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Using schools and clinics as hubs to create healthy communities: The example of Briya/Mary's Center

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Executive Summary

Improving the health and upward social mobility of households in poor neighborhoods has been at the forefront of concern nationwide. The question is how to attain that goal.

There are several overlapping hypotheses on how to achieve successful impact in these communities. One is the “two-generation” strategy that focuses on both child and parent. A second is creating a “place-specific” approach that focuses on services within the specific location. A third combines the other two with “hub” institutions such as schools, medical centers, churches and other organizations.

School-based hubs have been attracting attention, which in turn has raised interest in how to determine how effective these hubs can be to a community.

Briya Public Charter School in Washington, D.C., shares a location with a health center, Mary's Center and the partnership delivers social, medical and education services for children and adults. The partnership is unusual and provides a particularly interesting perspective on the value hubs can provide to a community.

Briya/Mary's Center is also an example of the challenges faced by new or innovative organizations in assembling and analyzing the data they need to improve operations, and for their programs to be rigorously evaluated so that others can learn from their success. To address these challenges, public and private funders need to focus on helping innovative hubs to build up their data collection and analytical capacity as well as funding their services. Moreover, it is important to recognize that the form of data and analysis needed during the early phase of programs differs from that required for the formal evaluation of mature programs.

INTRODUCTION

There are several often overlapping hypotheses of what strategies are best to improve conditions in struggling, low-income neighborhoods. One is that the condition of each individual must be in the context of the whole household, rather than as “children” or “parents” whose situations need to be addressed separately. For this reason there has been increasing attention to “two-generation” strategies.¹ Another hypothesis is that focusing on a particular community and coordinating services within it – a “place-conscious” or “place-specific” approach – will lead to better results than applying services separately to households.²

A third hypothesis, often building on the first two, is that certain institutions in the community can act as “nerve centers” or “hubs” and further increase the focus and impact of coordinated services. Historically, the African-American church has performed such a hub role in many communities. More recently, there has been a growing interest in the potential of other institutions, such as housing associations, health clinics and schools as hubs. The Harlem Children’s Zone (HCZ), for instance, has drawn attention with its education “pipeline”—centered on its own charter schools and reinforced with wraparound social services. The community schools approach is also based on the belief that schools can be the focal point of community improvement, not just institutions

of learning. The idea is that strategies designed to create the best learning environment with students “ready to learn” can radiate out from the school into the wider community and then back into the schools. These mutually reinforcing efforts are said to improve the neighborhood’s educational attainment and its physical and social health, and increase the prospects for upward economic mobility.

This third hypothesis does have its skeptics. The impact of HCZ’s wrap-around services and community interventions, for instance, has been disputed as a significant factor in

children’s educational outcomes.³ Others argue that long-term impacts are often not identified in test scores, and that educational and social effects are not easily separated.⁴ This in turn has triggered a debate about Promise Neighborhoods, which are an attempt to replicate HCZ on a national

level.

Whether and how school-based hubs might help achieve healthy neighborhoods is an important topic of inquiry in our efforts to turn around low-income communities. There is a growing number of school-based hubs projects and interest in measuring their effectiveness and replicating those that seem successful. But assessing their impact is a difficult task. Often systematic data is not available to confirm the apparent results, and experimental and quasi-experimental evidence is limited. In these projects the data

“ Whether and how school-based hubs might help achieve healthy neighborhoods is an important topic of inquiry in our efforts to turn around low-income communities. ”

¹ Moore, Caal, Carney, et al, Child Trends (2014).

² Turner, Pastor, The Urban Institute (2010).

³ Fryer, Dobbie (2011), Fryer, Dobbie (2014); Whitehurst, Croft (2010).

⁴ Canada (2010).

is rarely adequate to isolate the specific aspects of the integrative program that might be driving the outcomes. Moreover, many interesting approaches essentially lie undiscovered, either because organizations do not have the internal capacity to analyze the data to the degree needed for systematic evaluations, or researchers have not yet examined them. So there needs to be a better inventory of hubs, and at least an initial analysis of examples that seem particularly noteworthy, in order for us to be able to develop a clearer picture of their impact.

As a step in that direction for one such promising hub, this paper provides an overview and initial examination of Briya Public Charter School and Mary's Center in Washington, D.C. This is an interesting case study, among other reasons, because it combines school education services for young children – and also their parents – with a sophisticated health clinic for the entire family and a range of social services in strong partnership with public and private agencies throughout the city. In two of its sites, the clinic and school occupy the same building.

The education and health performance data available strongly suggest that Briya/Mary's Center is having a significant and positive impact on the families it serves. But as the paper will indicate, like so many other examples, Briya/Mary's Center not only faces a number of obstacles in pursuing and expanding its approach but also faces challenges in obtaining the resources and building capacity in data collection for rigorous evaluations that would enable analysts to understand its impact and replicate the model.

Among these challenges:

- It is difficult for such organizations to attract support for evaluation. Donors typically prefer to fund services rather than analysis. Yet adequate investment by private and public sources in data collection, analysis, and empirical evaluation is needed for us to measure the effectiveness of hubs like Briya/Mary's Center. An empirical evaluation, in the form of a mixed-methods research design — combining both qualitative and quantitative methodologies — is the most useful for capturing the many layers at work in these integrative models.
- Innovative organizations collect and utilize data primarily to guide their operations and improve services and procedures. Those services and procedures change as part of the innovative process, based in part on data, although the data organizations need for operational decisions is often different from that needed for formal evaluations. Formal evaluation is the gold standard for measuring the impact of programs, but organizations need flexibility to experiment with new programs, and to grow their existing programs in a way that is not constrained by the rigid structure of formal evaluations.
- To demonstrate the impact of such hubs, the hubs themselves as well as evaluators need to have greater access to longitudinal data and the capacity to analyze it. The belief of organizations like Briya/Mary's Center is that their investment in young children and their parents will pay off in the long-term, in several different ways. Longitudinal data and studies are needed to evaluate that proposition.

Overview of Briya/ Mary's Center

The Briya Public Charter School has three branches across Washington, D.C., two of which (in Petworth and Adams Morgan) share a location with Mary's Center – a community health center. A third Briya School, in the D.C. neighborhood of Mount Pleasant, is co-located with Bancroft Elementary School, a D.C. public school. There are other Mary's Center clinical sites in Maryland that are not connected to a school, and Briya families have access to any of the Mary's Center sites across the D.C. metropolitan region. The Mary's Center offers access to a series of wraparound services in health and social services to low-income, primarily immigrant households, and Briya provides education services to both children and adults.

Briya Public Charter School began in the neighborhood of Adams Morgan in 1989 as an Even Start program⁵, to help smooth the transition of newly arrived immigrant families, primarily from Central America and Vietnam. In 2005, the school obtained its charter status, and by 2014 its three branches had been established. Currently, the school has an annual enrollment of approximately 150 children, from birth to age five, and around 400 adults participating in their programs. In November of 2013, Briya was chosen⁶ by the D.C. government as one of six schools to receive a “community schools” grant, obtaining a sum of \$166,667 for the 2013-2014 year.⁷ The grant was intended to help

expand access to the community's dental and medical services, as well as the adult education and youth development programs, by fostering community partnerships. Especially when considering its partnership with Mary's Center, Briya may be described as an “integrated student supports” (ISS) model. According to a review published by Child Trends in 2014, “ISS is a school-based approach to promoting students' academic achievement and educational attainment by coordinating a seamless system of wraparound supports for the child, the family, and schools, to target students' academic and non-academic barriers to learning.”⁸

Briya offers adult education programs in addition to early childhood, and is the only school in D.C. that offers a two-generation, family literacy model. Teachers serve as coordinators between students and parents, helping parents to become better and more active participants in their child's education. Most of the families enrolled in the schools are immigrants, with around 80 percent self-identified as Hispanic.⁹ Although Briya does not have entrance requirements around English proficiency, the content of the adult program is built around English as a Second Language (ESL), so, by design, the participants that enroll in the program are less than proficient in English. The major components of the adult education program

⁵ Even Start is an education program for the nation's low-income families that is designed to improve the academic achievement of young children and their parents through: early childhood education, adult literacy, and parenting education (Even Start website).

⁶ Brown, *The Washington Post* (2013).

⁷ “A community school is a public and private community partnership to coordinate educational, developmental,

family, health, and after-school-care programs during school and non-school hours for students, families, and local communities, with the objectives of improving academic achievement, reducing absenteeism, building stronger relationships between students, parents, and communities, and improving the skills, capacity, and well-being of the surrounding community residents.” (District of Columbia Community Schools Incentive Act of 2012).

⁸ Moore, Caal, Carney, et al, Child Trends (2014).

⁹ D.C.. Public Charter School 2014 Early Childhood Centers PMF data.

are English, parenting¹⁰, digital literacy, and workforce development programs. The workforce development programs include a high school diploma, a child development associate credential training, and a medical assistant credential. Briya also hosts a series of speakers on various topics who offer important learning skills on-site, such as financial literacy.

