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Approval Sheet

A Monitoring And Evaluation Plan For Willow Wellness L.L.C., Willow Branch: A Project Focused On Minimizing The Barriers To Accessing Health Services For A Refugee Population

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An abstract submitted to the faculty of Rollins School of Public Health & faculty of the Physician Assistant Program at Emory University in partial fulfillment of the requirements for the degree of a Master of Public Health in the Department of Global Health and a Master of Medical Science Physician Assistant

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Abstract

A Monitoring And Evaluation Plan For Willow Wellness L.L.C., Willow Branch: A Project Focused On Minimizing The Barriers To Accessing Health Services For A Refugee Population

By Corban Sandoe

Background. Willow Branch Apartment Complex, situated in metro-Atlanta, contains high proportions of refugee residents and thus is an ideal location for a refugee specific intervention. These resettled refugees face a disproportionally high burden of disease and barriers in accessing health services. These barriers include difficulty accessing health services, language limitations, unfamiliarity with the U.S. healthcare system, minimal financial resources, and trouble in attaining health insurance. In order to reduce the health disparities with Willow Branch residents this project aims to address these barriers and increase use of existing health resources. A monitoring and evaluation plan (M&E), as an essential tool for assessing the success of a health intervention, became a crucial part of the Willow Wellness (WW) project.

Objective. To develop an M&E plan to ensure Willow Wellness L.L.C., Willow Branch project is relevant, impactful, effective, and successful for the community.

Methods. A comprehensive literature review was performed using Pubmed in order to understand refugee status in the U.S., refugee health problems, and barriers to accessing health services. The community needs assessment conducted by Emory University students was utilized in the formation of the WW project. The design process included the following sections: conceptual framework, results framework, narrative summary, Gantt timeline, and log frame. Each section was created and approved by WW staff in summer 2014.

Results. A culturally appropriate M&E plan was developed for the Willow Wellness L.L.C., Willow Branch project. The conceptual framework is a visual depiction used to acknowledge, evaluate, and analyze the underlying determinates of health. The results framework, narrative summary, and Gantt timeline organized and thoroughly describe the WW project. The log frame displays an unbiased systematic approach to measure and evaluate the project interventions.

Discussion. This M&E plan is a feasible, quantifiable, and efficient tool to measure the impact of the WW project because it is evidence based, follows a methodology recommended by well-respected organizations, and contains objective monitoring/evaluation markers. It has potential to diminish accessibility and affordability health barriers in the Willow Branch community. If successful, this same approach can be expanded to other neighboring refugee populations and eventually to national refugee communities.

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Chapter I - Introduction

Background. Resettled refugees disproportionately experience health problems when compared to their local communities (Alami et al., 2014; Amara & Aljunid, 2014; Barnett, 2004; Cote et al., 2004; Fox, Burns, Popovich, & Ilg, 2001; Geltman, Dookeran, Battaglia, & Cochran, 2010; Lifson, Thai, O'Fallon, Mills, & Hang, 2002; Miller et al., 2000; Varkey, Jerath, Bagniewski, & Lesnick, 2007; Yun et al., 2012). Consequently, refugees require numerous health services in order to cure or treat these ailments. Unfortunately, refugees also face numerous barriers in accessing health services (Burgess, 2004; Change Makers: Refugee Forum, 2011; Crosby, 2013; Devoe et al., 2007; Lawrence & Kearns, 2005; McKeary & Newbold, 2010; Morris, Popper, Rodwell, Brodine, & Brouwer, 2009; Perreira et al., 2012). These barriers included, but are not limited to, a lack of knowledge on the U.S. health system, language difficulties, cultural perspectives, low financial resources, and trouble in attaining insurance (Burgess, 2004; Change Makers: Refugee Forum, 2011; Crosby, 2013; Devoe et al., 2007; Lawrence & Kearns, 2005; McKeary & Newbold, 2010; Morris et al., 2009; Perreira et al., 2012). These obstacles inhibit refugees from getting appropriate care, which is detrimental to individual and community health (Crosby, 2013; McKeary & Newbold, 2010; Morris et al., 2009). These barriers need to be address in order for refugees to live the healthy and prosperous life they should be privileged to as U.S. inhabitants.

As the country with the largest number of resettled refugees in the world, the U.S. has a responsibility for refugee health (Crosby, 2013). In 2013 alone, more than 58,000 refugees were resettled nationally and 3,000 of them were relocated into the Atlanta metropolitan area (Department of Homeland Security, 2013; Georgia Department of Public Health, 2013a). In order to address the health needs of refugees within Clarkston, Georgia, Willow Wellness L.L.C. was created. Willow Wellness L.L.C. is a developing organization focused on increasing the health and wellbeing of low-income and low-health access populations. The mission of the Willow Wellness (WW) initiative is to increase the number of low-income and low-health access individuals who use existing health resources. They plan to reach their goal through facilitating community-specific activities that will increase the community use of primary care services. Some WW activities include providing staff to aid individuals in scheduling medical appointments, hosting events for community members to sign-up for health insurance, creating a community advisor board, and offering health education classes.

In order to determine the successfulness of their project activities, WW, is using Willow Branch Apartment Complex in Clarkston, Georgia as a pilot project. Willow Branch Apartment Complex is mostly comprised of low-income resettled refugees with limited access to healthcare services. Similarly to other refugee populations, Willow Branch residents excessively encounter barriers in accessing health services (e.g. lack of knowledge on the U.S. health system, language difficulties, cultural perspectives, low financial resources, and trouble in attaining insurance)(Aldosari, 2014; Hampton, LeePow, Lipus, Morgan, & Sclar, 2014). Willow Branch Apartment Complex is an ideal site for Willow Wellness, L.L.C. to implement the initial project due to its refugee population and closed community. Willow Wellness L.L.C. hopes once the project has been effectively and efficiently implemented in Willow Branch Apartment Complex, then the project may be expanded to other local communities with limited access to health services. However, in order to ensure the most successful dissemination of this project, the WW pilot program should include a well-designed monitoring and evaluation plan.

A monitoring and evaluation (M&E) plan is crucial in ensuring any intervention is successfully conducted with negligible harm to the target population (Boerma & de Zoysa, 2011; Centers for

Disease Control and Prevention, 1999). A M&E plan is a tool used by organizations to assess the project's goal, purpose, intended population outcomes, and project activities (Stein, 2014). The plan will give WW the necessary tools in order to assess project relevance, impact, contingencies, efficiency, and sustainability (Stein, 2014). For example, the M&E plan will allow WW to determine if their intervention has an effect on the target population, which activities have the greatest effect, and which programs were successful during the project implementation.

Aims and Objectives. This special studies project aims to document an M&E plan to ensure WW programs are relevant to the community, impactful, affective, and successful.

This M&E process will include the following objectives:

1. Creating a conceptual framework in order to understand the factors behind accessing healthcare services within the target population.
2. Using the analyzed data from the literature review and GH 542 in order to establish the project goal, purpose, intended population outcomes, and project activities based on community needs.
3. Creating a results framework, narrative summary and Gantt timeline in order to document the intervention of WW.
4. Creating a log frame to assess the WW implementation process.
5. Identifying any public health implications and limitations of the intended project

The documented M&E plan will facilitate WW in the necessary steps needed to conduct the M&E process. The M&E process will aid WW in future decision making and requesting monitoring contributions (Habicht, Victora, & Vaughan, 1999; A. D. Oxman et al., 2010). With the knowledge received from implementing the M&E plan, WW can increase the quality and quantity of services offered, which in turn will increase productivity in reaching their overarching goal. Furthermore, in order to expand WW's efforts to other local communities, M&E is necessary to assess the successfulness of the project and ensure standardization in future programs. The expansion of this health program could have substantial influences on improving the overall health for other vulnerable and low-income populations, and consequently the overall health of Georgia.

Chapter II - Review of the Literature

Literature Review Overview. The following literature review provides a summary of the current literature on refugee status within Metro-Atlanta, refugee health, and barriers refugees encounter in accessing healthcare services. Additionally the review also includes the importance of M&E plans and common methods to measure relationship dynamics, processes, and successes. Finally, the chapter ends with a preliminary data analysis of the Willow Branch Apartment Complex. This data presents population demographics, health needs, and barriers in accessing healthcare services within the target community. All information noted within the literature review aided in designing the M&E plan.

Refugee Status

Refugee Status Overview. According to the United Nations High Commissioner for Refugees (UNHCR), a refugee is defined as "someone who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country" (The United Nations High Commissioner for Refugee, 2014). In other words, refugees seek protection in countries, other then their country of origin, in order to escape persecution based on their beliefs, characteristics, or involvement in a defined group (Burt & Batalova, 2007). In 2012 alone, 45.2 million people (more than 10 million refugees) were forcibly displaced as a result of persecution, war or violence worldwide (Crosby, 2013). This is the largest number of displaced individuals since 1994 and will presumably increase as war and violence persist worldwide.

Refugees in the United States. The United States (U.S.) has the largest number of resettled refugees in the world. In 1980, the U.S. created the federal refugee resettlement program to provide resettlement and asylum opportunities for individuals in need (Crosby, 2013). Since 1980, between 40,000 and 75,000 refugees entered the U.S. each year and a grand total of three million refugees have been resettled throughout the country since it the program's implementation (Crosby, 2013). Compared to the other 10 countries that provide resettlement programs, the U.S. annually accepts more than double the number of refugees accepted by the other countries combined (Crosby, 2013). In 2013 alone, the Department of Homeland Security documented that 58,179 resettled refugees and 28,000 asylums from 80 countries were admitted into the United States (Department of Homeland Security, 2013). Even though these U.S. refugees originated from a wide variety countries, Burmese (25.9%), Bhutanese (24.3%), and Iraqis account for more than 70% of the resettled refugees (Burt & Batalova, 2007).

Georgia Refugee Population. Within the United States, Georgia is a home to one of the largest refugee populations. Following Texas, California, Florida, and New York, Georgia contains the sixth largest refugee population and houses 4.3% of all resettled refugees within the United States (Burt & Batalova, 2007). In 2012, the George Department of Health reported resettling 3,090 refugees in Georgia (Georgia Department of Public Health, 2013a; Office of Refugee Resettlement, 2013). Out of the total number of resettled refugees within Georgia in 2012, 94% were relocated to the Atlanta metropolitan area.

Metro-Atlanta Refugee Community. Metro-Atlanta is a significant refugee resettlement location and therefore a suitable setting to implement any refugee community development program. The ninth largest number of refugees in the U.S. is relocated to Metro-Atlanta yearly, with over 2,900 resettled refugees in 2012 (Georgia Department of Public Health, 2013b; Singer & Wilwon, 2007). From 2003

to 2012, approximately 24,218 refugees (94% of the total number of refugees within Georgia) were resettled in metro-Atlanta (Georgia Department of Public Health, 2013b). Georgia Department of Public Health documented 36% Bhutanese, 25% Burmese, 10% Somalis, 7% Iraqis and smaller percentages of refugees from multiple other countries (Georgia Department of Public Health, 2013b). Traditionally cities like New York and Los Angeles, held the role of major resettlement locations, however these trends are changing (Singer & Wilwon, 2007). New York and Los Angeles witnessed a decrease in arriving refugees over the last few decades while Atlanta has seen an increase in documented refugees (Singer & Wilwon, 2007). Based on this trend and evidence that refugees were overwhelmingly dispersed in metropolitan areas, it can be assumed that Atlanta will progressively become a more important location for refugee populations in the future and therefore an optimal location for a refugee specific intervention (Burt & Batalova, 2007).

Refugee Health Problems

Overview of Refugee Health Problems. Refugees are burdened with an extremely large number of physical needs. Many studies found refugees had a disproportionately high prevalence of health problems when compared to their neighboring local communities (Lawrence & Kearns, 2005). Refugee communities are uniquely susceptible to health problems due to elevated stressors from their past experiences. Some risk factors for poor health in refugees include trauma, lack of past medical care, poor living conditions, separation from family, and acculturation (Morris et al., 2009; Perreira et al., 2012). These stressors can increase a refugee's susceptibility to health conditions such as infectious disease, chronic disease, dental health, and mental health.

Infectious Disease. Refugees acquire a significant burden of infectious disease due to excessive exposures in their country of origin and migration activities (Barnett, 2004). Within the U.S., domestic health assessments documented high incidences of tuberculosis, malaria, hepatitis, and intestinal parasites in resettled refugees (Lifson et al., 2002; Miller et al., 2000; Shah et al., 2013; Varkey et al., 2007). Moreover, several studies found refugee status was significantly associated with several infectious diseases (i.e., tuberculosis, hepatitis B, malaria, malnutrition, conjunctivitis, trichinosis, anemia, leprosy and parasites) when compared to non-refugee individuals (Alami et al., 2014; Barnett, 2004). According to the U.S. Centers for Disease Control and Prevention (CDC), in 2013, foreign born individuals within the U.S. had a 13 times greater tuberculosis incidence rate when compared to native born individuals (Alami et al., 2014). Parasitic infections are also common refugee infectious diseases, but go unnoticed if not tested due to their asymptomatic features. Between 2010-2011, DeKalb County documented about one-fifth of pediatric refugees had stool parasites (Shah et al., 2013). In order to decrease the burden of infectious disease, refugees need annual primary care visits, in which they can be assessed for individual risk factors and asymptomatic diseases.

