Program Evaluation Plan Template

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# How to use this Evaluation Plan Template

Rural Health Innovations (RHI), LLC is a subsidiary of the National Rural Health Resource Center (The Center), a non-profit organization. Together, RHI and The Center are the nation’s leading technical assistance and knowledge centers in rural health. In partnership with The Center, RHI enhances the health of rural communities by providing products and services with a focus on excellence and innovation. RHI is providing TA to the Network Development grantees through a contract with the federal Office of Rural Health Policy.

Evaluation of grant funded programs is critical to both the success and sustainability of the program. It is critical to assess impact of the activities to demonstrate value, monitor progress toward the program goals, and to identify potential best practices and lessons learned. Evaluation findings are integrated back into the program to improve performance.

This template is supported with an Evaluation Plan Guide and an educational webinar: *Program Evaluation Planning and Tools.* The webinar will be recorded and saved on the *Aim for Impact and Sustainability* network resource webpage and as resources in The Center’s Resource Library.

The purpose of this template is to support your work in writing a program evaluation plan. Although a specific template for your Evaluation Plan is not required as part of your grant deliverable, the following components are recommended:

1. Program Description: setting context for the evaluation plan, program mission, vision, history and members.
2. Evaluation Design: describe the purpose and method of the evaluation including program goals and objectives. Include a diagram of your planning framework; such as, a strategic planning framework or a Logic Model framework.
3. Measuring and Reporting Data
   1. Track Activities: An important aspect of evaluating a program is to track implementation of activities with data.
   2. Monitor Objectives: Monitoring measureable program objectives are central to your evaluation plan.
   3. Consider Qualitative Information: Qualitative information provides insights on lessons learned and identifies best practices.
4. Evaluation Findings: Plan, Do, Study and Act: Evaluation findings illustrate program progress and impact to its members and the community and provide an opportunity to consider adjustments.
5. Communication of Evaluation Findings: A communication plan to share evaluation findings with stakeholders is key to illustrating program progress and impact.

# [Network organization] Program Evaluation Plan

1. Program Description: setting context for the evaluation plan, program mission, vision, history and members. Keep this section to no more than 1 page.
2. Program Description including program mission and vision. These may be program goals
3. Program and/or network history
4. Program and/or network members
5. Evaluation Design describe the purpose and method of the evaluation. Keep the narrative portion of this section to no more than 1 page. The key is to articulate and illustrate the alignment of program goals and objectives and clarify the planning framework being used.
6. Describe the rationale of the evaluation, i.e. why is evaluation important to this program? And how the evaluation findings will be utilized.
7. Describe the evaluation method by identifying the planning framework and listing the measureable objectives. Depending on the selected planning framework; objective may be either strategies or outcomes.
8. Provide a diagram to illustrate alignment of program objectives (strategies or outcomes) with program goals. *See Appendix A* for examples of a strategic planning approach and a Logic Model approach framework.
9. Measuring and Reporting

Tracking Activities: “Was the program implemented as planned?” is a means to measure program actions and processes that are put into place to execute on objectives. Tracking activities include counting historical actions or events, such as, # of events, # of participants, # of students, # of procedures, or # of calls, etc.

*Appendix B:* Action Tracking Chart: is a tool to collect data on activities that have been implemented in alignment with program objectives.

Monitoring Objectives: “What is the impact of the program?” is a means to measure program objectives, identified as either strategies or outcomes. The key to successfully monitoring objectives is to collect data on specific measurements that are attainable, realistic and timely; SMART objectives. It is worth the time and effort to revise strategies and outcomes into SMART objectives and utilizing a chart to collect information over time.

*Appendix B:* Monitoring Objectives Chart, tool to collect data on specific measurements of SMART objectives.

Qualitative Information: Qualitative information is a means to gather insights on lessons learned and identifies best practices of the program.

1. Describe the rationale for using qualitative information in the program evaluation, for example, identifying best practices, program success and challenges, or lessons learned
2. Describe method of collecting the information
3. Summarize results
4. Evaluation Findings**: Study and Act**

Evaluation findings provide a means of illustrating program progress and impact to its members and the community. It is also at this step that you consider what to do with the information you have been collecting as part of the Plan Do Study Act cycle. Consider using a dashboard chart to illustrate progress toward objectives and results.

