

Towards Evidence-Informed Practice Phase 1: Planning Phase

Program Assessment Worksheet

Introduction

This worksheet sets out criteria related to **Plausibility** (*to the extent the practice/program is likely to be effective based on formative/process evaluations and content attributes*) and **Effectiveness** (*to the extent the practice/program has met stated goals and objectives as assessed by an impact/outcome evaluation*) for community-based heart health promotion programs. The criteria have been grouped under four programmatic areas:

- a) Program Need
- b) Program Content
- c) Program Evaluation
- d) Program Process

The purpose of using the Plausibility and Effectiveness criteria in this project is to identify areas for enhancement to assist in future program planning and refinement.

Practicality (*to the extent the practice/program will be effective in the context of the adopting community*) criteria is another component commonly included in Best/Promising Practices assessment tools. Practicality addresses issues such as cost effectiveness, availability and fit. This criterion is not used for this phase of the project, as judging practicality of different approaches is best made at the community level by those who are considering adopting the practice and are aware of the opportunities and threats in the specific practice setting.

An **Assessment Guide** has been developed to illustrate conditions for assigning a rating level of 0 through 4 on each criterion:

Level 0 indicates that the criterion has not been addressed.

Level 1 indicates that there is extensive capacity for enhancement along the criterion.

Level 2 indicates considerable capacity for enhancement along the criterion.

Level 3 indicates some capacity for enhancement along the criterion.

Level 4 indicates best practice with very limited potential for enhancement along the criterion.

Procedure

1. Review the program description as it relates to each criterion. Compare the description provided to the Assessment Guide levels and assign a level of 0 through 4 as appropriate. Please assess the program on activities completed or in progress, rather than planned activities. Comments or supplemental ratings can be provided for the planned activities.
2. Note those points which support the level assigned (Rationale) and be prepared to discuss at the consensus meeting.
3. Please note any ideas or suggestions for enhancement, especially for those criteria which receive a lower rating.
4. The Internal Reviewer and the Survey Respondent should **not** collaborate to fill out the Internal Assessment. This is to ensure integrity in the process, maintain independence of reviewers and ensure all reviewers have access to the same information. All reviewers will have an opportunity to pose questions to the Survey Respondent during the consensus meeting.
5. Submit completed Program Assessment Worksheet to Dayna Albert, Program coordinator by email (dalbert@opha.on.ca) or by fax (416-367-2844) by the established deadline.

Program Assessment Worksheet

The Dissemination of Best and Promising Practices in Chronic Disease Prevention Project Phase 1: Planning Phase

Program Name:

Program Community:

Reviewer Name:

Reviewer Email:

Reviewer Phone #:

Date Review Completed:

Program Need

Criteria	Definition	Assessment Guide	Assessment
#1 Needs Assessment	The program* responds to demonstrated wants and/or needs of the primary audience*.	0. No evidence. 1. Some informal collection of information about the primary audience. 2. Existing statistical data used to confirm perceptions of need. 3. Formal needs assessment conducted and primary data collected, (e.g. survey, key informant). Needs have been prioritized. 4. Formal needs assessment conducted, analyzed and reported and results used to guide program development	Level: Rationale: Suggestions for Enhancement:

Program Content

Criteria	Definition	Assessment Guide	Assessment
<p>#3 Theory and Literature Evidence</p> <p>NOTE: See Summary of Health Promotion Theories appended to the end of the worksheet</p>	<p>The program* is informed by appropriate theoretical concepts (e.g. principles of behaviour change, social learning, etc.) review of literature and/or best practices.</p>	<ol style="list-style-type: none"> 0. No evidence. 1. Some evidence of having consulted the literature about appropriate foundations on which to base the program activities and objectives (e.g. read appropriate articles re theories, conceptual frameworks, research and/or best practices) 2. Some evidence of utilizing theory, literature review and/or best practices in program design 3. Evidence of utilizing theory, literature review and/or best practices in program design and delivery. 4. Intervention purposely designed around appropriate theoretical or conceptual model and program reflects relevant best practices 	<p>Level:</p> <p>Rationale:</p> <p>Suggestions for Enhancement:</p>

