Executive Summary:
Massachusetts Health Passport Project Evaluation
Final Report

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Massachusetts Health Passport Project Evaluation

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Massachusetts Health Passport Project Evaluation

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EXECUTIVE SUMMARY

This executive summary highlights the key findings to emerge from the Massachusetts Health Passport Project (MHPP) Evaluation, a multi-year study—with data collection spanning from November 2005 through December 2008—of MHPP. This executive summary includes a brief description of the program and the evaluation and summarizes key findings relevant to the program’s operations and attainment of goals.

Massachusetts Health Passport Project Services and Goals

The MHPP began in April 2004, as a pilot program of the Juvenile Rights Advocacy Project at Boston College Law School under the direction of Francine Sherman, Esq. The program was originally called the Girls’ Health Passport Project (GHPP) and was designed to address the unmet health needs and gaps in health care services for girls committed to the Massachusetts Department of Youth Services (DYS) and re-entering their communities from DYS assessment and treatment facilities. An advisory board of health, juvenile justice, philanthropy, and evaluation professionals assisted the program in its early development.

The original GHPP theory of change stated that, “Better health care access coupled with system change will yield better health for system involved girls” (Massachusetts Health Passport Project Planning Grant proposal to the Jacob and Valeria Langeloth Foundation, 2005). Four key program goals emerged from this program theory:

- Improve health care access for enrolled youth;
- Create changes in relevant systems;
- Improve social supports for enrolled youth; and
- Improve health status for enrolled youth.

Beginning in March 2007, the program expanded from serving DYS-committed girls in Boston to serving DYS-committed boys in Boston. Subsequently, the program expanded to Worcester, first to girls in November 2007 and then to boys in October 2008. Evaluation data indicate that the program served approximately 173 youth (109 girls, 64 boys), though this figure does not take into account youth who may have been served by the program informally or indirectly.

Until 2008, MHPP was intentionally staffed by nurses who could offer direct medical consultation to youth, access medical records, and educate youth and DYS staff about health issues and community health care services. In February 2008, the MHPP boys’ program in Boston was staffed by an HIV prevention counselor who had previously
worked within DYS facilities. The program has partnered with two community health centers in Boston, first Codman Square Health Center (CSHC) in Dorchester and then Sidney Borum, Jr. Health Center (SBHC) in Boston and one in Worcester, Great Brook Valley Health Center (GBVHC). The MHPP services have varied from site to site, though they have generally included the MHPP health advocates conducting health assessments, referring youth to health care providers and services in their communities, offering individual and group health education, and communicating with DYS and Community Re-entry Center (CRC) staff about clients and program operations.

Massachusetts Health Passport Project Evaluation

In November 2005, Sherman awarded a six-month planning grant to an evaluation team at Tufts University, headed by Professor Francine Jacobs of the Eliot-Pearson Department of Child Development and the Department of Urban and Environmental Policy and Planning.

The MHPP evaluation design is based on Jacobs’s Five-Tiered Approach (FTA) to evaluation.¹ The FTA is developmental in nature, organizing research activities at five levels. The first tiers are process, or operations, oriented, and the fourth and fifth tiers are focused on measuring or determining outcomes. The assumption inherent in this model is that outcome evaluation is built on the data collected at earlier stages.

The MHPP Evaluation was designed as both a process-oriented and an outcome-oriented evaluation. The research questions were as follows:

- What are the core needs and preferences for health care among system-involved girls? How do these needs and preferences compare to those articulated by system-involved boys?
- What are the processes by which the MHPP is implemented in its current sites? Who is the MHPP serving (numbers, demographics of youth served) and what are the ways in which these youth are being served by the program?
- How do changes in the program’s staffing and partnering health centers affect, if at all, the way the program is delivered and received?
- What does it mean for MHPP to be “gender-specific” or “gender-responsive”? Are there similarities and/or differences between how the MHPP is delivered to girls and how it is delivered to boys?
- What are the perceived roles that parents/guardians play in their child’s health

¹ Jacobs, 1988; Jacobs, 2003; Jacobs & Kapuscik, 2000
What are the perceived roles that parents/guardians play in the MHPP?

