs, or both;
- November 13, 2008 MAP Program Director and evaluator meet with MCPA project coordinator to reaffirm plans to move forward and to set clear tasks and dates that need to be completed if December meeting is to happen (MAP Director sent the list with dates to all parties shortly after the meeting to assure that everyone was in agreement as to what needed to happen)
- December meeting canceled and last attempt made to get MOAs in place by December 15th in the hope that a kick-off meeting could be scheduled for January 2009;
- January 6th 2009 MAP Program Director makes the decision to cease partnership building efforts and "pulls the plug" on the current Learning Collaborative model program.

Once the decision was made to not move forward with the initiative the focus of the evaluation activities associated with the initiative changed. Because the initiative did not get to the intervention stage where outcomes could be evaluated, the evaluation's direction became instead one of reviewing the partnership building process. With a focus on lessons learned in partnership building, a new set of evaluation questions were posed. The redirected evaluation then began to answer the following questions:

- What have we learned about partnerships?
- What lessons have we learned about creating new partnerships?
- How does partnership functioning influence program effectiveness?
- What evaluation information can we use to inform next year's program?

During the spring of 2009 the MAP independent evaluator met with the MAP Program Director to review the partnership building process and establish all the issues that impacted on the

dissolution of the partnership. Utilizing a reflective practice model for the review of what worked, what didn't work, what one might do differently next time, and lessons learned, the evaluator sought to provide answers to the new evaluation questions. Additionally, the evaluator completed a qualitative review of the correspondence to glean lesson learned about the process of embarking on this three-way collaboration between MAP, MCPA, and the FQHCs.

The results of the reflective practice session and the correspondence review revealed the following lessons learned:

- ❖ The correspondence review revealed that expectations, timeframes and accountability, all key dynamics needed for a successful collaboration, were clearly laid out and should be part of any future complex collaboration where funding is involved.
- ❖ While trust is critical to any partnership, it may need the added support of a written contract being in place for partnerships where MAP is financially supporting an initiative. [Note: Map subsequently developed a template for use with future collaborative initiatives that receive funds from MAP.]
- ❖ In a complex collaborative such as this one it may be more advantageous to have all partners at the table each step of the planning and implementation process. This initiative relied heavily on MCPA as a conduit for the FQHCs in the early planning stages, and it may be that having the FQHC voice right from the start could have prevented some of the issues that ultimately lead to the dissolution of the initiative.
- ❖ Flexibility is an essential ingredient in any collaborative and the ability to regroup and reframe are critical when working with an array of partners. That said, making the decision about when not to regroup, but to just let go, may have been made sooner in this instance. The balance of flexibility and letting go is always a difficult task.
- ❖ As with any statewide initiative, the Asthma Initiative of Maine has a vibrant political aspect to it that influences the programs and activities engaged in by all partners working to address asthma issues in Maine. It is critical to assess the political dynamics and adjust ones actions to account for those dynamics if a partnership is to be successful and on-going.
- ❖ The enhanced knowledge about Learning Collaboratives, what they are, how they function and how they can assist pediatric practices with improving asthma quality for their patients , was invaluable information and can be used by MAP in the future.

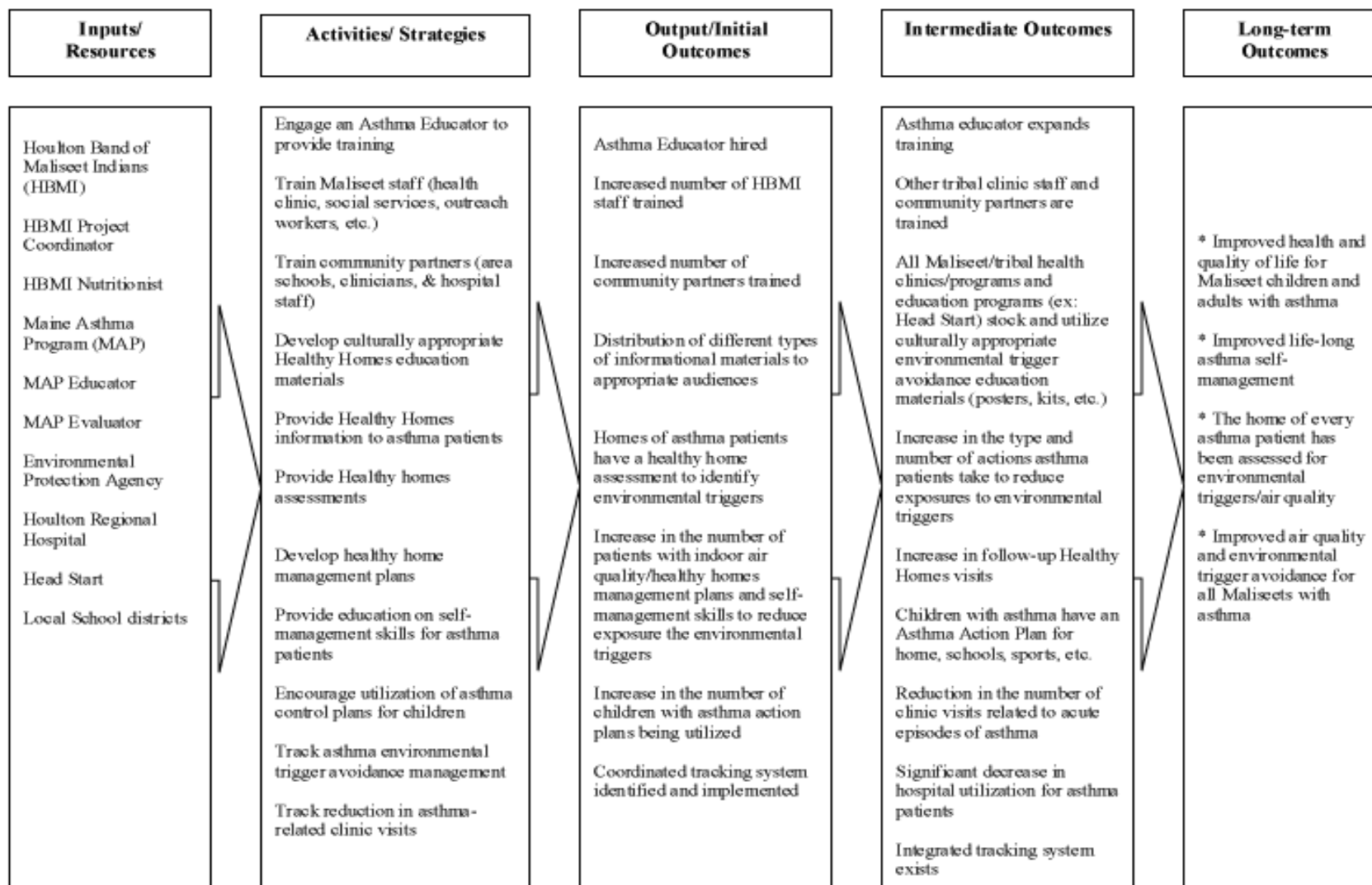
C. ASTHMA HEALTHY HOMES (AHH!) INITIATIVE: A Partnership with the Houlton Band of Maliseet Indians

The final partnership for which the MCPH provided evaluation support was The MAP partnership with the Houlton Band of Maliseet Indians (HBMI) around their initiative to prevent and control asthma environmental triggers. Over a two-year period, HBMI will develop an environmental trigger avoidance/Healthy Homes outreach and education program as part of a comprehensive Asthma Intervention Program. The MAP will be a key partner in these efforts through the provision of education and training resources and will work directly with the tribal community, not through a third party as happened with the unsuccessful MPCA/FQHC Learning Collaboratives Initiative. Instead, building on the lessons learned from that initiative, the MAP/HBMI partnership began with all the significant voices at the table right from the start.

The project goal for the Developing Asthma Healthy Homes (AHH!) Initiative is to improve the health and quality of life of Maliseet children and adults with asthma by supporting asthma self-management through avoidance of environmental triggers. The MAP believes community-based grass roots efforts are central to prevent and control asthma and can provide the technical expertise and resources necessary to support the HBMI in reaching its goal successfully. Figure 6 portrays the Logic Model developed by the MCPH evaluator with the key stakeholders for the initiative, HBMI and MAP.

