

The Need for Outcome Rather Than Process Evaluations¹

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ABSTRACT. This paper presents a theoretical model which discusses the value of and need for the use of outcome rather than process evaluations of programs for the elderly. The theoretical framework is based on the highly successful philosophical model of statistical quality control used in industry, which assumes the best way to improve quality is to look at the outcomes. Most accreditation associations, such as the Joint Committee on the Accreditation of Health Care Organizations (JCAHCO), tend to emphasize process evaluations. It is the position of this paper that a change is needed which would shift that evaluation emphasis to assessing program outcome. The authors identify how outcome evaluations can be developed, taking into consideration need assessment, procedures, and multiple stakeholder concerns within the design of the evaluation. Also included is a discussion of the value of a learning and motivational approach rather than one that is punitive and judgmental.

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INTRODUCTION

Program evaluation serves many different purposes. One purpose is to ensure that acceptable minimum standards are met. This is based on the assumption that desirable outcomes will be achieved by meeting specified standards. Very frequently, the next important step is never taken; that is, the resulting outcomes are not examined to determine whether they were desirable, cost effective, and to analyze which steps in the process had the greatest effect.

When outcomes are examined, as in a research study, there is a tendency to aggregate scores, which makes them less reflective of individual positive or negative outcomes. A more specific aggregation procedure is needed which is similar to a meta analysis in case studies. For example, instead of averaging a number of tests as survey scores across several individuals, where the same score can be more positive for one individual than it is for another, each score should be analyzed based on an individual case study which takes as its reference point each individual need at the time and the gain in satisfying that need.

Since the 1980s there has been wide recognition by industry that statistical quality control, which looks at outcome data, has had a tremendous impact on the improvement of delivery systems (Demning 1991). A parallel conceptualization specific to human service delivery systems needs to be developed.

Consistent with this, the suggested model is based upon an earlier paper by Newman, Vukovich, and Newman (1978) entitled "Evaluate Your Jewels: A GEM for the Counselor" (the GEM is the General Evaluation Model). The GEM makes the assumption that in almost all situations that are to be evaluated, the individual health care provider in conjunction with the client makes basic decisions regarding the behaviors which the client is to learn to change in treatment. These decisions become the

objectives. The GEM also identifies the clinical intervention that should be employed and the most effective methods for evaluating the success of the client's efforts. The GEM incorporates these decision-making steps and presents a logical pattern of action for the effective evaluation of client progress.

General Evaluation Model

The General Evaluation Model has six components:

1. *Awareness of Needs.* Pre-assessment may be thought of as pre-evaluation, for an assessment of the behaviors and knowledge which a client has upon entering counseling. It enables the health care professional to determine whether the client possesses the required, prerequisite information or skills needed to benefit from certain types of counseling procedures. The client's needs may be determined in a variety of ways: interviewing the client; testing; examining the records; interviewing significant others, such as spouse and children. In some situations, surveys may be appropriate. It is also important at this point to determine perception of deficiencies by different significant others involved with the client.
2. *Acceptance of the Deficiency.* It is important that the client be aware of his/her needs and that he/she accepts some of the responsibility for attempting to meet these needs. If the health care professional perceives a particular need in the client, but the client does not feel that the need is a deficiency, they must work together to resolve this difference of opinion before proceeding to the next step, planning objectives. Such a discrepancy may occur for two basic reasons: a) the client may not be ready to cope with this problem (in which case the professional should not press the issue at this time but rather

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consider those problems which the client is ready to accept), or b) the problem that the health care professional perceives may, in fact, not be a problem for the client in his/her normal surrounding.

One of the advantages of the model is that this second component allows the client to deal with those needs he/she is willing to accept. While these may not be all or even the most central problems, the recycling aspect of the model permits the therapist to help the client work through each as he/she is ready to confront these issues. Once the less threatening concerns are met, the client may be ready to focus on the more central problems.

