

***Products of  
Planning  
Activities***



## **Strategic Plans**

**C**ompletion of a strategic plan is both the end of one phase of your planning team's hard work and the beginning of another. Your community's strategic plan for long-term care will result directly from your team's development of a mission and vision; understand of the views of the consumers and other groups with an interest in your local long-term care system; evaluation of the core services in your community; and identification of goals, objectives, and outcomes. Writing the strategic plan will assist your team in focusing all of the ideas and plans from its previous work into a manageable roadmap for the next phase, implementation and evaluation.

Strategic plans vary in format (as you will see when you look at the samples listed in the resources), but most include these things.

1. Title page
2. Listing of planning team members, staff, and consultants
3. Acknowledgements, if necessary
4. Authorization page, if your county commissioners must give their approval, and possibly a letter from the chair of the county commissioners endorsing the plan
5. Executive summary
  - ◆ Try to keep it to one or two pages for easy distribution and to increase the chances that it will be read.
  - ◆ Include important background information, mission and vision statements, key issues, objectives, strategies, desired outcomes, and plan for evaluation.
6. Background information, possibly including brief descriptions of:
  - ◆ your existing community resources, including both informal and formal supports
  - ◆ description of the planning area and target populations
  - ◆ information on current issues and challenges your community is facing
  - ◆ why your community decided to develop a strategic plan, including any pertinent legislation or mandates
  - ◆ a description of the planning process and the services and issues your team focused on (some communities put this in an appendix. You could include a brief description in the actual body of the plan and elaborate in an appendix if you have a lot to discuss).

*A vision  
without a plan  
is just a dream.  
A plan without  
a vision is just  
drudgery.  
But a vision  
with a plan can  
change the  
world.*

*—Anonymous*

7. The planning team's vision and mission statements
8. Summary of the findings from your data-gathering activities. Briefly mention the methods you used (more detailed information can go in the appendixes).
9. Outcomes and their indicators, strategies, specific action steps and who is responsible for them
10. Appendixes might include
  - ◆ a more detailed discussion of your team's planning process
  - ◆ write-ups of your data-gathering activities, such as public forums, group interviews, information from the core long-term care service evaluation tools, SWOT analyses, community mapping, public comment activities, etc. Include blank copies of surveys or interview protocols.
  - ◆ a detailed budget, if necessary (summary budget information should be included with each objective and strategy; remember that in-kind contributions have a monetary value)
  - ◆ timeline
  - ◆ planned evaluation activities
  - ◆ planned marketing and outreach activities to communicate the strategic plan to stakeholders.

Strategic plans must be clear, concise, and realistic. Your community's plan should take into account the current barriers to change and limitations in resources, while offering creative solutions to existing issues. While writing, structure the plan so that it will be easy for your team members and other stakeholders to use it in various ways. Some of these might include

- ◆ guiding change in your community's long-term care system in the years to come
- ◆ evaluating your community's progress in attaining the outcomes
- ◆ communicating and marketing your planning team's work and ideas about necessary reform in your community to community organizations, media outlets, foundations and other funders, and local government
- ◆ educating the general public about community long-term care issues, possible solutions, and ways they can get involved
- ◆ identifying and recruiting additional stakeholders to your planning team and as volunteers for specific programs or activities introduced in the plan.

When the strategic plan is finally complete, make sure to take a little time and celebrate all that you've accomplished as a team during the past year!

## Resources

### Examples of Strategic Plans

#### Cities

*Aging and Disability Services Area Plan on Aging* (Seattle and King County, WA). <http://www.cityofseattle.net/humanservices/ads/AreaPlan/AreaPlan2004-07.pdf>

*Disability Action Plan* (Frankston City, Australia). [http://www.frankston.vic.gov.au/doc\\_display.asp?document\\_id=380](http://www.frankston.vic.gov.au/doc_display.asp?document_id=380)

*City of Toronto's Accessibility Plan 2003*. <http://www.city.toronto.on.ca/diversity/accessibilityplan2003/pdf/accessibilityplan2003.pdf>

#### Counties

*Citizens Task Force for LTC: Final Report* (Fairfax County, VA).