*Appendix C:* Dashboard to illustrate program status and progress.

1. Communication Plan of Evaluation Results describes how the findings of the evaluation will be shared with stakeholders. Keep the narrative of this section to no more than 1 page. A chart format may be useful in describing the communication plan.
2. Identify your audience of the evaluation findings
3. Identify appropriate modes, methods and timing for presenting the findings
4. Use a dashboard to share results and show progress over time.

# Appendix A: Examples of Strategic Planning & Logic Model Approach

**Example of Strategic Planning Approach**

| **Strategy** | **Measurement of Strategy & Definition** | **Measurement Target** | **Frequency of Measurement** | **Aligned Activities**  **(initiatives)** |
| --- | --- | --- | --- | --- |
| 1. **Create a Coordinated Care Process for 1 chronic illness population** | Number of new social service members, such as, transportation, schools, county social service dept. | 1 per quarter | Quarterly | 1a. Identify potential new social service members and implement outreach  1b. Adapt and implement best practice for one chronic disease |
| % of people receiving coordinated care within total chronic illness population | 15% | Quarterly |
| Positive health improvement measure of people receiving coord care compared to state or county benchmark for chronic illness | #>benchmark | Annually |
| 1. **Sustain Network Activity** | % of member representatives attending monthly committee phone conference | 90% | Monthly | Facilitate information and knowledge sharing between members at committee conferences |
| Utilization rate by network members of network services | 80% | Quarterly | Develop network services catalog, statement of work process, and dues structure |
| 1. **Provide IT Options and Coordination** | Utilization rate by members of network IT solutions | 80% | Quarterly | 3a. Secure network wide area network |
| Members participate in proposals written by network | 100% | Quarterly | 3b. Develop IT Proposal for member approval |
|  |
| 1. **Facilitate Communication to Improve Network Effectiveness** | Participation(attendance) rate at face-to-face board meetings | 100% | Quarterly | 4a. Increase board member’s awareness of their role on network board |
| Participation (attendance) at monthly information & discussion phone conferences | 100% | Monthly | 4b. Facilitate information and knowledge sharing between members at committee level |
| 1. **Cultivate Provider Champions** | Participation of physicians and advance practice nurses at network meetings | 1 provider per Member | Quarterly | 5a. Increase provider awareness of their role in network projects |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Example of Logic Model Approach** | | | | | |
| **Process** | | | ***Outcomes*** | | |
| ***Inputs*** | ***Activities*** | ***Outputs*** | ***Short*** | ***Long*** | ***Impact*** |
| * Network Members * New Network Members * Primary Care Practices Partners * Community Resource Partners * Network Staff * Grant Funding * Partner Funding * Member Dues | * Identify potential new social service members and outreach to them * Adapt and implement best practice for one chronic disease * Facilitate information and knowledge sharing between members * Develop network services catalog, SOW process, and dues structure | * 1 new social service members per quarter * 15% of people receiving coordinated care within chronic illness population * 90% of member representatives attending monthly committee phone conference * 80% Utilization rate by network members of network services | * Care coordination taking place between clinical and social service members * Network has defined services that are values by members | * A coordinated care process for one chronic disease population * Sustained network activity | * Increased access to quality care * Improved population health for [chronic disease or issue] |

# Appendix B: Tracking Activities and Monitoring Objectives

**Instructions**:

1. Customize the following chart with titles that match your Planning Framework, either Strategic Planning approach or Logic Model approach. For example with strategic planning your objectives may be called ‘strategies’ and with logic model your objectives may be called ‘outputs or outcomes’
2. Use the Program Goals that are articulated within your grant application, or that have been agreed upon by your network leadership, and write your program goals, one goal per section within the chart.
3. This evaluation chart, works from left to right. Within each appropriate Program Goal section, write the associated objectives (strategies or outcomes) into the far right column of the Evaluation chart.

1. For each objective work to the left to develop the information within each column. See the first row of the Evaluation Chart below as an example.

**TIP**: Refer to SMART goals appendix to revise your program objectives (strategies or outcomes) as needed, so that they are written to be specific, measureable, achievable realistic and timely

**TIP**: Limit the number of objectives (strategies or outcomes) to no more than 2 per program goal section

**TIP**: Develop at least 1 but no more than 2 measurements for each strategy or outcome

**TIP**: Keep the timeframe of the objective (strategy or outcome) to 12-36 months so that it can be measured within the timeframe of the grant project.

