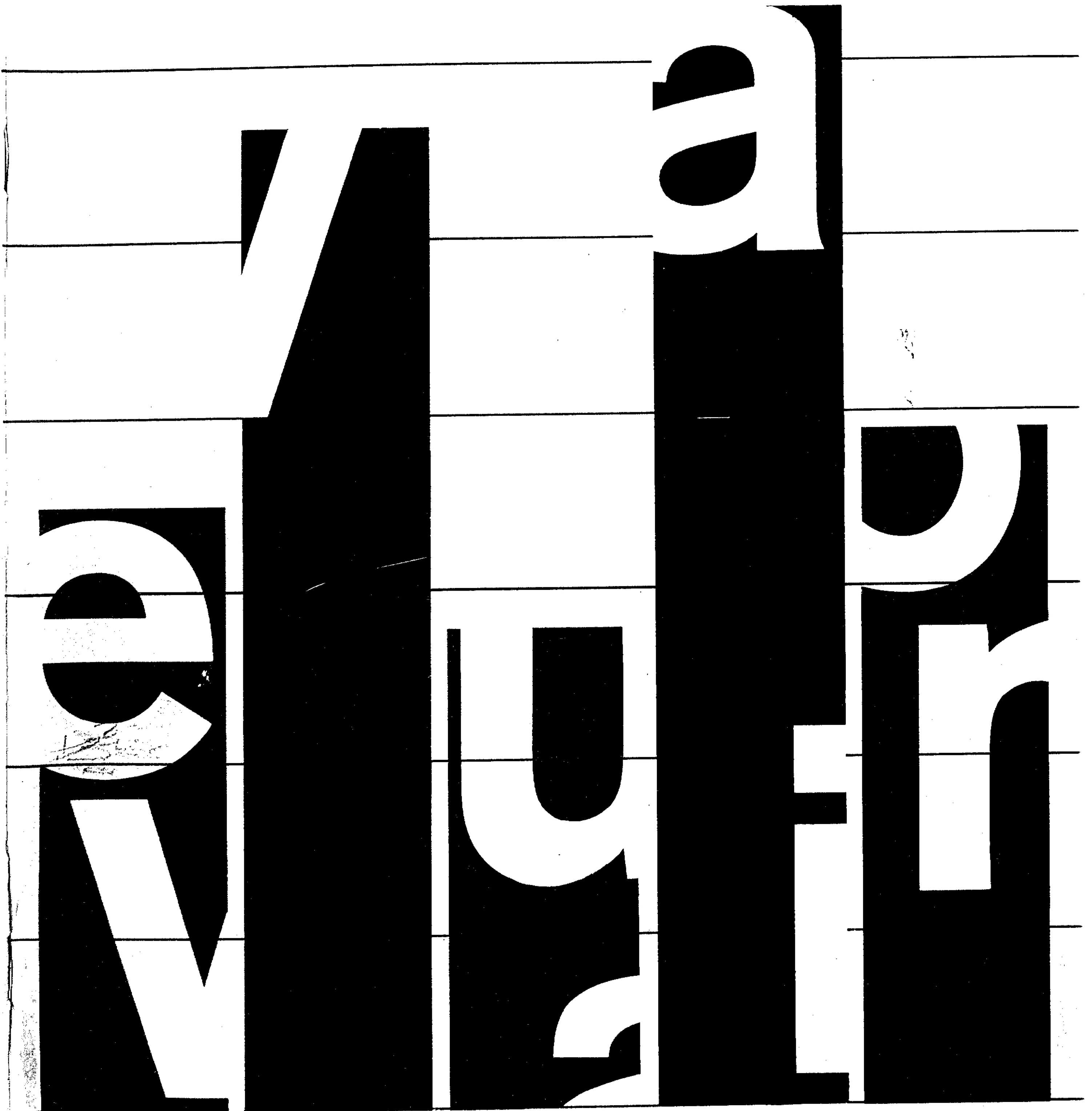
evaluation workshop '72



lakes area regional medical program inc.

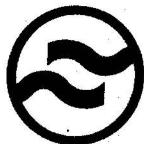
evaluation workshop

November 2, 1972 Treadway Inn, Niagara Falls, New York

Sponsored by Lakes Area Regional Medical Program, Inc.

Title The Process of Program Evaluation

Purpose To acquaint those persons associated with the Lakes Area Regional Medical Program with the evaluation mechanism, its complexity, and the need for overt commitment to its implementation.



