

Comprehensive Evaluation Plans

Healthy Lifestyle Improvement, Asthma Management Education, and School Nurse Programs at Children's Healthcare of Atlanta, Inc.

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Prepared for
Children's Healthcare of Atlanta, Inc.



Carl Vinson **Institute of Government**

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Athens, Georgia

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Introduction

Children's Healthcare of Atlanta, Inc. (referred to as Children's throughout this report), is a nonprofit organization dedicated to the goal of improving the lives of children through quality medical care. Children's operates two pediatric hospitals, Scottish Rite and Egleston, and a number of primary and immediate care facilities in the Atlanta area.

The Community Health Development and Advocacy Division (CHDA) operates health programs that focus on prevention and intervention in the areas of healthy lifestyle improvements and asthma management education, and also provides training and resources for professionals. CHDA staff have developed and implemented programs for multiple audiences and stakeholder groups, including children, parents, educators, and health care professionals. In this report, individuals implementing or teaching in these programs are referred to as CHDA staff or personnel, distinguishing them from Children's personnel who provide direct health care (physicians, nurses and other health care professionals).

CHDA programs rely in large part upon funding from outside organizations such as charitable foundations and state and federal agencies. These organizations typically require demonstrations of accountability so that they can be satisfied that their contributions are having a positive effect, and CHDA staff had evaluation measures for their programs in place. Knowing that demands from funding organizations would increase in the future, in early 2004 CHDA contacted the Carl Vinson Institute of Government (CVIOG) at the University of Georgia (UGA) for assistance. CVIOG is a public service and outreach unit with a 75-year history of service to the state of Georgia. Its mission is to translate the knowledge and resources of UGA into improved quality of life for all Georgians by assisting governments and public organizations.

The purpose of this report is twofold. The first goal is to examine the methods and instruments that are currently being used to evaluate the programs and to upgrade them as necessary. The second goal is to develop long-term evaluation plans. Some of these plans will guide the programs as they grow and change over time. Others will provide ways of assessing more distant outcomes of the programs, such as the health of clients in the years after they leave the programs.

The first section of the report summarizes each of the three content areas. The next section is dedicated to psychological and educational theories that relate to the CHDA programs. These theories explain not only how programs were developed but also how they will be evaluated. After the theoretical foundation has been laid, the logic models of the program areas and the general designs of their evaluation plans will be discussed. The current instruments and measures used for evaluation will be covered, and then changes and additions will be suggested. Finally, proposals are outlined for future changes in evaluation strategies to address long-term outcomes of clients and potential growth in the programs themselves.

Program Descriptions

This section provides summaries of the individual programs within three areas: Healthy Lifestyle Improvements (formerly Obesity Prevention), Asthma Management Education, and School Nurse Programs. Each program is outlined in terms of its goals, target audience(s), and format. This review provides a basic understanding of each program and a reference point for the discussion of the current and proposed evaluation measures and plans.

Healthy Lifestyle Improvement Programs

Obesity has been increasing in prevalence in Georgia and the United States over the last several decades. In 2001, 20.9 percent of American adults were overweight, an increase of 74 percent in just one decade. Over the same period of time, the statistics for adults in Georgia increased from 9.2 percent to 22.1 percent, a jump of 140 percent (Centers for Disease Control (CDC), 2005a). Obesity has been shown to be statistically linked to major diseases, including diabetes, cardiovascular disease, asthma, and arthritis (CDC, 2005b).

Obesity is also increasing in children. The CDC estimates that 16 percent of children were overweight in 2002, a 45 percent increase over a period of 14 years. Type 2 diabetes, the form of the disease that is linked to obesity, has been increasing in children as well. Previously uncommon in children, this type of diabetes has become an emerging public health problem (Jack et al., 2003).

Healthy lifestyle improvement programs make up the largest group of CHDA programs evaluated in this project. A spectrum of programs covers all the ages of childhood. All of the programs focus primarily on improving nutritional knowledge and behavior, as well as increasing physical activity. The main goal is to start a lifestyle in childhood that encourages lifelong health. Another common goal is decreasing “screen time,” which includes such sedentary pursuits as watching television and movies, playing video games, and using computers for recreation.

Take Charge of Your Family’s Health is a pair of programs that targets families with children from birth to five years of age. The two programs are the Stress-Free Feeding module which addresses the needs of infants and toddlers, and a module that was formerly called Fit Kids 3-5 for older children. Each program is designed to train professionals and paraprofessionals in techniques for communicating health promotion information on healthy eating and physical activity, as well as a version directly addressing parents and children.

Stress-Free Feeding topics include proper nutrition, how and when to introduce new foods, and techniques for making mealtimes more positive and less combative. The curriculum is covered in a six-week class that parents attend once per week. The other part of *Take Charge of Your Family’s Health* is a program which targets parents and their children from three to five years of age. As with Stress-Free Feeding, many of the goals

deal with nutrition and positive mealtime behaviors. This piece, however, also places a major emphasis on physical activity for children and their families.

The two programs are taught together to professionals and paraprofessionals. This is done as a full-day intensive workshop. The goal is to train participants to teach classes in the community. The curriculum is also taught to health care professionals in their own practice settings, so that they can communicate the information to their patients during office visits. A train-the-trainer version of the curriculum, with the goal of having participants train other professionals and paraprofessionals in the future, is taught as a two-day intensive workshop.

Fit Kids 6-12 targets overweight children from age 6 to 12. It is divided into classes for children age 6 to 8 and from 9 to 12. The program has a six-week class that parents and their children attend together, as well as a training version for professionals. As with the class that targets younger children in Take Charge of Your Family's Health, the goals involve improved nutrition, positive mealtime behavior, and increased physical activity. The difference is that overweight children are the specific target group.

Kids on the Move is a program geared toward professionals who operate after-school programs. The program was created to combat an increase in cardiovascular disease risk factors in children overall and in certain at-risk populations in particular, such as minority and inner-city children. Structured physical activities encourage children to get their exercise through play. Lessons on nutrition, human physiology, and the effects of tobacco use complement the activities. The target age group is children 8 to 12 years of age, and the program is designed to be eight weeks in length.

Talking About Weight is a four-hour training program for health care providers. It teaches them ways of addressing weight issues with overweight and obese adolescents. It also addresses the providers' own attitudes and beliefs about overweight clients. The goal is to encourage providers and children to cooperate in avoiding the long-term health risks of excess weight.

BMI in Clinical Practice is another training program for health care providers and paraprofessionals. Its emphasis is on correct measurement in order to calculate and interpret the Body Mass Index (BMI) as part of educational guidance related to healthy growth. BMI uses the relationship between height and weight to generate a score. Adults are considered overweight with a BMI of 25 to 29 and obese with a BMI of 30 or more. For children, BMI scores are normed by age and gender. A child with a BMI score in the 85th percentile or higher (that is, higher than 85 percent of children the same age and gender) is considered at risk for becoming overweight. A child with a score greater than the 95th percentile is considered overweight.

The last program in healthy lifestyle improvement is *Type 2 Diabetes Prevention*. Prolonged obesity can lead to the development of type 2 diabetes in children, even though this form of diabetes was previously known informally as "adult onset." This program is a 12-week intervention for children ages 8 to 18 who have been identified as

being at risk for developing type 2 diabetes. The goal of the program is to delay -- for life if possible -- the onset of diabetes. The intervention includes sessions with an exercise coach, a registered dietician, and a pediatrician. It is based in one of Children's primary care centers.

Asthma Management Education

Asthma affects about 10 percent of children in the United States. The prevalence of asthma has been steadily increasing over the last 20 years. Children in urban areas are at greater risk for suffering from it, as are low-income and minority children (Montalto et al., 2004).

The Asthma Management Education programs are designed to educate adults who care for children with asthma during the school day. Targeted groups include school nurses, teachers, coaches, and other school personnel. The main goal is to improve asthma control during school time in order to provide all-day control and improve asthmatic children's overall health.

Asthma Management Education is a 30-minute training session for school personnel. It is an introductory course created to teach basic knowledge of asthma and asthma management to school staff.

ACE (Asthma Center for Education) Asthma Educator Training is a 3-hour train-the-trainer program for nurses, school clinic assistants, and health care professionals. The goals for this program are to increase knowledge about asthma management and enable health care workers to spread this information to children and families, school personnel, and health care providers.

The *Asthma in School Age Children Conference* is an annual full-day educational program for all types of school personnel, as well as health care professionals from outside the school setting. Like the shorter Asthma Management Education, this program is designed to increase the knowledge level of participants. The daylong format allows more topics to be covered, including the use of medicines and medical devices.

School Nurse Programs

During the academic year, children spend a large portion of most days in school. They rely on the skills and knowledge of the school nurse and clinic staff to handle their medical needs during those times. Children with chronic conditions or special medical needs are even more reliant on those personnel, as they will need help more often than their healthier peers. The overarching goal of the School Nurse Programs is to provide school medical personnel with the knowledge and support they need to improve children's health during the school day.

The *School Nurse Update* program addresses the training needs of school nurses. The goal of the program is to provide at least four educational sessions per year.

In-service trainings at individual schools are also available. In addition, Children's coordinates a two-day conference for school nurse leaders from across the state to address infrastructure and goal setting for district policies and procedures.

The *School Nurse Consultant* program serves as an information resource and referral center for school nurses. Program personnel are available to answer questions on specific medical questions or situations that may arise during the school day. In addition, consultants can assist school nurses in finding specialized medical care for students or linking them with medical assistance programs.

The *School Nurse Liaison* program focuses on children who have a complex medical condition and/or who are returning to school after a hospital stay at Children's. Liaison staff members facilitate the relationship between school personnel and medical providers to smooth the child's transition back to school and support the child's health management during school hours.

Theoretical Foundations

This section outlines the theoretical underpinnings of the programs and their evaluation. The first three theories -- ecological perspective, social learning theory, and information-processing style -- are theories upon which the programs are based. The final theory presented, the tripartite theory of attitudes, not only relates to the design of the programs but also informs the evaluation design.

It must be noted here that these theories were not used explicitly in the original development of the programs. CHDA staff saw that there were needs in the community and sought to fulfill them in the most practical manner. Their educational methods are a common sense approach to communicating important health information. Their clients are very diverse, from doctors and other highly educated professionals to parents of all educational levels to children. Thus the programs must use a range of methods to deliver the information to these groups. The approaches taken by the programs are, however, consistent with the theories.

Applying theory, even after the fact, has several benefits. First, it makes explicit the assumptions used in creating the programs. All educational programs make assumptions about how people learn and the best ways to communicate information. When changes or additions are made to the curriculum, they need to be matched to the philosophy of the program in order to be implemented successfully. Second, knowing the theoretical bases makes it easier to assess the degree to which staff members are correctly implementing the program. This issue is not a concern for CHDA staff at this point, as the originators of the programs are the ones teaching them. In the future, however, new staff members will join the organization, and their adherence to the format of the programs will become salient. Delivering the program the way it was designed is an issue for programs with a train-the-trainer format or in which providers are taught information that they will pass along to their own clients. It is crucial to ensure that the information is transmitted accurately so that it has the desired impact, whether it is delivered by CHDA staff or their clients.

Ecological Perspective

Ecological perspective has its roots in the biological sciences, but it has also been an important outlook in social science as well. Urie Bronfenbrenner (see Bronfenbrenner, 1986) is one of the most important ecological theorists in family science. He defines human development as the interaction between a person and the environment. His model outlines the relationships between a person and the many spheres in which he or she operates.

Context is very important in this model, because a person has different roles and experiences in different contexts. For example, a child is part of a family, which is almost always the most important arena of the child's life. But a child also has a school life that includes relationships with peers, teachers, administrators, and support personnel such as school nurses. A child with a health problem (or even one who merely receives regular

preventative care) has relationships with doctors and nurses. It is likely that the child acts differently in each context. He or she may be more compliant or more receptive to information in some contexts than others. Previous research indicates that programs addressing obesity and health improvement should make use of multiple contextual avenues, including families, schools, and medical professionals (Flodmark et al., 2004; Whittemore, D'Eramo, and Grey, 2004).

CHDA programs seek to improve the health of children by communicating information to people who occupy a variety of contexts in a child's life -- including parents, teachers, school nurses, and medical professionals -- as well as by informing the children themselves. In the array of healthy lifestyle improvement programs, all of these contexts are represented. Fit Kids and Stress-Free Feeding address families directly, while Kids on the Move reaches children through after-school programs. Take Charge of Your Family's Health, Talking About Weight, and BMI in Clinical Practice affect families through the health care arena. The asthma management programs reach children and families indirectly through the contexts of school and medical care by targeting professionals and paraprofessionals in those areas. The Nurse Liaison program helps organize the efforts of families, doctors, and school personnel to help children transition back to school and to create continuity of care across the contexts of school, home and medical office.

Another important piece of Bronfenbrenner's model is the portrayal of time as a context. Time systems include the time in which a person is born, or cohort, and the present time in which the person operates. Most important to the current programs is that the model deals with themes such as developmental appropriateness, or whether a child is physically or mentally able to understand lessons or learn new behaviors. Programs targeting children must take into account their developmental level in order to communicate with children effectively.

Among the healthy lifestyle improvement programs, one reflection of awareness of developmental levels is the range of Fit Kids programs, which group children by age range and modify the content to be appropriate for each age group. The ACE Asthma Educator Training addresses the different approaches needed for children at various ages. For example, younger children are more likely to need assistance from a school nurse in administering medication, while older children will be more competent in computing doses for themselves and using medical appliances. For the School Nurse Liaison Program, there is the recognition that the process of readjusting to school and smoothing out medical needs in that environment is an ongoing one. Each intervention is individualized not just to the child's condition but also to his or her cognitive and educational needs.

