Evaluation of the Maximizing Office Based Immunizations in Kansas (MOBI-KS) Program

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Sharon M. Homan, Ph.D.
Tatiana Y. Lin, JD (Russia), M.A.
Anne K. Nugent, M.P.H.

KANSAS HEALTH INSTITUTE

212 SW Eighth Avenue, Suite 300
Topeka, Kansas 66603-3936
(785) 233-5443
www.khi.org

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EXECUTIVE SUMMARY

MOBI-KS (Maximizing Office Based Immunizations) is an educational program to improve immunization rates at physician offices. MOBI-KS is administered by Kansas Chapter of the American Academy of Pediatrics (KAAP) in partnership with the Kansas Department of Health and Environment (KDHE), and is endorsed by the Kansas Academy of Family Physicians (KAFP). MOBI-KS is in the second year of operation. The mission of MOBI-KS is to raise the overall immunization rate in Kansas among 2-year-old children to 90 percent or greater by examining ways to improve existing office policies and practice. The goal is to improve immunization rates "one practice at a time."

The purpose of this evaluation was to study the organizational structure, processes and outcomes of the MOBI-KS program to: (1) assess whether and how MOBI-KS is making progress toward achieving its mission and goal, and (2) identify processes that can be improved.

There were insufficient outcome data (i.e., data on immunization timeliness and coverage) for assessing MOBI-KS progress toward achieving its mission and goal. Progress could only be evaluated in terms of program design and implementation. The MOBI-KS program logic is strong, with clear goals, well-defined activities and well-defined measurable outcomes. Three major strengths of MOBI-KS are:

1. MOBI-KS "gets into the office where the immunizations are given and it works with people doing the ground work in the trenches."
2. MOBI-KS is delivered by a team of highly qualified expert-trainers who help practices identify best practices to improve immunization rates, while also building awareness among immunization providers about the Vaccines for Children (VFC) program, enrollment in the Kansas Immunization Registry (KSWebIZ), and the importance of immunization in a medical home.
3. Providers highly value the pre-MOBI-KS and post-MOBI-KS AFIX reports.

Specific recommendations to improve MOBI-KS are as follows:

MOBI-KS administration can be improved by:

- Reviewing and updating training materials biannually instead of annually to accommodate changes in immunization recommendations and requirements (Figure 3, box d);
- Strengthening the follow-up with participating providers (Figure 3, boxes h, i, and j);
- Creating an evaluation system (including protocols for tracking immunization coverage pre- and post-MOBI-KS intervention, tracking provider changes related to MOBI-KS, and tracking immunization coverage in non-intervention practices for comparison purposes);
- Inviting local health departments to participate in the program and serve as a local resource for immunization education; and
- Involving the MOBI-KS Advisory Board more (including establishment of criteria for mutual accountability [Figure 3, box b]; and clearer delineation of administrator roles and responsibilities).

MOBI-KS training can be improved by:

- Shortening time spent on the immunization registry and spending more time on advising best practices during the MOBI-KS presentation to providers;
- Increasing the number of trainers;
- Expanding provider participation to include more non-VFC providers;
- Improving the post-MOBI-KS follow-up process (Figure 4, boxes c, d, and e); and
- Establishing a communication process between MOBI-KS and the Kansas Immunization Program (KIP) to assure follow-up with providers for KSWebIZ access.

MOBI-KS program delivery can be improved by:

- Receiving information from trainers about practice improvements that are practical, feasible, and affordable;
- Increasing the availability of MOBI-KS program to more practices across the state (Figure 3, box a);

- Getting the clinics and practices on the KSWebIZ after the MOBI-KS training;
- Clarifying strategies to reducing immunization barriers and the description of a reminder/recall system; and
- Creating a relational database system for MOBI-KS (Figure 3, box c). Detailed suggestions related to data management are listed in Appendix D.

MOBI-KS AFIX reporting and program evaluation can be improved by:

- Developing a clear protocol for:
    - Capturing provider initiation of actions taken to improve vaccination coverage and timeliness (Figure 5, boxes b and c);
    - Adequately sampling patient records within defined pre- and post-MOBI-KS intervals (Figure 6, box b); and
    - AFIX reporting.
- Resolving specific AFIX problems including the following:
    - Establishing a set time period for when VFC AFIX reports are used instead of generating a new report for MOBI-KS. For example, a VFC AFIX report could be used for MOBI-KS if it is performed 60 days prior to the MOBI-KS presentation date and/or one year post-intervention date (Figure 6, box a);
    - Storing complete paper and electronic copies of pre-and post-MOBI-KS AFIX reports in one central location (MOBI-KS Office) (Figure 6, box c);
    - Adhering to the KIP standards for the minimum number of records used for the MOBI-KS AFIX assessment, which is 50 records for practices with 50 or more 2- to 3-year-old children in the practice and all records for practices with less than 50 and more than ten 2- to 3-year-old children in the practice; and
    - Recording the number of 2- to 3-year-old children in the practice at the time of the AFIX assessment (Figure 6, box b).
- Establishing methods for determining and tracking why a child who is included in the AFIX report is not up-to-date (i.e., physician behavior, patient behavior, or administrative challenges).

PURPOSE

MOBI-KS (Maximizing Office Based Immunizations) is an educational program to improve immunization rates at physician offices. MOBI-KS is administered by Kansas Chapter of the American Academy of Pediatrics (KAAP) in partnership with the Kansas Department of Health and Environment (KDHE), and is endorsed by the Kansas Academy of Family Physicians (KAFP). MOBI-KS is in the second year of operation.

The mission of MOBI-KS is to raise the overall immunization rate in Kansas among 2-year-old children to 90 percent or greater by examining ways to improve existing office policies and practice. The goal is to improve immunization rates "one practice at a time."

The purpose of this evaluation is to study the organizational structure, processes, and outcomes of the MOBI-KS program to: (1) assess whether and how MOBI-KS is making progress toward achieving its mission and goal, and (2) identify processes that can be improved. In particular the evaluation offers insight into how well components of MOBI-KS function and why components may or may not work. Program components include the administration, physician training, MOBI-KS intervention, immunization tracking, and ongoing evaluation of MOBI-KS.

METHODS

EVALUATION PLANNING

In January 2009, the KHI evaluation team (three people) met with MOBI-KS evaluation stakeholders to discuss the *evaluability* of MOBI-KS and agree on an evaluation framework. Stakeholders included several MOBI-KS Coordinating Team members: Chris Steege, executive director, KAAP; Sue Corrales, KAAP; and Sue Bowden, immunization director, KDHE. The evaluation team and stakeholders agreed that MOBI-KS was *evaluable.*

The evaluation was commissioned by the Immunize Kansas Kids (IKK) steering committee. The IKK steering committee wanted to evaluate MOBI-KS in order to understand how well MOBI-KS is aligned with IKK priorities and how much progress MOBI-KS is making toward

achieving IKK immunization goals. Further, IKK seeks to make informed decisions about expanding MOBI-KS to additional practices and continuing funding for the program.

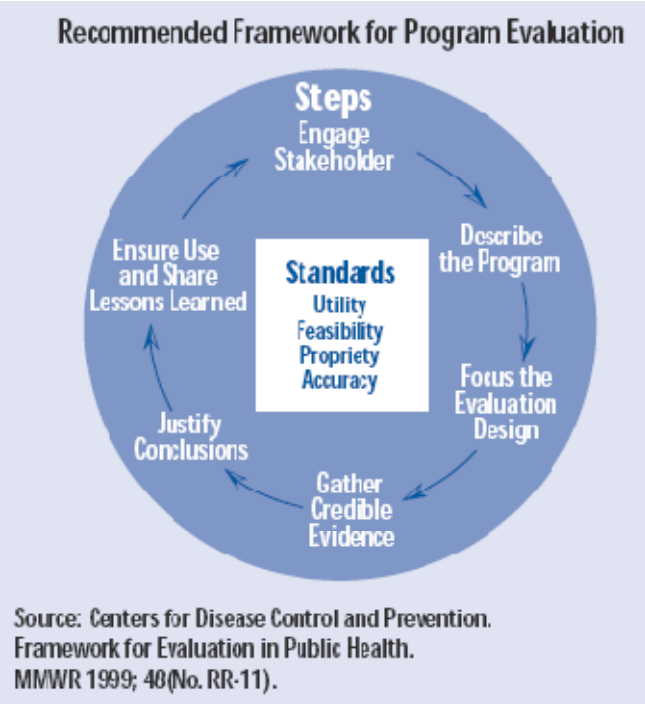
The KHI evaluation team and MOBI-KS stakeholders discussed: (1) the evaluation framework, (2) the extent to which MOBI-KS is ready for full evaluation (i.e., evaluability assessment). The evaluability assessment included discussion of the "logic" of the MOBI-KS program; that is, the relationships of the program objectives, theory of how program components produce outcomes, and the performance indicators for the objectives (i.e., the logic model components).

The methods used in the evaluation planning included: (1) incorporating Centers for Disease Control and Prevention (CDC) evaluation framework; and (2) assessing evaluability. These methods are now described.

Evaluation Framework

The KHI evaluators and stakeholders agreed to follow the CDC's recommended framework and steps for program evaluation (see Figure 1).

Figure 1. **Framework for Evaluation in Public Health**



At the core of the CDC Framework for Evaluation in Public Health are 30 evaluation standards. These standards, adopted from the Joint Committee on Educational Evaluation, are organized into the four groups: utility, feasibility, propriety, and accuracy. They are an approved standard by the American National Standards Institute (ANSI) and have been endorsed by the American Evaluation Association. These standards are described in Appendix A. The KHI evaluation team applied these standards throughout the evaluation process.

The evaluation steps taken by the KHI evaluation team are as follows.

Step 1. Engage stakeholders: During this step, several MOBI-KS Coordinating Team members met with the KHI evaluation team to provide input into evaluation design, ensure the evaluation plan meets the needs of the MOBI-KS Coordinating Team, and provide insight into political issues that require consideration.

Step 2. Describe the program using logic model: KHI evaluators discussed with stakeholders the MOBI-KS mission, goals, objectives, and program strategies. Drawing on the knowledge and experience of MOBI-KS program staff, the KHI team developed a logic model. Since MOBI-KS has only been in the community for a year, MOBI-KS does not have discernable long-term effects and evaluation measures. This is reflected in the logic model.

Step 3. Focus the evaluation design: KHI evaluators developed an evaluation methodology to accurately assess the process and outcomes of MOBI-KS while minimizing cost and time. To focus the evaluation design, the MOBI-KS Coordinating Team members clarified the primary purpose of the evaluation. The primary purpose is to improve MOBI-KS functioning (process evaluation) and to identify early indications of effectiveness of the MOBI-KS intervention (outcome evaluation). KHI evaluators selected methods that directly connect to the planned use of data.

Step 4. Gather credible evidence: KHI evaluators obtained data from MOBI-KS program participants, stakeholders, and administrative records. With input from the MOBI-KS Coordinating Team, KHI evaluators described *in advance* all necessary aspects of data collection, including logistics. Involving the MOBI-KS Coordinating Team in the design of the

evaluation was done to enhance credibility, ensure that all points of view were considered, and increase the likelihood that the evaluation findings are meaningful to users. KHI worked with the MOBI-KS Coordinating Team members to identify measures that relate to program goals as defined in the logic model, and the time frame for achieving them.

Step 5. Justify conclusions: Following data collection and interviews, KHI evaluators synthesized, analyzed, and interpreted the data. Level of institutionalization of MOBI-KS was assessed. Pre- and post-immunization rates were compared. Level of satisfaction of MOBI-KS program participants was reported. Qualitative interview data describing the MOBI-KS administration, provider training, and practice intervention was used to document MOBI-KS processes and make recommendations for improving processes.

Step 6. Ensure use and share lessons learned: The MOBI-KS Coordinating Team members decided in advance that the evaluation results will be presented to users and stakeholders. Throughout the evaluation, KHI evaluators shared information, solicited feedback and responded to any concerns raised. KHI evaluators prepared a final report to disseminate findings in a format that is easily understood and accurately depicts the information and analysis. Plans were made to present findings to the MOBI-KS Coordinating Team and Immunize Kansas Kids (IKK) Steering Committee on May 11, 2009.

Evaluability Assessment

Evaluability is the extent to which a program is ready for full evaluation. The evaluability process described by Trevisan and Huang[1] served as a rough guide for our assessment process. The KHI evaluation team met with several members of the MOBI-KS Coordinating Team to determine an appropriate and realistic level and type of evaluation. Our steps were to:

- Involve intended users of MOBI-KS program evaluation (MOBI-KS Coordinating Team, IKK members).
- Clarify evaluation intentions: goals, expectations, causal assumptions, information needs and priorities of key stakeholders.
- Clarify performance indicators and other evidence of which MOBI-KS can be evaluated.
- Agree on evaluation design.

The following questions guided the discussion of the evaluability of MOBI-KS:

- Is there reasonable agreement on program goals and performance criteria?
- Are the program goals plausible? Is there a high likelihood goals will be achieved?
- Are there key MOBI-KS program inputs, program activities, outcomes (results) that can be measured and obtained?
- Are the evaluation findings going to be used to improve performance or to communicate value of program activities to higher policy levels?