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contents

3 Foreword by John R. F. Ingall, M.D.
4 Welcome by Irwin Felsen, M.D.
5 The Agenda
7 Executive Director's Address
9 Highlights of Secretary Richardson's Remarks
11 Keynote Address
14 Model of the Process of Program Evaluation
16 Discussion Groups
17 Interaction
19 Reaction
21 Participants

foreword

The Workshop vividly portrayed evaluation as an integral process of all Lakes Area Regional Medical Program activities.

It provided participants with a keen understanding of the evaluation process, its methods and procedures, and its overwhelming contribution toward the improvement of health care delivery systems.

In addition to assessing program and project effectiveness, participants were shown how the evaluation process provides opportunity for learning, how it identifies strengths, and how it pinpoints weaknesses — all of which serves to improve program and project operations.

The information contained on the following pages expresses the pride of Lakes Area Regional Medical Program staff in conducting this Workshop as well as the sincere interest shown by its many participants.

John R. F. Ingall, M.D.
Executive Director

Welcome

Irwin Felsen, M.D., President, Lakes Area Regional Medical Program - Regional Advisory Group, Inc.

"I would like to welcome you to our Second Annual Regional Medical Program Workshop. The topic of this conference is 'The Process of Program Evaluation.' At our Regional Medical Program in Western New York and Northwestern Pennsylvania, we are pledged to plan and to coordinate programs to strengthen the health care system capable of responding to the needs of all our people. That is our major objective. At last year's workshop we established our goals and objectives. During the year we formed the Program Committee to serve as a long range planning group. This committee is responsible for today's program. I would like to give special thanks to Patricia Hoff, Joseph Reynolds, Tony Zerbo and Dr. James McCormack for helping in the mechanics necessary for the conference.

We make policy and when we make policy we are betting on the future. The great danger of any policy is to project the present into the future. Today we seek some objective yardsticks for measuring our Regional Medical Program's actual impact on society. We are interested mainly in estimating the program's ultimate health benefits.

We are exploring ways to assess the health impact of our projects, and to develop a meaningful method of evaluation. We seek 'workable' machinery.

Can we do anything about it? I will confess that I am an optimist; one who draws confidence from facts as well as from hopes. I am sure we will find means of dealing with the problem, and be able to narrow the gap between promise and performance.

We seek participation from all of you present. We are not too proud, too rigid, too blind, or too complacent to change. I am sure that we are all looking forward to a valuable learning experience.

the agenda

Thursday, November 2, 1972

9:00-10:00
Registration - Ballroom
coffee

10:00-10:10
Welcome
Irwin Felsen, M.D.
President, Lakes Area Regional
Medical Program
Regional Advisory Group, Inc.

10:10-10:30
"Program Evaluation and the Mission of Lakes Area Regional Medical Program"
John R. F. Ingall, M.D.
Executive Director
Lakes Area Regional Medical Program

10:30-12:00
"A Design for Program Evaluation"
John C. Cassel, B.Sc., M.P.H.,
M.D., B., Ch., Int. Med.
Department of Epidemiology
University of North Carolina
Chapel Hill, North Carolina

12:00-1:30
Luncheon

Thursday Afternoon

1:30-2:35
Introduction of
HEW Secretary Elliot L. Richardson
John R. F. Ingall, M.D.

Elliot L. Richardson
Secretary
United States Department of Health,
Education and Welfare
Washington, D.C.

2:40-3:15
Small Group Discussions, Niagara Room, Ballroom

Discussions will be based upon the objectives and activities proposed in local funded grant applications. A skillful leader will be assigned to direct the discussion of the group around Doctor Cassel's presentation of his evaluation model. The participants will use Doctor Cassel's model to work toward the creation of an evaluation approach for the proposal. Participants will be given an opportunity to become directly involved in the process of program evaluation.

3:15-4:15
Group Reports

4:15-5:15 **Panel Reactors**

Moderator

J. Warren Perry, Ph.D.
Dean, School of Health Related Professions
State University of New York at Buffalo
Buffalo, New York

Panel

Harry A. Sultz, D.D.S., M.P.H.
Professor, Department of Social and
Preventive Medicine
State University of New York at Buffalo
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Elsa R. Kellberg, M.A.
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State University of New York at Buffalo

