

DOCUMENT RESUME

ED 136 082

CG 011 087

AUTHOR Koroluk, Igor; Lund, Donald A.
 TITLE The Program Evaluation Van: A Way to Demystify Program Evaluation.
 PUB DATE Mar 76
 NOTE 17p.; Paper presented at the Annual Meeting of the American Orthopsychiatric Association (53rd, Atlanta, Georgia, March 3-6, 1976)

EDRS PRICE MF-\$0.83 HC-\$1.67 Plus Postage.
 DESCRIPTORS *Evaluation; *Helping Relationship; *Human Services; Humor; Intervention; *Program Effectiveness; *Program Evaluation; Sociopsychological Services; Speeches

ABSTRACT

This paper offers a humorous parody of the way in which evaluation teams often enter clinical institutions to do program evaluation studies. The parody emphasizes the over-use of sophisticated techniques and methodologies; as well as expensive equipment. The authors then define evaluation as "determining the degree to which a program is meeting its objectives, the problems it is encountering and the side effects it is creating." They contend that in order to evaluate effectively, one must consider the context of the program. Program objectives should be stated in terms of structure, process and outcome, all of which are further defined. Sociodemographic data is generally available about the specific populations served and should also be utilized. Outcome evaluation is seen as the most difficult and costly type of evaluation, but of extreme importance. Outcomes should be defined and explicated. Simplifying the terminology and process of evaluation is essential for improving human service delivery. (NG)

 * Documents acquired by ERIC include many informal unpublished *
 * materials not available from other sources. ERIC makes every effort *
 * to obtain the best copy available. Nevertheless, items of marginal *
 * reproducibility are often encountered and this affects the quality *
 * of the microfiche and hardcopy reproductions ERIC makes available *
 * via the ERIC Document Reproduction Service (EDRS). EDRS is not *
 * responsible for the quality of the original document. Reproductions *
 * supplied by EDRS are the best that can be made from the original. *

ED 136082

THE PROGRAM EVALUATION VAN: A WAY
TO DEMYSTIFY PROGRAM EVALUATION

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRO-
DUCED EXACTLY AS RECEIVED FROM
THE PERSON OR ORGANIZATION ORIGIN-
ATING IT. POINTS OF VIEW OR OPINIONS
STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF
EDUCATION POSITION OR POLICY.

Igor Koroluk
Program Analyst
Bureau of Program Evaluation
State of New York
Department of Mental Hygiene

Donald A. Lund, Ph.D.
Director, Bureau of Program Evaluation
State of New York
Department of Mental Hygiene

Presented to the 53rd Annual Meeting
of the American Orthopsychiatric
Association, Atlanta, GA March 3 - 7, 1976

GG 011087

Imagine it! A convoy, led by the "program evaluation van", rolls through the gate of "Mending Minds" Psychiatric Hospital and parks in a circular formation on the ninth hole of the hospital's golf course. Members of the crew gingerly unload highly volatile tanks of G.A.S.,¹ ATGON,² and SCL-90.³ Other crewmen rapidly plug the van into a power source as technicians activate the van's System 3 computer. It's capabilities are augmented by virtual memory and dynamic reallocation. The process of unloading complex and sophisticated mental health program evaluation gear continues as the PATS team prepares its PEP⁴ procedures and program auditors conduct a PASS Review.⁵

Several large hoses are removed from their racks and connected to receptacles in nearby wards. The equipment begins to whir and grind as vacuum suction pulls in some of the ward's atmosphere. Immediately, complex analyses are performed to produce a score on the Ward Atmosphere Scale.⁶ Highly sensitive sensors measure organization climate⁷ and levels of staff empathy.

Quietly and efficiently "Mending Mind's" patients are led to the entrance of interconnected semi-trailers in which they pass through an optical scan device (laser based and similar to those new-fangled checkout counters in the supermarket) which quickly reads their identity from the small lines printed upon their wrist bracelets. They are, then, seated in comfortable arm chairs attached to a conveyor belt (just like in the Haunted

Mansion at Florida's Disney World). Gradually, they move through a series of stations at which their physical health and mental status are examined. As they exit, results of this multiphasic screen, measures of their functional status,⁸ adaptive behavior skills,⁹ level of psychopathology and an instant diagnosis are miraculously produced.