- What efforts, if any, has the MHPP made to involve parents?

- What are the perceived outcomes of parent involvement (or lack thereof) in the program?

- What do program staff, partners, and youth participants perceive to be the effects, if any, of the MHPP to date?

- What changes, if any, in the DYS’s approach to health care have occurred since the MHPP’s inception? What is the perceived role of the MHPP in facilitating these changes in the system?

Methodology

Sample Size

The data collected and analyzed over the course of the MHPP evaluation include interviews and focus groups with senior DYS officials, DYS health care and direct service workers, MHPP staff, community health center partners, and funders (N = 94), as well as interviews and focus groups with system-involved girls and boys (N = 41), a pilot health survey administered to a group of DYS-committed boys (N = 20) and interviews with individuals outside of DYS with expertise in providing health and/or support services to adolescents (N = 4).

It should be noted that it was difficult for the evaluation team to gain access to youth due to their frequent movement in and out of the community, the consent requirements of the Tufts Institutional Review Board, and the assistance with recruitment of youth and getting consent forms signed by youth and parents that the evaluators needed from already overextended MHPP and DYS staff.

In total, we collected data from 61 youth (22 girls and 39 boys) through interviews, focus groups, and surveys. A portion of these youth were involved in MHPP and a portion of these youth were not. In their subgroups (e.g., the six girls interviewed for the parent study), the numbers are undoubtedly too small on which to base program initiatives. However, even these small numbers of youth raise provocative issues that program developers might consider. Further, aggregated across subgroups (e.g., girls interviewed for the needs assessment, boys participating in the health pilot survey, and girls

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2 It was the initial intention of this evaluation to assess both MHPP program processes and its observed outcomes. However, due to an unexpected drop in the census of girls at the participating CRCs, and a smaller research budget than anticipated, the assessment of program outcomes is, rather, at the level of perceived effects, or those program effects as perceived and reported, but not “observed,” by key informants.
interviewed for the parent study) and about a particular topic, for example, their health concerns, or their desire for parents to be involved in their health care, their perspectives take on additional weight.

Data Sources

The data sources for the MHPP evaluation include the following:

- Key informant interviews and focus groups with adults;
- Key informant interviews and focus groups with youth;
- MHPP and DYS databases;
- MHPP health advocates’ monthly reports;
- Notes from CRC site visits;
- Meeting notes;
- Program documents (e.g., proposals for funding, logic model);
- DYS documents (e.g., annual reports); and
- Review of relevant literature.

Data Analysis

Our interview and focus group transcripts were coded using a qualitative data analysis software package, ATLAS.ti. Codes were generated directly from the data and organized thematically. We used cross-case analysis (Miles & Huberman, 1994) to examine perceptions of systems change shared across the interviews. Analysis of the MHPP database and health utilization surveys involved using a quantitative data analysis program, SPSS, in which a variety of statistical analyses were employed (e.g., descriptives, chi squares, correlations).

Major Findings

The evaluation produced scores of findings with relevance to MHPP operations and the attainment of its goals. The findings noted here are considered the most consequential for policymakers and program designers.

- **MHPP is an example of a promising private/public partnership in health care.** Collaborations of this sort generally are difficult to establish and maintain; Sherman’s considerable skills in this area, combined with DYS’s and the partnering health centers’ willingness to join the effort, represent a core strength of this program. This is an essential element of any attempt to innovate in health care services for youth in the juvenile justice system.