<http://www.co.fairfax.va.us/services/hd/hdpdf/ltcfullversion.pdf>

*Orange County [N.C.] Master Aging Plan 2001–2005*.

<http://www.co.orange.nc.us/aging/map/mapreport.pdf>

*Senior Services Center Strategic Plan* (Alameda County, CA).

[http://www.larpd.dst.ca.us/Sr\\_StrategicPlan.pdf](http://www.larpd.dst.ca.us/Sr_StrategicPlan.pdf)

*Orange County [Calif.] AAA Service Area Plan 2001–2005*.

[http://www.officeonaging.ocgov.com/PDFs/Area\\_Plan\\_2001-2005.pdf](http://www.officeonaging.ocgov.com/PDFs/Area_Plan_2001-2005.pdf)

#### States

*The Aging of North Carolina: The 2003–2007 North Carolina Aging Services Plan*. <http://www.dhhs.state.nc.us/aging/sasp2003.pdf>

*Serving Persons with Disabilities in Appropriate Settings: The North Carolina Plan, 2003*. <http://www.dhhs.state.nc.us/docs/OlmsteadPlan.pdf>

*N.C. Council on Developmental Disabilities Five Year State Plan with Amendments*. <http://www.nc-ddc.org/> (Click on the “Council State Plan” link.)

*Strategic Plan for Seniors* (Nevada Division for Aging Services).

[http://www.nvaging.net/strategic\\_plan.htm](http://www.nvaging.net/strategic_plan.htm)

*The Office on Health and Disability: Strategic Plan 2002* (Mass.).

[http://www.state.ma.us/dph/fch/ohd/ohd\\_plan.pdf](http://www.state.ma.us/dph/fch/ohd/ohd_plan.pdf)

*More Than Bricks and Mortar* (New Mexico Aging and Long-term Care Department). <http://www.nmaging.state.nm.us/StrategicPlan1203.pdf>

*Disability Plan 2002–2006* (Queensland, Australia).

<http://www.disability.qld.gov.au/publications/stratplan/index.cfm>

#### Other Resources

Anon. Develop strategic and action plans. *The Community Toolbox*, <http://ctb.ku.edu/tools/developstrategicplan/narrativeoutline.jsp>

Bryson, John, and Farnum Alston. 1995. *Creating and Implementing Your Strategic Plan: A Workbook for Public and Nonprofit Organizations*. San Francisco: Jossey-Bass.

Nagy, Jenette, and Stephen Fawcett. Developing successful strategies. *The Community Toolbox*, [http://ctb.ku.edu/tools/en/sub\\_section\\_main\\_1088.htm](http://ctb.ku.edu/tools/en/sub_section_main_1088.htm)



Forthcoming

***Getting  
Started  
and  
Tracking  
Progress***



**Y**our planning process has been under way now for months, perhaps even a year or more. You have identified outcomes, goals, and strategies. You probably have at least one strategy concerned with finding funding to enable you to meet some of your objectives. Although financial support may come from any of a number of sources, grants may be one of your prime targets, especially in times when public funding is stable or decreasing.

The goal of grant writing is to match the needs identified by the planning group to the objectives of the granting organization. Here are some steps in developing fundable grant proposals.