Social Learning Theory

Albert Bandura's social learning theory includes two important concepts related to how CHDA programs are taught. The first is self-efficacy, a person's belief that he or she can attain a goal (Bandura, 1998). Personal beliefs evolve over time as a person

interacts with the environment. These experiences shape a person's expectations of what he or she can and cannot do. The programs discussed in this report are based on the assumption that people can change their behavior to improve their health. Information and activities are presented in such a way that clients can take charge of the process and continue to use them on their own after they leave the program.

Modeling is another central concept of social learning theory. The theory is based on learning from other members of one's social group both directly and indirectly. Children can learn how to do something by watching someone else. This approach appears in the curriculum in two ways. First, the person teaching a program will demonstrate an activity or behavior for a client. The play activities in Kids on the Move is an example. The providers in the after-school program who are attending the training must learn how to do the activities in the first place. They in turn model the activities to the children in their classes, so there are two instances of modeling. Another example comes from the Fit Kids programs. They teach parents to model healthy eating and exercise behaviors. Children are much more likely to adopt behaviors that are modeled by their parents. There is the added benefit of improving the parent's health as well. These types of modeling are also apparent in the asthma management programs. Professionals and paraprofessionals are trained how to use various devices for administering asthma medication. The participants then model those procedures for students and help the children attain mastery at using the devices.

Information-Processing Style

Information-processing style is based on work in the field of education (i.e., Watt, 1993). The theory asserts that individuals have a primary mode in which they process information the best and easiest way for them. Visual learners are most adept at seeing and reading. They prefer textbooks, handouts, and demonstrations. Auditory learners get the most information by hearing it. They flourish in the traditional lecture format. Kinesthetic learners need to do something to master it. Whether it is solving a math problem or learning an exercise, they need to participate in the activity itself. All people can learn in each of the modes, but, according to the theory, each is strongest in one.

In order to reach out to all learners, a good program conveys information in all three modes. CHDA programs offer visual information in a variety of ways: handouts, PowerPoint presentations, flip charts, books, and videotaped vignettes. For auditory learners, there are lectures, discussions, and videotaped vignettes. Kinesthetic learning is facilitated by exercise activities and homework assignments.

Tripartite Attitude Theory

The study of attitudes has a long history in social psychology and plays an important role in all fields of social science. Nisbett and Ross (1980) conceptualized attitudes as having three components: affect, behavior, and cognition. Affect is an emotional response to a stimulus. It includes attaching a positive or negative value to an

object (called the attitude object), as well as a measure of the strength of one's response to it. Cognition is a more rational thought process, a consideration of the characteristics of the attitude object. Behavior encompasses the actions taken toward or about the attitude object. One can embrace or avoid it in a range of possible actions.

As an example, one might look at the attitudes of school nurses toward asthma management strategies. The cognitive component is based on knowledge of how effective a strategy is and how well it works for children at the age of the students in the nurse's school. The affective component could be based on how easy it is to learn the strategy, the "gee whiz" factor of the technology involved, and how motivated the person is to employ that strategy with students. The behavioral piece might involve how easy it is to use a given medical instrument, how similar the process is to what the person has used before, and how much effort the nurse must expend to ensure better health for a student.

The relative strength of each component will vary by attitude object and by person. Some people put more reliance on affect or "gut feeling," while others will carefully consider the facts, and yet others will simply do what they always do. On the other hand, some attitude objects may encourage one component to be the primary one. A person's reaction to a physical activity will probably be based mainly on how much fun it is. Knowing the health benefits of exercise, especially for someone who is not exercising regularly, is not likely to be as powerful as experiencing enjoyment while actually performing it. A program like Kids on the Move plays to the strengths of affect by training providers to involve children in activities they will continue to do because they enjoy them.

Sometimes the components of an attitude can contradict each other, causing confusion for the person who holds such an attitude. Attitudes toward food are relevant examples in this case. Clients in the healthy lifestyle improvement programs are taught that sugared drinks such as sweetened tea are bad for them, a fact they will integrate into the cognitive component of their sweet tea attitude. But people who grow up in the American South are likely to enjoy the taste and associate it with memories of family and community events. Whether their attitude toward sweet tea becomes more negative or not depends on how they value each component. Will knowing that it is unhealthy outweigh taste and history? Or will they continue to drink it, feeling at least vaguely guilty because they know they should be drinking water instead?

For most attitudes, however, the components are consistent with each other. People try to avoid having inconsistent attitudes as it causes discomfort when they try to determine the overall tenor of their attitude. This discomfort is called cognitive dissonance (Festinger, 1957). People will tend to change either the strength or the content of one of the components of an attitude in order to eliminate discord and restore harmony among the three elements.

In terms of program design, incorporating attitude theory means providing information that targets each of the components of an attitude. Mere recitation of the facts will not necessarily change a person's overall attitude. For example, in addition to telling

people that being more active will make them healthier, programs engage participants in structured activities. When people actually do the exercise, it activates the behavior component. By associating that activity with fun and a feeling of greater well-being, the affective component is engaged.

Evaluation Design

Attitude theory has an additional application for our purposes. It speaks to the way in which clients of the programs are expected to change over time. Clients enter the programs having already formed attitudes about their health, eating practices, and activity levels. The ultimate goal of all the programs discussed in this report is to improve the health of children. Working backwards from there, it is possible to outline the chain of events that leads to that outcome. In order to improve overall health, children's behavior will need to change in certain ways. They will need to eat in a more nutritionally sound manner and increase their level of physical activity. Making these behaviors part of a family's lifestyle requires a change in their underlying attitudes toward the behaviors. The first link in the chain is communicating effectively the information that can change the behaviors. In the case of training health care professionals and other non-family members, there is an additional step because these participants must receive the information accurately and then relate the information to family members in turn.

These linkages can be made explicit by the use of a logic model. A logic model is a graphic representation of how a program is expected to work. The Asthma Management Education program logic model in Appendix A is one example. All the inputs to the program are listed, including staff and resources. Then the activities that will be implemented are listed. Finally, the expected results of each of the activities are enumerated. In this example the results are divided into three categories, named outputs, outcomes, and impacts. These can also be thought of as short, intermediate, and long-term results, respectively.

Thinking in terms of attitude theory, one can reconceptualize the outputs and outcomes in terms of changes in affect, cognitions, and behaviors. These correspond to three types of instruments that will be used in evaluating the programs. Knowledge tests are used to measure how well participants understand the factual information they were presented. These instruments correspond to the cognitive part of an attitude. The affective part of the equation is measured by instruments measuring participants' attitudes toward and motivation to use the information they have learned. Behaviors are measured by instruments examining participants' health-related behaviors before and after attending the programs. In the case of professional participants, the behavioral component involves using information and handouts and changing the ways they deal with their clients or students.

As stated above, this approach means expecting affective and cognitive changes in the short term and more permanent changes in behavior in the medium and long term. By using this plan, the timing of when to use certain measures becomes clear. Knowledge and attitudes will be assessed immediately after the end of the program, while behaviors will be assessed both immediately after the program and at a later time. Both knowledge and behaviors will be assessed at the beginning of each program to determine the initial levels for each participant.

Following up with participants over time after they complete programs will be the key to determining whether these interventions have produced a lasting impact. The ultimate goal of these programs is to help clients make healthy behaviors routine. The only way to determine that with any certainty is to reassess them in the years after they leave the program. Whether they retain the specific information from the programs is not crucial for this purpose; the bottom line is behavior change. One would expect that the knowledge might fade over time but that the knowledge acquired had resulted in changed behaviors.

Another level of complexity is added for the programs aimed at non-family participants. Because the aim is to change the behavior of children and families, another layer is added. The information must be effectively conveyed to health professionals, who must then convey it in the same manner to their client families. Therefore, the behavioral measures for professional participants must be assessed differently. In this case, evaluators must observe them teaching families and use a behavioral observation form to rate their effectiveness. Such a form would cover both the accuracy of the information and the presentation style of the professional. Ideally, the behavioral observation will be done in person. It may be more practical, especially for providers from outside the Atlanta area, for providers to send in a videotape of a client session to be screened by evaluators.

Professional participants would then be required to administer the pretest and posttest forms, as well as provide contact information for their clients so that evaluators from Children's could conduct follow-up surveys. Their clients would also have to fill out the usual informed consent and access-to-information waiver forms they would have filled out if they had taken the class from Children's personnel.

Using doctors or primary health care providers as conduits for information does have an additional advantage. If patients agree, the doctors can provide basic health information, which would greatly assist the evaluation. Data on patients' height and weight over time, plus information on whether they have or when they develop conditions such as diabetes and heart disease, would directly address the health objectives of the programs. These types of information are gathered routinely by primary care providers and would be invaluable to this research. Gaining use of this information would require careful negotiations with health care providers as well as strict adherence to federal Health Insurance Portability and Accountability Act (HIPAA) guidelines regulating the distribution of protected health information.

Changes in Measures

Determining the proper way to measure change follows logically from the areas that have been described so far: program objectives, theoretical foundations, and the type of outcome expected at a given stage in the process. The measures already in use by CHDA were examined to determine if they fit the program objectives and the overall evaluation plan. Instruments that were useful were checked for any wording that could be improved and questions that might be added or deleted. Missing pieces were created and will be noted in the discussion below. The forms are displayed in Appendix B.

Where possible, the same questions and wording were used across instruments and across programs. By standardizing questions, direct comparisons can be made with greater certainty that the same thing is being measured in each case. For example, many of the questions on the follow-up forms for the Nurse Liaison program are either identical or almost so for school nurses, doctors, and parents. This consistency allows the data to be analyzed for differences in outlook among the groups and thus possible problems for one group relative to the others.

Scales were also standardized across items and forms. For most items, a five point scale of “Strongly Disagree” to “Strongly Agree” with a central “Neutral” choice was used. In all cases, the most negative score (i.e., “Strongly Disagree” or “Never” in a frequency question) is on the left-hand side of the scale and the most positive score (i.e., “Strongly Agree” or “Always”) is on the right side. If applicable, a “Not Applicable” category is always to the right of the most positive score and shaded or otherwise marked to differentiate it from the scale. If the question does not apply to the participant, he or she should not use the scale. If an individual does mark both an answer and the “Not Applicable” box, their answer should be ignored and scored as “Not Applicable.”

Standard demographic items measuring participants’ gender, race, Hispanic ethnicity, and educational attainment were also added to most forms. They provide information on the participants themselves and how representative the group receiving training is of the population it represents. In addition, breaking down responses by these items allows CHDA staff to determine if there are any group differences that need to be addressed by modifying program content or delivery.

In the rest of this section, a number of terms will be used to denote the timing of assessment. A pretest is an instrument that is administered either before or at the very beginning of the program. Pretests assess the starting point of a participant. A posttest is administered at the end or in the last session of a program. Change in scores from pretest to posttest help show the immediate effects of a program. A follow-up instrument is administered after participants have finished the program, usually months or years afterward. These measures are designed to show the longer-term effects of programs. Follow-up instruments can be administered several times to track the health and behaviors of participants to examine how long the benefits of a program might last.

Healthy Lifestyle Improvement Programs

Take Charge of Your Family's Health. The original pre- and posttest forms used a mixed bag of attitude, knowledge, and behavior questions, in addition to a mainly affective evaluation form at the end of the program. The knowledge and behavior items were separated, although they remain as two sections on the same form for the sake of simplicity. The questions were reworded to better match the objectives of the course. Because the behavioral outcomes are designed to be implemented at every mealtime, it is appropriate in this case to assess behavioral change at posttest. Their follow-up survey consists of the behavioral questions from the posttest.

Professional and paraprofessional participants in the Stress-Free Feeding program also take a knowledge pre- and posttest and an affective instrument administered at posttest. Their follow-up survey asks about changes in practices with their clients. Additionally, they will be observed live or by videotape while teaching the program to their clients. As mentioned in the previous section, CHDA personnel will rate the providers on how well and accurately they communicate the information, based on the program's principles.

Fit Kids 6-12. For Fit Kids 6-12, there are forms for both parents and children. While some of the items are the same or similar for both, parents are asked additional questions concerning behavioral issues. Items were examined and reworded to more accurately reflect program objectives. The forms for children in the 6-8 and 9-12 age groups were modified to be as similar in wording as possible. Items were rewritten to a lower reading level so that younger children would be able to answer the same items as their older counterparts.

A weekly goal sheet, which measures mealtime behaviors and family physical activities, was added as a behavioral measure at pretest, posttest and follow-up. This measure provides another indicator of behavior that speaks to the objectives of the program. Research has found that children as young as fourth graders can give valid and reliable data this way (Crawford et al., 1994) and parents can fill out the goal sheet for younger children.

Follow-up measures will include the goal sheet and the behavioral questions given at posttest. In addition, referring physicians will be asked to furnish the heights and weights of children so that BMI can be calculated. Changes in BMI Z scores over time will be calculated and assessed for stabilization or decrease in BMI percentile based on the age and gender of the children.

Kids on the Move. An affective posttest form for participants was retained with only minor changes. A short knowledge pretest and posttest related to program objectives were created. An observation form for CHDA staff to evaluate participants teaching the class had already been created and was kept intact.

Talking About Weight. To date, this program had used a single evaluation form in which participants rated their confidence about how well they mastered the objectives of the program. This form was modified to be more similar to the affective posttest measures of the other healthy lifestyle improvement programs. A short knowledge pre- and posttest was created to assess learning, with one question for each of the course's objectives. Because the goal is to help health care professionals start a discussion about healthy lifestyles with clients, long-term health outcomes are not reasonable outcomes for this program. If participants implement the strategies they learn, the program will be considered successful.

