Examples of Evaluations and Measurable Outcomes

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Example #1

Funder: California Council of the Arts, Arts in the Schools

Submitted by: Ink People Center for the Arts

Grant request: $12,000 + $12,000 match for total of $24,000

Project Description: Residency project to enrich classroom curriculum, promote multi-cultural tolerance, support opportunities for community involvement, connect each student's learning to a deeper understanding of themselves, and develop their sense of what they like and dislike, as well as gaining new interest in expressing themselves differently.

Evaluation
Describe how you will assess and evaluate student progress and program effectiveness. Choose at least two of the outcomes you described in the Project Design section of this application, and for each, describe how you will measure whether or not the program achieved the outcome. While you should not expect to attain statistically valid findings, you may set benchmark goals such as "At least two thirds of the students will achieve the standard according to our measurement." Then discuss how, or to what extent, the overall effectiveness of the program can be demonstrated by such measures. You may also include discussion of other likely effects of the program with benefits beyond student achievement of VAPA standards.

EXAMPLE ONE

What is the Activity?	Desired Outcome?	How will you measure?
Using the French Impressionists' watercolor method of layering colors to create movement in space, students will draw and paint trees with blooming cherry blossoms.	Students will learn to paint with short & immediate brush strokes while mixing colors directly on the painting. They will learn how to draw deciduous trees and describe repetitive patterns in nature.	A complete painting will be filled from edge to edge. Appearance of this painting technique. Students will evaluate their work by selecting something they like about their work and things they would like to change.
Evaluation Plan: Discussion		
We believe that almost all students will achieve both visual art standards 1.1 "Describe and replicate repeated patterns in nature, in the environment, and in works of art.," and 2.2 "Mix secondary colors from primary colors and describe the process," by students revisiting their completed works and comparing similar areas of color mixed with each other. They will be able to identify the methods they used to achieve mixing secondary colors by overlapping primary colors.		

EXAMPLE TWO

What is the Activity?	Desired Outcome?	How will you measure?
Observe and discuss the work of Takeshi Kawashima's large triptych of biomorphic pictograms relating to Japanese family crests. Students will create circular symbols from common nature objects for a printmaking project.	The achievement of a clear simple shape. Consistent use of texture for emphasis of shapes. Good craftsmanship in using the printmaking materials.	There will be criteria for completion of art work. Students will evaluate their process of printmaking.
Evaluation Plan: Discussion		
To achieve 3rd grade standards we will use standards 1.5 "Identify and describe elements of art in works of art, emphasizing line, color, shape/form, texture, space, and value," 2.6 "Create an original work of art emphasizing rhythm and movement, using a selected printing process," 3.4 "View selected works of art from a major culture and observe changes in materials and styles over a period of time," and 4.2 Compare the different purposes of a specific culture for creating art." Our assessment criteria will depend on students' evaluations of each other's art works with the criteria guidelines of a) having one clear simple shape, b) presence of consistent use of texture for emphasis of shapes, and c) good craftsmanship in using the printmaking materials, by identifying how to achieve a good		

Example #2

Funder: County of Riverside

Submitted by: Family Service Association of Western Riverside County (FSA)

Grant request: Not disclosed

Project Description: To fund Prevention and Early Intervention (PEI) services through a program called CARE (Community Assistance and Resources for the Elderly) to older adults in three communities of the East Valley Region of San Bernardino County. Services will focus on assisting seniors before possible mental health issues escalate to higher levels of treatment. They will be provided in community-based settings (i.e. Senior Centers and Senior Nutrition sites and in the homes to frail or geographically/socially isolated elders) and will include the prevention and early identification of depression, dementia, substance abuse and suicide and other mental health issues due to the aging process, trauma and/or bereavement.

Provide some examples of the outcomes expected.

The project is designed to achieve the stated objectives of the PEI established by DBH:

Increase collaboration between senior centers and DBH and community-based organizations

- Seek and identify older adults in need of prevention and early intervention services
- Improve access to mental health services for older adults living in remote areas
- Decrease the number of older adult hospitalizations
- Increase the services for seniors who are caretakers of children or disabled adults
- Increase the number of activities and events for seniors
- Reduce the rate of suicide

Provide a description of your current data management capability which can include: how data is obtained, tracked, warehoused, shared, what data sources will be used for baseline measurements.