Chronic Disease. Many studies have suggested that refugees carry a significant burden of chronic diseases, when compared to other surrounding communities, especially those who are uninsured (Yun et al., 2012). According to the Center for Managing Chronic Disease, chronic disease is defined as long-lasting conditions that can be controlled but not cured (The Centers for Managing Chronic Disease, 2011). Common chronic diseases within the refugee community include hypertension, overweight/obesity, diabetes, heart disease, cancer, chronic respiratory disease, and anemia (Amara & Aljunid, 2014; Bhatta, Shakya, Assad, & Zullo, 2014; Geltman et al., 2010; Shah et al., 2013; Yun et al., 2012). One study conducted in 2012 found that 50% of adult refugees had at least one chronic non-communicable disease and approximately 10% had three or more. Refugees who had been in the U.S. for at least one year were found to have a 1.37 risk of having chronic disease, 2.49 risk of having heart disease, and 5.87 risk of stroke when compared to other immigrant individuals (Yun et al., 2012). Overweight/obesity and hypertension rates within refugee

populations are documented at 46-65% and 25% of the refugee community, respectively (Bhatta et al., 2014; Geltman et al., 2010). Unfortunately, the burden of chronic disease is rising worldwide and will continue to remain a prevalent problem within refugee communities unless something changes. Therefore, in order to address the high prevalence of chronic disease it is crucial for these populations to receive culturally appropriate counseling on risk reduction lifestyles. Encouraging annual visits to primary care providers (PCPs) might be the solution in maintenance and prevention of chronic diseases in the refugee community (Geltman et al., 2010).

Dental Health. Dental health problems are common among refugee populations usually due to a lack of available dental services in their country of origin, lack of dental coverage and lack of knowledge on the importance of preventative medicine (Cote et al., 2004; NSW Refugee Health Service, 2004). For example, DeKalb County, the largest refugee resettlement area in Georgia, found dental problems to be the most common health problems among refugee populations in 2006, 2007, and 2008 (DeKalb County Board of Health, 2009). Dental complications have remained a current problem for refugees. Between 2010-2011, DeKalb County found that nearly 50% of refugees had untreated dental cavities (Shah et al., 2013). Refugees, in general, have a higher risk of poor oral health because of torture-related injuries to the mouth, lack of availability in dental services, poor diet, lack of fluorinated water, and prolong anxiety that can result in acidic reflux, grinding, and bruxism (NSW Refugee Health Service, 2004). One study assessing the oral health status of refugee torture survivors found that 76% had untreated cavities and 90% required immediate or near-immediate dental care (Singh et al., 2008). There is an obvious need to address oral health within the refugee community and health education classes on oral hygiene, worrisome symptoms, and how to seek needed dental care would help in eliminating dental problems.

Mental Health. Mental health including depression, post-traumatic stress, and general anxiety are significant problems among refugee populations. Refugees have a high risk for developing mental health problems when compared to their neighboring populations (Mao Thao Wilder Research, 2009). Mental health issues within refugees include depression, anxiety, and personal identity problems (Fox et al., 2001; Maddern, 2004; Mollica et al., 2001; Pumariega, Roth, & Pumariega, 2005). Risk factors for mental health within the refugee population include previous trauma, stress of resettlement, poverty, education, unemployment, low self-esteem and poor physical health (Hermansson, Timpka, & Thyberg, 2003; Hsu, Davies, & Hansen, 2004; Pumariega et al., 2005; Weine et al., 2000). Refugees encounter traumatic experiences such war, natural disaster, famine, torture, violence, poverty and acculturation that alter their state of mind. Even though mental health problems are common among refugees, they are not recognized in many refugee cultures because emotion is stigmatized or viewed as a weakness (Mao Thao Wilder Research, 2009). Subsequently, mental illness is frequently untreated in refugee communities and consequently continues to adversely affect other aspects of a refugee's life. There are significant mental health problems within refugee populations that need to be treated. Health education classes to bring awareness, provide support, and discuss treatment options would help decrease this health problem.

Refugee Barriers to Accessing Healthcare Services

Barriers to Accessibility Overview. There is a full array of barriers that prevent refugees from accessing healthcare services (Burgess, 2004; Change Makers: Refugee Forum, 2011; Crosby, 2013; Devoe et al., 2007; Lawrence & Kearns, 2005; McKeary & Newbold, 2010; Morris et al., 2009; Perreira et al., 2012). Despite the availability of local healthcare programs and services, refugees encounter multiple obstacles in accessing these services in order to sufficiently meet their health needs. These obstacles result in negative healthcare experiences for the patient, delay in appropriate care, and increased disease prevalence (Crosby, 2013; McKeary & Newbold, 2010;

Morris et al., 2009). The major barriers for refugees, discussed in further detail below, include language, unfamiliarity with the U.S. healthcare system, cultural perspectives, cost for services, insurance status, and logistical difficulties. All these barriers both independently and synergistically inhibit both the quantity and quality of available health services.

Language. Language is a major barrier for most refugees in accessing healthcare because English proficiency is required at every level of the U.S. healthcare system (Burgess, 2004; Morris et al., 2009; Unite for Sight, 2013). For example, language skills are required for making appointments, filling out paperwork, communicating symptoms to doctors, understanding written health materials, listening to the treatment instructions, and communicating to pharmacist for the prescription (Burgess, 2004; Morris et al., 2009; Unite for Sight, 2013). Inability to communicate properly can result in frustration and mistrust for both providers and patients. In a qualitative study conducted by Morris *et al.,* many refugees stated they get so frustrated with trying to communicate during a health appointment that they only go to the doctor if something is seriously wrong (Morris et al., 2009). It also becomes difficult or in some cases impossible for healthcare providers to properly diagnose patients when communication is broken (Unite for Sight, 2013). The quantity and quality of healthcare services is influenced by the ability to communicate properly. Language has not only been an obstacle for accessing healthcare, but poor language skills have also been associated with low quality health services and negative health outcomes (Crosby, 2013; McKeary & Newbold, 2010; Unite for Sight, 2013). Language barriers can be minimized with using interpreters at medical appointments, translated medical documents, or providing staff to aid refugees in filling out English forms.

In order to overcome health barriers due to linguistic competencies, interpreters and translators have been found to be helpful (Lawrence & Kearns, 2005; Unite for Sight, 2013). Many refugees rely on friends and family members, even sometime children, as interpreters. Despite the convenience and comfort of having friends and family translate, using untrained interpreters can pose risk for both patients and translators (Perreira et al., 2012). Friends and family may be reluctant to discuss sensitive topics due to cultural norms therefore limiting diagnosis and treatment options (Crosby, 2013). Allowing children to translate allocates unnecessary stress and inappropriate power to the child that can later lead to an unhealthy relationship with their parents (Unite for Sight, 2013). Children should not act as translators in any healthcare environment due to their inability to understand and translate medical information secondary to their limited vocabulary and emotional immaturity. Therefore, to maximize the clinical experience between a patient and provider, certified professional interpreters should be present during all visits (Change Makers: Refugee Forum, 2011; Crosby, 2013).

Unfamiliarity of the U.S. Healthcare System. Many refugees have difficulty understanding and utilizing the U.S. healthcare system due to its excessive complexity. Refugees from countries lacking a defined medical system have minimal experiences with western medicine (Burgess, 2004). They are unfamiliar with the U.S. medical system including the process of referral, waiting lists, and the recommendation to use PCPs as their primary source of healthcare (Lawrence & Kearns, 2005). Due to this unawareness, their expectations of the U.S. healthcare systems can be unrealistic and inaccurate (Burgess, 2004). The U.S. healthcare system is extremely complicated with many possible healthcare models depending on the patient's eligibility. The three main healthcare models used by refugees within the U.S. are the Beveridge Model, used by Medicaid participants, the Bismarck Model, used by private insurance participants, and the Out-of-pocket Model, used by those who are uninsured (Reid, 2009). Each model has unique attributes, requirements, and roles, which makes it even more complicated for refugee families with a preexisting unfamiliarity of the system and mixed insurance statuses. The families' lack of

knowledge on the insurance application process, eligibility systems, healthcare hierarchy systems, and available healthcare resources inhibits them using available health system resources.

As a result of this unfamiliarity of the U.S. healthcare system, refugees utilize some services inappropriately and do not use other necessary resources. For example many studies have suggested that refugees, similar to many other low-income populations, depend on emergency rooms as their primary source of healthcare, even for non-urgent conditions (Burgess, 2004; DeShaw, 2006; Hargreaves et al., 2006; Mahmoud & Hou, 2012). Studies also discovered utilizing the emergency room for non-urgent conditions led to patient dissatisfaction, delay in treatment, and elevated health expenses (Hampers, Cha, Gutglass, Binns, & Krug, 1999; Norredam, Mygind, Nielsen, Bagger, & Krasnik, 2007; Rodi, Grau, & Orsini, 2006). On the other hand, some refugees refuse assistance in health services. Refugees felt ashamed to accept available public benefits because it conflicted with their cultural values on familial support and self-reliance (Perreira et al., 2012). Therefore, in order to combat unfamiliarity within refugee communities patient education (on U.S. medical care, health benefits, and eligibility) and as well as physically engaging medical services would be helpful (Burgess, 2004).

Cultural Perspectives. Cultural perspectives influence refugees' ability to access healthcare services. Cultural perspectives, defined as the inherent beliefs, traditional values, social norms, and personal principles, influence a patient's healthcare decisions. Some refugees, due to their cultural upbringing, are accustomed to using traditional medicine to treat physical ailments and therefore seek similar services when inhabiting the U.S. (Morris et al., 2009). This lack of knowledge on western medicine can lead to skepticism and distrust of American doctors' recommendations. Refugees often have been taught alternative causes for disease and physical illnesses that do not align with the western provider's views (Burgess, 2004). Therefore, when providers do not culturally respect one's beliefs and norms, refugees can be discouraged to visit a western doctor for any physical needs. Therefore, it is crucial for refugee advocates to inform primary care physicians on cultural competence in order to better fulfill the health needs of their patients (Change Makers: Refugee Forum, 2011). Health education classes and community discussions would also be helpful in not only educating refugees on western medicine but also allowing culturally similar people to discuss how their values, social norms, and inherent beliefs affect their healthcare decisions.

Lack of Insurance. A lack of insurance is a significant barrier in accessing health services specifically for refugee communities. A national survey found that approximately 50% of refugees were uninsured (Yun et al., 2012). Moreover, insurance status was observed to be the primary concern for acquiring healthcare in low-income families followed by access and costs (Devoe et al., 2007). Refugees, similar to many other low-income populations, have a high risk of being uninsured due to a multitude of obstacles. Language proficiency, lack of available employee insurance plans, complexity of the application process, eligibility requirements, and verification documents can all inhibit refugees from acquiring coverage (Morris et al., 2009; Perreira et al., 2012). Fortunately, the new Medicaid coverage guidelines allowed more refugees to be eligible for government insurance plans. However, refugees can still benefit from individual direction during the application process.

Cost of Health Services. Cost is a significant determinant for accessing healthcare services, especially for low-income or uninsured populations (Change Makers: Refugee Forum, 2011). For example, even refugees who are able to obtain health insurance still face difficulties with paying additional medical costs such as copayments, prescription drugs, and health insurance premiums (Devoe et al., 2007). Cost becomes a more pertinent problem for refugees with multiple or complex health problems that require extensive medical interventions (Lawrence & Kearns, 2005). As previously

mentioned, the prevalence of health problems is high among refugee communities and consequently healthcare costs can be astronomical.

Therefore, the cost of healthcare services must be addressed in order to eliminate its role in preventing refugees from accessing healthcare services. Some health expenses are minimized for refugees through insurance plans. Encouraging all eligible refugees to apply and continually renew their Medicaid insurance could ease the burden of health costs. However, this will not minimize the health expenses for all refugees. Therefore, it is important for providers to work in conjunction with refugees in cost saving measures without compromising their quality of healthcare. With an extreme affordability need in refugee communities, trained personnel to individually help refugees in creating a plan for medical expenses could address this obstacle and improve accessibility of healthcare services.

