Evaluating Respite: A Primer

Why evaluate
What to evaluate
Finding the tools

Presented by Casandra Firman, ARCH Evaluation Specialist

Adapted with permission from “Data in the Real World”, a tool developed by the FRIENDS National Center for CBCAP
Really? Evaluation? Is this necessary?

Evaluation is necessary for accountability.

It helps “tell our story” and justifies our work, especially if using public resources.
We evaluate because we have an obligation:

- To learn if our services result in the positive changes they are designed to achieve.
- To adjust and improve services based on data.
- To tell our story and advocate for our program.

Ethical need: Funders should know what is happening with their money

Practical need: Establishes a case for sustainability and guides continuous quality improvement
Should someone ask about your program. . .

Does it work?
Our program is evidence based—Of course it’s working!

We’ve been doing it for years.

We’re funded to provide it. Who’d fund something that didn’t work?

It feels right. It has a good vibe about it.
Show me your data.

What data?

Data?

?#!@
‘Data’ means *information*.

We need it to . . .

Calculate  Analyze  Explain
Types of data needed to . . .

Calculate

Analyze

Explain

Quantitative

Qualitative

Numbers

Text

notes

Graphics

Audio
the King went on, “I shall never, never forget.”

“You will, though,” the Queen said, “if you don’t make a memorandum of it.”

illustration from *Alice’s Adventures Wonderland*, drawn by John Tenniel
We need data to answer evaluation questions like:

- How were caregivers different as a result of our services? To what degree?
- What parts of our program worked? What didn’t?
- Did we do provide the services we planned?
- Did we reach the caregivers we tried to reach?
- What did our services cost?
Back to the question . . . *Does it work?*

First, be sure you can articulate:

- What *it* is
- What *work* means

Where do we start?
Begin with a Logic model
Torture will be your primary responsibility. Are you familiar with Logic Models?
It’s a template for . . .

- Planning services
- Implementing services
- Evaluating services
- Reporting
Why Do We Need Logic Models?

- A logic model is an illustration of a thought process.
- Developing a logic model ensures critical thinking is applied as services are designed.
- It is a document that describes the links between populations served, services, desired outcomes, and the data needed to demonstrate outcome achievement.
Logic Model Components

- **Vision**
- **Population served**
- **Services** (what it is—the activities that lead to outcomes.)
- **Assumptions** (theory of change—why you think the services will result in the outcomes)
- **Outcomes** (what happens when ‘it’ works.)
- **Indicators**
- **Resources** (what it takes—staff, space, money, etc.—to provide the services)
- **Measurement Tools/Data Sources**
The Title of Your Project

**Vision (or Goal, long-term):** What motivates the need for change? What is the spirit behind the activities. An example: “Families in our community are strong, stable and nurturing.”

**Population:** A description of the population your program is targeting for services. You may also indicate the needs of the target population that you intend to address through your services.

<table>
<thead>
<tr>
<th>Services/Activities</th>
<th>Outcomes</th>
<th>Indicators</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The activities, strategies or approaches, you will employ.</td>
<td>Broad statements about how the target population’s beliefs, behaviors, and status will change as a result of your services. They answer, “What is the desired change our services will bring about?”</td>
<td>Concrete descriptions of what you would see, hear, count or otherwise measure as evidence that an outcome is achieved. They provide a direct link to the data you need to collect and the tool or tools you will use to measure it. Indicators may include targeted numbers or percentages for achievement. Each outcome should have at least one or two indicators. Indicators operationalize and define the outcome. They clarify what you plan to measure. If you can’t measure it, don’t include it.</td>
<td>Tools and data sources for capturing information about outcome achievement. They must be tied to indicators. Measurement tools can be simple, such as checklists or tally sheets used to count the number of referrals received, or hours of service. They can also be more complex—such as scaled surveys or observational assessments.</td>
</tr>
</tbody>
</table>

**Resources (inputs):** Funding, infrastructure, training, and other necessities for implementing services. Identify secured resources as well as those sought.