Figure 6: AHH! Initiative Logic Model

AHH! Initiative - HBMI & MAP Partnership



The HBMI have the appropriate infrastructure, staff levels and environmental, health and social programs in place to successfully integrate asthma self-management into an overall wellness program. They also have the ability to identify and target Maliseet families dealing with asthma. What they lack is appropriate training, culturally appropriate outreach and education materials and management tools. It is in these areas that the MAP can provide critical resources to this project, as well as reaching out to the broader community. For example, all training sessions provided for the project will be made available to local schools, clinicians and Houlton Regional Hospital, community resources utilized by many Maliseet households that are educated or treated at these facilities.

Activities planned for the first year of the project include:

- Engagement of an Asthma Educator through the MAP to train Maliseet Nutritionist, Environmental Planner, Health Clinic staff, Social Services and Health Outreach Workers, Youth Workers, and Headstart staff using the National Asthma Education & Prevention Program guidelines;
- Provision of training opportunities to include areas schools, clinicians and Houlton Regional Hospital;
- Development of a culturally appropriate Healthy Homes education and outreach program informational materials;
- Provision of Healthy Homes information to asthma patients at the Maliseet Health Clinic;
- Provision of Healthy Homes information to attendees of the annual Health Fair, to Head Start and Youth Programs participants, and in a quarterly Environmental Health Newsletter; and
- Develop and implement a partnership process evaluation and develop an outcome evaluation plan.

Activities planned for the second year of the project include:

- Encouraging tribal families with asthmatic members to sign up for healthy home visits/assessments;
- Providing healthy home assessments;
- Improving self-management skills for asthma patients;
- Improving the utilization of Asthma Action Plans for Maliseet children with asthma;
- Tracking changes in indoor air quality/asthma trigger avoidance management through clinic and follow-up healthy homes visits;
- Tracking of health improvements as a result of improved asthma trigger avoidance through clinic visits; and
- Complete an outcome evaluation.

In its partnership with MAP, the AHH! Initiative anticipates impacting the type and number of actions asthma patients take to reduce exposures to environmental triggers, and to lower the number of clinic visits related to acute episodes of asthma. Both of these outcomes can be reached through education and training, materials distribution, healthy home assessments, and the development of management plans to reduce exposure to environmental triggers.

This partnership is a new one and as such the evaluation will be on-going into the next cooperative agreement. As part of its on-going program evaluation, MAP will work with its independent evaluator to design a process evaluation for the partnership activities involved with the AHH! Initiative. Additionally, in concert with the HBMI project lead, the MAP Program Director and program evaluator will design an outcome evaluation for the implementation of the program activities. Finally, this partnership has already resulted in a request to the CDC for additional funding in the 09/10 grant year to expand the AHH! Initiative to an additional four Maine tribes, Penobscot, Maliseet, Passamaquoddy and Micmac, through working with the Tribal Health Directors who meet on a regular basis.

IV. Conclusion and Next Steps

As this evaluation reflects, the MAP is “off life support” and healing and growing extremely well. The MAP staff has provided much needed direction, support, and outreach to the asthma community in Maine this past year and the results have been positive and well received. In the upcoming year MAP has developed an ambitious work plan to keep the momentum and focus on asthma going. Anticipating that MAP’s cooperative agreement will be refunded through the CDC, the projected work plan includes significant evaluation activities for 2009/10. It is important to reiterate that the activities referenced below will need to be adjusted, either in extent and or timeframe, once the new funding requirements are finalized in the fall of 2009.

As the three tables of evaluation activities from that work plan (shown below in Table 4) indicate, there is much evaluation work to be done. In the upcoming year the MCPH evaluator will work with MAP staff and key stakeholders to develop a five-year evaluation plan for MAP’s on-going cooperative agreement with the CDC. The MCPH evaluator will complete the Maine Asthma Council Satisfaction Survey and will include some key informant interviews as part of the Council assessment in the next year. Additionally, the MCPH evaluator will provide direction for the development of a process, and any tools needed, for tracking the New Asthma Plan progress on a yearly basis. Finally, the MCPH evaluator will provide technical assistance and reports, as needed, for the MAP concerning its program partnerships and activities.

Table 4: 2009-2010 Proposed Evaluation Activities

Objective #1: Complete the comprehensive five-year evaluation plan for the MAP

	Activity/Strategy	Timeline	Measure of Accomplishment/Progress
1.1	Meet with MAP staff to develop timeline for initiatives that will be evaluated over the five years.	10/09-11/09	Design timeline and content for 5-year evaluation plan is developed
1.2	Identify key partners for each initiative and met with stakeholder groups to identify evaluation needs	11/09-1/10	Meetings set and list of evaluation needs is compiled for MAC decision-making about priorities
1.3	Develop logic models for the key components/initiatives of the MAP to be included in the five year plan	1/10-3/10	Logic models developed
1.4	Develop evaluation questions and evaluation plans from the logic models and then propose a framework for integrating all the component plans	4/0-6/10	Evaluation questions identified; Five-year framework developed
1.5	Braid component evaluation pans into the overarching 5-yr. evaluation plan structure that Council agrees upon	7/10	Braided five-year framework is approved
1.6	Draft 5-yr. plan for review by MAC and other stakeholders and secure approval of plan	7/10-8/10	Draft plan reviewed and approved by appropriate stakeholders and MAC
1.7	Edit and submit plan to CDC and begin implementing specific pieces of the plan	08/10 forward	Final draft of plan is completed, approved and forwarded to CDC

Objective #2: Complete annual program evaluation for the Maine Asthma Program.

	Activity/Strategy	Timeline	Measure of Accomplishment/Progress
2.1	Develop evaluation survey tools for individual trainings and events	On-going as requested	Evaluation design and tools developed
2.2	Administer evaluation tools when appropriate	On-going as requested	Evaluation administered
2.3	Analyze data and provide feedback with written report to component or initiative stakeholders	On-going as requested	Reports completed
2.4	Administer the annual Council Satisfaction survey and produce a report of the findings for MAC to use	5/09	Report Completed
2.5	Provide a partnership process assessment if requested	TBD	TBD
2.6	Provide an intervention evaluation if requested	TBD	TBD

Objective #3: Provide evaluation Technical Assistance (TA) to the MAP, including program-specific and interdepartmental across multiple chronic disease programs at the Maine CDC.

	Activity/Strategy	Timeline	Measure of Accomplishment/Progress
3.1	Provide TA in evaluation, survey development, and evaluation capacity building as needed	On-going as requested	TBD
3.2	Provide TA and evaluation support to MAP within the context of the Maine CDC's Division of Chronic Disease	On-going as requested	TBD
3.3	Produce the Annual Evaluation Report	8/10	Annual MAP Evaluation Report is produced

V. Appendices

Appendix 1: Maine Asthma Council Partnership Self-Assessment Report of Findings – August 2007

Appendix 2: Maine Asthma Program Phoenix Event: Summary of Evaluation Findings – May 2008

Appendix 3: Maine Asthma Council Satisfaction Survey (2009)

Appendix 4: Maine Asthma Program MPCA/ FQHC Initiative Logic Model

Appendix 5: Maine Asthma Program MPCA/FQHC Initiative Evaluation Plan

Appendix 1: Maine Asthma Council Partnership Self-Assessment Report of Findings-August 2007

The Maine Asthma Council, Partnership Self-Assessment

Report of Findings – August 2007

Background

Addressing the burden of asthma on Maine's people takes the work of many people, in many places, and at many levels. A major goal of the Maine Asthma Program, therefore, is to optimize collaboration, efficiency, and effectiveness of all partnerships. In order to begin to evaluate the effectiveness of such partnerships, the Maine Asthma Program conducted a partnership self-assessment with the Maine Asthma Council. Through the Maine Asthma Council, the Asthma Program and its partners have published the statewide Maine Asthma Plan, a roadmap designed to provide the people of Maine with activities to address asthma. Thus, the evaluation of this partnership is a critical step in assessing the effectiveness of their collaborative efforts.

