

**INSTRUCTOR'S MANUAL: A SUPPLEMENTARY PUBLICATION FOR *DESIGNING
AND PLANNING PROGRAMS FOR NONPROFIT AND GOVERNMENT
ORGANIZATIONS***

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PREFACE

Most of the materials in this manual have been developed for the graduate course Program Planning in the Policy, Planning, and Administration Concentration (PP&A) in the School of Social Work at Western Michigan University (WMU). The materials have also been used in an elective planning course in the Nonprofit Leadership Certificate Program at WMU. To help you understand the domain, design, and evolution of the planning course, I briefly describe the graduate program in which the course is embedded.

The Structure of the PP&A Concentration

Program Planning is one of five required academic courses in the PP&A Concentration. The other courses focus on project management, budgeting, management information systems, leadership, human resource management, grant writing, and policy practice. PP&A students are also required to enroll in an internship for two semesters. Academic and internship assignments are integrated—that is, some course assignments can be completed in the internship, and some internship assignments can be used to satisfy course requirements. Prior to entry into the Concentration, students must complete two prerequisite courses that focus on policy and organizational analysis.

Instructors who have taught a course several times know that it represents a series of fine-tunings (and perhaps one overhaul) and that colleagues and students contribute one way or another to each version. Course and curriculum development in the PP&A Concentration have

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always been faculty team efforts. For each course in the Concentration, PP&A faculty have developed a Master Syllabus that includes a course title, description, and topics, and the learning outcomes that must be achieved by students. PP&A faculty members may add topics and learning outcomes to their syllabi, but they are expected to follow the Master Syllabus. During PP&A faculty meetings, course assignments are discussed to assess whether they are designed to achieve Concentration objectives. Faculty members exercise academic freedom and instructional independence within an agreed-upon curriculum program structure to ensure that students have opportunities to master essential competencies. Thus, all courses in the PP&A curriculum have an independent and a collective imprint. Accordingly, I want to acknowledge the help of my colleagues, John Flynn and Dan Thompson, who shared their ideas as I made adjustments in the planning course over the years.

PP&A students also have contributed to the development of Program Planning and other courses in the PP&A curriculum. They evaluate every course, and the results are shared with instructors. Shortly before graduation, students also complete a standardized assessment of their experience in the PP&A program. The results are shared with students and faculty during a joint student-faculty debriefing session. Students recommend retention and revisions of the curriculum that are later considered by the faculty. Regarding the planning course, a substantial majority of students endorsed the exercises, the case studies, the writing assignments, and the design of the planning course as presented in this manual. The PP&A faculty have also conducted focus groups with administrators and planners to evaluate and revise the curriculum. Thus, readers who wish to adopt or adapt the materials in this manual can be assured that these were “tried and tested” and that faculty colleagues, graduate students, and practitioners in the field have influenced the development of the planning course.

Instructors as Coaches and Mentors

The structure and objectives of the PP&A Program, including the program planning course, provide students with opportunities for individualized plans of study. A mentoring approach is used, and some assignments are used as educational assessment opportunities. If students do not perform well, the results of the assessment are shared with them, their written product is viewed as a work in progress (WIP), and they are given opportunities to remediate their work. The PP&A faculty instituted this approach because the skills that students are expected to acquire are not easily mastered in one trial. Furthermore, in the real world, much policy, planning, and administration work is carried out by teams, and staff and volunteers help one another. For these reasons, the faculty decided on a coaching approach. Even experienced students have reported that the three writing assignments in the planning course—the proposal for a needs assessment, the goals and objectives exercise, and the program design paper—are challenging. Thus, coaching and remediation approaches are followed with students whose work needs further development.

Experiential Learning

Experiential learning is a key feature of the PP&A Concentration and the planning course. Students participate in exercises and simulations and are given writing assignments to help them comprehend basic information, apply knowledge to real materials, and develop analytical and technical skills. Students are divided into work groups early on and remain within the assigned work groups for the whole term. At the first class, a questionnaire is distributed to students asking them to identify their degrees, majors, work and volunteer experience, and years of employment. These factors and the personal characteristics of the students are used to form groups that are composed of diverse members.

Introduction to the Manual

This manual includes a syllabus consisting of a course description, a list of overall course objectives, a list of objectives for each course module, required and supplementary readings, writing assignments, small-group exercises, and a simulation. The manual also has a Proposal for a Diabetic Education Program, an outreach program to migrant workers with diabetes. It is used in the last class in a simulation in which student work groups assume the roles of members of a management team engaged in an evaluation of the proposal with the executive director (the instructor). A chart, Guidelines for the Evaluation of Program Proposals, is included to help students engage in a systematic evaluation of the proposal.

This manual also includes Guidelines for Audiotaped Evaluations of Student Writing Assignments for those of you who may want to try this approach. Because students put substantial time and effort into the course writing assignments, they deserve substantial feedback. Audiotaped evaluations enable me to easily provide detailed assessments of their written work. The audio record is particularly useful when students must remediate a work in progress. I can guide students through some daunting aspects of their work and can offer suggestions for improvement. Virtually all of the students who received audio feedback gave it high marks and appreciated the thoroughness of the critique that the audio method allows.