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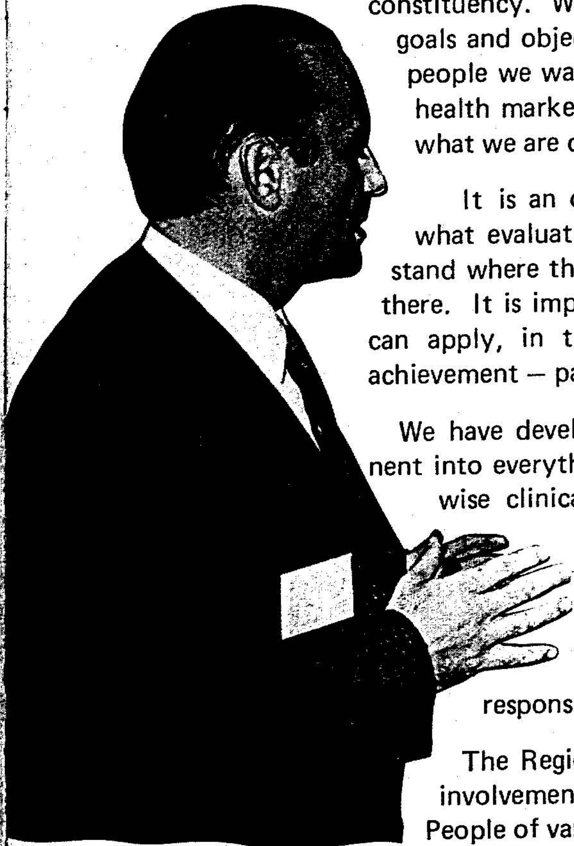
Assistant Professor
University of Connecticut - Health Center
Hartford, Connecticut

executive director's address

John R. F. Ingall, M.D., Executive Director,
Lakes Area Regional Medical Program



Program Evaluation and the Mission of Lakes Area Regional Medical Program

"The Lakes Area Regional Medical Program is responsive to a large constituency. We have the capacity to catalyze efforts towards their stated goals and objectives, which in time become ours. In serving this body of people we want to enable them to attack the deficits in our nine county health market area. To accomplish this, we need to measure respectively what we are doing and what we have achieved.

It is an obligation for those in receipt of our funds to appreciate what evaluation means. It is important for programs to clearly understand where they are; where they are going; and how they are going to get there. It is important for project directors to establish what measures they can apply, in the time frame they have set for themselves, to portray achievement – particularly the ability to become self-supporting.

We have developed and will continue to construct an evaluation component into everything we do. Evaluation is essential for diagnosis; crucial to wise clinical judgements; and essential in measuring outcome. This process is without punitive overtones; it is a mechanism which will allow a diagnosis of performance and impact. We can, and must, refine this mechanism in order to produce an effective effort toward correcting well-stated deficits in the health market area to which we are responsible.

The Regional Medical Programs of this country have, by industrious involvement with the grassroots community, made things happen. People of various disciplines are meeting for the first time. An informed, representive constituency of responsible individuals are sensitive to community deficits in the health services. The involvement of this informed community must be augmented. The fact that it is being developed, that it is underway and has momentum, is a major achievement and must be recognized. Involving intelligent people in the validation and interpretation of reliable data leads to intelligent decisions. These decisions are the first steps in regionalization which is implied in our title.

Regional Medical Programs are 'enabling' agencies. They recognize the industry required in bringing groups together and convening them for specific purposes with specific challenges. Their unique role in maintaining momentum by judicious staff support, enhances the ability of established agencies to deliver and to improve upon previous performance. They have facilitated many agencies now carrying out their mandated functions. They have the ability to meet challenges whether they be in the professional arena or in the consumer population.

A recurring theme is the ability to deliver and to measure the amount of goods to the maximum amount of people. The funds to this purpose are tax dollars as venture capital which are invested in economically viable projects. We have sought to involve all health professionals, particularly the private and voluntary groups.

Regional Medical Programs had dramatic visibility in developing categorical disease components, such as the coronary care training program for nurses and physicians. The categorical killers are not in any way negated by our broader approach to the health problems. The first of our goals is prevention. It is an area where the biggest impact on human morbidity can be anticipated. In stimulating efforts towards prevention, the factor of dramatic visibility, which in turn releases tears and money, is absent. A crippled child will release more funds by being exhibited, than a normal child, who is so by virtue of preventive methods which are hard to render glamourous.

Education of the consumer is important. The question of its feasibility, the economy of doing so, and the method of evaluating these efforts is a challenge to the Regional Medical Programs for the future. We must try to teach the difficult problems which will have impact on the categorical diseases. A problem well stated is half solved.

It seems to me we have problems. It seems to me these can be given dimensions. In doing so, we can remeasure these programs. That we do so in an objective, clear, and responsible fashion is an essential ingredient in our evaluation. I anticipate today will be a learning experience and an exercise in working towards a lucid understanding of measures of achievements and their validity."