Mary's Center was founded in 1988, and is now a multi-service, integrative medical center, which offers an array of health, social and professional education services, outlined in the following sections. Mary's Center has four medical locations in the Washington metropolitan area (two within the boundaries of D.C. and two in suburban Maryland) as well as a senior wellness center, and two mobile units that travel throughout D.C. offering dental and health promotion services to

women of childbearing years. Families in the Briya School can access the health and social services offered by the other Mary's Centers around the city, and the services provided by Mary's Center can be accessed independently of the school. In 2014, 60 percent of the families enrolled at Briya chose to take advantage of the health and social services provided by Mary's Center.¹¹

Figure 1 below maps the location of the Briya Schools and Mary's Centers and the percentage of Hispanics in D.C. Not surprisingly, the Briya Schools and Mary's Centers lie in some of the areas of D.C. with the highest concentration of Hispanics, in census tracts where Hispanics make up between 10 and over 40 percent of the population. Moreover, the Centers are also located in places with high concentrations of low-income Hispanics.

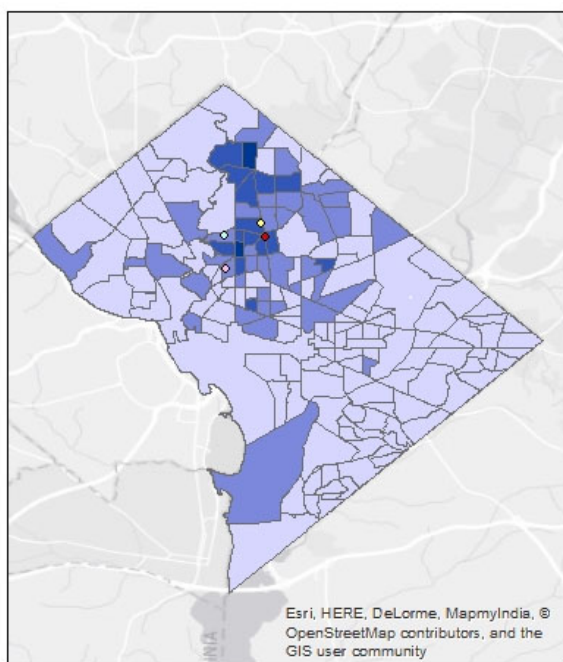
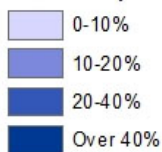


Figure 1) Percent Hispanic and Briya-Mary's Centers in D.C.
2009-2013 ACS 5-year Estimates

- ◆ Mary's Senior Wellness Center
- ◆ Briya School and Mary's Center Petworth
- ◆ Briya School and Mary's Center Adams Morgan
- ◆ Briya School Mt. Pleasant

Percent Hispanic

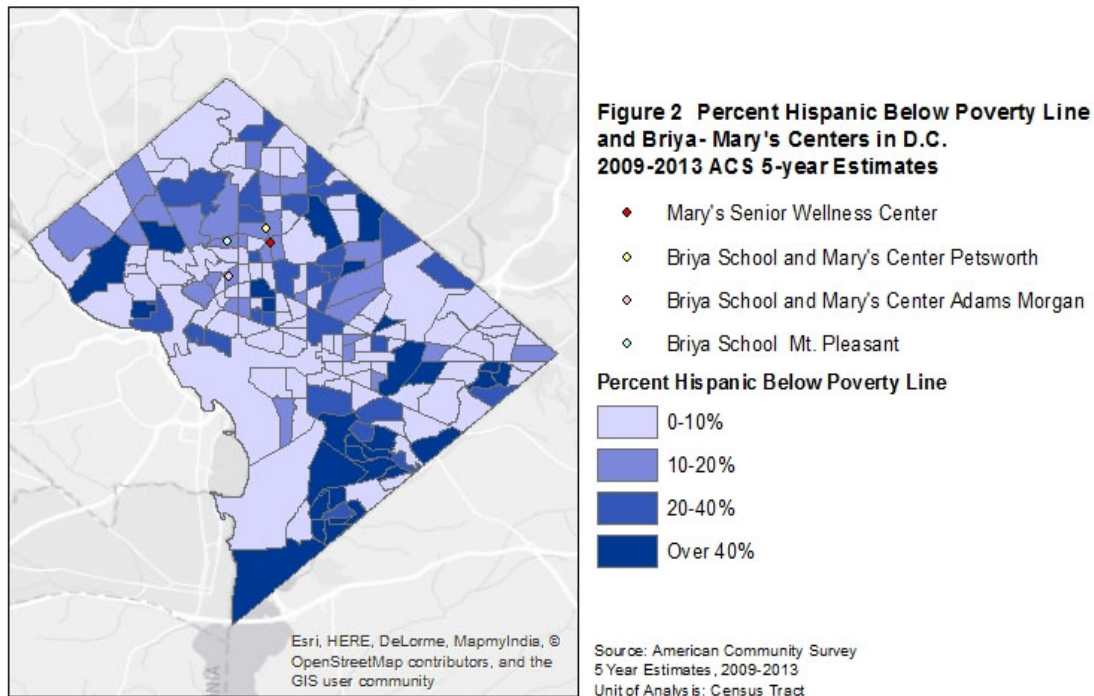


Source: American Community Survey
5 Year Estimates, 2009-2013
Unit of Analysis: Census Tract

¹⁰ Developing parenting skills appears to be an effective strategy to improve the conditions of low-income families and the opportunities for children. See Reeves, Howard (2013).

¹¹ This number is based on a point in time analysis of service utilization. Cara Sklar, Research and Policy Director at the Briya Public Charter School, suggests that the number is likely to be higher, as some of the grants received within the last year have enhanced and formalized the ways of linking students with Mary's Center services.

Figure 2 maps the location of the Briya Schools and Mary's Centers against the percentage of Hispanics living below the poverty line; anywhere from 10 to 20 percent of Hispanic families living in the tracts where the Centers are located have a household income that falls below the poverty line.



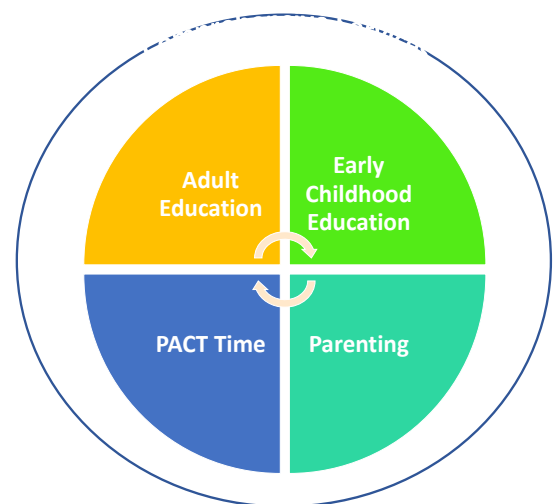
Briya/Mary's Center Programs

The Briya–Mary's Center partnership offers an array of services for families, aimed at tackling multiple sources of family distress together and at one location. These include:

Briya Public Charter Schools Services

Briya is a Public Charter School that follows a family-literacy, two-generation model. Its mission is to provide a high-quality education for adults and children that empower families through a culturally sensitive family literacy model. It offers English, computer skills, parenting and civics training to parents while preparing children of ages birth to five for future school success¹².

Figure 3 Briya Family Literacy Model



Source: Cara Sklar, Research and Policy Director, Briya Public Charter School

¹² Briya Public Charter School website.

Two-Generation Early Childhood

Education and Family Literacy: The pre-school serves children from birth to age five. It is open from 9:00 to 3:00, and infant, toddler and pre-k classes are held at the same time as adult classes. One of the central features of Briya is its two-generation model, where teachers serve as facilitators between parents and their children. The parent is often brought into the classroom to learn alongside the child and they are continuously involved in setting their child's goals and monitoring their child's progress.¹³

Adult Education and Parenting Classes: All classes offered by Briya are free, including for adults, but once a child is accepted the parents are encouraged to participate in all components of the program — including as a family in the family literacy program. Parents are encouraged to sign a document agreeing to spend at least 2 ½ hours a day in the school during the day or in the evenings. Briya offers a variety of adult classes. These include six levels of English for Speakers of Other Languages (ESOL), computer classes, a National External Diploma Program (NEDP), and career training.¹⁴ Typically, the enrolled adult students have less than 6 years of education in their country of origin. To promote leadership and democratic participation among students, the adults have organized a Student Council, which meets regularly to voice the needs of students.¹⁵

In addition to general education classes, the adults are also taught parenting and “practical life” skills. Parenting skills include early childhood development, language, and

literacy development techniques, as well as classes on general support to the child's education, discipline, and nutrition. For practical life skills, parents are taught a variety of services, such as: “how to complete health, school, and work forms, read medicine labels, and ask questions at doctor appointments.”¹⁶

Briya also offers two credentialing services: the Registered Medical Assistant Programs, and the Child Development Associates Program. The Registered Medical Assistant Program is an 18-month course that prepares adult students to conduct clinical and administrative duties, and the Child Development Associate (CDA) credential is a 120-hour course with a 480 hour practicum that allows graduates to become credentialed early care professionals.