Overview

The web-based *Partnership Self-Assessment Tool* was administered as part of a larger web-based survey to a total of 50 members of the Maine Asthma Council during February 2007. Members were selected to participate in this survey if they met the following two criteria: 1) were a member of the Maine Asthma Council 2) had an e-mail address.

The survey included a series of 70 questions. The majority of questions were based on the *Partnership Self-Assessment Tool* developed and tested by the Center for the Advancement of Collaborative Strategies in Health at The New York Academy of Medicine. Questions pertaining to the partnership tool were used to assess how well the Council's collaborative process was working and to identify specific areas for improvement. Additional questions provided information about a participant's involvement in the Council, including the length of time involved and the level of involvement.

Response Rate and Participant Characteristics

A total of 16 members completed the survey during the two week timeframe for a response rate of 32%. Over 80% of respondents indicated that they had been involved in the Council for one year or more, 44% of whom have been a member of the Council for greater than three years. Approximately 25% classified themselves as "involved," or "very involved" and one-third (31%) self-classified as "somewhat involved" and the remaining 43% classified themselves as "rarely" or "not at all involved" when asked about their involvement in the Council *over the past 6 months*.

Involvement in Council	Percent
Length of Time Involved in Council	
Not a member	0
Less than 6 months (new member)	6.2%
6 months to one year	6.2%
One to three years	37.5%
Greater than three years	44%
Other (<i>not sure</i>)	6.2%
Level of Involvement over past 6 months	
Not at all involved	31%
Rarely involved	12%
Somewhat involved	31%
Involved	6%
Very involved	19%

Table 1. *Involvement in Council* (n=16)

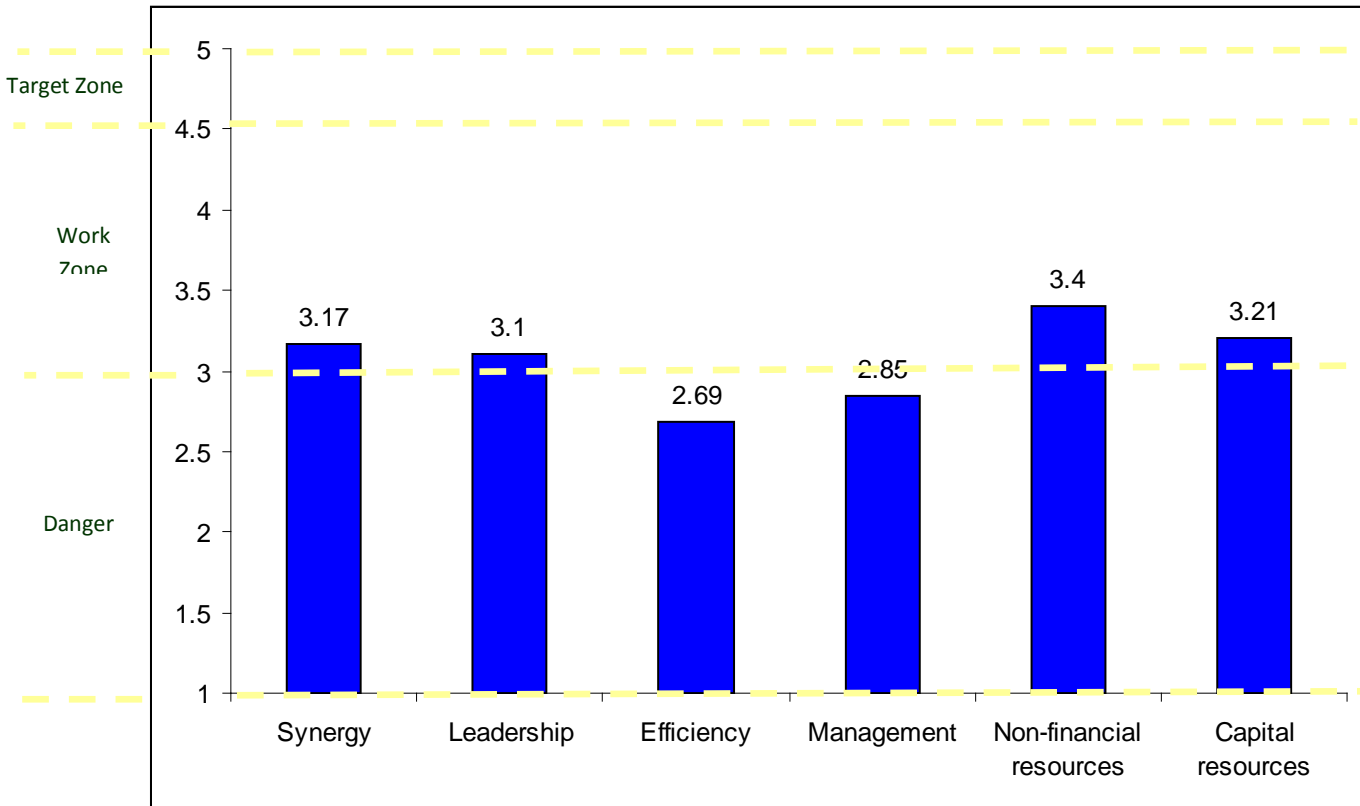
Table 1 provides a summary of responses. As planned, the results suggest that only current members participated in the survey. The responses also reflect a mix of views from members at varying levels of involvement.

Overall Partnership Tool Results: Synergy

The self-assessment tool focuses primarily on a construct known as *partnership synergy*. This construct is used to determine how well a collaborative process is working. The term synergy is defined as a partnership’s ability to accomplish more collectively compared to what could be achieved individually (Weiss, Miller Anderson, & Lasker, 2002). A partnership’s collaborative process achieves high levels of synergy by combining different kinds of knowledge, skills and resources of its participants.

- The overall results of the *Partnership Self-Assessment Tool* are illustrated below in Figure 1. A total of 14 people answered the self-assessment questions. These results include the partnership’s overall synergy as well as four factors that have been identified to relate to a partnership’s ability to achieve high levels of synergy. These factors include:
 - Effectiveness of the partnership’s leadership
 - Efficiency of the partnership
 - Effectiveness of the partnership’s administration and management
 - Sufficiency of the partnership’s resources (non-financial and capital)
- Findings indicate that the Council scored within the second or “work” zone for all but two of the six domains. Areas currently in the “work zone” include:
 - Synergy, leadership, non-financial resources and capital resources
 - More effort is needed in these areas in order to maximize the partnership’s collaborative potential and in order to achieve scores within the “target zone” (optimal performance).
- The Council scored in the “danger zone” for the overall efficiency and management of the partnership. A lot more effort is needed in these areas to maximize the effectiveness of the Council.

Figure 1. Partnership Self-Assessment Overall Results, (n = 16)



The Council has several noteworthy strengths and accomplishments. The following tables highlight these strengths as well as the weaknesses in each area.

Partnership Synergy Results

Each item listed below in Table 2 represents one attribute of synergy, as operationalized by this instrument.

- The overall results, calculated based on the mean of all items, suggest an overall synergy score of 3.21, indicating the Council is doing “well” in terms of overall synergy.
- This score can be interpreted to fall within the “work zone” thus, indicating more effort is still needed to maximize the Council’s full potential.
- The scores depicted below indicate that the Partnership is doing “well” with regard to the items listed in Table 2.

Table 2. *Partnership Synergy Results*

Synergy Items	Mean
	1 = Not well at all 5 = Extremely well
By working together, how well the Council members are able to:	
Identify new and creative ways to solve problems	3.2
Include the views and priorities of the people affected by the Council's work	3.2
Develop goals that are widely understood and supported among partners	3.4
Identify how different services and programs in the community relate to select problems	3.4
Respond to the needs of the community	3.0
Implement strategies that are likely to work in the community	3.1
Obtain support from those who can block the Partnership's plans	3.3
Carry out comprehensive activities	3.1
Clearly communicate to people how the Partnership will address problems	2.9

Leadership Results

Leadership has been shown to be the most important indicator of partnership synergy (Weiss et al., 2002). In order to achieve a high level of synergy, partnership leadership needs to be able to promote productive interactions among diverse people and organizations.