Simultaneously, the staff as they munch on "Evalutreats",¹⁰ are entertained by "Reddy Evaluator", an electronic marvel on the side of the van who preaches the gospel of program evaluation and presents the most recent dymaxion (20-sided) projection¹¹ of evaluative levels and utility for decision-making.

Now wait a minute! This is getting terribly absurd! What does all of this mean? G.A.S., for instance, is an acronym used with reference to the Global Assessment Scale¹² or as a generic label applied to a number of goal attainment scaling strategies including Kiersuk's "Goal Attainment Scaling, Wilson's ATGON (Automated Tri-Informant Goal Oriented Progress Note) and Eval-U-Treat developed by Benedict. Rather than being a highly volatile substance, SCL-90 is a 90 item symptom check list. PAT (Psychiatric Audit Team) members perform the JCAH's Performance Evaluation Procedure for Auditing and Improving Patient Care while other teams utilize Wolfensberger's Program Analysis of Service Systems methodology. Certainly, these are all appropriate and well-developed methodologies. Likewise, examination

of ward atmosphere and its consequences or the impact of organization climate on treatment outcome are important elements of program evaluation. Cubistic models of evaluation strategy, including those published by Schwab and Warheit,¹³ Bell,¹⁴ and Atkisson and colleagues,¹⁵ also have their value. However, are all of these necessary, desirable or, even more important, do they remove the basis of responsibility for decision-making from the clinical manager and evaluation from the context of the service delivery system? "The inability of a majority of... directors and administrators to utilize these complex computer-based evaluation systems does not negate, however, the importance of 'evaluation'."¹⁶

Trappings, jargon and inordinate concern with issues more appropriate to clinical research, distract from our view of evaluation as "determining the degree to which a program is meeting its objectives, the problems it is encountering and the side effects it is creating."¹⁷ "In practice, evaluation services usually go beyond this definition, to concern themselves with the need for the program, its scope in relation to the needs, and the internal processes of program functioning. This extension is necessitated by the fact that program effectiveness often can be discerned only through examination of the program's context and its operational processes."¹⁸

"Evaluations exist (or perhaps only should exist) to

facilitate intelligent decision-making."¹⁹ In our view, evaluation is a tool to allow the clinical manager to make rationale data-based decisions and to alert him to situations in which management intervention may be necessary. "Evaluation may provide data which will reduce uncertainty as to what's really happening inside the program and begin to clarify the pluses and minuses of various decisions. In a way it will allow us to see the values and preferences of the decision-makers more clearly."² From this perspective, evaluation can be done using less sophisticated techniques, less technology and with minimal allocation of resources. All of the trappings and expensive equipment mentioned above may be superfluous to the tasks at hand.

This is not to say that those techniques and methodologies explicitly or implicitly referenced in our parody are not useful, practical or reliable. Rather, they are, with due recognition of both their assets and deficits, respectable components of the evaluative technology. It is the obfuscation created by these acronyms and the technical complexity with which they are presented which detract from their ready implementation. They may be applicable to many issues that clinical managers may wish to address and can be utilized without reference to the aura of reverence or complexity which surrounds them. In point of fact, we encourage evaluators to utilize existing instrumentation and technology rather than to expend valuable resources on what is

often duplicative.

There are multiple levels of evaluation. We can do evaluation at some level even without technical expertise, computer access or high resource expenditure. We can accomplish more with the availability of technical experts.

Availability of technical experts with the infusion of state of the art technology and almost unlimited resources can often achieve evaluative "nirvana" (as a state of self-delusion). However, the lack of technocrats, computer access, and unlimited resources IS NO EXCUSE FOR FAILURE TO EVALUATE.