Figure 3 offers a graphical representation of Briya's “family literacy” model, indicating how the different programs—Adult Education, Early Childhood Education, Parenting, and Parent and Child Together time (PACT)—are meant to work in coordination with each other with the curriculum of each reinforcing the other.

Mary's Center Services

Mary's Center is a Federally Qualified Health Center (FQHC). This means it is a community health center that receives enhanced federal reimbursements for providing comprehensive care to underserved areas or populations.¹⁷ In 2011, Mary's Center also received recognition as a National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) —a model that delivers high quality care and leads to improved health through increasing access to care, teamwork,

¹³ Mary's Center brochure.

¹⁴ Mary's Center website.

¹⁵ Cara Sklar, Research and Policy Director, Briya Public Charter School.

¹⁶ Briya Public Charter School website.

¹⁷ U.S. Department of Health and Human Services website, What are federally qualified health centers (FQHCs)?

and use of appropriate health information technology.¹⁸

Figure 4 Mary’s Center Social Change Model



Source: Mary’s Center |Saving Lives and Strengthening Communities, One Family at a Time. “Our Model.” Web.

Mary’s Center employs a multi-pronged approach, known as the ‘Social Change Model,’ to address the complex needs of its community.¹⁹ As depicted in *Figure 4*, at the center of this model is the idea that providing individuals and families with an integrated set of health care, education, and social services—instead of only addressing their health issues—is more effective in enabling them to achieve stability, economic independence, and overall good health. The Center offers health care, education, and social services to about 40,000 beneficiaries per year. An internal analysis conducted in 2014 found that about 40 percent of these beneficiaries receive all three services.²⁰ The center

operates across four medical locations, one senior wellness center, and two mobile units in Washington, D.C., and Maryland. The Center employs full-time and part-time staff, with full-time equivalent employees (FTEs) constituting about 92 medical staff members; 20 dental staff members; 19 mental health staff members; and 62 ‘enabling services’ staff members which include case managers, patient education specialists, outreach workers, and eligibility assistance workers. *Figure 5* provides a breakdown of the Center’s personnel and the number of clinical visits they provided in 2014.

Figure 5 Mary’s Center Staffing and Utilization in 2014

Personnel by Service Category	Full-Time Equivalent Employees	Clinical Visits
Family Physicians	2.41	8,839
Internists	1.61	4,889
Obstetrician/Gynecologists	0.60	2,549
Pediatricians	11	39,900
Nurse Practitioners	6.10	19,789
Physician Assistants	1	3,559
Certified Nurse Midwives	6.35	21,737
Nurses	12.08	672
Other Medical Personnel	50.32	-
Total Medical Staff	91.47	101,934
Total Dental Staff	20.33	28,603
Total Mental Health Staff	18.51	13,918
Total Enabling Services Staff	62.19	14,494

Source: Mary’s Center 2014 Uniform Data System (UDS) data (internal report)

¹⁸ Mary’s Center Earns National Recognition for Patient-Centered Care, [Press Release] June 11 2014

¹⁹ ‘Our Model,’ Mary’s Center, <http://www.maryscenter.org/content/our-model>.

²⁰ Conversation with Alis Marachelian, Senior Director, Health Promotion Department and Maria Gomez, CEO of Mary’s Center.

Health: Mary's Center offers a variety of health services. Among these are: (1) adolescent and adult care that includes physical exams, family planning, and prenatal care; (2) health promotion and disease prevention services including health screenings and in-depth, participatory health education counseling on the spectrum of cardiovascular, sexual, reproductive, and respiratory health, as well as nutrition and cancer navigation services; (3) mental health care; (4) dental care; (5) pediatric care; and (6) senior care.²¹

The Center has two mobile health units that provide outreach, health screening, and educational services to underserved neighborhoods. The Community Outreach van, known as the "Mama & Baby Bus," a partnership with the March of Dimes, offers families services ranging from health screenings, domestic violence, and depression screenings and referrals, as well as helping families to navigate insurance enrollment and to help access other health and social services. Through the use of mobile dentistry equipment, Mary's Center Dental Cruiser offers pediatric dental services at four middle schools in Prince George's County, Maryland. These mobile services are provided in the same way as all of Mary's Center services—the units take insurance, and for those clients without it, payment is charged based on a sliding scale.

Social Services: Mary's Center offers families a variety of social services including (1) domestic violence support; (2) support programs to help families access employment, housing, food, financial assistance and legal services at each of their clinical sites; (3) a father-child program to help fathers be better involved in their children's lives; (4) a home visiting program called Health Start Healthy Families (HSHF) to help prevent child abuse and neglect; (5) early intervention services for children with disabilities; (6) an after school teen program that also provides social

services support for both youth and their families; and (7) senior care.

Moreover, Mary's Center's Bilingual Health Access Program (BHAP) works in partnership with the D.C. Office of Public Benefits to help families assess their eligibility for insurance and assistance programs. For example, the program helps

patients apply for health insurance, including through Medicaid, the D.C. Children Health Insurance Program (CHIP), and Marketplace plans. Families are also assisted in applying for various entitlement benefits such as: the Special Supplemental Nutrition Assistance Program (SNAP), a federal food stamp program intended to help low-income families buy food to maintain healthy lives; the Women, Infants, and Children (WIC) home visiting program, which offers food vouchers and education to mothers and infants under the age of five; and the Temporary Assistance for Needy Families (TANF), a federal program

“...providing individuals and families with an integrated set of health care, education, and social services – instead of only addressing their health issues – is more effective in enabling them to achieve stability, economic independence, and overall good health.”

²¹ Mary's Center website, Health Services.

that provides temporary financial assistance to families, with the primary aim of allowing them to achieve self-sufficiency through employment.

Professional Education and Teen

Preparation: In addition to the education services provided at Briya, Mary's Center also offers an array of adult education services. For example, Mary's Center has a child care licensing program where early childhood professionals can receive training, technical assistance, and coaching from Mary's Center staff to learn how to open their own child care facilities. Mary's Center has also recently been awarded a grant from the D.C. Office of the

State Superintendent of Education to serve as a hub for a network of family child care providers – who care for infants and toddlers – to receive training and technical assistance to ensure they meet the Early Head Start quality standards.²²

The Center also provides teen educational programs to help first- and second-generation youth prepare for college, avoid unintended pregnancy, learn how to have healthier nutrition and a physically active life, and find meaningful work during the summer months. The adolescent services offered include tutoring, SAT preparation, community projects,

job readiness, job opportunities, health education workshops, behavioral health, school advocacy, and collaboration with school counselors.²³

Significantly, many of the students who enroll in these programs and receive credentials go on to join Briya's and Mary's Center staff. The

“In many cases, the Center has therefore developed an interesting cyclical pattern whereby individuals that were at one time offered health care, education and social services, become qualified and return to the Center to provide those services to others.”

new Medical Assistant Program, for instance, has now graduated one class of 20 students, and four of these students were hired by Mary's Center. The CDA program, started in 2007, has graduated 298 students of whom 18 currently work at Briya.²⁴ Several of Mary's Center's and Briya's current employees were also

originally mothers who received pre-natal care services. In many cases, the Center has therefore developed an interesting cyclical pattern whereby individuals that were at one time offered health care, education and social services, become qualified and return to the Center to provide those services to others.

Cooperation and Coordination with Other Institutions

The Briya/Mary's Center network operates as a hub in the sense of individuals and families coming to facilities in order to receive onsite education and services. But it also radiates into the community as well, having an impact outside the walls of its facilities. The mobile health units are one example. Briya/Mary's Center also partners with other institutions in

²² D.C.gov; “Mayor Bowser Launches Early Learning Quality Improvement Network.” web. 6 June 2015.

²³ Mary's Center website, Education Services.

the community, leveraging its expertise and systems in symbiotic relationships to enhance the effectiveness of other organizations.

Bancroft Elementary School. For example, the Briya School of the D.C. neighborhood of Mount Pleasant is co-located with the bilingual Bancroft Elementary D.C. public school. Not surprisingly, Bancroft is often top of the list for Briya students moving on to a D.C. public school. In addition, the relationship is strengthened because several of the Briya staff and adult students are also Bancroft parents and serve on parent teacher groups and other organizations within Bancroft.

Mary's Center's partnerships are, for the most part, determined by the specific needs and funding of each department within the organization. For instance, Briya tries to connect its adult students to different service providers within Mary Center, as well as with other organizations in the community, to try to address the broader social needs of the adult students. Meanwhile a Community Schools grant provided Briya with funding to organize a "know your rights" event, for which they invited different legal and social work organizations within the community to connect with the students and provide legal consultations on-site.