- **MHPP appears to have influenced DYS’s approach to providing for the health needs of youth under its supervision, as well as the partnering health centers’ level of attention to, and**
interest in addressing, those needs. The MHPP’s focus on the health of system-involved youth, and the imperative to have good quality health care available when they return to their neighborhoods and communities, was reported by many to have affected the institutional behaviors of both systems. In this sense, MHPP appears to have made significant progress toward achieving its desired outcome of system change. On the other hand, MHPP, in its current form, has not been fully adopted by either system, and is unlikely to be in the near future.

- The principles that undergird MHPP have found broad resonance among the evaluation’s informants, and across the relevant theoretical, empirical, and practice-oriented literatures. These principles pertain both to the desired outcomes for health-related interventions for system-involved youth, and to the approaches to be used to achieve them. They include, for example, the goal of improved health access, and ultimately health status, of system-involved youth; the promotion of gender-responsive programming; the investment in developing and sustaining professional collaborations; and the belief that building supportive and nurturing relationships with youth is the cornerstone to achieving these goals.

- While the full MHPP model may not be sustainable or replicable, there are specific elements of the model which seem eminently exportable. The MHPP model in its current form, with its emphasis on independent health professionals managing youth’s health care at community reentry centers, appears not to be sustainable within this state’s juvenile justice system. In addition, other contextual factors such as the reliance on private funding, a relatively health resource-rich state that provides health insurance coverage to all youth committed to DYS, and a relatively progressive juvenile justice system make the model less exportable to other states without such an infrastructure in place. However, certain programmatic components—for example, connecting youth to a community health provider, providing youth with health education, and building relationships between community agencies in the interest of serving youth’s health needs—are likely generalizable to other contexts.

- The MHPP goals were overly ambitious for a program of its scale, supported by “soft” funding, and dependent on the active support and participation of the agencies and individuals involved. However energetic the program’s director and staff, there are limits on the ability of a modest program such as MHPP to have the effects—on health access, health practices, health status, social supports, etc.—it intended. At a minimum, this is an issue of “dosage”—too little intervention to comprehensively address the health care needs of system-involved youth. Further, factors on the individual, family, community, and system levels (e.g., the transience and fluctuating census of committed youth, lack of long-term investment in the program from the partnering systems) likely moderated the program’s ability to achieve its goals.
It is difficult to estimate the reach or “penetration” of MHPP into the population of DYS-involved youth needing its attention. The program database includes ~116 youth, across the sites, over the five years of MHPP’s operations; a percentage of these youth were seen more than once, some on numerous occasions. In addition, MHPP health advocates interacted informally with other youth who are not represented in the database. The MHPP staff work limited hours, and spent a percentage of their time providing indirect or collateral services for their clients—consulting to DYS and CRC personnel on specific health problems, working through health insurance matters, etc. Since the program did not set target figures for the number of clients to serve, and indeed, the census at CRCs fluctuates sufficiently to make that hard to do anyway, we cannot judge the effectiveness of MHPP’s outreach efforts. There was, however, a large drop-off in Boston girls served which warrants further investigation.

While MHPP did not develop a formal health “passport” document, it did demonstrate—with individual youth—the possibility of providing continuous care and executing appropriate transfer of medical records. The process of developing and implementing a specific passport was more complicated than initially expected, due in large part to issues of confidentiality and practicality. However, examples from this study suggest that the program’s aim to provide continuous care to youth was attainable. Our evaluation documented cases of prerelease health planning for youth, communications, follow-up, and transfer of medical records among facility and community providers facilitated by MHPP health advocates. In at least one case, MHPP staff successfully advocated for a participating youth recently reconfined to a DYS facility, to receive uninterrupted care from a community health provider.

The program’s visibility faded over the period of the evaluation. During the early phase of this evaluation, the program enjoyed relatively high visibility, related to some degree, to the several advisory committee meetings that occurred during that time and to the first health advocate’s regular communications with DYS staff in facilities and in the CRCs. As the program proceeded, this initial level of communication among program partners was not sustained, which might account, in part, for the decrease in visibility. For example, during our final set of interviews, several informants indicated that numbers of youth, parents, and DYS staff were unaware of the program, or had heard of it, but were unsure of the services offered. This appears different than what was the case earlier on.