Table 3 highlights the results of specific leadership attributes that are linked to high levels of synergy.

- Overall, the findings suggest several strengths including: fostering respect, trust, and inclusiveness, creating an environment where differences of opinion can be voiced, and resolving conflict among partners all of which received an average rating of 3.5 or above.
- Most areas received ratings near or above 3.0 suggesting the Council is doing “well” in leadership effectiveness but has room for improvement.

- Areas needing the most attention included: inspiring or motivating people involved in the partnership and communicating the vision of the partnership.

Table 3. *Leadership Results*

Leadership Effectiveness Items	Mean
	1 = Poor 5 = Excellent
Leadership attributes:	
Taking responsibility for the partnership	3.3
Inspiring or motivating people involved in the partnership	2.6
Empowering people involved in the partnership	3.0
Communicating the vision of the partnership	2.6
Working to develop a common language within the partnership	3.2
Fostering respect, trust, inclusiveness and openness	3.6
Creating an environment where differences of opinion can be voiced	3.6
Resolving conflict among partners	3.7
Combining the perspectives, resources and skills of partners	2.9
Helping the partnership be creative and look at things differently	2.9
Recruiting diverse people and organizations into the partnership	2.8

Efficiency Results

Table 4 depicts the results of how well the Council optimizes the involvement of its members.

- Based on the scores below, the Maine Asthma Council does a “fair” job using its members’ in-kind resources, and drawing on the financial resources and time of the members.
- As noted in the overall synergy findings, these results indicate a need to improve the efficiency of the Council in order to maximize the collaborative effectiveness.

Table 4. *Efficiency Results*

Efficiency Items	Mean	
	1 = Poor	5 = Excellent
How well the partnership uses its partners’:		
Financial resources	2.7	
In-kind resources	2.8	
Time	2.6	

Administration and Management Results

The administration and management of a partnership attempting to achieve a high level of synergy is typically one that provides an orientation to new members, minimizes the barriers for involvement, facilitates timely communication, coordinates meetings and other activities, applies for and manages funds, and provides analytic support.

- As seen in Table 5, the Council’s “management” has room for improvement in all areas, however, coordinating communication among partners, organizing activities, and minimizing barriers for participation in meetings and activities are clear areas of strength for the Council.
- The Council is also doing well in other areas such as secretarial duties and communication outside of the partnership.
- The scores suggest that providing orientation to new members and evaluating the progress and impact of the Council are areas most in need of improvement.

Table 5. *Administration and Management Results*

Administration and Management Items	Mean
	1 = Poor 5 = Excellent
Council administration and management activities:	
Coordinating communication among partners	3.3
Coordinating communication outside of partnership	2.9
Organizing partnership activities, including meetings and projects	3.0
Applying for and managing grants and funds	2.8
Preparing materials that inform partners and timely decisions	2.8
Performing secretarial duties	2.9
Providing orientation to new partners	2.5
Evaluating the progress and impact of the partnership	2.6
Minimizing barriers for participation in meetings and activities	3.0

Non-Financial Resources Results

The Council’s ability to secure sufficient non-financial resources from its members is an important dimension of Partnership synergy.

- Overall, the Council has “most of what it needs” in terms of skills and expertise, legitimacy and credibility, the ability to bring people together for meetings, and data and information.
- The Council also has at least “some of what it needs” in terms of political connections and connections to people affected by asthma.

Table 6. *Sufficiency of Non-Financial Resources Results*

Non-Financial Resources Items	Mean
	1 = None 5 = All of what it needs
Kinds of non-financial resources:	
Skills and expertise	3.2
Data and information	3.4
Connections to target populations	3.4
Connections to political decision-makers, government, and others	3.6
Legitimacy and credibility	3.8
Influence and ability to bring people together for meetings, activities	3.0

Financial Resources Results

Although the relationship of financial resources to a partnership’s level of synergy may be indirect, financial and capital resources are essential to carry out the management of activities.

- The results suggest that the Council has “what it needs” in terms of equipment, goods, and space and “some of what it needs” in the area of money.

Table 7. *Sufficiency of Financial Resources Results*

Financial and Other Capital Resources Items	Mean
	1 = None 5 = All of what it needs
Kinds of financial resources:	
Money	2.9
Space	3.5
Equipment and goods	3.3

Decision-Making Process and Satisfaction Results

As seen in Table 8, the results suggest that a slight majority (57%) of the members of the Council are very to extremely comfortable with the way decisions are made.

- The majority of respondents (78%) supported the Council’s decisions “most to all of the time,” and only 29% (4 respondents) felt left out of decisions “some of the time.”
- In terms of satisfaction with the Council, respondents were most satisfied with the way the partners work together, their influence in the partnership, and the partnership’s plans for achieving its goals.
- Respondents were least satisfied with their role in the Council and the way in which the implementation of the Council’s plan (i.e., Asthma Plan)
- While the majority of respondents were “completely” or “mostly” satisfied with the way the partners work together, their influence, and the planning process, there is room for improvement, particularly since satisfaction impacts involvement and commitment levels.

Table 8. *Decision-Making and Satisfaction with Participation*

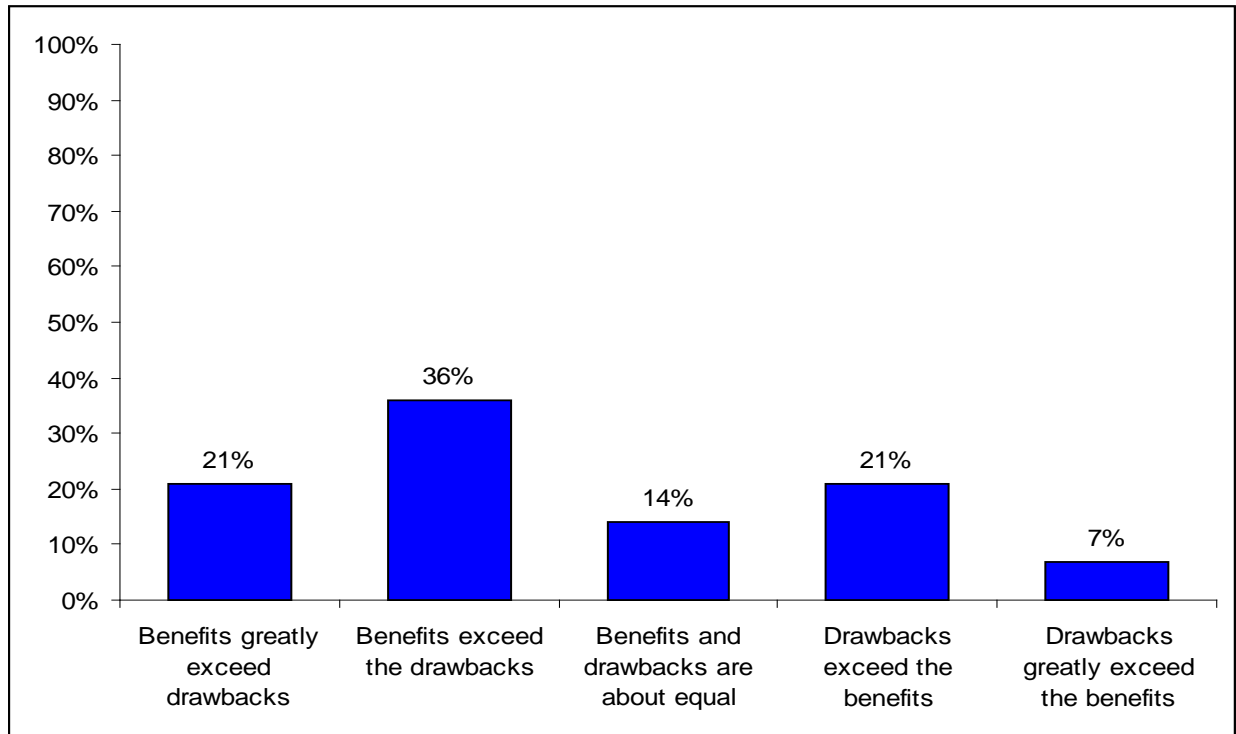
Items	Scale				
Decision-Making:	Not at all Comfortable	A Little Comfortable	Somewhat Comfortable	Very Comfortable	Extremely Comfortable
Comfort with the way decisions are made	0%	14%	29%	50%	7%
Decision-Making:	None of the Time	Almost None of the Time	Some of the Time	Most of the Time	All of the Time
How often partnership’s decisions supported	0%	0%	21%	57%	21%
How often left out of decision-making	36%	36%	29%	0%	2%
Satisfaction with Partnership	Not at All Satisfied	A Little Satisfied	Somewhat Satisfied	Mostly Satisfied	Completely Satisfied
The way partners work together	7%	14%	21%	36%	21%
Influence in partnership	0%	0%	36%	43%	21%
Role in partnership	7%	0%	46%	23%	23%
Partnership’s plans for achieving its goals	0%	0%	18%	63%	18%
Implementation of the plan	14%	29%	14%	21%	21%

Benefits versus Drawbacks Results

The perceived benefits and drawbacks of a partnership are perhaps two of the most important factors that influence participation.