Teen Program. This is another example of how Mary's Center radiates into the community. Every young person (aged 12 to 21) that comes through the Center is given an "intake questionnaire," asking him/her a series of questions on such things as relationships, schools, drug usage, and depression. This tool is then used to connect students to different services or organizations based on

their identified needs, either on- or off- site. For instance, if the intake suggests that the teen requires GED classes, Mary's Center connects the teen with the college preparation services offered by the Latin American Youth Center. If the intake suggests that the teen has a smoking issue, he/she is connected with the health promotion department at Mary's Center. One core endeavor of the teen program services is its paid summer job program, which lasts six weeks, accepts over 100 students every summer, and involves workshops and job opportunities, both on- and off- site. Many of the interns work within Mary's Center where they are mentored by various medical and social services providers, and some offer assistance to Briya. For off-site internships, the Teen Program partners with the D.C. government to connect their students to internships across various organizations such as embassies, Blue Cross Blue Shield-CareFirst, and The Museum of National History at the Smithsonian. These internships are for the most part funded by the D.C. Mayor's Summer Youth Program and the Office of Latino Affairs.

Mental Health Clinic. Another example of how Mary's Center partners with community organizations is its school-based mental health clinic. As part of this initiative, Mary's Center has partnered with 11 schools in D.C. in an effort to open a school-based clinic within each school. The program involves sending a therapist to the school, working closely with the school administrator, to "enhance teachers' and counselors' ability to support students and families without having to travel off-campus while also caring for the behavioral needs of children on-site."²⁵

²⁵ Mary's Center website, Health Care Services.

Evaluation of the Briya/Mary's Center Model

The Data Gathering Process

Just how successful is Briya/Mary's Center in enhancing the lives of people in its community and which programs are the keys to success? If models like this are indeed successful, we would want to replicate the model elsewhere. Yet although Mary's Center has a robust system for keeping track of utilization and has several other performance metrics for the many families that they serve, there are still obstacles that prevent us from knowing the full effect of the programs. The Center has not secured the funding needed to conduct an empirical evaluation of the program. Moreover, the performance data they collect, while ample and thorough, may not fully capture what is needed for a full assessment of progress. Moreover, as the organization evolves and experiments, the data and analysis needed for operational decisions and to guide change is not necessarily the same that is needed for a full evaluation.

Quality Assurance and Outcomes

Department. Still, Mary's Center has invested in a Quality Assurance and Outcomes Department over the last several years, which has included expanding and refining its data collection process. In 2008, Mary's Center adopted EMR Systems Go — an electronic medical record that provides a single repository for all data collected within the organization.²⁶ A copy of this database is then connected to Structured Query Language (SQL) programming software, which is in turn used by a programmer within the Outcomes

Department to generate internal reports. Every program within Mary's Center logs data into the centralized Electronic Health Record (EHR). Selected staff within each department receives regular training on how to log in and retrieve the data from the dashboard. The online record holds extensive documentation on any individual who has ever accessed any of the services offered at Mary's Center. Among many clinical and social conditions, the EHR has individual-level information on: demographics; details on the individuals' health promotion received; and whether the individual received counseling on sexually transmitted diseases, nutrition, asthma, etc. The database also holds information on the types of services the individuals accessed, as well as the dates and length of the individuals' engagement with Mary's Center.

The Outcomes Department provides most of the internal data reporting for the organization. Their central task is to generate a quarterly report on the progress of all individual departments within the organization, based on pre-assigned annual goals. On the clinical side, the goals are determined according to the national objectives set by the Office of Disease Control and Health Promotion.²⁷ The individual programs providing education and social services set their goals internally. These quarterly reports are reviewed by the Mary's Center Board, as well as peer reviewed by the board of Continuous Quality Improvement (CQI), which meets monthly, before being distributed to heads of every department in the organization to assess if there needs to be a change in process or delivery of care to address outcomes not met. The Quality Assurance and Outcomes Department also

²⁶ Bethany Sanders, Outcomes Director, Mary's Center

²⁷ Office of Disease Prevention and Health Promotion website, Healthy People Initiative.

provides individual departments with metrics based on each department's needs and demands: they provide departments with the metrics they need to report on their grants and they provide departments with monthly data on patient tracking, as well as a series of other metrics based on individual departmental requests.

Some Challenges in Program Evaluation and in Collecting and Analyzing Data

Although advanced electronic data collection systems are in place to provide data analysis to track and improve its operations, the Briya/Mary's Center model, like similar approaches, struggles to allocate resources and attract funds to enable the organization to develop rigorous empirical analyses of its programs, which is a common challenge for such innovative models. But without an empirical evaluation, it is difficult for public and private funders to know whether supporting the expansion and replication of a seemingly promising approach is a wise investment.

But a rigorous evaluation of such programs is not a simple task, even with adequate funding and internal capacity. Although rigorous research methodologies have been used to evaluate integrated “wraparound” services, the precise impact of interconnected services is difficult to quantify, as it is hard to isolate the effect of various services on the individual. Yet central to the logic of the Mary's model is that these outcomes are working in conjunction with each other and that their effects are best measured collectively.

On another note, there is also a question of

whether the type of data normally collected to keep track of the performance of an organization is actually useful in analyzing the progress of those families served specifically at Briya/Mary's Center. One reason for this problem is that the data collected to comply with the terms of a government program or private grant may not actually cover the apparent “secret sauce” of an innovative approach. So there can be a disconnect between the data collection requirements of funders and payers and the data that is needed by the organization to track how individuals benefit from promising strategies. Another challenge is that in a creative, evolving organization, different kinds of information may be more important at different stages of development. For example, there is a difference between the data needed to help plan and tweak a continually changing and evolving organization and what is needed to fully evaluate a mature and stable organization that may be a candidate for replication.²⁸

Creating centralized data systems within the organization may also have its downside. One issue when data is centralized in an organization is that individual departments may not have the technical capacity to pull-up data reports on a regular basis. Mary's Center is in the process of training people within departments to better develop the skillset they need to do this. But this is often the kind of challenge that impedes the flow of information down the organization.

There is also an issue with the scope of the data that organizations can access and track. A constant source of frustration expressed by

²⁸ Butler, Muhlhausen, *National Affairs* (2014).

Mary's Center leaders is the absence of infrastructure available to gather and track longitudinal data on clients, and to keep track of their activities once they leave Mary's Center. This is a capacity issue, but also a privacy issue. Privacy statutes, such as the Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA), often hinder the sharing of data across organizations.

These data and evaluation challenges make it difficult to assemble the analysis needed to demonstrate with confidence the degree to which Briya/Mary's Center model has been successful, and to determine what constitutes its key elements of success.

But Briya/Mary's Center does seem to be on the right path; the evidence on the many individual components of Briya/Mary's Center—English-language, two-generation programs, integrated student supports, patient-centered medical homes (PCMHs), school-based health centers (SBHCs), and mobile health units—have shown positive, albeit modest, effects. Likewise, the preliminary education and health performance data at hand suggests that that it is performing well.

What Other Research Suggests About the Briya/ Mary's Center Approach

Reviewing the body of existing research, there is evidence to suggest that two-generation

programs and integrated student supports can be effective programs for boosting outcomes among infants and toddlers.

“ Briya/Mary's Center does seem to be on the right path; ... the evidence on the many individual components of Briya/Mary's Center have shown positive, albeit modest, effects. ”

An initial review of the literature suggests that, other than the evaluations of federal programs such as the Even Start Family Literacy Program and the Enhanced Early Head Start²⁹ (both of which had issues of implementation and showed poor results), the recent wave of two-generation family literacy

models—those initiated since the 2000s, which Chase-Lansdale and Brooks-Gunn refer to as two-generation programs 2.0.³⁰—have not been evaluated under experimental or quasi-experimental conditions. So we do not yet fully understand the causal effect of these programs on families and children. Nonetheless, there is evidence to suggest that these models offer a promising approach for child and family development.

Two-Generation Models. The Brookings-Princeton joint journal collaboration *The Future of Children* dedicated its spring 2014³¹ issue to examining the current and potential success of two-generation programs. Although the contributing authors echo the need for more rigorous evaluations of the interventions in place before being able to draw strong conclusions on their efficacy, they are optimistic about the potential of these models to exert a positive impact on families. Among other things, the authors suggest that two-generation programs seek to tackle multiple sources of family distress—stress regulation,

²⁹ [Pierre](#), Ricciuti, Tao, Department of Education (2003), Huseh, Farell (2012).

³⁰ The Future of Children 24.1 (2014).

³¹ The Future of Children 24.1 (2014).

parental education, parental health, family income, employment and assets—which have shown to be linked to a child’s development.

In this same *Future of Children* issue, Chase-Lansdale and Brooks-Gunn argue that providing infants with a continuously positive and embracing surrounding environment, and offering intensive interventions in more than one area of a child’s life during the early years—both of which are covered under two-generation models—are essential to a child’s wellbeing.