3. *Treatment Objectives.* The objectives are an outgrowth of the needs assessment completed in the first component. There are generally three functions of an objective: a) it states the behavior required of the client, b) it delimits the conditions under which the behavior is to be performed, and c) it establishes a criterion on which success can be evaluated. The objectives are perhaps the most important component in the model. They are the foundation on which the GEM is based. The objectives make it possible to evaluate more efficiently since the criterion is already stated in measurable terms.
4. *Procedures.* Procedures should be an outgrowth of the stated objectives which evolved from the needs of the client, as determined by pre-assessment. This component should specify the counselor's theoretical framework and/or accepted operating procedures while considering standards of excellence.
5. *Modification.* Modifications are the changes that occur in the client as a result of the interventions. These modifications should then be evaluated in terms of the objectives.
6. *Evaluation.* Evaluation is a continuous process which provides constant feedback concerning the need for additions, eliminations, and modifications in each of the preceding components. For example, after pre-assessing client needs, the health care provider may determine that the client has the prerequisite skills for certain types of behavior. However, during the evaluation it may be discovered that the client really did not have the identified skills and, therefore, the Awareness of Needs component of the model had not performed its task (it was invalid). The evaluation results would then be used to identify this weakness and provide the information necessary to make the proper adjustments throughout the model.

Evaluation efforts may just as likely reveal problems relative to the client's acceptance of a problem

(Component 2). While the client may verbally acknowledge a given problem, an evaluation of his/her behavior may indicate otherwise.

By analyzing the objectives (Component 3) that have been attained and the number of clients who attended them, evaluation can help form a realistic picture of what can be expected and accomplished in a given situation. The analysis could lead to a revision of the objectives.

Evaluation can also help to determine if the procedures (Component 4) have been successful in achieving the objectives. More specifically, it may indicate which procedures are most successful with which type of objectives.

It is worth re-emphasizing that evaluation is an ongoing process. Therefore, as modifications (Component 5) are incorporated, they, too, are evaluated and subjected to other revision. It is through such continuous evaluation efforts that intelligent changes, modifications, and improvements designed to facilitate client growth can occur. In addition, because the model provides constant feedback relative to the effects of his methods, the therapist should also be stimulated toward growth.

By using the model as a conceptual basis, one can view a need assessment from a multiple-stakeholder perspective. That is, one can observe the need assessment from the point of view of the client, family, health care provider, and significant others, each of which may identify different needs. To evaluate the client holistically, at least a minimum of these different perspectives are necessary. This model places the emphasis on the outcome without denying the importance of the process variables and their need to be evaluated in light of the outcome.

Anthony and Farkas (1982) emphasize the importance of outcome variables in psychiatric rehabilitation and identify a model and sets of constructs that should be considered. They believe that by the very nature of considering these variables in an evaluation, the therapist is likely to increase his/her sensitivity and effectiveness in dealing with clients. These same variables, with slight modifications, are likely to be as important when trying to improve the quality of care among the elderly.

The following are the variables defined by Anthony and Farkas:

1. The degree of the client's involvement in the choice of treatment.
2. The client's understanding of the available programs or treatment and why they are being suggested.
3. Skill acquisition—some sort of pre-post assessment of change in the targeted skills.
4. A change in the behavior that can be assessed within the training environment.
5. The ability to apply acquired skills outside of the training environment.

An example of how these five variables apply to treatment of the elderly follows.

1. Many older adults in need of services and treatment are cognitively capable of making decisions related to their well being. To the extent that choices of treatment are available and the client is involved in the process of making these choices, a number of positive client outcomes are likely to be expected, such as:

- Perceived validation and respect for the client's abilities, therefore yielding improved self-esteem and self-respect.
- Increased willingness to cooperate and work toward the success of the treatment they helped select.
- A decrease in learned helplessness because the client is actively involved in the process.
- A potential increase in internal locus of control.

2. To the extent that the elderly client is given information about the treatment plans and an opportunity to question and clarify information about their individual needs and circumstances, the treatment plan is more likely to be tailored to fit the client's needs and, therefore, produce a better outcome.