BMI In Clinical Practice. The changes in this program mirror the changes discussed for Talking About Weight. The original evaluation form was changed to match other programs more closely. As with Talking About Weight, the goal is to help participants learn skills that lay the foundation for creating a healthy lifestyle plan for their clients. If participants implement these skills as part of an overall treatment plan, it is expected that their clients will be more likely to have a healthier lifestyle, but that is not a direct consequence of the program itself.

Type 2 Diabetes Prevention. The health outcomes of this study are clearly defined. The program monitors BMI, glucose levels, insulin levels, and cholesterol levels over time, as well as the onset of diabetes if it occurs; these are the major long-term measures of program success. Early data from the program indicate that few children reduce their BMI scores from the beginning of the program to the end, and blood chemistry changes are also small. This finding does not mean that the program has no effect. One possibility is that the intervention stabilizes these measures, which may have been increasing before the start of the program. It would be useful to have as much information from before participants started the program as possible to help determine what the trends were for these indicators before treatment.

The other evaluation instruments were left largely as designed. A readiness-to-change form administered by a health professional is an affective measure of participants at pretest. Its instructions were modified slightly for clarity, but the questions were left intact. The eating habits form assesses part of the child's behavioral component at pretest and posttest. The instructions were also clarified on that form, and information on serving sizes was added for greater accuracy. The physical activity form, also administered at pretest and posttest, was not changed. The eating habits and physical activity forms will also be administered at follow-up.

Asthma Management Education

Asthma Management Education. Because this program is a 30-minute training session, it is not expected to have a large effect on children's health outcomes. Therefore a simple affective form is the only instrument required. The existing form was slightly revised, dividing a double-barreled question into two questions and adding the standard demographic items.

ACE Asthma Educator Training. The existing knowledge pretest and posttest were not changed, except to add demographic items to the pretest. These items are not needed on the posttest as the two instruments are linked by using the participant's name. The affective posttest was modified in several ways. The set of questions aimed at gauging the usefulness of information and its delivery were matched to the Asthma Management Education form, while a preexisting question about resources given out as part of the course was retained. A second section dealing with how well participants thought they had learned the objectives of the session remained the same.

The follow-up survey already in use has a section dealing with participant behaviors and one for student outcomes. It was retained intact with one major change. The scale for the battery of questions dealing with student outcomes was changed from a "Yes/No" format to a more descriptive five-point occurrence scale. The possible responses are now "Never," "Rarely," "Sometimes," "Often," and "Always."

Asthma in School Age Children Conference. Like Asthma Management Education, there is currently only an affective posttest instrument. The instrument, which focuses on how well objectives are covered and how motivated participants are to use the information in their work, has been retained intact with the addition of demographic items. The follow-up survey for ACE training was added to serve as a long-term assessment of the impact of the conference.

School Nurse Programs

School Nurse Update. The school nurse update training sessions are mainly 90-minute classes that cover a specific topic. Because of the limited nature of these classes, it is not considered cost-effective to include them in the overall evaluation plan. For the two-day convention, a number of existing forms were consolidated into a single form using a five-point answer format consistent with forms used in other programs. It is mainly concerned with affective issues. Participants are asked if the information was useful and communicated effectively, as well as how likely they are to change their practice based on that information. There is a set of questions for each speaker so that presenters can be evaluated individually. This form will be administered at the end of the conference. No longer-term follow-up is planned at this time, but it should be considered if resources allow in the future.

School Nurse Consultant. Because the school nurse consultant program operates as an information service, pretests on knowledge and behavior are not appropriate. The instruments for this program are strictly for short-term follow-up purposes. The most important information necessary for evaluation purposes is to learn whether the school nurses received the information they needed in a way that was useful to them.

Separate forms were created for the information and access-to-care aspects of the program. The two forms, however, are almost identical. Both tap into largely affective content, asking the school nurses their perceptions of the information they received and their satisfaction with the program. The access-to-care form has additional

items relating to behavioral outcomes, asking if the child in question was seen by a health care professional and/or referred to a community agency.

School Nurse Liaison. Like the consultant program, the school nurse liaison program has only a follow-up evaluation form. For this program, however, there are three forms, one for each of the major client groups in the program: school nurses, parents, and doctors. There is currently no form for the children involved; developing one may be a consideration in future planning. The focus of the program is to coordinate the child's medical care between doctors and school nurses, so the child's perceptions of the program, while possibly useful, are not crucial to the evaluation of the program.

The follow-up forms focus on two areas: benefits to the student and the respondent's experience with the program. The three versions of the follow-up form are very similar. The parental form has been modified to reflect that the student in question is the respondent's child. In addition, some wording was changed to make the form easier to understand for parents with lower reading levels. Doctors are asked about the student's overall health and continuity of care across contexts in the place of some questions about care at school for which they could not be expected to know answers.

Future Directions

Healthy Lifestyle Improvement Programs

One gap in the current set of measurements is the lack of any assessment of mental health, especially depression. Obesity has links to mental health, although these connections are not as clear as in the arena of physical health. Studies have found conflicting results linking obesity with depression in adults (Faith, Matz, and Jorge, 2002). Longitudinal studies with children have found effects in both directions. Children with major depression are more likely to have higher BMI in adulthood than nondepressed children (Pine et al., 2001). Among teenagers in the highest 20 percent of BMI, those with depression were more likely to gain weight over the next two decades of life (Barefoot et al., 1998). Obesity is also predictive of higher levels of depression (Roberts et al., 2000). These studies do not, however, illuminate whether the link between obesity and depression is direct or involves mediating or moderating variables (Faith, Matz, and Jorge, 2002).

In the future, depression scales for children and parents should be given at pretest and follow-up. While the literature is not completely clear on how depression and obesity are related, it would be wise to use depression scores as a covariate to examine whether the condition has an effect. Future research in the area may illuminate the connections, and having the data already on hand would put the evaluation process in a good position to account for those effects. Having both depression and health data available would also provide another research area for publication and dissemination by CHDA personnel.

Other instruments associated with psychological characteristics would also be helpful in assessing how well parents and children are able to apply the knowledge they gain in these programs. Measures of self-efficacy would address how competent participants feel in applying the information. Locus-of-control scales measure how much of their lives participants feel they control and how much is out of their control. These concepts are crucial components of willingness and ability to change. Instruments for both children and adults are available for both self-efficacy and locus of control. They would be administered at pretest and again at follow-up. One would expect better health outcomes for people who are higher in self-efficacy and feel more in control of their lives. It is possible that people who show better health outcomes could show improvements in these scales as a reflection of successfully changing their behaviors.

The issue of ensuring that professional participants communicate program information as effectively as CHDA personnel has been summarized earlier in this report. Another mechanism for assessing possible differences is to have providers administer knowledge pre- and posttests to clients as if they had taken the course directly from CHDA staff. Client contact information will be made available to Children's staff so that follow-up procedures will be the same for families who received the information directly and those who received it from a provider who took the course. Comparing the two groups of families will help assess if both are receiving the information in equally useful ways.

Another methodological issue that needs to be addressed is the lack of a comparison or control group with which program participants can be compared. Currently, participants serve as their own control group, and their change from the time they started a program is assessed. This method leaves open the possibility that some participants would have improved (i.e., lost weight, exercised more, and developed healthier eating habits) on their own (what is known as a maturation effect).

Given that the Children's system provides primary and specialty care for a large number of families, it may be possible to use the families that do not participate in these programs as a comparison group. Recording height, weight, and BMI is already a standard practice for all patient visits at Children's. For evaluation purposes, this practice provides a rich dataset from which researchers could draw a sample of families that match the program participants. Matching could be based on demographic variables such as race and socioeconomic status as well as BMI.

Implementing such a system would take time, but it would greatly increase the power of the design. The increased number of participants in the study would make small effects of the program easier to discern. In addition to the benefits for evaluation, there is a larger benefit to Children's and its clients. By ensuring that this information is gathered on all clients, staff will be using best practices to identify people whose health is at risk due to being overweight or obese. Explicitly identifying at-risk patients will make it more likely that they will receive the care they need to avoid the chronic disease consequences of obesity.

Asthma Management Education

While the Asthma Management Education programs are targeted at health care professionals and educators, the long-term goals involve improving the health of children. The proposed follow-up survey asks participants about their perceptions of child outcomes in general, but more direct measures of child health and well-being are needed. Data gathered at the individual level would be much more useful in this regard.

The first recommendation is to add training for participants to administer the Pediatric Asthma Quality of Life Questionnaire (PAQLQ; Juniper et al., 1996). Quality of life is a major dependent variable in the asthma research literature. The PAQLQ is a common measure with several advantages. It has been validated for children from ages 7 to 17 in a variety of nations. There is also a Spanish language version, an important asset with Georgia's growing Hispanic population. Equally important from a resource standpoint is that its authors make it available free to nonprofit organizations. Using this instrument will provide valuable data on how participants' clients' lives are affected by asthma. The PAQLQ would be administered as soon as possible after training to get a baseline number for each child. Follow-up administrations at six-month intervals would provide a measure of the effect of participant training on their clients' lives over time.

The second recommendation is more far-reaching. To test many of the asthma program objectives, measures of health at school are necessary. Currently there is no

comprehensive record-keeping system in place in Georgia public schools. Ideally, such a system would have a common form that all schools would use to record reasons for clinic visits, actions taken, reasons and times that students left school early or arrived late, and reasons for missing entire days. The database created should be searchable and easy to use for entering records and extracting data for analysis.

Certainly it would help a number of programs at Children's if such a database could be created and maintained. The benefits to the Georgia Department of Education (GDOE) would be impressive as well. From a public health perspective, data on communicable illnesses such as the flu would be valuable in tracking and treating diseases. Information on the prevalence of a number of diseases and chronic conditions would be a check on prevalence numbers now estimated by state and federal agencies. Also, GDOE has its own health initiatives, such as the program that trains school nurses and other school personnel about diabetes. These programs have their own evaluation needs, which would be advanced by the availability of these data.

It would be worthwhile for Children's to explore the possibilities of collaborating on the design and implementation of such a system with GDOE and other interested organizations such as universities, advocacy groups, and federal agencies. The current state of education funding in Georgia works against such a plan because resources are difficult to find for non-curricular activities, but federal or nonprofit organization funds may be available to create such a rich source of data.

School Nurse Programs

At this juncture, no longer-term outcomes need to be followed for the School Nurse Update and School Nurse Consultant programs. Without the suggested school medical information system discussed above, following up on student health outcomes would be both logistically difficult and prohibitively expensive.

The School Nurse Liaison program, however, presents an excellent opportunity to pursue the long-term health outcomes of the students involved. Each student has an identified health condition, and the child's physician is already part of the study. With parental permission, it will be possible to follow students for several years or longer after they return to school. It will be necessary to establish proper measurements of health for each condition. Diabetic students, for example, might have a number of variables measured over time. Measures such as hemoglobin A1C, cholesterol, and BMI could be recorded quarterly by the physician and sent to CHDA personnel. In addition, the onset of complications or other related conditions would be tracked.

Apart from strict health measures, more global measures would give a view of the child's overall life. An instrument that assesses quality of life, like the one discussed for asthma patients, would address how the child and family perceive the condition affects their lives. Another instrument focusing on continuity of care across home, school, and medical settings would address issues of coordination that were assessed with the follow-up surveys that have already been proposed.

Conclusion

This report presents systematic evaluation plans for the healthy lifestyle improvement, asthma management education, and school nurse programs at Children's Healthcare of Atlanta, Inc. An overall model of how the programs are expected to improve health in the children of the area has been outlined based on the design of the programs and social science theories they reflect. Existing evaluation instruments have been modified and new ones created to reflect more accurately the evaluation design and the objectives of the various programs. Most, if not all, of these changes can be implemented in the short term. Finally, possibilities for improving the measurement of long-term outcomes in children are outlined. These changes are more ambitious and would require a larger commitment of both time and resources. They are presented as a best-case scenario that would strengthen the overall evaluation plans and provide a rich source of data for both CHDA personnel and the entire public health community.

The methods and instruments proposed in this report do not guarantee that the data gathered will show clear evidence that the programs are having an effect. Many variables affect how people behave in regards to their own health. Other factors such as injury, illness, access to health care, access to health insurance, and environmental factors can impact health and health behaviors directly. No evaluation plan can reasonably control for all of these possible variables.

The plans presented here measure outcomes as directly as possible given the practical and budgetary limitations of the real world. The short and intermediate-term outcome measures reflect the objectives of their respective programs. The longer-term outcomes are mostly measures of health that are the most desirable to funding entities. Funding organizations support educational interventions knowing that they may create only limited change, but hoping to create far more. These plans give Children's the ability to show them how its programs will impact the children and families of Atlanta and Georgia.