Logistical Difficulties. Many refugees face logistical difficulties in acquiring healthcare, including a lack of transportation and childcare, long wait times, difficulty scheduling appointments, and non-flexible work schedules (Change Makers: Refugee Forum, 2011; McKeary & Newbold, 2010; Unite for Sight, 2013). Transportation is one of the main logistical challenges for refugees (Morris et al., 2009; Unite for Sight, 2013). Without access to a car, making and keeping appointments can be difficult for refugees. Unreliable public transportation can inhibit accessing healthcare services. For example, most doctor appointments are canceled if the patient is more than 15 minutes late. Patient tardiness is a concern for medical services treating refugees due to their use of unreliable public transportation, inability to set appointment times, and low prioritization of being on time. Medicaid does provide transportation services for eligible beneficiaries, however this service usually requires a three-day notice, which is not always feasible, especially for sick appointments (Georgia Department of Community Health). Obviously, there is a significant barrier due to logistical difficulties and refugees would benefit from adequate transportation, medical facilities that provide grace for patients with unreliable transportation, and refugee education on the importance of punctuality within the U.S. healthcare system.

Monitoring and Evaluation (M&E) in Public Health Interventions

M&E Overview. Monitoring and evaluation (M&E) plans are essential in many public health interventions for both learning and accountability (Boerma & de Zoysa, 2011; Centers for Disease Control and Prevention, 1999). An M&E plan is a tool used by any organization to assess the project's goal, purpose, intended population outcomes, and project activities (Stein, 2014). The purpose of M&E is to assess relevance (appropriateness), impact (effects on health indicators), contingencies (identification of health barriers), efficiency (timeliness, cost-effectiveness), and sustainability (long-term goals) through an unbiased, systematic approach (Stein, 2014). The process, according to the CDC Framework, involves engaging stakeholders, describing the program, focusing the M&E design, collecting credible data, justifying the conclusions and ensuring the lessons learned are shared and used (Centers for Disease Control and Prevention, 1999).

M&E are complimentary processes, with individual roles and characteristics within a public health intervention. Monitoring is an ongoing process of collecting and analyzing data to compare how well a program/project is being implemented against expected benchmarkers (Stein, 2014). Evaluation is an assessment of a planned, ongoing, or completed activity that covers the program's need, design, implementation, impact, efficiency, and sustainability (Stein, 2014). Depending on the objective of the evaluation, three different types of evaluation processes could be used including adequacy, plausibility, and probability.

Adequacy Evaluation. Adequacy assessment is the simplest type of evaluation as it measures program activities and observed general trends over time but does not appropriately link indicators to program activities (Habicht et al., 1999). For example, adequacy assessments are conducted to evaluate how well community health workers have been trained, how many teenagers used the intervention, or what coverage rate has been achieved in the target population. Adequacy assessments are usually cheaper and do not require control groups. Unfortunately, they are unable to plausibly link program activities to observed changes. Instead, adequacy evaluations only provide necessary reassurance that the goals and objectives are being met (Habicht et al., 1999).

Plausibility Evaluation. A plausibility evaluation is a better approach than adequacy evaluation because the results are supported with further reliable evidence (Habicht et al., 1999). For example, in a plausibility evaluation, there is plausible assurance that the observed behavioral changes are outcomes of the intervention (Habicht et al., 1999). Plausibility evaluations measure the longitudinal change before and after the intervention by controlling for external factors. It requires a control group as a reference for change related to the intervention (Habicht et al., 1999). Plausibility evaluation cannot rule out all alternative explanations for the observed differences, as is the case with a probability assessment.

Probability Evaluation. Probability evaluation aims to ensure minimal probability that the difference between the intervention group and the control group was due to confounding factors, bias, or chance (Habicht et al., 1999). Since it requires randomization of the treatment and control activities, the probability process is the most reliable assessment. However, probability assessments are often not conducted due to feasibility (monitory expenses) and ethical reasons (having a control group). Never the less, probability evaluations are the gold standard of academic efficacy research for all public health interventions (Habicht et al., 1999).

M&E Benefits. M&E has numerous benefits for public health interventions including, but not limited to, determining the effects of the interventions, making evidence based decisions, and requesting monetary contributions (Stein, 2014). By reporting accurate, timely, and comparable data, M&E uses a systematic and transparent process to assess the program. The information attained through the M&E process is beneficial for determining the affects an intervention had on its target population, which program activities had the greatest impact, and which projects were successful during the project implementation. Good intentions and plausible theories are inadequate for making decisions (A. D. Oxman et al., 2010). Instead, evidence based data (collected through the M&E process) is necessary to make informed, life-changing decisions on public health interventions (A. D. Oxman et al., 2010). Furthermore, M&E allows organizations requesting donor support to verify why monetary contributions should be distributed within their project activities (Habicht et al., 1999). In summary, M&E plans should be included in all legitimate public health interventions because of its numerous benefits.

M&E Limitations. Even through M&E is helpful in improving and accounting for program activities, there are limitations to the process. Primarily, M&E plans are most effective if created during the project design stage. Health programs are increasingly spending money to conduct retrospective evaluations on current programming. However, prospective evaluations specifically in large-scale programs are minimal (Boerma & de Zoysa, 2011). Without baseline data, as is the case in retrospective evaluation, there is no foundation to determine the effect of the intervention. Evaluations, even if performed prospectively, have limitations. For example, evaluations are limited to identifying trends instead of making associations (Habicht et al., 1999). This can be detrimental if stakeholders do not fully understand the limitations but instead use the data as concrete evidence for association. Similarly, if there is no control data, the stakeholders could extrapolate inaccurate

conclusions on the intervention because there is no comparison. Therefore, it is crucial that M&E plans are thoroughly and thoughtfully designed, with any limitations noted, in order to decrease inaccurate conclusions.

M&E and Refugees. M&E are even more necessary for interventions dealing with vulnerable and multi-cultural populations because the program's impact can vary drastically depending on the participants. An intervention might aim for a specific positive outcome, however due to unforeseen cultural assumptions, the result might be negative. This is even more of a concern since interventions are usually designed and implemented by individuals outside the targeted population. Consequently, these designers and implementers have partial knowledge on the cultural beliefs and assumptions of the target population. Public health interventions working with refugees must conduct M&E plans in order to measure the intervention's influence on the community.

Preliminary Analysis – Community Needs Assessment

Preliminary Analysis Overview. Between February and May 2014, preliminary data on Willow Branch residents was collected, analyzed and presented by Emory University's Rollins School of Public Health students to Willow Wellness (WW). The mix-method needs assessment included key informant interviews, focus groups, quantitative surveys, and qualitative in-depth interviews. There was a need for community-specific data in order to competently develop the strategic plan of WW at Willow Branch Apartment Complex. The purpose of the needs assessment was to characterize resident demographics, identify barriers to accessing healthcare services, and detect the perceived health needs among Willow Branch residents in Clarkston, Georgia. The intended outcome of the preliminary data was used to guide WW in defining priorities and creating strategies to improve the health of Willow Branch residents by minimizing barriers to accessing healthcare services. The analysis and recommendations from Emory University students significantly influenced the creation of the following M&E plan (Aldosari, 2014; Hampton et al., 2014).

Data Collection and Analysis. Data was collected using a mix-method approach by students from GH542 (Evidence-Based Strategic Planning) global health class and BSHE524 (Community Needs Assessment) behavior sciences and health education class at Rollins School of Public Health. A total of seven key informant interviews, two residential focus groups, 89 surveys, and 10 in-depth interviews were conducted. The key informant interviews were conducted amongst informants from Transitional Care Management, the Willow Branch apartment complex, and the Clarkston Development Foundation. Themes were extracted from the key informant interviews and used to create the focus group guide. One focus group was facilitated with Spanish speaking residents (6 women) and one with Nepali speaking residents (5 women and 1 man). Both the key informant interviews and focus groups thoroughly discussed barriers to accessing healthcare services, perceived health needs, and potential solutions to the community needs. Inductive and deductive coding was performed to extrapolate significant themes for each focus group (Aldosari, 2014; Hampton et al., 2014).

Concurrently to the informant interviews and focus groups, students were conducting quantitative surveys and in-depth interviews. The 27-question quantitative survey was created, edited, validated by WW, and pilot tested before its implementation in February 2014. The survey instrument encompassed information on population demographics, residential healthcare needs, health insurance status, health service utilization, and barriers to accessing healthcare services. All survey data was compiled and cleaned with EpiInfo 3.5.3 software and analyzed using SAS 9.3. In-depth interviews were also conducted in February 2014 with Willow Branch residents through convenient sampling. Key themes were identified after the hour-long interview was transcribed

(Aldosari, 2014; Hampton et al., 2014).

Results Overview. A wide variety of results were extrapolated from the preliminary data. Only pertinent results in developing WW's goal, purpose, outcomes, and activities as well as the M&E plan have been included within this paper. The major findings from the research data can all be characterized into three different dimensions: resident demographics, health needs, and health access barriers. The results from each category are described in detail below.

Population Demographics. Willow Branch residents encompass a multicultural, highly uninsured, low English proficiency community. With a predominant refugee-population, the Willow Branch community comes from 11 different countries and speaks more than 25 languages. A large majority (75%) of the residents were from Southeast Asia; including Burma, Bhutan, Nepal and Thailand. With a large number of cultures, it can be assumed that there are numerous health beliefs, values, and varying knowledge on the U.S. healthcare system. Residents could benefit from a unified and detailed explanation of western medicine and the U.S. healthcare system. Moreover, collaboration with local providers and payers on cultural differences and refugee specific health barriers could help the overall health of the community (Aldosari, 2014; Hampton et al., 2014).

Willow Branch residents have a high incidence of uninsured rates. More than 90% of residents have lived within the U.S. for more than one year. However, even with time to acculturate, residents still seek employment and consequently health insurance. Less than half of the resident participants were employed (43%) and 17% were actively seeking employment. Approximately 52% of the interviewed residents declared they were uninsured. Of the insured individuals, 43% had insurance through an employer and 42% had Medicaid insurance (Aldosari, 2014; Hampton et al., 2014). This data suggests there is an obvious lack of health insurance within the Willow branch community that needs to be addressed.

Despite most community inhabitants living within the U.S. for more than one year, English proficiency is minimal. Only 37% of residents speak English at an adequate level. Additionally, merely 3% listed English as their primary language and 11% were fluent in their English skills (Aldosari, 2014; Hampton et al., 2014). Therefore, it is necessary that the WW project adapt their interventions to achieve success despite low English proficiency.

Residents verbalized a desire to live within a healthy environment but recognized that Willow Branch Apartment complex is currently an unhealthy community. Residents defined a healthy environment as the following: to encompass a community that works together and trusts one another, maintains adequate communication, possesses appropriate hygiene and sanitation standards, experiences satisfactory medical care, and encourages consistent physical activity. The focus groups identified Willow Branch Apartment Complex as an un-healthy community with a significant need for change. Fortunately, there is passion and empowerment among the community members for transformation. Healthcare was recognized as a high priority and many seemed willing to personally participate in a wellness intervention (Aldosari, 2014; Hampton et al., 2014).

Community Health Needs. Major community health needs identified at Willow Branch Apartment Complex included chronic conditions, preventative medicine, and emergency health problems. The term "healthcare needs" was defined "as the residents' perceived health concerns (either disease or services), the prevalence of health problems within the community, and the current usage of health services (Aldosari, 2014)." Participants were asked a variety of questions related to their health needs including their current health conditions, common community health problems,

primary reasons they seek healthcare, what services they have ever used, and their most important health concern. Three common themes emerged as the most significant health needs within the community. These themes were chronic disease, preventative medicine and emergency health problems, all of which could be addressed through regular primary care visits (Aldosari, 2014; Hampton et al., 2014). There is a great demand for primary care visits in which chronic disease would be managed, health education for preventative diseases would be addressed, and health problems could be averted before emergency conditions arise.

Health Access Barriers. Numerous barriers to accessing healthcare services were noted in every study method. The leading obstacles included limited health insurance coverage, financial constraints, inability to speak English, lack of transportation and unfamiliarity with the U.S. healthcare system. Lack of insurance was found to be the primary barrier to accessing healthcare services. Within the surveys, approximately 25% of the participants stated that not having insurance prevented them from accessing healthcare services. Residents stated securing health insurance was particularly difficult due to the cost. If a resident tried to get a job to increase their income, Medicaid was usually lost and consequently health insurance was unaffordable (Aldosari, 2014; Hampton et al., 2014). It is crucial that this gap in accessing healthcare services due to high-uninsured rates is addressed in WW's project.

The second major hindrance for residents in accessing healthcare services was cost. Approximately 14% of survey participants stated that cost was the main reason they did not go to the doctor. The data showed costs to include both direct and indirect expenses of health services. Residents classified costs to accessing healthcare services as co-payments, prescriptions, treatments, transportation, and childcare. Therefore, financial constraints were found to be a significant obstacle for not only obtaining health insurance but also for accessing health services (Aldosari, 2014; Hampton et al., 2014). An intervention focusing on either limiting health costs via obtaining health insurance or creating financial plans would be beneficial in dealing with cost related problems.