Other positive client outcomes are:

- The client-therapist dialogue can provide a check of earlier assessment judgments to verify client needs.
- Increased client knowledge of options available through the health care system is likely to result in better utilization of available services.

3. If the treatment of the client is to improve certain behaviors, it is imperative that appropriate training be provided and evaluated for its effectiveness. For example:

- If the treatment is to improve client skills in social support networking, it is desirable to identify whether the client has the information necessary, such as phone numbers, times, who to contact for various types of services, realistic expectations, etc.
- These pre-post assessments are crucial for estimating not only the effectiveness of treatment, but also to determine if additional training is needed to meet the objectives, and in which area. Thus, the pre-post assessment is also a learning process for the therapist.

4. Once the skills are taught, it is important to estimate how well a client can use them.

- It is desirable to determine if the client can demonstrate these skills in a simulated setting.
- Does the client know when it would be appropriate or inappropriate to access various resources?
- Does the client have realistic expectations regarding services provided?

5. Maybe the more important and more difficult aspect to assess is the client's ability and willingness to apply the acquired skills in their personal environment. To do this, one has to develop longitudinal or follow-up procedures. Needless to say, this is the bottom line. This is what really counts and is often the aspect most frequently overlooked because of the time and cost involved. At the very best, it is most often estimated from Step 4; however, this is not sufficient because one's personal environment may have unique factors that may mitigate the training effects identified in the more controlled, simulated environment. It is necessary to identify these factors to improve training as well as outcomes for clients.

Almost all assessments of the elderly should include a quality-of-life construct, which is central to the psychological and physical well being of the client. Franklin et al. (1987) presented a simplified model of quality of life that we believe should also be considered as part of outcome variables when evaluating progress effectiveness with the elderly. This may be illustrated by the following example:

<u>Objectives for Life Situations</u>	<u>How Satisfied</u>
A. Type of Housing (Living Conditions)	1 2 3 4 5
B. Living Arrangements	1 2 3 4 5
C. Social Support System	1 2 3 4 5
D. Type and Number of Leisure Activities	1 2 3 4 5
E. SES (Income)	1 2 3 4 5
F. Condition of Employment	1 2 3 4 5

Note: 1 = not at all satisfied; 5 = very satisfied

Adaptation to Life Situation

- A. Activities of Daily Living
- B. Affect Balance
- C. Self-Concept and Esteem
- D. Other Factors (Unspecified)

It is the authors' position that if the models suggested in this paper are incorporated in any evaluation design, there are likely to be a number of positive consequences derived such as:

1. Increasing accountability and sensitivity of the professionals responsible for outcome.
2. Increasing awareness of the need for input from the multiple-stakeholders.
3. Increasing the likelihood of relating to the client holistically so that one does not interpret a gain in one area as positive if the overall net gain score in the quality of life has suffered.
4. Increasing one's awareness of the variety of constructs such as quality of life, client involvement, and client understanding, that should be considered.

Conceptualizations by Anthony and Farkas (1982) and Franklin et al. (1987) can be used as starting points or subsets within the GEM model. For example, in the GEM model, the first component is that one must be aware that a need exists before it can be accepted as a deficiency. The Anthony and Farkas (1982) model similarly indicates the importance of the client's involvement and understanding of their choices. This is consistent with the GEM's underlying assumptions, that before a client is likely to invest the effort to maximize success, he or she has to be able to accept that a need exists.

Anthony and Farkas also state that one needs to evaluate the effectiveness of the training in the clinical and natural settings. This can be easily related to the GEM feedback loops among the components. The Franklin et al. (1987) model also has the potential to increase the awareness and sensitivity of evaluators as to what should

be considered as appropriate outcome variables.

It is hoped that the GEM model presented will also increase practitioners' awareness of the value of incorporating outcome variables in an evaluation design. It is believed this model can provide a framework from which these much needed outcome-evaluation design can be developed.

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