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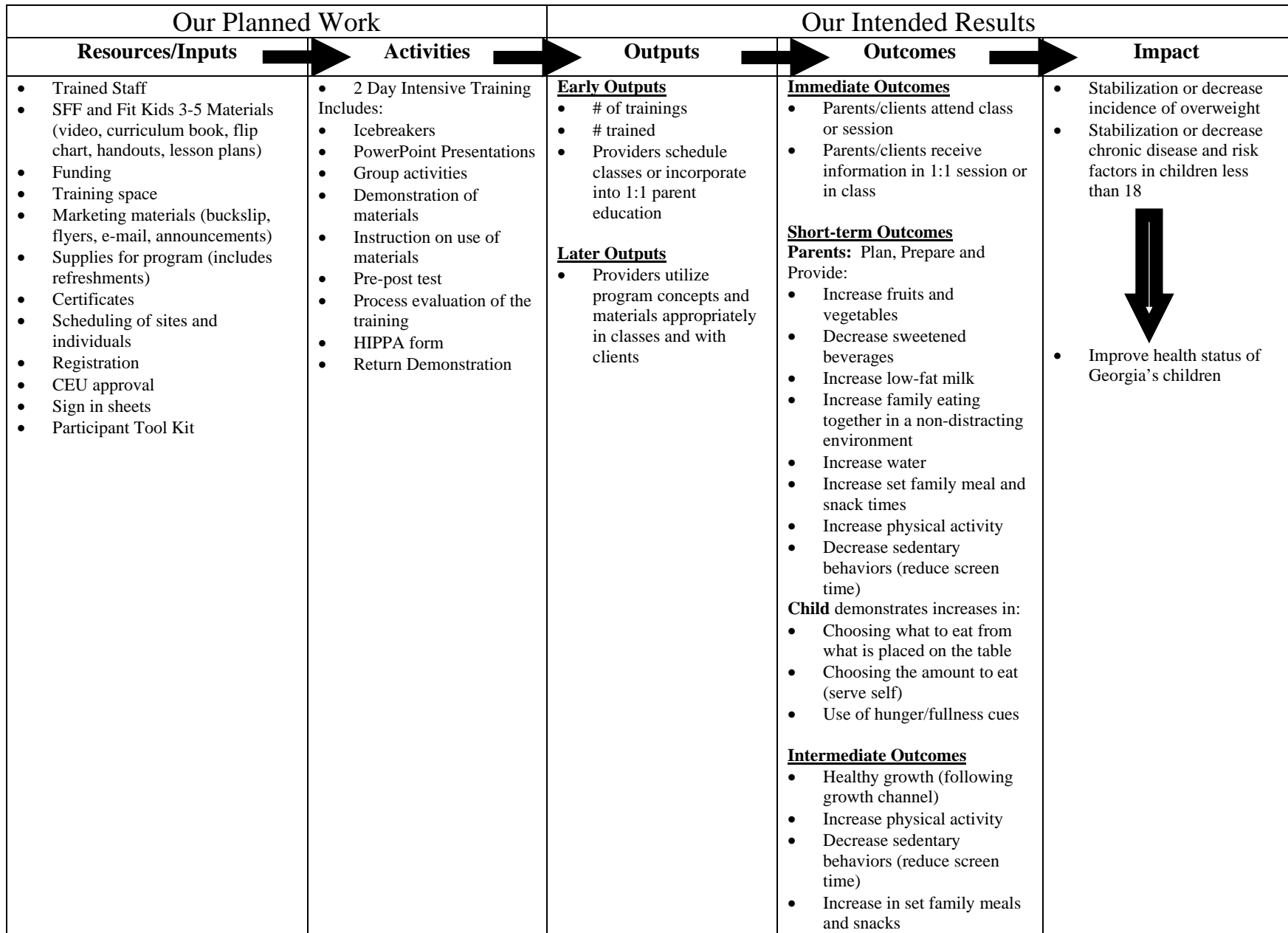
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Appendix A: Logic Models

Childhood Obesity Prevention Training Logic Model



Asthma Management Education Program Logic Model

Our Planned Work		Our Intended Results		
Resources/Inputs	Activities	Outputs	Outcomes	Impact
<ul style="list-style-type: none"> • Trained Staff • Asthma Basics brochures • What is Asthma? poster • ACE Asthma-What You Need to Know flipchart, medication and equipment teaching sheets • Protecting Children From Air Pollution handout • Asthma Resource folders for school staff • Funding • Training space • Marketing materials (flyers, e-mail, web announcements, collateral) • Supplies for program • Certificates • Scheduling of sites and individuals • Registration • CEU approval • Sign in sheets 	<ul style="list-style-type: none"> • 30-minute education for school staff • 3-hour train-the-trainer program • Full Day Educational Conference <p>Includes:</p> <ul style="list-style-type: none"> • PowerPoint or Overhead Presentations • Demonstration of use of asthma devices/equipment • Instruction, demonstration, role play practice with flipcharts, and return demonstration in the train-the-trainer program • Pre- and post- testing and follow-survey in the train-the-trainer program • Program evaluations 	<p><u>Early Outputs</u></p> <ul style="list-style-type: none"> • # of training sessions provided • # trained • Collateral/resources provided <p><u>Later Outputs</u></p> <p>School staff:</p> <ul style="list-style-type: none"> • promote asthma management in children • promote the use of asthma action plans • make modifications to control asthma triggers at school • identify students having symptoms or signs of distress • follow asthma action plan <p>School nurses do the above as well as educate the student, parents and staff on asthma management, monitor the health of student on on-going basis, document health status, make appropriate referrals</p>	<p><u>Immediate Outcomes</u></p> <ul style="list-style-type: none"> • School staff and health professionals attend class or session • School staff and health professionals receive education and resource materials <p><u>Short-term Outcomes</u></p> <p>School staff and health professionals:</p> <ul style="list-style-type: none"> • Reduce exposure to asthma triggers • Send parents Student Asthma Action Cards to be completed by parent and physician and have returned to school • Make referral to school nurse/physician if child: is showing asthma symptoms but not yet diagnosed, has symptoms of exercise-induced asthma and may need to use inhaler before exercise, is avoiding exercise or has high rate of school absence, has asthma symptoms and is using quick-relief medicine more than 2xs/week 	<ul style="list-style-type: none"> • Decrease incidence of asthma symptoms and exacerbations • Decrease in missed school days and missed participation in physical activity • Asthma control achieved <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Improve health status of Georgia's children

School Nurse Consultant/Liaison Program Logic Model

Our Planned Work		Our Intended Results		
Resources/Inputs	Activities	Outputs	Outcomes	Impact
<ul style="list-style-type: none"> • Trained staff of licensed nurses • 461 page School Health Resource Manual • Fact Sheets • Building Bridges Teaching Calendar • Building Bridges Newsletters • Website • Funding • Buckslip Information • Supplies • Medical Equipment for underserved • HIPPA Compliant Releases • Cerificates • Sites and speakers for conferences/workshops • Registration • GNA approval of CEUS • Sign in sheets • Medical/Family Libraries on both campuses 	<ul style="list-style-type: none"> • Consultation by phone or visit to school nurses and school staff in 22 metro-counties, 28 metro school districts on pediatric health issues • All day school nurse workshops on needs assessed topics • Collaborative conferences with GASN, DOE • Liaison for recently discharged patients' school re-entry • Presentations at schools on requested health topics • Advocate for School Nurses 	<p><u>Early Outputs</u></p> <ul style="list-style-type: none"> • # of Consults-illnesses advised • #of Liaison cases • # of Workshops provided and attendees • projects completed <p><u>Later Outputs</u></p> <ul style="list-style-type: none"> • School Nurses provide illness management for students • Promote use of resources provided by program School Health Manual 	<p><u>Immediate Outcomes</u></p> <ul style="list-style-type: none"> • School staff attend education offerings, call to discuss health issues as needed • School Staff receive education and resources <p><u>Short term Outcomes</u></p> <ul style="list-style-type: none"> • School Staff understand health accommodations or care needed to enhance students ability to stay in school and learn • Increase the number of school nurses 	<ul style="list-style-type: none"> • Decrease incidence of missed school days • Parents more confident that child's health needs are met during school day • School nurses are more current in pediatric health information <p style="text-align: center;">↓</p> <p style="text-align: center;">Improve the health status of Georgia's children</p>

Appendix B: Healthy Lifestyle Improvement Instruments

Take Charge of Your Family’s Health	
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Parent Behavior Pretest	33
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Take Charge of Your Family's Health Program

Parent Class Knowledge Quiz Pretest

Date: _____ Teacher for class: _____

Location of class: City _____ County: _____

Your Name: _____ Phone # _____

Address: _____ City: _____ Zip Code: _____

Ages of children who live with you: _____

Please *circle* the answer that best fits each question.

1. Circle the person who should decide each of the following at meal time:

- | | | |
|---|--------|-------|
| A. What foods should be served | parent | child |
| B. What your child should eat | parent | child |
| C. How much your child should eat | parent | child |
| D. When meals and snacks should be served | parent | child |

2. What should children drink between meals and snacks?

- A. Water
- B. Juice
- C. Sweet Drinks

3. How much television should a child watch at meal time?

- A. None
- B. No more than 30 minutes
- C. As much as he or she wants

4. Who should eat at the table?

- A. Parent or caregiver only
- B. Children only
- C. Parent or caregiver and child(ren)

Please Turn Over→

5. Describe one physical activity or exercise that you can do with your child.

Please tell us a little about yourself. This information will be kept confidential. Circle the correct answer.

6. What is your gender?

- Male
- Female

7. Which category best describes you? (Circle only one)

- White
- Black/African American
- Asian
- American Indian
- Multiracial
- Other

8. What is your age?

- Under 18
- 18-24
- 25-34
- 35-44
- 45-64
- 65 or older

9. Are you Hispanic or Latino/Latina?

- Yes
- No

10. What is the highest level of education you have completed? (Circle only one)

- Did not graduate High School
- High School graduate
- Some college
- Technical College or Associate degree
- Graduated college (Bachelor's degree)
- Masters degree
- Doctoral degree (PhD, MD or other professional degree)



Take Charge of Your Family's Health Program
Parent Class Knowledge Quiz
Posttest

Your Name: _____ Date: _____

Please *circle* the answer that best fits each question.

1. Circle the person who should decide each of the following at meal time:

- | | | |
|---|--------|-------|
| A. What foods should be served | parent | child |
| B. What your child should eat | parent | child |
| C. How much your child should eat | parent | child |
| D. When meals and snacks should be served | parent | child |

2. What should children drink between meals and snacks?

- A. Water
- B. Juice
- C. Sweet Drinks

3. How much television should a child watch at meal time?

- A. None
- B. No more than 30 minutes
- C. As much as he or she wants

4. Who should eat at the table?

- A. Parent or caregiver only
- B. Children only
- C. Parent or caregiver and child(ren)

5. Describe one physical activity or exercise that you can do with your child.

7. How often does your child eat meals or snacks while watching TV or videos?

- | | |
|------------------|------------------|
| Always | Most of the time |
| Some of the time | Never |

8. Who usually eats with your child at home? (Circle all that apply)

- | | |
|-----------------|----------------|
| No one | Parent |
| Other caregiver | Other children |

9. How often do you offer your child water to drink?

- | | |
|---------------------|---------------------------|
| Never | 1 – 2 times per day |
| 3 – 5 times per day | More than 5 times per day |

10. Describe one physical activity or exercise that you do with your child.

11. How many hours of TV or videos does your child usually watch each day?

- | | |
|-------------|-------------------|
| None | Less than 1 hour |
| 1 – 2 hours | 2 – 3 hours |
| 3 – 4 hours | More than 4 hours |

12. **During the past week**, how many minutes did you or any adults in your family take part in any physical activities or exercise with your child?

- | | |
|----------------------|-----------------|
| None | 1 –10 minutes |
| 11 – 20 minutes | 21 – 40 minutes |
| More than 40 minutes | |

6. Where in the house does your child **usually** have his or her meals and snacks? (**circle only one**)

- | | |
|------------------------|-------------------------------------|
| Dining table | On bed |
| Snack table or TV tray | Other (please write in where) _____ |

7. How often does your child eat meals or snacks while watching TV or videos?

- | | |
|------------------|------------------|
| Always | Most of the time |
| Some of the time | Never |

8. Who usually eats with your child at home? (Circle all that apply)

- | | |
|-----------------|----------------|
| No one | Parent |
| Other caregiver | Other children |

9. How often do you offer your child water to drink?

- | | |
|---------------------|---------------------------|
| Never | 1 – 2 times per day |
| 3 – 5 times per day | More than 5 times per day |

10. Describe one physical activity or exercise that you do with your child.

11. How many hours of TV or videos does your child usually watch each day?

- | | |
|-------------|-------------------|
| None | Less than 1 hour |
| 1 – 2 hours | 2 – 3 hours |
| 3 – 4 hours | More than 4 hours |

12. **During the past week**, how many minutes did you or any adults in your family take part in any physical activities or exercise with your child?

- | | |
|----------------------|-----------------|
| None | 1 –10 minutes |
| 11 – 20 minutes | 21 – 40 minutes |
| More than 40 minutes | |



Take Charge of Your Family's Health Program

Parent Class Evaluation

Class Site _____

Children's ages _____ **Date** _____ **County** _____

Please check the box that best describes your opinion of the workshop:

	Yes	No	Not Sure
The class will help me as a parent or caregiver.			
I learned something new about feeding.			
I will change the way I feed my child.			
The handouts are useful for understanding the information I learned today.			

Please write any comments or questions you may have:

Thank you for completing this evaluation!

6. Where in the house does your child **usually** have his or her meals and snacks? (**circle only one**)

Dining table

On bed

Snack table or TV tray

Other (please write in where) _____

7. How often does your child eat meals or snacks while watching TV or videos?

Always

Most of the time

Some of the time

Never

8. Who usually eats with your child at home? (Circle all that apply)

No one

Parent

Other caregiver

Other children

9. How often do you offer your child water to drink?

Never

1 – 2 times per day

3 – 5 times per day

More than 5 times per day

10. Describe one physical activity or exercise that you do with your child.

11. How many hours of TV or videos does your child usually watch each day?

None

Less than 1 hour

1 – 2 hours

2 – 3 hours

3 – 4 hours

More than 4 hours

12. **During the past week**, how many minutes did you or any adults in your family take part in any physical activities or exercise with your child?

None

1 – 10 minutes

11 – 20 minutes

21 – 40 minutes

More than 40 minutes



Take Charge of Your Family's Health Program

Provider Knowledge Quiz Pretest

Date: _____ Teacher for class: _____

Location of class: City _____ County _____

Please *circle* the answer that best fits each question.