**TIP**: Evaluation plans do not include monitoring of activities. Monitoring of activities (process outputs) is completed through work plans or action plans within a project action or task force.

**NOTE**: Broad, complex, and long-term objectives (strategies or outcomes) may require significant investment of resources and time and we recommend that you approach them as problems to solve or initiatives to act on. For example, to measure overall improvement of the health of your community, clinical quality data or public health surveillance data may require secondary sources. To revise this objective into a SMART objective that is measureable, consider milestones that are in a 12-36 month timeframe, which will move the project toward being able to measure the objective.

**Appendix B: Tracking Activities and Monitoring Objectives**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | What | Where | How | When | Who |
| **Program Objective** | **Measure and Target** | **Source of Data** | **How is the data Collected** | **Frequency of data collection** | **Who is responsible for gathering the data** |
| EXAMPLE:  Create a Coordinated Care Process for 1 chronic illness population | 1 Number of new social service members | Network Membership spreadsheet | Network director tracks number of potential new customers, out-reach & results | Quarterly | Network Director |
| 15 % of people receiving coordinated care within chronic illness population | Primary Care Member tracking process results | Network members report monthly total population and count of those receiving care coordination service within the month | Quarterly | Project Manager |
| Positive health improvement measure compared to state or county benchmark for chronic illness | 1. County database 2. Primary Care member tracking process results | For chronic illness measure: 1) County benchmark, most recently published, 2) Members report average measurement for the same time period | Annually | Project Manager |

# Appendix C: Dashboard

Diagrams or charts that illustrate the status and progress of program goals using simple communication methods, such as, charts, and color coding of actual results as a comparison to the target result.

**Tips:**

* Assign responsibility of gathering the results to those that are actively involved in the work of that strategy/outcome activity
* Assign one person to be responsible for building and maintaining the Dashboard. It requires routine commitment to updating the charts and diagrams.

**Instructions:**

1. Use your Tracking and Monitoring Chart to translate the data to the Dashboard
   * Goals
   * Objectives (SMART strategies or outcomes) with a letter to identify on the far left column of the dashboard, i.e. A, B, C, D, etc.
   * Measurement of process and strategy or outcomes
   * Measurement Target (identified in numbers, percentages, or percent change over time)
   * Measurement Frequency (how often are you reporting this measure, monthly, quarterly, semi-annual, annually)
2. Document the definition of the measurement, i.e. how you are calculating or counting the measure. See first row of Dashboard template for example
3. Color-code results to quickly identify those objectives that require adjustments in actions or measurement
   * Blue = exceeded target
   * Green = On target )within 5%
   * Yellow = Caution – below target (up to 10%)
   * Red = Risk – below target > 10%, yellow and red)
4. Trending is an effective means of communicating results. If possible, include a chart, graph, or diagram that illustrates the results over time
5. As an addendum or possible as notes to embed within the Dashboard: provide an explanation and options for adjustments if results are significantly above or below the target, Blue or Red

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Obj** | **Measures** | **Target** | **Frequency** | **Findings** | | | | **Trending** |
| **Goal 1: Improve the health of our community** | | | | | | | | |
| A | EXAMPLE:  % of people receiving coordinated care within chronic illness population | 15% | Quarterly |  |  |  |  |  |
| Measure definition: # people receiving care coord. Service during quarter/total number of population of this chronic disease as of the beginning of the year.  Method of tracking: tracks within spreadsheet and identifies total population at the beginning of the year. | | | | | | | | |
| A | EXAMPLE:  Positive Health improvement measure compared to state or county benchmark for chronic illness | + number > benchmark | Annually |  |  |  |  |  |
| Measure definition: Actual result – benchmark measurement  Method of tracking” For chronic illness measure: 1) County benchmark, most recently published, 2) Members report average measurement for the same time period | | | | | | | | |
| B |  |  |  |  | |  | |  |
| Measure definition:  Method of tracking: | | | | | | | | |
| **Goal 2: Network Sustainability** | | | | | | | | |
| C |  |  |  |  | | | |  |
| Measure definition:  Method of tracking: | | | | | | | | |