Outcomes will be evaluated through Continuous Quality Improvement (CQI) process on a quarterly basis and measured annually. CQI involves monthly meetings of all Program Directors with CQI staff to discuss quality issues. On a quarterly basis, the group reviews outcome measures and progress towards achieving these measures. Any changes or mid-course corrections are then made to assure the achievement of the annual outcomes. All outcomes are documented (tracked) on an ongoing basis (i.e. Pre/Post Test results, surveys, attendance records, etc.) and evaluated annually:

- Attendance logs
- Surveys
- Pre/Post Tests
- Assessments
- Case notes

FSA is accredited by the Council on Accreditation for Children and Family Services (COA) that requires all programs/departments to conduct outcome studies to review the effectiveness of our programs. FSA's Mental Health Department does an outcome study each year on one of its clinical counseling programs and the results of that study are utilized for program quality improvement across programs to all services in the department. FSA's clinic department additionally has a QA committee that meets regularly and reviews client charts for completion of all required information.

In addition, FSA utilizes independent Program Evaluators for various mandated evaluations over the last few years. FSA has utilized the feedback from those outside evaluators to evaluate and improve our client services. Also, FSA conducts client satisfaction surveys on all programs and utilizes that feedback as well as feedback from client focus groups to improve our programs.

Example #3

Funder: Grossmont Health Care District

Submitted by: ElderHelp

Grant request: $75,000

Project Description: To fund the Elder-Help Concierge Club to combine high quality care management services with in-home volunteer services and use an innovative fee-based system – membership program that delivers the support systems seniors need at a price they can afford – that will support ElderHelp to both serve more seniors and better sustain the program over time.

Measurable Objectives related to each goal include:

Goal 1: Of those Concierge Club members who feel at risk of losing their ability to age in place, a significant number will feel an increased sense of independence and ability to remain in their own homes through participation in the Concierge Club.

Goal 1 Objectives:

- ElderHelp will enroll a minimum of 130 Concierge Club members over the 12 month grant period.
- 80% of members enrolled will utilize Concierge Club services.
- ElderHelp will retain 85% of its members after 12 months.
- Member Care Managers will assess and develop care plans for Concierge Club members in need of long term care management.
- Member Care Managers will reassess, monitor and conduct home visits with each member quarterly.
- ElderHelp will recruit, train and personally match a minimum of 97 volunteers over the 12 month grant period.

Goal 2: The Concierge Club is cost-effective by delaying and averting nursing home costs and spend-downs on Medi-Cal, saving each member $1,600 annually on home care services, and discounting up to 25% of additional services.

Goal 2 Objectives:

- Volunteers will donate a minimum of 6,500 hours or $143,000 of home-based services to Concierge Club members over the 12 month grant period.
- ElderHelp will assess each member for their risk of nursing home placement utilizing the Instrumental Activities of Daily Living Scale, the Activities of Daily Living Scale and availability of family support.
- 80% of members enrolled in Concierge Club will utilize the Preferred Provider Network

Goal 3: The Concierge Club will significantly and meaningfully improve the quality of life for members.

Goal 3 Objectives:

- 90% of members will report satisfaction with Concierge Club benefits and services members over the 12 month grant period.
- ElderHelp will retain 75% of all volunteers after 12 months.
- 85% of volunteers will fulfill their 1 year, 6 hour per month commitment.
- ElderHelp will fulfill 100% of ride requests to personal, social, recreational and medical appointments within 7 days of request receipt.
- Of those Concierge Club members with low socialization, ElderHelp will personally match these members with a friendly visitor who will provide up to 4 activities per month.

Goal 4: Of Concierge Club members identified with one or more chronic disease, a significant amount will report an increase in knowledge and a reduction in healthcare utilization.

Goal 4 Objectives:

- Support chronic disease management by linking and transporting members to health screenings, clinics and health education opportunities each quarter.
- Member Care Managers will accompany members to medical appointments for advocacy and improved medical literacy and understanding.

Goal 5: Of those Concierge Club members determined to be at risk for falls, monthly participation in specified membership activities will contribute to a statistically significant decrease in risk.

Goal 5 Objectives:

- ElderHelp Member Care Managers will administer a minimum of 75 Falls Prevention Risk Assessments over the 12 month grant period.
- 90% of non-driving, high risk members will utilize escorted transportation services
- The volunteer-led home repair team will respond to 100% of all home modification requests for falls risk reduction.
- 100% of friendly visiting volunteers will learn specialized senior fitness and strengthening tools to apply during their member visits to decrease falls risk.

Goal 6: Provide Outreach and Information & Referral services to seniors in the Grossmont Healthcare District to increase awareness and accessibility to services.

Goal 6 Objectives:

- ElderHelp will provide a minimum of 750 seniors with Information & Referral services over the 12 month grant period.
- ElderHelp will conduct 6 outreach activities each quarter.
- ElderHelp will conduct outreach activities reaching a minimum of 1200 seniors and community residents.