EVALUATION DESIGN AND METHODS

Based on the evaluability assessment, the KHI evaluation team designed an evaluation to examine the organizational structure, processes, and outcomes of MOBI-KS.

Evaluation of Organizational Structure

We evaluated the launching, administration, and institutionalization of the MOBI-KS program by reviewing the written and Web-based program materials, understanding the role of the IKK steering committee in supporting and launching MOBI-KS, creating a program logic model, and administering the Level of Institutionalization (LoIn) questionnaire.[2] The LoIn questionnaire was developed by Goodman and colleagues to measure the extent of program integration into organizations, which is referred to as "institutionalization." Institutionalization is the degree to which a program becomes fully functioning, supported, and funded within an organization. Institutionalization is a function of the production of program-related activities, the management of the program, maintenance of program (including administration, staffing, activities), and support for the program. The LoIn instrument is contained in Appendix B. The MOBI-KS program administrators at KAAP completed the tool and scored institutionalization of MOBI-KS.

Process Evaluation

We used process evaluation tools to describe the activities and outputs of MOBI-KS, evaluate *how well* components of MOBI-KS function, as well as *why* components may or may not work. The process evaluation methods included:

- Analyzing and describing MOBI-KS development, context, and operations.

- Interviewing MOBI-KS administrators, physician trainers, and staff at MOBI-KS participating family physician and pediatric practices.
- Flow charting of MOBI-KS program components.

A total of eighteen semi-structured phone interviews were conducted (one person was interviewed as a trainer as well as an administrator). All the interviews were conducted between March 1–31, 2009. Nine out of the 27 practices (five family practice physicians and four pediatricians), four program administrators, and five program trainers were selected after discussion with the KHI evaluation team to cover a range of particular interests of this study, namely a VFC provider, an urban provider, and a rural provider. Key informants were also selected to represent a variety of points of view and experience. Among the nine practices surveyed, two practices participated in the first year of the MOBI-KS program (2007) and seven participated in the second year of the MOBI-KS program (2008). In addition, four out of the nine practices were VFC providers.

Open-ended questions were developed to collect data from key informants with respect to their views on the quality of program delivery, and the extent to which the program achieved its intended outcomes (see Appendix C). Several open-ended questions asked respondents to identify key barriers and their overall assessment of functionality of the program. Interviews lasted between 15–45 minutes. All interviews were transcribed by two analysts of the KHI evaluation team with the assistance of an intern. Interviews were not transcribed verbatim. The transcribed data were coded and analyzed to identify recurring themes reported by interviewees. No names were mentioned in the transcripts.

Outcome Evaluation

Because it was not possible to obtain comparison group immunization data, the KHI evaluation team used a pre-post study design to compare practice-level immunization coverage, as determined by the AFIX survey[3], before and one year after the MOBI-KS presentation was given at the six participating sites in 2007. The presentation was given at the same site twice and the AFIX report for one site was misplaced, resulting in available pre- and post-intervention data for four sites.

Outcome evaluation methods included:

- Assessing provider satisfaction following MOBI-KS training.
- Estimating and comparing pre- and post-MOBI-KS immunization coverage and timeliness using physician records and AFIX reports.

Attendee satisfaction data through November 20, 2008, were summarized by KAAP. Answers to the evaluation questions were aggregated in a spreadsheet and written comments were recorded. KHI evaluators analyzed these data and interpreted findings in light of the qualitative data obtained as part of the process evaluation.

The Assessment, Feedback, Incentives, and Information eXchange (AFIX) survey is a process improvement tool for assessing immunization coverage. KDHE submits data to the CDC through the VFC Management Survey. MOBI-KS uses the Assessment portion of AFIX to determine immunization coverage rates of 2- to 3-year-old children before and one year after the MOBI-KS presentation. All pre- and post-MOBI-KS AFIX reports were performed by either a KDHE immunization nurse consultant, if the providers participated in the VFC program, or the MOBI-KS nurse specialist, if the providers were not VFC providers or if the dates of the VFC AFIX reports did not coincide with MOBI-KS presentation dates. If clinics were VFC providers and the MOBI-KS presentation date was near the VFC AFIX assessment date, then the VFC AFIX report was used in place of a MOBI-KS AFIX report. It was assumed that standard protocol for AFIX reporting was followed. The VFC program requires that at least 50 records be examined for each AFIX report. Some clinics had fewer than 50 records examined and the MOBI-KS nurse specialist explained that some MOBI-KS clinics, which were not VFC providers, may have had fewer than 50 patients who were ages 2 to 3 years in their practice at that time.

All AFIX reports were completed prior to MOBI-KS program evaluation and were retained by multiple people including MOBI-KS administrators, the KDHE immunization nurse consultant, and the MOBI-KS nurse specialist. Only those individuals who performed the assessment had access to complete MOBI-KS AFIX reports and, because two individuals created the reports, there was no simple way to access all of the data from one source. Complete reports, including the summary report, the diagnostic report, and the single antigen report, were obtained

and secondary analysis of selected outcome measures was performed. Indicators were summarized in a spreadsheet and included MOBI-KS presentation date, pre- and post-MOBI-KS AFIX dates, number of charts reviewed for each AFIX report, percent of children up-to-date for the standard vaccine series, percent of children up-to-date by each vaccine type, and percent of missed opportunities pre- and post-MOBI-KS presentation. Averages for number of charts, percent up-to-date for all vaccines, percent up-to-date for individual antigens, and percent missed opportunities were calculated. The averages were not weighted when calculated due to limited data.

FINDINGS

EVALUATION OF ORGANIZATIONAL STRUCTURE

In this section we describe the context and impetus for creating MOBI-KS, illustrate the program with a logic model, and discuss the administration and institutionalization of MOBI-KS.

Launching of MOBI-KS: History and Context

On March 13, 2006, KDHE and KHI issued a press release, *Focused effort started to boost childhood immunization in Kansas*, which launched IKK. IKK, a multiyear project funded by the Kansas Health Foundation, was created to bring together state organizations to better understand why Kansas vaccination rates lag behind other states and to develop strategies to improve childhood immunization rates. Based on the 2004 National Immunization Survey data, Kansas ranked 43rd among states administering the 4:3:1:3:3 standard vaccination series to protect children from diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, Hepatitis B, and some types of meningitis. With an immunization rate of 77.5 percent, Kansas fell short of the national average of 80.9 percent and the 90 percent goal of Healthy People 2010. High immunization rates in communities not only ensure immunized children are protected but offer herd immunity to those not immunized.

Between 2006 and 2008, the IKK steering committee developed strategies to improve immunization practices and coverage in Kansas. In March 2008, the IKK steering committee released a report, *How to Achieve and Sustain High Vaccination Rates Among Kansas Children:*

An Action Plan.[4] The report highlighted 31 strategies to raise and sustain Kansas immunization rates.

One of the action items recommended by the IKK steering committee was to continue MOBI-KS and to evaluate MOBI-KS during the first year (2008) as a KDHE-funded program. The rationale for promoting MOBI-KS was that educating Kansas providers on measurement and administration of immunizations increases timeliness of recommended immunizations, which in turn will increase the state's immunization rate. Further, the steering committee noted that focusing on maximizing office based immunization through use of feedback programs and evidence-based strategies is a cost-effective approach compared to other outreach activities.

In terms of evaluating the structure, processes, and outcomes of MOBI-KS, it is important to understand the significance of MOBI-KS as an IKK strategy. MOBI-KS is more than an educational intervention. It is also viewed by the IKK steering committee as a potentially powerful quality improvement tool. Adoption of MOBI-KS practices could not only impact individual practices, but has ramifications related to vaccine storage, vaccine coverage, provider behavior, and immunization tracking, as illustrated by the following IKK description of the MOBI-KS program rationale .[5]

> Assessment and feedback (i.e. AFIX) and education through MOBI-KS are well established; however, practices have difficulty making the changes on their own which sustain improvement. Incentives are challenging. The VFC Program has not been well received by practices in Kansas for a number of reasons, mostly due to misconceptions regarding financial losses the practices could experience. Improvement and support of the VFC program in office based practices would allow for vaccines to be administered in a medical home, which has been shown to improve vaccination coverage rates. The use of a statewide immunization registry is a powerful tool to accomplish high immunization rates. Immunization registry use allows for identification of children without a regular source of care as well as neighborhoods that are pockets of need. KSWebIZ is the Kansas Immunization Registry that is being rolled out and placing this important resource in private practices will be a challenge. These practices need to be educated as to the importance of the

registry and that it is easier to use than they anticipate. A minority of immunization providers measure their own rates. With proper evaluation, a solid case can be made for continuing and even expanding the project.

MOBI-KS Program Description

MOBI-KS is advertised on the KAAP website as follows[6]:

> MOBI-KS (Maximizing Office Based Immunizations) program, an educational program to improve immunization rates at physician offices, is a partnership between the Kansas Chapter of the American Academy of Pediatrics and the KDHE and is endorsed by the Kansas Academy of Family Physicians. The mission of MOBI-KS is to raise the overall immunization rate among Kansas' 2-year-old children to 90 percent or greater by examining ways to improve existing office policies and practice. The goal is to improve immunization rates "one practice at a time."
>
> MOBI-KS is a free one-hour educational opportunity (offering CME and CEU credit) addressing strategies to improve immunization rates in individual offices. It is tailored to each unique practice setting and provides practical information to providers on how to achieve complete and timely immunizations for infants and children. This program provides the latest information on new immunization recommendations, new vaccines, childhood immunization schedule changes and missed opportunities and common misconceptions. MOBI-KS staff goes to physician offices to present this program at a time that is convenient for physicians and staff.
>
> MOBI-KS has been planned and implemented in accordance with the Essential Areas and Policies of the Kansas Medical Society through the joint sponsorship of Wesley Medical Center and the Kansas Chapter of the American Academy of Pediatrics. Wesley Medical Center is accredited by the Kansas Medical Society to sponsor education for physicians. Wesley designates this activity for a maximum of 1.0 *AMA PRA Category 1 credits*™. The Kansas State Nurses Association, as an approved provider of Continuing Education by the Kansas State Board of Nursing, offered this program for 1.2 contact hours of credit

applicable for RN and LPN relicensure (Kansas State Board of Nursing Approved Provider Number: LT0141-0927).

All MOBI-KS speakers have no financial relationships to disclose. (See brochure at http://www.aapkansas.org/content/chapterFocus/immunizations/mobi/brochure.pdf) The 2008 MOBI-KS program includes the Provider Grant Incentive Program. Each office that hosts a MOBI-KS presentation (one hour) is eligible to apply for grant funding ($3,000 maximum) to help with office purchases that would help with vaccine administration or storage, i.e., a vaccine refrigerator, freezer, alarm system, generator, computer, or data entry help to get office records on the Registry. Offices that complete the 12 month follow-up requirements will be eligible for additional grant funding ($1,000 maximum). To schedule a MOBI-KS program or receive additional information, health care providers can contact the MOBI-KS office at 785-250-1119 or mobikansas@aol.com.

MOBI-KS was created in January 2007 and was based on a similar program in Ohio. During the interviews, the administrators of the program provided conflicting information on who introduced the program to stakeholders, leading to its adoption in Kansas.

Five persons are involved in the administration of MOBI-KS — two KAAP staff members, the KDHE director of immunization program, a nurse specialist, and one MOBI-KS project director.

During the two-year period since inception, 27 practices were enrolled, and 8 physician trainers were recruited and trained. Participation by trainers and practices is voluntary. Trainers and practices are recruited through advertisement via the KAAP web site, mailed brochures with KAAP newsletters, the annual state immunization conference, and word of mouth. Over 500 pediatricians receive the KAAP newsletter, which regularly features MOBI-KS information. KAAP also supplies information to KAFP for their family physician newsletter and other electronic communications.