Highlights of Secretary Richardson's remarks

We perceive very clearly that we cannot effectively improve the quality of health care delivery in the United States; we cannot improve access to good care; we cannot overcome the gaps and deficiencies in our delivery system by Washington decree. We cannot build from the top down without displacing in the process, not only the contribution of local resources, but the contribution of local concern.

If we are genuinely interested in bringing about the kind of coalition of resources at the local level that is involved in putting the existing pieces together with optimal efficiency, we have to rely on people like yourselves to carry out that process. There is just no way in which federal bureaucrats can know enough about the capabilities of existing components of the health delivery system in any community to know how to fit them together in a more coherent whole. The initiative for this and the exercise of carrying it out must be in local community and regional hands.

Awareness of need

A very valuable quality of American life is the devotion of community concern to meeting the problems of people. However, local response to problems can lead to fragmentation because so many well meaning citizens may be motivated to create community agencies or organizations that often do not communicate sufficiently with each other or do not participate in joint efforts to create a more total effort. But it is that kind of response, that kind of 'awareness of need' within a community, that is part of what we are as a people. The very idea that you can rely on the government to solve these problems and to meet these needs can only have the consequence of drying up the springs of local concern and compassion.

There are two values at stake here. One is the capacity of local service to provide agencies that can fit their efforts together. The second is the preservation of community response to problems that derives from a sense of need. This is what leads us to resist building from the top down through a structure that would

necessarily displace state and local initiatives. The planning capability at the Federal level is so enormous, that, in order to get anything done at all, the solutions prescribed would have to be uniform, and they would have to displace local responsiveness and local concern.

Initiatives Applauded

We look to the kind of effort that you represent and the kinds of things that are being done in response to the problems of sparsely populated rural communities in this nine county area. These include your efforts to make more accessible improved care for coronary and respiratory patients; to promote regional linkage among health care providers through your Telephone Lecture Network which enables them to keep their skills up to date; and to develop a data base that can contribute to the planning capabilities that are required in order to fit the pieces together. These are all the kinds of initiatives that we in HEW applaud and seek to encourage.

Develop Planning Capabilities

In my view, if we are to achieve the development of an adequate network of services through building from the community level up, rather than imposing solutions from the top down, we can only do it through substantial improvement in our planning capacity. Under the leadership of Dr. Merlin DuVal, Assistant Secretary for Health Affairs, through whose general aegis the Regional Medical Program comes, we in HEW are now reviewing all of the present legislative authorities that would impinge in any way upon the planning process. We are seeking to strengthen the capacity as well as the authority and responsibility of planners at the local and regional levels. There is a limited amount of time and unless we move more quickly now to develop our planning capabilities, we may get left behind or be overwhelmed by the pressures which insist that you just are not going to get there from here, that you have got to let Washington do it. That, to me, would be profoundly wrong.

keynote address

Highlights of Dr. John Cassel's Speech

While there is a great deal of activity in the field of evaluation, most attempts have ended in rather dismal failures, producing very little in the way of data or results; and those that have produced results have usually led more to anger than to action.

There seems to be three crucial reasons why current attempts at evaluation have been less than successful. The first is a confusion about the purposes of evaluation. Evaluation is often confused with inspection, whereby it is seen as a method of forcing program people to account for their actions. Results of such accounting would be a change in budget, elimination of jobs, and downgrading or upgrading personnel. Such an unfortunate set of purposes leads to a stand-off in the personnel involved in the program and those involved in evaluation, with one trying to defend their position and the other trying to attack it. There has to be some method of public accountability for the use of public funds, but I choose for the purposes of clarity not to call that evaluation. It would be more precise to consider evaluation as a type of diagnosis. It is an integral part of practice, concerned with providing such information for program personnel as how to change, improve, or modify their actions. If we regard evaluation as a diagnostic probe rather than an inspection, we would be in a lot better shape.

In addition to confusion as to purposes, there is confusion about the types of information needed for evaluation. Many evaluation programs restrict themselves to gathering data about activities. How many tons of literature are disseminated? How many blood counts did you do? How many patients did you see? I agree, there is a place for counting activities, but it produces no indication whatsoever of program outcomes, and program outcomes should be the heart and soul of any evaluative exercise.