1. What exactly will the money be used to do? To prepare for writing a grant, it is important to be able to explain concretely and succinctly what you plan to do, what results you expect to see, and how you (and the funder) will know that you've gotten those results.
2. Develop a preliminary budget, so that you will know approximately how much it will cost to carry out the project. For very expensive projects, you may want to identify stages or modules that are stepping stones to the final objective, but which also provide a tangible benefit even if you are not able to find funding for the whole project.
3. Because your proposal is the result of a community planning process, it helps to have developed a boilerplate paragraph or two describing the history of the process (you'll be able to use this for such other purposes as marketing and education). Also, in your environmental scan, you will have looked to see if other communities have done what you're planning and with what results. It helps to have a page or two describing those results.
4. Foundations often will not make grants to individuals, and the fiduciary responsibility of managing a grant is large. Early on, you should agree which organization(s) will be responsible for submitting and managing grants. However, control of the funds by one or more community organizations, particularly if they are the usual public service entities, may make it difficult to maintain community participation and support. At the least, the proposal should contain a plan for a community steering committee or board. It also might be helpful to solicit a match for the grant amount in donations of time or money from individuals or organizations. Finally, when you submit the grant proposal, you may be asked to include letters of support or memoranda of understanding from the

## **Grant Writing**



partnering organizations, so it's necessary to negotiate those agreements when you begin your search for a funder.

5. Plan carefully how you will sustain the work begun by your funded proposal, and describe those plans. If you ask for a building, how will you maintain and staff it? If you ask for personnel, how will you keep them employed when the grant ends? If you need changes in public policy or regulations, how will you work toward those?
6. Once you can express clearly and succinctly how the money will be used, it's time to find a granting organization that has a track record of funding (1) the type of project you are proposing and (2) doing so at the level you plan to request (that's why you have prepared a budget). Perhaps the best online resources for researching private grant-making organizations is The Foundation Center (<http://www.fdncenter.org>). Many of their online resources are free—see their pages on grant writing—but some require a subscription. However, public libraries and college and university libraries may have their annual review of foundations in their holdings.
7. Once you have identified potential funders, contact their program officers to discuss your proposal. Program officers can keep you from spending a lot of time applying to the wrong foundation, and if their organization might be interested in your proposal, they can often help you strengthen your application or target it more accurately to their mission. If they do not fund what you're proposing, they may recommend another foundation that does.
8. If you are encouraged to make a proposal, take special care in preparing it, because it demonstrates the kind of attention to detail that you would give to the project itself. Employ your best writers and editors, follow the directions *carefully*, be specific and brief, "sell" your proposal, proofread.
9. Foundations are not the only source of funding. Many corporations also have giving programs, usually in the communities where they are located.
10. The search for funding should become part of the regular activities of the planning team from the beginning. Remember that most foundations and corporate donors make their decisions only once or twice a year, and that there is often a six- to eight-month lag between the submission deadline and any award of money.

## Resources

### Websites

- Arkansas Watershed Advisory Group, <http://www.awag.org/Grant%20Seekers%20Tool%20Kit/granttraining.htm> (A good list of linked articles and sites.) *The Chronicle of Philanthropy* (online), <http://philanthropy.com/> See their bookshelf and idea sections in particular.
- The Foundation Center, <http://www.fdncenter.org/>). See in particular their “Proposal-writing short course,” the page on statistics of grant-making organizations, and their “Foundations Today” tutorial. Also see their online book (excerpts): *The Foundation Center’s Guide to Grantseeking on the Web*, <http://fdncenter.org/learn/bookshelf/grantseek/text.html>
- Granthelp.com, <http://granthelp.clarityconnect.com/bookstore.htm>
- Grantproposal.com, <http://www.grantproposal.com/>
- Griesman, Donald A. 2004. Grant writing tools websites, <http://www.nonprofits.org/npofaq/19/64.html>
- On Philanthropy.com, <http://www.onphilanthropy.com/> See their extensive collection of articles and book reviews.