Some items in the section entitled Other Exercises and Case Examples have not been used in the planning course but were developed for inclusion in the manual to provide case examples in diverse organizational, professional, and occupational settings. However, the exercises and discussion questions are similar to those in the case examples that have been used in the planning course. These additional case examples can be used as substitutes for the assignments and exercises embedded in the syllabus.

I taught Program Planning for twenty-two years. At the end of every year, I would say, "Next year, I'm going to get it right." About five years before I retired, one student wrote the following statement on the course evaluation form: "The course rocks." That's when I decided I got it right. I hope that these materials help you get it right sooner than it took me to get it right. I welcome your comments and the opportunity to see your course materials.

Erratum

It appears that I still have to work at getting it right. When I read the book after it was published, I found that one letter was missing from the name of a Web site on page 142: www.mygoal.com should be www.mygoals.com. I apologize for the error and the inconvenience.

SECTION 1 MODEL SYLLABUS FOR A FIFTEEN-WEEK COURSE ON PROGRAM PLANNING

Course Description

The course addresses the models, stages, and tasks of program planning in nonprofit and governmental organizations. Students learn how to work with a team in planning a service program. The course focuses on the tasks that are essential in initiating a planning project, carrying out a problem analysis and needs assessment, formulating program goals and objectives, designing service programs, and writing program proposals.

Program Planning is organized into modules. Upon completion of the introductory sessions, the modules focus on the stages and tasks of planning. Each module has one or two classes that consist of lectures pertaining to the tasks and issues of a particular stage of planning. The lectures are followed by one or two classes of participatory learning, including small-group exercises and simulations that require application of what is learned through the readings and lectures. (Each class is two and a half hours long.)

Students are divided into work groups composed of four to five members who remain in the same group for the whole term. Work groups assume they are planning teams carrying out several aspects of planning projects. Members are encouraged to rotate into the roles of team chairperson and presenters as new simulations and exercises are introduced.

Overall Objectives (Objectives pertaining to each module are embedded in the course schedule below.)

- Know the stages and tasks of program planning and the ways in which they can be carried out.
- Know and understand the essential components of problem analysis and needs

assessment including definitions and types of need, purposes and methods, and demonstrate skill in their application.

- Know the properties of program goals and objectives and demonstrate skill in their formulation.
- Know and understand the components of the program design stage of planning, and demonstrate skill in their application.
- Identify the key elements of a grant application and program proposal, and demonstrate skill in evaluating a program proposal.
- Demonstrate understanding of and sensitivity to issues in program planning relevant to women, minorities, ethnic groups, and other special populations (for example, the composition of planning teams, inclusion of representatives as subjects and participants in the study process, variations in conceptions and meanings of need, and adaptations in design responsive to different target populations).
- Demonstrate awareness of and sensitivity to the interactive and political aspects of the planning process during class discussion of case examples, exercises, and critical incidents in planning.

Text

Pawlak, E.J., and Vinter, R. D. *Designing and Planning Programs for Nonprofit and Government Organizations*. San Francisco: Jossey-Bass, 2004.

Supplementary Reading

McClendon, B., and Catanese, A. J. *Planners on Planning: Leading Planners Offer Real-Life Lessons on What Works, What Doesn't, and Why*. San Francisco: Jossey-Bass, 1996.

Relevant Journals

Administration in Social Work; American Demographics; American Journal of Public Health; Evaluation and Program Planning; Journal of Community Practice; Nonprofit and Voluntary Sector Quarterly; Public Administration Review; Social Problems; Social Service Review; Social Work.

Course Schedule

Session 1: Introduction: Models and Stages of Planning

Module Objectives

(As a consequence of attending the lectures, participating in class exercises and simulations, and completing the reading and writing assignments, students should be able to achieve the objectives of each module.)

- Define and differentiate program planning, social planning, urban planning, and strategic planning.
- Know the features of the rational, synoptic, mixed scanning, disjointed incremental, transactive, advocacy, and asset-based models of planning.
- Identify the organizational contexts of program planning.
- Identify current issues in program planning.
- Identify principles of planning and explain their significance in planning projects.
- Identify values that organizations and planners bring to the planning project and explain how these values might influence planning processes and decisions.

Required Reading

Pawlak and Vinter, Chapter One.

Lauffer, A. A. *Social Planning at the Community Level*. Upper Saddle River, N.J.:

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Prentice Hall, 1978, pp. 5-29 (located in the course pack and on reserve). (Complete Item # 5 on page 29 and come to second class prepared to discuss planning principles.)

Supplementary Reading

Chaves, M., and Tsitsos, W. "Congregations and Social Services: What They Do, How They Do It, and with Whom." *Nonprofit and Voluntary Sector Quarterly*, 2001, 30(4), 660-683.

Lampkin, L., Romeo, S., and Finnin, E. "Introducing the Nonprofit Program Classification System: The Taxonomy We've Been Waiting For." *Nonprofit and Voluntary Sector Quarterly*, 2001, 30(4), 781-793.