The third major deficit concerns the methods used to accomplish evaluation. It is too often thought that if you want to have an evaluation, you must go out, hire an evaluator and say to him or her, "Evaluate please, and give me a report." This is obviously an oversimplification, but I think you recognize how pervasive and insidious it is. There is a place for professional evaluators; but is a very specific place and it is not something one can turn over to an 'outside' agency or individual.

The argument is made that self-evaluation is very difficult because of personal bias. I counter that by saying that the most important principle of any evaluation is that there be an on-going partnership between those people organizing and providing the service, and those people with the technical skills to conduct evaluations. If evaluation is to be successful at all, there not only has to be an acceptance that evaluation is desirable and necessary, but a commitment on the part of those who have the responsibility for providing the service to be involved in this evaluation process from the beginning through to the end, in partnership.

Too frequently, people state their goals in "for-mother and against-sin" terms, such as "This program is supposed to improve the health of all the people". This is relatively useless, because the questions that follow must be: "What aspect of health, what evidence would you accept that this program will make any difference in anyone's health?" Such vague, global statements are desirable, but unpractical or unrealistic in terms of the action taken. Another error often made in defining goal statements is to state them in terms of 'services provided'.

These are not goals. They are the means to accomplish something. What they aim to accomplish and what evidence they can produce to measure that accomplishment are the direct concerns of the program and its evaluation. It is necessary for a dialogue to take place between all those people who are going to contribute to the evaluation, in order to specify what could be the feasible and acceptable goals of such an activity.

Having specified the goals, what information would **you** accept as evidence that you have arrived there? Having stated the goals, unless there is clear understanding about the nature of the evidence that would be acceptable, conducting an evaluation exercise that produces unacceptable evidence is not going to lead to any change.

It takes time. There is no instant solution. It takes a lot of dialogue because people have been unaccustomed to think in these terms. And it takes professional judgement.

A very difficult and important question follows: "Given the objectives, and given that a certain set of information would be acceptable evidence, what needs to be changed in order to accomplish these objectives?" What should be done that is not being done now; what sorts of procedures and techniques are available; and what will be used in order to accomplish these changes and lead to the desirable program goals?

Evaluations will tell us how accurate and useful our original formulations have been and enable us to reformulate them in a second go around, or a third if need be. This becomes a feedback situation. It is the evaluator's responsibility to pick up the dialogue, to take the ideas that have been developed by the program people and to translate them into measurable quantitative data. This step of translating information into data requires the skill of a professional evaluator.

There are three general types of data that are needed in evaluation. First, data must show that the program is being successful; that there has been a change in health status or change in health behavior. The question is, "What sort of data do we need that will measure sick people in need of care?" Objective and subjective data have to be presented back to the people responsible for the program, who must then determine what would be appropriate sorts of information labeling people as sick and in need of care.

Homogenous groups of patients should be specified so that it would be possible to develop a basis for describing the problem that has to be changed in order to affect the health status or health behavior of such people.

The second type of data needed pertains to the changes that have been postulated as necessary. If you talk about preventing heart disease by changing diet, you not only must know how to measure heart disease, but how to measure the diet. You should have some information about the occurrence of the phenomena that are going to be changed and whether one can see if they have changed.

The third type of data concerns the services or techniques that have been used. It does become necessary in this whole picture to measure whether the activities have been carried out, how frequently etc., in order to find out if they have been successful in bringing about the change.

There are three general types of strategy that can be used in gathering and analyzing data: to compare the situation before and after the program has been introduced; to compare one program with another or with the absence of another program; and to engage in some sort of randomized trial. Common to all three approaches is that similar types of subjects are to be compared. All factors likely to affect the outcome should be similar as far as possible.

The before and after comparisons involve finding out what the situation is, introducing the program or service, and measuring the same phenomenon at the second point in time. The advantage of this approach is that it is simple and usually feasible. If there is no difference between the before and after comparison, the program has been unsuccessful. If you do find a difference, however, it is not certain that it is due to the program or whether there were other factors not measured. A control or situation would make this method more rigorous. Another alternative is to collect as much data as possible to provide the program with influential factors.