### Books

- Barbato, Joseph, and Daniell S. Furlich. 2000. *Writing for a Good Cause: The Complete Guide to Crafting Proposals and Other Persuasive Pieces for Nonprofits*. New York: Simon and Schuster (Fireside Books).
- Brown, L. G., and M. J. Brown. 2001. *Demystifying Grant Seeking*. New York: Jossey-Bass.
- Browning, B. A. 2001. *Grant Writing for Dummies*. New York: Hungry Minds.
- Carlson, Mim, and the Alliance for Nonprofit Management. 2002. *Winning Grants: Step by Step*. 2nd ed. New York: Jossey-Bass
- Clarke, C. A. 2001. *Storytelling for Grantseekers: The Guide to Creative Nonprofit Fundraising*. New York: Jossey-Bass.
- Karsh, Ellen, and Arlen Sue Fox. 2003. *The Only Grant Writing Book You’ll Ever Need: Top Grant Writers and Grant Givers Share Their Secrets!* San Francisco: Carroll & Graf.
- Tremore, Judy, and Nancy Burke Smith. 2003. *The Everything Grant Writing Book: Create the Perfect Proposal to Raise the Funds You Need*. (Everything Series) Avon, Mass.: Adams Media.



Is what we're doing making a difference?" That's the question in the minds of anyone involved in community planning. Once the plan is in place and the first strategies begun, how do you know if you are getting closer to the vision you identified in the beginning?

Although all the stakeholders in the planning process would like to see *scientific* proof that their investment of time and energy is producing results, truth to tell, efforts at producing social change make for very difficult science indeed. In a laboratory, you can isolate two groups of organisms, control their environments, treat them differently, and after quite a few repetitions of the process, conclude with some confidence that what you did to each of them caused a certain result. Human societies, though, are a one-time-only experiment with no control group for comparison.

So, what to do in the face of this discouraging prospect? You almost always *can* find out whether the desired change has occurred—whether things are moving in the direction you wanted them to go—even though you will likely never be absolutely, scientifically, certain that *what you did* made the difference. If no change in outcome has occurred, then however good your actions may be, they are not producing the results you want and you need to try something else. If they are changing in the way you want, even if some other events may share the credit for making a difference, you have a strong basis for continuing your approach. In this short chapter, we'll provide you with some things to think about at the beginning of your planning, and some resources to spark your imagination about how to measure outcomes.

### Why Evaluate?

- ♦ to identify and demonstrate successes
- ♦ to encourage the buy-in of clients and families, as well as other stakeholders, as they participate in your programs or activities
- ♦ to be accountable to the public and funders
- ♦ to identify what is most effective and what needs to be improved
- ♦ to provide decisionmakers with reliable information
- ♦ to motivate team members undertaking the strategies by helping them focus on positive outcomes and the reasons for celebrating them, as well as on the work still needing to be done
- ♦ to provide data for grant applications, accreditation processes, and collaborative activities in the community
- ♦ to support future planning
- ♦ to help market strategies and activities by describing what they accomplish.



## Short- and Long-term Evaluation

## Ongoing Self-evaluation

Human services provider agencies at the state and local level used to put a lot of energy into short-term “projects.” Sometimes, because of time-limited funding for the changes we want to implement, we still think that way. However, ever since the mid-1990s, researchers and practitioners have realized that we can’t make real differences in people’s lives if we try something for six months or a year and then move on to the next thing. We don’t need projects. We need reform initiatives. In an article entitled “From social experiments to reform initiatives: Implications for designing and conducting evaluations,” C. L. Usher remarks: “Indeed, stakeholders use the phrase ‘reform initiative’ intentionally to connote long-term commitment to systemic change in contrast to the tentative ambivalence of the term ‘project’” (1995, p. 1). Just as in Usher’s work to improve child welfare, successful development of a long-term care system necessarily must be a reform effort rather than a project.

Usher has long been a proponent of *self-evaluation* for reform efforts. The *self* in self-evaluation suggests that the tools for learning about outcomes and for making changes in strategy should be in the hands of the stakeholders who do the work of reform, because it is consonant with a long-term investment in improving quality of life in communities.