There are other sources of evidence pointing to the impact of two-generation programs. The National Center for Families Learning conducted a qualitative evaluation on the performance of Hispanic-focused family literacy programs in 53 schools around the nation, and found that the programs increased student achievement and parental engagement with their children and schools. Moreover, an eight-year longitudinal mixed-methods (non-randomized) evaluation³² of a family literacy program in Los Angeles found that the program led to increased parent participation in their respective homes, schools and communities, even after the program ended. Lastly, there is also evidence to suggest that focusing on boosting the English-language proficiency of children and adults can lead to better outcomes for families.³³

Multi-Service, Comprehensive School Models. In February 2014, Child Trends published the most comprehensive compilation of evidence to date on the efficacy of these school models, which they call

“integrated student supports.” The authors looked at the evidence surrounding nine of these models, which together serve more than 1.5 million students in nearly 3,000 elementary and high schools across the country.³⁴ One of these is the “Communities in Schools” program, which is part of the “Coalition for Community Schools.”³⁵ The Briya/Mary’s Center partnership has been closely aligned with this model since its inception, and in 2013 Briya/Mary’s Center was a grantee of the first wave of “Community Schools” grants given by the D.C. government. Overall, the report finds integrated student supports (ISS) to be a promising approach, well-grounded in child-development research, and that have shown modest but positive effects in boosting student outcomes.³⁶

One of the most valuable parts of the Child Trends report is the review of 11 evaluation studies that have used an experimental or quasi-experimental design to evaluate the efficacy of these integrated service schools. The review from the quasi-experimental studies suggests that these models can have significant effects on student progress, school attendance, GPA, and reading achievement/English Language (ELA) test scores (pg.62). The four randomized controlled trials studies that were reviewed also found positive, albeit significantly less frequent, effects of the school models on student test scores.

To be sure, even though the education research would suggest Briya/Mary’s Center approach is in line with study findings, the partnership is charting new ground and there are at least two caveats about the applicability

³² Quick, Manship, et al, American Institutes for Research (2011).

³³ Kim, Curby, Winsler (2014), Ross, CAP (2015).

³⁴ Moore, Emig, ChildTrends (2013).

³⁵ See Community Schools website <http://www.communityschools.org/>.

³⁶ Moore, Caal, et al, ChildTrends (2014).

of the general research to the Briya/Mary's Center model.

First, the evidence on integrated student support models concentrates on the effect of the school models on students in grades 1-12. A review of the literature suggests that no study has looked at the effects of integrative programs on early-childhood scores.

Second, although the evidence suggests that integrative models can boost student outcomes, it is not clear *which* of the many services being offered by the schools is influencing the scores, or *which* factors are most influential in a child's development.³⁷ Given the inter-connectedness of these services, the full benefits of having children exposed to a continuous set of "wraparound services" are difficult to quantify, and it is particularly tough to isolate the particular services that are the most effective in promoting child development. There is also conflicting research on whether providing social services and community-level interventions have an effect on student outcomes.³⁸ These are crucial issues to wrestle with when thinking about which features of a model are the keys to success in replication.

The Performance Data on Education

Given the evaluation challenges described previously, Briya's impact on early childhood and adult education cannot yet be determined with confidence.³⁹ Still, as mentioned previously, there is evidence to suggest that

the different components of the Briya/Mary's Center model—two-generation programs, English literacy programs, as well as the integrated, multi-service health and social supports—can indeed boost human capital development among children.

What about the performance data that *is* available? The available preliminary data on adult and student scores shows promising results.

There are about 60 public early childhood charter schools and eight chartered adult education programs in D.C. As recent as 2013, The Public Charter School Board piloted its first common accountability tool—The Performance Management Framework (PMF)⁴⁰—to measure early childhood and adult education programs across its schools.

To be sure, the performance assessments of these programs are still in their infancy, and the data available is too preliminary in nature to allow us to make any definitive statements about the performance of Briya at this point. Further, demographic differences across schools, differences in the details of the content of the programs and curriculums, the small number of early childhood and adult education programs sampled, and possible differences in the way the data was collected complicates the use of the PMF as a source of evaluation across schools. In many ways, therefore, using PMF data to compare schools is not an "apples to apples" comparison. However, with these caveats in mind, a first look at this data suggests that Briya is doing better than the rest of the D.C. early childhood schools and adult education schools, but is

³⁷ Moore, Caal, et al, ChildTrends (2014) (pg.6).

³⁸ Fryer and Will (2011) and Fryer and Will (2014) and Glover and Craft (2010).

³⁹ When asked about this, Cara Sklar, Research and Policy Director at the Briya Public Charter School, cited a lack of funding.

⁴⁰ 2013-2014 Performance Management Framework: Guidelines and Technical Guide.

nevertheless struggling with below-average levels of child attendance.

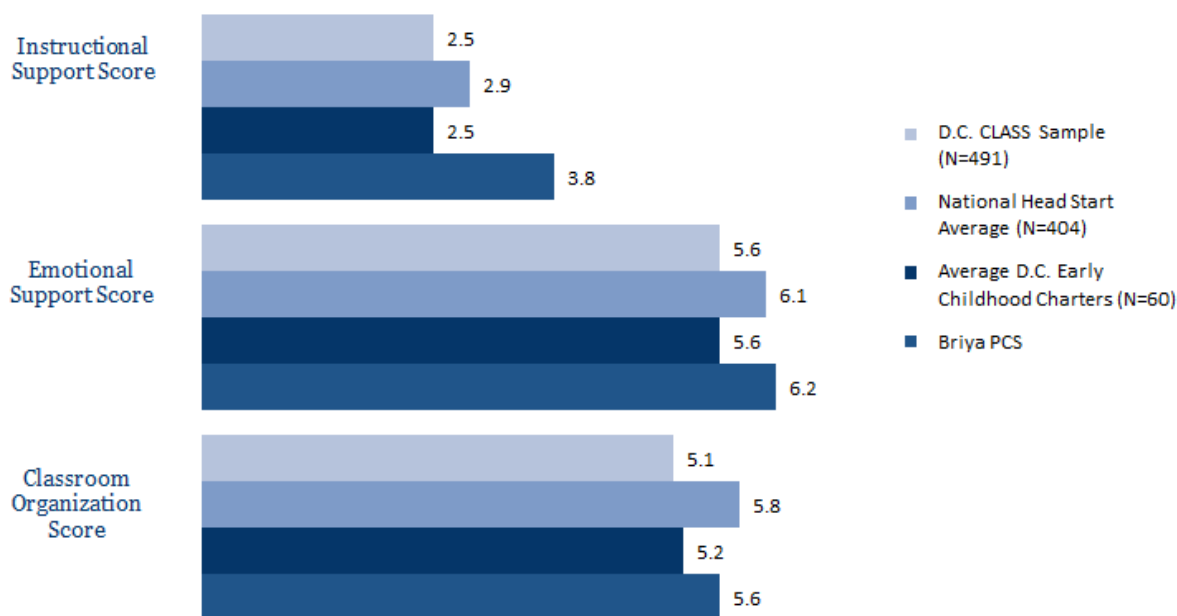
The PMF was adopted by the D.C. Public Charter School Board in 2013 with the logic of creating a standardized way of measuring the academic performance of the programs across schools, while allowing schools the flexibility to choose from a menu of student assessments they consider best fit their schools' program and demographics. In 2013-2014, D.C. Public Charter School Early Childhood schools were measured based on

interaction and attendance (which together account for 50 percent of the PMF assessment)⁴¹.

Figure 6 compares the results of Briya teacher interaction with those of its peer D.C. charter schools, with the average of a sample of schools in D.C. taken by the Office of the State Superintendent of Education in 2014, and with the national Head Start averages.⁴²

This comparison uses the Classroom Assessment Scoring System (CLASS) metric,

Figure 6 Teacher Interaction - 2013-2014
Briya PCS vs. other Early Childhood Centers
(scores using Classroom Assessment Scoring System)



the following metrics: student growth in education domains, a self-assigned mission-specific goal, attendance, and teacher-student interaction. We compared Briya to its peer charter schools based on the two measures that are the most easily generalizable across early childhood centers: teacher-student

which is an in-person, qualitative evaluation that records and measures student-teacher interactions, and is considered one of most reliable, scalable ways to evaluate the success of an early childhood program. The CLASS scores account for 40 percent of the Charter Schools' PMF evaluation. CLASS

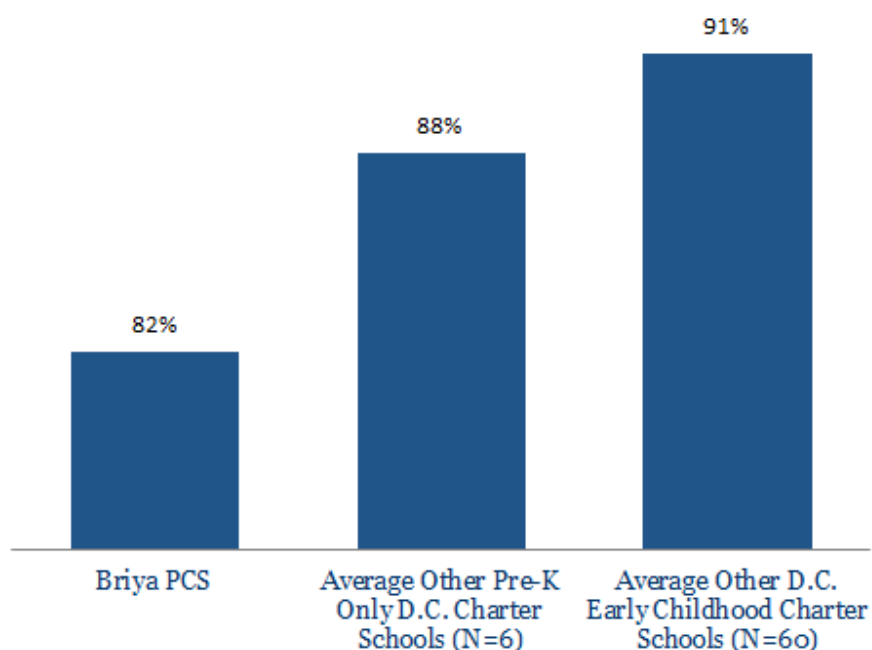
⁴¹ 2014 Early Childhood Performance Management Framework, D.C. PCSB.