Sessions 2, and 3: The Initiation Stage of Planning

Module Objectives

- Identify the elements of a planning charge and planning mandates.
- Identify the factors to consider in forming planning work groups.
- Develop skill in disassembling and analyzing a planning charge and skill in its formulation.
- Identify the properties of a work plan.

Required Reading

Pawlak and Vinter, Chapters Two and Three.

Assignment for Module 1. (To be completed in class during the third session.)

During Session # 3, work groups will address the following tasks.

In preparation for the exercise, for each member of your work group, bring a copy of a written charge to a committee from your place of employment or internship. While participating

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in your work group, you will be asked to disassemble the charge and identify its substance, authority, scope, and determinateness. Pretend that you are a member of the planning team. Explore the charge, including its substance, source of authority, scope, and determinateness. Is the charge clear enough to commence planning? How would you interpret the planning charge? What questions do you have about the work that the planning team is being asked to accomplish? Are there any external mandates that have a bearing on the process or substance of the planning effort? Who are the important stakeholders in the planning venture? What is the composition of the planning team? Does the charge have the essential requirements to commence the planning project? How would you rewrite the charge?

Sessions 4, 5, and 6: The Analysis Stage of Planning

Module Objectives

- Define problem analysis and needs assessment.
- Identify and demonstrate understanding of the factors that influence definitions of need, including sex, race, ethnicity, sexual orientation, education, income, religion, and other social factors.
- Identify and define the four categories of need.
- Define planning concepts related to needs assessments—for example, incidence, prevalence, population-at-risk, target population.
- Identify the requisite tasks in conceptualizing, initiating, implementing, and completing a needs assessment, including adaptations that are essential to be responsive to women, minorities, ethnic groups, and other special populations.
- Identify methods of needs assessment and their advantages and disadvantages.
- Identify the factors that are used in setting priorities and give examples of each.

- Critically evaluate a needs assessment plan and instrument during the class exercise.
- Demonstrate skill in formulating a written plan to carry out a problem analysis and needs assessment by completing the writing assignment.
- Develop skill in focus group techniques through participation in the focus group demonstration by the instructor.
- Develop skill in accessing databases on the Internet pertaining to demography and communities and to social conditions, issues, and problems

Required Reading

Pawlak and Vinter, Chapter Four.

Supplementary Reading

(Select those that will be helpful as you develop your plan to conduct a problem analysis and needs assessment.)

Saulnier, C. F. "Deciding Who to See: Lesbians, Discuss Their Preferences in Health and Mental Health Care Providers." *Social Work*, 2002, 47(4), 355-365.

Balaswamy, S., and Dabelko, H. L. "Using a Stakeholder Participatory Model in a Community-Wide Service Needs Assessment of Elderly Residents: A Case Study." *Journal of Community Practice*, 2002, 10(1), 55-70.

Raskoff, S. A., and Sundeen, R. A. "Cultural Diversity and High School Community Service: The Relationships Between Ethnicity and Students' Perceptions." *Nonprofit and Voluntary Sector Quarterly*, 2001, 30(4), 720-746.

Bardach, A. L.. "The White Cloud." *The New Republic*, 1995, 212(23), 27-31.

Rosin, H. "The Homecoming." *The New Republic*, 1995, 212(23), 21-26.

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The Rosin and Bardach articles in the course pack address African American and Latino perceptions of and experiences with AIDS. Both articles have import for approaches to needs assessment and problem analysis that are sensitive to diversity.

Stone, D. "Helter Shelter" (book reviews). *The New Republic*, 1994, 210(26), 29-34.

Stone reviews books on the homeless.

Cleary, P. D., and Demone Jr., H. "Health and Social Service Needs in a Northeastern Metropolitan Area: Ethnic Group Differences." *Journal of Sociology and Social Welfare*, 1988, XV(4), 63-76.

Liburd, L. C., and Bowie, J. V. "Intentional Teenage Pregnancy. A Community Diagnosis and Action Plan." *Health Education*, 1989, 20(5), 33-38.

Problem Analysis Needs Assessment Methodologies

Krueger, R. A. *Focus Groups: A Practical Guide for Applied Research* (3rd ed.). Thousand Oaks, Calif.: Sage, 2000.

Soriano, F. I. *Conducting Needs Assessments: A Multidisciplinary Approach*. Thousand Oaks, Calif.: Sage, 1995.

Witkin, B. R., and Altschuld, J. W. *Planning and Conducting Needs Assessments: A Practical Guide*. Thousand Oaks, Calif.: Sage, 1995.

Liss, P. E. *Health Care Need*. Newcastle upon Tyne, Great Britain: Atheneum Press Ltd., 1993.

Gilmore, G. D., Campbell M. D., and Becker, B. L. *Needs Assessment Strategies for Health Education and Health Promotion*. Indianapolis: Benchmark Press, 1989.

Instructions for the Problem Analysis/Needs Assessment Assignment

The assignment is intended to help you gain experience in conceptualizing and designing a written problem analysis/needs assessment plan. Your plan should address the following elements.