Table 1. **Characteristics of MOBI-KS Program Participants**

Year	Number of practices	Number of family physician practices	Number of pediatric practices	Number of trainers	Number of VFC practices	Number of VFC practices in process or considering becoming a VFC practice	Number of KSWebIZ practices	Number of practices in process or considering becoming a KSWebIZ practice	Number of staff who attended MOBI-KS presentation
Year 1 (2007)	6*	1	5*	3	5	0	2	0	54
Year 2 (2008)	21	12	9	5	14	3	5	9	293

*One practice participated in two MOBI-KS presentations

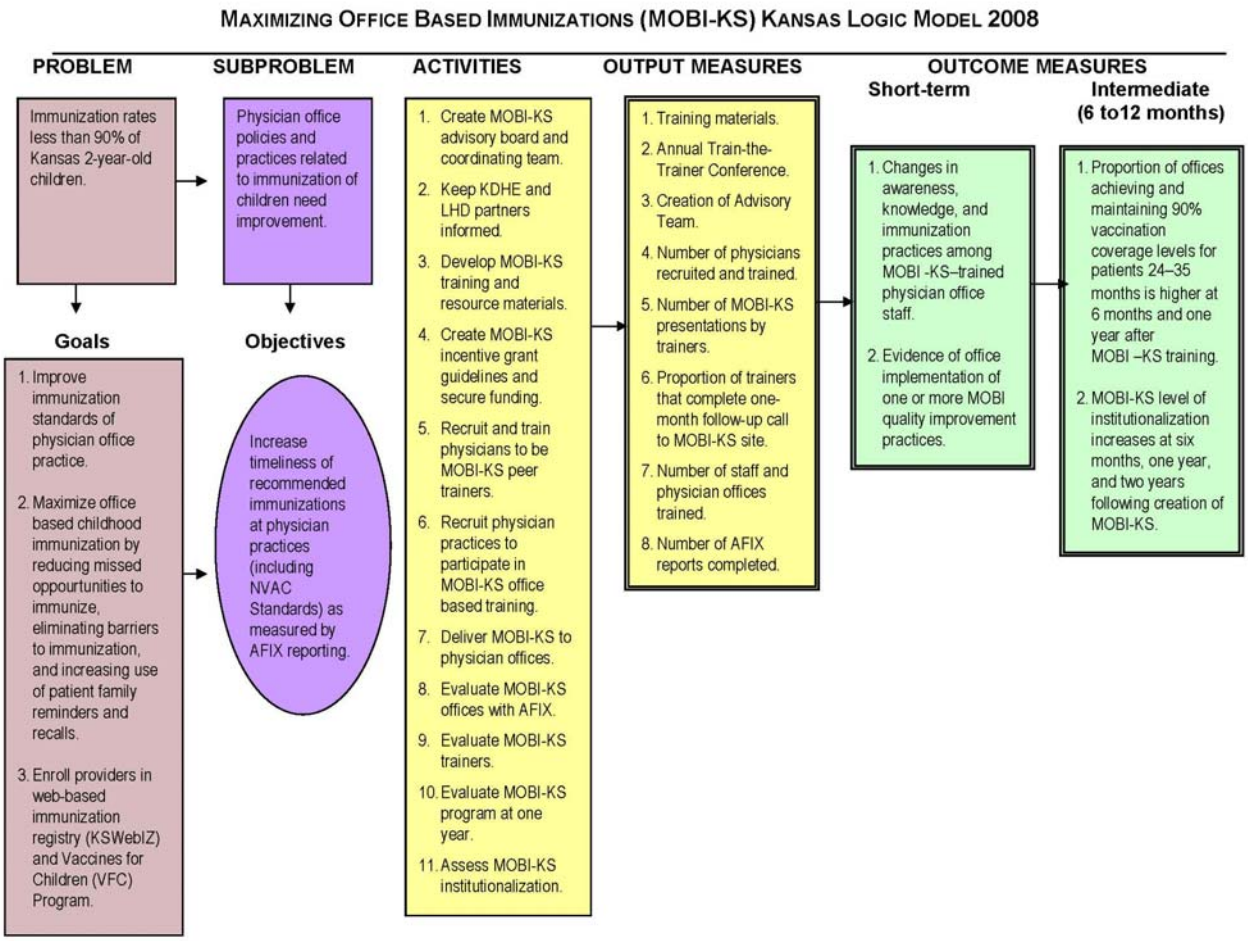
The MOBI-KS Advisory Board was established by the MOBI-KS Coordinating Team to provide information regarding concerns in the community about immunization issues, advice on how to encourage practices to participate and how to overcome barriers to immunization in the medical home. The MOBI-KS Advisory Board is composed of sixteen members. Thirty-seven percent of board members are physicians. Based on the evaluation findings, the MOBI-KS Advisory Board had limited strategic-level involvement. According to best practices, programs with early and strategic-level board involvement are generally more successful than those with limited board involvement. The MOBI-KS Advisory Board members must avoid circumstances where a conflict of interest or bias might impair their work or professional judgment. Specifically, board members should consider potential conflicts of interest, such as if a board member is involved directly in MOBI-KS program management and receives a MOBI-KS provider incentive grant.

Logic Model

A logic model for the program was created during this evaluation to illustrate the interrelationships of the program goals, activities, and outcomes (Figure 2). Ideally, a logic model would have been created in the design of MOBI-KS. However, while there was not a formal logic model, the MOBI-KS administrative team clearly articulated the program mission, goals, activities, and desired outcomes. The logic of MOBI-KS was not based on a particular theory (e.g., transtheoretical model). The MOBI-KS program logic is strong, with clear goals, well-defined activities, and measurable outcomes. Strong elements of the model include: (1) a

focused set of practical and achievable goals with measureable outcomes; (2) well-defined and tested (OHIO MOBI) activities; (3) peer-to-peer intervention strategy; (4) output and outcome measures that can be built into existing systems (AFIX and KSWebIZ), thereby increasing the likelihood of quality monitoring and evaluation activities being sustained over time.

Figure 2. **MOBI-KS Logic Model**



The logic model does not prioritize the type of practices to be recruited for MOBI-KS participation. In the logic model the subproblem is defined as "physician office policies and practices related to immunization of children need improvement." Maximizing office based immunizations is the primary strategy for addressing this problem. However, local health

departments also immunize children. In small counties, MOBI-KS may threaten local health departments that depend on revenue from immunizations.

Administration and Institutionalization

MOBI-KS is administered by KAAP. MOBI-KS administrators, trainers, and providers view the administration of MOBI-KS as being highly effective, particularly in achieving the following educational goals of the program that are indentified in the contract between KDHE and KAAP: providing a continuing education presentation on immunization updates, building awareness among immunization providers about the VFC program, and identifying specific strategies and office system changes that have been proven to increase immunization rates in children. Administrative goals were being met, including increasing the number of practices considering enrollment in the KSWebIZ and increasing the provider awareness of the importance of immunization in a medical home. KAAP markets MOBI-KS via brochures, newsletters, presentations to providers and provider groups, and Web-based materials. The brochures, Web site, PowerPoint presentations, and other materials used to market MOBI-KS are well-designed with clear messages, and consistent in describing MOBI-KS. Some administrative processes can be improved, particularly in managing data and AFIX reports.

While KAAP has only been operating MOBI-KS for less than two years, it has made good progress toward institutionalization. The overall level of institutionalization is low to moderate, which reflects the young age of MOBI-KS. Institutionalization was measured on four subsystems: production (i.e., program activities), managerial oversight, maintenance (operations, staffing, advocacy for program), and support (e.g., funding) within larger organizations. In terms of production, the overall goals, objectives, plans, procedures, timelines, and schedules for MOBI-KS are in place; however, not all of the components of MOBI-KS have written plans, procedures, timelines, and schedules. Two production strengths are that all aspects of MOBI-KS have been adapted to fit local circumstances, and formal program evaluation efforts are being put in place.

In terms of the management component of institutionalization, there is strong overall program management with formal job descriptions, supervision, and evaluation reporting. The MOBI-KS

Advisory Board involvement was limited. There was ambiguity among several members of the MOBI-KS Coordinating Team about who was responsible for certain reports and MOBI-KS activities, as well as a lack of accurate and prompt contact and correspondence with trainers and participating practices.

In terms of the maintenance aspect of institutionalization, MOBI-KS is strong. Retaining permanent staff is key to the maintenance of any program. All MOBI-KS staff members are permanent employees. Administrative staff members actively contribute to MOBI-KS program operations and actively promote continuation of MOBI-KS. The support system for MOBI-KS is also strong with permanent office space and organizational support for MOBI-KS being housed at KAAP.

Institutionalization also relies on stable funding, external support, and good fiscal management. Table 2 provides a summary of the components of the cost of the MOBI-KS Program. The costs are grouped by the program expense type. The total cost of the program is $215,000 including staff, supplies administration, and incentive provider grants. Of the total 2008 budget, 46 percent supports the Incentive Program Budget while 54 percent supports the Program Delivery Budget. The total cost per practice ranges from $3,000 to $4,000. (Participating practices are eligible for additional grant funding [$1,000 maximum] upon completion of the 12 month follow-up requirements). The budgeted program components do not include program evaluation and quality improvement. These activities are necessary for the ongoing viability of MOBI-KS.

Table 2. **Project Cost for Maximizing Office Based Immunizations (MOBI-KS) by Expense Type, 2008**

Program Expense	Unit Cost ($)	Total ($)
Personnel		
- Executive Director	9,600	
- Chapter Coordinator	12,500	
- Benefits and Taxes	2,370	24,470
Contractor		
- Program Director	14,000	
- Nurse Specialist	8,000	
- Data Entry Assessment	3,000	
- Conference Attendance	2,500	27,500
Training		
- **Physicians**		
1. Stipend	16,000	
2. Train the Trainer Conference	12,000	
- **HD Immunization Specialist**		
1. Stipend	5,000	
2. Train the Trainer Conference	7,000	
- Trainers Travel — Mileage	2,250	42,250
Office	12,730	12,730
Miscellaneous		
- Promotional Items	2,500	
- CME/CEU	3,000	
- Advisory Board	2,000	
Conference Attendance		
- Coordinating Team Meeting	500	
- Travel	2,050	10,050
Incentive Program Budget		
- Provider Grants — Phase 1	75,000	
- Provider Grants — Phase 2	5,000	
- VFC Enrollment — HD	18,000	98,000
Grand Total		**215,000**

PROCESS EVALUATION

Using flow diagrams, each of four core processes of MOBI-KS were illustrated (see Figures 3 to 6): administration, processes related to trainers, processes related to delivering program to providers, and AFIX reporting.

Based on the interviews with administrators, trainers, and providers, we evaluated how well components of MOBI-KS function, as well as why components may or may not work. We used these findings to recommend improvements to the MOBI-KS processes. These recommended

improvements are highlighted in the red boxes in the flow charts, and discussed in the section entitled *Conclusions and Recommendations*.

Flowcharts of MOBI-KS Processes

Flowcharts of the MOBI-KS processes are shown on the following pages.