- Respondents were asked to compare the benefits and drawbacks they were experiencing as a result of their involvement in the Council
- Overall the results suggest that, of those who completed the survey, approximately 85% believed that the benefits exceeded or greatly exceeded the drawbacks.

Figure 2. *Drawback and Benefits of Participation*

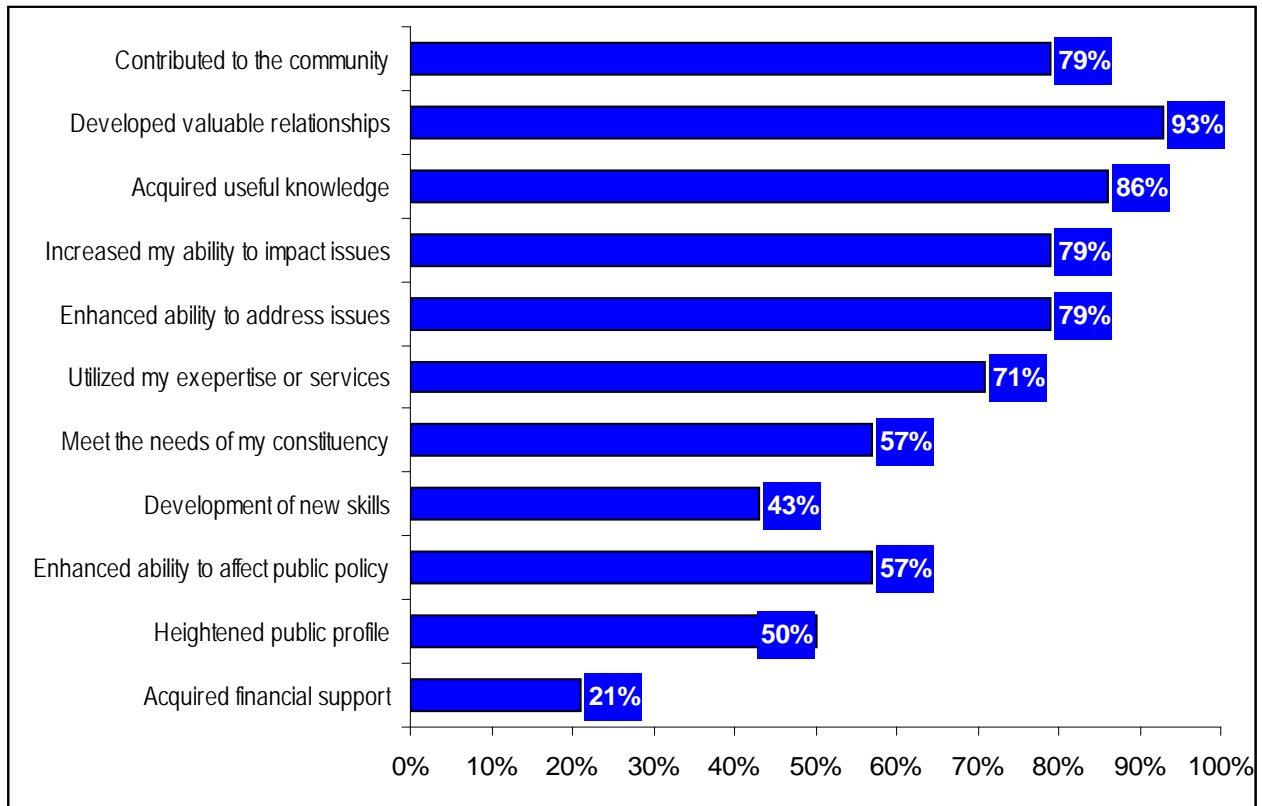


Specific Benefits Results

Respondents were also asked to identify whether or not they received 11 specific benefits as a result of their participation in the Council.

- Overall, the results suggest that members who responded are receiving substantial benefit.
- Most of those who completed the survey indicated that the Council enhanced their ability to: 1) develop valuable relationships; 2) acquire useful knowledge; 3) contribute to the community; 4) address the issue of asthma and; 5) have an impact on issues asthma-related issues.
- Of the listed benefits, acquisition of additional funding support ranked the lowest.

Figure 3. *Benefits Experienced by Respondents*



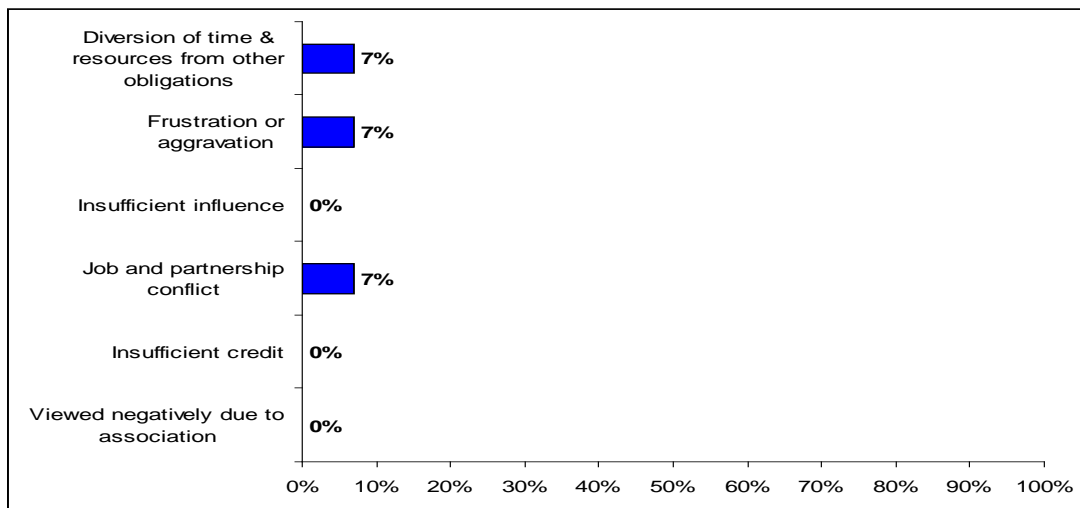
Specific Drawbacks Results

- Respondents were asked to identify whether or not they experienced a set of six drawbacks resulting from their participation in the Council.
 - As shown in Figure 4, few respondents reported experiencing any drawbacks to participation. The only drawbacks noted by 7% of respondents ($n = 1$) were diversion of time, frustration, and job and partnership conflict.
 - Although only one person noted the drawbacks of participation in the Council, several respondents made comments regarding frustration or aggravation with the Council, diversion of time away from other obligations and job conflicts. These responses are provided below.