- (1) Briefly describe the condition (s) or problem that will be the focus of your problem analysis and needs assessment (PA & NA).
- (2) Indicate whether there are elements of the planning charge and/or external mandates that provide guidelines for or constraints on the problem analysis and needs assessment. If there are guidelines or constraints, briefly describe them.
- (3) What objective(s) do you want to achieve with the problem analysis and needs assessment?
- (4) Identify the segment of the community, the condition, or the population that will be the focus of the PA & NA (for example, population-at-risk, population-in-need, target population, service population, or the identifying or qualifying characteristics for inclusion in the assessment and the number of people or units to be included in the assessment).
- (5) What do you (or the members of your planning committee) already know about the problem and needs and the persons affected?
- (6) What more do you or the members of your planning committee want to know about the problem? Specify the information to be obtained, including the categories and the specific information you plan to gather. What do you want to know about a particular social problem, condition, or needs? Do you want to know about (a) their features and how they manifest themselves, (b) their consequences, (c) the factors that sustain the problem, condition, or need or that block its amelioration, (d) their scope and distribution,

- (e) and the characteristics of those who are experiencing the problem, condition, or need?
- (7) How is the problem experienced by those who are affected by it? (How will you learn about this?)
- (8) Do you intend to ascertain the magnitude of the problem/needs? How? If magnitude cannot be efficiently determined, how will you make an estimate of magnitude? Do you really need an estimate of magnitude given your particular planning purposes?
- (9) Why do you want to this information? What is the rationale for gathering the information you want? What do you intend to do with the information after you get it—that is, what kinds of planning or program design decisions do you believe the information will help you make?
- (10) How are you going to get the information? Describe the methodology to be utilized and the rationale for selecting a particular approach. Your design should identify the source of data and the methodology to be used in obtaining and analyzing the data (that is—sampling strategy, data collection techniques, and so forth). Identify some of the survey questions, the interview questions, the stimulus question for the focus group, whatever. If you intend to do a file extraction analysis, develop a rough draft of the form to guide the extraction of information from the files.
- Address the logistics and mechanics of data acquisition and the recording, storage, retrieval, and analysis of data. For example, do you intend to tabulate frequencies and percentages? Do you intend to conduct a content analysis of qualitative data?
- (11) Provide a rough estimate of the major costs of the assessment, including staff resources and time requirements.

Sessions 7 and 8: The Goals and Objectives Stage of Planning

Module Objectives

- Identify the properties of goals and objectives.
- Evaluate and determine whether objectives are well formulated during a class exercise.
- Define and differentiate the types of goals and objectives.
- Demonstrate skill in the formulation of objectives.

Required Reading and Internet Exploration

Pawlak and Vinter, Chapter Five.

www.mygoals.com is entirely devoted to goals, including goal plans—premade or customized—pertaining to many subjects germane to human service organizations of all sorts.

Conduct an Internet search using the following descriptor. *program goals and objectives in human service organizations*. Print out the most complete set of program goals and objectives that you find pertaining to a health or human service agency. Bring the printout to class.

Supplementary Reading

Some publishers specialize in curricula that concentrate on goals and objectives such as curricula on life skills pertaining to child development, education, and disabilities (www.brookespublishing.com).

Garwick, G. B., and Brintnall, J. E. *An Introduction to Goal Attainment Scaling, Catalogue-Assisted and the Ideabook: 550 Indicators for Use in Setting Goals*. Minneapolis: Technical Assistance for Program Evaluation, 1977.

Assignment for the Goals/Objectives Module

During the second class of this module, students are required to bring a copy of a set of program objectives to class and share them with members of the work group. Work groups will evaluate whether the statements are well formulated or are in need of further development. In the latter case, students will work on improving objectives such that these statements have the desired properties discussed in the text.

Following the completion of the goals and objectives module, students are required to submit written formulations of one program outcome goal and a subsidiary set of program outcome, process, and output objectives. These formulations may be based on programs from places of employment or internships. Identify the source if you extracted them from an agency document and reformulated the statements.

Sessions 9, 10, 11, and 12: The Program Design Stage of Planning

Module Objectives

- Identify the import of the planning charge and mandates on program design.
- Identify the relationship between conceptions of the problem and the design of the program.
- Identify the relationship between needs and problems, client characteristics, goals, program design, and staff competencies and qualifications.
- Identify and define the essential components of service programs and demonstrate skill in their application, including the adaptation of designs to members of special populations as providers and recipients of services.
- Demonstrate skill in designing service programs.

Required Reading

Pawlak and Vinter, Chapters Six and Seven.

Supplementary Reading

Boehm, A. "Managing the Life Cycle of a Community Project: A Marketing Approach." *Administration in Social Work*, 2003, 27(2), 19-38.

Cohen, B. "Alternative Organizing Principles for the Design of Service Delivery Systems." *Administration in Social Work*, 2002, 26(2), 17-38.

Hatchett, B., and Duran, D. A. "An Approach to Community Outreach Practice in the 21st Century." *Journal of Community Practice*, 2002, 10(2), 37-52.

Libby, M. K., and Austin, M. J. "Building a Coalition of Non-Profit Agencies to Collaborate with a County Health and Human Services Agency: The Napa County Behavioral Health Committee of the Napa Coalition of Non-Profits." *Administration in Social Work*, 2002, 26(4).