Figure 3. **Flowchart for Administration of MOBI-KS**

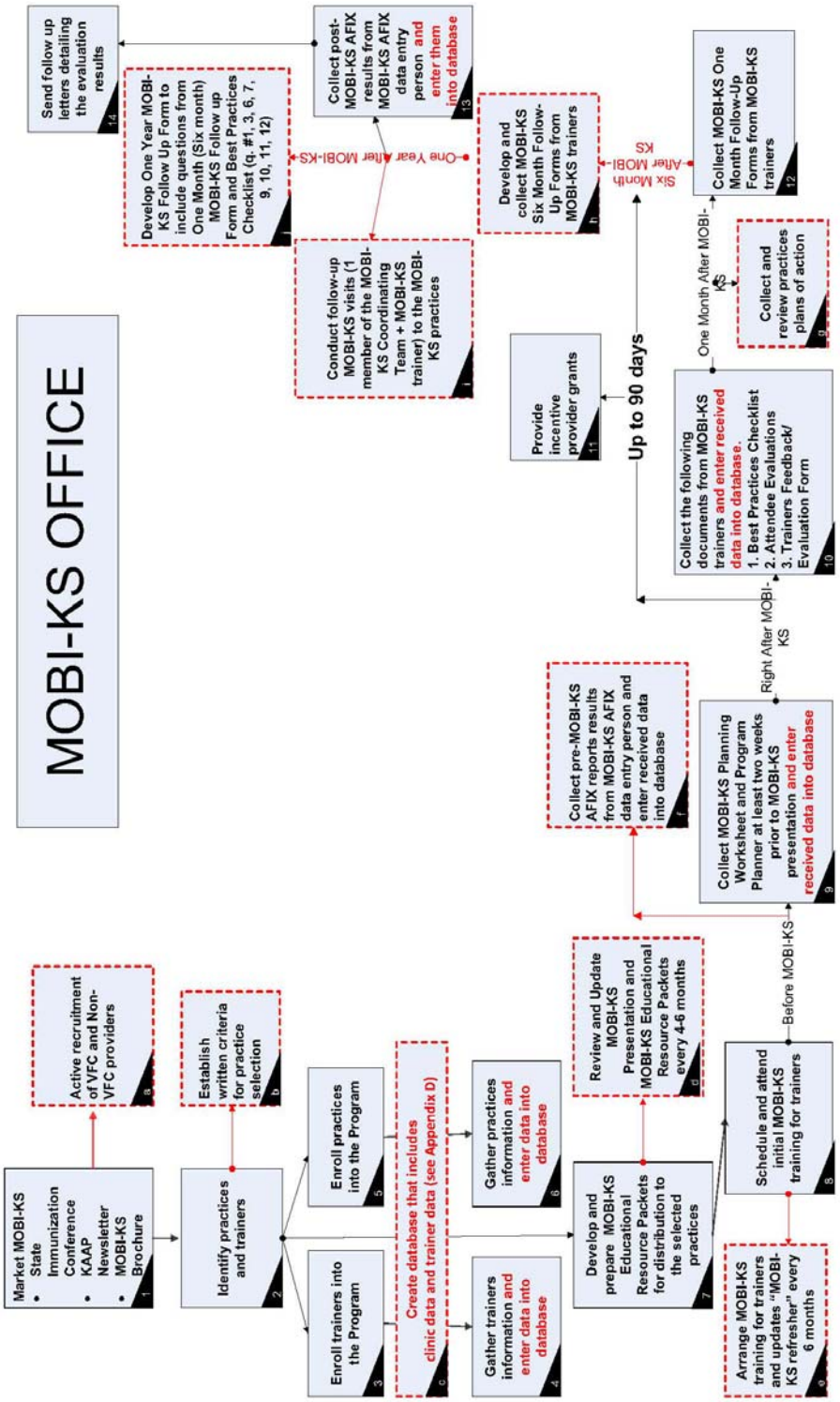


Figure 4. **Flowchart for MOBI-KS Processes Related to Trainers**

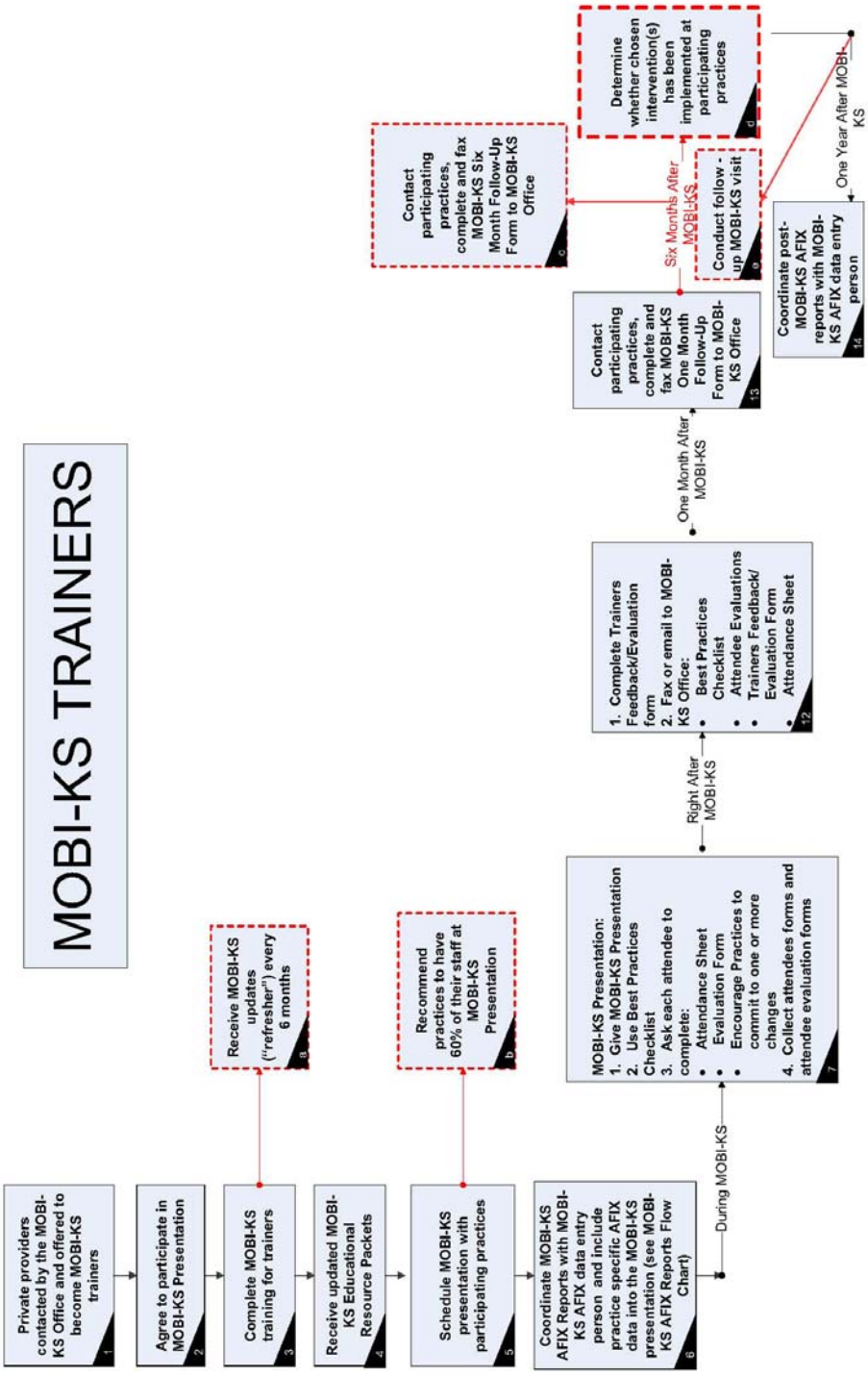


Figure 5. **Flowchart for MOBI-KS Processes Related to Delivering MOBI-KS to Providers**

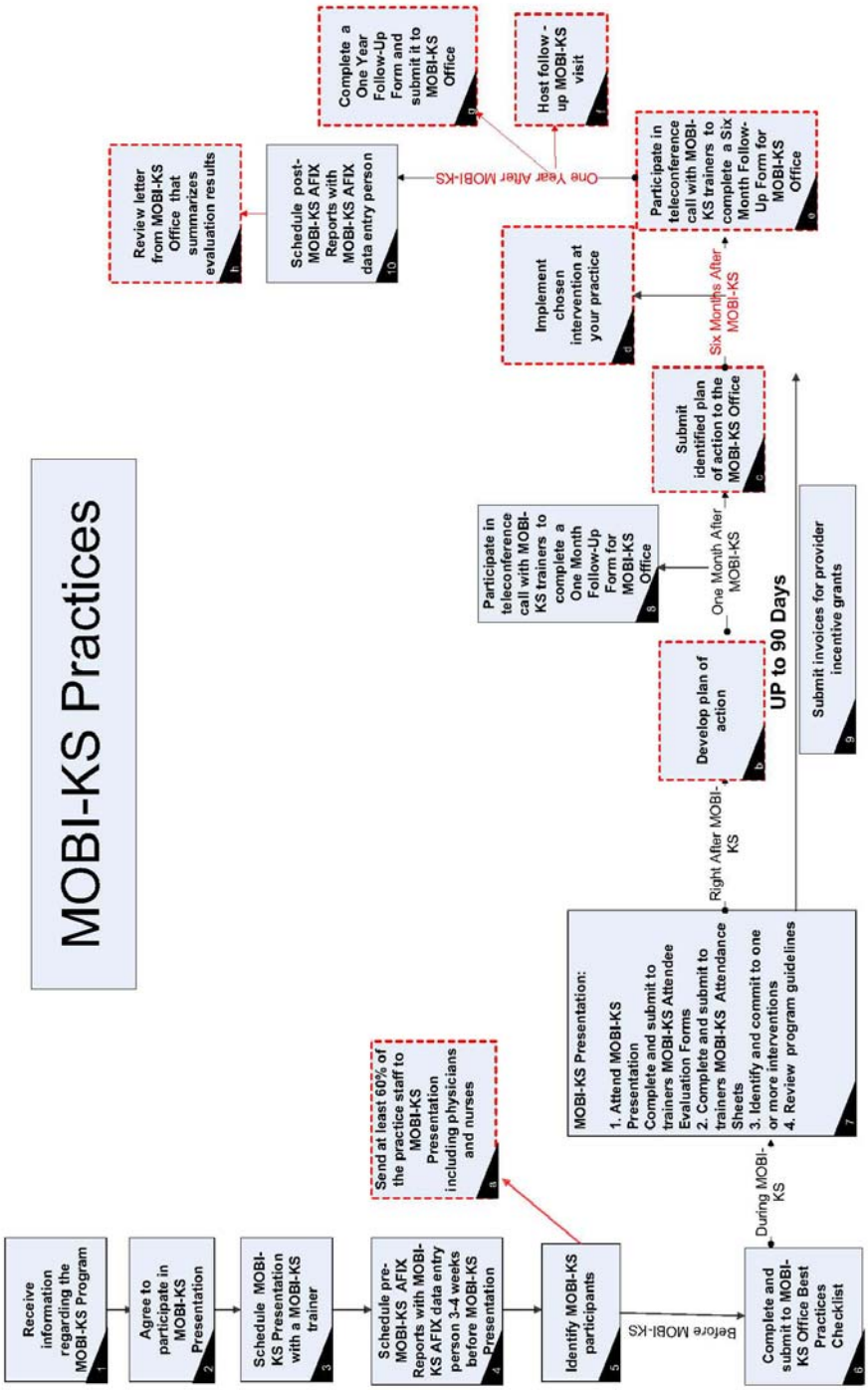
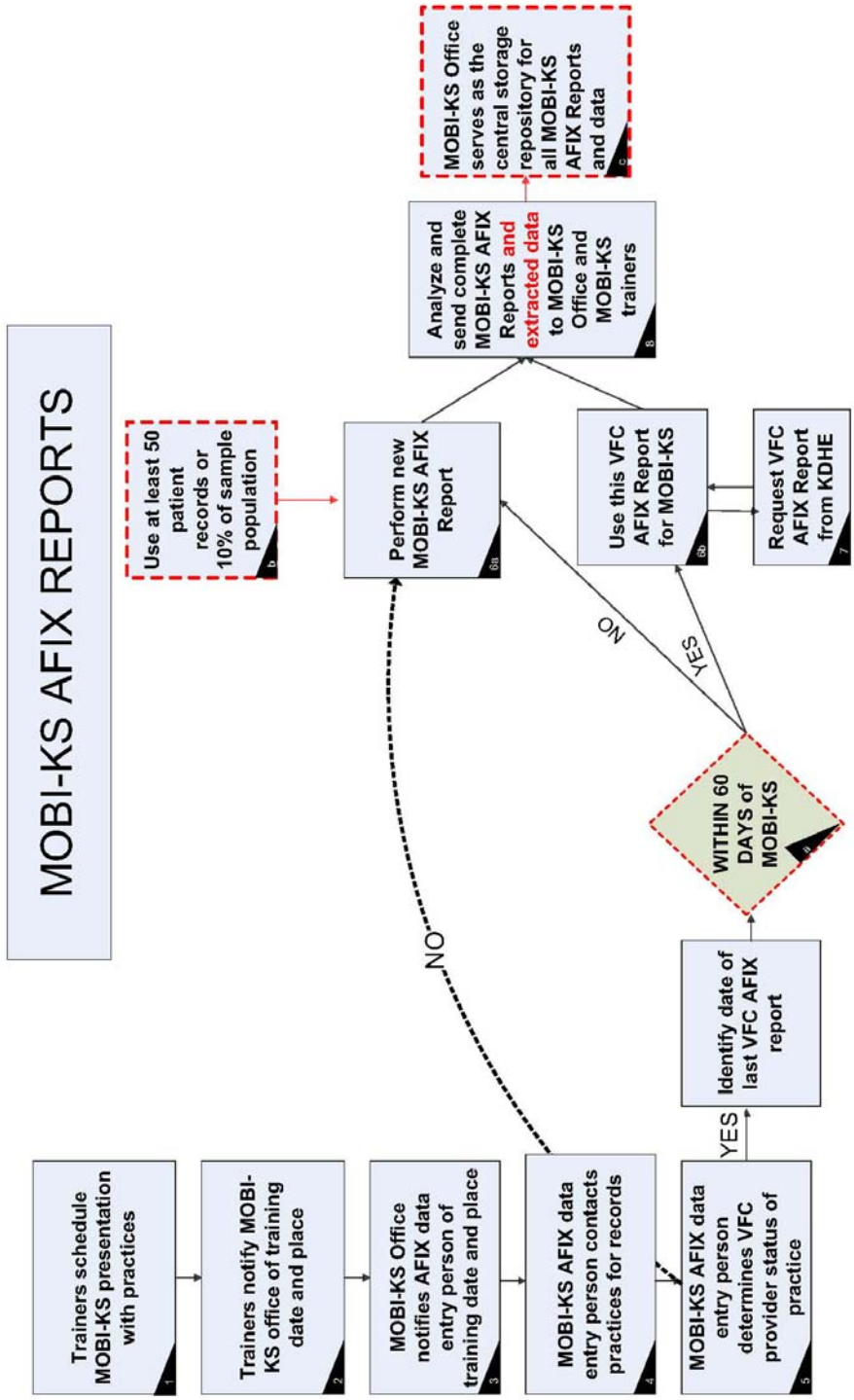


Figure 6. **Flowchart for MOBI-KS AFIX Reporting**



MOBI-KS Experiences: Administrators, Trainers, Providers

Administrators

The MOBI-KS administrators, in general, indicated that they believed that the program was successful. The majority of MOBI-KS administrators saw the program as being effective at achieving its goals. The respondents also felt that the program has been most successful in achieving its educational goal, specifically building awareness among immunization providers about the VFC program. Other goals identified by respondents include increasing the number of practices who are enrolled in the KSWebIZ and increasing the providers' awareness of the importance of immunization in a medical home.

There was a high level of agreement among the MOBI-KS administrators that the major strength of the program is that "this program actually gets into the office where the immunizations are given and it works with people doing the ground work in the trenches." Among other major areas of *strength of the program* identified by the MOBI-KS administrators were "a team of highly qualified expert-trainers", "advocacy of immunization in a medical home," and "peer-to-peer education."

When asked about the program governance structure, some MOBI-KS administrators expressed the following concerns: the MOBI-KS Advisory Board "hasn't been utilized to the fullest extent" and that there was some tension and confusion in the role sharing of Program Director (an immunization expert pediatrician) and other program administrators. Thus, the interviewees highlighted the greater need for collaboration, mutual accountability, and clearer definition of administrators' roles and responsibilities. In addition, planning time was an issue for some respondents. They felt that they could have implemented the program more effectively if planning had started much earlier.