**Assumptions:** The reasons you believe your services will bring about the desired outcomes. The services you offer should be based on what is most likely to be effective. Briefly describe the rationale for using the particular intervention, including factors such as: “lessons learned” for similar projects previously tested in your community, or in other areas of the country; factors in the larger environment that have created the “right conditions” for the intervention (e.g., existing social, economic or political factors that you’ll be able to take advantage of, etc.)
Outcomes

Movement towards or attainment of a change in attitude, belief, behavior

What has changed for the people you serve as a result of the services you offered?

If you conduct your program’s activities with fidelity, what do family caregivers believe, know, have or do as a result?
Challenges in Evaluating Outcomes

- Claiming responsibility for preventing negative outcomes or things that didn’t happen.
- Assuming responsibility for outcomes that were influenced by factors outside your control.
- Showing long-term growth within a short and rigid time-frame
Outcomes

Short-term
Engagement. Changes in attitudes or beliefs.
Caregivers recognize their need for short breaks.

Intermediate
New behaviors, steps toward sustained change.
Caregivers add respite to their weekly schedule.
Caregivers report reduced levels of stress.

Long-term
Sustained changes in behaviors, health and well-being.
Caregivers schedule and use respite routinely.
Caregivers experience improved well-being in domains they identify as important.
Outcomes Need Indicators

Desired Change

Evidence of Change
Indicators

✔ Indicators are specific signs needed to track progress

✔ Indicators answer the question:

– What would I see or hear that would tell me that the outcome was being achieved?

Indicators specify what will be measured. They can set a level of achievement to attain in #’s or %’s
Outcome: Caregivers develop supportive social relationships.

Indicators:

- Caregivers identify individuals or groups they enjoy connecting with.

- Caregivers schedule the respite time they need to able to maintain social connections.

- Caregivers use their respite time to participate in the social activities of their choice.
Tools can be simple, such as checklists, attendance rosters, and tally sheets. They can also be surveys, tests, case notes, and observational assessments.
# Measurement Tools

allow us to measure the degree to which an indicator was achieved

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicator</th>
<th>Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Caregivers experience improved health and well-being.</td>
<td>1.1. Caregivers have daily interactions with peers.</td>
<td>Tally sheet</td>
</tr>
<tr>
<td></td>
<td>1.2. Caregivers have a decrease in stress associated with caregiving.</td>
<td>Caregiver Self-Assessment Questionnaire</td>
</tr>
<tr>
<td></td>
<td>1.3. Caregivers perceive an improvement in their overall health.</td>
<td>Caregiver Self-Assessment Questionnaire</td>
</tr>
</tbody>
</table>
Caregivers have a decrease in stress associated with caregiving.

Caregivers perceive an improvement in their overall health.
ARCH resources for identifying outcomes and tools

- **Research Agenda for Respite Care**
  
  [https://archrespite.org/library/a-research-agenda-for-respite-care/](https://archrespite.org/library/a-research-agenda-for-respite-care/)
  
  See pages 16 & 17 for *Taxonomic Schema of Related Proximal and Distal Outcomes*, a table that identifies caregiver wellness-related outcomes.

- **Measuring Systems Change and Consumer Outcomes**
  
  
  Starting on page 21, a table linking caregiver outcomes with data sources and possible measurement tools is presented.

- **Evaluating and Reporting Outcomes: A Guide for Respite and Crisis Care Program Managers**
  
  
  The guide explains what outcomes are and shows why programs need to be able to demonstrate their outcomes. It also discusses ways to identify, evaluate and report outcomes.
The FRIENDS National Center for Community-Based Child Abuse Prevention (FRIENDS) also has resources for evaluation.

https://friendsnrc.org/evaluation/evaluation-planning/outcome-accountability-process/

https://friendsnrc.org/evaluation/logic-models/compendium-of-annotated-tools/

https://friendsnrc.org/evaluation/logic-models/logic-model-builder/.
## Perceived Stress Scale

**Scoring and Interpreting Results**

The PSS does not include instructions for administration.