Basic to the capability to evaluate is a context in which program objectives,²¹ either explicit or implicit, exist and are understood. These can, and should, be stated in terms of structure, process and outcome.²² We advocate a rather simple "verb-noun" approach to setting clear, concise, and easily understood goals, for example: "reduce length of stay." These goals then can be operationalized by first determining the present level or baseline (i.e., current length of stay is 30 days), determining a target, neither too easily reached nor too difficult to attain (i.e., reduce length of stay by 4 days) and specifying a deadline (i.e., within 6 months). Remember, these objectives are not cast in bronze, they can and should be revised with experience.

Objectives addressing structural program issues, such as adequacy of physical plant, of staff/patient ratio and/or staff

qualifications as related to program needs, while the subject of much external review in the form of inspection for compliance with standards, can be the basis for rigorous periodic self evaluation. The clinical manager can compare the current program environment and staffing against his objectives or JCAH (Joint Commission on the Accreditation of Hospitals) standards relevant to his particular type of facility, and initiate intervention where appropriate. Common structural goals such as:

1. Decrease patient/direct service staff ratio,
2. Humanize wards, and
3. Develop outreach clinics,

can be specified in ways which will make them measurable and give the clinical manager real information concerning program structure. The objectives written from the above might be:

1. Decrease the existing patient/psychologist ratio (100 to 1) to 50 to 1 by the end of the current fiscal year,
2. Hang drapes meeting 1974 - federal fire resistant regulations in all residential living units within 3 months, and,
3. Open a store front satellite clinic within one year in the identified high risk area of "Freud's Station."

Within the realm of process, it is possible in programs with limited access to technocrats and resources to make use of the already available information base at the service delivery level. Systematic examination of these data or their recombination

into indices or ratios can provide an insight into attainment of process objectives.

Process evaluation looks at the operations of the program, the practices within it, (the patterns which develop), and the ways that program approaches and interacts with the mental health system... It is useful as a quality measure when process results are compared against baseline data, norms, standards and realistically determined objectives.

Since in most cases process objectives are indirect measures of quality, why look at process? Process evaluation is immediately attainable. It relies on a basic data set... which may already exist or can, with little effort (and additional cost) be developed within a program. Measurable and observable process objectives can be set for areas and population groups to be served, modalities of service to be used, equity and availability of services, and continuity of care within the system based on needs assessment, census data and baseline information on current operations.²⁴

For example, a goal of "reducing injury producing incidents" has been set. This has been operationalized as "reduce by 50% the frequency of injury (average of 8 per month) to residents over the next 6 months." This objective can then be monitored by using incident reports which are often completed when an injury causing event occurs. Typically, one copy of such a report is sent to a review committee and one is filed in the involved individual's record. These incidents are then reviewed on a case-by-case basis, which of course is necessary. Rarely, however, does the clinical manager keep a continuous

record of these incidents to determine if any patterns emerge as to time, place, type of incident or individuals involved. Yet, this is exactly the information he needs to determine the achievement of his stated objective.

Similar uses can be made of aggregate morbidity and mortality information, medication profiles, or, even examination of changing patterns of utilization of isolation rooms, restraints, emergency ambulance services, and intramuscular injections (especially when used for behavior management). Longitudinal examination of the entire range of treatment modalities provided can also illuminate the existing operational processes. Still within the context of readily accessible data sources is the treatment documentation yielding information about the process of patient care. A system of explicit objectives, or criteria, is necessary to focus the review of treatment documentation and to select information elements to be abstracted, such as "each therapist will develop at least 3 observable behavioral objectives for each of his patients within one month." Simple examination to ascertain whether documentation is completed within prespecified time constraints, whether indicated risks are managed in accordance with criteria for risk management, whether services are provided within a temporally appropriate sequence, and whether adequate justification and documentation exists for continued maintenance at the current level of care is

possible based upon accepted criteria. A methodology for such review using existing treatment documentation, variously termed psychiatric audit or medical care evaluation studies²⁵ has been proposed by the JCAH under the title Performance Evaluation Procedure.