The MOBI-KS administrators offered specific suggestions on how to improve the program. These suggestions included: review and update materials biannually rather than annually to accommodate changes in immunization recommendations and requirements, and strengthen the follow-up process, including tracking providers' progress on selected MOBI-KS interventions

and the need for technical assistance. The MOBI-KS administrators also emphasized the importance of attracting local health departments to participate in the program and to serve as a local resource for immunization education. The MOBI-KS administrators acknowledge that several health departments expressed deep concerns regarding the program because they felt that it might negatively impact their vaccine revenues allocation. Thus, engaging the local health departments in a collaborative endeavor, such as developing the educational aspects of the program, could provide them a sense of ownership and investment in outcome.

Trainers

Overall, the MOBI-KS trainers were satisfied with the program. The most common reasons given for participation in the program were to increase childhood immunization rates. The majority of MOBI-KS trainers also agreed that their expectations for the program were met. Most respondents expected the program to help practices to identify their missed opportunities for child immunizations and to help improve their immunization rates. In addition, three of the five respondents expected the program to provide practices with the information about the VFC program and the KSWebIZ, as well as conduct in-service education about updated vaccination recommendations and requirements.

All MOBI-KS trainers felt that the training/presentation was well received by the participants. Although the majority of respondents believed that the content of the presentation was adequate, two of the five noted that the section regarding the KSWebIZ should be shortened. According to one of the respondents "registry is an important part of immunizations, but I felt we took too much time there and could have spent the time on advising best practices."

Respondents were also asked to identify the strengths and weaknesses of the program. All the respondents gave recognition to the availability of in-house practice specific training and the importance of peer-to-peer education. Respondents also cited several weaknesses of the program. Half of the respondents identified a shortage of MOBI-KS trainers and limited participation of non-VFC providers as two primary weaknesses.

The MOBI-KS trainers' recommendations echoed similar priorities identified by administrators. The most frequent suggestion offered by respondents to improve the program was to strengthen the follow-up process and to provide more timely technical assistance to practices to gain access to the KSWebIZ.

Providers

Generally respondents were very satisfied with the MOBI-KS program. When asked about their reasons for participating in the MOBI-KS program, five of nine interviewees stated that they participated because they were interested in receiving information regarding new immunization recommendations and in making their vaccination programs more effective. One of the nine respondents stated that they were interested in becoming a VFC provider. Please note that four out of the nine interviewed practices were VFC providers. Two of the nine respondents wanted to validate their current immunization practices. One respondent had difficulty with this question as he did not remember participating in either the MOBI-KS program or training. With regard to the experiences of being in the program, most program participants agreed that this program helped them to identify missed opportunities in their clinics and learn how to improve immunization rates.

Respondents also reported that the MOBI-KS training experience was helpful and met their expectations. When asked to list a few recommendations made by the MOBI-KS trainers, the respondents named the following two recommendations: setting up an immunization reminder/recall system and vaccinating at acute care visits. However, their opinions were mixed whether it is feasible to set up immunization reminder/recall systems in their practices. Although seven respondents found this recommendation helpful, two of the nine respondents found this recommendation either impractical or costly.

Participants were asked to identify the aspect of the MOBI-KS presentation that they found to be most useful. Each of the nine participants answered this question in a different way. The information provided about immunization rates in their practices was identified most frequently as the most useful aspect of the training.

- "They were able to go through the reports and tell us about our specific issues."

- "It was good information, good reminder to the staff and to the physicians."
- "Great information about new immunization recommendations and requirements."

The program participants were also asked if their immunization practices had changed since they started participating in the MOBI-KS program. Two of the nine respondents reported no changes in their immunization practices after the MOBI-KS training. Seven respondents noted that they have been or are involved in implementing changes to their current immunization practices. Among the seven who chose to implement changes, four respondents reported focusing on vaccination during acute care visits, two respondents indicated setting up immunization reminder/recall systems in their offices, and the remaining respondent chose to become a VFC provider. The respondents were also requested to indicate how useful they found the program intervention funding. All respondents were very positive about the funding. A majority of respondents chose to purchase refrigerators.

The final section of the instrument focused on identifying suggestions and recommendations of respondents related to program improvement. The respondent suggestions for improving the program were related to the availability of the MOBI-KS program to more practices across the state and getting the clinics/practices on the KSWebIZ shortly after the MOBI-KS training.

In summary, the participating providers indicated that:

- Overall, the training sessions, materials, and support were very well received and well liked by the respondents.
- They would like to implement the program again next year and would highly recommend it to colleagues.
- Data analysis support is invaluable. The preliminary evaluation data (pre-MOBI-KS AFIX reports) provided desirable information and has been helpful in garnering the support of others and proving the value of the program.
- The MOBI-KS trainers were well-prepared, organized, and enthusiastic. The quality and expertise of the MOBI-KS trainers, value of the resources and handouts were particularly noted.

Outcome Evaluation

Provider Satisfaction

- Sixty percent of program participants ranked overall satisfaction of the MOBI-KS presentation as excellent and 40 percent ranked overall satisfaction as good.
- Seventy-seven percent of program participants rated the description of strategies to reduce barriers to immunization as excellent and 76 percent of program participants rated the description of an immunization reminder/recall system as excellent.

MOBI-KS Immunization Coverage and Timeliness

AFIX reports were only available for four participating provider sites. Based on an analysis of the AFIX reports, we found that:

- Three of the four provider sites showed a decrease in percent of 2- to 3-year-old children who were up-to-date and on-time for the 4:3:1:3:3:1 standard vaccination series to protect children from diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, Hepatitis B, and varicella. On average, 79 percent of children were up-to-date pre-MOBI-KS and 58 percent of children were up-to-date one year post-intervention.
- Rates were examined by vaccine type. A decrease in the average percent of children up-to-date was observed for all individual vaccine types. The biggest drop was observed with the DTaP and HIB vaccines. Eighty-five percent of children were up-to-date with the DTaP vaccine before MOBI-KS and 66 percent were up-to-date one year post-intervention. Ninety-five percent of children were up-to-date with HIB before MOBI-KS and 80 percent were up-to-date post-MOBI-KS intervention.
- Three of four provider sites showed an increase in missed opportunities to immunize. On average, missed opportunities increased 14 percent over the one-year period. Missed opportunities were defined as children who did not receive all of the immunizations they were eligible for on their last immunization visit.

Although the immunization coverage rate of 2- to 3-year-old children decreased over the one year following the MOBI-KS presentation in the four clinics examined for this evaluation, further evidence is needed to determine overall effectiveness of the intervention. Several external factors may have contributed to the decline. Patient family behaviors, such as parents opting out

of vaccines for personal or religious reasons, vaccine shortages, and data entry errors may have had an effect on coverage rates.

AFIX is a process improvement tool and it may not be the best instrument for quantifying the impact of MOBI-KS. AFIX may not have accurately captured the rate of immunization due to missing data, inconsistent methods of sampling patient records for AFIX reporting, and incomplete AFIX records. Finally, AFIX assessments do not document why children are not up-to-date with immunizations and cannot differentiate between children who are not up-to-date with their immunizations due to physician behaviors from those who are not up-to-date due to patient behaviors, vaccine supply, and administrative challenges.

CONCLUSIONS AND RECOMMENDATIONS

There were insufficient outcome data (i.e., data on immunization timeliness and coverage) for assessing MOBI-KS progress toward achieving its mission and goal. Progress could only be evaluated in terms of program design and implementation. The MOBI-KS program logic is strong, with clear goals, well-defined activities, and well-defined measurable outcomes. Three major strengths of MOBI-KS are: (1) MOBI-KS "gets into the office where the immunizations are given and it works with people doing the ground work in the trenches." (2) MOBI-KS is delivered by a team of highly qualified expert-trainers who help practices identify best practices to improve immunization rates, while also building awareness among immunization providers about the VFC program, enrollment in the KSWebIZ, and the importance of immunization in a medical home. (3) Providers highly value the pre-MOBI-KS and post-MOBI-KS AFIX reports.

Specific recommendations to improve MOBI-KS are as follows.

MOBI-KS administration can be improved by:

- Reviewing and updating training materials biannually instead of annually to accommodate changes in immunization recommendations and requirements (Figure 3, box d);
- Strengthening the follow-up with participating providers (Figure 3, boxes h, i, and j);

- Creating an evaluation system (including protocols for tracking immunization coverage pre- and post-MOBI-KS intervention, tracking provider changes related to MOBI-KS, and tracking immunization coverage in non-intervention practices for comparison purposes);
- Inviting local health departments to participate in the program and serve as a local resource for immunization education; and
- Involving the MOBI-KS Advisory Board more (including establishment of criteria for mutual accountability [Figure 3, box b]; and clearer delineation of administrator roles and responsibilities).

MOBI-KS training can be improved by:

- Shortening time spent on the immunization registry and spending more time on advising best practices during the MOBI-KS presentation to providers;
- Increasing the number of trainers;
- Expanding provider participation to include more non-VFC providers;
- Improving the post-MOBI-KS follow-up process (Figure 4, boxes c, d, and e); and
- Establishing a communication process between MOBI-KS and the Kansas Immunization Program (KIP) to assure follow-up with providers for KSWebIZ access.

MOBI-KS program delivery can be improved by:

- Receiving information from trainers about practice improvements that are practical, feasible, and affordable;
- Increasing the availability of MOBI-KS program to more practices across the state (Figure 3, box a);
- Getting the clinics and practices on the KSWebIZ after the MOBI-KS training;
- Clarifying strategies to reducing immunization barriers and the description of a reminder/recall system; and
- Creating a relational database system for MOBI-KS. (Figure 3, box c). Detailed suggestions related to data management are listed in Appendix D.

MOBI-KS AFIX reporting and program evaluation can be improved by:

- Developing a clear protocol for:
    - Capturing provider initiation of actions taken to improve vaccination coverage and timeliness (Figure 5, boxes b and c);
    - Adequately sampling patient records within defined pre- and post-MOBI-KS intervals (Figure 6, box b); and
    - AFIX reporting.
- Resolving specific AFIX problems including the following:
    - Establishing a set time period for when VFC AFIX reports are used instead of generating a new report for MOBI-KS. For example, a VFC AFIX report could be used for MOBI-KS if it is performed 60 days prior to the MOBI-KS presentation date and/or one year post-intervention date (Figure 6, box a);
    - Storing complete paper and electronic copies of pre-and post-MOBI-KS AFIX reports in one central location (MOBI-KS Office) (Figure 6, box c);
    - Adhering to the KIP standards for the minimum number of records used for the MOBI-KS AFIX assessment, which is 50 records for practices with 50 or more 2- to 3-year-old children in the practice and all records for practices with less than 50 and more than ten 2- to 3-year-old children in the practice; and
    - Recording the number of 2- to 3-year-old children in the practice at the time of the AFIX assessment (Figure 6, box b).
- Establishing methods for determining and tracking why a child who is included in the AFIX report is not up-to-date (i.e., physician behavior, patient behavior, or administrative challenges).

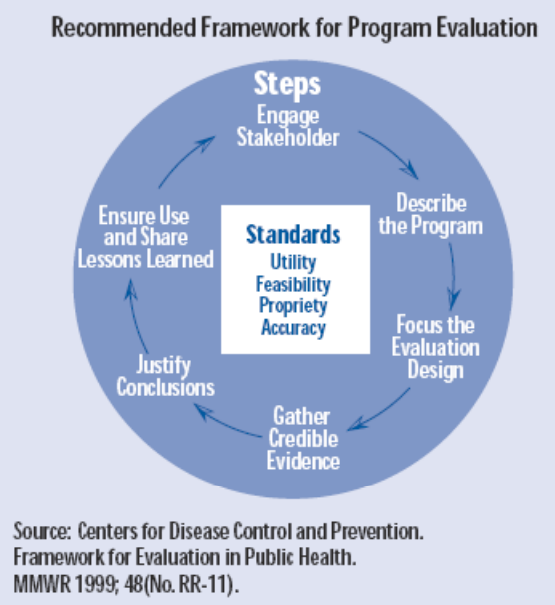
APPENDIX A. CDC EVALUATION FRAMEWORK

In January 2009, the KHI evaluation team met with MOBI-KS evaluation stakeholders to discuss the *evaluability* of MOBI-KS and agree on an evaluation framework. Stakeholders included several MOBI-KS Coordinating Team members: Chris Steege, executive director, KAAP; Sue Corrales, KAAP; and Sue Bowden, immunization director, KDHE. The evaluation team and stakeholders agreed that MOBI-KS was *evaluable.*

EVALUATION FRAMEWORK

The KHI evaluators and stakeholders agreed to follow the CDC's recommended framework and steps for program evaluation (see Figure A-1)[78]. The steps taken by the KHI evaluation team are briefly described, followed by a discussion of the standards (see center of Figure A-1).

Figure A-1. **Framework for Evaluation in Public Health**



Evaluation Steps

Step 1. Engage stakeholders: During this step, several MOBI-KS Coordinating Team members met with the KHI evaluation team to provide input into evaluation design, ensure the evaluation plan meets the needs of the MOBI-KS Coordinating Team, and provide insight into political issues that require consideration.