Many system-involved youth who participated in MHPP reported having primary health care providers. Nonetheless, health advocates reported that many were also responsive to, and appeared to need, MHPP services. Adult informants during the needs assessment phase of this evaluation frequently reported that system-involved girls often did not have primary health care providers; these concerns were expressed about boys as well.
While this is likely true for a proportion of this population, both girls and boys, our findings suggest that youth may well be more connected to care than some expect. What remains unclear, however, is the extent to which these system-involved youth have a true health care “home” (as opposed to a primary care physician)—an entity that, similar to the MHPP model, coordinates care (including mental health services), follows up on referrals, advocates for the clients in dealings with other institutions, etc. This might be a better indicator of health care coverage for this population, and we suspect that such a gap still exists for numbers of these youth.

- Many of the health concerns expressed by youth, and by others on their behalf, are shared by girls and boys. Issues that affected both girls and boys included those related to sexual health; hygiene, nutrition and exercise; and mental health; however, these issues appear to affect girls and boys in different ways. Thus, a gender-responsive orientation to discerning effective ways of addressing these topics with system-involved youth remains a useful approach to programming.

- It appears that youth’s parents are more involved in their health care than was initially assumed. The MHPP model does not include parents or other family members in a central way. The origins of this decision are not clear, but they likely reflect the desire to protect youths’ confidentiality in these matters, and also perhaps the assumption that the relationships between youth and their parents are often strained, that parents would not choose to be involved or would be unable to maintain involvement, and that the youth would just as soon negotiate these issues themselves. In our view, this choice should remain the youth’s to make, however, MHPP might profitably research this issue, with the possibility of including parents and families in some planful way.

- Both the nurse health advocates, and the HIV prevention counselor (non-nurse) health advocate, offered thoughtful, generally well-received, programming. This might suggest that the specific credentials of the health advocates are less important than their ability to build relationships with youth and staff and to implement services that are based on sound judgments about what their potential clients want and need, and that fit their own expertise. This evaluation, however, could not ascertain whether, by whatever approach, the goals of the program were met, so the necessity of using medical personnel remains an open question.

- In general, MHPP’s constituencies appreciated its intentions and the efforts of its director and staff. Across the evaluation, key informants we interviewed reported positive impacts of MHPP on specific individuals involved in the program and conveyed a sense that the program has strong potential over the long-term. Some of the promising elements they noted were in the areas of increased connections to health care, continuity of health care, and increased awareness of preventive care.
Although the evaluation did not analyze data to establish “observed effects,” individual examples of the desired results were repeatedly brought to our attention—a promising if not conclusive, finding. The following adapted case, based on interview data from the current Boston-based health advocate, serves as one such example:

…Two nights ago there was a young man who is involved in the program who was shot in his neck…he’s still in the hospital and undergoing surgery…his caseworker contacted me because when he got to the hospital his heart rate was very low, so the nurses were asking if there were any medical records or if there were issues with his heart rate before, blood pressure or anything like that…so she contacted me and I called Dr. Vettes immediately the next morning…and then contacted “Laura” the nurse over at DYS who had dealt with him for a couple years. Information was exchanged between “Laura” and Dr. Vettes, which went over to the hospital. They were able to give the history because he had just had his physical with Dr. Vettes and had special blood work done because of his high blood pressure…Dr. Vettes is going to the hospital to see how he is doing and kind of check in with him because they had started to create a relationship…when he gets released from the hospital, Dr. Vettes can continue with his after care and follow up with him on everything….

Recommendations

The purpose of this set of recommendations is two-fold, first to guide MHPP staff and collaborators in their thinking about how to export core elements of the program to other settings, and second to highlight areas for further research pertinent to the development and potential adaptation of a program such as MHPP.