The PSS is scored with a 4-point Likert scale with 0=never and 4= very often.

PSS total scores are obtained by reversing responses to the four positively stated items, and then summing across all scale items. Additional instructions for scoring and for comparing scores with a normative group are included with the scale through the following link:


**Technical Properties and Research**

The PSS has reliability and validity coefficients of .85. Test-retest reliability is stronger for time periods of shorter duration.

The PSS has been shown to correlate positively with depressive and physical symptoms, use of health services, and social anxiety among other indicators.

Additional information about the development and psychometric properties of the PSS may be found through the following citations:


**Cost**

The PSS is available at no cost through Mind Garden with permission of the American Sociological Association.


**Contact and Ordering**

Mind Garden

info@mindgarden.com

www.mindgarden.com
<table>
<thead>
<tr>
<th>Factors in Selecting a Tool</th>
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<tbody>
<tr>
<td><strong>Readability</strong></td>
</tr>
<tr>
<td><strong>Cultural appropriateness</strong></td>
</tr>
<tr>
<td><strong>Length/Number of items</strong></td>
</tr>
<tr>
<td>(time to complete)</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
</tr>
<tr>
<td><strong>Special credentials</strong></td>
</tr>
<tr>
<td>(e.g. licensure) to acquire/use</td>
</tr>
<tr>
<td><strong>Environment/Context for administration</strong></td>
</tr>
<tr>
<td><strong>Training to administer, score, &amp; utilize results</strong></td>
</tr>
<tr>
<td><strong>Reliability and Validity</strong></td>
</tr>
</tbody>
</table>
Reliability and Validity: Why Does it Matter?

So you know...

you are measuring what you think you are measuring.

results from a given tool are consistent.
Reliability and Validity

- **Reliability = consistency**
  - An instrument measures the same way each time it is used.
  - **Example:** Each time you weigh yourself, the scale reads 150 pounds. Good reliability!

- **Validity = accuracy**
  - An instrument measures what it is designed to measure.
  - **Example:** The scale reads 150 pounds but you weigh 130 pounds. Poor validity!

- Measures can be reliable but not valid.
If you MUST . . . Creating an Evaluation Tool

- **Check:** Your outcomes clearly defined
- **Check:** There are no existing tools that are appropriate

With a team of stakeholders, draft your instrument.

Review by 6-10 consumers for readability and clarity.

Review by “experts” for relevance and appropriate content.

Regular review by program staff for needed adjustments.

Partner with a university or other research institution
Thank you!

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TOOL ADMINISTRATION
Tool Administration

✓ Face-to-Face Administration
✓ Self-Administered
  • Paper
  • Tablet or web-based
  • Mailing
Tips for Face-to-Face Administration

- Tell consumers ahead of time
- Avoid influencing responses
- Normalize less desirable responses
- Practice with staff and monitor periodically
Self-Administered paper, mail or electronic

- Tell consumers ahead of time
- Include written information and/or informed consent
- Response Reminders

**Pros** – Reduces staff time for administration, reaches wider population of consumers

**Cons** – Reduced response rate, less control over administration
Guidelines for Tool Administration

- Have clear administration protocols. This includes...
  - timelines for pre and post administration.
  - policies for data management
  - Staff assignments and expectations.

- Follow protocol as written

- Keep track of what you did and how you did it.
Best Practices in Data Collection

- Prepare staff to administer tool and manage data
- Complete Informed Consent
- Confidential vs. Anonymous Administration
- Protecting Data Integrity – who needs to know
- Handling Sensitive Questions

Evaluation should be part of everyday practice. It’s not an “add-on”; it’s business as usual.
Guidelines for Data Collection

- Determine if IRB approval is needed to collect data
- Collect an informed consent form from the participant
- Determine when and who will collect the data
- Identify how much time is needed to collect the data
- Gain staff buy-in for data collection
- Develop rules about how data will be used and shared.
Preparing Staff to Administer a Tool

Use the tool’s administration script or create one. It should . . .

