

Project HEAL: Health through Early Awareness and Learning

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Purpose

- Project HEAL is an implementation trial
 - Funded through the National Cancer Institute (CA147313)
 - Conducted in 14 African American churches
 - Prince George's County, MD
 - Aims to compare two approaches to training lay peer community health advisors
 - Traditional in-person/classroom
 - Online training

Method

- Community health advisors complete training
 - certified by knowledge exam
- Conduct 3 educational workshops on cancer early detection (breast, prostate, colorectal)

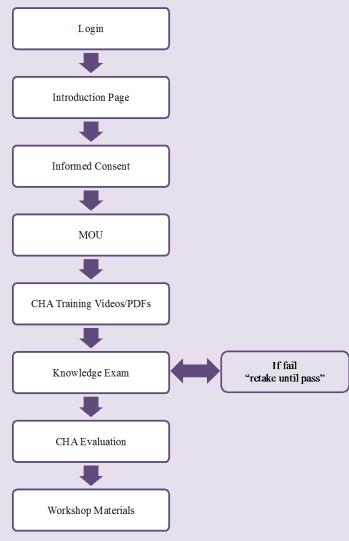
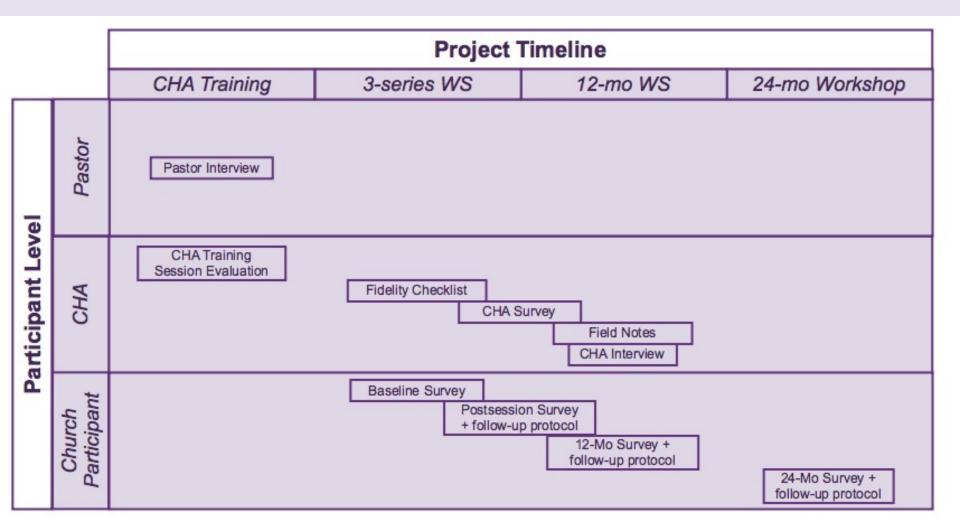


FIGURE 1—Project HEAL Web-Based Training Flow Diagram

Data Collection



Dimension	-AIM Framework to Project HEAL How Operationalized in Proposed	Source of Data	Level
	Study		Level
Reach – extent to	-% of eligible congregation that	-church enrollment	Individual
which participants are	enrolled in the project	logs	
representative of	-Number of participants that attended educational sessions	-church attendance	
priority population; and extent to which	educational sessions	logs	
they participated in			
intervention			
Efficacy – success	-Knowledge	-participant surveys	Individual
rate; positive minus	-Perceived benefits		
negative outcomes	-Perceived barriers		
	-Self-efficacy for screening		
	-Self-report screening -Ratings of program		
Adoption – proportion	-Ratings of program -Cooperation rate of churches (#	-program logs and	Organizational
of settings that will	agreed / total approached)	records	O I garii Lattoriai
adopt the intervention	дости при при при при при при при при при пр	1000100	
Implementation –	-Number of training events	-staff & church logs	Organizational
extent to which	-Number of CHA trainees	-staff & church logs	
intervention is	-Completion of training	-staff & church	
implemented as		records/CHA	
intended in real world	-Adherence to program delivery	certification	
	protocol	-random staff	
		observations;	
	0.5 4.5 55.5	participant surveys	
	-Self-report of modifications or	-CHA quarterly	
	problems with program delivery	interviews/surveys	
	-Number of booster sessions -Number and percent of survey	-staff & church records -survey completion	
	completion	rates	
	-Number of educational sessions	-church attendance	
	participants attended	logs	
Maintenance – extent	-Number of additional training cycles	-staff & church records	Organizational
to which intervention	completed by location and year		- · g
is sustained over time	-Amount of supplemental funding for	-CHA interviews; key	
	health education	informant interviews	
	-Amount of marketing done for the	-staff observations;	
	program (flyers, announcements)	CHA and key	
		informant interviews	
	-Number of collaborative meetings	- CHA quarterly	
	among CHAs (not initiated by	interviews/surveys	
	researchers)	-CHA interviews, key	
	-Additional health promotion activities	informant interviews	
	-Participant-level outcomes (e.g.,	-Follow-up surveys	Individual
	screening)		

<u>Preliminary</u> Findings

- Online community health advisor training was feasible but human technical assistance was needed
- Reach: 43% traditional; 22% online; but hard to accurately estimate the denominator
- <u>Efficacy</u>: Both groups increased in knowledge and some screenings over time; group difference NS
- Adoption: Once churches enrolled, they were retained (except 2 out of 14)
- Implementation: Workshops implemented; but timeline by church varied
- Maintenance: Evidence for sustainability (e.g., additional health activities in the churches)

Challenges/Lessons

- Community based participatory research
 - Variable implementation by church
 - Variation among community health advisors
- Online training still needed technical assistance
 - Future use of a "hybrid" design

Next Steps

- Examine role of context (e.g., church/organizational factors) in study outcomes
 - Participant level
 - Organizational level
- Cost comparison of the training/intervention approaches