1. Circle the person who should decide each of the following at meal time:

- | | | |
|---|--------|-------|
| A. What foods should be served | parent | child |
| B. What a child should eat | parent | child |
| C. How much a child should eat | parent | child |
| D. When meals and snacks should be served | parent | child |

2. What should children drink between meals and snacks?

- A. Water
- B. Juice
- C. Sweet Drinks

3. How much television should a child watch at meal time?

- A. None
- B. No more than 30 minutes
- C. As much as he or she wants

4. Who should eat at the table?

- A. Parent or caregiver only
- B. Children only
- C. Parent or caregiver and child(ren)

5. Describe one physical activity or exercise that an adult can do with a child.

Please Turn Over→

Please tell us a little about yourself. This information will be kept confidential. Circle the correct answer.

6. What is your gender?

- Male
- Female

7. Which category best describes you? (Circle only one)

- White
- Black/African American
- Asian
- American Indian
- Multiracial
- Other

8. What is your age?

- Under 18
- 18-24
- 25-34
- 35-44
- 45-64
- 65 or older

9. Are you Hispanic or Latino/Latina?

- Yes
- No

10. What is the highest level of education you have completed? (Circle only one)

- Did not graduate High School
- High School graduate
- Some college
- Technical College or Associate degree
- Graduated college (Bachelor's degree)
- Masters degree
- Doctoral degree (PhD, MD or other professional degree)



Take Charge of Your Family's Health Program

Provider Knowledge Quiz Posttest

Date: _____ Teacher for class: _____

Location of class: City _____ County _____

Please *circle* the answer that best fits each question.

1. Circle the person who should decide each of the following at meal time:

- | | | |
|---|--------|-------|
| A. What foods should be served | parent | child |
| B. What a child should eat | parent | child |
| C. How much a child should eat | parent | child |
| D. When meals and snacks should be served | parent | child |

2. What should children drink between meals and snacks?

- A. Water
- B. Juice
- C. Sweet Drinks

3. How much television should a child watch at meal time?

- A. None
- B. No more than 30 minutes
- C. As much as he or she wants

4. Who should eat at the table?

- A. Parent or caregiver only
- B. Children only
- C. Parent or caregiver and child(ren)

5. Describe one physical activity or exercise that an adult can do with a child.



**Take Charge of Your Family's Health
Follow-up Survey**

Please check the box of the correct answer.

	None	1 - 10 families	11 - 25 families	25 - 50 families	Other (specify)
If you provide patient education, on the average, with how many families per month do you share this information?					

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The training and materials enhanced or changed how I counsel families.					
I am comfortable with my ability to present the information to families.					

I recommend the following enhancements be made to the materials and/or training. _____

Please complete the following information:

Profession/job title _____ **County** where you work _____

Training attended (check all that apply):

- | | |
|--------------------------------|----------------------------|
| _____ Fit Kids 3 - 5 | _____ Stress-Free Feeding |
| _____ BMI | _____ Talking About Weight |
| _____ 2-day Intensive Workshop | _____ Not sure |

Please turn over→

Please provide us with a little information about yourself. This information will be kept confidential. Circle the correct answer.

What is your gender?

- Male
- Female

Which category best describes you?

- White
- Black/African American
- Asian
- American Indian
- Other
- Multiracial

What is your age?

- 18-24
- 25-34
- 35-44
- 45-64
- 65 or older

Are you Hispanic or Latino/Latina?

- Yes
- No

What is the highest level of education you have completed?

- Did not graduate High School
- High School graduate
- Some College
- Technical College or Associate degree
- Graduated college (Bachelor's degree)
- Masters degree
- Doctoral degree (PhD, MD or other professional degree)



PARENTS
Pretest



Parent Name:
Date:

For each statement, please place an **X** in the box that most closely reflects your answer.

	Agree	Maybe or Sometimes	Disagree
1. Weight does not determine fitness level.			
2. It is important for the family to participate in fun movement and physically active games together.			
3. Some people are naturally bigger than others.			
4. It is safe for my child to be on a diet before he/she stops growing.			
5. I serve water or milk only with meals.			
6. Stress can affect the quality and quantity of my family's food consumption.			

PLEASE TURN THIS SHEET OVER FOR ADDITIONAL INFORMATION!

For each statement, please place an X in the box that most closely reflects your answer.

	Agree	Maybe or Sometimes	Disagree
1. It is my child's responsibility to decide how much he/she will eat.			
2. My child knows when he/she is hungry or full.			
3. I eat meals with my child everyday.			
4. I allow my child to have food between meals and snacks.			
5. I offer fruit and vegetables everyday.			
6. The TV is usually on during meals and/or snacks.			
7. When choosing food for my family, I look for high nutrient rather than low calorie foods.			
8. I know when I am feeling hungry or full.			
9. I stop eating when I feel full.			



PARENTS Posttest



Parent Name:
Date:

For each statement, please place an **X** in the box that most closely reflects your answer.

	Agree	Maybe or Sometimes	Disagree
1. Weight does not determine fitness level.			
2. It is important for the family to participate in fun movement and physically active games together.			
3. Some people are naturally bigger than others.			
4. It is safe for my child to be on a diet before he/she stops growing.			
5. I serve water or milk only with meals.			
6. Stress can affect the quality and quantity of my family's food consumption.			

Please turn this sheet over for additional information.

For each statement, please place an X in the box that most closely reflects your answer.

	Agree	Maybe or Sometimes	Disagree
1. It is my child's responsibility to decide how much he/she will eat.			
2. My child knows when he/she is hungry or full.			
3. I eat meals with my child everyday.			
4. I allow my child to have food between meals and snacks.			
5. I offer fruit and vegetables everyday.			
6. The TV is usually on during meals and/or snacks.			
7. When choosing food for my family, I look for high nutrient rather than low calorie foods.			
8. I know when I am feeling hungry or full.			
9. I stop eating when I feel full.			



FIT KIDS Parent Evaluation

CLASS LOCATION: _____

DATE: _____

1. Why did you take this class?

2. What changes have you made in your family's daily routines as a result of taking this class?

3. What did you find most helpful in the class?

4. What did you find the least helpful?

5. What suggestions do you have for improving the classes?

6. Would you recommend this class to others? YES NO MAYBE

7. Other comments:

Follow-up Survey



Name: _____

Date: _____

Please check one response to each statement.

	Yes	Maybe	No
1. It is my child's responsibility to decide how much he/she will eat.			
2. My child knows when he/she is hungry or full.			
3. I eat meals with my child every day.			
4. I allow my child to have food between meals and snacks.			
5. I offer fruit and vegetables everyday.			
6. The TV is usually on during meals and/or snacks.			
7. When choosing food for my family, I look for high nutrient rather than low calorie foods.			
8. Stress can affect the quality and quantity of my family's food consumption.			
9. I know when I am feeling hungry or full.			
10. I stop eating when I feel full.			
11. Do you stay active as a family each week?			
12. Have you reduced "screen time"?			

Please answer the following questions based on the previous week:

1. Did you complete a family activity last week?	
2. How long were you active (in minutes)?	
3. How many family members participated in the family activity?	
4. Estimate the total amount of "screen time" (includes television, videos, games, computer) viewed in the home this week by all family members (in hours).	
5. How many planned family meals were served at home this week?	
6. How many drinks other than milk or water were served at home this week?	

Comments: _____

**Please mail back in the enclosed envelope
or fax back to: 404.785.7243**

Thank you,
Beth Passehl, MS
FIT KIDS Program Coordinator
1655 Tullie Circle
Atlanta, GA 30329
404.785.7236



KIDS Pretest



CLASS/SESSION:
NAME:
DATE:

For each of the statements below, please make an X next to your answer.

	ALWAYS or AGREE	SOMETIMES or MAYBE	NEVER Or DISAGREE
1. I play and try to be physically active every day.			
2. I pick out my own snacks.			
3. I stop eating food when my stomach feels full.			
4. I drink water every day.			
5. I believe I am healthy.			
6. Eating fruits and vegetables is important for our bodies.			
7. I eat when I am bored.			
8. I would like to be more active.			
9. Drinking water is one way to be healthy.			
10. I know the names of at least 3 muscles in my body.			



KIDS Posttest



CLASS/SESSION:
NAME:
DATE:

For each of the statements below, please make an X next to your answer.

	ALWAYS or AGREE	SOMETIMES or MAYBE	NEVER Or DISAGREE
1. I play and try to be physically active every day.			
2. I pick out my own snacks.			
3. I stop eating food when my stomach feels full.			
4. I drink water every day.			
5. I believe I am healthy.			
6. Eating fruits and vegetables is important for our bodies.			
7. I eat when I am bored.			
8. I would like to be more active.			
9. Drinking water is one way to be healthy.			
10. I know the names of at least 3 muscles in my body.			



KIDS Evaluation



1. Check off the boxes next to your **favorite things** to do in FIT KIDS:

444		444	
	Ps and Cs		Muscles
	Hunger & Fullness		Outside Games
	Healthy Heart		Soda vs. Water
	Spinach Dip		Yoga

2. Check off the boxes next to anything that you **DID NOT LIKE** in FIT KIDS:

444		444	
	Ps and Cs		Muscles
	Hunger & Fullness		Outside Games
	Healthy Heart		Soda vs. Water
	Spinach Dip		Yoga

4. Check off what you think it means to be **HEALTHY?**

444		444	
	Eat vegetables		Get lots of sleep
	Eat fruit		Play
	Watch less t.v.		Eat slowly
	Drink water		Be physically active

Circle Your Answer

- | | | |
|---|-----|----|
| 5. I would tell a friend to sign up for FIT KIDS. | Yes | No |
| 6. I eat more fruits and vegetables now. | Yes | No |
| 7. I drink more water now. | Yes | No |
| 8. We play more as a family now. | Yes | No |



Weekly Goal Sheet



NAME:	Last Week	WEEK 2	WEEK 3	WEEK 4	WEEK 5	WEEK 6
Did you complete a family activity?						
How long did were you active? (In minutes)						
How many family members participated in the family activity?						
Total "screen time" in hours: (Includes television, videos, games, computer)						
How many planned family meals were served at home this week?						
How many drinks other than milk or water were served at home this week?						

Kids on the Move Training Workshop Pretest Assessment
--

Name _____ Title _____ Date _____

Directions: Read each question carefully and circle ONE response.

1. The goal of the Kids on the Move program is
 - a. To provide mentoring for children after school.
 - b. To improve reading scores of children in after-school
 - c. To reduce cardiovascular risk factors in children.
 - d. To put children on weight reduction diets.

2. Which of the following is not an objective of the Kids on the Move program?
 - a. To teach kids how to play competitively
 - b. To increase knowledge of healthy lifestyle choices.
 - c. To improve physical skills and increase confidence.
 - d. To increase enjoyment of active play.

3. Key elements that have resulted in the success of the Kids on the Move program include the following:
 - a. organization, equipment and discipline
 - b. fun, structure and adult participation
 - c. competition, prizes and rest breaks

4. Which of the following is the recommended disciplinary procedure for Kids on the Move?
 - a. Require the child who is breaking a rule to sit out of the activity session for 5 to 10 minutes depending upon the age of the child and contact parents after the second offense.
 - b. Require the child who is breaking a rule to run one to two laps around the field or gym and contact parent if there is more than one offense.
 - c. Require the child to review the rules and contact parent if there is more than one offense.

5. Which of the following is the first step in setting up a Kids on the Move program in your school?
 - a. Recruit children for the program to be sure there is interest.
 - b. Present program concept to administrators and obtain approval.
 - c. Purchase equipment for the active play sessions.
 - d. Conduct a "Parent Night" to explain program to parents.

Kids on the Move Training Workshop Posttest Assessment

Name _____ Title _____ Date _____

Directions: Read each question carefully and circle ONE response.

1. The goal of the Kids on the Move program is
 - a. To provide mentoring for children after school.
 - b. To improve reading scores of children in after-school
 - c. To reduce cardiovascular risk factors in children.
 - d. To put children on weight reduction diets.

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 - a. Recruit children for the program to be sure there is interest.
 - b. Present program concept to administrators and obtain approval.
 - c. Purchase equipment for the active play sessions.
 - d. Conduct a "Parent Night" to explain program to parents.

Kids on the Move Process Evaluation
--

Date _____

Directions: Please read each statement and check the box that best represents your assessment of this workshop.

<u>Statement</u>	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. The workshop was informative.					
The workshop content is relevant to my work.					
2. The workshop was well organized.					
3. The facilitators demonstrated knowledge of the topics.					
4. The “hands-on” activities were valuable.					
5. The facilitators held my interest.					
6. The video was helpful in explaining the program.					
7. The training has prepared me to facilitate the Kids on the Move program.					
8. The atmosphere was conducive to learning.					

Comments on the Workshop:

Thank you for attending the Kids on the Move workshop and for taking the time to complete this evaluation.

**Kids on the Move
Trainee Observation**

Behavior	Very Competent	Competent	Somewhat Competent*	Needs Improvement*
Adheres to the lesson plan content and methods outlined in the <i>Kids on the Move</i> manual.				
Gives clear directions for class activities.				
Maintains time schedule.				
Encourages everyone to participate in the energizer, active play, and relaxation activities.				
Encourages questions from participants.				
Facilitates a warm, relaxed, friendly atmosphere.				
Handles questions when the answer is unknown.				
Acknowledges and encourages appropriate behavior throughout the session.				
Administers appropriate discipline when necessary.				
Demonstrates cheerful and energetic attitude.				
Assures that all materials and equipment are available and in working order.				

Please describe concerns when “*Somewhat Competent*” or “*Needs Improvement*” is checked. Use the back of this page.