- Explain the purpose of survey and review informed consent

Practice administering the tool with script:

- Have new users practice administration with experienced staff
- Monitor or follow up with staff to assure proper administration

Administer the tool:

- Establish rapport
- Follow the administration script
- Provide adequate time for questions
- Use consistent procedures
- Check for inconsistencies in interpretation of items, blanks, etc.

Manage data:

- Have a data management plan in place BEFORE you collect data
- Staff should follow the plan
When Should a Pre-test be Administered?

1st Contact

Pro: Assess functioning prior to any program involvement.

Con: Responses may be less than honest due to lack of trust/involvement w/program

After 1st Contact

Pro: May increase honest responses due to established relationship/trust.

Con: May not capture change occurring since 1st contact
What Other Data Should We Collect? *

- Demographic information
- Services: Type and Frequency/Dose
- Fidelity to your service model
- Cost
- Outcome data
  - Quantitative
  - Qualitative

*Any data collected should be consistent with your overall evaluation plan*
Collect ONLY What You Need
WHAT DATA SHOULD WE COLLECT?
DEMOGRAPHIC INFORMATION
Demographics

Target population

- Race/ethnicity
- Age of caregiver, age of care recipient (s)
- Gender
- Marital status
- Adults / children in household
- Housing
- Other identifying characteristics (example: criteria for your program, diagnoses, ages served.)
Formats and Categories for Demographic Information

How you format and categorize the demographic information is important.

Some examples:

**Income** – do you need/want a total amount of *monthly* household income, *annual* household income or set income *ranges*?

**Housing** - do you want to know if someone is sharing housing because they *want* to or because they have no choice? Do you want to know if they are homeless or at risk of homelessness?

**Education** - Do you want to know if a person has completed high school or the number of years they have attended school?
WHAT DATA SHOULD WE COLLECT?
SERVICES AND FIDELITY INFORMATION
Services

Activities –
- Intakes completed
- Families enrolled
- Services delivered

Participation –
- Number or participants who received respite
- Units of service (hours or days of respite)

Participant feedback –
- Satisfaction
- Future / other interests
Model Fidelity

the degree to which a program as implemented corresponds with the program as described

- **Common Components of Fidelity:**
  - Dosage/Exposure
  - Quality of Program Delivery (staff training and support, family-centered practices, etc.)

- **Fidelity measures** are tools to assess the adequacy of the implementation of the program as described.
  - fidelity checklists and guidelines.
WHAT DATA SHOULD WE COLLECT?
COST BENEFIT / EFFECTIVENESS INFORMATION
How much did it cost to provide the services to achieve the intended outcome?

- Program budget
- Number of participants
- Units of Service
- Outcome achievement
To Begin Calculations You Need

Fiscal data, such as . . .

Fixed Costs
- Rent
- Salaries
- Phone

Variable Costs
- Food
- Transportation
- Supplies

These data should answer: What did it cost to provide my services?
What Else Do You Need?

Program Data

<table>
<thead>
<tr>
<th>Numbers Served</th>
<th>Units of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregivers</td>
<td>Hours of respite</td>
</tr>
<tr>
<td>Care recipients</td>
<td>Number of Visits</td>
</tr>
<tr>
<td>Families</td>
<td>Auxiliary services</td>
</tr>
</tbody>
</table>

These data should answer:

What services did my investment purchase?
What Will You Do With This Data?

Establish what it costs to deliver services

Establish what it costs to achieve positive outcomes

Use cost data to help with CQI.

Was this a good use of resources?

Were the costs worth the outcomes?

Could outcomes have been achieved more economically?

How will we adjust services based on findings?
To Make the Link Between Cost and Benefit, We Need

Outcome Data

Evaluation results—observable changes in

- Behavior
- Health
- Status

These data answer: To what degree did services affect family change?
Thank you!

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