In ambulatory settings aggregation of data concerning "no shows" and "service dropouts" in terms of frequency of occurrence, and a time of day and day of week format can reveal patterns of utilization and accessibility. Against a goal such as "improve temporal accessibility," these data can be used by the clinical manager to schedule services and staff time at high utilization periods, and conversely, to schedule administrative functions such as staff meetings during periods of low utilization. Thus objectives of "move staff meetings to Monday morning by March" and "open the outpatient clinic three nights a week by April" might be established.

Simple comparisons of sociodemographic data concerning the population served and the general population can provide a wealth of information on who the program is reaching and how well it is doing in terms of its own assumptions and/or community expectations of who it should be serving. A readily available source for these data are the publications of the Bureau of the Census as well as the entire National Institute of Mental Health Series C publications (including titles such as "A Model for

Estimating Mental Health Needs Using 1970 Census Socioeconomic Data")²⁶ which provide a working model for the clinical manager on not only evaluation, but also topics such as accounting, cost finding and information systems. As technocrats and resources become available, sociodemographic comparisons can be made not only between the population served and the general population, but also between the population served and the population-at-risk as defined using some sociotechnologic approximation of prevalence.

Outcome evaluation is generally considered the highest level of evaluation and therefore it is assumed to require the greatest infusion of resources for its support. A major reason for its cost is that it is often geared toward assessing the individual and attempts to measure change in condition over time. Measuring change of the human psychopathologic, symptomatic, or functional condition generally requires standardized instruments or techniques. These, in turn, require training to administer, ability to analyze, and at least two administrations (pre and post) for purposes of interpretation. (Ciarlo, has proposed a "post" only methodology which may be effective as well).²⁷

These techniques generally key on multiple items or specific individualized goals. The goal attainment scaling techniques perviously mentioned all rely, in one form or another, on a simple process of a therapist setting an observable objective

and monitoring progress toward that objective on a prespecified continuum. However, it is possible to look at a limited set of conditions or goals to which the program is specifically directed. For instance, in a retardation program a program goal can be "to toilet train the residents." Following review of baseline performance data, this goal can be operationalized by stating, "75% of the residents will toilet independently after completing the six week training program." In certain settings, such as a chronic geriatric unit, a maintenance goal may be established which targets maintenance of a functional state as a successful outcome. An example might be "maintain present level of functioning for 97% of patients over the next six months."

The effects of utilization review and the development of PSRO's have already led to a more well-defined data base in inpatient programs which may be useful for outcome evaluation. Within the utilization review process, it is necessary to establish criteria with which to determine whether admission and continued stay are appropriate. It is also possible to measure symptom relief, improvement or change in function based on those same criteria. At this level of evaluation instruments such as the Global Assessment Scale or the SCL-90 become useful in measuring progress along pre-determined and standardized items.

From the foregoing examples, by no means the universe

of techniques available to the clinical manager we hope that we have shown that it is in fact possible to conduct evaluation, without becoming mired in the jargon of the field or expending an inordinate proportion of the service delivery systems resources.

We, as evaluators, do ourselves and our clients a disservice by allowing technical shorthand to infiltrate our communications to the detriment of our concern for rational data-based management toward the goal of effective and efficient human service delivery.