Step 2. Describe the program using logic model: KHI evaluators discussed with stakeholders the MOBI-KS mission, goals, objectives, and program strategies. Drawing on the knowledge and experience of MOBI-KS program staff, the KHI team developed a logic model. The logic model illustrates the needs addressed by MOBI-KS, the expected outcomes of activities and strategies employed with MOBI-KS, as well as available resources.

Since MOBI-KS has only been in the community for a year, MOBI-KS does not have discernable long-term effects, and evaluation measures. The logic model reflects this.

Step 3. Focus the evaluation design: KHI evaluators developed an evaluation methodology to accurately assess the process and outcomes of MOBI-KS while minimizing cost and time. To focus the evaluation design, the MOBI-KS Coordinating Team members clarified the primary purpose of the evaluation. The primary purpose is to improve MOBI-KS' functioning (process evaluation) and to identify early indications of effectiveness of the intervention (outcome evaluation). KHI evaluators selected methods that directly connect to the planned use of data. The evaluation methods included questionnaires (provider knowledge, satisfaction, and behavior), structured qualitative phone interviews with MOBI-participating office staff, and estimation of immunization coverage and timeliness using physician records and reports.

Step 4. Gather credible evidence: KHI evaluators obtained data from MOBI-KS program participants, stakeholders, and administrative records. With input from the MOBI-KS Coordinating Team, KHI evaluators described *in advance* all necessary aspects of data collection, including logistics. Involving the MOBI-KS Coordinating Team in the design of the evaluation was done to enhance credibility, ensure that all points of view were considered, and increase the likelihood that the evaluation findings are meaningful to users. KHI worked with the MOBI-KS Coordinating Team members to identify measures that relate to program goals as defined in the logic model, and the time frame for achieving them.

Step 5. Justify conclusions: Following data collection and interviews, KHI evaluators synthesized, analyzed, and interpreted the data. Level of institutionalization of MOBI-KS was assessed. Pre- and post-immunization rates were compared. Level of satisfaction of MOBI-KS

program participants was reported. Qualitative interview data describing the MOBI-KS administration, provider training, and practice intervention was used to document MOBI-KS processes and make recommendations for improving processes.

Step 6. Ensure use and share lessons learned: The MOBI-KS Coordinating Team members decided in advance that the evaluation results will be presented to users and stakeholders. Throughout the evaluation, KHI evaluators shared information, solicited feedback, and responded to any concerns raised. KHI evaluators prepared a final report to disseminate findings in a format that is easily understood and accurately depicts the information and analysis. Plans were made to present findings to the MOBI-KS Coordinating Team and IKK Steering Committee on May 11, 2009.

Evaluation Standards

At the core of the CDC Framework for Evaluation in Public Health are 30 evaluation standards. These standards, adopted from the Joint Committee on Educational Evaluation, are organized into the four groups: utility, feasibility, propriety, and accuracy. They are an approved standard by the American National Standards Institute (ANSI) and have been endorsed by the American Evaluation Association. The specific standards are as follows[9]:

Utility

The utility standards are intended to ensure that an evaluation will serve the information needs of intended users. These standards are as follows:

1. Stakeholder Identification: Persons involved in or affected by the evaluation should be identified, so that their needs can be addressed.
2. Evaluator Credibility: The persons conducting the evaluation should be both trustworthy and competent to perform the evaluation, so that the evaluation findings achieve maximum credibility and acceptance.
3. Information Scope and Selection: Information collected should be broadly selected to address pertinent questions about the program and be responsive to the needs and interests of clients and other specified stakeholders.

4. Values Identification: The perspectives, procedures, and rationale used to interpret the findings should be carefully described, so that the basis for value judgments are clear.
5. Report Clarity: Evaluation reports should clearly describe the program being evaluated, including its context, and the purposes, procedures, and findings of the evaluation, so that essential information is provided and easily understood.
6. Report Timeliness and Dissemination: Significant interim findings and evaluation reports should be disseminated to intended users, so that they can be used in a timely fashion.
7. Evaluation Impact: Evaluations should be planned, conducted, and reported in ways that encourage follow-through by stakeholders, so that the likelihood that the evaluation will be used is increased.

Feasibility

The feasibility standards are intended to ensure that an evaluation will be realistic, prudent, diplomatic, and frugal. The standards are as follows:

1. Practical Procedures: The evaluation procedures should be practical, to keep disruption to a minimum while needed information is obtained.
2. Political Viability: The evaluation should be planned and conducted with anticipation of the different positions of various interest groups, so that their cooperation may be obtained, and so that possible attempts by and of these groups to curtail evaluation operations or to bias or misapply the results can be averted or counteracted.
3. Cost Effectiveness: The evaluation should be efficient and produce information of sufficient value, so that the resources expended can be justified.

Propriety

The propriety standards are intended to ensure that an evaluation will be conducted legally, ethically, and with due regard for the welfare of those involved in the evaluation, as well as those affected by its results. These standards are as follows:

1. Service Orientation: Evaluation should be designed to assist organizations to address and effectively serve the needs of the full range of targeted participants.

2. Formal Agreements: Obligations of the formal parties to an evaluation (what is to be done, how, by whom, when) should be agreed to in writing, so that these parties are obligated to adhere to all conditions of the agreement or formally to renegotiate it.
3. Rights of Human Subjects: Evaluation should be designed and conducted to respect and protect the rights and welfare of human subjects.
4. Human Interactions: Evaluators should respect human dignity and worth in their interactions with other persons associated with an evaluation, so that participants are not threatened or harmed.
5. Complete and Fair Assessment: The evaluation should be complete and fair in its examination and recording of strengths and weaknesses of the program being evaluated, so that strengths can be built upon and problem areas addressed.
6. Disclosure of Findings: The formal parties to an evaluation should ensure that the full set of evaluation findings along with pertinent limitations are made accessible to the persons affected by the evaluation, and any others with expressed legal rights to receive the results.
7. Conflict of Interest: Conflict of interest should be dealt with openly and honestly, so that it does not compromise the evaluation processes and results.
8. Fiscal Responsibility: The evaluator's allocation and expenditure of resources should reflect sound accountability procedures and otherwise be prudent and ethically responsible, so that expenditures are accounted for and appropriate.

Accuracy

The accuracy standards are intended to ensure that an evaluation will reveal and convey technically adequate information about the features that determine worth or merit of the program being evaluated. The standards are as follows:

1. Program Documentation: The program being evaluated should be described and documented clearly and accurately, so that the program is clearly identified.
2. Context Analysis: The context in which the program exists should be examined in enough detail, so that its likely influences on the program can be identified.
3. Described Purposes and Procedures: The purposes and procedures of the evaluation should be monitored and described in enough detail, so that they can be identified and assessed.

4. Defensible Information Sources: The sources of information used in a program evaluation should be described in enough detail, so that the adequacy of the information can be assessed.
5. Valid Information: The information gathering procedures should be chosen or developed and then implemented so that they will assure that the interpretation arrived at is valid for the intended use.
6. Reliable Information: The information gathering procedures should be chosen or developed and then implemented so that they will assure that the information obtained is sufficiently reliable for the intended use.
7. Systematic Information: The information collected, processed, and reported in an evaluation should be systematically reviewed and any errors found should be corrected.
8. Analysis of Quantitative Information: Quantitative information in an evaluation should be appropriately and systematically analyzed so that evaluation questions are effectively answered.
9. Analysis of Qualitative Information: Qualitative information in an evaluation should be appropriately and systematically analyzed so that evaluation questions are effectively answered.
10. Justified Conclusions: The conclusions reached in an evaluation should be explicitly justified, so that stakeholders can assess them.
11. Impartial Reporting: Reporting procedures should guard against the distortion caused by personal feelings and biases of any party to the evaluation, so that evaluation reports fairly reflect the evaluation findings.
12. Metaevaluation: The evaluation itself should be formatively and summatively evaluated against these and other pertinent standards, so that its conduct is appropriately guided and, on completion, stakeholders can closely examine its strengths and weaknesses.

APPENDIX B. LEVEL OF INSTITUTIONALIZATION SCALES

LEVEL OF INSTITUTIONALIZATION (LOIN) SCALES FOR HEALTH PROMOTION PROGRAMS

FROM

Goodman, R.M., McLeroy, K.R., Steckler, A., Hoyle, R.H. "Development of Level of Institutionalization (LoIn) Scales for Health Promotion Programs." *Health Education Quarterly,* Vol 20 (2), 1993, 161-178.

PRODUCTION SUBSYSTEM

1a. Have the program's goals and/or objectives been put into writing?

Yes No Not sure/Not applicable

↓ ↓

1b. If yes, for how many years have written goals & objectives actually been followed?

Year(s)

Go to question 2

↓ ↓

1c. Of all the aspects of the program that could have written goals and objectives, what is your best estimate of the proportion which actually have written goals and objectives?

None Few Most All

1 2 3 4

2a. Have any of the plans or procedures used for implementing this program been put in writing?

Yes No Not sure/Not applicable

↓ ↓

2b. If yes, for how many years have such written plans or procedures actually been followed?

Year(s)

Go to question 3

↓ ↓

2c. Of all the aspects of the program that could have written plans and procedure, what is your best estimate of the proportion which actually have written plans and procedures?

None Few Most All

1 2 3 4

3a. Has a schedule (e.g. timetable, plan of action) used for implementing program activities been put in writing?

Yes No Not sure/Not applicable

↓ ↓

3b. If yes, for how many years have written schedules actually been followed?

Year(s)

Go to question 4

↓ ↓

3c. Of all the aspects of the program that could have written schedules, what is your best estimate of the proportion which actually have written schedules?

None Few Most All

1 2 3 4

4a. Have the strategies for implementing this program been adapted to fit local circumstances?

Yes No Not sure/Not applicable

↓ ↓

4b. If yes, for how many years have logically adapted strategies actually been followed?

Year(s)

Go to question 5

↓ ↓

4c. Of all the aspects of the program that could be adapted to fit local circumstances, what is your best estimate of the proportion which actually have?

None Few Most All

1 2 3 4

5a. Has a formal evaluation of the program been conducted?
Yes No Not sure/Not applicable
↓ ↓
5b. If yes, how many times has the program been formally evaluated?
Year(s)
Go to question 6
↓ ↓
5c. Of all the aspects of the program that could be formally evaluated, what is your best estimate of the proportion which have been formally evaluated?

None Few Most All
1 2 3 4

MANAGERIAL SUBSYSTEM

6a. Has a supervisor (e.g., section chief, department head) been formally assigned to oversee the program?
Yes No Not sure/Not applicable
↓ ↓
6b. If yes, for how many years has such a supervisor actually been formally assigned to oversee the program?
Year(s)
Go to question 7
↓ ↓
6c. Of all the aspects of the program that could receive supervision, what is your best estimate of the proportion which actually receives such supervision?

None Few Most All
1 2 3 4

7a. Have formalized job descriptions been written for staff involved with this program?
Yes No Not sure/Not applicable
↓ ↓
7b. If yes, for how many years have formalized job descriptions actually been followed?
Year(s)
Go to question 8
↓ ↓
7c. What is your best estimate of the number of staff involved in the program who have written job descriptions?

None Few Most All
1 2 3 4

8a. Are evaluation reports of this program done on a schedule similar to evaluation reports for most other programs in your organization?
Yes No Not sure/Not applicable
↓ ↓
8b. If yes, for how many years have evaluation reports actually been produced on a schedule similar to such reports for most other programs in your organization?
Year(s)
Go to question 9
↓ ↓
8c. What is your best estimate of the extent that evaluation reports for this program are produced on a schedule similar to evaluation reports for most other programs in your organization?

None Few Most All
1 2 3 4

MAINTENANCE SUBSYSTEM

9a. Have permanent staff been assigned to implement this program?

Yes No Not sure/Not applicable

↓ ↓

9b. If yes, for how many years have permanent staff been assigned to implement this program?

Year(s)

Go to question 10

↓ ↓

9c. What is your best estimate of the number of staff who implement the program that are in permanent positions?

None Few Most All

1 2 3 4

10a. Has an administrative-level, individual within your organization been actively involved in advocating for this program's continuation?

Yes No Not sure/Not applicable

↓ ↓

10b. If yes, for how many years have written goals & objectives actually been followed?

Year(s)

Go to question 11

↓ ↓

10c. What is your best estimate of how active this administrative level individual has been advocating for the program's continuation?

Not at all Minimally Moderately Very

1 2 3 4

11a. Do staff in your organization, other than those actually implementing the program, actively contribute to the program's operations?

Yes No Not sure/Not applicable

↓ ↓

11b. If yes, for how many years have such staff in your organization actively contributed to the program's operations?

Year(s)

Go to question 12

↓ ↓

11c. Of all the staff in your organization who could contribute to the operation of this program, what is your best estimate of the proportion that actually contribute to it?

None Few Most All

1 2 3 4

SUPPORTIVE SUBSYSTEM

12a. Has the program made a transition from trial or pilot status to permanent status in your organization?

Yes No Not sure/Not applicable

↓ ↓

12b. If yes, for how many years has this program had permanent status?

Year(s)

Go to question 13

↓ ↓

12c. What is your best estimate of how permanent this program is in your organization?

Not at all Minimally Moderately Very

1 2 3 4

13a.Has the program been assigned permanent physical space within your organization?
Yes No Not sure/Not applicable
↓ ↓
13b. If yes, for how many years has it maintained such permanent space?
Year(s)
Go to question 14
↓ ↓
13c. Of all the permanent space that this program needs, what is your best estimate of the proportion of permanent space it currently occupies?