Criteria	Definition	Assessment Guide	Assessment
<p># 7 Sequencing</p>	<p>The program is sequenced appropriately.</p> <p>Sequencing refers to the building of program activities upon each other over time, in order to maximize population impact (e.g. awareness, skill building, environmental support, policy development)</p>	<p>0. No evidence.</p> <p>1. Program activities address at least two of the four approaches (awareness, education/skill building, environmental support, policy) but no evidence of systematic planning for progression from one approach to the next.</p> <p>2. Activities within the program address at least two of the four approaches in a systematic manner.</p> <p>3. Activities within program address at least three of the four approaches in a systematic manner.</p> <p>4. Program plan or program logic model clearly demonstrates activities that support program progression through four approaches: awareness, education, environmental support and policy.</p>	<p>Level:</p> <p>Rationale:</p> <p>Suggestions for Enhancement:</p>

Activity	Several activities make up a program. Activities are usually time-limited and task-oriented. Using the workplace example, a Cafeteria program might involve the following activities: signage for tables, menu items, training for staff, and promotion to employees.
Audience	Those people whom the program intends to reach.
Channel	Sites where programs/activities are carried out and where the audience will be most effectively reached (e.g., schools, worksites, health care settings, etc.).
Cooperation	Cooperation involves informal trade-offs and agreements established in the absence of formal rules (from the Chronic Disease Prevention Alliance of Canada web site @ http://www.cdpac.ca/content/faqs/alliance_definitions.asp).
Coordination	Coordination involves formalized, defined relationships among organizations (from the Chronic Disease Prevention Alliance of Canada @ http://www.cdpac.ca/content/faqs/alliance_definitions.asp).
Collaboration	Collaboration is an emergent and evolving process of building substantive agreement. It is a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own visions of what is possible. Four features are critical to collaboration: <ul style="list-style-type: none"> • the stakeholders are interdependent, • solutions "emerge" by dealing constructively with differences, • decisions are jointly owned, and • stakeholders assume collective responsibility for the future direction of the domain. (from the Chronic Disease Prevention Alliance of Canada @ http://www.cdpac.ca/content/faqs/alliance_definitions.asp)
Objectives	Clear, realistic and measurable outcomes that are taken in order to reach an overall goal, within a given time period. Should identify how much of what should happen to whom by when.
Outcomes	A change in the health status of an individual, group or populations attributed to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.
Formative Evaluation	Focuses on the early developmental phase of the program, during which time the relevance, comprehension and acceptability of activities, materials, etc. for the intended audience are assessed.
Process evaluation	Focuses on programs that are already underway. Examines the procedures and tasks involved in providing a program, and seeks to answer the question: "What services are actually being delivered and to whom?" . Examines how this compares to the original plan.
Outcome Evaluation	Focuses on programs that are well established, and the assessment of the outcomes/ impacts of these programs.
Program	A well-organized series of activities designed to facilitate change in a well-defined target group.
Strategy	Refers to a group of programs that have the same goal, usually within a setting or a population. Strategies are often based on pressing issues or challenges affecting the achievement of the mission and vision, values and services. They describe a major area of responsibility over a 2-4 year period and usually require collaboration among stakeholders to ensure success, so therefore are usually tied to stakeholder needs and expectations in order to engage them. In the context of the Ontario Heart Health Program (OHHP), a community partnership might establish a workplace strategy, a youth strategy or a physical activity strategy. Often the structure of work groups is based on these strategies.