R E F E R E N C E S

- ¹ Davis, H. 1973. Four Ways to Goal Attainment. Evaluation. 1 (2): 43-48.
- ² Wilson, N. 1974. An Information System for Clinical and Administrative Decision-Making Research and Evaluation. In Progress in Mental Health Information Systems. J. Crawford, D. Morgan and D. Gieruch, eds. Ballinger, Cambridge, MA.
- ³ Derogatis, L., Lipman, R. and Covi, L. 1973. SCL-90: An Outpatient Psychiatric Rating Scale (preliminary report). Psychopharmacology Bulletin. 9:13-28.
- ⁴ Joint Commission on Accreditation of Hospitals. 1975. The PEP Primer for Psychiatry. Joint Commission on Accreditation of Hospitals, Chicago.
- ⁵ Wolfensberger, W. and Glenn, L. 1973. PASS: Program Analysis of Service Systems. National Institute of Mental Retardation, Toronto.
- ⁶ Moos, R. 1974. Evaluating Treatment Environments. John Wiley, New York.
- ⁷ Levinson, H. 1972. Organizational Diagnosis. Harvard University Press, Cambridge.
- ⁸ Weissman, M. 1975. The Assessment of Social Adjustment. Archives of General Psychiatry. 32: 357-365.
- ⁹ American Association on Mental Deficiency. 1975. Adaptive Behavior Scale for Children and Adults. American Association on Mental Deficiency, Washington, D.C.
- ¹⁰ Benedict, W. 1973. Eval-U-Treat, A Unified Approach to Evaluation and Treatment in a Residential Treatment Center. Lutheran Social Services of Wisconsin and Upper Michigan, Stoughton, WI. (monograph).
- ¹¹ Fuller, R.B. 1967. The Honeywell Edition of Fuller Projection. Honeywell Inc., Minneapolis.
- ¹² Spitzer, R., Gibbon, M. and Endicott, J. 1973. Global Assessment Scale. (unpublished).
- ¹³ Schwab, J., Warheit, G. and Fennell, E. 1975. An Epidemiologic Assessment of Needs and Utilization of Services. Evaluation. 2 (2): 65-67.

¹⁴Bell, R. 1973. Systematic Dimensions of a Comprehensive Evaluation Model. In Southern Health and Family Life Studies. Community Mental Health Center, Winter Haven, FL.

¹⁵Atkisson, C. et al. 1974. A Working Model for Mental Health Program Evaluation. American Journal of Orthopsychiatry. 44 (5): 741-753.

¹⁶Biegel, A. 1974. Evaluation on a Shoestring: A Suggested Methodology for Evaluation of Community Mental Health Services Without Budgetary and Staffing Support. In Resource Materials for Community Mental Health Program Evaluation (Part 1). W. Hargreaves, et al., eds. National Institute of Mental Health, San Francisco.

¹⁷Southern Regional Education Board. 1973. Definition of Terms in Mental Health, Alcohol Abuse, and Mental Retardation. (Department of Health, Education and Welfare Publication No. (ADM) 74-38) U.S. Government Printing Office, Washington, D.C.

¹⁸Smith, J. 1974. Manual of Principles and Methods for Program Evaluation in Resource Materials for Community Mental Health Program Evaluation (Part 1). W. Hargreaves, et al., eds. National Institute of Mental Health, San Francisco.

¹⁹Edwards, W., Guttentag, M. and Snapper, K. 1975. A Decision-Theoretic Approach to Evaluation Research. In Handbook of Evaluation Research (Vol. 1). E. Struening and M. Guttentag, eds. Sage, Beverly Hills.

²⁰Van Maanen, J. 1973. The Process of Program Evaluation: A Guide for Managers. National Training and Developmental Service Press, Washington, D.C.

²¹Morrissey, G. 1970. Management by Objectives and Results. Addison-Wesley. Reading, MA.

²²Donabedian, A., ed. 1969. Medical Care Appraisal: A Guide to Medical Care Administration (Vol. 2). American Public Health Association, Program Area Committee on Medical Care Administration, New York.

²³Accreditation Committee for Psychiatric Facilities. 1972. Accreditation Manual for Psychiatric Facilities. Joint Commission on Accreditation of Hospitals, Chicago.

²⁴Koroluk, I. 1975. Process Evaluation. Ripple. 2:6. (Newsletter of the Bureau of Program Evaluation, New York State Department of Mental Hygiene, Albany, NY).

²⁵Department of Health, Education and Welfare Social Security Administration. 1974. Conditions of Participation Hospitals and Nursing Facilities (Utilization Review). Federal Register. 39 (231): 41607.

²⁶Rosen, B. 1974. A Model for Estimating Mental Health Needs Using 1970 Census Socioeconomic Data. (Department of Health, Education and Welfare Publication No. (ADM) 74-63) U.S. Government Printing Office, Washington, D.C.

²⁷Ciarlo, J. et al. 1972. A Multi-Dimensional Outcome Measure for Evaluating Community Mental Health Programs. (unpublished).