None A small amount Most that it needs All it needs
1 2 3 4

14a. Is this program's source of funding similar to the funding sources for other established programs within your organization?
Yes No Not sure/Not applicable
↓ ↓
14b. If yes, for how many years has this program's funding sources been similar to those for other established programs within your organization?
Year(s)
Go to question 15
↓ ↓
14c. In your best estimate, how permanent is the program's source of funding?

None Minimally Moderately Very
1 2 3 4

15a. Is the staff most closely associated with this program's implementation hired from a stable funding source?

Yes No Not sure/Not applicable

↓

15b. If yes, for how many years has the staff most closely associated with this program's implementation been hired from a stable funding source?

Year(s)

↓

15c. What is your best estimate of how permanent the funding is for the staff most closely associated with this program's implementation?

Not at all Minimally Moderately Very

1 2 3 4

Scoring the LoIn Scale

The grid on the next page can be used to score the LoIn scale in conjunction with the following directions:

Each question has three sub-questions (a, b, and c). Sub-questions "a" and "b" are scored together, resulting in one score for the two sub-items, and sub-question "c" forms is scored separately.

For all "a" and "b" sub-questions, score as follows:

- If you checked "No" or "Not sure/not applicable" for "a" then the score for the sub-item = 0;
- If you checked "Yes" for "a" ***and*** wrote "0" or "1" for "b", then the score for the sub-item = 1;
- If you checked "Yes" for "a" ***and*** wrote "2" or "3" for "b", then the score for the sub-item = 2;
- If you checked "Yes" for "a" ***and*** wrote "4" or "5" for "b", then the score for the sub-item = 3;
- If you checked "Yes" for "a" ***and*** wrote "6" or more for "b", then the score for the sub-item = 4;

For all "c" sub-questions, score them as the number that you circled for that item (e.g., if you circled a "2" then the score for that item = 2).

Each three-part item represents one of the following organizational sub-systems: production (items 1–5), managerial (items 6–8), maintenance (items 9–11), and supportive (items 12–15).

Using the grid on the next page, add the score for all sub-items "a" and "b" as indicated and divide by the number listed on the grid. Follow the same procedure for all "c" sub-items.

For sub-items "a" and "b":

- If the mean score is "1" or less then institutionalization is low;
- If the mean score is greater than "1" but less than or equal to "3" then institutionalization is low to moderate;
- If the mean score is greater than "3" but less than or equal to "5" then institutionalization is moderate to high;
- If the mean score is greater than "5" then institutionalization is high.

For sub-items "c":

- If the mean score is less than or equal to "2" then institutionalization is low;
- If the mean score is greater than "2" but less than or equal to "3" then institutionalization is moderate;
- If the mean score is greater than "3" then institutionalization is high.

*In which subsystems did you score **low?** What can you do to increase the institutionalization score for that subsystem?*

SCORE SHEET FOR PROGRAM INSTITUTIONALIZATION

ITEMS "A" AND "B" Subsystem	Item	Item Score	Mean Score
PRODUCTION		1 "a" and "b"	
2 "a" and "b"			
3 "a" and "b"			
4 "a" and "b"			
5 "a" and "b"			
Item sum =		Item sum/5 =	
MANAGERIAL		6 "a" and "b"	
7 "a" and "b"			
8 "a" and "b"			
Item sum =		Item sum/3 =	
MAINTENANCE		9 "a" and "b"	
10 "a" and "b"			
11 "a" and "b"			
Item sum =		Item sum/3 =	
SUPPORT		12 "a" and "b"	
13 "a" and "b"			
14 "a" and "b"			
15 "a" and "b"			
Item sum =		Item sum/4 =	

APPENDIX C. PHONE INTERVIEW QUESTIONS: ADMINISTRATORS, TRAINERS, PROVIDERS

The interviewer begins the phone interview by informing the interviewee about the purpose of the evaluation study and length of interview. The interviewer explains that interview is confidential. Identifying information will be deleted from transcription and report. Only aggregate results will be presented.

For MOBI-KS Administrators and IKK Governance

First, let's talk about the program's mission and administration.

1. Could you please describe what you consider to be the essential features of the program?
2. How is the program administered? What are your thoughts about the program's structure?
3. What resources and inputs are invested?
4. How does funding impact the way MOBI-KS is run?

Now, let's talk about the design of MOBI-KS.

5. How was the one-hour intervention designed and/or adapted for Kansas? (Who designed? Borrow from CDC or other state?)
6. How was information determined to be included/excluded? How can the MOBI-KS presentation be improved?
7. Who carries out the program? What do you think about the effectiveness of the trainers?
8. How do trainers and providers get recruited into the program?

Next, what about implementation of MOBI-KS?

9. What is the status of the program's progress toward achieving its goals and objectives?
10. What difficulties did you find in implementing this program?
11. Did practices implement recommendations by the proposed date as outlined in their plan?

Let's shift now and talk about your perceptions, and those of the MOBI-KS trainers, about the strengths of MOBI-KS and how MOBI-KS can be improved.

12. What do trainers/providers consider to be strengths of the program?
13. What do you consider to be strengths of the program?
14. What do trainers and/or providers recommend to improve the program?
15. How well do you think the MOBI-KS program goals and objectives can be achieved with the MOBI-KS educational intervention?
16. How can the program be improved from your perspective?

For MOBI-KS trainers and train-the-trainers (sample of 4–5)

Thank you taking time today for me to interview you about your participation and activities related to MOBI-KS, an educational program to maximize office based immunizations one practice at a time. The one-hour MOBI-KS educational program is tailored to each individual practice setting and provides practical information to providers on how to achieve complete and timely immunizations for infants and children. I'd like to ask you questions about why you are participating as a trainer, how you do the training, and your ideas about making MOBI-KS training more effective.

How about if we begin with your reasons for participating, your expectations, and your satisfaction with MOBI-KS administration.

1. When and how did you decide to become a part of the program?
2. How would you describe your interactions with the MOBI-KS administrators?
3. What were your expectations regarding the program?

Next, let's discuss how you deliver a MOBI-KS training.

4. Could you please describe a typical MOBI-KS presentation?
5. Which activities contribute most/least?
6. Are there variations in the way the presentation and training are delivered?
7. What delivery methods did you use?
8. Was training curriculum delivered in its entirety?

9. What can make your presentation more effective (resources; additional administrative support, etc)?

Finally, let's talk about your sense of how well the program is working?

10. How was the training received by providers/participants?
11. What are the strengths and weaknesses of the program?
12. What do you think MOBI-KS' short-term impact is on office practices?

For providers

Thank you taking time today for me to interview you about your participation and activities related to MOBI-KS, an educational program to maximize office based immunizations one practice at a time. The one-hour MOBI-KS educational program is tailored to each individual practice setting and provides practical information to providers on how to achieve complete and timely immunizations for infants and children. I'd like to ask you questions about why your practice participated, and whether MOBI-KS helped you identify and put in place evidence-based office interventions.

How about if we begin with your reasons for participating, your expectations, and your satisfaction with MOBI-KS administration.

1. What motivated you to participate in MOBI-KS training?
    - When and how did you decide to become a part of MOBI-KS?
2. How would you describe your interactions with the MOBI-KS administrators/trainers?
3. What were your expectations regarding the MOBI-KS training?
4. What do you think about the value of this program for you?
5. What do you think about the quality of the training?
    - How the trainers delivered the presentation?
    - How well did trainers deliver the message?
    - What changes would you recommend for the training?

Next, I'd like to ask you what you learned at the MOBI-KS training.

6. Did trainers make recommendations to improve vaccination practices? What do you think about those recommendations?
7. How well did the training help office staff identify 'missed' opportunities for immunization?
8. Did the training help you think about whether an immunization reminder system might work in your office?
9. Were you able to identify strategies to reduce office barriers to immunization?

Now, let's discuss whether your thinking changed about monitoring immunization, and if you took any action steps.

10. How has your behavior toward vaccine administration changed?
11. What missed immunization opportunities have you identified in your practice?
12. Did you change the way you monitor vaccination coverage after the MOBI-KS training?
13. What intervention strategy did you choose to focus on?
14. When did you implement recommendations?
15. Was the funding helpful?

Finally, can you share with me your current processes for ensuring vaccination coverage?

16. How is vaccination coverage monitored in your practice?
17. Are you a VFC provider?
    a. Are there plans to become a VFC provider?
    b. Did MOBI-KS impact your decision to become a VFC provider?

APPENDIX D. MOBI-KS DATABASE RECOMMENDATIONS

To enhance quality improvement efforts in the MOBI-KS program, it is recommended that a relational database be created to store all necessary data, reports, and information related to MOBI-KS administration, trainers, providers, and vaccination coverage. A relational database can link administrative data (e.g., contact data for trainers and providers) with programmatic data (e.g., program participation information) and with evaluation data (e.g., AFIX data). A relational database management system can reduce data entry, ensure updates occur simultaneously on related data files and forms, and expand administrative capacity with enhancements such as pre-defined queries, tables, forms, and reports. Tracking contacts, creating reminder systems, and other tasks can be accomplished.

For monitoring quality and producing evaluation reports, the following items are recommended for inclusion in the database.

Clinic data:

- Date of first contact by MOBI-KS office

- Clinic information
  - Clinic contact person: name, position title, phone number, and e-mail
  - Clinic address
  - Practice type: pediatrics or family practice
  - Number patients served per year
  - Number 2- to 3-year-old patients served per year
  - Clinic staff
    - Physician(s) names
    - Number physicians, number nurses, number admin staff
  - VFC provider yes/no
  - KSWebIZ user yes/no

- Pre MOBI-KS AFIX
    - Date of assessment
    - VFC AFIX report used yes/no
    - Name of person who performed AFIX
    - Number charts reviewed
    - Number 2- to 3-year-old patients in the practice at that time
    - Percent up-to-date for vaccine series (4:3:1:3:3:1)
    - Percent up-to-date for individual antigens
    - Percent missed opportunities

- MOBI-KS presentation
    - Presentation date
    - Trainer name
    - Number of clinic staff in attendance, broken down by position type

- Paperwork completed by trainer and/or filed with MOBI-KS yes/no
    - Attendance sheet
    - Attendee evaluation forms
    - Trainer feedback form
    - Best practice checklist

- Date of one month follow-up
    - Name of person who did follow-up

- Intervention chosen by clinic

- Clinic plan of action submitted yes/no

- Date and amount of funding provided

- Date of six month follow-up
    - Name of person who did follow-up

- Date of 12 month follow-up
    - Name of person who did follow-up

- Post MOBI-KS AFIX
    - Date of assessment
    - VFC AFIX report used yes/no
    - Name of person who performed AFIX
    - Number charts reviewed
    - Number 2- to 3-year-old patients in the practice at that time
    - Percent up-to-date for vaccine series (4:3:1:3:3:1)
    - Percent up-to-date for individual antigens
    - Percent missed opportunities

Trainer data:

- Contact information: address, phone number, and e-mail address

- Position, title

- Training to become a trainer
    - Date
    - Name of person who performed training
    - Number of presentations shadowed

- MOBI-KS presentations given
    - Total number given
    - List date and clinic name for each presentation

- Continuing education in immunizations yes/no

- MOBI-KS refresher dates

APPENDIX E. LIST OF ACRONYMS

AFIX: .....Assessment, Feedback, Incentives, and Information eXchange

AMA PRA: ...American Medical Association Physician's Recognition Award

ANSI: .....American National Standards Institute

CDC: .....Centers for Disease Control and Prevention

CME: .....Continuing Medical Education

CEU: .....Continuing Education Unit

IKK: .....Immunize Kansas Kids

KAAP: .....Kansas Chapter of the American Academy of Pediatrics

KAFP: .....Kansas Academy of Family Physicians

KDHE: .....Kansas Department of Health and Environment

KHI: .....Kansas Health Institute

KIP: .....Kansas Immunization Program

KSWebIZ: .....Kansas Immunization Registry

LoIn: .....Level of Institutionalization

MOBI-KS: .....Maximizing Office Based Immunizations

VFC: .....Vaccines for Children

APPENDIX F. MOBI-KS FORMS

MOBI-KS Planning Worksheet

Use this reminder sheet to complete all steps of MOBI-KS
Practice Name_____
MOBI KS Presentation Date_____

BEFORE MOBI-KS PRESENTATION

- ☐ Identify practice desiring MOBI-KS
- ☐ Schedule AFIX preferrably 3-4 weeks before MOB
  (if practice willing, ideally some time prior to MOBI-KS)
- ☐ Schedule MOBI-KS date:_____
- ☐ Invite Local HD Name_____ date:_____
- ☐ Fax MOBI-KS Planning Worksheet & Program Planner (Page 1&2) to MOBI-KS Office
  FAX: 785/478-9566
  (Please submit two or more weeks prior to MOBI-KS presentation)
  (Please indicate whether it is for a rescheduled presentation)
- ☐ Complete MOBI-KS Best Practices Checklist (Page 3)
- ☐ Plan your presentation based on Best Practices Checklist

DURING MOBI-KS PRESENTATION

- ☐ Have each attendee legibly complete the Attendance Sheet (May need to communicate in advance with Office Manager or Head Nurse to be sure they get filled out!)
- ☐ Have each attendee complete Evaluation Form (Page 6)
- ☐ Use Best Practices Checklist during presentation
- ☐ Encourage practice to commit to one or more changes
  (make note of change on Trainer Feedback/Evaluation form so you don't forget!)
- ☐ Collect Attendance Form and Attendee Evaluation Forms

IMMEDIATELY FOLLOWING MOBI-KS PRESENTATION

- ☐ Complete Trainer Feedback/Evaluation Form (done by trainer)
- ☐ Fax (785)478-9566 or e-mail to MOBI-KS Office mobikansas@aol.com:
  a) Best Practice Checklist(Pg 3&4) b) Attendee Evaluations (Pg 6)
  c) Trainer Feedback/Evaluation Form (Pg7)

ONE MONTH FOLLOWING MOBI-KS PRESENTATION

- ☐ Contact practice and complete MOBI-KS Follow-Up Form (Pg 9)
- ☐ Fax Follow-Up Form to MOBI-KS Office FAX: 785/478-9566

ONE Year FOLLOWING MOBI-KS PRESENTATION

- ☐ Fax Follow-Up Form to MOBI-KS Office FAX: 785/478-9566

MOBI-KS Program Planner

(Please submit one program planner per program)

Trainer Name _____ Phone _____ Ext._____

Trainer Address _____

E-mail Address _____

Where will the MOBI-KS program take place?