Table 9. Qualitative Responses Regarding Drawbacks

Type of Drawback	Qualitative Responses
Frustration or aggravation	<ul style="list-style-type: none"> • Need a stronger lead in the meetings to direct and move the meetings along and keep focused. Often other people have to take over or direct a meeting that has lost focus or is going nowhere. • It just feels like we spin our wheels sometimes. • I haven't seen anything accomplished in the past 2-3 years • Inability to garner more participation. • Wishing that we could be more effective and DO more together and better utilize the strengths of the membership. I would also like to see new energy in the Council – new members, new successes that will fuel future work and keep people motivated. There is obviously a lot going on – it is just harnessing it and using it to the best of our abilities.
Diversion of time and resources away from other obligations	<ul style="list-style-type: none"> • Travel to attend the meetings take away from work time. Not much gets done during meetings. • All give, no get. The people are great but participation is not with the time. • I have a job that overrides everything. • Meetings....
Job/Council conflict	<ul style="list-style-type: none"> • Time, loss of income • Job comes first. • Meetings... • Unable to attend meetings for past year

Figure 4. Drawbacks Experienced by Respondents



Qualitative Comments

Participants were invited to make additional comments regarding the survey or Council. Most comments related to suggestions for improving or keeping up the work of the Council. Verbatim comments are provided below:

- Keep up the good work that provides a forum for many groups seeking to minimize asthma impacts!
- Having a formal annual meeting would be nice with formal elections to formal positions of chair and vice-chair and secretary, etc. Instead of the same people taking over the positions year after year that may generate new interest and bring fresh faces and fresh ideas to the group. Charging membership fees would lend more legitimacy to the group and would fund those positions.
- Great job
- [Chair] has done a great job in leading the Council. I think that a challenge will be in reestablishing the relationship with the MAP once a new manager is hired.

Limitations

The results of the *Partnership Self-Assessment Tool* are intended to be used to identify strengths and weaknesses of the Maine Asthma Council. The findings provide a springboard for discussion on what is working and those areas that may require additional effort, as resources permit, in order to maximize the Council's potential.

Given the intended use of this information, it is important to keep in mind that there are several limitations that warrant attention. They include:

- The information provides a snapshot approach of the partnership and its members at a given point in time. The Council is a dynamic partnership. Membership and level of involvement are subject to change.
- Of the 50 members in the sample, only 16 (34%) completed the computer-based survey. This group of participants may not adequately reflect the views of all Council members.

Discussion and Recommendations

These results provide the Maine Asthma Program, the Maine Asthma Council as well as its stakeholders and partners documentation of the "synergy" or "outcome" of the collaborative process. In terms of the results, the Maine Asthma Council is doing "well" in terms of its synergy but has room for improvement. Synergy is not easy to achieve so the strengths in this area (e.g., leadership and use of resources) should be celebrated. For example, the results indicated strengths in leadership and use of Council resources. In order to continue to build upon these strengths the following recommendations are provided:

1. Discuss findings at a Council meeting to determine if members have or know someone who has leadership skills that the partnership is under-utilizing or lacking.
2. Leadership skills that help foster effective partnerships include the ability to promote productive interactions among a diverse group of people. Consider recruiting members with experience in multiple fields and understand different perspectives.

In order to improve the synergy of the Council, synergy results should be discussed with Council members with particular attention given to those areas of weaknesses⁴. These areas in need of improvement include:

- Efficiency (e.g., use of members' time, Council resources) and management of the Council. Overall, efficiency was shown to be in the "danger zone"; however, these results were inconsistent with the respondent's rating of the Council's use of financial and non-financial resources. Thus, these results may be indicative of a need to improve the Council's use of members' resources, skills, and involvement.
- The management of the Council was also in the "danger zone." Areas relating to the management of the Council needing the most improvement included:
 - Inspiring or motivating people to be involved in the partnership
 - Communicating the vision of the partnership.
 - Providing orientation to new members

In order to address these areas in need of improvement, the following recommendations have been provided:

1. Strengthen the management of the Council in order to make it more efficient. Consider increasing or enhancing the current resources devoted to the communication of the council.
2. Develop an orientation for new members outlining the vision of the Council, its members, history, and contact lists.
3. Consider developing workgroups in order to maximize the utilization of members' time and skill sets. Workgroups could be regional to enhance statewide participation and limit travel time for members.
4. Conduct statewide outreach clarifying the role and vision of the Maine Asthma Council. Include in the efforts to disseminate Statewide Asthma Plan.

References

Weiss, E. S., Miller Anderson, R., & Lasker, R. D. (2002). Making the most of collaboration: Exploring the relationship between partnership synergy and partnership functioning. *Health Education & Behavior*, 29(6), 683-698.

⁴ Follow-up interviews with a sample of active and non-active members are in the process of being conducted in order to begin exploring this topic with members.

Appendix 2: Maine Asthma Program Phoenix Event: Summary of Evaluation Findings – May 2008

Maine Asthma control and Prevention Program

Phoenix Event ~ Summary of Evaluation Findings

May 2008

Submitted by: Amy Black, PhD

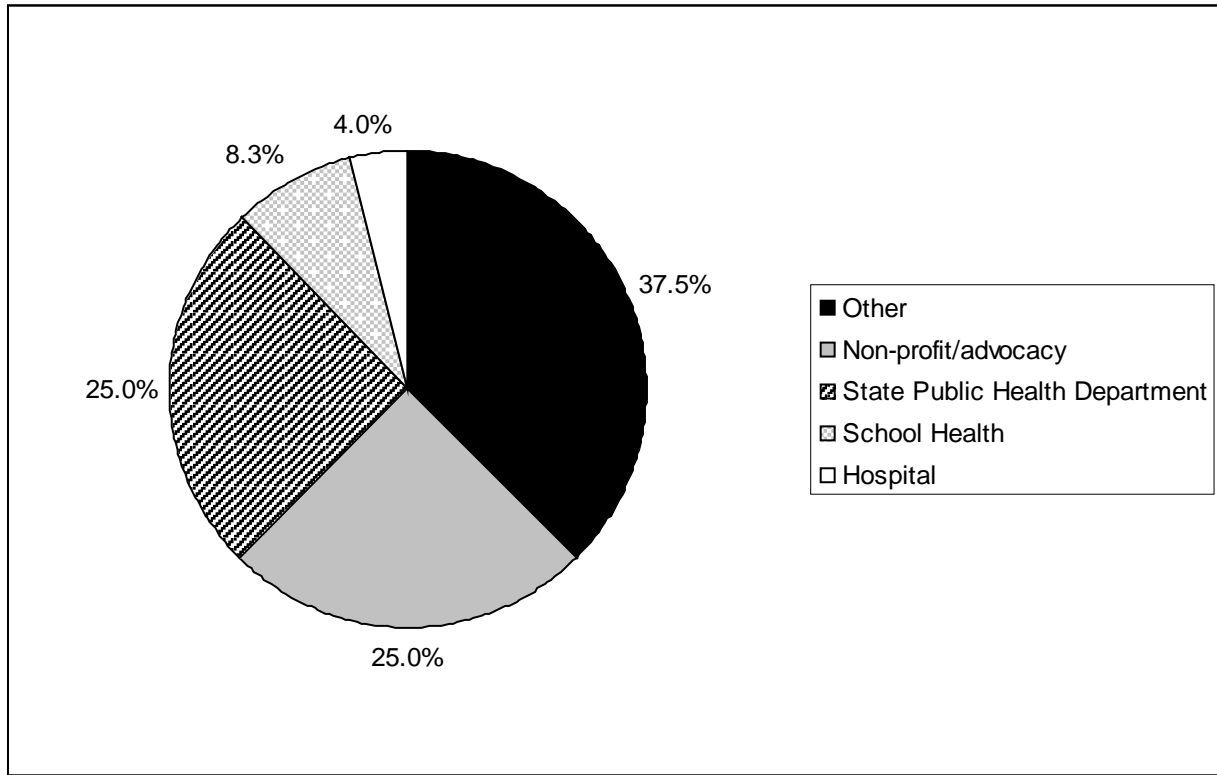
June 2008

The Maine Asthma Program held its *Phoenix Event* with the primary purpose of celebrating the past and reactivating the coordination of asthma activities in Maine. Fifty-eight people attended. Of these, 24 people returned evaluation surveys (41%). The purpose of the survey was to capture attendees' feedback regarding the meeting goals and to gauge the participants' level of engagement and plans for future involvement. The findings are summarized below.

Participant Characteristics

A total of 24 people returned evaluation surveys. Participants represented a variety of sectors with most coming from a school or state government setting (e.g., State Public Health Department, Department of Labor). These results are shown in the following figure.