The inability for residents to speak English competently influenced all aspects of retrieving and receiving health services. More than 63% of Willow Branch residents have insufficient English skills to adequately communicate within the U.S. healthcare system. The study found that English-proficient individuals used health services more frequently when compared to residents with limited English skills. Moreover, those with limited English skills stated they experienced negative healthcare interactions due to communication. Residents stated a lack of adequate communication made it impossible to effectively interact with the medical personnel. They often felt misunderstood and vulnerable even with the help of an interpreter. They stated that individual support in English related activities (filling out forms, setting up appointments, requesting trained interpreters) could positively influence their experiences with health services in the future (Aldosari, 2014; Hampton et al., 2014).

Another burden to accessing healthcare services for Willow Branch residents is a lack of transportation. Many residents felt that scheduling appointments was difficult due to unreliable transportation. Residents preferred easier and more direct access to the provider, however many were required to utilize public transportation. According to the focus groups, residents with support from family members, friends, and neighbors, had less difficulty seeking healthcare services. Willow branch residents were interested in help obtaining transportation services and/or knowledge on PCP within walking distance, which consequently could help diminish this burden.

The final main hindrance in accessing healthcare services for the local community was unfamiliarity with the U.S. healthcare system. Residents stated that they would benefit from more knowledge on the U.S. healthcare system. Focus groups and in-depth-interviews showed that residents lacked knowledge on accessing Medicaid services, available services, and networking with providers (Aldosari, 2014; Hampton et al., 2014). The health of community could greatly profit from a unified and detailed explanation of western medicine and the U.S. healthcare system.

Recommendations. The GH542 (Evidence-Based Strategic Planning) global health class and BSHE524 (Community Needs Assessment) behavior sciences and health education class at Rollins School of Public Health recommended a wide variety of strategies to address the needs of Willow Branch residents. The ultimate recommendations for the two classes are the following (Aldosari, 2014; Hampton et al., 2014):

1. WW collaborates with local partners within Willow Branch, the Clarkston community and the Atlanta metro area.
    a. WW needs to create an advisory board.
2. WW defines the program goals and program strategies based on the conducted community needs assessment.
3. WW creates a formal and extensive database of resident demographics.
4. WW provides residents with an onsite case manager to assist residents with accessing healthcare by acting as a liaison to healthcare facilities.
5. WW provides monthly health education classes for residents to support a healthy diet and lifestyle as well as disease prevention.
6. WW distributes a Health Resource Guide (HRG) to Willow Branch residents.

Summary

The content of the literature review aided in the designing of the following M&E plan. In summary, the literature review focused on refugee health status and barriers to accessing healthcare, M&E dynamics in public health interventions, and a preliminary analysis of the target population. Many studies have concluded that refugees have unique experiences and perspectives that make them susceptible to health problems. Yet, due to the excessive number of health barriers they are inhibited from accessing adequate health facilities when necessary. There is a significant need to alleviate both health problems and health barriers in refugee communities through public health interventions.

The following highlights were deducted from the literature review and preliminary analysis to develop the M&E plan:

1. Metro-Atlanta is an ideal location for a refugee specific intervention due to the large refugee population and the potential for an influx of refugee inhabitants in the future.
2. Refugees have a disproportionally high burden of disease when compared to neighboring communities. There is an enormous need to address infectious disease, chronic disease, mental health, and dental health within these communities.
3. There are a wide variety of barriers that prevent refugees from accessing healthcare services and consequently influence their overall health. There is need to tackle the most significant barriers including language, unfamiliarity with the U.S. healthcare system, cultural perspectives, lack of insurance, cost of health services, and logistics.
4. An M&E plan is an essential tool for assessing the success of a refugee specific public health intervention due to the multi-cultural population and subsequently variable possible result outcomes.

5. The preliminary data determined it is necessary to intervene on the following community characteristics in order to benefit the overall health of the community:
    a. Residents encompass a multicultural, highly uninsured, and low English proficiency community who desire a healthy living environment.
    b. Major community health needs are chronic disease, preventative medicine, and emergency health problems.
    c. Present health barriers include limited health insurance coverage, financial constraints, inability to speak English, lack of transportation, and a lack of knowledge on the U.S. healthcare system.
6. Recommendations from Emory University students focused on collaborating with local partners, defining Willow Wellness L.L.C., Willow Branch project, creating a database, providing liaisons between residents and healthcare facilities, offering health education classes, and distributing a HRG.

In order to reduce the health disparities within Willow Branch residents, Willow Wellness L.L.C., Willow Branch will design a refugee specific intervention addressing their unique individual, cultural, and structural challenges. Consequently, since monitoring and evaluation is a crucial part of determining whether health interventions are effectively and efficiently achieving their goal, the following M&E plan is proposed for Willow Wellness L.L.C., Willow Branch. The literature review findings, the preliminary data analysis, and recommendations from Emory University students significantly influenced the creation of the M&E plan and will continue to remain the foundation for any WW planning in the future.

Chapter III - Methods

Overview of M&E Plan. A monitoring and evaluation plan (M&E) was created in order to ensure that the Willow Wellness (WW) project is a high quality community program with evidence of the effectiveness of their activities for funders. This M&E plan was designed specifically for Willow Wellness L.L.C., Willow Branch. The objectives of the M&E plan included creating a conceptual framework in order to understand the factors behind accessing healthcare services within the target population; using the analyzed data from the literature review and GH 542 in order to establish the project goal, purpose, intended population outcomes, and project activities based on community needs; creating a results framework, narrative summary and Gantt timeline in order to document the intervention of WW; creating a log frame to assess the WW implementation process; and identifying any public health implications and limitations of the intended project.

Design Process. The M&E plan includes the following components:

- A conceptual framework
- A results framework
- A narrative summary
- A Gantt timeline
- A log frame

The design stage of the M&E plan was conducted during the summer of 2014. Each section of the M&E was first created and then presented to WW staff for feedback and modification. Collaboration on the M&E plan occurred in meetings with the investigator and WW staff from May 2014 to July 2014. Each meeting lasted between 1.5-3 hours and focused on creating, editing, or finalizing sections of the M&E plan. For a full list of meeting members, time length, and meeting outcomes, view Table 1.

Dates	Meeting Outcome	Length of Meeting	WW Members Present
5/14/14	Introduction; Explanation of the M&E process and purpose; Analyzed the preliminary data collected by the graduate students at Emory University's Rollins School of Public Health; Discussion on the strategic objective of Willow Wellness, L.L.C	3 hours	Christina Ottis Jeremy Lewis Ben Spivey
5/22/14	Determined goal and purpose of for Willow Wellness, L.L.C; Explanation of conceptual framework process and purpose	1.5 hours	Christina Ottis Jeremy Lewis Ben Spivey
5/28/14	Explanation of the results framework process and purpose; Designed results framework for Willow Wellness, Willow Branch Apartment project	2.5 hours	Christina Ottis Jeremy Lewis Ben Spivey
6/3/14	Finalized conceptual framework; Finalized results framework	1.5 hours	Christina Ottis Jeremy Lewis
6/5/14	Explaination of log frame process andpurpose; Edited Narrative Summary	1.5 hours	Christina Ottis Jeremy Lewis
6/6/14	Edited the log frame sections including goal, purpose, and outcomes	1.5 hours	Christina Ottis Jeremy Lewis
6/10/14	Edited the log frame activies and input sections; Edited Gantt timeline	1.5 hours	Christina Ottis Jeremy Lewis
6/12/14	Finalized Gantt timeline; Discussed logistics of the evaluation process; Finalized list of deliverables required for M&E plan; Discussed designing resident surveys	1.5 hours	Christina Ottis Jeremy Lewis

Table 1: Willow Wellness L.L.C. 2014 summer meeting outcomes

Conceptual Framework. In order to recognize and identify the underlying determinants affecting Willow Branch residents from accessing health services, a conceptual framework was developed as follows:

1. Review of the data: A comprehensive review of the literature was performed. The topics reviewed included refugee status within the U.S., refugee health problems, refugee

barriers to accessing health services, M&E plans, and Willow Branch community needs assessment. These topics were reviewed using a PubMed search followed by reviews of the references in the identified papers. The "Willow Branch Community Needs Assessment" was provided by the WW staff.

2. Creation of the conceptual framework: After reviewing the data, the WW staff met to discuss the elements of the U.S. healthcare system – payer, provider, and patient. It was agreed that WW would focus their attention onto the patient aspect of the healthcare system. Four determinants of health were identified. These determinants include: accessibility, availability, acceptability and affordability. With the help of WW staff and the literature review (Step 1), each determinant was further divide into factors. For example, factors under the determinant of accessibility included local health services, medical personnel, transportation, patient schedules, interpretation services, and childcare services.
3. Approval of the conceptual framework: WW approved the conceptual framework during the third meeting.

Results Framework. Subsequently, the results framework was designed in order to create a visual depiction of how WW plans to intervene for the health of their community. The process of developing the results framework included the following steps:

1. Identification of a target population: The current M&E plan was created for WW's project at Willow Branch Apartment Complex, which targets Willow Branch residents. No direct data was collected for this special studies project instead the preliminary data was analyzed in order to understand the demographic population of the residents.
2. Identification of the community needs: The preliminary meeting with WW focused on reviewing the literature and prioritizing the community needs identified by GH 542. It was determined there is a significant need for a multicultural, refugee specific health intervention addressing the high burden of disease and barriers to accessing health services found within the Willow Branch residents. The following recommendations were made by GH 542 to address the needs of the WW community:
    a. WW collaborates with local partners within Willow Branch, the Clarkston community and the Atlanta metro area.
        i. WW needs to create an advisory board.
    b. WW defines the program goals and program strategies based on the conducted community needs assessment.
    c. WW creates a formal and extensive database of resident demographics.
    d. WW provides residents with an onsite case manager to assist residents with accessing healthcare by acting as a liaison to healthcare facilities.
    e. WW provides monthly health education classes for residents to support a healthy diet and lifestyle as well as disease prevention.
    f. WW distributes a Health Resource Guide (HRG) to Willow Branch residents.
3. Interpretation of the conceptual framework: As a result of creating the conceptual framework, WW identified a significant need for Willow Branch residents to access healthcare. Willow Branch residents, as refugees, experience numerous health conditions (e.g., chronic disease, infectious disease, mental health problems, and dental conditions) and simultaneously have a restricted use of healthcare services. To address this problem, WW filled the gap between their resident population and the U.S. healthcare system with a health intervention prioritized on healthcare accessibility, followed by affordability, acceptability and availability.

4. Creation of the results framework: Based on the target population, interpretation of the conceptual framework, community needs and recommendations of GH 542, the results framework was constructed. The results framework was created to depict the goals of the organization by displaying the strategic objectives, intermediate results, and activities of Willow Wellness, L.L.C.
5. Approval of the results framework: WW staff approved the results framework during the 4th meeting.

Narrative Summary. A narrative summary was crafted in order to further explain the results framework. The summary is divided into sections retrieved from the results framework including the project goal, purpose, outputs, and activities. Each section includes a paragraph further clarifying each part of the results framework. This paragraph not only includes definitions but also implementation details. It was created in conjunction with WW staff and officially approved during one meeting.

Gantt Timeline. A Gantt timeline was created for the duration of the project's implementation (Jan 2014 - Dec 2018). The timeline was created in order to display in chronological order the list of necessary events required to have a successful program. It contains all the required activities WW must complete in order to achieve their goal. During one meeting, WW edited and approved the timeline.

Log Frame. The log frame was created to record, in chart-form, how the project's goal, purpose, outputs, and activities will be monitored and evaluated. The log frame was created using the narrative summary as a foundation. It documents objectively identifiable indicators, means of verification, and assumptions. The log frame was created with feedback from past WW meetings and later approved by the WW staff.

Chapter IV - Results

Results Overview. This chapter presents the formulated monitoring and evaluation plan (M&E) for Willow Wellness L.L.C.'s pilot project at Willow Branch Apartment Complex. The chapter begins with a conceptual framework, a visual presentation of the theoretical framework that underpins the project. The chapter continues with the results framework and narrative summary demonstrating the project's strategic plan for the intervention. The chapter concludes with a detailed Gantt timeline and log frame to convey the monitoring and evaluation steps needed to achieve the desired impact of the project.

Conceptual Framework

In order to recognize the underlying determinants affecting Willow Branch residents from accessing health services, a conceptual framework was created. The conceptual framework depicts a visual representation of factors that influence a patient's ability to utilize health services.