Site Name _____

Site Street Address _____

City _____ State: KS Zip _____

County _____

Site Contact _____ Phone No. (_____)_____

Date of Planned Program _____ Time _____ to _____ AM PM

☐ This is a rescheduled program for which a planner had previously been sent.
Date of original program _____

LOCATION
__Physician office practice
__Clinic (other outpatient setting)
__Meeting facility (auditorium/conference)
__Other _____

REPRESENTATION
__From one practice
__Group practice from multiple locations
__From multiple practices
__Other _____

SPECIALTY
__Pediatrics
__Family Medicine
__Multi-Specialty
__Other _____

FOR PRACTICE/CLINIC LOCATIONS
AUDIENCE (check all that apply)
__Physicians __Nurse Practitioners
__Nurses __Physician Assistants
__Medical Assistants
__Non-medical staff (clerks, office managers)

FOR MEETING-BASED LOCATIONS
PRIMARY AUDIENCE (check only one)
__Physician/Nurse Practitioners
__Nurses
__Residents
__Other _____

MOBI-KS Audience Resource Packs: Number needed _____

Other Resources: Pink Book ☐ Yes ☐ No

Food/beverages (if any) provided by: _____

Please fax program planner to: **MOBI-KS Office/KS AAP**
Fax: (785) 478-9566
Phone: (785) 250–1119

Questions about immunization policy, guidelines, recommendations or MOBI-KS content – contact Jo-Ann Harris MD at jharris7@kumc.edu.
Questions about scheduling or conducting presentations and materials – contact MOBI-KS Office kansasaap.@aol.com or (785) 250-1119.

PLEASE SUBMIT AT LEAST TWO WEEKS PRIOR TO YOUR SCHEDULED PRESENTATION

Call the MOBI-KS Office if presentation is sooner than two weeks.

MOBI-KS Best Practices Checklist (please complete prior to a MOBI-KS)

This information is best obtained from the "immunization expert" at the practice. Adapt your presentation and review this questionnaire just before presenting, to refresh your memory.

Please return to MOBI-KS Office immediately after presentation.

When gathering this information, tell your contact from the practice that in order to customize your presentation and make it valuable to them, you need to ask a few questions. This will make the presentation more worthwhile.

PLEASE review this form with the audience during your presentation of slides # 6-8 "MOBI-KS Best Practices". Provide positive feedback for all yes answers and ask them to consider doing some of the others.

Trainer Name:	
MOBI-KS Presentation Site:	
Person Providing Responses:	
Planned Date of MOBI-KS Presentation:	

Type of practice: ☐ Pediatric ☐ Family Practice ☐ Other _____

Which of the following immunizations have you begun to give routinely to patients in your practice?	☐ rotavirus ☐ hepatis A ☐ 2nd dose varicella ☐ adolescent pertussis (Tdap) ☐ meningococcal ☐ HPV	
Which of the following combination vaccines does your practice use?	☐ Pediarix ☐ Comvax ☐ ProQuad ☐ none	
1) Does your practice have someone you consider your immunization expert?	☐ YES ☐ NO	Note: If YES, make sure that person attends the MOBI –KS presentation.
2) Has your practice measured its immunization rates within the past year?	☐ YES ☐ NO	**If YES, by whom?_____when?_____** Note: If YES, may be able to skip slides #20-21 "AFIX".
3) Is your practice a Vaccines for Children (VFC) provider?	☐ YES ☐ NO	Note: if YES, skip slide #34 "VFC".
4) Does your practice have a written plan for saving vaccine in case of a power outage?	☐ YES ☐ NO	Note: If NO, reinforce sample emergency plans in the Resource Pack.
5) Does your practice provide a current Vaccine Information Statement (VIS) to parents for every shot at every visit and allow them to take it home?	☐ YES ☐ NO	Note: If NO, reinforce "It's Federal Law" in the Resource Pack.

Please complete this information, so it can → be matched with the previous page:

Trainer name: _____

MOBI-KS Site name: _____

Date of Planned MOBI-KS: _____

6) Does your office use an immunization reminder and/or recall system for every patient?	Remind parents that a vaccine is due or coming due? ☐ YES ☐ NO Recall patients past due for vaccines? ☐ YES ☐ NO	**If YES to either, briefly describe:**
7) Has your office received training on Kansas' Immunization Registry, KS WebIZ?	☐ YES ☐ NO	**If YES, ask if they are using it regularly for:** ___ lookup past immunizations __ some patients __ every patient ___ enter vaccines as given __ enter later that day or beyond __ enter as patient seen __ entry via billing system ___ enter historical shot records __ as patients seen __ historical data for entire practice has been entered
8) As a rule, does your practice give hepatitis B #1 to newborns, prior to hospital discharge?	☐ YES ☐ NO	**If NO, ask if the reason is:** ___ they want to use combination vaccines later -- if this is the reason, ask if they know that it is acceptable to give hep B at birth and still give 3 doses of a combination vaccine (total of 4 doses of hep B) __knew __didn't know ___ some other reason specify this reason if they volunteer it _____
9) As a rule, does your practice give all vaccines that are due, regardless of the number of injections?	☐ YES ☐ NO	**If NO, what is the maximum number of injections at one visit? _____** Note: If NO, please spend more time on slide #24, No.3
10) As a rule, does your practice give shots to children with minor illnesses, like colds, diarrhea and low grade fever?	☐ YES ☐ NO	Note: If NO, please spend more time on slide #25 "Reasons to Withhold Vaccine" and slide #26 "Six Screening Questions".
11) As a rule, does your practice give shots to children at sick visits?	☐ YES ☐ NO	**If NO, ask if the reason is related to payment?** __Yes it is __No
12) As a rule, does your practice allow patients to come in the same day for an immunization-only nurse visit?	☐ YES ☐ NO	Note: If NO, spend more time on slide #27

RETURN THIS FORM TO THE MOBI OFFICE ALONG WITH OTHER FEEDBACK MATERIALS IMMEDIATELY FOLLOWING YOUR MOBI PRESENTATION.

Continuing Education Attendance Form

Title of Continuing Education Event: Maximizing Office Based Immunization -KS

Provided by: KS Chapter, American Academy of Pediatrics
9905 Woodstock Street
Lenexa KS 66220

Date of Event: _____ Time of Event: _____

Location: Site Name: _____

Presenter Name: Person Submitting Application:

City: _____, KS Zip: _____ _____

All course participants must complete this form to receive continuing education credit.
Please Print Clearly.

	Name (First, MI, Last) Please PRINT Name	Profession MD RN DO LPN MA	Initials	Address	City	State	Zip	OFFICE USE ONLY Certificate Awarded	Contact Hours /CME Awarded
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									

Contact Sue at susanc0189@sbcglobal.net for the sign-in sheets and CME and CEU certificates to be computer generated for each site! This is just a sample!

MOBI-KS Attendee Evalution

Print Name _____ Sign Name _____ Date _____

In order to receive continuing education, you must complete and sign this form. Pease turn it in to the MOBI-KS speaker at the conclusion of the presentation. Also complete the attendance sheet.

Please rate the program by circling the appropriate number:
1= Poor 2= Needs improvement 3 = Average 4= Good 5 = Excellent N/A = Not Applicable

The following objectives for the program were met:

1.	Identify current recommended childhood immunization schedule.	1 2 3 4 5 N/A
2.	Name one method to measure an office's immunization rates.	1 2 3 4 5 N/A
3.	Define "missed opportunities" for immunization.	1 2 3 4 5 N/A
4.	Describe an immunization reminder/recall system.	1 2 3 4 5 N/A
5.	Identify strategies to reduce office barriers to immunization.	1 2 3 4 5 N/A
6.	The presentation was well organized and logically sequenced.	1 2 3 4 5 N/A
7.	Speaker demonstrated topic expertise:	1 2 3 4 5 N/A
8.	The teaching methods were effective.	1 2 3 4 5 N/A
9.	Difficulty of material.	level too difficult about right too low
10.	New information gained.	a great deal some new information nothing new
11.	Appropriateness of meeting room.	excellent good fair poor
12.	Overall evaluation of this session.	excellent good fair poor

Additional Comments or Suggestions:

_____

_____

_____

_____

MOBI-KS Trainer Evaluation/Feedback (trainer must complete immediately following a MOBI-KS)

Trainer Name:			
MOBI-KS Presentation Site:			
Date of MOBI-KS Presentation:		Time of MOBI-KS:	am pm

1) Were you able to complete the MOBI-KS presentation (including Q&A)? ☐YES ☐NO

2) What was the total number of attendees? _____

3) What was the number of attendees from each group below?
____Physician ____Adv Practice Nurse/PA ____Nurse ____MA ___Other

4) Please list questions asked by the audience and indicate any needing follow-up. (continue on back)

5) Are there any slides, material, or information that you would like to see added or deleted? (continue on back)

6) Were food/beverages provided? ☐ YES, provided by_____ ☐NO

7) Was AFIX performed prior to the MOBI-KS? ☐ YES, date _____ ☐NO

8) If not, is AFIX planned? ☐ YES, date _____ ☐ NO, reason _____ ☐MAYBE

9) During the MOBI-KS presentation, the practice committed to do the following:

	DONE/DOING ALREADY	WILL DO (YES)	MAYBE
Have an AFIX measurement			
Become a VFC provider			
Check immunization status at every visit			
Give vaccines even if mild illness is present			
Give all vaccines that are due			
Update policies/procedures to reduce barriers			
Institute a reminder/recall system			
Sign up and use KS WebIZ (Registry)			
Other_____			

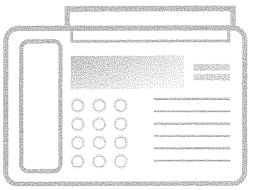
10) Does the practice expect you to follow-up in one month? ☐YES ☐NO

11) Does the practice expect an AFIX follow-up in one year? ☐YES ☐NO

Please return this form immediately following a MOBI-KS presentation along with Best Practices Checklist, attendee evaluation forms and the attendance sign-in sheet to the MOBI-KS Office:

MOBI-KS c/o KS Chapter, AAP **call if questions: (785) 250-1119**
9905 Woodstock St, Lenexa KS 66220

MOBI-KS REFERRAL FAX



To: The Kansas Department of Health
Immunization Program

Fax number: **(785) 478-9566**

From: _____
MOBI-KS trainer

Health District: _____

Phone: _____

E-mail: _____

Fax Date: _____

The office practice/clinic below had a MOBI-KS presentation on _____
date of MOBI-KS

and would like more information on the following:

- ☐ Vaccines for Children Program
- ☐ KS WebIZ (Statewide Immunization Information System)

Office/Clinic Name: _____

Address: _____

_____

_____

Phone: _____

Office contact person: _____

E-mail contact: _____

MOBI-KS One-Month Follow-Up (trainer must complete one month after a MOBI-KS)

Trainer Name:			
MOBI-KS Presentation Site:			
Date of MOBI-KS Presentation:		Date of Follow-Up:	

1) Name of practice staff person providing information _____

Position: ☐physician ☐adv practice nurse/PA ☐nurse ☐MA ☐other, specify_____

2) During the MOBI-KS presentation, the practice committed to do the following:

	During MOBI-KS committed to:			One month later	
	DONE/DOING ALREADY	WILL DO (YES)	MAYBE	YES	NO
Have an AFIX measurement					
Become a VFC provider					
Check immunization status at every visit					
Give vaccines even if mild illness is present					
Give all vaccines that are due					
Update policies/procedures to reduce barriers					
Institute a reminder/recall system					
Sign up and use KS WebIZ (Registry)					
Other_____					

3) Would the practice like more assistance making these changes? ☐ Yes ☐ No

Specify_____

4) Comments

Please fax this form to the MOBI-KS Office
FAX: 785/478-9566

APPENDIX G. ENDNOTES

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