Figure 1 . Sector Representation of Respondents, (n = 24)



Note: The majority (78%) of respondents in the “Other” category represented state agencies such as Department of Labor, Department of Education, Department of Environmental Protection or MaineCare.

Respondents were asked to rate their level of involvement in asthma-related issues. Most (79%) indicated they were at least somewhat involved in asthma-related issues in Maine.

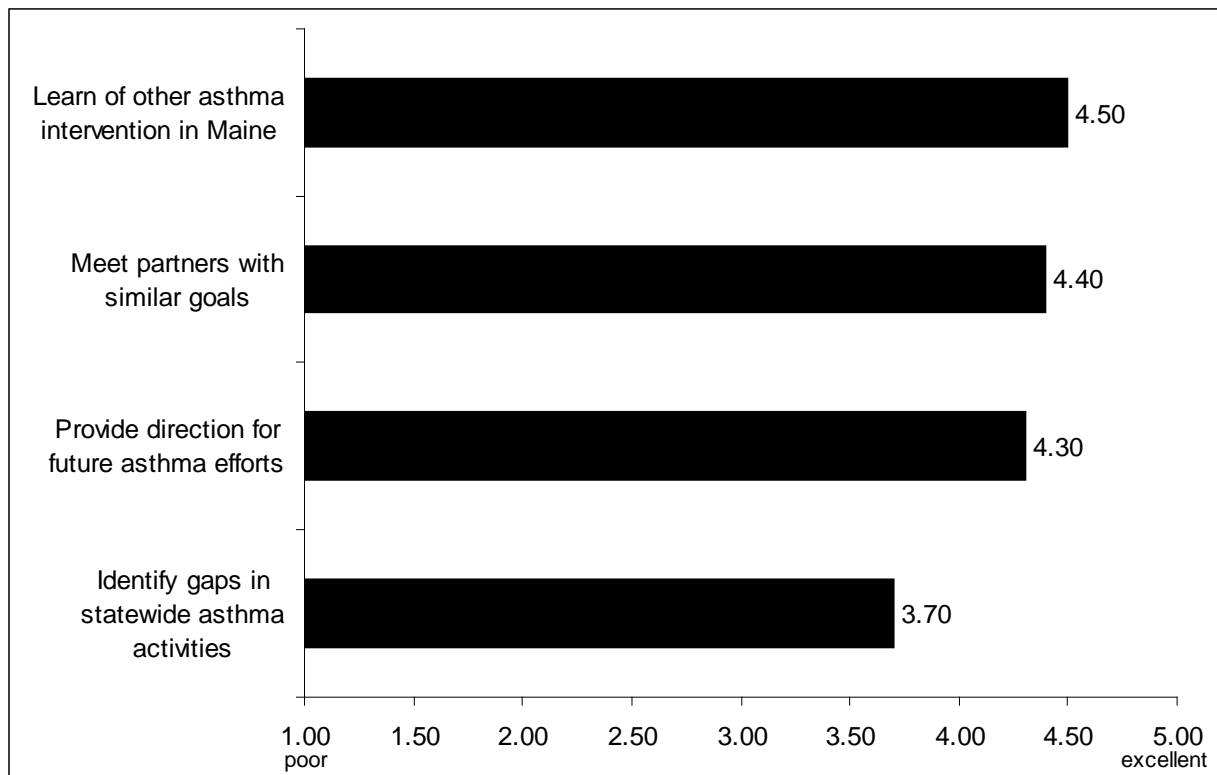
Level of Involvement	Percentage of respondents
Not involved	21%
Somewhat involved	46%
Involved to very involved	33%

Table 1. Respondents’ Perceived Level of Involvement in Asthma

Feedback on Meeting Goals

Using a 5-point scale, (1 = very poor; 5 = excellent) participants rated how well the meeting goals were achieved. All of the goals were rated high with average ratings ranging from 3.7 to 4.5. As shown in the following figure, participants rated the opportunity to learn about other asthma interventions in Maine and meet partners with similar goals as the highest. Qualitative findings from open-ended responses provided on the evaluation forms provided additional support for these findings with the majority of respondents noting the presentations about the asthma activities in Maine, networking and collaborative opportunities as the most useful aspects of the meeting. The identification of gaps in statewide asthma efforts was rated slightly lower. In addition, qualitative responses indicated a desire for more time for networking and brainstorming ideas for future asthma efforts. These findings suggest only minor improvements could be made in order to reach the meeting goals.

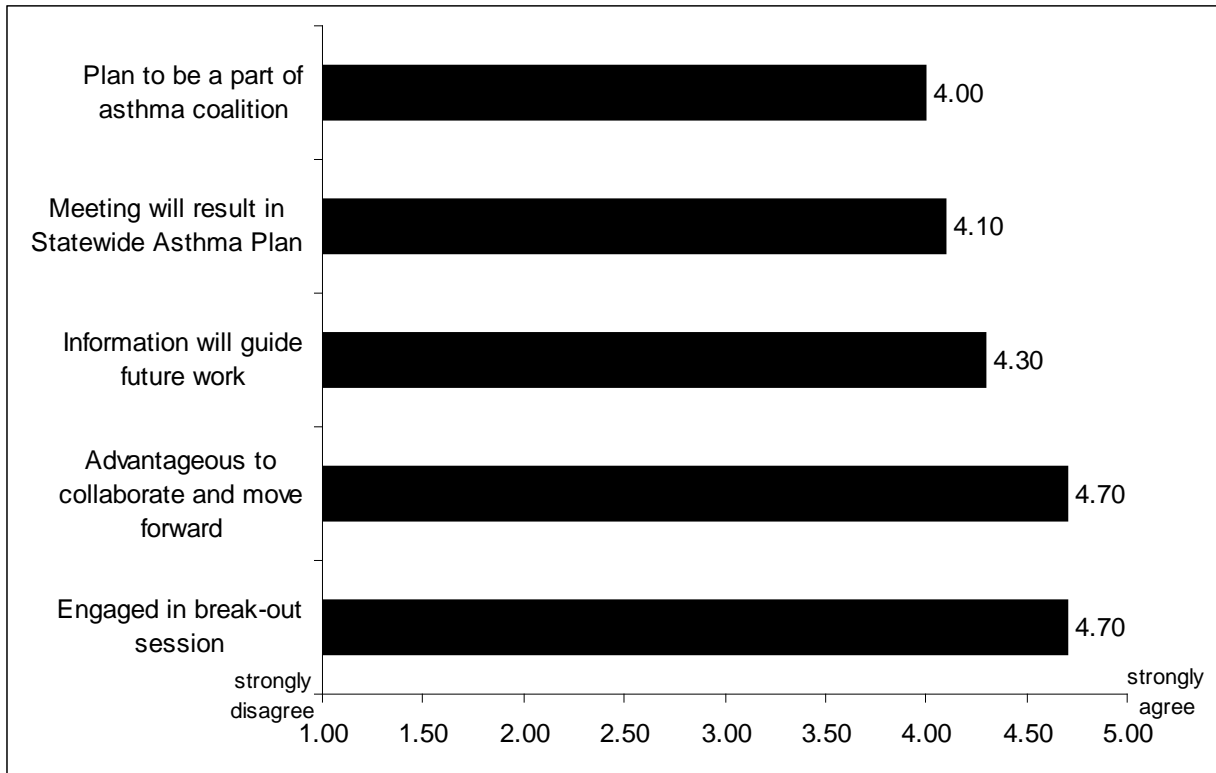
Figure 2. Average Respondent Ratings of Meeting Goals, (n = 24)



Participants were asked to indicate their agreement with statements regarding their level of engagement in the meeting as well as their investment in re-energizing the asthma efforts in Maine. As shown in Figure 3, respondents indicated a high level of agreement with averages ranging from 4.0 to 4.7, with feeling engaged in the breakout sessions and supportive working in collaboration having the

significantly highest ($p < .05$) level of agreement. Moreover, all but six people (25%) agreed firmly to be part of the emerging Statewide asthma coalition. Thus, these results suggest a high level of engagement and investment on behalf of the participants.