Program efficacy is monitored on a regular basis through numerous avenues.

New and ongoing member cases are discussed during monthly care management meetings. These sessions ensure that the target population is being served, that each member's problems have been correctly assessed, and that the identified solutions are appropriate. In addition, each Concierge Club member who receives long-term care management receives monthly and quarterly follow-up to determine whether the member's status has changed, been maintained, or improved as a result of services. For those members receiving volunteer services only, a monthly phone call is made to monitor and track member well being as well as satisfaction in regards to specific services.

Concierge Club members are asked to complete a Satisfaction Survey on a semi-annual basis. Questionnaires are distributed by mail and inquire as to the member's satisfaction with the services received, volunteers, care managers, frequency of contacts, as well as to determine the likelihood of continuing utilization of services and recommending services to others. Additionally, ElderHelp administers a semi-annual Impact Survey to gauge the influence of the programs and services. If completion of written questionnaires and surveys is inconvenient, members are given the opportunity to respond directly via telephone. Surveys are collected and monitored by the Member Services Manager.

The Concierge Club will fulfill the concluding element of the Grossmont Healthcare District's Mission Statement. This drive to "anticipate and recognize the unmet health care needs of the communities we serve, and provide suitable services to satisfy those otherwise unmet needs to the greatest possible extent…" is perfectly positioned for the Concierge Club as it is an innovative solution to the need for providing suitable services. ElderHelp's Concierge Club also provides a creative way to help reduce the health care burden hospitals and long-term care facilities face in caring for the elderly population. The assessment, care management and volunteer services provided through the Concierge Club assure that seniors receive the health and social services they need.

B. Measurable Outcomes / Objectives only Examples

Example #4

Funder: Department of Health and Human Services

Submitted by: Family Service Association of Western Riverside County (FSA)

Grant request: not stated

Project Description: New program entitled – "No HIV for Me" will provide realistic, gender-specific prevention education services focused on the intersection between juvenile delinquency and STD/HIV infection for female adolescents. The program will specifically target young women ages 9-17 who are deemed at risk for juvenile delinquency and will provide a gender specific approach that is focused on HIV/AIDS awareness, prevention and support services in a collaborative manner.

The **specific and measurable objectives** of the project include:

Prevention Education:

- Identify a minimum of **75 girls** at-risk of juvenile delinquency to participate in the project, including 60% Latinas, and 30% African American representation.
- 80% of participants will complete the curriculum.
- 75% of participants will demonstrate an increase in HIV/AIDS/STD knowledge (based on Pre/Post Tests).
- 50% of participants will undergo HIV/AIDS/STD testing (appointment verification).
- 50% of participants will self-report involvement in positive youth development activities in the community.
- 25% of participants who complete either curriculum will participate in the Supplemental Program bi-monthly group sessions held at the FSA Community Centers and YWCA.

Capacity Building and Community Awareness:

- Formation of a 10 member Advisory Committee of project collaborators, youth participants and parents to meet on a Quarterly basis to monitor implementation and evaluate progress.
- Quarterly training sessions for youth serving workers, parents and other caregivers on HIV prevention
- Community awareness activities held at least quarterly, including participation in National HIV Prevention Day

The **time specific objectives** for the project are:

- Train the FSA LVN/Health Educator in the delivery of the two identified curricula to provide professional facilitation within the first two months of the project.
- Purchase program supplies and materials within first two months of the project.
- Schedule four quarterly Advisory Committee meetings and recruit additional members within first two months of the project.
- Schedule quarterly Community Awareness Activities with collaborative partners and Advisory Committee members. (One activity will focus on Women and Girls HIV/AIDS Awareness Day).
- Schedule first round of sessions at each of the four sites (two FSA Community Center, YWCA and Operation SafeHouse) within the first two months of the project.
- Conduct recruitment and training of participants within first two months of the project.
- At conclusion of first round of prevention sessions, conduct evaluation activities and provide results to the Advisory Committee for input.
- Schedule second round of sessions at each of the four sites (two Community Centers, YWCA and Operation SafeHouse within the sixth month of the project.
- Conduct recruitment and training of participants within the sixth month of the project.
- At the conclusion of the second round of prevention sessions, conduct evaluation activities and provide results to the Advisory Committee for input.
- Within first three months of the project, begin planning for the participation of the project in the National HIV Prevention Day (March 2010)

Example #5

Funder: US Department of Health and Human Services, Administration for Children and Families

Submitted by: Little Tokyo Service Center (LTCS), Community Development Corporation.