scores account for 40 percent of the Charter Schools' PMF evaluation.⁴³

The preliminary numbers suggest that Briya is doing better than the average of its D.C. early

Although this is good news for Briya, its attendance rates are lower than those of its peer charter schools. *Figure 7* compares the in-seat attendance rate⁴⁴ of Briya with the average for D.C. early childhood charter

**Figure 7 In-Seat Attendance Rate 2013-2014
Briya vs. Other Early Childhood Centers D.C.**



childhood peers, across all three measures of teacher-classroom interaction. It is also doing better than the average of the D.C. Schools sampled annually by the Office of the State Superintendent of Education, and approximately the same as the national Head Start average (and in the case of instructional support, better).

schools and pre-k-only D.C. charter schools (national averages not available). Pre-k-only charter schools are included because this captures the universe of early childhood chartered schools for which attendance is not mandated by law. Attendance accounts for 10 percent of a Charter Schools' PMF evaluation.

⁴³ Briya is part of state pre-k, not a part of Head Start. In lieu of better data, Head Start numbers were taken as a proxy for the national averages of early childhood centers serving low-income families. Head start link: <http://eclkc.ohs.acf.hhs.gov/hslc/data/class-reports/docs/national-class-2014-data.pdf>.

⁴³ Early Childhood Performance Management Framework, D.C. PCSB..

⁴⁴ In-seat attendance measures days present over total days enrolled. Many other states around the country measure average daily attendance rate, which is days present plus excused absences over total days enrolled. It is important to note this distinction when comparing D.C. Public Charter School to other schools in the nation.

Eighty two percent is hardly a low attendance rate, especially for non-compulsory grades such as pre-k, but it is lower than the comparable early childhood charter schools in D.C. Why might that be? A possible explanation is that in an attempt to promote “the family literacy model,” the school might be unintentionally driving up absences. Briya expects parents are expected to spend 2.5 hours a day in adult education and parenting classes, and are not encouraged to just “drop the children and leave.” This may cause some parents to keep their children out of school on some of the days the adults cannot attend, especially given the costs for low-income families: sacrificing over two hours of their time during the work-day can be very high. Another possible reason, as Briya staff point out, is that the school is working with some of the most vulnerable families in the city. For instance, Briya has the highest percentage of student English language learners of all the early childhood charter schools in D.C. Still, their below-average attendance rate is a source of concern.

Adult Education. The PMF also sampled adult education data comparing Briya with the other schools. The adult education programs were measured based on test scores in English proficiency, how much the students progressed throughout the year, and whether the adult student managed to obtain/retain a job or enter postsecondary school.⁴⁵ The many differences between the adult education programs, the small sample of schools (n=7), and the vastly different curriculums and demographics across programs make the comparisons across adult programs problematic. Thus, we omitted them from our

analysis. Nevertheless, at first glance,⁴⁶ based on D.C. Public Charter School Board PMF data, Briya is doing as well as, or better than, the other adult education programs.

Given that the PMF was only piloted in 2013-2014, it is hard to make any conclusive statements about Briya compared with the other schools. But a first look at the data suggests that the adult and early childhood programs from Briya are doing well, and on most accounts better than the other D.C. public schools. By the end of this school year (2014-2015), the D.C. Public Charter School Board intends to use these metrics to start dividing the early childhood and adult education programs into different tiers, depending on their performance.

The Evidence on Healthcare

As mentioned earlier, given the uniqueness of the Briya/Mary’s Center model, and the challenges the Center faces in financing data evaluation and the collection of data over time, it is difficult to quantify its effect on the community it serves. However, as in the case of the education programs, the research literature would lead us to expect that several features of Mary’s Center and its services should be effective in improving community health outcomes.

Several studies, for example, have found that the quality of care provided in community health care centers is high compared with other usual sources of primary care. For example, one cross-sectional analysis comparing the performance of Federally Qualified Health Centers (FQHCs) and look-alikes with that of private practice primary care

⁴⁵ 2013-2014 Adult Education Performance Management Framework, D.C. PCSB.

⁴⁶ D.C. Public Charter School Board Annual Report 2014.

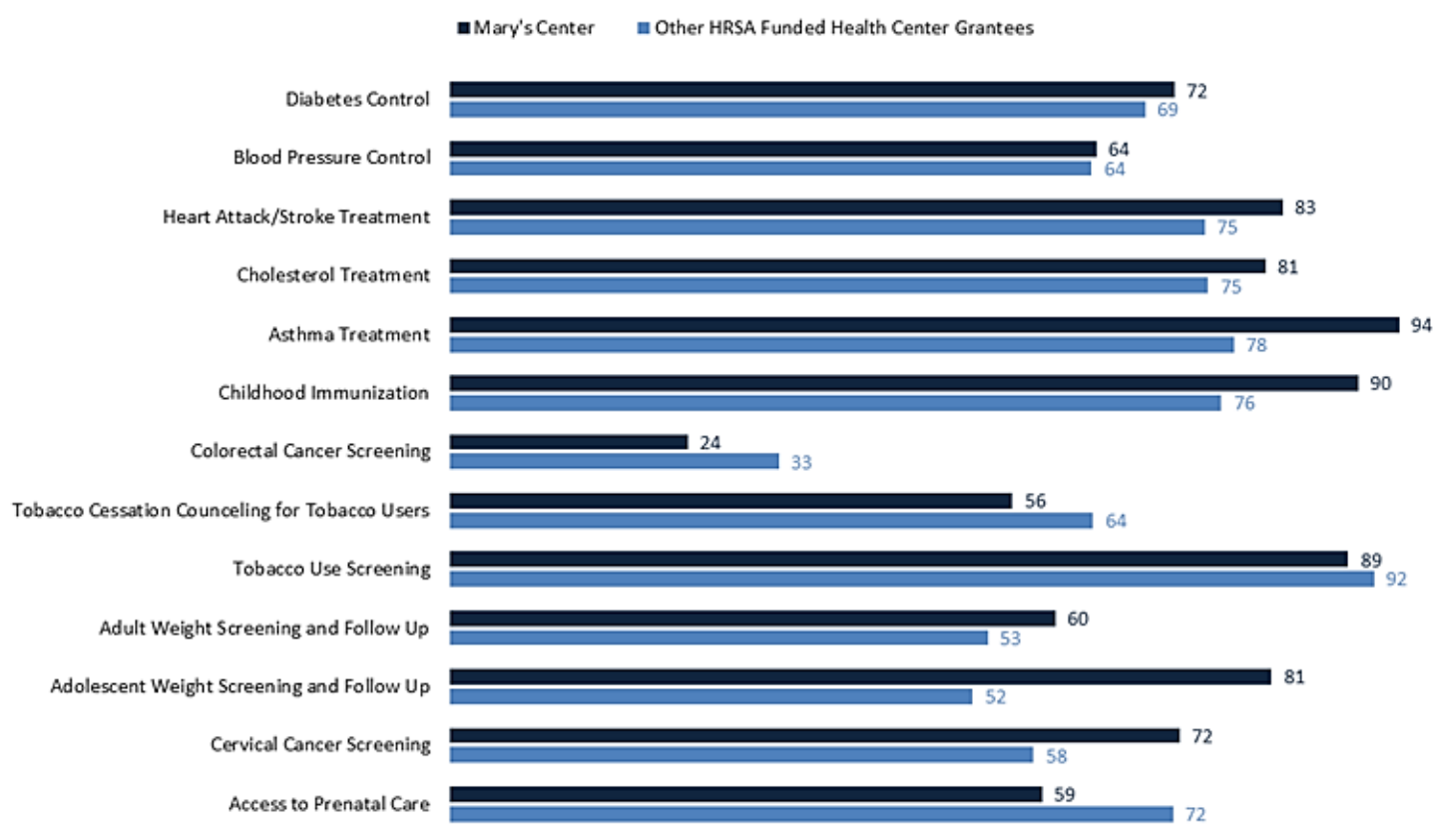
physicians (PCPs) on a set of ambulatory care quality measures showed that FQHCs and look-alikes had equal or better performance than private practice PCPs.⁴⁷ These results are especially meaningful given that these FQHCs and look-alikes served a disproportionate share of patients with chronic diseases and socioeconomic challenges, as is mostly the case in community health centers. Similarly, another study found that one in every ten community health centers is consistently high performing, and that most perform well in managing diabetes and high blood pressure when compared to Medicaid managed care organizations (MCOs).⁴⁸ These results are impressive, given that MCO patients all have insurance—unlike the

typically low insurance rates of individuals using community health centers.