TRAINEE: _____ **LOCATION:** _____

EVALUATION COMPLETED BY: _____ **DATE:** _____



**Talking About Weight
Knowledge Pretest**

Date: _____	Training Site: _____
--------------------	-----------------------------

Position/Title: _____

Please check either True or False:

Question	True	False
Body size shows how fit a person is.		
Beliefs, attitudes, and biases may affect the way a provider treats an overweight person.		
All children are the same size at the same age.		
Children should choose what to eat and how much to eat.		
Kids, particularly girls, eat more when parents try to restrict their intake.		
Mothers who are restrained eaters exert more control over their children's intake.		
Children at age 3 are usually able to compensate for high energy intakes by eating less later.		
Children at age 5 are more likely to overeat when presented with larger portions.		
Children who are more accustomed to high fat, high sugar foods at home are more likely to overeat them.		

Please tell us a little about yourself. This information will be kept confidential. Circle the correct answer.

What is your gender?

Male

Female

Which category best describes you?

White

Black/African American

Asian

American Indian

Other

Multiracial

Please Turn Over→

Are you Hispanic or Latino/Latina?

Yes

No

What is your age?

18-24

25-34

35-44

45-64

65 or older

What is the highest level of education you have completed?

Did not graduate High School

High School graduate

Some College

Technical College or Associate degree

Graduated college (Bachelor's degree)

Masters degree

Doctoral degree (PhD, MD or other professional degree)



**Talking About Weight
Knowledge Posttest**

Date: _____	Training Site: _____
--------------------	-----------------------------

Position/Title: _____

Please check either True or False:

Question	True	False
Body size shows how fit a person is.		
Beliefs, attitudes, and biases may affect the way a provider treats an overweight person.		
All children are the same size at the same age.		
Children should choose what to eat and how much to eat.		
Kids, particularly girls, eat more when parents try to restrict their intake.		
Mothers who are restrained eaters exert more control over their children's intake.		
Children at age 3 are usually able to compensate for high energy intakes by eating less later.		
Children at age 5 are more likely to overeat when presented with larger portions.		
Children who are more accustomed to high fat, high sugar foods at home are more likely to overeat them.		



**Talking About Weight
Provider Workshop Evaluation**

Date: _____	Training Site: _____
-------------	----------------------

Position/Title: _____

Please check the box that represents your level of agreement:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I can list current trends, causes, and health impacts of childhood obesity.					
The activities helped the group to process attitudes, beliefs, and assumptions about body size.					
I can discuss how everyone has the capacity to follow his or her own internal cues of hunger and fullness.					
I can identify information and tools for schools, health care providers, parents, and children to use to address childhood weight problems.					
The materials presented will help me in my job.					
The environment stimulated participation.					
The teaching methods were effective.					
The instructors were effective.					

Please provide any additional comments that will help us improve our workshops

Please turn over→

**Please tell us a little about yourself. This information will be kept confidential.
Circle the correct answer.**

What is your gender?

Male
Female

Which category best describes you?

White
Black/African American
Asian
American Indian
Other
Multiracial

What is your age?

18-24
25-34
35-44
45-64
65 or older

Are you Hispanic or Latino/Latina?

Yes
No

What is the highest level of education you have completed?

Did not graduate High School
High School graduate
Some College
Technical College or Associate degree
Graduated college (Bachelor's degree)
Masters degree
Doctoral degree (PhD, MD or other professional degree)



**Talking About Weight
Follow-up Survey**

Please check the box of the correct answer.

	None	1 - 10 families	11 - 25 families	25 - 50 families	Other (specify)
If you provide patient education, on the average, with how many families per month do you share this information?					

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The training and materials enhanced or changed how I counsel families.					
I am comfortable with my ability to present the information to families.					

I recommend the following enhancements be made to the materials and/or training. _____

Please complete the following information:

Profession/job title _____ **County** where you work _____

Training attended (check all that apply):

- | | |
|--------------------------------|----------------------------|
| _____ Fit Kids 3 - 5 | _____ Stress-Free Feeding |
| _____ BMI | _____ Talking About Weight |
| _____ 2-day Intensive Workshop | _____ Not sure |

Please turn over→

Please provide us with a little information about yourself. This information will be kept confidential. Circle the correct answer.

What is your gender?

- Male
- Female

Which category best describes you?

- White
- Black/African American
- Asian
- American Indian
- Other
- Multiracial

What is your age?

- 18-24
- 25-34
- 35-44
- 45-64
- 65 or older

Are you Hispanic or Latino/Latina?

- Yes
- No

What is the highest level of education you have completed?

- Did not graduate High School
- High School graduate
- Some College
- Technical College or Associate degree
- Graduated college (Bachelor's degree)
- Masters degree
- Doctoral degree (PhD, MD or other professional degree)



BMI Training Knowledge Pretest

Date: _____ Training Site _____

Position/title: _____

Please circle the correct answer.

- 1. To correctly measure the height of a child, the child's head should be:**
 - A. Looking down
 - B. Looking up
 - C. Looking straight ahead
 - D. Facing the stadiometer

- 2. To assess overweight status of children the following procedure is recommended:**
 - A. Visually assess the child's body size
 - B. Determine the child's height and weight
 - C. Calculate BMI and refer to the BMI adult tables available from CDC
 - D. Calculate BMI and plot on the appropriate BMI for age percentile chart

- 3. How many times should you measure a child's height or weight?**
 - A. Only once
 - B. Twice, taking an average of the two measurements
 - C. Twice unless the two measurements exceed the tolerance limit. Then a third measurement should be taken and the two closest measurements should be averaged.
 - D. Three times

- 4. To obtain a child's weight, the following procedure is recommended:**
 - A. Ask child to remove shoes, belt, purse, items in pocket, and outer garments (i.e. jacket, sweatshirt)
 - B. Weigh child in private area
 - C. Announce child's weight
 - D. A and B

Please turn over→

**Please tell us a little about yourself. This information will be kept confidential.
Circle the correct answer.**

What is your gender?

Male
Female

Which category best describes you?

White
Black/African American
Asian
American Indian
Other
Multiracial

Are you Hispanic or Latino/Latina?

Yes
No

What is your age?

18-24
25-34
35-44
45-64
65 or older

What is the highest level of education you have completed?

Did not graduate High School
High School graduate
Some College
Technical College or Associate degree
Graduated college (Bachelor's degree)
Masters degree
Doctoral degree (PhD, MD or other professional degree)

Thank you!



BMI Training Knowledge Posttest

Date: _____ Training Site _____

Position/title: _____

Please circle the correct answer.

- 1. To correctly measure the height of a child, the child's head should be:**
 - A. Looking down
 - B. Looking up
 - C. Looking straight ahead
 - D. Facing the stadiometer

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 - D. Calculate BMI and plot on the appropriate BMI for age percentile chart

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 - A. Only once
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 - C. Twice unless the two measurements exceed the tolerance limit. Then a third measurement should be taken and the two closest measurements should be averaged.
 - D. Three times

- 4. To obtain a child's weight, the following procedure is recommended:**
 - A. Ask child to remove shoes, belt, purse, items in pocket, and outer garments (i.e. jacket, sweatshirt)
 - B. Weigh child in private area
 - C. Announce child's weight
 - D. A and B



**BMI Training
Process Evaluation**

Date: _____ Training Site: _____

Position/title: _____

Please check the box that represents your level of agreement:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I can define BMI and its role in physical fitness.					
I can identify the recommended equipment to use when weighing and measuring a child.					
I am confident that I can correctly weigh a child.					
I am confident that I can correctly measure a child's height.					
I am confident that I can communicate in a non-judgmental manner with a child while weighing and measuring.					
I am confident that I can determine the correct BMI for a child.					
I am confident that I can determine the correct BMI percentile for a child.					
I am confident I can provide the proper safeguards to protect a child's privacy during weighing and measuring.					
I am able to assess BMI accurately using a growth chart.					
I can describe my role in the measurement of BMI as a key component of the physical evaluation of children.					
The teaching methods were effective.					

Please turn over→

Please provide comments on the materials and training content:

**Please tell us a little about yourself. This information will be kept confidential.
Circle the correct answer.**

What is your gender?

- Male
- Female

Which category best describes you?

- White
- Black/African American
- Asian
- American Indian
- Other
- Multiracial

Are you Hispanic or Latino/Latina?

- Yes
- No

What is your age?

- 18-24
- 25-34
- 35-44
- 45-64
- 65 or older

What is the highest level of education you have completed?

- Did not graduate High School
- High School graduate
- Some College
- Technical College or Associate degree
- Graduated college (Bachelor's degree)
- Masters degree
- Doctoral degree (PhD, MD or other professional degree)

Thank you!



**BMI in Clinical Practice
Follow-up Survey**

Please check the box of the correct answer.

	None	1 - 10 families	11 - 25 families	25 - 50 families	Other (specify)
If you provide patient education, on the average, with how many families per month do you share this information?					

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The training and materials enhanced or changed how I counsel families.					
I am comfortable with my ability to present the information to families.					

I recommend the following enhancements be made to the materials and/or training. _____

Please complete the following information:

Profession/job title _____ **County** where you work _____

Training attended (check all that apply):

- | | |
|--------------------------------|----------------------------|
| _____ Fit Kids 3 - 5 | _____ Stress-Free Feeding |
| _____ BMI | _____ Talking About Weight |
| _____ 2-day Intensive Workshop | _____ Not sure |

Please turn over→

Please provide us with a little information about yourself. This information will be kept confidential. Circle the correct answer.

What is your gender?

- Male
- Female

Which category best describes you?

- White
- Black/African American
- Asian
- American Indian
- Other
- Multiracial

What is your age?

- 18-24
- 25-34
- 35-44
- 45-64
- 65 or older

Are you Hispanic or Latino/Latina?

- Yes
- No

What is the highest level of education you have completed?

- Did not graduate High School
- High School graduate
- Some College
- Technical College or Associate degree
- Graduated college (Bachelor's degree)
- Masters degree
- Doctoral degree (PhD, MD or other professional degree)



Type 2 Diabetes Prevention Program Process Evaluation

Directions: Please read each statement and choose one of the responses – Strongly disagree, Disagree, Not sure, Agree, Strongly Agree.

Statement	Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree
1. I enjoyed being in the program					
2. The activity sessions were fun.					
3. The activity coach was helpful.					
4. I liked the activity equipment.					
5. The nutritionist was helpful.					
6. I received helpful information about healthy food choices.					
7. I liked keeping the food/activity log.					
8. Keeping the food/activity log was helpful.					
9. The "Setting Healthy Goals Worksheet" was a helpful tool.					
10. Setting goals helped my change my eating and activity habits.					

What did you like best about the program? _____

What did you like least about the program? _____

If you could make changes in the program, what would you change?



Eating Habits Questionnaire Type 2 Diabetes Prevention Program

Name _____ Age _____ Date _____ Site: Decatur ____ or Marietta ____

Parent/Caregiver (name/relationship) _____ Nutritionist _____

Instructions: For each eating time listed below please mark an "X" in the column which best describes how often you ate last week.

	Every day	3-6 times last week	1-2 times last week	Not last week	What time	Where
Breakfast						
Lunch						
Supper						
Snacks or treats (between meals)						

Instructions: For each beverage listed below, mark an "X" in the column which best describes how often you drank that beverage last week.

Beverage (8 ounces = 1 serving)	3 or more times a day	1-2 times a day	3-6 times last week	1-2 times last week	Not at all last week	Never drink it
Diet or caffeine free diet soda (Diet Coke®, Diet Pepsi®, Diet Sprite®, Fresca®, etc.)						
Regular or caffeine free regular soda (Coke®, Pepsi®, 7-Up®, Root Beer etc.)						
Fruit flavored soda (Sunkist Orange®, Welch's Grape®, Cherry, etc.)						
Kool-Aid®, Hawaiian Punch®, Hi-C®, Tropicana Twisters®, sweet tea, etc.)						
Fruit or vegetable juice (orange juice, apple juice, V-8, tomato juice, grapefruit juice etc.)						
Water						
Whole milk						
Lowfat milk (2%, 1%, 1/2%, skim)						
Sports drinks (Gatorade®, Powerade®, etc.)						

Instructions: For each food item listed below, mark an "X" in the column which best describes how often you ate each food last week.

	3 or more times a day	1-2 times a day	3-6 times last week	1-2 times last week	Not at all last week	Never eat it
Pizza (any type)						
Hamburgers						
Mexican food: tacos, burritos, enchiladas, etc						
French Fries						
Chicken fingers or nuggets						
Hotdogs, corn dogs (all types)						
Cheese nachos						

Instructions: For each food item listed below, mark an "X" in the column which best describes how often you ate that food last week.

	3 or more times a day	1-2 times a day	3-6 times last week	1-2 times last week	Not at all last week	Never eat it
Cake, brownies, (1 serving = 1 inch slice or 1 small square) pie or cobbler (1/8 pie)						
Cookies						
Doughnuts, sweet rolls, biscuits, pastries, muffins, Hostess®, Little Debbie® cakes, Twinkies®						
Frozen yogurt, ice milk, ice cream, popsicles, pudding or custard						
Soft candy (Fun Fruit® Fruit Roll-ups®, Gummi Bears)®						
Hard candy (Life Savers®, Mentos® Altoids®, Tic Tacs®, Sweet N' Sour Tarts®, etc)						
Candy bars, fudge, caramel, M & M's®						
Chips, Doritos®, Cheetos®, Fritos®, etc. (10 chips = 1 serving)						
Sugar (on cereal, in coffee or tea, etc), (1teaspoon or packet = 1 serving)						
Crackers, such as Cheez-its®, Ritz®, Nabs/ Lance® packaged crackers						
Chewing gum or bubble gum, Regular						

Instructions: For each food item listed below, mark an "X" in the column which best describes how often you ate that food last week.