Somewhere in the process, preferably early on, the planning team should help stakeholders develop an evaluation plan that indicates who will be involved in ongoing data collection and bear the cost of it, who will make sense of the data and disseminate the findings, how often they will do this, and how the implementation team will use the findings to adjust either the strategies or how they are carried out. This can be an expensive proposition in terms of personnel and funds. It also requires good negotiation skills, because organizations that previously have not shared information or that have different ways of collecting it have to come to some agreement about how they will collaborate. However, this is the “proof of the pudding” or the “rubber meeting the road”—that is, how the community demonstrates its accountability to older adults, younger adults with disabilities, and their families.

## When Should You Begin Measuring Outcomes?

Almost before the ink dries on your vision statement, it’s important to start identifying ways of evaluating your progress toward outcomes. Your vision is not an outcome, but rather the situation you will see when positive outcomes have been accomplished. To determine progress toward outcomes and the vision, generally you will develop a *logic model* or *theory of change*, that is, a set of statements or a drawing that shows

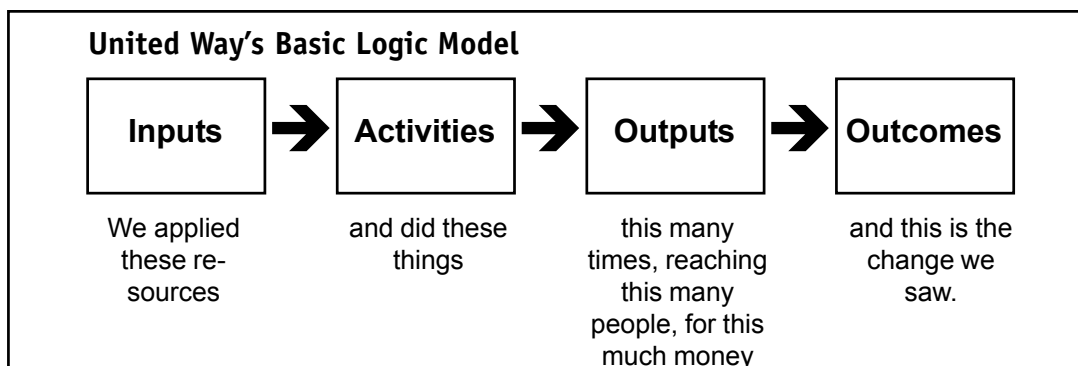
causes and effects for the situation you are trying to change and how you expect your strategies and activities to lead to the desired result. For each step in the process, you identify one or more *outcome indicators* intended to measure how well that step has accomplished the result you wanted to see.

Among the things you have done as part of the planning process is gather data about your community. This is important as the groundwork for developing your plan and strategies, and it also furnishes you with the baseline from which you measure outcomes. By the time you have gathered data for planning, you know what kind of community-level information is already being gathered by government agencies or other organizations. To build on what you have learned at the beginning of the process, you will develop a way to continue to gather data relevant to your outcomes.

## Things to Measure

United Way has been very involved in finding ways to measure the effects of the funding they provide to community organizations. Indeed, many of the stakeholders in any long-term care planning group will have a good, basic understanding of outcomes as a result of working with their local United Way offices. The national website has a wealth of resources on measuring outcomes, as well as links to other websites on the subject (<http://national.unitedway.org/outcomes/>). They identify four principal areas—inputs, activities, outputs, and outcomes—that can be measured to understand the relationship between effort and result. The diagram shows their very generalized logic model for programs and community efforts.

- ♦ *Inputs* are the resources devoted to creating change, and they can be money, time, and in-kind contributions (e.g, freeing hours of staff time to work on implementation; waiving standard procedures to allow staff to try things a different way; making copies of documents, hosting a website, making data available).
- ♦ *Activities* are the planned strategies and ways of accomplishing them (e.g., creating and offering



caregiver training, recruiting faith communities to “adopt” people with disabilities directly through care teams, or indirectly through paying the cost of delivering services to five people on the waiting list).