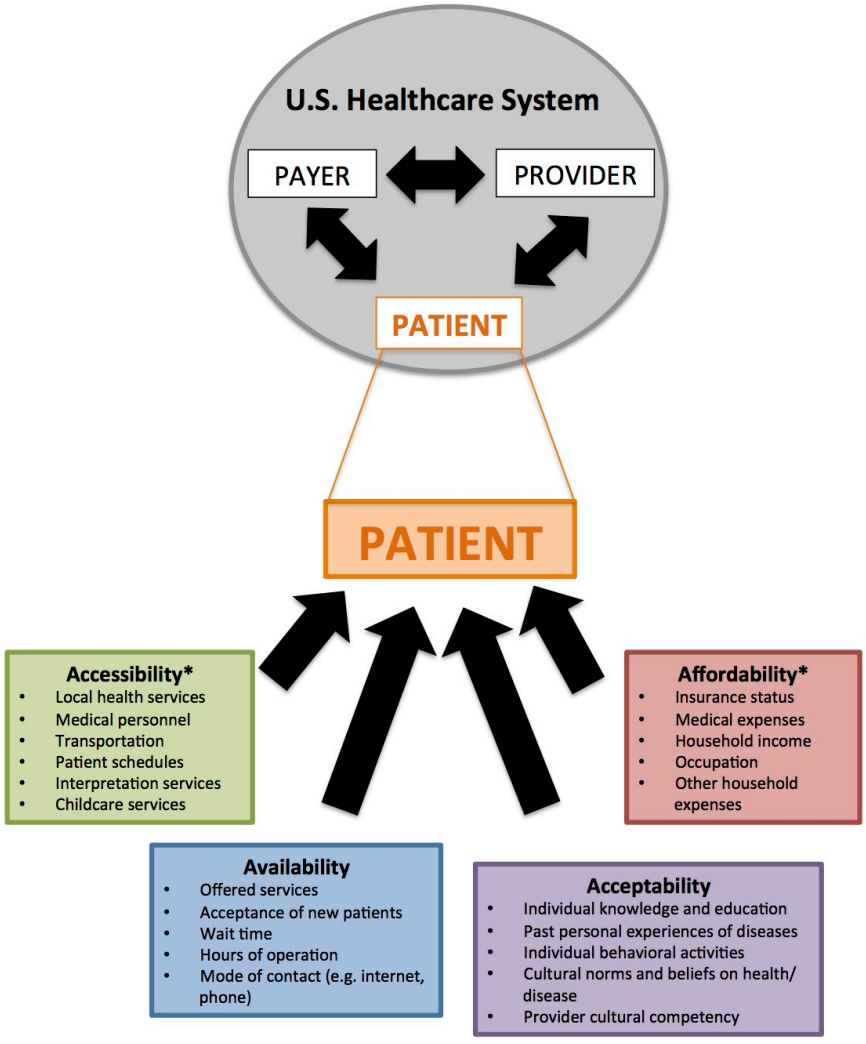

Figure 1: Conceptual framework of underlying determinants of accessing healthcare for refugee individuals.
*Symbolizes Willow Wellness (WW) priorities

Explanation of Conceptual Framework. The conceptual framework displays the underlying determinants that impact a refugee's capacity to access healthcare. The U.S. healthcare system is a complicated, integrated system of payers, providers and patients. The payers are those responsible for financing the cost of health services. Payers include patients, health insurance plans, and government programs. The providers are the suppliers of medical services including doctors, medical staff, clinics, pharmacists, and hospitals. The patients are the individuals receiving medical treatment or services delivered by the providers. Providers, payers, and patients are all equally necessary in order for the U.S. healthcare system to effectively work. However, many Americans, including refugee populations, are inhibited from participating as patients.

There are many underlying causes that influence a refugee's capability to become a patient in this system. These underlying determinants can be summarized into four dimensions: accessibility, availability, acceptability, and affordability. Accessibility is the ease and convenience of a patient to obtain and use the available health services. Availability is the existence of health services. Acceptability is the degree to which the recipient of the health services believes that the services are compatible with their cultural beliefs, values, and worldview. And finally, affordability is the capacity of the patient to pay for the expenses of health services. All four of these underlying determinants – accessibility, availability, acceptability and affordability – can be further divided into other factors, as noted in the visual depiction above. For example, accessibility can be further divided into other attributing factors such as local health services, medical personnel, transportation, patient schedules, interpretation services, and childcare services. In summary, the conceptual framework is able to categorize and simplify the numerous factors affecting the health of a patient and consequently helps to identify all the possible avenues for interventions.

Results Framework & Narrative Summary

In order to clarify terms, document the intended public health intervention, and define avenues of change, the results framework and narrative summary were created. The results framework details the primary goal, objective, and associated activities that Willow Wellness L.L.C., Willow Branch project plans to achieve during the years 2014-2018 to improve residents' access to healthcare. The program interventions, in the results framework, are color coordinated with the underlying determinant they address in the conceptual framework. For example, WW's intermediate result and activites (in the green boxes of the results framework) address the underlying determinant accessibility found in the green box in the conceptual framework. The narrative summary describes each of the sections within the results framework in more detail. Each section includes a paragraph further clarifying each part of the results framework with associated definitions and implementation details.

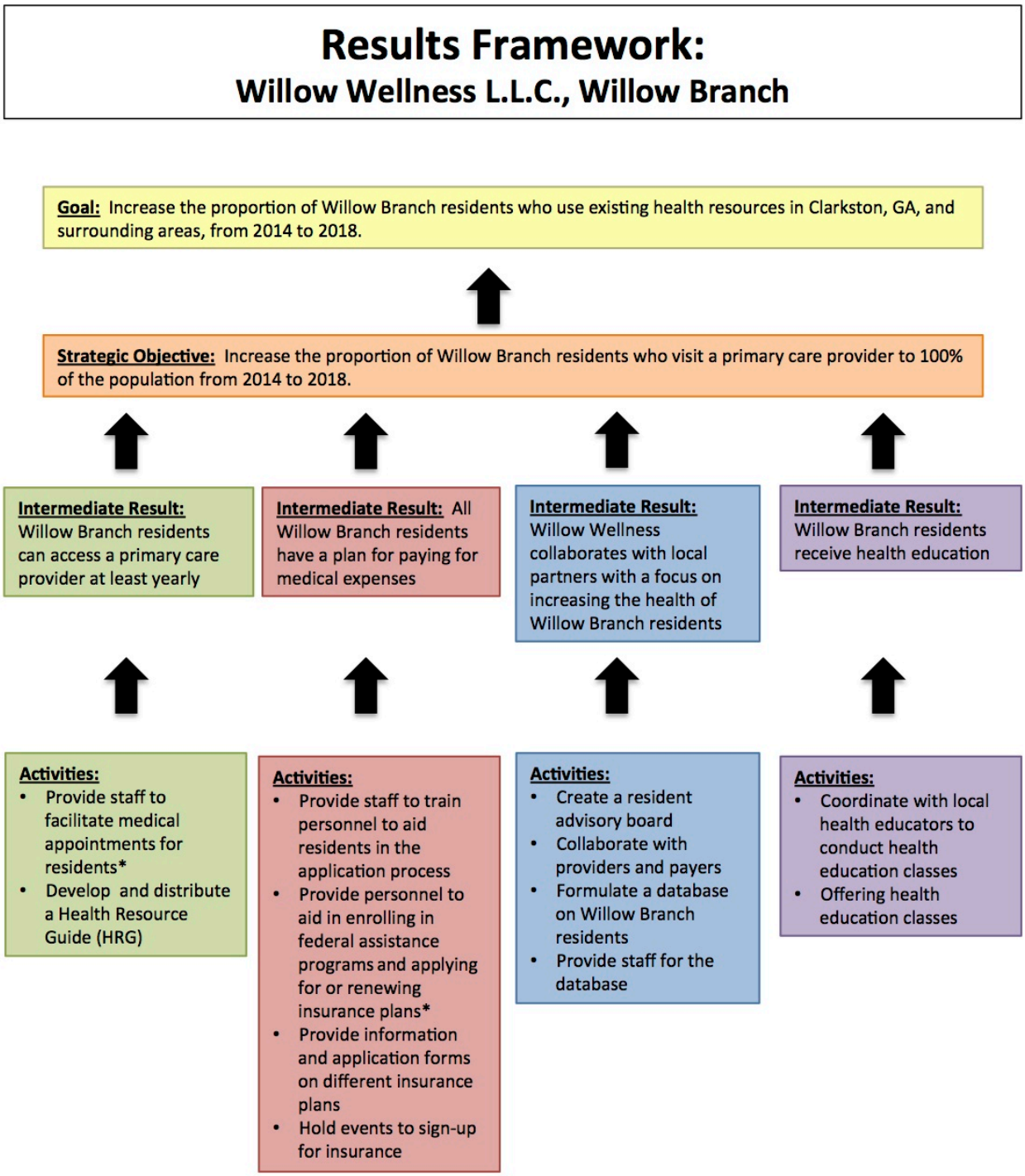

Figure 2: Results Framework - Strategic plan for Willow Wellness L.L.C., Willow Branch.
* Symbolizes WW priority activities

Narrative Summary

1.1 Goal: Increase the proportion of Willow Branch residents who use existing health resources in Clarkston, GA and the surrounding areas from 2014 to 2018. By 2018, the percentage of Willow Branch residents who use existing health resources will increase from the baseline evaluation conducted in 2014. For this study, health resources are defined as the materials, personnel, facilities, funds, health supplies and equipment required to prevent the impairment of, improve, or restore the physical and mental health of an individual. Examples of health resources include health informational packages, required documentation, federal and state programs, insurance plans and other assistant programs, medical staff, transportation services, hospitals, and other medical facilities.

2.1 Purpose: Increase the proportion of Willow Branch residents who visit a primary care provider (PCP) to 100% of the population from 2014 to 2018. By 2018, the proportion of Willow Branch residents that visit a PCP yearly will rise to 100% of the target population. PCPs are defined as generalist physicians who address acute and chronic physical aliments, mental problems, and social health issues by being the first point of contact for a patient in seeking healthcare services. PCPs provide a wide variety of services including health promotion, disease prevention, health maintenance, counseling, patient education, and diagnosis and treatment of acute and chronic illness. Examples of PCPs include general practitioners, family practitioners, nurse practitioners, pediatricians, physician assistants, and behavioral care providers.

3.1 Outputs:

3.1.1 Willow Branch residents can access a primary care provider at least yearly. Willow Branch residents will receive the necessary health resources in order to access a PCP at least yearly.

3.1.2 All Willow Branch residents have a plan for paying for medical expenses. WW will work with Willow Branch residents to identify, select, and enroll in the appropriate method to pay for medical expenses. Possible methods include medical insurance plans, federal assistance programs, or personal savings.

3.1.3 Willow Wellness collaborates with local partners with a focus on increasing the health of Willow Branch residents. WW works closely with Willow Branch residents, PCPs, healthcare facilities, insurance agencies, refugee assistance organizations, and other entities to increase the resident's ability to access health services. Possible local partners include Willow Branch Apartment Complex, Oakhurst Medical Center, DeKalb County Board of Health, DeKalb Medical Center, World Relief, and Refugee Family Services. WW will create an inventory of all local partners in order to assist with correspondence.

3.1.4 Willow Branch residents receive health education. Willow Branch residents will attend health education classes in order to increase knowledge on health-related topics.

4.1 Activities:

4.1.1 Provide staff to facilitate medical appointments for residents. WW will hire and train at least one person to aid Willow Branch residents in accessing healthcare services. Staff responsibilities will include finding an appropriate PCP for residents, aiding residents to select PCP on health insurance plan, calling and making appointments in an efficient and timely manner for residents, requesting required documents from offices, aiding residents in filling out information before scheduled appointments, informing patients on co-payment information, and arranging transportation services.

4.1.2 Develop and distribute a Health Resource Guide (HRG). A HRG is a comprehensive resource guide of health service providers and

medical interpreters in Clarkston and surrounding areas. It will be developed and available for WW personnel and Willow Branch households. The document will included helpful information on local healthcare services such as office hours, phone numbers, directions, available services, interpretation services, and accepted insurance. It will also include a rating system for all healthcare facilities. The HRG will originally be available in English with the hopes of translating it to other languages including Nepali and Burmese.

4.1.3 Provide staff to train personnel to aid residents in the application process. WW will hire and train at least one staff member to train volunteer personnel in aiding residents. Staff responsibilities will include identifying, hiring, and training volunteer personnel to sufficiently aid in the health insurance application process.

4.1.4 Provide personnel to aid in enrolling in federal assistance programs and applying for or renewing insurance plans. WW will provide volunteer personnel to aid residents in applying for or renewing insurance plans and enrolling in assistance programs in order to help residents pay for medical expenses. All volunteer personal will initially be trained by WW staff on the process and will sign a HIPPA confidentiality contract for all sensitive information they encounter. Federal assistant programs are defined as government-funded programs that directly assist organizations, families, or individuals in education, health, and public welfare. Grady Memorial Hospital and other federally qualified health centers are examples of federal health assistant programs. Federally qualified health centers in DeKalb and Fulton Counties include Oakhurst Medical Centers, St. Joseph's Mercy Care Services, Southside Medical Center, and Meridian Education Resource Group.