Figure 3. Average Respondent Level of Agreement, ($n = 24$)



Overall Satisfaction with the Event

All 24 respondents noted their overall satisfaction with the event. As previously reported, participants found networking and opportunities for collaboration, learning about asthma activities and data in Maine, and breakout sessions as the most useful aspects of the event. Qualitative responses also indicated a desire for more time to brainstorm in the breakout sessions and network with colleagues and others conducting asthma-related activities in Maine. Both areas of improvement suggest a desire for more involvement rather than lack of satisfaction with the event

Appendix 3: Maine Asthma Council Satisfaction Survey (2009)

Maine Asthma Council Satisfaction Survey February 11, 2009

The purpose of this survey is to determine if the Asthma Council meetings are useful to you and future asthma-related efforts throughout the state. Please answer the questions to the best of your ability. Thank you!

1. Please indicate the sector you represent

- Non-profit/advocacy
- Hospital
- Healthy Maine Partnership
- School Health / HMP
- State Public Health Department
- Other _____

2. How involved in asthma-related issues would you say are?

Not at all involved	Somewhat Involved	Very Involved
1	2 3 4	5

The Council meetings provide an opportunity to...

- | | | | |
|--|-------------------------------|--|-----------|
| 3. Learn what other asthma activities are going on in the state: | Very Poor | | Excellent |
| | 1 2 3 4 5 | | |
| 4. Meet partners who are working on similar activities: | Very Poor | | Excellent |
| | 1 2 3 4 5 | | |
| 5. Provide direction for future asthma efforts: | Very Poor | | Excellent |
| | 1 2 3 4 5 | | |

Please rate your agreement to the following statements...

6. I feel the Council meetings are a good

use of my time:

	Disagree		Strongly Agree
1	2	3	4 5

7. The Council meetings are addressing the important

aspects of asthma:

Disagree

Strongly Agree

1 2 3 4 5

8. The Statewide Asthma Plan is a useful tool for all of us:

Disagree

Strongly Agree

1 2 3 4 5

9. I plan to stay part of this statewide asthma coalition/council:

Disagree

Strongly Agree

1 2 3 4 5

10. Overall, are you satisfied with the content areas and direction of the current Council meetings?

Yes

No - Please explain: _____

11. Please share any content areas or alternative directions you feel the Council could be addressing or taking: _____

12. Please share any suggestions you have about how to enhance the Council meetings or expand Council membership: _____

13. My preferred involvement with the Maine Asthma Council is (check all that apply to you):

Attend Council meetings _____

Attend Council Workgroup meetings _____

Receive E-mail Updates _____

Receive Council or Workgroup meeting minutes _____

Other _____

None at this time _____

Thank You! Your feedback is greatly appreciated.

Appendix 4: Maine Asthma Program MPCA/FQHC Initiative Logic Model

MAINE ASTHMA PROGRAM MPCA/FQHC INITIATIVE

GOAL: *Increase quality of life for people who have asthma by decreasing exacerbations of people treated at federally qualified health centers in areas of the state of Maine with a high burden of asthma.*

STRATEGY: *Asthma Learning Collaborative*

INPUTS	ACTIVITIES	OUTPUTS	INITIAL OUTCOMES	INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES
<p>Maine Asthma Program</p> <p>Maine Primary Care Association</p> <p>Medical Care Development</p> <p>Federally Qualified Health Centers</p> <p>Community Health Centers</p> <p>Private Health Care Practices</p>	<p>*Hold initial informational meeting for Collaborative members on Dec.'08</p> <p>*Identify best practice management guidelines and measurements for asthma (based on the PTE benchmarks for best practice in Asthma care/control)</p>	<p>*Expert meeting in Portland to kick off initiative (10/28/08)</p> <p>*The Asthma best practice and guidelines/measurements document</p> <p>*Training protocol for Best Practice document</p> <p>*Twice monthly conference calls with collaborative members</p>	<p>* PCPs, including those of participating FQHCs, understand clinical guidelines for best practice asthma care management by Jan.'09</p> <p>* PCPs, including those of participating FQHCs, implement best practice for asthma care management by 3/09</p>	<p>* 10% decrease (at the end of one year) in ER admissions for asthma patients at FQHCs participating in the collaborative</p> <p>* 10% decrease (by 6/09) in school absenteeism for children w/asthma who are patients at participating FQHCs</p>	<p>*Lessen burden of Asthma for patients who have been diagnosed with it</p> <p>* Asthma disease management at primary care level</p> <p>*All Collaborative members meet the Pathways to Excellence's Blue ribbon status measurements for Asthma care and management</p>

ACTIVITIES(cont.)	OUTPUTS (cont.)	INITIAL OUTCOMES (cont.)	INTERMEDIATE OUTCOMES (cont.)	LONG -TERM OUTCOMES (cont.)
<p>*Train on clinical guidelines and planned care model (Dec. '08)</p> <p>*Embed asthma plan in medical record for asthma patients</p> <p>*Chart Review</p> <p>*PCP Satisfaction surveys on Survey Monkey</p>	<p>*WebEx sessions</p> <p>*Phone and e-mail support</p> <p>*Site visits by MPCA quality staff</p> <p>*At least one site visit by MAP program staff</p> <p>*Severity Assessments (annually)</p> <p>*Simple Asthma Care Plan</p> <p>*Second face-to-face collaborative meeting(May '09)</p>	<p>* Simple Asthma Care Plan embedded in practice medical record beginning Feb. '09</p>	<p>* 10% decrease (by July '09) in work absenteeism for parents of children w/asthma who are patients in participating FQHCs</p> <p>* Improve Asthma Control Test scores (by July '09) for children w/asthma who are patients at participating FQHCs</p> <p>* Learning Collaborative members see patients when they need to be seen</p>	<p>*Universal Asthma Plan format for state of Maine</p>

Appendix 5: MAP/ MPCA/FQHC Initiative Evaluation Plan

MAINE ASTHMA PROGRAM MPCA/FQHC INITIATIVE EVALUATION PLAN

GOAL: *Increase quality of life for people who have asthma by decreasing exacerbations of people treated at federally qualified health centers in areas of the state of Maine with a high burden of asthma.*

STRATEGY: *Asthma Learning Collaborative*

PROCESS EVALUATION:

<i>PROCESS INDICATOR</i>	<i>MEASURES</i>	<i>SOURCE OF DATA</i>	<i>DATA COLLECTION METHOD</i>
Initial informational meeting for Collaborative members on Dec. '08	* Meeting attendance *satisfaction with the meeting *number of members recruited	*Registration list *meeting evaluations *collaborative membership list	Collect at the December meeting
Complete bi-monthly conference calls with collaborative membership	*Conference call minutes *number of members participating in calls	Conference call minutes	Review minutes
Complete WebEx sessions	Member attendance at sessions	Minutes from sessions	Review minutes
Provide phone and e-mail support to the membership	Description of support given	MAP and MPCA staff	Review Phone logs and/or staff interviews
MPCA site visits are completed	*Site visit record *Activities implemented	*Visit record/log *MPCA staff	Review record and/or staff interview
MAP site visits are completed	*Site visit record *activities implemented	*Visit record *MAP staff	Review record and/or staff interview
Second “live” meeting of the collaborative takes place in central location	* Meeting attendance *satisfaction with the meeting	*Registration list *meeting evaluations	Collect at the meeting

<i>PROCESS INDICATOR</i>	<i>MEASURES</i>	<i>SOURCE OF DATA</i>	<i>DATA COLLECTION METHOD</i>
Identify best practice management guidelines and measurements for asthma	Guideline and measurements document	*Guideline and measurements document *PTE Asthma Quality Measures	*Review document *Compare PTE measures with document
Train on clinical guidelines and planned care model (11/08)	*Training protocol document *Utilization of guidelines	*Training protocol document *PCP survey	*Review document *Compile surveys
Embed asthma plan in medical record for asthma patients	Asthma plans exist in medical records	Medical records	Review Medical records
Chart Review	Medical charts reflect best practice guidelines and measures	Medical charts	Review Medical charts
PCP Satisfaction surveys	High level of satisfaction	Surveys and/or PCP interviews	Compile surveys and or interviews