Kruzich, J. M., Friesen, B. J., Williams-Murphy, T., and Longley, M. J. "Voices of African American Families: Perspectives on Residential Treatment." *Social Work*, 2002, 47(4), 461-470.

Manela, R. W., and Moxley, D. P. "Best Practices as Agency-Based Knowledge in Social Welfare." *Administration in Social Work*, 2002, 26(4), 1-24.

Ng, B., Kent, J. D., and Egbert, M. A. "A 'Total Cycle Time' Approach to Re-Engineering Social Services." *Administration in Social Work*, 2000, 24(3), 35-51.

Zippay, A. "Establishing Group Housing: Community Outreach Methods." *Administration in Social Work*, 1999, 23(2), 33-46.

Guttman, D., and Sussman, M. B. *Exemplary Social Intervention Programs for Members and their Families*. New York: Haworth Press, 1995.

Biegel, D. E., and Blum, A. *Innovations in Practice and Service Delivery Across the Life Span*. New York: Oxford University Press, 1999.

Crane, J. *Social Programs That Work*. New York: Russell Sage Foundation, 1988.

The Structure of the Program Design Module

The First Class Session. The program design module consists of four sessions. The first class consists of a lecture on program and service delivery design, including principles of design and the implications for program design given the planning team's conception of the problem or need. I also demonstrate (in condensed form) how a planner goes about designing a program.

The Second and Third Class Sessions: The Program Design Group Project. Each work group selects a problem or need, formulates a few program objectives, and designs at least two different programs to achieve program objectives (that is, two ways of achieving the same objectives, two ways of solving the problem or meeting the need). I rotate often among the work groups to help the process along and to lead some aspects of the planning session if necessary.

The Fourth Class Session. This class session is devoted to group presentations of the program designs. A division of labor is worked out whereby each member of the work group has a role or makes part of the presentation (for example, overall facilitator, presenter of the needs assessment or problem analysis, presenter of one of the program designs and its advantages and disadvantages).

Suggested Approaches to the Group Project. As a group, select a need or a problem. In the past, students have focused on latchkey children, drug abuse among the elderly, teen suicide, infants with AIDS, the need for day care for working mothers. Don't pick a need or

problem about which you know little or nothing unless you are prepared to become informed about it within two weeks. If you decide to focus on an unfamiliar need or problem, make certain that you have easy access to information about the problem or need. Usually, the work groups pick an emerging problem or need or a problem or need that one or two members are informed about but that interest everyone in the work group. Those informed students usually provide leadership to the group.

You also should be cautious about selecting a problem or need with which all or most group members are thoroughly familiar. For example, if you have been working in adult protective services for ten years, why pick elder abuse? I am not saying that you can't do that. I'm saying this: pick a need or problem that will challenge you to apply what you have learned in the course. In previous courses, students with the same work experience have made good presentations, and the students who were in the audience learned a lot, but the presenters were not challenged by the project. On the other hand, taking a familiar problem, challenging old ways of dealing with it, and coming up with new ways of dealing with it might be challenging even to a group of jaded veterans. After you select a problem/need, you need to focus on the target population, formulate goals, and design two programs. Your presentation should not exceed thirty minutes—the amount of time your local United Way Allocations Committee allows for presentations. You will not be able to formulate a complete and well-documented program design for your presentation. Don't worry about that. You are not being asked to write a detailed documentation of the program design. You are being asked to design two programs in five hours of class time. You can more fully develop the design when you submit your final paper.

Required Components of the Class Presentation

1. A brief statement of the problem/need

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2. A statement of a few program objectives
3. A partial description of the service program (rely on Chapter Seven of the text)
 - (a) Activities, technologies, interventions to be used in the program
 - (b) A synthesis of staff and recipient participant activities in each phase of the service program
 - (c) Duration of the service program, frequency of service provision
 - (d) Accessibility
 - (e) Service roles
 - (f) The rationale for your designs and the advantages and disadvantages of alternative service programs

Some Do's and Don'ts Regarding the Class Presentation

(To get you into the right mind-set, assume that you are making a presentation to a United Way Program Allocations Committee.)

- Don't just talk to the audience during the whole presentation.
- Do have some variety in your presentation (handouts, graphics, project transparencies on a screen, slides, short demonstrations, and/or PowerPoint).
- Do not distribute handouts that contain everything that you intend to say prior to your presentation. The audience will stop paying attention to you. Do provide an outline that helps your listeners follow you through your presentation. If you want to distribute a complete handout, do so after your presentation.
- Do devote most of your presentation to the components of the proposed programs.

- Do not write on the board or on a newsprint pad while making your presentation. That represents a poor use of your presentation time, indicates that you are not prepared, and annoys your listeners, who must spend their time watching you compose your message.
- Do not verbally present statistics without a visual aid or a handout. Verbal presentations of statistics, one after the other, overwhelm most listeners.
- Make sure that you know how to use any technology that you intend to use or that a knowledgeable person is available.
- Above all, keep in mind that you are teaching people, not a subject.
- Don't make your presentations to the tune of the Flight of the Bumblebee.