- ◆ *Outputs* are such things as the number of activities accomplished, the number of consumers reached, or the amount of funds spent (e.g., number of caregivers trained, number of clients moved from the waiting list to services, number of miles of paratransit provided in an area that previously had no transportation for people with disabilities).
- ◆ *Outcomes* are the result of the first three—the difference between the situation before and the situation after the activity. Outcomes can be considered in the short, middle, and long term (e.g., decrease in the average number of days a person remains in a residential facility after a stroke; increase in the number of people with specific disabilities who have been able to live independently for at least six months; decrease in the number of hospitalizations or emergency room visits for people with terminal diagnoses).

Not surprisingly, it is relatively easy to identify and quantify inputs and outputs (e.g., dollars received or clients served, respectively), a bit more difficult to come to grips with activities, and sometimes very challenging to design and measure outcomes.

Activities can be counted—for example, training sessions for caregivers, interagency meetings for service providers, increase in the number of certification programs for nursing aides—but often their role in the progress toward outcomes depends not only on your theory about what causes a situation in your community but also on the quality and context of the activities. To look at just the first example, your theory of change might be, “If we provide training to family caregivers, they will be able to care for their family members better and/or longer.” This theory might be false, but if it is true, the outcome will also depend on how effective the training session was in changing caregivers’ behavior and whether a significant proportion of family caregivers in the community attended the training (for example, if only one in a hundred attended, there would be very little measurable impact on the community). Particularly when the effort toward change is made jointly by organizations in the community as a whole, it can be very difficult to identify which activities are most effective or interact critically with one another to be effective.

## **Data and the Logic Model**

Let's look more closely at the categories in the United Way logic model and consider what kind of data your planning group should be prepared to find or collect.

### **Inputs**

We suggest in several places in this guide that you make a cost estimate for planning activities you undertake: How much money, time, and in-kind resources do you need to accomplish them? Once you have developed the plan itself, each of the strategies should be associated with a similar estimate and a way of tracking who supplies the resources and how they are used. These will be the inputs—the resources devoted to creating change.

### **Activities**

These, in fact, may be single strategies or clusters of activities that make up a strategy. Tracking activities may consist of verifying that they were done and done on time, but there also may be room to look for indicators of the qualities of the activities and whether they had the effect you were expecting. In our example of training caregivers, activities shared among different stakeholders might include some or all of the following: researching existing training, selecting an existing training curriculum or creating a new one; identifying the skills and competencies the curriculum is designed to provide; making sure that caregivers know about the training opportunities; making arrangements for respite to allow caregivers to participate; arranging transportation to the training for caregivers who don't drive; delivering the training or arranging for training to be delivered on a contractual basis. It is important to document who did each of these, when, and, preferably, some description of how it was done.

### **Outputs**

When you have decided what outcome to measure, you need to think carefully about how you will track outputs so that you will have the appropriate data available. Just as for inputs, for each strategy, there should be an accounting of what was done, to whom, by whom, in what circumstances. Very often you will also want to understand characteristics of consumers (usually demographic information), services, and service providers. To some degree the outputs are the measures of your activities. To go back to our example, if one of your strategies is to improve care for people at home by providing training to family caregivers, your outputs would probably include number of caregivers informed about the training, number signing up for it, number actually completing it and possibly

what satisfaction rating participants gave to the training. You might then look at those demographic indicators compared to the characteristics of people who received the training to see if you are reaching both men and women caregivers, caregivers from different ethnic groups in proportion to their numbers in the community, and those with low and middle income.

As in outcome research overall, you are mostly working to eliminate the negative. If your strategy doesn't produce the outcome you want, you will try to determine which of the following things happened:

- (1) The activity was done the way it was designed, but it didn't work, so we need to plan a different activity to do what we thought this activity would do.
- (2) The activity was done, but it did not really meet the quality specifications designed for it, so we don't know whether it would have worked if the quality were better. We might want to fix it and try it again before trying something different.
- (3) The activity was barely done—just a few times for a few clients—so we don't know if it would have worked or not. We need to give it a fair try.