Summary of Health Promotion Theories

Theory	Stages of Change (Transtheoretical)	Health Belief Model	Theory of Reasoned Action/Theory of Planned Behaviour	Stress, Coping and Health Behaviour	Social Cognitive/ Learning	Diffusion of Innovations	Precede Proceed Model**
Focus	INDIVIDUAL	INDIVIDUAL	INDIVIDUAL	INDIVIDUAL	INTRAPERSONAL	GROUP	COMMUNITY
Key Names	Prochaska and DiClemente	Hochbaum Rosenstock	Fishbein	Cannon, Lazarus, Folkman and Moskowitz (Transactional Model of Stress and Coping)	Bandura	Rogers	Green and Kreuter
When did it appear?	1980s	1950s, 60s	1960s	1930s, 80s, 90s	1970s, 80s	1960s	1970s (Precede) 1980s (Proceed)
Summary	<i>An individual goes through 5 stages as s/he learns a new health behaviour</i>	<i>What people believe about a condition or behaviour will influence what they do about it</i>	<i>There is a connection between beliefs, attitudes, intentions and 'planned' behaviours</i>	<i>A number of factors will mediate and moderate an individual's ability to cope with stressful life events and other demands that upset our 'balance'. All together these processes will affect various health outcomes</i>	<i>Behaviour is a product of both personal and environmental factors</i>	<i>In trying to 'spread' or diffuse a new idea through a social system, we can make use of 6 kinds of community members, categorized by how long it takes them to adopt a new idea or practice</i>	<i>A series of steps or phases in the planning, implementation, and evaluation process</i> <i>The identification of priorities and the setting of objectives in the PRECEDE phases provide the objects and criteria for policy, implementation, and evaluation in the PROCEED phases</i>
Key Concepts	<ol style="list-style-type: none"> 1. Precontemplation: S/he is not thinking about changing (i.e. quitting smoking) 2. Contemplation: S/he starts thinking about it 3. Preparation: S/he prepares to change. 4. Action: S/he begins to change 5. Maintenance: S/he maintains the change over 2-3 years 	<p>Health beliefs are influenced by:</p> <ol style="list-style-type: none"> 1. Perceived susceptibility (Will I get cancer from smoking?) 2. Severity (How bad could it be?) 3. Benefits (If I do something about the smoking how will it benefit me?) 4. Barriers (What's in the way of me doing something?) 5. Cues to action (What do I need to help me do this?) 6. Self-efficacy (Am I confident enough to do something about this?) 	<p>Three factors influence how we plan behaviour.</p> <ol style="list-style-type: none"> 1. Attitude (What we believe about a behaviour and what we think might happen as a result) 2. Norms (What we believe others think about a behaviour and how motivated we are to comply with them) 3. Behaviour Control (Our beliefs about how much control we have over a behaviour) -Working together they create our behavioural intention or how feelings about whether we will or will not do X behaviour 	<p>These factors include:</p> <ol style="list-style-type: none"> 1. What we think of an event (primary appraisal) 2. How we think it can be controlled (secondary appraisal) 3. Our coping efforts 4. Our ability to manage problems 5. Our ability to 'regulate' our emotions 6. Processes that create positive feelings (meaning-based coping) 7. Our general coping styles 8. Level of optimism 9. Our information seeking style and whether we are a self-monitor or avoider 	<p>To encourage 'healthy' behaviour, we may need to change a person's environment</p> <p>We may need to find out their beliefs as well for they may need to be Corrected</p> <p>Folks may need training and may learn better with role models</p> <p>Rewards and praise will help, as will helping folks realize benefits</p> <p>Ultimately folks need to take it slow, building their confidence as they go</p>	<p>Six types of people:</p> <ol style="list-style-type: none"> 1. Innovators 2. Early adopters 3. Early majority 4. Late majority 5. Late adopters 6. Laggards <p>Their decisions about the new idea are made according to how compatible, flexible, reversible, easy, 'good', cheap and risky the innovation is</p> <p>Also central are:</p> <ol style="list-style-type: none"> 1. communication channels 2. time it takes to diffuse or adopt a new idea 3. Social systems in which this diffusion takes place 	<p>PRECEDE (Predisposing, Reinforcing, Enabling, Causes in, Educational Diagnosis & Evaluation):</p> <ol style="list-style-type: none"> 1. Social assessment 2. Epidemiological assessment (e.g. morbidity, mortality) 3. Behavioural/ environmental assessment 4. Education and organization assessment according to: predisposing factors (e.g. knowledge, attitudes), enabling factors (e.g. programs, services), and reinforcing factors (e.g. social support, peer influence) 5. Administrative and policy assessment <p>PROCEED (Policy, Regulatory, Organizational Constructs in Educational & Environmental Development):</p> <ol style="list-style-type: none"> 6. Implementation 7. Process evaluation 8. Impact evaluation

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(*) denotes words defined in appended Glossary of Terms