Grant requested: not stated

Project Description: To provide a suite of critically needed supportive services that help individuals and families achieve self-sufficiency, strengthen families, and make a positive investment in the future. This continuum begins with care for infants, on through early and later childhood years, youth, families and working adults. Will also provide bilingual case management, employment preparedness, parenting classes, childcare, financial/family literacy and computer learning skills with the goal of empowering people to seek employment or start new career paths leading towards greater self-sufficiency.

Legal Name of Lead Agency: **LTSC Community Development Corporation**

Outcome4004	**Total # of Clients Expected to Achieve Outcome**	**Aggregated $ Amounts** (Savings, Credits, etc.)	**Describe calculation method and how results will be documented**
Outcome 1: Increase Family Income/Resources			
Indicators			
Obtained a Job	15	116,400	
Obtained a Short-term Job	15		
Opened a Bank Account	10	$7,500	Average savings 750 per client X 10 documented by bank statements
Obtained EITC Credit	25	$62,500	25 clients X $2,500 EITC Credit, documented by tax documents
Obtained Child Tax Credit			
Obtained Child Support			
Obtained Child Care	15	$4,500	15 clients x $300 child care = $4500, documented by enrollment documentation from provider
Enrolled in Utilities Discount Program			
Obtained Low Income Auto Insurance			
Obtained Health Services/Insurance			
Obtained Food Stamps	25	20,000	25 clients x $160 monthly food stamp value documented by DPSS award letter
Obtained TANF (CalWORKS)			
Obtained WIC			25 clients x $150 per month x 9 months = $33,750, documented by copies of vouchers or cards
Obtained Other Public Benefit (Income) Assistance			
Obtained Post-secondary Education Financial Aid			
Obtained ABE/GED			
Obtained a Training Program Certificate			
Other:			

Legal Name of Lead Agency: **LTSC Community Development Corporation**

Outcome4004	**Total # of Clients Expected to Achieve Outcome**	**Aggregated $ Amounts** (Savings, Credits, etc.)	**Describe calculation method and how results will be documented**
TOTAL	**270**	$4,500.00	

Legal Name of Lead Agency: **LTSC Community Development Corporation**

Outcome	**Total # of Clients Expected to Achieve Outcome**	**Aggregated $ Amounts** (Savings, Credits, etc.)	**Measurement Tool**
Outcome 2: Increase Youth Academic Performance			
Indicators			
Improved Grades	20		s or report cards
Improved Reading/Math skills			s
Improved school attendance			s
Grade Level Advancement (Retention)			s, school advancement or graduation records
Re-entered School (for Out-of-School Youth Only)			
Other:			
TOTAL	80		

C. Evaluation-only Examples

Example #6

Funder: Unnamed Foundation funding senior health

Submitted by: Little Tokyo Service Center (LTCS), Community Development Corporation

Grant request: $50,000

Project Description: To support the Senior Services Program and its endeavors to serve Japanese and API seniors living in Los Angeles. Three areas of particular need in this senior population are bilingual case management, care giving to delay nursing home care and alleviate isolation, and transportation services.

Evaluation: To ensure the understanding of the program mission, goals, objectives, and service criteria the Program Director (LCSW) will conduct staff trainings. The trainings will aid in promoting proper documentation and reporting procedures. The Program Supervisor will supervise the staff on a weekly basis with case management meetings. The Program Director will meet bi-weekly with the Program Supervisor to evaluate progress on the project. Monthly reports will be prepared by the staff for review by the Program Director to ensure that client goals are being met. When the program goals are not met, the Program Supervisor and Program Director will meet to discuss and implement changes.

A client satisfaction survey will be distributed among the clients who utilized the services as a way to immediately evaluate the program. This survey will measure effectiveness and quality of case management services, the caregiver program as well as transportation accessibility, if appropriate. The survey will be returned to the Program Supervisor directly. All the surveys will be carefully reviewed and compiled by the Program Supervisor to be reported to Program Director. When necessary the Program Supervisor will develop a plan of corrective action. The Program Supervisor will also meet with the staff to discuss the results of the surveys so the staff may improve the service activities if needed.

The case file is also a valuable tool to assess the program's effectiveness. Particularly, the Case Management Plan and Outcome forms document both the needs of the client as determined in the needs assessment, the service plan, the target date of completion of services and how each client's need was actually met. All the case management files and activity documentation will be reviewed by the Program Supervisor regularly to ensure the quality of the program services.

After one year, staff will review and analyze all Outcome forms and produce a year-end summary documenting the number of clients who received information and referral, case management, the number of caregivers placed into homes and the number of clients enrolled in transportation programs. In addition staff will analyze the client satisfaction surveys to determine the overall effectiveness of the program.