Research on the effects of Patient Centered Medical Homes (PCMHs) on patient care and health is gaining momentum. A recently

published evaluation of 28 publications, including peer-reviewed literature, state program evaluations, and industry reports found evidence for improved quality of care, access to care, and patient satisfaction in PCMHs.⁴⁹ A review of 19 peer-reviewed studies found that PCMHs showed small to moderate positive effects on patient experiences and on the delivery of preventive care services.⁵⁰ Other studies have found that medical homes can result in significant

Figure 8 Percentage of Patients Quality of Care Services in 2013



⁴⁷ Goldman et al., 2012.

⁴⁸ Paradise J., et al. 2013.

⁴⁹ Nielsen M., et al., 2015.

⁵⁰ Jackson G.L., et al. 2013.

reductions in unmet health care needs across racial and ethnic groups, and that patients belonging to a medical home experienced reduced or eliminated racial and ethnic disparities in access to care and quality of care.^{51,52}

Though the evaluation of school-based health centers (SBHCs) is complex, studies have indicated that these models are successful at increasing access to care and improving the educational and health outcomes of students.⁵³ SBHCs are characterized by the delivery of team-based and interdisciplinary care in school settings, and have shown positive impacts on the provision of preventive care and reproductive health services, and the management of chronic care among adolescents. Moreover, school-based mental health programs have been shown to be effective in increasing access to treatment and at improving knowledge and awareness of mental illness among both faculty and students.^{54,55}

Research has also found that mobile health units are successful at providing care to underserved communities, improving health outcomes and decreasing health disparities. For example, one study showed that a

specialty-based mobile asthma clinic in Baltimore, known as The Breathmobile, significantly improved the symptom-free days (SFD) in a year for the population that it served.⁵⁶ Similarly, other studies have found these models are successful in decreasing blood pressure in underserved populations, and delivering overall preventative care.^{57,58}

What Does Mary's Center's Data Tell Us?

Mary's Center is one of the many centers supported by The U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA), known as HRSA Funded Health Center Grantees. These centers are required to collect and publically report Uniform Data System (UDS) data—which includes information on patient demographics, services, clinical quality indicators and cost—on a yearly basis.⁵⁹ As shown in Figure 7, Mary's Center's UDS data suggest that, in 2013, the Center performed better than other HRSA funded health centers nationally, on most of its quality of care indicators.^{60, 61,62} When adjusted according to the percentage of uninsured, minority, homeless, farmworker and minority patients served, and according to electronic health record status, in 2013, Mary's Center ranked particularly well (among the highest 25

⁵¹ Aysola J., et al., 2013.

⁵² Hernández S.E., et al., 2008.

⁵³ Keeton V., Soleimanpour S., Brindis C.D., 2012.

⁵⁴ Fazel M., et al. 2014.

⁵⁵ Stein B.D., et al. 2012.

⁵⁶ Bollinger ME, Morpew T, Mullins CD, 2011.

⁵⁷ Song Z., et al. 2013.

⁵⁸ Hill C., et al. 2012.

⁵⁹ U.S. Department of Health and Human Services, Health Center Program.

⁶⁰ U.S. Department of Health and Human Services, Health Center Data & Reporting, Mary's Center data.

⁶¹ U.S. Department of Health and Human Services, Health Center Data & Reporting National Program Grantee Data.

⁶² U.S. Department of Health and Human Services, Health Center Data & Reporting, Look-Alikes Data.

percent of reporting health centers) on four quality of care indicators⁶³:

1. **Heart attack/stroke treatment** – 83% of patients with Ischemic Vascular Disease (IVD) received aspirin therapy compared with 75 percent in health centers nationally.
2. **Asthma treatment** – 94% of patients with persistent asthma received an acceptable pharmacological treatment plan compared with 78 percent in health centers nationally.
3. **Adolescent Weight Screening and Follow Up** – 81% of children and adolescents were screened and received counseling on nutrition and physical activity compared with 52% in health centers nationally.
4. **Cervical Cancer Screening** – 72% of patients were screened compared with 58% in health centers nationally.

Limitations of the Data: Although these data may be an indication that Mary's Center is having a positive effect on the health outcomes of the population that it serves, it is unfortunately purely descriptive and has many limitations. In particular, this list of purely clinical measures does not capture the full effects of the other services and programs that might positively influence the health of Mary's Center's community. For example, the data does not capture the repercussions that social services might have on patients' short-term

and long-term health, such as help signing up for health insurance and finding better housing, school-based mental health programs, or health education. In other words, the limitations of the available health data unfortunately cannot give us important insights on the effectiveness of a multiservice, comprehensive strategy—the essence of the Briya/Mary's Center strategy.

Moreover, this point-in-time data only provide a snapshot of Mary's Center's performance during 2013 and might therefore hide fluctuations in performance at different points in time. A series of historical data may better help evaluate how a program is faring over time, and whether it is showing overall improvement. Indeed, to truly evaluate the effects of Mary's Center's unique structure on patients, the collection and reporting of longitudinal data would be necessary to see whether patients reap the benefits of these interventions throughout their lives.

What Briya/Mary's Center Tells Us about the Data Needs of Innovative Community-based Strategies

Briya/Mary's Center is an interesting case of how a school-clinic hub can impact the medical, social and educational health of a community, potentially laying the foundation for greater economic mobility in a neighborhood. The approach of merging a community health center with a charter school—using a dual generation strategy, and fostering strong partnerships with other schools, health care and social service providers in the community—could be a model

⁶³ Health Resources and Services Administration, Uniform Data System (UDS) Health Center Adjusted Quartile Ranking Description.

for other communities to follow. The available education and health performance data suggest that Briya/Mary's Center is having a significant and positive impact on the families it serves. However, data challenges render it difficult to understand *the degree* to which such models work and *how* they work. A better understanding of these factors is needed if such models are to be successfully scaled and replicated.

The specific challenges include:

The lack of resources for rigorous program evaluation makes estimating the model's effects difficult.

Briya/Mary's Center collects important data on student performance and the utilization of health, mental health, and social services, and these data suggest that their students and patients benefit from the services they provide. Yet the lack of

funds for investment in empirical evaluation makes it difficult to determine the efficacy of the model or what elements of that model are most important. Briya/Mary's Center is not alone. Such organizations typically lack the ability to attract financial resources to set up and carry out a rigorous analysis of the more interesting or innovative features of their model. Funders and government programs understandably tend to focus on delivery of

services and on investigating what they think is important. Thus organizations tend to be already burdened by carrying out the data collection required by their funders (e.g. health care quality outcomes or student test scores).

Performance tracking criteria used to measure and compare outcomes within organizations need further development.

Briya/Mary's Center faces another common challenge in assembling metrics that can both serve the needs of the organization while allowing comparisons at the city or nationwide level.

The D.C. Public Charter School Board is currently developing and refining the common metrics by which it evaluates and compares the performance of early-childhood and adult education programs. This will help, provided the systems do not conflict with the metrics that Briya/Mary's Center needs to evaluate its approach. A

positive step is that the weights of the different components of the evaluations are being developed in collaboration with local charter school leaders, and are being adjusted according to their input. These moves echo a larger positive national trend in early childhood evaluation, in which the states and D.C. are actively seeking to standardize the metrics and accountability of their early childhood centers.⁶⁴

“ These moves echo a larger positive national trend in early childhood evaluation, in which the states and D.C. are actively seeking to standardize the metrics and accountability of their early childhood centers. ”

⁶⁴ See the QRIS National Learning Network Services, which Washington D.C. belongs to, as an example of states trying to develop a common accountability mechanism for early childhood centers.

The health care measures used to evaluate the performance of Federally Qualified Health Centers (FQHCs) such as Mary's Center also have their limitations. The "process measures" described earlier establish whether care guidelines have been followed, but they do not discern whether the care provided has actually improved patient health.⁶⁵ For example, to perform well on the "adult weight screening and follow up" indicator, physicians have to chart the Body Mass Index (BMI) of patients aged 18 and older, and for those patients who are over-weight or under-weight, a follow-up plan must be documented. This indicator does capture whether a physician has documented a follow-up plan for a patient who has an unhealthy weight. But it does not indicate whether the patient eventually achieved a good health outcome over time by reaching and maintaining an appropriate BMI. Outcome measures are necessary to establish whether desired results have been achieved.

Aware of such limitations, Mary's Center is striving to move beyond just capturing these process measures. Through the use of certain features on the Electronic Medical Record (EMR), the Outcomes Department and the Continuous Quality Improvement (CQI) team has come up with "Universal Care Plans." In these plans, individual visit notes from each department, relevant medical history, medicines taken, and latest labs are automatically populated into an individualized care plan for each patient. The plan can be printed and given to the patient to review in future visits and to hold for reference as he/she works on improving on certain health goals. These care plans are in the preliminary pilot phase and hold promise in helping to

demonstrate whether true health outcomes are achieved.