Program Design Writing Assignment

Select one of the program designs that was presented to the class by your work group and submit a paper on program design or negotiate an alternative program design assignment (for example, a project at your internship). You may take one of two approaches. You may more fully develop as many elements as possible within all phases of the service program, or you may select one to two phases and fully develop the elements of that particular phase (for example, admissions). Do not exceed ten pages with 1.5 line spacing. Submit the paper no later than the last class. Rely on the elements of the design stage of planning in Chapter Seven to structure your paper.

Sessions 13 and 14: The Documentation Stage of Planning

Objectives of the Module

- Identify the essential components of a program proposal.

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- Demonstrate skill in the analysis and evaluation of program proposals during the simulation of a management team meeting focused on the review of program proposals.

Required Reading

Pawlak and Vinter, Chapter Eight.

Assignment: Simulation of a Proposal Review by Organizational Officials

During the last class, I will lead a simulation in which I will serve as an executive director and you will serve as members of my management team. We will meet to evaluate proposals that have been submitted by planning teams within the organization.

Students are expected to come to the last class prepared to apply what has been learned in the course by evaluating the two proposals in the course pack. Everyone must read both proposals, but work groups will be assigned to evaluate and discuss only one proposal. One hour will be devoted to each proposal.

Each work group will be divided into dyads that will be assigned to critique particular sections of the proposal. Dyads should meet outside class to prepare their assessments. Each dyad will decide on a spokesperson to report its findings and defend its conclusions at the “management team meeting.” Use the table distributed in class to guide and organize your evaluation.

Assignments and Grading

1. Work group exercise. Analysis of a planning charge, mandates, and directives. In the third session.

2. Needs assessment proposal (35 percent of the final grade). Due the seventh session.
3. Goals and objectives exercise (15 percent of the final grade). Due the eighth session.
4. Program design assignment (35 percent of the final grade). Due the last session.
5. Program design exercise.
6. Course participation (15 percent of the final grade).

Submit a 2" X 4" audiocassette (not a minicassette) with the needs assessment and program design assignments. Students will be provided with an audiotaped evaluation of their work.

Author's Note

Fifteen percent of the grade is given for class participation in discussions, work group exercises, simulations, and roles served in class presentations. Students are given a chart to rate their participation, and they can decide whether or not to submit it to me at the end of the semester. (Chart 2.1 is presented below.) After each class in which there is student participation, I use the chart to evaluate each student's participation. This is not as burdensome as it may seem. At the end of the semester, I use the students' ratings (if submitted) and my own to decide a participation grade.

SECTION 2

CHART 2.1 RECORDING STUDENT PARTICIPATION IN CLASS EXERCISES AND DISCUSSIONS

(Enter the class activity in the cells in the first row and a rating in the appropriate cell.)
 (Rating scale: A=well done; B= meets expectations; C=Needs development)

(You **may** submit the completed form to the instructor during the last week of the semester for consideration in determining the grade for class participation.)

Name of Student _____

Class Activity									
Criteria									
1. Volunteers to participate									
2. Participates when called									
3. Shows understanding of material									
4. Skillfully applies material from readings/lectures									
5. Respectfully challenges									
6. Thinks critically									
7. Probes for information									
8. Displays self-awareness									
9. Discerns social cues									
10. Generates alternatives									
Comments									

SECTION 3
DIABETIC EDUCATION PROGRAM: A PROPOSAL
Jan Tiderington

Foreword

Students in the PP&A Program are required to submit a program proposal no later than one month before their graduation. These proposals are usually written on behalf of programs within the nonprofit or governmental agencies in which students have their internships under the guidance of a field instructor and a faculty member. Every year, a few exemplary proposals are selected for inclusion in a file that is accessible to students or in a course pack developed for the planning course.

Although a proposal may be deemed exemplary, that accolade does not exclude the need for fine-tuning, revisions, and further development. In some simulations, proposals that are “unfinished symphonies” are put to instructional use by challenging students to detect aspects of the proposal in need of further development or revision. In fairness to students, sometimes they are unable to put the finishing touches on a proposal through no fault of their own (for example, tardy distributions of Requests for Proposals by funders, or agency officials postponing decisions about program priorities).

Usually, two exemplary proposals are used in proposal review simulations to give students an opportunity to analyze and evaluate what they shortly will have to produce by themselves. Students have an example of what is expected of them, and it boosts their confidence in their own ability to complete a challenging project. The proposal seeking support for a Diabetic Education Program is one of those exemplary products. It was written by Jan Tiderington when she was an intern at a rural health services agency. I am grateful to Jan, who generously agreed to have her proposal included in my course packs and in this manual.

Edward J. Pawlak

Supplement to *Designing and Planning Programs for Nonprofit and Government Organizations*, by Edward J. Pawlak and Robert D. Vinter, ISBN 0-7879-7412-9, cloth, ©2004 Jossey-Bass, An Imprint of Wiley.

Summary

This proposal seeks funding for a Diabetic Education Program (DEP) designed to provide linguistically and culturally accessible information to diabetic migrant farmworkers and their families in southwest Michigan. The DEP's goal is to reduce the incidence and severity of diabetic complications among Spanish-speaking residents and migrant farmworkers in the InterCare service area. Preventive in nature, the program will provide intensive individual and group educational sessions to persons with diabetes and to their families. The educational curriculum will emphasize the importance of lifestyle modifications in the successful management of the disease—simple preventive measures that can strongly affect the patient's morbidity and mortality resulting from the disease.