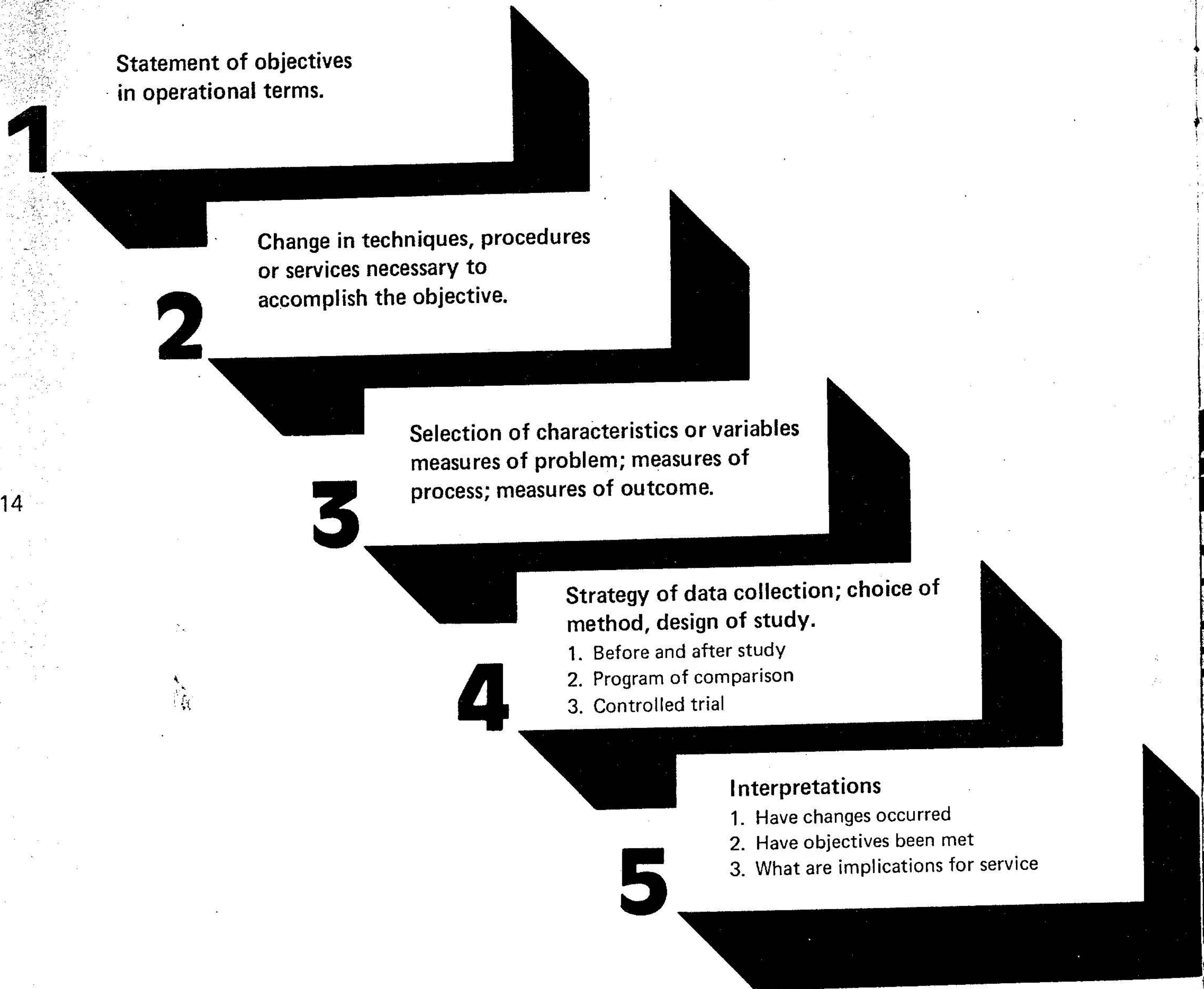
Or there is the option to replicate, to repeat the program in other surrounding regions that exhibit similar needs.

The second strategy for program evaluation is a comparison of two or more different programs operating under the same needs or toward the same goals. If the programs are operating in the same or adjacent localities, it is reasonable to compare just the after data on the assumption that the sort of people and conditions being treated are relatively similar.