4.1.5 Provide information packets and insurance application forms on different insurance plans. WW will provide access (either digital or hardcopy) for residents to necessary health insurance documents. These documents will include informational packets and insurance application forms. Residents will be given blank applications, aided in filling out applications (see Activity 4.1.4), and aided in submitting the completed applications (see Activity 4.1.4) but no applications will actually be collected by WW.

4.1.6 Hold events to sign-up for insurance. WW will host yearly events for residents to apply for or renew health insurance plans.

4.1.7 Create a resident advisory board. WW will recruit Willow Branch residents to join as advisory board members. The resident advisory board will advise and guide WW on community health priorities, needs, and desires.

4.1.8 Communicate with providers and payers. WW will reach out to local providers and payers via telephone, meetings, and email in order to determine the most efficient way to fulfill the health needs of Willow Branch residents. Examples of possible providers and payers include Oakhurst Medical Center, DeKalb Medical Center, local PCPs, and Medicaid.

4.1.9 Formulate a database on Willow Branch residents. WW will create a database to document information on Willow Branch residents. Collected data will include demographics, reported health problems, and resident usage of WW services. Information will be utilized for project monitoring, evaluating, and funding purposes. Only information from consented residents will be documented within the database. Staff monitoring the database will sign HIPPA confidentiality contracts.

4.1.10 Provide staff for database. WW will hire and train at least one staff member to build, implement, and maintain the database.

4.1.11 Coordinate with local health educators to conduct health education classes. WW will recruit health educators to conduct monthly health education classes. Health educators are defined as individuals who inform and train residents on health-related topics. The health educator's responsibilities will include planning, developing, and implementing health education curriculum. They will be expected to educate residents on health-related issues, encourage healthy behaviors, and appropriately handle culturally sensitive health issues.

4.1.12 Offering health education classes. WW will offer monthly education classes for Willow Branch residents on available health resources, common health problems, and healthy lifestyles and preventative healthcare.

Gantt Timeline

This timeline gives a scheduled timeframe for which the required activates need to be performed in order to achieve their Willow Branch project plans. The timeline starts at the initiation of the project, Jan 2014, and ends with the termination in Dec 2018. Specific activites included in the timeline range from creating the project, fundraising, hiring staff, implementing the plan, and finally evaluating the success of the program.

	2014												2015											
Activities	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Conduct community needs assessment		X	X	X																				
Plan project activities					X	X	X																	
Create M&E plan					X	X	X																	
Review project with planning group							X																	
Establish working agreement with funder(s)							X	X																
Create a resident advisory board								X	X															
Fundraise								X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Network with local partners									X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hire WW staff										X			X											
Train WW staff										X			X			X			X			X		
Create database on residents										X														
WW staff available to aid residents											X	X	X	X	X	X	X	X	X	X	X	X	X	X
Provide pamphlets & application forms											X	X	X	X	X	X	X	X	X	X	X	X	X	X
Create HRG											X													
Maintain and distribute HRG												X	X	X	X	X	X	X	X	X	X	X	X	X
Communicate with health educators											X	X	X	X	X	X	X	X	X	X	X	X	X	X
Offer health education classes													X	X	X	X	X	X	X	X	X	X	X	X
Train Non-WW staff to aid residents														X		X		X		X		X		X
Hold insurance event																X						X		
Monitor program																								X
Evaluate program												X												

Activities	2016-2017												2018											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Conduct community needs assessment																								
Plan project activities																								
Create M&E plan																								
Review project with planning group																								
Establish working agreement with funder(s)																								
Create a resident advisory board																								
Fundraise	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Network with local partners	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hire WW staff																								
Train WW staff	X			X			X			X			X			X			X			X		
Create database on residents																								
WW staff available to aid residents	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Provide pamphlets & application forms	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Create HRG																								
Maintain and distribute HRG	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Communicate with health educators	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Offer health education classes	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Train Non-WW staff to aid residents		X		X		X		X		X		X		X		X		X		X		X		X
Hold insurance event				X						X						X						X		
Monitor program												X												X
Evaluate program																								X

Log Frame

The log frame is used to monitor and evaluate the success of the Willow Wellness L.L.C., Willow Branch project at various different levels. It documents objectively identifiable indicators, means of verification, and assumptions for the project's goal, purpose, outputs and activities.

	Narrative Summary	Objectively Identifiable Indicators	Means of Verification	Assumptions
Goal	1.1 Increase the proportion of Willow Branch residents who use existing health resources in Clarkston, GA, and surrounding areas, from 2014 to 2018.	1.2.1 Percent of Willow Branch residents who say they use existing health resources when needed. Success is at least 50% of Willow Branch residents use existing health resources.	1.3.1 Residential questionnaires, conducted yearly.	1.4.1 Residents who access PCP yearly will have the tools to use existing health resources when needed. 1.4.2 Accurate data collection. 1.4.3 Residents available and willing to participate. 1.4.4 Materials and funding available. 1.4.5 Residents truthful in answering surveys. 1.4.6 Interpretation available.
Purpose	2.1 Increase the proportion of Willow Branch residents who visit a primary care provider to 100% of the population from 2014 to 2018.	2.2.1 Percent of residents who visit a primary health provider at least once yearly. Success is 90% of Willow Branch residents visit a PCP yearly.	2.3.1 Residential questionnaires, conducted yearly.	2.4.1 Residents can access PCP with WW services. 2.4.2 Residents can afford PCP visits by identifying an appropriate avenue for paying for medical expenses. 2.4.3 Health services are available for residents in Clarkston, GA and surrounding areas. 2.4.4 Acceptance and receptiveness of PCP visits. 2.4.5 Accurate data collection. 2.4.6 Residents available and willing to participate. 2.4.7 Materials and funding available. 2.4.8 Residents truthfully answer survey questions.

Outputs/ Outcomes	3.1.1 Willow Branch residents can access a primary care provider at least yearly. 3.1.2 All eligible Willow Branch residents have a plan for paying for medical expenses. 3.1.3 Willow Wellness collaborates with local partners with a focus on increasing the health of Willow Branch residents. 3.1.4 Willow Branch residents receive health education.	3.2.1 Percent of residents who used WW services to access PCP. Success is at least 50% of Willow Branch residents use WW services yearly. 3.2.2 Percent of residents with a plan for paying for medical expenses. Success is 90% of Willow Branch residents, yearly. 3.2.3 Percent of local partners WW collaborates with yearly. Success is if WW collaborates with least 50% of local partners from the inventory. 3.2.4.1 Percent of Willow Branch residents who attend a health education class yearly. Success is at least 10% of Willow Branch residents yearly. 3.2.4.2 Percent of Willow Branch residents who attend at least six health education classes yearly. Success is at least 2% Willow Branch residents attend at least six health education classes yearly.	3.3.1 Willow Branch resident database, compiled yearly. The database will log the resident's name and any services offered. 3.3.2 Willow Branch resident database. Database will log the resident's name and whether they have a specific plan for paying for medical expenses. The information will be compiled yearly. 3.3.3 WW correspondence logs, which document any collaboration and communication with local partners. This information will be gathered yearly. 3.3.4 Health education class logs, which document participant's names. This information is compiled yearly.	3.4.1 Residents want and utilize the services WW provides. 3.4.2 Local organizations willing to work in conjunction with WW. 3.4.3 Accurate data collection. 3.4.4 Materials and funding available.
Activities	4.1.1 Provide staff to facilitate medical appointments for residents.	4.2.1 Percent of residents who use WW services to set up medical appointments yearly. Success is at least 25% of all Willow Branch residents yearly.	4.3.1 Database, compiled yearly.	4.4.1 Staff members available and willing to help residents. 4.4.2 Residents will use WW staff if available. 4.4.3 HRG is available for distribution.

	4.1.2 Develop and distribute a Health Resource Guide (HRG).	4.2.2 Number of HRGs available for resident households. Success is at least five HRGs are always available for immediate viewing at WW facility and at least 100 HRGs are possessed by community households yearly.	4.3.2 Distribution logs, compiled yearly.	4.4.4 Residents available and willing to accept HRG. 4.4.5 Residents will be able to read HRG or have assistance to read HRG if they receive a HRG. 4.4.6 Personnel are adequately trained to aid residents in the application process. 4.4.7 Materials and funding available. 4.4.8 Residents will come to WW events. 4.4.9 Local providers and payers are willing to communicate with WW. 4.4.10 Willow Branch residents consent to their enrollment in the database. 4.4.11 Health educators available and willing to lead classes. 4.4.12 Facility available for health education classes. 4.4.13 Accurate data collection.
	4.1.3 Provide staff to train personnel to aid residents in the application process.	4.2.3 Number of volunteer personnel trained to assist residents in the application process yearly. Success is at least 10 personnel yearly.	4.3.3 WW training logs, yearly compiled.	
	4.1.4 Provide personnel to aid in enrolling in federal assistance programs and applying for or renewing insurance plans.	4.2.4 Percent of residents who use WW services to enroll in federal assistance programs and applying for or renewing insurance plans yearly. Success is at least 40% of all Willow Branch residents yearly.	4.3.4 Database, compiled yearly.	
	4.1.5 Provide information and application forms on different insurance plans.	4.2.5 Percent of residents who receive access (e.g. digital or paper) to pamphlets and application forms on different insurance plans yearly. Success is 25% of Willow Branch residents receive access to information pamphlets and application forms due to WW services.	4.3.5 Database, yearly compiled.	
	4.1.6 Hold events to sign-up for insurance.	4.2.6 Number of events where residents can apply for or renew health insurance plans. Success is at least two events yearly.	4.3.6 WW event log, yearly compiled.	
	4.1.7 Create a resident advisory board.	4.2.7 Number of resident advisory boards that meet at least six times yearly with at least five members.	4.3.7 Resident advisory board member log, compiled yearly.	

		Success is one resident advisory board yearly.		
	4.1.8 Communicate with providers and payers.	4.2.8 Number of providers and number of payers WW communicates with yearly. Success is at least three providers and three payers yearly.	4.3.8 WW correspondence logs, which document any collaboration and communication with local partners. This information will be gathered yearly.	
	4.1.9 Formulate a database on Willow Branch residents.	4.2.9 Number of databases on Willow Branch residents with at least 50% of Willow Branch residents enrolled. Success is one database.	4.3.9 Database participation logs, compiled yearly.	
	4.1.10 Provide staff for database.	4.2.10 Number of staff who adequately design, implement, and maintain database on Willow Branch residents quarterly. Success is at least one staff member.	4.3.10 WW audit, compiled quarterly.	
	4.1.11 Coordinate with local health educators to conduct health education classes.	4.2.11 Number of local health educators who teach a health education class at Willow Branch. Success is at least one health educator yearly.	4.3.11 Health education class logs, which document educator's name, class date, and class curriculum. This information is compiled yearly.	
	4.1.12 Offering health education classes.	4.2.12 Number of health educational classes yearly. Success is at least 12 health educational classes (at least three classes for each of the themes: healthcare system, common health problems, healthy lifestyles and preventative healthcare).	4.3.12 Health education class logs, which document educator's name, class date, and class curriculum. This information is compiled yearly.	

Explanation of Log Frame.
Goal 1.1. This project seeks to increase the proportion of Willow Branch residents who use existing health resources in Clarkston, GA, and surrounding areas, from 2014 to 2018. To monitor the goal, the M&E team will compute the number of Willow Branch residents who say they use existing health resources when needed. The M&E team will include four people – one WW staff, two Willow Branch residents, and one external overseer such as an Emory Public Health Student. Residential surveys will be conducted yearly to acquire whether the goal was successful. Residents will be reminded that no identification information will be used on the questionnaires to encourage truthfulness. Questionnaires will be available in English, Burmese and Nepali. Surveys will ask residents if they use any of the following health resources when needed: federal and/or state programs, insurance plans, transportation services, and medical services. Translators and volunteers will be available to read questionnaires to residents as needed. The M&E team will compile the data yearly to assess whether the residents are using existing health resources. Success is attained when at least 50% of Willow Branch residents are using existing health resources.

Purpose 2.1. WW will achieve their goal by increasing the proportion of Willow Branch residents who visit a PCP yearly. To monitor the purpose, the M&E team will analyze the number of residents who visit a PCP at least yearly. Residential surveys will be conducted yearly to acquire whether the purpose was successful. The M&E team will use the same surveys mentioned above in collecting the required information. On the survey, the resident will be asked if they visited a PCP within the last year (yes/no), the name of the doctor, and the date of the visit. The M&E team will compile the data yearly to assess whether the residents visit a PCP at least once yearly. Success is observed when at least 90% of Willow Branch residents visit a PCP yearly.