Because Spanish-speaking migrant farmworkers face multiple barriers in accessing health services and education, this program will seek to address these barriers by providing educational materials and lessons in the Spanish language, in locations accessible by this rural population. InterCare nurse/educators will provide services at migrant living sites, schools, and churches, rather than requiring the patients to attend educational sessions at the clinic.

This program also includes the implementation of a new diabetic-screening protocol at all InterCare clinics, which will ensure the early diagnosis of many migrants who would not become aware of their diabetic condition until some serious, chronic symptoms appeared. This proposal requests funds to put the program in place. Application will be made for Michigan Department of Public Health (MDPH) certification as a diabetic education provider. Such certification will provide future funding assistance to InterCare in support of this important effort to improve the health of this high-risk population—migrant farmworkers.

This program is budgeted at \$50,739, which reflects the salaries of two staff educators, at \$45,360 (including fringe benefits), and \$5,379 for equipment, mileage, and educational materials, which are necessary for the program's first season.

Introduction

InterCare (Community Health Network) is a private, nonprofit organization founded in 1972 to provide primary health care services to migrant and seasonal farmworkers in Cass County. Over the years, the organization's scope and service area have expanded considerably, to the point that it now operates four separate health centers, serving the citizens of five different counties in southwest Michigan. These accomplishments have occurred within the framework of the agency's mission, which is "to furnish a readily accessible program of cost-effective, high-quality, comprehensive primary health care" to members of InterCare's targeted population, whether they are migrant and seasonal farmworkers or the rural or urban poor of our local communities.

InterCare's Bangor Community Health Center and administrative office are located together in Van Buren County. The Bangor Community Health Center is federally funded as both a rural and migrant health center. Both medical and dental services are provided at the Bangor site. The Dolores Solis Memorial Health Center in Eau Claire (Berrien County) is InterCare's strictly seasonal operation for migrants, which is open each year from May through October. The Holland Migrant Health Center in Ottawa County serves migrant and seasonal farmworkers on a year-round basis, while the Mercy Family Medical Center in Benton Harbor functions as an urban health initiative for the provision of both medical and dental services. Dental services for migrants are provided at the Holland Migrant Health Center and Solis Health Center seasonally through the use of InterCare's mobile dental van.

InterCare recognizes that the provision of health care encompasses far more than simply the treatment of a disease or illness. The agency's service design promotes the advocacy, support, and promotion of patient awareness of preventive measures to complement the skilled diagnostic and primary care services provided by the professional staff. Services provided by InterCare include primary care, prenatal care, dental care, Maternal Support Services, Early Periodic Screening Diagnosis and Treatment (a well-child preventive health program), nursing and dental outreach, and Women, Infants, and Children (WIC) nutritional support services. InterCare will soon begin implementation of Infant Support Services, a comprehensive program providing nursing, social work, and nutritional support services to low-income families with infants identified to be at high risk for morbidity and mortality.

Last year, InterCare had over 124,000 health care or health-related encounters. About 60 percent of its total service population is composed of Hispanics. A large proportion of InterCare's staff is Hispanic and/or bilingual, increasing the organization's ability to serve this population.

InterCare services are supported through federal, state, and private funding sources. Last year, federal grants for migrant health initiatives amounted to 99.5 percent of the agency's total revenue. In the past twenty years, a shift to 45.7 percent in federal grants support covering migrant, rural, and urban health projects has taken place. This change is a result of a dramatic increase in revenue from patient fees and third-party payees. InterCare accepts and bills traditional third parties such as private insurance, Medicaid, and Medicare. However, almost 73 percent of the agency's clients have no form of health insurance. Almost nine of ten clients live at or below the federal poverty level. A sliding fee scale, based upon family income and size, is used to determine eligibility for patient pay amounts. Most clients pay a set fee of \$10 per medical or dental visit. No client, however, is denied treatment because of an inability to pay.

The InterCare year-round staff numbers over a hundred individuals, including nine full-time physicians and three full-time dentists. A wide range of professional and support staff includes registered dietitians, nurses, hygienists, mid-level practitioners, a midwife, and social workers.

For over twenty years, the agency has been privileged to be a part of the nationwide, six hundred-member Community and Migrant Health Center movement. As such, the agency has been involved in many special advocacy efforts that have focused on such issues as migrant housing, field sanitation, health care for the homeless, AIDS awareness, pesticide exposure, breast-feeding, and the Benton Harbor People Plan.

Efforts to develop and provide high-quality primary and preventive health care services have resulted in InterCare's receipt of numerous honors and grants of financial assistance. Recent supports for special projects and honors have come from the U.S. Public Health Service, National Migrant Resource Program, the Michigan Department of Public Health, and the Michigan Department of Education.

InterCare is honored to have been one of eight migrant health centers in the United States to participate in a blind study sponsored by the Centers for Disease Control, investigating the prevalence of AIDS among farmworkers. The agency was also one of only nine national migrant centers to participate in a National Migrant Resource Program study on the integration and coordination of services at migrant health centers in the United States.