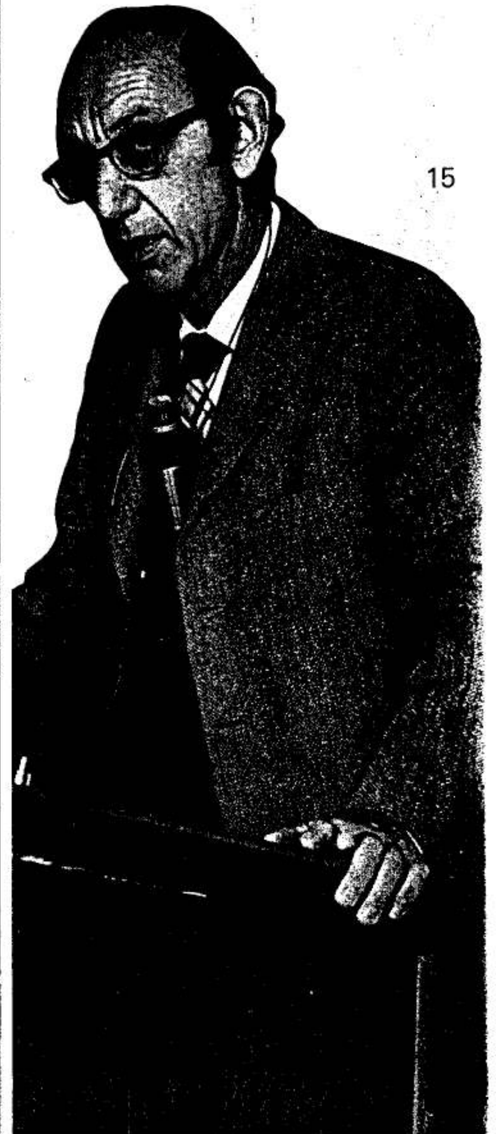
The third method is the randomized control trial. If there is the option of two programs or treatments to be introduced and evaluated, eligible patients can be identified and randomly assigned to program A and program B. The hope is that by random assignment the other factors that influence outcome are equalized. The outcome of the treatment should remain unknown to the provider and the patient, in order to avoid bias.

All of this sounds awfully formidable and long-term. It certainly has its complex problems. I feel, however, that there would be a lot more progress made in the area of evaluation if, in addition to this formalized approach that involves a lot of dialogue and a lot of cooperation, we made it desirable, possible, and expected for every professional person working within a program to ask himself, "What would I accept as evidence that I am doing my job well?" We can make it less formal, more personalized, and more involved. We can involve ourselves so that we, as professional people providing services, can begin to get some sort of feedback as to how effective our actions are and where we need to modify these activities. Again, evaluation is an integral part of practice, not an extraneous set of activities for inspection. It can lead to improvement in our knowledge and in our ability to deliver services. We can learn from our failures as well as our successes, and we can begin to make knowledge cumulative. If we can do this, then I think we have a fighting chance of getting something useful done.

the process of program evaluation·a model by Dr. John Cassel



evaluation workshop '72



discussion groups

The following projects were discussed in separate group discussions

Group	Project Directors
1. Telephone Lecture Network	Joseph Reynolds, TLN Coordinator
2. Comprehensive Continuing Care for Chronic Illness	Evan Calkins, MD, Chairman, Department of Medicine, State University of New York at Buffalo; E. J. Meyer Memorial Hospital
3. Pulmonary Rehabilitation	
4. Pulmonary Home Care (The above two projects are a part of the Chronic Respiratory Disease Program)	John Vance, MD, Clinical Associate Professor of Medicine, State University of New York at Buffalo; Millard Fillmore Hospital
5. Model Program for Comprehensive Family Health	Ernest Haynes, MD, Director, Family Practice Center, Deaconess Hospital, Buffalo
6. Community Health Information Profile (CHIP)	Harry Sultz, DDS, MPH, Professor, Department of Social and Preventive Medicine, State University of New York at Buffalo
7. Model Stroke Rehabilitation Proposal for Regional Community Hospitals	William Kinkel, MD, Clinical Associate, Professor Neurology, Anatomy, State University of New York at Buffalo; Millard Fillmore Hospital

interaction

Seven groups met to evaluate individual **LARMP** projects, and found themselves **QUESTIONING...**

We had better decide first what we are going to define as **SUCCESS** and if we do arrive at this success, **WHAT ARE WE GOING TO DO ABOUT IT?**

HOW FAR DO YOU GO in a study? **WHEN** do you say it is **SIGNIFICANT?**

What measures are **VALID** in a particular case that could really measure **CHANGE?**

We want to know if this kind of program will help people to **BETTER COPE** with the problems of living in contemporary society?

WHY DO THIS?

and questioning

We question the **SCOPE** of evaluation, the **BOUNDARIES** of evaluation...**WHERE DO YOU STOP?**

What caused the drop in **USE** of this program; Was it **CONTENT** or **COST** or both?

Do other **PEOPLE** in the community ever **FIND OUT** about these programs?

How many times do you have to **WORK THROUGH** these steps and then **WORK BACK?**

Are the **MEANS** getting mixed with the **ENDS**; are **ACTION** programs getting mixed in with the **OBJECTIVES?**

A physician must question, "Are there functions physicians have traditionally performed that would better be performed by others?"