Program-specific Recommendations

There are several MHPP program elements that emerge from this study that appear critical for any program such as MHPP, serving the health needs of system-involved youth. These include establishing inter-agency collaboration, building relationships at all levels, facilitating continuous care through transfer of medical information and records, and connecting youth to community health providers committed to them. The following recommendations speak to these program elements:

- **Concentrate efforts on developing and maintaining strong interagency relationships.** System-involved youth appear to be best served when multiple agencies collaborate to meet their needs. These interagency relationships often develop from relationships on the individual level, e.g., between program staff and youth, between their caseworkers and their health care providers, between youth and their health care providers, and so forth. In order to maintain the active engagement of partnering organizations, regular opportunities for developing these individual relationships as well as for collaborators to meet and exchange ideas is critical.
• Hire program staff with experience, expertise, and/or a vested interest in building relationships with system-involved youth and staff; provide training and supervision for that dimension of the job. Developing strong relationships with youth and those who work with them inside and outside the system is essential to serving them well. Given their often complex relationships to authority figures and other adults in their lives, system-involved youth require time and a variety of methods to build trusting relationships with those attempting to assist them. In addition, caseworkers and other juvenile justice and community health care staff need opportunities to develop strong working relationships with those outside the system.

• Use these strong relationships to facilitate transfer of medical information and records. Given that system-involved youth often confront serious medical conditions and that they experience many interruptions to their health care due to their system involvement, and at times, transient lives, the facilitation of medical information and records is critical.

• Connect youth to community health providers, or preferably, to a health care “home,” invested in building long-term relationships with youth. System-involved youth, like all youth, need continuous, consistent, integrated health care services. This type of care is found in the health care “home” model, in which individuals are connected to a variety of health care services, receive follow up on referrals, and have the opportunity to develop long-term relationships with providers. Ideally, the connection to this care is coordinated prior to youth re-entering their communities. In communities where there are health centers that are invested in, cater to, or have interest in and knowledge of serving system-involved youth, a health care professional on staff could perform outreach to youth and serve as the interface between youth and juvenile justice staff and other community health services. This health center professional could also consult to or train juvenile justice staff in helping youth to manage their health care upon community re-entry.

• Establish a facilitative, working relationship between the “inside” providers of health care (when youth are detained) and the youth’s “outside” providers (primary care physicians, or health care homes, in the community). These outside providers should include the MHPP health advocate, or the person in that role. Quality health care for these youth requires continuity between these two providers. The obligation to develop this relationship is equally the community provider’s, who should be available to consult while the youth is detained, and to participate in pre-release planning related to health care.

• Integrate health education into pre- and post-release services for system-involved youth. Similar to most adolescents, system-involved youth are in need of assistance managing their health care. Integrating the type of health education that addresses how to get medical records, how to make a doctor’s appointment, how to know
when to seek urgent care versus routine care would greatly benefit youth. Ideally, such education would occur prior to and following youth’s community re-entry, during which youth are assisted in establishing a long-term health care plan.

Research-based Recommendations

A central premise of this evaluation is that good data are critical to good decisions about programs. For that reason we offer here recommendations for the direction that further research should take. These recommendations are organized into two broad categories: The first contains activities to help understand, validate, and/or challenge the theoretical assumptions undergirding a program such as MHPP—for example, the extent to which system-involved girls and boys differ in their preferred mode of health care. The second set relates to specific program components, and are meant to clarify aspects of MHPP’s actual operations—for example, the calculation of the “coverage” (percentage served) that MHPP achieves among eligible youth—and to determine program effects. The FTA\(^3\) considers both types of research activities as essential components of a comprehensive evaluation strategy.

Establishing the Program’s Theoretical Base

In this country, most public programs are initiated to fill the gap between the current circumstances for a particular population, on the one hand, and what is considered an acceptable circumstance for those individuals, on the other.