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							9. Outcome evaluation
Pros	<ul style="list-style-type: none"> -Tells you more about your 'audience' -Does not assume everyone same -Developed in practice setting 	<ul style="list-style-type: none"> -Helps folks tailor messages to audiences -Relevant for working with/understanding cultural/class health beliefs, ethno-specific populations and the barriers they may believe are in the way (taboos, cultural norms) 	<ul style="list-style-type: none"> -Through analysis of questionnaires and interviews, the theory helps us see where to intervene, what kinds of messages might work and where (i.e. control messages) -Also helps us understand the power of community norms and why certain behaviours are more widespread in certain communities 	<ul style="list-style-type: none"> -Useful for identification of who might relapse and why, how folks maintain positive health change over time -Makes visible link between mind/body, how changes in workplace may affect health outcomes, how stressful life events affect health such as loss/unemployment/divorce -Helpful when used in conjunction with other models such as social networks, ecological theory 	<ul style="list-style-type: none"> -Based on research -Also shows how variety of factors influence behaviour -Looks at big picture -Advocates use of peer leaders 	<ul style="list-style-type: none"> -Ideal for education campaigns -Highlights issue of timing, readiness -Assumes community members not same -Can help us tailor messages -With more visible 'early adopters or innovators', can help diffuse idea faster 	<ul style="list-style-type: none"> - Synthesizes a number of academic disciplines and professional disciplines (i.e. epidemiology; the social, behavioral, and educational sciences; and health administration) and provides direction
Cons	<ul style="list-style-type: none"> -Not as much research/evaluation as others -May ignore reasons why people might be at different stages -May ignore context/environment, assumes the 'change' will be good for everyone 	<ul style="list-style-type: none"> -Starts to get at culture but focuses on individual as opposed to context -Assumes people will take action or control unhealthy behaviour if provided with 'right' info but does not take into account abilities -Power analysis 	<ul style="list-style-type: none"> -Is a tendency to just focus on one area (i.e. #1) and ignore all three, also need to think about how interventions may positive affect some beliefs and negatively affect others 	<ul style="list-style-type: none"> -Focus on individual agency leaves out structural issues, reasons why 'stressors' happening in first place, has been criticized as band-aid approach -May be part of trend towards lower cost/individual efforts which may channel funding away from community efforts -May make individual feel worse if unable to 'manage' anger in 'suitable' way or self-monitor 	<ul style="list-style-type: none"> -Health promoters have tendency to focus on one concept (self-efficacy or role models) and ignore environment, theory has also been accused of over-simplifying issues 	<ul style="list-style-type: none"> -May ignore other factors influencing decision -Does not focus on whether behaviour is lasting, assumes the innovation is 'better' -May put too much onus on early adopters, may blame the victim (i.e. use of word laggards) 	

** Not a theory, but a structure to which other theories can be applied

Summary of Health Promotion Theories Continued

Theory	Social Networks and Social support	Behavioural Community Psychology	Community Organization	Community Capacity Building	Social Marketing	Ecological Model of Health Behaviour
Focus	GROUP	GROUP	COMMUNITY	INDIVIDUAL ORGANIZATION COMMUNITY	GROUP COMMUNITY	INDIVIDUAL GROUP, COMMUNITY, ENVIRONMENT
Key Names	House Israel	Elder et al.	Rothman, Truman, Minkler	McKnight, Kretzman, Mattesich et al., Raphael	Kotler	Skinner, Laurin, Barker, Bronfenbrenner
When did it appear?	1980s	1980s	1980s, 90s	1990's	1980s, 90s	1950s, 60s, 70s
Summary	<i>Through social networks, individuals may be provided with the support necessary for healthy, help-seeking behaviour</i>	<i>In any given group or community, there are certain psychological factors that increase the chances of health behaviour change</i>	<i>Community members can work together to identify and create solutions for health related issues</i>	<i>Individuals in a community or organization have assets such as skills and relationships that can be enhanced to address key problems</i>	<i>The use of the media may be very helpful in making folks aware of a new idea or health practice that will help meet their needs</i>	<i>To understand 'health' and health behaviour, we must focus on people's transactions with their physical and social surroundings or 'environment'</i>
Key Concepts	<p>1. Social networks are person-centred webs of social relationships influenced by: reciprocity, intensity (emotional closeness), complexity, density (member familiarity), level of homogeneity, geographic location</p> <p>2. Social support is the aid and assistance exchanged through social relationships in social networks. Types include: emotional (love and caring), instrumental (tangible aid), informational (advice) and appraisal (info for self-appraisal)</p>	<p>These factors include:</p> <ol style="list-style-type: none"> 1. Positive reinforcement for healthy behaviour (i.e. transportation, low cost) and increased barriers for unhealthy behaviour 3. Differential reinforcement for good and bad behaviour (like prizes and contests) 5. Use of feedback measures such weight, blood pressure 6. Combination of above <p>Again, activities will need to be easy, flexible, cheap, acceptable, visible and involve community leaders.</p>	<p>Three types:</p> <ol style="list-style-type: none"> 1. Social planning- Experts from outside solve problems with help of community members 2. Locality development- Experts and community members work together as equals 3. Social action- Community members drive the change process 	<p>Can build:</p> <ol style="list-style-type: none"> 1. Organizational capacity through training, participatory decision-making 2. Community capacity through a shared vision, strengthening linkages with other networks, developing collective processes 3. Individual capacity through increasing access to information, skills and networks that help folks participate in communities and organizations <p>-Process is holistic, parts interconnected -Focus on assets, participation</p>	<p>Key ideas:</p> <ol style="list-style-type: none"> 1. Exchange theory: the buyer 'spends' time/money/ effort on a service/idea/ practice provided by the seller 2. Consumer orientation: focus on the buyer 3. Audience analysis: identify needs of those buyers 4. Audience segmentation: identify needs of subgroups of buyers 5. Marketing integration: focus on price, product, promotion and place as well as participation of some 'key buyers' in activities such as planning and focus groups 	<p>Central principles::</p> <ol style="list-style-type: none"> 1. Factors at multiple levels influence health behaviour (individual, group, community) 2. Many different kinds of environmental influences affect health behaviour including the weather, food, buildings, community design etc. 3. Behaviour-specific goals are helpful 4. But multilevel interventions may be most effective (so to get people walking more may need to hand out pamphlets AND build sidewalks, establish walking clubs, improve cross walks) 5. These kinds of interventions need multisectoral groups to keep them going and 6. also need different forms of evaluation (outcome, process) 7. But political dynamics/ battles/agendas can limit ecological interventions, so they to need to analyzed as part of the environment
Pros	-Can help us understand	-Relatively easy to learn	-Familiar to many health	-Focus on assets	-Emphasis on consumer	-Useful when working on