It is currently difficult to track individuals longitudinally and outside the program in order to show success and modify strategies.

One of the central obstacles to understanding whether the Briya/Mary's Center model is successful comes from the absence of available longitudinal data to track individuals after they leave the institution. Without institutions maintaining compatible data tracking the same individuals, and sharing that data, it is difficult or impossible to demonstrate the long-term effectiveness of a hub or to establish feedback loops to help the hub adjust and improve its approach over time. Like other organizations focusing on early education and on two-generation strategies, Briya would benefit highly from having greater access to longitudinal data. The lack of access to children's data once they leave school renders it difficult to determine whether the program has effects that carry into a child's adolescence and adulthood. The same lack of longitudinal data impedes Briya's ability to track whether its approach to parenting classes and parental involvement in the school actually leads to stronger family units and beneficial long-term effects.

There are also limitations in tracking beneficiary outcomes outside of the program itself in order to evaluate the broader, social effects of the program. Mary's Center has shown some ability to do this with its access to the D.C. Health Matters web portal. This portal connects members of the D.C. Healthy Communities Collaborative—a partnership

⁶⁵ Berenson R.A., Pronovost P.J., Krumholz H.M., 2013.

between four non-profit hospitals and three other FQHCs—and allows them to share patient health data. However, Mary’s Center would benefit from greater data sharing with the broader community service agencies to which it refers its patients. These agencies offer services that might also be contributing to overall health (as well as decreasing their medical expenditures), including housing centers/shelters, behavioral health and addiction, and legal aid centers.

Privacy rules pose barriers to community-level data sharing.

Privacy rules provide important safeguards, but they also pose another challenge for organizations like Briya/Mary’s Center that seek to collaborate with other institutions in ways that require sharing data. This can be especially difficult when trying to gather sensitive patient-level or student-level data, which is protected by stringent and complex privacy laws such as the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA). Some data-intermediaries, such as the D.C. Health Matters initiative and Neighborhood Info D.C. (housed at The Urban Institute) are helping to address this problem by improving access to community-level data and offering strategies to work within the existing HIPAA and FERPA laws.

For instance, one of the recommendations that Neighborhood Info D.C. made to the U.S. Department of Education for evaluating the roll-out of Promise Neighborhoods is to establish a written data-sharing agreement with the different entities that are involved in

safeguarding the data under HIPAA and FERPA. In the case of FERPA, the school district can give written consent, and in the case of HIPAA, they can get consent from an adult individual or a personal representative of the patient. The aim is to have a central database with individual level data that can capture the holistic nature of the intervention by tracking an array of student and family outcomes. To protect privacy, once the data is centralized, all unique individual direct identifiers are removed.

Steps to Help Measure the Effectiveness of Integrative, Multi-Service Organizations

A number of steps could be taken to address some of the challenges faced by the Briya/Mary’s Center partnership, and similar organizations, in measuring their program’s effectiveness:

1. In addition to funding programs and services, philanthropists and government should increase the priority and funding for the collection and analysis of data and rigorous evaluation.

It is always more attractive for funders to put money into direct services rather than into the “overhead” of data collection. But without data and the tools to analyze it, we can only guess how or whether an innovative approach actually works. Moreover, replicating approaches without rigorous evaluations risks spending a lot of money with little to show for it. For this reason, there needs to be a better

⁶⁶ Measuring Performance: A Guidance Document for Promise Neighborhoods on Collecting Data and Reporting Results, February 2013.

balance between funding services and funding data analysis and rigorous evaluation.⁶⁷

Governments can help this process. In Maryland, for instance, the state has essentially earmarked funds from a range of programs to create a pool of money available for data and organizational infrastructure. In Baltimore, the non-profit Family League of Baltimore and the city's community schools have tapped into these funds to help build data and tracking systems to help evaluate community schools as neighborhood hubs.

The private sector can also take a lead. As a recent Urban Institute study on place-conscious strategies observed:

"Foundations can and should encourage and support continuous learning within the organizations and initiatives they fund. This means investing the financial, technological, and intellectual resources required to support the hard work of defining meaningful outcome goals and indicators, collecting needed data, and analyzing progress in real time"⁶⁸

Adequate funding would allow organizations pursuing multi-service, integrated models like Briya/Mary's Center to use a mixed-methods approach in a formal evaluation, incorporating both quantitative (in the form of an experiment or a quasi-experiment) and qualitative methodologies (surveys, teacher observations, focus groups, etc.) to best capture the many inter-connected layers involved. This form of evaluation would offer a clearer picture of the collective impact of the

many programs within innovative organizations. These evaluations have been used to evaluate integrative models before, including the case of the five-year national evaluation of the Communities in School Model.⁶⁹

There are intermediate and less costly options that would allow an adequate yet rigorous measurement of impact. For instance Briya and similar organizations could set-up natural longitudinal experiments, and compare the outcomes of children who were randomly assigned and admitted to schools through lotteries with those who were not. Although not easy to accomplish, such a study might be easier to execute than an experimental design since charter schools already have the admissions data, and it would also ensure

randomization. This type of evaluation has been used by the Institute of Education Sciences to evaluate charter middle schools.⁷⁰

“ Support is also needed to maintain novel initiatives so that they can complete the initial learning phase. ”

Despite the current lack of longitudinal outcomes data and the other challenges, Mary's Center has made progress towards more systematic evaluation by collaborating with scholars, academic institutions, and foundations to evaluate some of their programs. Research opportunities are reviewed by an inter-disciplinary Research Review Committee, which allows the Center to explore and review research opportunities and to start measuring the impact and effectiveness of some of their programs that affect health, social, and educational outcomes for the populations served. One example is analyzing the impact of a program

⁶⁷ Haskins, Margolis (2014).

⁶⁸ Turner, et al, Urban Institute 2014.

⁶⁹ ICF international, 2010.

⁷⁰ Gleason, Clark, et al, 2010.

aimed at preventing postpartum depression.⁷¹ But according to Alis Marachelian, Senior Director of Community Health & Strategic Alliances at Mary's Center, and Maria Gomez, President & CEO, funding and technical capacity are the biggest impediments preventing the organization from adding evaluations to other programs or to the whole organization.

2. While funding is needed for the formal evaluation of mature programs, such evaluations should not be commenced too early. During the early phase of programs, the need instead is for adequate performance and data tracking to allow the program to evolve.

While formal evaluation is the “gold standard” for measuring the impact of programs, the timing of such evaluations is important. In the early stages of implementation of a program or initiative, organizations need the flexibility to undergo a trial-and-error period, during which they experiment and modify their initiatives based on what they learn. Launching a formal evaluation too early constrains the organization and can “freeze” the initiative rather than permit it to evolve. During this early phase, the need is for properly funded performance and data tracking mechanisms to provide the organization with feedback and allow it to adapt to input from the community it serves. Support is also needed to maintain novel initiatives so that they can complete the initial learning phase. At that point, formal evaluation is appropriate if the initiative appears to be successful.

The challenge for many organizations like Briya/Mary's Center is both that often they lack the funds for operations and adequate

performance data to complete the early phase, and that, as mentioned previously, many of their apparently successful programs have not been formally evaluated. The result is that effective programs are often not identified, recognized, and replicated. The absence of evaluation can be either because the organization lacks the resources and sometimes technical skills to do so itself, or because a lack of adequate performance data in the early phase means the programs are overlooked by potential evaluators in the public or private sectors.

3. Many research gaps still need to be addressed.

Many gaps in the research still need to be filled to help us gain a better understanding of the components and impact of innovative multi-service hubs like the Briya/Mary's Center partnership. First, further research is needed on the impact of integrated student supports on children's outcomes, especially as it pertains to early-childhood and K-12 education. Second, more research is needed on the impact and success of two-generation strategies. The Ascend Initiative⁷² within the Aspen Institute has been funding two-generation approaches to combating poverty around the country. The Initiative has invested in 58 different organizations that are innovating in such programs and have been documenting the best practices of these programs across the nation. Initiatives and partnerships like Aspen's are encouraging, but more are needed. Overall, for models involving integrated student supports and two-generation programs, the research has shown positive, albeit modest, results. Additional research, qualitative as well as experimental

⁷¹ Mary's Center, Research Studies.

⁷² The Ascend website, About.

and quasi-experimental, would enable us to understand which elements in the mix of services actually work best and hence what is the best design of a hub with an array of services. Third, although early studies on the effects of Patient-Centered Medical Homes (PCMHs) on the health care outcomes of patients and families show promising results,

more robust analyses are needed to quantify the effects PCMHs have on improving their overall patient population's health.⁷³ Greater investments in developing standardized and clinically meaningful quality measures are necessary to ensure that these models are being effectively evaluated.

⁷³ Nielsen M., Nwando J.O., et al, 2014.

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