Is it a VIABLE program or is it NOT?

Could we turn success
into **USEFUL ACTION;**
and, if not,
we **QUESTION**
the whole worth
of the whole evaluation.

?

and concluding

We are concerned with the **TOTAL** well-being of the patient, not strictly a particular health problem.

The most important thing is to determine whether there is a **NEED** for a program or an **ADVANTAGE** in having one.

If you break
an objective down
to a specific point,
it starts
to **MAKE SENSE.**

difficult to ACCESS TOTAL IMPACT

There are parts of health care
that cannot be measured.

Evaluation is like salt:

every meal **IMPROVES** with salt;
some foods **NEED MORE** than others;
but there can be **TOO MUCH** salt!

Are the objectives **WORKABLE?**

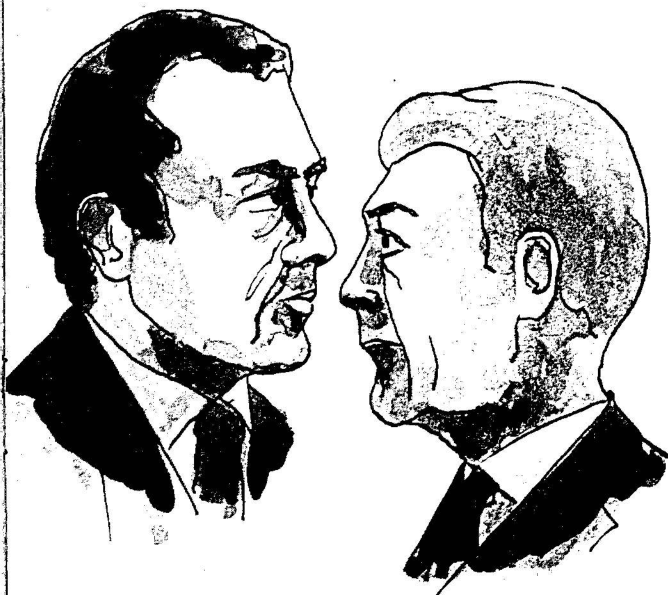
Periodically there should be an assessment of data.
Based upon the insights of the professionals,
you could make sound decisions to **BUILD ON.**

There are many **VARIABLES** to consider: **TIMING; PROGRAM; HOW** and **WHEN PEOPLE ARE INVOLVED; WHO** they are trying to reach...you must **CLARIFY** your thinking.

Data collection can be a valid **INDICATION** of **CHANGE.**

This is all based on the assumption that
we **BELIEVE** it will **WORK!**

reaction



program committee meeting on the EVALUATION of the evaluation WORKSHOP

Father Cosmos Girard, Chairman
Dean Virginia Barker
Dr. Theodore Bronk
Dr. Irwin Felsen
Dr. Larry Green
Dr. Bert Klein
Dr. Harry Sultz
Mr. A. Burton Kline
Dr. LaVerne Campbell
Dean J. Warren Perry

L.A.R.M.P. Staff
Dr. John Ingall
Patricia Shine Hoff
Dr. James McCormack
Joseph Reynolds
Anthony Zerbo
Elsa Kellberg

WHY A WORKSHOP ON PROGRAM EVALUATION?

Evaluation is an essential component in all of the Lakes Area Regional Medical Program's projects and program activities. It is a mechanism that promotes sound planning, productive operation, and innovative re-planning. The purpose of the workshop was to acquaint those persons associated with the Lakes Area Regional Medical Program with the evaluation mechanism, its complexity, and the need for overt commitment to its implementation. Evaluation efforts depend upon the cooperation of project sponsors and administrators; and cooperation depends upon understanding. The workshop proved to be a workable way to accomplish that understanding, for both project and Program people.

WHAT DID THE WORKSHOP ACCOMPLISH?

What was indeed accomplished was an attitudinal change toward evaluation. Those attending realized the importance for evaluation, and demonstrated an increased appreciation of its relevance to program goals and objectives. The Workshop produced rationales for 'why' evaluation is necessary in terms of planning and outcome. It forced basic and direct questions about the need, motive and direction behind projects. It lead to the clarification of individual goals, demonstrating the need for relevant, workable, and specific objectives. In an attempt to evaluate particular projects of **LARMP**, participants were confronted evaluation problems. They found that as they shaped evaluation, they re-shaped the project. Evaluation began as an idea and emerged as a functional process that required work, understanding, and unqualified commitment from every facet of every program.

Lakes Area
Regional
Medical Program

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