	<ul style="list-style-type: none"> resiliency, mind/body link, incidence and differences in certain disease outcomes, how certain individuals seek and stay with healthier behaviours -Has been used to look at recovery and prevention around cancer, smoking, stroke 	<ul style="list-style-type: none"> and implement -Shorter time-lines -Research suggests use of contests effective in working class areas, use of measures effective 	<ul style="list-style-type: none"> promoters, compatible with democratic process -Can enable sustainable change -May increase social support/networks, create greater community capacity -Where types 1 and 2 used in conjunction has worked well 	<ul style="list-style-type: none"> -In line with social determinants of health -Brings power back into analysis -Appeals to many, has been especially popular in Ontario over last decade -Many local/Canadian leaders in the field (Raphael, OPC, Hershfield) 	<ul style="list-style-type: none"> in line with current trends in health promotion -Enables us to better understand target audience -May be more popular with funders -Enables higher visibility, helps reach wider/different audience, makes use of new technologies such as multimedia CD ROMs, interactive web sites, web television, automated phone counseling and tailored print communications 	<ul style="list-style-type: none"> widespread issues in a community such as obesity and smoking in public places -Emphasis on multiple factors at different levels brings in social determinants of health, structural issues such as power/race/class/SES -Most effective model for in-depth analysis and sustainable change and capacity building at community and policy level -Involvement of multi-sectoral groups may enhance funding/resources, sustainability, congruent with health promotion principles spelled out in Ottawa charter, particular useful when part of combined approach using community organization and or/social support models
Cons	<ul style="list-style-type: none"> -Difficult to ascertain hard data on effects of social support/networks -Softer' outcomes only visible over longer-time-lines -Not as strong when used in isolation 	<ul style="list-style-type: none"> -Difficult to maintain -Difficult to reduce all barriers to participation -Visibility of 'differential reinforcement' may create stigma -Community divide and other issues related to social isolation/support/mental health 	<ul style="list-style-type: none"> -Can ignore more disadvantaged community members -'Equality' of #2 may not be achievable, can end up dominated by professionals and 'elite' - #1 or 3 may alienate/divide community, may not be as popular with government/funders given recent focus on individual 	<ul style="list-style-type: none"> - May be very time-consuming -Have been criticisms of McKnight's original approach including fact that in more rural areas neighbourhoods may not exist (Stirling 2000) -Much debate around meaning of and use of key concepts -Some confusion around what capacity means -Recent work suggests shift in application from community to individual with some see as problematic 	<ul style="list-style-type: none"> -When used on its own research suggests low impact -Can be high cost -Can oversimplify issues -Break down complex arguments into 'sound bites' -Does not emphasize skill building -Assumes homogeneity -May blame the victim by assuming individual able to make change 	<ul style="list-style-type: none"> -Multi-sectoral collaboration often difficult to create -May be issues around process/negotiation of goals and planning -May not work in tighter time-lines often faced by individual health promoters -Emphasis on multiple forms of evaluation may not fit with trend towards outcome-based work -Emphasis on analysis of political agendas may place organizations in advocacy roles not in keeping with funder/ agency's agenda -Analysis of environmental influences impacting health behaviour may uncover issues outside 'scope' of program -If collaboration not supportive, may lead to power struggles and burnout

Adapted from: Green, L. & Kreuter, M. (1991). *Health promotion planning: An educational and environmental approach* (2nd edition). Mountain View, CA: Mayfield Publishing Co.
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References

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