Sometimes the problem is more subtle. Suppose you find that your outcome worked for women but not for men. Is it because (1) men and women took the training but it only helped the women; (2) men and women were both told about it and encouraged to come, but only women found it interesting so that men either never came in the first place or dropped out; (3) the marketing was really designed for women and the men never really got a chance to come to the training?

### **Outcomes**

Desired outcomes are often framed in very general terms. To make it possible to see whether your strategies are working, it's important to develop outcome indicators for each one. To continue our example, this might be one outcome of a long-term care planning process:

Family caregivers of adults with disabilities are supported by the community in ways that enable them to continue giving care as long as possible while preserving their own health and well-being.

This statement alone isn't specific enough to be measurable, but it does suggest some possible outcome indicators that would be.

First the strategy: Our theory is that with additional training, family caregivers will be able to continue longer and in better health. Our strategy is to provide that training and see if it helps. Here are two possible outcome indicators:

- ♦ *“Preserving their own health.”* Family caregivers rate their health before the training and at intervals after the training—three months, six months, a year, perhaps—while they are still providing care. (As it happens, the question “How is your health? Excellent, good, fair, poor?” is a valid, easy measure of health status.) An indicator of positive outcome might be that as a group they say their health has at least remained the same or declined only slightly. (It would be really good news if it improved, but that’s probably not likely—caregiving is hard work.) But what does “only slightly” mean? How do you measure that? Your belief that your training had the desired outcome will be to find a similar group of caregivers and measure their self-reported health in each of the same time periods. Be aware however, that whole books have been written about the multiple biases introduced by comparison groups, and the ethical issues inherent in randomized trials. It’s very important to work with someone in a nearby college or university or a company that does survey research to help you design this indicator.
- ♦ *“Continue giving care.”* You determine whether care recipients are still at home, have moved to a different care situation, or have died. To turn this into a meaningful outcome indicator, though, it would be good to compare the care recipients of people who took the training with a matched group of care recipients whose caregivers didn’t take the training. Here, too, you might choose to use a comparison or control group as described above. If one of your group’s tasks is to make data about clients available across agencies, you might be able to use these data to look at the time from a client receiving his or her first in-home service to placement or death at home and see if this time frame is different for those who had caregivers participating in your training program. Again it would be helpful to have professional consultation on appropriate use of these data.

If both of these indicators appear to be positive (little or no decline in health, care recipients mostly still at home), we might begin to believe that our strategy was working.

If your planning team has developed more than one strategy to produce an outcome—for example, increasing the availability of respite services for caregivers—you might want to compare caregivers who had training and the same amount of respite as before, more respite but no training, training and more respite together, and neither training nor respite. Then

it might be possible to learn which strategy, if either, produces the best outcome or whether the two together produce better outcomes than either alone.

Here are some of data you might want to collect to construct your outcome indicators for this example.

- ◆ Identify the family caregivers in your community (or a representative sample—see the chapter on home-grown data about this).
- ◆ Collect their demographic information, as well as information about their well-being at the beginning of the reform effort.
- ◆ Collect similar information about the care recipients.
- ◆ Plan when and how you are going to recheck this information to see what has changed.
- ◆ Implement your strategies.
- ◆ Collect process information about the strategies: how, how much, who.
- ◆ Evaluate your results according to your schedule and make corrections as necessary.

## **How Short is Short-term; How Long is Long-term**

Plantz, Greenway, and Hendricks remark on the tricky problem of choosing outcomes to measure:

A recurring, and vexing, issue in outcome measurement is deciding how far out the outcome chain a program should go in selecting its longest-term outcome. This decision requires a balance between two needs:

The longest-term outcome must be far enough out on the if-then chain to capture meaningful change for participants and reflect the full extent of the program's benefit for them. . . .

On the other hand, the longest-term outcome should not be so far out on the if-then chain that the program's influence is washed out by other factors. . . .