	3 or more times a day	1-2 times a day	3-6 times last week	1-2 times last week	Not at all last week	Never eat it
Broccoli, cabbage, spinach, greens						
Carrots, cauliflower, celery, cucumber, squash, tomato						
Eggplant, green beans, okra, wax beans						
Beans (red, baked, butter, field peas, etc.)						
Apples, bananas, cantaloupe, grapes, peaches, pears, etc UNcooked or raw						
Apples, apricots, blueberries, strawberries, peaches, etc COOKED						
Oranges, grapefruits, kiwi, etc Uncooked						
Dried fruit (apples, apricots, figs, raisins, dates, etc.)						
Avocado (guacamole), coconut, olives						

Instructions: For each food item listed below, mark an "X" in the column which best describes how often you ate that food last week.

1/2 cup = 1 serving	3 or more times a day	1-2 times a day	3-6 times last week	1-2 times last week	Not at all last week	Never eat it
Dry cereal (pre-sweetened: Cap'n Crunch®, Frosted Mini Wheats®, Cinnamon Toast Crunch®, etc)						
French Toast, pancakes, waffles						
Whole grain bread or pasta						
Hot cereal (oatmeal, etc)						
High fiber dry cereal						
Brown rice						

Who usually prepares your meals? _____



**Type 2 Diabetes Prevention
Physical Activity Questionnaire**

Name _____ Date _____

Please circle the best answer for each question.

1. On how many of the **past 7 days** were you physically active for a total of **at least 60 minutes per day**?

(Add up all the time you spent that day in any kind of physical activity that increased your heart rate and made you breathe hard at least some of the time. Examples include dancing, basketball, football, bicycling, rollerblading, fast walking, and soccer.)

0 1 2 3 4 5 6 7

2. Over a **typical or average week**, on how many **days** are you physically active for a total of **at least 60 minutes** per day?

0 1 2 3 4 5 6 7

3. On an average **school day**, how many **hours** do you watch TV?

0 less than one 1 2 3 4 5+

4. On an average **non-school day**, how many **hours** do you watch TV?

0 less than one 1 2 3 4 5+

5. On an average **school day**, how many **hours** do you spend playing video games or using the computer?

0 less than one 1 2 3 4 5+

6. On an average **non-school day**, how many **hours** do you spend playing video games or using the computer?

0 less than one 1 2 3 4 5+

OFFICE STAFF ONLY

PATIENT NAME: _____

Date: _____

BMI: _____	BMI-for-age percentile (circle):	< 5 th	5 th -< 84 th	85 th -94 th	≥ 95 th
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COUNSELING GUIDE

ADVISE: All patients about healthy behaviors

- Review BMI-for-age percentile status with patient / parent.
- Address eating patterns, food choices, physical activity habits, and TV/computer/video game time.
- Express your availability as a resource to the patient.

COUNSEL: If patient is “at risk” or “overweight” (≥ 85th percentile), review family medical history and potential complications of overweight. Then, ask the following questions verbatim:

1. Are you concerned about your weight? Yes No (If NO, see **NOTE** below)
2. Are you and your family ready to make changes now? Yes No (If NO, see **NOTE** below)
3. What changes do you think would work best for you and your family?

Nutrition Behaviors

- Eat more family meals together at home
- Eat a healthy breakfast
- Increase fruit & vegetable intake
- Reduce sweetened fruit and soda drinks
- Reduce sweets and salty snacks
- Reduce portion size
- Join weight loss or weight maintenance program
- Other actions: _____

Activity* and Sedentary Behaviors

- Limit TV time
 - Limit video games / computer time
 - Regular activity (e.g., walk, bike, jog, swim)
 - Participate in PE class at school
 - Regular home exercise / workouts
 - Regular gym/health club exercises/workouts
 - Read more about weight control and health
- * 60 minutes/day, 5 days/week, short or long periods

NEXT STEPS:

- Help patient/parent select one nutrition goal and one activity goal.
- Complete the Healthy Living Prescription form.
- Follow-up every 2-3 weeks, assess progress and provide positive reinforcement for behavior changes.

NOTE: If patient/parent is not concerned about weight or not ready to change behavior, ask:

What would make you decide to do something about your (the patient’s) weight?

___ If it gets worse/higher

___ If I feel depressed or out of control

___ If I am teased

___ If medical or health complications arise

Other: _____

NEXT STEP: Use Counseling Guide to assess readiness to change at next visit.

Clinician’s Signature: _____



Type 2 Diabetes Prevention Setting Healthy Goals

<u>Healthy Goals</u> Choose one or more daily goals to work on for next week.	Number of days I will reach this goal next week.	I want to reach this goal. Using a scale of 1 – 5: 0 = not at all interested; 5 = very interested in reaching the goal.	I believe I can reach this goal. Using a scale of 1 – 5: 0 = do not believe I can reach this goal 5 = I strongly believe I can reach this goal.	Why did you make these choices?
I will eat _____ serving(s) of fruits and/or vegetables.				
I will drink water between meals.				
I will limit juice consumption to 8 ounces a day.				
I will limit sweetened beverage consumption to 12 ounces.				
I will eat breakfast.				
I will eat at least ___ serving(s) from the milk group.				
I will be physically active for _____minutes.				
I will limit screen time to _____minutes.				

Name _____ Date _____



Healthy Lifestyle Improvement Train the Trainer Observation Form

Provider evaluated: _____

Number of clients present: _____

Date: ___/___/_____

Evaluator: _____

Instructions

Please consider each item carefully and assign highest scores only for unusually effective performance.

Rate each item using a number from 1 to 5, where 1 is unsatisfactory, 3 is satisfactory and 5 is excellent.

- ___ 1) Defines objectives for the presentation
- ___ 2) Effectively organizes learning situations to meet the objectives of the presentation
- ___ 3) Uses instructional methods encouraging relevant client participation in the learning process
- ___ 4) Uses presentation time effectively
- ___ 5) Demonstrates enthusiasm for the subject matter
- ___ 6) Communicates clearly and effectively to the level of the clients
- ___ 7) Explains important ideas simply and clearly
- ___ 8) Demonstrates command of subject matter
- ___ 9) Responds appropriately to client questions and comments
- ___ 10) Encourages critical thinking and analysis

Appendix C: Asthma Management Education Instruments

Asthma Management Education

Affective Posttest	82
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ACE Asthma Educator Training

Knowledge Pretest	83
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Follow-Up	94

Asthma in School Age Children Conference

Affective Posttest	95
Follow-Up	96



Evaluation Asthma Education School Personnel

Date: ____ / ____ / ____

Directions: Please check the box that best represents your answer.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The content presented was useful to me.					
I feel better prepared to work with children with asthma.					
The presenter's method of delivery was effective.					
The course was organized in a logical manner.					
I would recommend this program to others.					

This program could be improved by:

What is your gender?

- Male
- Female

Which category best describes you?

- White
- Black/African American
- Asian
- American Indian
- Other
- Multiracial

Are you Hispanic or Latino/Latina?

- Yes
- No

What is the highest level of education you have completed?

- | | |
|---------------------------------------|--|
| Did not graduate High School | Graduated college (Bachelor's degree) |
| High School graduate | Masters degree |
| Some College | Doctoral degree (PhD, MD or other professional degree) |
| Technical College or Associate degree | |

Number of years experience working with children with asthma: _____



ACE Asthma Educator Training

Pre Test

Participant #: _____

Date: ____/____/____

Number of years experience working with children with asthma: _____

Directions: Please mark answers on the answer sheet provided. Circle one letter for each question.

- 1) A wheezing episode usually requires:
 - A. hospitalization
 - B. warm liquids
 - C. treatment with a bronchodilator
 - D. oral steroids

- 2) The muscles closing tight around the airways are best treated with:
 - A. Albuterol
 - B. Ventolin
 - C. Proventil
 - D. All of the above

- 3) A nine-year old girl has newly diagnosed asthma. You explain that asthma education is a partnership of:
 - A. parent and child
 - B. team effort of the child and all who care for the child
 - C. parent and doctor
 - D. ask the child who she wants to partner with

- 4) Examples of long term control medicines for mild to moderate asthma include all of the following **except**:
 - A. Prelone
 - B. Vanceril
 - C. Flovent
 - D. Singulair

- 5) In a phone conversation with the mother of a two-year old with moderate persistent asthma, the mother tells you that she has stopped taking the Intal (cromolyn sodium) because her child no longer has asthma symptoms. Your best response to this comment is:
 - A. Congratulate her on stopping the medicine at the appropriate time
 - B. Explain the Intal must be continued until there are no symptoms for one week
 - C. Remind her of the chronic inflammation and the need to continue Intal even when there are no symptoms noticed
 - D. Remind her that since Intal treats muscle spasm it should not be stopped suddenly

- 6) The peak flow meter:
- A. gives an indication of how well air moves out of the lungs
 - B. should only be used in ages 15 and older
 - C. both A and B
 - D. none of the above
- 7) The growth chart indicates that a child has grown 2.5 inches taller in the last 13 months. You would expect that the peak flow meter reading:
- A. would not change due to growth
 - B. has decreased
 - C. has remained the same
 - D. has increased
- 8) When instructing a father on the use of his son's Ventolin inhaler, you explain that:
- A. common side effects are: fast heart rate, shaky feeling, increased activity
 - B. it should never be used more than three times a day
 - C. it is not safe to take for long periods of time because his son will become addicted
 - D. none of the above
- 9) A parent of a child with asthma calls the office and states that she gave her two-year old son two puffs of his albuterol inhaler 10 minutes ago and his symptoms are no better. You instruct her to:
- A. float the inhaler to see if its empty
 - B. not to worry, it takes 45-60 minutes for albuterol to begin working
 - C. use the peak flow meter to see if he's in the yellow zone
 - D. none of the above
- 10) This same mother says that she knows the inhaler is not empty because she can hear liquid in the inhaler when she shakes it. Your response is:
- A. Tell her to put the inhaler in the water, if it floats it is full
 - B. Agree that if she can hear something in the inhaler it is not empty
 - C. That it is not a reliable test- she could be hearing only the remaining propellant in the inhaler
 - D. None of the above
- 11) To interpret a child's current peak flow reading, the best comparison is:
- A. to the personal best
 - B. to the predicted score
 - C. to the highest score the child has ever obtained
 - D. none of the above
- 12) Infections are the most common asthma trigger in young children.
- A. True
 - B. False

- 13) Which environmental control is most effective for dust mites in the bedroom?
- A. wash bedding in lukewarm water twice a week
 - B. keep home humidity over 50%
 - C. encase mattress and pillow in zippered covers
 - D. spray tannic acid on upholstered furniture
- 14) You are teaching a teenager to use a MDI (Metered Dose Inhaler). The best statement is:
- A. the faster he inhales the more medicine he will get
 - B. activate the canister at the end of inhalation
 - C. rapidly exhale after breathing in the medicine
 - D. activate the canister at the beginning of inhalation
- 15) All of the following are early warning signs of an asthma episode **except**:
- A. peak flow reading in the yellow zone
 - B. skin sucking in between the ribs
 - C. runny nose
 - D. tired, irritability
- 16) The doctor recommends the two-year old child use a mask during home aerosol treatments. Your tips for the family include:
- A. let Mom wear it first to show it doesn't hurt
 - B. let him keep the mask in his mouth
 - C. place him in a head-lock to show who is boss
 - D. let him lay in bed prone
- 17) If a child has exercise induced asthma, this may indicate:
- A. the child should not participate in any sports that require running
 - B. the need to use quick relief medicine at least 20 minutes before exercise
 - C. the need to use a quick relief medicine at least one hour before exercise
 - D. the need to have an exercise challenge test monthly
- 18) The one way flap moves on the Aerochamber with mask while the child is inhaling. This indicates:
- A. the child is getting the medicine
 - B. the child needs to switch to an Aerochamber with mouthpiece
 - C. the Aerochamber needs to be replaced
 - D. the mask is not sealed on the face tight enough
- 19) A mother states that her two-year old does well with the inhaler and doesn't need a spacer:
- A. This is acceptable if there are no side effects
 - B. This is a precocious child and you compliment her
 - C. You instruct her she only needs to use the spacer when the child wants to
 - D. You instruct her on the reasons for using the spacer with a two-year old

- 20) The main reason we suggest “rinsing and spitting” after using an inhaled steroid is to prevent a bad taste in the mouth.
- A. True
 - B. False
- 21) Upon taking a history on a patient who hasn’t been seen in four months, she tells you that her asthma is doing fine - the only medicine she needs to use is an albuterol inhaler three times a day everyday. You think to yourself:
- A. She should be using her medicine four times a day
 - B. Since bronchospasm is the primary issue with asthma, a bronchodilator is needed
 - C. This is not pertinent information to put in the chart
 - D. I will make sure the doctor is aware of this
- 22) All of the following are signs of respiratory distress in an infant **except**:
- respiratory rate of 45
 - vigorous suck on a bottle
 - weak cry
 - skin sucking in between the ribs and below the collarbones
- 23) As you are giving a mother a new prescription for an inhaled steroid, she tells you that she is afraid to give it to her child because she has read about serious side effects of long term steroid use. Your best response is:
- A. Go speak to the doctor to make sure this is the medicine he intended for the child
 - B. Tell her not to believe everything she reads
 - C. Explain the difference between long term use of oral steroids vs. inhaled steroids
 - D. Explain this medicine is the inhaled form of anabolic steroids that athletes use
- 24) A parent who smokes states that she does not smoke in the car or house when her child is with her. Your best response is:
- A. The smoke is absorbed by the upholstery and will irritate the child’s airways when he is near it
 - B. This is adequate since the child is not in her presence while she is smoking
 - C. Tell her she may smoke in the car or house only if the windows are open
 - D. Smoke is not a significant trigger for children with asthma
- 25) Upon seeing Jeffrey in the office for an acute asthma episode, the father tells you that Jeffrey has had a runny nose and cough for several days but he was waiting to start the albuterol when he could tell if it was a cold or the asthma. The best response to this comment is:
- A. Review the action plan with him and point out that albuterol can only be started in the red zone
 - B. He did the right thing since it is not safe to give albuterol until he is sure the asthma is flaring up
 - C. Review early warning signs and explain why albuterol should be started immediately
 - D. He did the right thing since it is not safe for parents to begin asthma medicines at home

**Please tell us a little about yourself. This information will be kept confidential.
Circle the correct answer.**

What is your gender?