Example #7

Funder: The Ford Foundation

Submitted by: The Academy for Educational Development (AED)

Grant request: not disclosed

Project Description: To continue to plan, put into action, and give proof of the remarkable impact that the New Voices National Fellowship program is having on individuals and social justice efforts in the Gulf Coast. We strive to continue our work in the region of promoting effective leadership, strengthening nonprofits, and engaging people in systemic change that creates opportunities, provides financial support, and offers hope to activists, organizations, and communities demoralized by the negligence of governmental structures, the ineffectiveness of local authorities, and the apathy of the privileged.

Evaluation: An important indicator of success with this upcoming year's initiatives will be tangible influence in public policy discussions and helping to shape public opinion. We also hope to see strategic, coordinated base building for current and future human rights campaigns and other initiatives in the region.
We hope that the third year extension will reduce the stresses associated with finding a new job and alleviate organizational struggles for retaining the Fellows. Through the third year, we also hope to see an intensification of Fellows' collaborative efforts and networking.

Other measures of success include high quality conferences (as measured by participant evaluations), effective mentoring relationships, press coverage, and alumni connections and engagement.

Through biannual reports, site visits, and regular communications with the Fellows, their mentors, and their executive directors, we will be tracking a number of other outcomes of interest:

- Stronger organizational capacities to achieve missions
- Victories in the courts
- Formation of new coalitions and networks
- New social justice products
- New investments in human service delivery systems
- Engagement of local youth and artists
- Funds raised by Fellows for their organizations and issues
- Impact on individuals and communities (i.e., improved human conditions)
- Fellows developing the leadership capacities of others.

NAME and NAME will continue to document events and activities through photography and videography. NAME, Class of 2001, will develop case studies that reflect some of the impact Fellows are having in the region and how they have progressed in their own careers. Community gatherings will also provide an opportunity to reflect on and celebrate accomplishments.

Example #8

Funder: Build-a-Bear Foundation

Submitted by: The Ink People Center for the Arts

Grant request: $9,000

Project description: To fund The MARZ project, an alternative after-school-program for low-income, seriously at-risk youth. Through vocational media and leadership skills development program focusing on storytelling, digital media, and community change, the project will integrate visual and performing arts, media production, exploratory writing and current events discussion groups into workshops and youth designed action projects focused on community and social change.

How will you measure or quantify the success of this funding? (Required)

MARZ relies on basic numbers of service and budget, along with anecdotal evidence of progress gathered by our teachers and weekly staff reviews. To better serve the youth, program staff meets weekly to discuss individual needs and methods of service, as well as curriculum variations. The program also documents demographic information and implements a system of pre- and post-participation testing of youth to measure skill and behavioral development. We will continue to strive to weigh program success related to income and expenditures and, whenever possible, seek to improve on its outreach effectiveness and the efficiency of scale.

Example #9

Funder: Rosehills Foundation

Submitted by: Shoes that Fit

Grant request: $25,000

Project Description "Proposal to Rose Hills Foundation from Shoes That Fit to fund Back-to-School and Holiday Shoes and Clothing Project, in which 25,000 local schoolchildren in need will be given new items so so that they could attend school in comfort and with dignity."

EVALUATION (MEASUREMENT) PLAN

Agency Name: Shoes That Fit **Program Name: Shoes That Fit**

OUTCOME	INDICATORS	DATA SOURCE	DATA COLLECTION METHOD	DATA COLLECTION TOOL	DATA COLLECTION FREQUENCY/ SCHEDULE	SAMPLE SIZE
Schoolchildren in need have shoes suitable for school and play	Students identified as having inappropriate shoes and were provided with new, appropriate shoes.	School liaisons and Shoes That Fit staff.	School staff identifies child's needs, measures children and provides to STF.	Lists school staff provides.	Track in database as distributed.	Local participants
Children's mental/physical health improves	# & % who report improvement in: • Participating in play/playing with others • Feeling good about themselves • Behavior • Feeling about school • Participation in physical activities • Interaction with peers/staff	Children Teachers	Children Survey Teacher Survey	Children Survey Teacher Survey	Pre-and post test conducted at shoe measurement and 1 month after shoe distribution	Local participants
Children who receive needed shoes do better in school	# & % of participants who show improvement in • Attendance • Class Participation • Attitude/behavior • Academic performance	Teachers	Teacher Survey	Teacher Survey	Pre-and post test conducted at shoe measurement and 1 month after shoe distribution	Local participants