Output 3.1.1 In order to achieve the goal and strategic objective, the proportion of residents who can access a PCP needs to increase. To monitor this specific output (increase the proportion of residents who can access a PCP), the M&E team will calculate the number of residents who utilize WW services to visit a PCP yearly. Utilization of WW services, for this project, is defined when a residents uses any personnel or materials provided by WW. WW staff will be required to record the name of any residents who utilized these services and the specific services offered in the database. The M&E team will consolidate the information from the database yearly to assess whether residents are utilizing WW services to access a PCP yearly. Success will be obtained when 50% of Willow Branch residents use WW services yearly. This information will be collected in a resident database by WW staff. The database is meant to monitor residents' capability of accessing primary healthcare services by recording the usage of health resources as a proxy indicator.

Activities 4.1.1 & 4.1.2 To achieve the desired outcome (to increase the proportion of residents who can access a PCP), the program will focus on two specific activities: the provision of staff to facilitate medical appointments and the distribution of a HRG. WW will provide staff to find an appropriate PCP for residents, call and make appointments in an efficient and timely manner for residents, request required documents from offices and aid residents in filling out this information before scheduled appointments, and arrange transportation services. This activity will be monitored by tracking the percentage of residents who utilize WW services to set up medical appointments. WW staff will record any residents that use WW services in the resident database. The M&E team will compile information from the database yearly to determine if WW successfully provided staff to facilitate residents in their medical appointments by observing the number of residents who used their services.

A HRG will also be created and distributed among residents by Dec 2014. The HRG is a comprehensive resource guide of health service providers and medical interpreters in Clarkston

and surrounding areas. The document will include helpful information on local healthcare services such as office hours, phone numbers, directions, available services, and accepted insurance. After its creation, WW staff will record all HRG distributions in the distribution logs in order to monitor household possession and eliminate excess distribution. Success of this activity is defined as the distribution of 100 HRGs to different households within the Willow Branch community and the presence of 5 HRGs within the WW facility for public use. The M&E team will compile the data yearly to determine if the activity was successfully implemented.

Impact Evaluation. In order to evaluate the impact of the intervention, the M&E team will analyze the relationship of programmatic activities with WW's goal and purpose. This evaluation will assess whether the project activities (e.g., providing staff to help residents, developing a HRG, providing staff to train personnel, etc.) might have caused the observed effect of either the goal or the purpose. Ideally, WW hopes to observe an increase in the proportion of Willow Branch residents who use existing health resources yearly. Additionally, WW hopes to detect an increase in the proportion of Willow Branch residents who visit a PCP yearly. The database and surveys will be used to assess residential involvement in program activities, their utilization of existing resources, and visits to PCPs. The M&E team will analyze the collected data to determine any association between the programmatic activities and observed goal and purpose outcome.

The impact evaluation will be conducted in Dec 2018 as long as the activities are executed as anticipated. The impact evaluation will longitudinally measure change in resident's use of health resources and PCP services before and after the intervention. The baseline evaluation will be conducted between Aug-Dec 2014. This baseline information will be collected during a resident's first encounter with WW services. Residents will be asked a series of questions including demographic information, their usage of health resources, and their utilization of PCP services. All the baseline data will be compiled into a baseline report in December 2018. The data will be analyzed using EPI INFO. The primary markers of success for the impact of the WW project will be the number of residents who visit a PCP yearly. As previously mentioned the goal of the project is 100%. However, any change from the baseline data will be utilized to mark the impact of the project on the community.

Chapter V – Discussion and Recommendations

Overview. A monitoring and evaluation (M&E) plan was created as a tool for Willow Wellness (WW) to evaluate the effectiveness and efficiency of their strategic plan for a refugee-specific health intervention improving access to health services while addressing the unique health disparities of the Willow Branch community. With a focus on individual, cultural, and structural challenges of the community, this M&E plan will be the optimal tool for success of the WW project. This chapter comprises a discussion of the M&E plan and its limitations, a comparison of this M&E plan to other M&E plans, a synopsis of the public health implications on Willow Branch residents, and recommendations for the future of WW.

Discussion of the M&E Plan

Overview of the M&E Plan. This M&E plan will ensure that the WW project reaches its intended goal and purpose within the community: to increase the proportion of Willow Branch residents who use existing health resources and increase the proportion of residents who visit a primary care provider (PCP) at least once yearly. The following sections will discuss the literature on access to healthcare services, the methodology of this specific M&E plan, the conceptual framework, and the strengths/weakness of specific aspects of the plan.

Healthcare Accessibility. The WW project focuses on improving the health of the community by focusing predominantly on accessibility to healthcare. As previously mentioned, refugees have numerous barriers that both independently and synergistically inhibit the quantity and quality of available healthcare services. These barriers include language, unfamiliarity with the U.S. healthcare system, cultural perspectives, lack of insurance, cost of health services, and logistics (Crosby, 2013; McKeary & Newbold, 2010; Morris et al., 2009). The aim of the WW project is to improve the health status of the refugee community by aiding residents in overcoming the barriers preventing them from using existing health resources and thus increasing accessibility.

Interventions confronting healthcare accessibility problems are complex and multifocal. A systematic review of 75 worldwide health interventions focusing on enhancing access to healthcare was conducted in order to determine successful characteristics. It was found that interventions were most successful when using strategies of both patient demand and service provision (Korotana, Dobson, Pusch, & Josephson, 2016). The WW project aims to do just that. This project will intervene on patient demand by providing patient education classes and creating a database of residential health demographics. The strategy for intervening on service provision includes creating financial health plans, increasing awareness of local available health resources (i.e., Health Resource Guide - HRG), and collaboration with health educators. Despite the complexity of the WW project, a multifocal public health intervention addressing both patient demand and service provision will be most optimal in dealing with accessibility problems.

Methodology. This M&E plan follows the methodology recommended by other organizations such as the United Nations International Children's Emergency Fund (UNICEF), International Federation of the Red Cross & Red Crescent Societies, and U.S. Centers for Disease Control and Prevention (CDC). According to UNICEF, M&E plans should include the developmental steps written below (UNICEF, 2015). An explanation of how each of these steps has been fulfilled through this M&E process has been included.

Step 1: Agree on the conceptual framework. This step is documented in the results chapter of this special studies project.

Step 2: Gather the evidence. The evidence for this M&E plan is noted in the literature review.

Step 3: Assess the data quality. All the data from the literature review comes from reliable and credible sources. See references as needed.
Step 4: Analyze the community needs. This step is achieved with the preliminary data.
Step 5: Design a program with clarified theories of change, defined impact, and defined indicators. This step is fulfilled through the results framework, narrative summary, and log frame.

The International Federation of the Red Cross & Red Crescent Societies recommends that M&E plans be completed during the planning stage and include a comprehensive understanding of the project intervention, detailed summary definitions, SMART indicators, objective means of verification, and noted assumptions (Societies, 2010). This M&E plan was compiled during the planning stage of the project by those implementing the project (i.e., WW). The results framework systematically explains the intended intervention while the narrative summary defines terms. The indicators follow the SMART parameters (specific, measurable, achievable, relevant and time-bound). The means of verification were objectively chosen and the assumptions have been documented.

Following the firm foundation of indicators and objective means of verification recommended by Oxman, *et al.* and the CDC, this M&E plan is a feasible, accurate, quantifiable, and efficient tool for evaluating the success of the project. These recommendations include clear objectives aligned to the program's goals, SMART indicators, measurable and feasible outcomes, and prioritization of activities based on community need (CDC, 1999; Andrew D. Oxman et al.). The indicators and means of verification have been thoroughly determined as optimal for this project based on these recommendations. For example, the indicator for creating a resident advisory board is the number of resident advisory boards that meet at least six times per year with at least five members. The means of verification is a yearly compiled log of the residential advisory board members. The indicator is aligned with the program's goal of increasing the use of existing health resources within the community by advising and guiding WW on community health priorities, needs, and desires. This indicator is specific, measurable, achievable, relevant, and time bound. This indicator and means of verification are feasible with financial, human, physical, and informational resources of WW. Finally, WW has prioritized activities (i.e., provide staff to facilitate medical appointments for residents and provide personnel to aid in enrolling in federal assistance programs and applying for or renewing insurance plans) based on the community needs.

Despite the strengths of this M&E plan, there are some limitations. If these indicators and means of verification are inadequate, the potential of this tool is restricted. For example, if the indicators were not a suitable representation for the goal, the data retrieved from the M&E plan could show more or less benefit than actually present. Second, if the list of assumptions cannot be followed, the tool may be unable to collect data, gather inaccurate data, or cultivate data bias. For example, it is assumed that materials and funding will be available to hold events to sign-up for insurance (Activity 4.1.6); however, if the adequate funding and materials are unavailable, then Activity 4.1.6 wouldn't happen as planned and consequently residents may not have a plan for paying for medical expenses.

Conceptual Framework. Conceptual frameworks are crucial part of the M&E plan because they acknowledge, evaluate, and analyze the situation at hand (CDC, 1999; (UNICEF, 2015). This specific conceptual framework was formulated in order to identify and understand the underlying determinates of accessing health services for Willow Branch residents. As a result of its formation, two key underlying determinates of health (accessibility and affordability) became the emphasis of the WW project. Its limitations are minimal because of its use of evidence-based literature. In the

future, this same conceptual framework can be used for developing other program interventions related to accessing healthcare.

Overview of Specific Interventions. This next section will discuss the evidence based foundation, strengths, and weakness set forth in this plan. It will be further divided into the project goal, purpose, an outcome, two activities, and the impact evaluation. Each section will include an explanation of the specific intervention, the literature supporting this emphasis, the strengths, and finally the weaknesses of the project.

Goal 1.1. Increase the proportion of Willow Branch residents who use existing health resources in Clarkston, GA and surrounding areas from 2014 to 2018. This evidence-based goal has many benefits including a foundation of support from literature reviews, a reliable and unbiased indicator, and minimal limitations. The goal was developed in order to increase the overall health of the community by addressing the problem of accessibility (i.e., use of health resources) within the Willow Branch community. The obstacle to accessibility within this community is the large quantity of refugee specific barriers including language (Burgess, 2004; Morris et al., 2009; Unite for Sight, 2013), unfamiliarity with the U.S. healthcare system (Lawrence & Kearns, 2005), cultural perspectives (Morris et al., 2009), cost for services (Lawrence & Kearns, 2005), insurance status (Devoe et al., 2007), and logistical difficulties (Change Makers: Refugee Forum, 2011; McKeary & Newbold, 2010; Unite for Sight, 2013). Therefore, the theory of WW is that a decrease in the number of health barriers will result in residents being able to access healthcare services when needed and subsequently result in improved overall community health.

This theory is supported by a systematic review conducted with 25 studies analyzing the outcome of accessibility when primary care interventions focused on minimizing refugee specific barriers (Joshi et al., 2013). The authors found that accessibility was improved with multidisciplinary staff, use of interpreters, interventions minimizing cost to patient, outreach services within refugee homes or communities, transportation services, and patient advocacy. Furthermore, they concluded that these elements noted above were associated with improved health access, coordination, quality of care, and general health outcomes. The results from the systematic review are the foundation of WW's goal. By minimizing accessibility barriers in refugee populations, WW will improve not only accessibility but community health status as well.

Strengths of this goal include a reliable and unbiased indicator, objective means of verification, and documented assumptions recommended by The International Federation of the Red Cross & Red Crescent Societies, CDC, and UNICEF ((Societies, 2010) (CDC, 1999; Andrew D. Oxman et al.; UNICEF, 2015). This goal will be measured by directly asking residents if they use existing health resources when needed via yearly surveys. The indicator follows the SMART parameters and is a simple, achievable, and quantifiable method for WW to obtain needed information. The means of verification are objectively collected using surveys and the assumptions are all noted in the log frame. This indicator is the best representation for the project's goal.

The limitations to this goal include recall bias, social desirability bias, and indicator assumptions. As is the case with any surveys, there will be recall bias. In order to decrease this potential bias, the residents will be ask to include specific details in their answers. For example instead of just asking if the residents use health resources, residents will be asked to include details such as the number of resources, resource names, dates, and locations. Social desirability bias is also a limitation. Due to low literacy rates of the residents, questionnaires may need to be read to residents. Consequently, residents might feel inclined to answer the question in a manner viewed favorably by others. In

order to minimize this bias, residents will be encouraged to answer the questions honestly and reassured of confidentiality.

The assumptions of this goal also have some limitations. For the success of this goal, materials and funding must be available, residents must also be willing to participate in the survey, accurate data must be recorded in surveys, and interpretation must be accessible to participants. It is also assumed that residents who access a PCP yearly will develop the tools necessary to use existing health resources when needed. This might not always be the case, especially in a refugee community struggling with not only accessibility but also affordability, availability, and acceptability of healthcare. However, the hope is with time, the activities of the WW project will give residents the required tools to access health services.