Male

Female

Which category best describes you?

White

Black/African American

Asian

American Indian

Other

Are you Hispanic or Latino/Latina?

Yes

No

What is the highest level of education you have completed?

Did not graduate High School

High School graduate

Some College

Technical College or Associate degree

Graduated college (Bachelor's degree)

Masters degree

Doctoral degree (PhD, MD or other professional degree)

In what setting do you work ? (circle one)

School

Public Health

Private Practice

Hospital

Other, please specify _____

What is your job classification? (circle one)

RN

LPN

Clinic Worker

Respiratory Therapist

Teacher

Other, please specify _____

Thank you!



ACE Asthma Educator Training

Posttest

Participant #: _____

Date: ____/____/____

Number of years experience working with children with asthma: _____

Directions: Please mark answers on the answer sheet provided. Circle one letter for each question.

- 1) A wheezing episode usually requires:
 - A. hospitalization
 - B. warm liquids
 - C. treatment with a bronchodilator
 - D. oral steroids

- 2) The muscles closing tight around the airways are best treated with:
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 - D. I will make sure the doctor is aware of this
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- A. Review the action plan with him and point out that albuterol can only be started in the red zone
 - B. He did the right thing since it is not safe to give albuterol until he is sure the asthma is flaring up
 - C. Review early warning signs and explain why albuterol should be started immediately
 - D. He did the right thing since it is not safe for parents to begin asthma medicines at home



Evaluation ACE Asthma Educator Training

Presenter: Robin Hyman, RRT, AE-C

Children's Healthcare of Atlanta

Date: ___/___/___

Number of years experience working with children with asthma: _____

Directions: Please check the box that best represents your answer.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The content presented was useful to me.					
I feel better prepared to work with children with asthma.					
The presenter's method of delivery was effective.					
The course was organized in a logical manner.					
I will use the teaching tools (flip chart, action plan, etc.) in practice.					
I would recommend this program to health care providers.					

The following presentation objectives were met:

I am able to:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Identify symptoms of asthma.					
Discuss prevalence of asthma in children.					
Identify asthma triggers and discuss environmental controls.					
Demonstrate appropriate use of metered dose inhalers, diskus inhalers and peak flow meters.					
Discuss the use and importance of an asthma action plan.					

This program could be improved by:

Please turn over→

**Please tell us a little about yourself. This information will be kept confidential.
Circle the correct answer.**

What is your gender?

Male
Female

Which category best describes you?

White
Black/African American
Asian
American Indian
Other

Are you Hispanic or Latino/Latina?

Yes
No

What is the highest level of education you have completed?

Did not graduate High School
High School graduate
Some College
Technical College or Associate degree
Graduated college (Bachelor's degree)
Masters degree
Doctoral degree (PhD, MD or other professional degree)

ACE Asthma Educator Training Participant Follow-up Survey



Participant #: _____ Date: ___ / ___ / ___

1. In the last 12 months, I have worked directly or indirectly to provide care, consultation and/or education for the following number of children with asthma (please give best estimate):

Directions: Please check the box that represents your level of agreement. If the question is not applicable to you, please mark N/A.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
2. I have used the information learned in the asthma training in my work with children and/or families.						
3. The resource information (e.g. teaching binder, educational handouts) has been useful in my work.						
4. The asthma training changed or enhanced my work in the schools or community.						
5. I feel asthma education programs offered through a pediatric hospital are important for improving asthma management in school-age children.						

6. Through my work and my increased asthma management knowledge from the training, I have observed or am aware of following impacts on the children/students that I serve:

	Never	Rarely	Sometimes	Often	Always	N/A
Fewer school absences						
Fewer times sent home from school due to asthma symptoms						
Increased time spent in class						
Decreased time spent in the school clinic						
Increased participation in physical activities						
Fewer visits to the doctor's office						
Fewer hospitalizations or emergency room visits						
Increased control of asthma						
Improved overall well-being of the child						



Evaluation Asthma Education Asthma in School Age Children Conference

Date: ____ / ____ / ____

Directions: Please check the box that best represents your answer.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The content presented was useful to me.					
I feel better prepared to work with children with asthma.					
The presenter's method of delivery was effective.					
The course was organized in a logical manner.					
I would recommend this program to others.					

This program could be improved by:

What is your gender?

- Male
- Female

Which category best describes you?

- White
- Black/African American
- Asian
- American Indian
- Other
- Multiracial

Are you Hispanic or Latino/Latina?

- Yes
- No

What is the highest level of education you have completed?

- | | |
|---------------------------------------|--|
| Did not graduate High School | Graduated college (Bachelor's degree) |
| High School graduate | Masters degree |
| Some College | Doctoral degree (PhD, MD or other professional degree) |
| Technical College or Associate degree | |

Number of years experience working with children with asthma: _____

Asthma in School Age Children Conference Participant Follow-up Survey

Participant #: _____ Date: ___ / ___ / ___

1. In the last 12 months, I have worked directly or indirectly to provide care, consultation and/or education for the following number of children with asthma (please give best estimate):

Directions: Please check the box that represents your level of agreement. If the question is not applicable to you, please mark N/A.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
2. I have used the information learned in the asthma training in my work with children and/or families.						
3. The resource information (e.g. teaching binder, educational handouts) has been useful in my work.						
4. The asthma training changed or enhanced my work in the schools or community.						
5. I feel asthma education programs offered through a pediatric hospital are important for improving asthma management in school-age children.						

6. Through my work and my increased asthma management knowledge from the training, I have observed or am aware of following impacts on the children/students that I serve:

	Never	Rarely	Sometimes	Often	Always	N/A
Fewer school absences						
Fewer times sent home from school due to asthma symptoms						
Increased time spent in class						
Decreased time spent in the school clinic						
Increased participation in physical activities						
Fewer visits to the doctor's office						
Fewer hospitalizations or emergency room visits						
Increased control of asthma						
Improved overall well-being of the child						

Appendix D: School Nurse Program Instruments

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School Nurse Update Evaluation

Please check the box of the best answer for each item.

Dr. Robert Campbell Implementation of a School AED Program	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The speaker was knowledgeable.					
The speaker's methods were effective.					
The content was relevant to my work.					
The handouts were useful.					
The speaker covered all the stated objectives.					

Dr. Benjamin Gold Irritable Bowel Disorders	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The speaker was knowledgeable.					
The speaker's methods were effective.					
The content was relevant to my work.					
The handouts were useful.					
The speaker covered all the stated objectives.					

Cara Brown Bleeding Disorders, Hemophilia & von Willenbrand	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The speaker was knowledgeable.					
The speaker's methods were effective.					
The content was relevant to my work.					
The handouts were useful.					
The speaker covered all the stated objectives.					

Please circle the best answer for each of the following items.

How likely are you to change your practices, based on the information you received today?

Not at all likely Not very likely Somewhat likely Very likely

Was the atmosphere conducive to learning?

Yes No

Comments: _____

What other topics would you like to have addressed for upcoming School Nurse Updates?

**Children's Healthcare of Atlanta
School Nurse Consultant Program (Access to Care)
Follow-Up Survey**

Date of initial contact: ___/___/____ (filled in by Children's personnel)

District name: _____ (filled in by Children's personnel)

Nurse's name: _____ (filled in by Children's personnel)

You recently called the School Nurse Consultant Program regarding access to health care for a student. As part of our efforts to evaluate and improve our services, we would like you to tell us about your experience with the program.

1. Please rate how much you agree or disagree with the following statements. Check the box of the best answer for each item.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The information I received fit the student's needs.					
The information I received was accurate.					
My question was answered quickly.					
I was treated with courtesy.					
The information will change the way I deal with similar situations in the future.					

2. What is your overall satisfaction with your experience with the program? (Circle the best answer.)

Very Dissatisfied Somewhat Dissatisfied Neutral Somewhat Satisfied Very Satisfied

3. Was the child seen by a health care professional for this condition?

Yes No

4. Was the child referred to a community agency?

Yes No

5. How likely are you to call the program again for access to health care for your students?

Not at all likely Not very likely Somewhat likely Very likely

6. Please provide any suggestions on how we can improve the School Nurse Consultant Program or other comments on your experience with the program.

Thank you for taking the time to provide this valuable feedback. Please return the survey by fax to 404-785-7257 as soon as possible.

**Children's Healthcare of Atlanta
School Nurse Consultant Program (Information)
Follow-Up Survey**

Date of initial contact: ___/___/____ (filled in by Children's personnel)

District name: _____ (filled in by Children's personnel)

Nurse's name: _____ (filled in by Children's personnel)

You recently called the School Nurse Consultant Program for information. As part of our efforts to evaluate and improve our services, we would like you to tell us about your experience with the program.

1. Please rate how much you agree or disagree with the following statements. Check the box of the best answer for each item.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The information I received fit my needs.					
The information I received was accurate.					
My question was answered quickly.					
I was treated with courtesy.					
The information will change the way I deal with similar situations in the future.					

2. What is your overall satisfaction with your experience with the program? (Circle the best answer.)

Very Dissatisfied Somewhat Dissatisfied Neutral Somewhat Satisfied Very Satisfied

3. How likely are you to call the program again for access to health care for your students?

Not at all likely Not very likely Somewhat likely Very likely

4. Would you recommend the program to another school nurse or school health worker?

Yes No

5. Please provide any suggestions on how we can improve the School Nurse Consultant Program or other comments on your experience with the program.

Thank you for taking the time to provide this valuable feedback. Please return the survey by fax to 404-785-7257 as soon as possible.

**Children's Healthcare of Atlanta
School Nurse Liaison Program
Follow-Up Survey**

Start date: ___/___/_____ (filled in by Children's personnel)
Child's name: _____ (filled in by Children's personnel)
Nurse's name: _____ (filled in by Children's personnel)

1. Please rate how much the student has benefited from the services of the School Nurse Liaison Program. Check the box of the best answer for each item.

	Negative Effect	No Benefit	Some Benefit	Great Benefit
Time spent in the classroom				
Time spent in school clinic				
Number of days absent				
Health management at school				
Adherence to individual health plan				
Student's comfort in classroom				

2. Please rate how much you agree or disagree with the following statements. Check the box of the best answer for each item.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The services fit the student's needs.					
The information I received was accurate.					
My questions were answered quickly.					
The services were delivered in a timely manner.					
The student was well prepared to re-enter school.					
The school was well prepared to receive the student.					
I was treated with courtesy.					
I am satisfied with the results of the program.					

3. Please describe any other benefits or drawbacks of the program for the student.

4. Please provide any suggestions on how we can improve the School Nurse Liaison Program or other comments on your experience with the program.

Thank you for taking the time to provide this valuable feedback. Please return the survey by fax to 404-785-7257 as soon as possible.

**Children’s Healthcare of Atlanta
School Nurse Liaison Program
Doctor Follow-Up Survey**

Start date: ___/___/_____ (filled in by Children’s personnel)
Child’s name: _____ (filled in by Children’s personnel)
Doctor’s name: _____ (filled in by Children’s personnel)

1. Please rate how much the student has benefited from the services of the School Nurse Liaison Program. Check the box of the best answer for each item.

	Negative Effect	No Benefit	Some Benefit	Great Benefit	Don’t Know
Time spent in the classroom					
Time spent in school clinic					
Number of days absent					
Health management at school					
Continuity of care					
Overall health					

2. Please rate how much you agree or disagree with the following statements. Check the box of the best answer for each item.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The services fit the student’s needs.					
My interactions with school personnel improved.					
My questions were answered quickly.					
The services were delivered in a timely manner.					
The student was well prepared to re-enter school.					
The school was well prepared to receive the student.					
I was treated with courtesy.					
I am satisfied with the results of the program.					

3. Please describe any other benefits or drawbacks of the program for the student.

4. Please provide any suggestions on how we can improve the School Nurse Liaison Program or other comments on your experience with the program.

Thank you for taking the time to provide this valuable feedback. Please return the survey by fax to 404-785-7257 as soon as possible.

**Children’s Healthcare of Atlanta
School Nurse Liaison Program
Parent Follow-Up Survey**

Start date: ___/___/_____ (filled in by Children’s personnel)

Child’s name: _____ (filled in by Children’s personnel)

1. Please rate how much your child has benefited from the services of the School Nurse Liaison Program. Check the box of the best answer for each item.

	Negative Effect	No Benefit	Some Benefit	Great Benefit
Time spent in the classroom				
Time spent in school clinic				
Number of days absent				
Health management at school				
Following the individual health plan				
Your child’s comfort in the classroom				

2. Please rate how much you agree or disagree with the following statements. Check the box of the best answer for each item.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The services fit my child’s needs.					
The information I received was accurate.					
My questions were answered quickly.					
The services were delivered in a timely manner.					
My child was well prepared to re-enter school.					
The school was well prepared to receive my child.					
I was treated with courtesy.					
I am satisfied with the results of the program.					

3. Please describe any other good or bad parts of the program for your child.

4. Please provide any suggestions on how we can improve the School Nurse Liaison Program or other comments on your experience with the program.

Thank you for taking the time to provide this valuable feedback. Please return the survey by fax to 404-785-7257 as soon as possible.



The University of Georgia

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