- **Program architects should be able to support their call for a new or modified program with evidence that such a gap or problem actually exists, and with data that detail the nature and magnitude of that problem.** These are the core elements of a needs assessment. The problem needs to be defined precisely, but at least initially, without the preferred solution tucked into that definition. For example, with reference to a program such as MHPP, one might focus, first, on the disparity in health status between system-involved youth and other youth in comparable communities, rather than on data confirming the relatively low percentage of these youth who have a primary care physician. It may end up that increasing the percentage of youth with primary care physicians is the best strategy toward improving their health status, but other possible programmatic options that may be more immediately achievable, or more reasonable given the particular community, are obscured if the needs assessment is organized around data with an implied solution.

Analysis of the problem includes presenting the data in meaningful subgroups for comparison—by gender, place of residence, age, family configuration, etc., as

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3 Jacobs, 1988; Jacobs, 2003; Jacobs & Kapuscik, 2000
well as by health concern or condition. (The data from MHPP confirm that understanding the differences and similarities of the health problems of girls and boys is particularly critical to designing promising health support programs.) It could be, for example, that youth in certain communities are more affected by particular conditions (e.g., urban neighborhoods and asthma) than others; these data are critical to establishing the dimensions of a problem. There are several public sources of these kinds of data; in addition, a survey of current system-involved youth would help define the range of health problems to be addressed.

Occasionally, at the end of this phase it is determined that the identified problem does not exist, or exists only in a limited fashion, not warranting a new intervention. This is one appropriate conclusion to a needs assessment.

- A thorough review of extant data on the implementation and outcome results of programs designed to address similar problems should be undertaken. There are many potential sources of data for this review, ranging from evaluation studies reported in academic and professional journals, and on reputable public agency websites, to detailed “best practices” reports available from professional membership and/or advocacy organizations. The weight given to the evidence should reflect the rigor of the research design employed; nonetheless, all these materials help array the options for programming in a broad manner, so that considered choices can be made.

- Programs should be designed in a way that credits the views, and preferences for service modality, expressed by all stakeholders, but in particular, by their potential consumers; the process of collecting and analyzing these data is called a demand assessment. Too often programs are initiated without input from the people to be served by them. In our view it is imperative to collect, analyze, and make use of data that describe how these individuals define their problems, and how they would like to receive help to ameliorate them. In the case of MHPP, for example, participants extolled the virtues of health care professionals (including MHPP advocates), who worked to establish relationships with them, respected their opinions (even though they did not always agree), treated them as real people. Indeed, sometimes it seemed to us that the content of any given interaction was less consequential, from the youth’s perspective, than the feeling he/she had that someone interpersonally trustworthy was available to them. If this is the case, then the training of health advocates should entail at least as much attention to this aspect of the program than to the equally necessary other, more knowledge-based training subjects. Youth’s preferences for the degree of parent involvement in these services, and the type of service (e.g., group discussion of health education topics vs. accompanying youth to medical appointments and chatting on the way) to be offered, for example, should be reflected in the program’s
Programs should be designed to reflect their particular contexts—the opportunities and constraints—that existing policies and already established institutions present to implementing a successful program. At a community level, this activity is called an environmental scan. Not only should programs be responsive to the various stakeholders’ ideas of how services should be provided, and be knowledgeable about what the research literature recommends. Their design should also be based, empirically, on knowledge of what resources to solve the identified problem already exist in that locality; and the strengths and limitations of, and possibilities in, those institutions in playing the desired service role. An excellent health center that is located in a neighborhood that youth do not feel comfortable visiting is not the best choice for a health care partner; a service model that relies on health professionals who are in great demand, and therefore are expensive to employ and difficult to keep, might likewise be a less promising choice in a particular economy than it might be at another time. Infrastructural issues—transportation, building accessibility, manpower availability—must be considered as well.