Unfortunately, there is no hard-and-fast rule for doing this. In our example of the caregiver training, we probably would not see much improvement in health after a few weeks, although we might see improvement in quality of life or some other indicators. A year later, the caregivers might have little memory of how the training made them feel better or improved their quality of life, but if the training motivated them to increase a self-care behavior such as getting regular exercise, you might see good outcomes at one year. (Don't forget to collect information on the closer-range outcome, how many actually started getting regular exercise after taking the training.)

Just as for activities, community outcomes are the result of a confluence of forces, some under the control of the planners and many not. It is not easy to change human behavior or to change community systems. Be sure to celebrate small victories. If 12 percent of caregivers receiving the training begin exercising and only 2 percent of other caregivers do so, and this is a statistically significant difference, this is a real improvement! It is incredibly hard to get people to exercise. (But also consider whether the cost of the training is in line with changing the behavior of only 12 percent, if this is the only positive benefit you observe.)

Here is something particularly important for long-term care planners to remember. If the goal of a reform effort is to slow decline in a population, it can be even more difficult to demonstrate positive outcomes. Each individual is unique, and you have to have a lot of them, all behaving in the same way, to be confident that something has changed because of your efforts. The stark fact is that for any population, the mortality rate is eventually 100 percent. In planning for long-term care, you are working to assist vulnerable populations—both caregivers and care recipients. For people with chronic degenerative illnesses, success will likely not be improvement in health status. More likely, it will be maintaining abilities and satisfaction with quality of life for as long as possible. Similarly, for family caregivers, a favorable outcome would be that they are able to continue providing good care with less physical, emotional, or financial cost to themselves.

The picture may be a little more encouraging for younger people with disabilities. Because they may have disabling but not life-threatening conditions, it may be possible to measure successful integration in the community or strides toward greater independence. Even here, though, there will be limitations on how much change you will be able to see or measure. Don't be discouraged, but be both realistic and hopeful in your selection of outcomes.

## **Where Do Good Indicators Come From?**

Flora and colleagues at the North Central Regional Center for Rural Development have put together a very helpful online guide to outcome measurement. Among other things, it contains examples of indicators based on a community planning project. Some of the ones they mention are a little surprising. For example, one measure they chose as an indicator of a more healthy, diverse local economy was the number of homes in the community with more than one phone line. Why? Having more than one often indicates a home business, which adds to the local economic base (in the days

before cell phones, though, it might indicate teenagers). Similarly, to monitor improvement in economic status, the community in their case example looked not only at number of households receiving food stamps but also at what percentage of utility bills were paid on time, because that could indicate that people had enough money each month to meet current expenses.

Your stakeholders are a good place to start in identifying indicators. You can ask the questions, “How would you know things are a little better?” and “How would you know we’ve got our outcome?” to identify intermediate and long-term indicators. To continue our example, a caregiver who had taken the course might answer the first question, “Last week I managed to use what I learned about interacting with people with dementia, and I didn’t get as frustrated with Mom’s repetitive questions.” He or she has learned and is practicing a new behavior that may reduce stress. Answering the second question, a local human services provider might report, “When my clients call needing emergency respite, I can always find someone to provide it.”

It’s important to celebrate attainment of both short- and long-term outcomes. Most of the stakeholders in your reform effort devote a large portion of their lives to trying to make the world at least a little better for people who come into the long-term care system. Often their days are full of losses, big and small. After all, their clients or church members or neighbors with disabilities may be less likely to call on them when everything is going well. The whole point of measuring outcomes is to show that their hard work is making a difference, and to help them evaluate new options to make things better still.

## References

There is a lot of information on the web about evaluation; this list should give you a start. Many of the websites have lists of links to other helpful sites.

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Association for Community Health Improvement, [http://www.communityhlth.org/communityhlth/resources/indicators\\_data.html](http://www.communityhlth.org/communityhlth/resources/indicators_data.html) See the sections on tools for planning outcomes and on indicators.

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