Purpose 2.1. Increase the proportion of Willow Branch residents who visit a primary care provider (PCP) to 100% of the population from 2014 to 2018. This purpose has many strengths, including an evidence-based foundation, a reliable and impartial indicator, and minimal limitations. This purpose was developed in order to increase the number of yearly PCP visits within the community thus improving the use of local health resources and ultimately the resident's health. PCP visits were chosen as the emphasis for this purpose due to their association with improved accessibility (as explained above), ability to address the specific healthcare needs of refugees, and the association with a wide variety of healthcare benefits (Joshi et al., 2013; Rao & Pilot, 2014; Starfield, Shi, & Macinko, 2005; WHO, 2011).

Refugees have many complex healthcare needs that should be addressed by a PCP (Joshi et al., 2013). Primary care delivers a wide variety of benefits to the overall health (Rao & Pilot, 2014; Starfield, Shi, & Macinko, 2005; WHO, 2011) including care of chronic disease, infectious disease, mental health, and dental health that are extremely prevalent in refugee communities (Lifson et al., 2002; Miller et al., 2000; Shah et al., 2013; Varkey et al., 2007). Primary care visits are associated with improved management of chronic illness due to increased patient education, disease detection and early treatment initiation (Starfield et al., 2005; WHO, 2011). Infectious diseases require comprehensive evaluation for detection and treatment by primary care visits (Eckstein, 2011). A systematic review looking at over 99 studies concluded that cognitive-behavioral therapies in a primary care setting showed improved mental health and reduced health-risk behaviors (Korotana et al., 2016). And finally, primary care visits have also been associated with increased patient education on cavity prevention and consequently improved oral health (Kranz et al., 2014; Liu et al., 2014).

Similar to the goal, the purpose includes an accurate and unbiased indicator, objective means of verification, and minimal limitations. The purpose will be measured by directly asking residents if they are visiting a PCP provider yearly via surveys. Bias on these surveys will be minimized using the same procedures mentioned for the goal. The indicator is measurable, relevant, and time bound and therefore can be viably monitored by the M&E team. Its limitations are noted in the assumptions. The plan assumes that residents can access a PCP with WW services, residents can afford PCP visits with a plan, local health services are available, and residents are receptive to PCP visits. For example, acceptability and receptiveness of PCP visits have been associated with increased accessibility of healthcare services (Joshi et al., 2013), therefore if the population is not receptive to PCP visits then it would be difficult for the purpose and goal to be achieved.

Output 3.1.1 Willow Branch residents can access a primary care provider at least yearly. This output has similar strengths and limitations to the purpose and goal mentioned above. The output will be examined by analyzing the percentage of residents documented in the Willow Branch resident

database, who use WW services to access PCPs yearly. Overall, utilizing a database to record the number of residents who use WW services is an appropriate and reasonable measurement for the outcome. The M&E team can monitor this SMART indicator since it is feasible, applicable, simple, and time bound. Limitations for this indicator include the assumptions that residents will seek help in accessing health services and WW health services will actually allow patients to adequately access health services. For the success of this output, health materials and funding must be available, residents must also be willing to participate in the intervention, and accurate data must be recorded in a database.

Activity 4.1.1 Provide staff to facilitate medical appointments for residents. This activity was created based on the results of a systematic literature review addressing PCP interventions with refugees. WW chose this activity with the theory that minimizing barriers to accessing healthcare services will result in more PCP visits. A systematic review of public health strategies focused on minimizing barriers to accessing healthcare services (e.g., outreach interventions in the refugee homes or communities, use of interpreters, teaching on the U.S. healthcare system, and transportation services) resulted in improved accessibility for PCP visits (Joshi et al., 2013). Therefore, WW determined that addressing barriers specific to the Willow Branch community would be optimal for the community's overall health.

The 4.1.1 Activity directly focuses on the following barriers: language (Burgess, 2004; Morris et al., 2009; Unite for Sight, 2013), unfamiliarity within the U.S. healthcare system (Burgess, 2004), and logistics (Change Makers: Refugee Forum, 2011; McKeary & Newbold, 2010; Unite for Sight, 2013). Despite the language barriers, residents will be able to set up a medical appointment with the help of the WW project. The staff member will request a trained translator to be present at the PCP visit and help the resident fill out English documentation before the office visit. During this time, the staff member will also be able to educate residents on the U.S. healthcare system, the prime usage of PCPs for health problems, the cost of co-pays, and the importance of timeliness to appointments. Educating refugee patients on how to navigate the healthcare system has led to increased utilization of health services (Joshi et al., 2013). The staff member will also be able to help alleviate the barrier of logistics by calling to set up the appointment, aiding in filling out documentation, and setting up transportation. Transportation services, especially free transportation, have increased accessibility to health services among refugee populations (Joshi et al., 2013).

Activity 4.1.2 Develop and distribute a Health Resource Guide (HRG). This evidence-based goal has many strengths, including a foundation of literature reviews, a reliable and unbiased indicator, and minimal limitations. The activity was developed with the mindset that an informational health document would give residents the tools to access local health services, thus increasing PCP visits and ultimately improving general health. Systematic evidence supports this assumption. Culturally appropriate informational packets (similar to the purposed HRG) have been associated with health literacy and increased access to health services (Joshi et al., 2013). The HRG will include information on local healthcare services such as office hours, phone numbers, directions, available services, interpretation services, and accepted insurance. This activity will aim to reduce logistical barriers associated with the refugee population and thus be an effective tool in improving accessibility.

Activity 4.1.1 and Activity 4.1.2 are both suitable plans because they include a reliable and unbiased indicator, objective means of verification, and few limitations. Activity 4.1.1 will be measured by utilizing the database to analyze the percentage of residents who use WW services to set up a medical appointment. Activity 4.1.2 will be measured by the number of HRGs available for resident households via distribution logs. The resident database and the distribution logs are objective and

thus reasonable measurements for the activities. These SMART activity indicators are measurable, attainable, and time bound and therefore can be feasibly monitored by the M&E team.

These two activity indicators have some limitations. The activities are based on the assumption that residents will use staff to aid in accessing health services, the HRG will be available for distribution, and residents are literate enough to read the HRG. For the success of these activities, materials and funding must be available, both residents and staff members must also be willing to participate in the intervention, and accurate data must be recorded in the distribution logs and database. Despite its limitations, these two indicators are the ideal measures of obtaining the required data with the available resources.

Impact Evaluation. The impact evaluation was created because it is the most efficient and effective way to fulfill the goal and purpose of the WW project (Habicht et al., 1999; A. D. Oxman et al., 2010; Stein, 2014). The evaluation will direct WW in what activities are most relevant within the population to achieve their goal and purpose since good intentions and plausible theories are inadequate for decision making (A. D. Oxman et al., 2010). For example, if the impact evaluation report determines that the distribution of HRGs are not positively influencing resident's utilization of health services then providing HRGs to the community will be removed from the list of WW activities. As a result, the evaluation process will minimize unnecessary expenses and efficiently utilize WW resources in the project implementation.

This evaluation is considered an adequacy assessment instead of a plausibility or possibility assessment (A plausibility assessment is used for plausible assurance that the observed behavioral changes are the outcome of the intervention while a probability evaluation uses randomized control trials to determine the effect of the program activities on the indicators of interest by minimizing any confounding factors or bias). An adequacy assessment is the simplest type of evaluation as it measures program activities and observed general trends over time but does not appropriately link indicators to program activities (Habicht et al., 1999). Since adequacy evaluations are cheaper (which is required with the financial constraints of WW) and don't require control groups (which would be unethical in this implementation), this evaluation method is the most feasible approach for WW. Even though the evaluation will not provide probability, it will provide the necessary reassurance that the goals and purposes are being met (Habicht et al., 1999). In conclusion, with this evaluation, the M&E team will be able to observe whether the changes in utilizing health resources and/or visiting a PCP are positively influenced by WW activities.

Comparison to other M&E plans

This M&E plan is comparable to other M&E plans within the public health community because it follows the recommended methodology of well-respected organizations, includes the key elements of an M&E plan, and has a similar structured format to other M&E plans. As previously discussed, the recommendations of UNICEF, International Federation of the Red Cross & Red Crescent Societies, and CDC were utilized in the creation of this M&E plan. These recommendations resulted in a systematic, detailed, feasible and objective M&E plan focused on the needs of the target population. Following these recommendations is a huge asset because the formation of the plan is then structured on the opinions and experiences of multiple established organizations.

M&E plans have a variety of formats but all respectable plans should include key elements such as assessing the appropriateness of the intervention, identifying health barriers, organizing the project's intervention, detecting efficiency in an unbiased systematic approach, and evaluating the impact on health indicators (Stein, 2014). This M&E plan fulfills these qualifications. The literature

review discusses the appropriateness and great need for this intervention. The conceptual framework identifies the health barriers. The project's interventions have been developed and organized in the results framework, narrative summary, and Gnatt timeline. The log frame creates an unbiased systematic approach to measure the efficiency of the project interventions. And finally, the impact of the health indicators has been explained in the discussion section under public health implications.

This M&E plan format differs but is comparable to other developmental program M&E plans. According to CARE International, the M&E plan should include an executive summary, project background, M&E planning section, M&E information matrix, M&E workplan matrix and M&E timetable (CARE, 1999). The executive summary will explain the overview of the plan and public health intervention and is described in the introduction section. The project background information (i.e., main goals and objectives, needs assessment, target population demographics, and timeline of the implementation process) is included within the special studies project but not under one designated project background section. The M&E planning section, explaining the methodology used for the creation of the plan, is found within the methods section. The M&E information matrix is a table documenting the indicators and their definitions, sources of information, methods of gathering data, collectors of data, and frequency of reporting. The M&E workplan matrix is a table that documents the activities, involved participants, and frequency of collected data. Both the M&E information matrix and the M&E workplan matrix are not documented in this M&E plan but the information is consolidated into the log frame. Finally, the M&E timetable is documented as the Gantt timeline displaying the project timeframe.

Public Health Implications

The Willow Wellness L.L.C.'s pilot study at Willow Branch Apartment Complex has two key public health implications for its residential community - affordability of healthcare services and accessibility of healthcare services. As noted in the conceptual framework, both affordability and accessibility are major determinants of health, especially in a refugee community. WW expects to reduce affordability barriers by aiding residents in enrolling in insurance plans, providing informational packets and application forms, and holding health insurance events. WW aims to diminish accessibility barriers by aiding residents in accessing PCPs yearly, providing staff to facilitate medical appointments for residents, developing and distributing a HRG, providing health education classes, and collaborating with local partners. Through this special studies project, the Willow Wellness L.L.C. project has the potential to minimize the barriers of health for this refugee community and subsequently preserve their quality of life.

Accessibility Health Implications. The health implications of limiting accessibility barriers are numerous. As previously mentioned, increased accessibility has been associated with better health outcomes in refugee specific communities (Joshi et al., 2013). According to Healthy People 2020, access to health services is important because it increases overall physical, social, and mental health status, prevents disease and disability, allows for detection and treatment of health conditions, improves life expectancy, decreases preventable death, and increases quality of life (ODPHP, 2014). This project has the potential to exponentially improve individual and community health amongst refugees in numerous avenues.

Affordability Health Implications. Affordability of health services results in improved overall health. The UN Refugee Agency conducted a review on the health outcomes of affordability interventions. They found that interventions associated with decreasing the refugee financial barriers in health services (i.e., conditional cash transactions and vouchers) were associated with an increased

utilization of health services and in turn improved health status (UNHCR, 2015). Financial incentives such as reduced costs or free services were associated with increased refugee health status (Comino et al., 2012). This M&E plan is not offering conditional cash transactions/vouchers or financial incentives but plans to minimize financial barriers through aiding residents in developing a medical expense plan. This includes helping residents apply for federal assistance programs and insurance plans.

The health implications of interventions focused on healthcare accessibility and affordability cannot be ignored. They may be difficult programs to implement because they are multifactorial, but their impact affects not only the individual but also the community, and the generations to come. These types of interventions allow disadvantaged refugee communities to live high quality lives with no impediments associated with preventable health problems. Accessibility and affordability barriers need to be address in order for refugees to live the healthy and prosperous life they should be privileged to as U.S. inhabitants.

Recommendations for the Future

If this project is successful at Willow Branch Apartment Complex, then this same approach can be expanded to other neighboring refugee populations. The M&E plan can serve as a guide for WW in executing refugee community development programs throughout Clarkston. Using this template for future projects will continue to ensure WW programs are relevant to the community, impactful, effective, and successful. Both identifying the strengths and limitations of the pilot program will be crucial in cultivating the success of future WW projects.

Conclusion

In summary, there is a vast health disparity among Willow Branch residents that needs to be addressed. Willow Wellness L.L.C., Willow Branch proposed a refugee specific intervention addressing their unique community, cultural, and structural challenges. The proposed M&E plan will allow Willow Wellness L.L.C., Willow Branch to assess the effectiveness and efficiency of their intended interventions. This M&E plan includes population-specific elements that create the foundation for the success of the Willow Branch project. Despite its limitations, this M&E plan will serve as a template for WW in cultivating other developmental programs within the refugee community nationally.

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