Recommendations for Research on Program Operations

This evaluation assumes a continuous demand for program-based research—in essence, evaluation—to maintain a nimble, well-functioning program, best able to achieve the desired results. The following recommendations are offered in that spirit:

- To begin, a juvenile justice system must have the technical capability to generate data about its youth, the conditions of their system involvement, their family and community relationships, and their health status and health care utilization. This participant data system must be flexible, relatively easy to use, and accessible to juvenile justice personnel both inside detention facilities and in the community. Periodic aggregated reports that include the health status of youth in individual facilities, and those reporting to individual CRCs, should be generated to allow for contemporaneous comparisons across sites, and comparisons across time within individual sites. In this way, particular needs (for example, for primary health care coverage) within particular geographical locations, or evidenced by particular subpopulations, can be identified and possibly addressed. To the extent possible, in the context of confidentiality requirements, data on individual youth might be shared with community-based health care personnel, to facilitate the re-entry of youth to their communities.

- Health centers, for their parts, should use their extant databases to better understand the health needs of youth in their caseloads. Presumably community health centers
maintain considerable patient databases. Again, within the parameters of confidentiality requirements, they could anonymize, and then analyze, aggregated data to help plan health services for all youth, including those in the juvenile justice system.

- **The environmental scan proposed for the design phase should be periodically updated to reflect changes in community resources, new opportunities or necessities for collaboration.** Since any program dedicated to improving the health status and health care access and utilization of youth depends on resources outside the juvenile justice system, continuous attention to that larger context is warranted. Systematic tracking of these resources within communities, and across states for that matter, keep programs alert, and facilitate possible partnerships, for example, in securing grant funding for innovations.

- **A schedule of periodic data collection from stakeholders in any health-focused initiative should be developed and implemented.** Program consumers have critical information to share— not at a single moment in time, but as they continue to use (or cease using) services, as programs change their offerings or their personnel, and as, in this case, they mature and their concerns or requirements change. The perspectives of other stakeholders—program staff, parents, agency personnel, community providers, for example—also likely change over time, and should be considered periodically as well. Among the topics to include in these data collection activities are the following:

  o Satisfaction with/perceived effects of particular program components (location, personnel, specific activities); probe for gender, regional, age differences (youth);
  o Satisfaction with/perceived effects of program, program components; by affiliation, professional discipline, geography, familiarity with program (other stakeholders);
  o Topics to include in health education components (youth, other stakeholders); and
  o Extent to which parents should be involved in programming (youth, parents, other stakeholders).

- **A series of in-depth studies of particular service-related issues that might affect program design in the future should be initiated.** Several of these topics surfaced during this evaluation that could not be addressed sufficiently, and exemplify the type of issue that might warrant further attention. These include the influences that parents, families, and cultural communities have on youth’s health practices and beliefs; the nature of the health advocate/youth relationship; perceptions of these youth by community health care professionals; parenting among youth in custody, to name a few.
At the appropriate time, an outcome study to measure program results— to answer the “does it work?” question, should be undertaken. Ultimately, programs should be held accountable to the standards for effects they set for themselves in their stated goals and objectives. Data collected for this purpose should be “observed” (objectively reported), in addition to “perceived” (reported as having occurred, without external confirmation), and the research design should include a comparison group so that differences in effects can be plausibly attributed to the program. This outcome study would answer the following questions:

- What dosage (how much service, of what kinds) is needed to achieve a positive result?
- Which issues of concern related to health status, access to health care, individual health practices, are the most amenable to intervention?
- In what ways do individual and community characteristics moderate the effects of programs?
- Which aspects of programs, or which program in their entirety, are more cost-effective and/or cost-beneficial?

Program-based research should be a standard component of program operations. Given the complexity of the issues being addressed here, and the “constancy of change” in our current social and economic environment, program-based research seems a virtual necessity for any intervention of this nature. While some portion of this work requires independent contractors, much of it can be done “in-house,” with relatively modest amounts of training and support, strategically scheduled.
References