For twenty-one years, InterCare has continually improved and increased services to its target populations. This has only been possible through cooperative efforts with national, state, and local organizations that are also working to improve the health status of the nation's least fortunate. This proposal describes InterCare's most recent attempt to address a serious health problem facing the nation's Hispanic population—diabetes.

Problem Statement

Diabetes is a major health problem among Hispanic Americans, the fastest-growing minority group in the United States. Mexican-Americans have a threefold greater prevalence of non-insulin-dependent diabetes mellitus than white, non-Hispanic Americans (Haffner, 1988). More than one in ten (12.6 percent) of the Mexican-American population has diabetes, a chronic disease that has no cure (National Institutes of Health, 1988).

Diabetes: A Manageable Disease

Diabetes is a disease in which the body does not produce or properly use insulin, a hormone that is needed to convert sugar, starches, and other food into energy needed for daily life. The cause of diabetes is a mystery, although both genetics and environment appear to contribute to its development.

There are two major types of diabetes: (a) insulin dependent, called Type I, insulin-dependent diabetes mellitus (IDDM), or juvenile onset diabetes, and (b) non-insulin dependent, called Type II, non-insulin-dependent diabetes mellitus (NIDDM), or maturity-onset or adult diabetes.

Type I is an autoimmune disease in which the body does not produce insulin. Type I diabetes occurs most often in childhood or adolescence. People with Type I diabetes must take daily insulin injections to stay alive. Type II is a metabolic disorder resulting from the body's inability to make enough or properly use insulin. This is the most common form of diabetes in the general population. About 95 to 98 percent of diabetic Mexican-Americans have this form of the disease (National Institutes of Health, 1988).

Diabetes cannot be cured but can be controlled. This is a disease in which the patient must be actively involved in self-care for optimum health. Standard diabetes treatment involves keeping blood glucose levels in the near normal range; preventing diabetes emergencies such as insulin reactions, high blood glucose, and ketoacidosis; and maintaining good nutrition and a near normal body weight. Because blood glucose is affected by foods eaten and exercise or activity levels, both of these aspects are included in the treatment of diabetes.

Medications for diabetes include insulin and hypoglycemic oral medications. Insulin is taken by injection for Type I diabetes. Because of the timing of insulin action, foods must be eaten to match the amount and kind of insulin injection. Other medications are useful for some people with Type II diabetes. Many Type II diabetics, however, can control the disease through diet and exercise, without the use of medicine. All persons with diabetes should test the level of glucose in their blood on a regular basis so they can adjust their treatment plans as needed.

Diabetes often results in serious, long-term health problems, such as blindness, kidney disease, heart disease, stroke, limb amputations, and impotence. For many diabetics, one of these health conditions may be the first indication that they have the disease. These diabetes-related conditions contribute to the fact that diabetes is one of the ten leading causes of death in Michigan and one of the leading causes of premature death. Diabetes is a significant component of health care expenditures in Michigan, with the hospitalization costs of diabetes estimated at \$1 billion per year (Diabetes Education and Minority Health Coalition, 1989).

Many complications of diabetes can now be treated effectively. With up-to-date health care and conscientious self-care, it is possible to reduce or even prevent the toll of diabetes complications. Amputations can often be prevented through proper and thorough daily foot and limb examinations. Diabetic retinopathy, if detected early, can now be treated to halt its progression to blindness. Decline in kidney function can be slowed and the risk of heart and

blood vessel disease minimized with blood pressure management. Proper self-care helps people with the disease to feel well and lead active, productive lives. Such self-care practices must be taught to all diabetic patients as early as possible after diagnosis. Diabetes patient education is integral to the care of this chronic disease and to the prevention of complications and premature mortality.

Mexican-Americans: A High-Risk Population

Mexican-Americans appear to be in "double jeopardy" when it comes to diabetes. Hispanics not only have an increased risk of developing Type II diabetes, but once having developed it they are at an increased risk of developing complications (Jewler, 1988). Diabetes-related kidney disease requiring dialysis is six times more common in Hispanics than in non-Hispanic whites. Retinopathy is two to three times more common (Haffner, 1988). Studies have found that Mexican-Americans with Type II diabetes have more severe hyperglycemia (high blood sugar), are often more sick, have more severe retinopathy, and are more likely to have had a stroke than white, non-Hispanics (Haffner, 1988; Jewler, 1988). Diabetes as a cause of death is two to four times more frequent in the adult Mexican-American population than among the general U.S. population (Jewler, 1988).

In the first major health study of Hispanics living throughout the United States, the Hispanic Health and Nutritional Examination Survey (HHANES) of 1982–84 found an extremely high rate of impaired glucose tolerance (IGT) among older Hispanics. IGT is the strongest known risk factor for diabetes. The HHANES data showed that about half of the Mexican-Americans over age fifty-five either had IGT or diabetes (Jewler, 1988).

These findings may indicate a genetic predisposition to diabetes among those of Mexican heritage. Environmental factors, however, cannot be ignored when the development

and progression of the disease are considered. Most Mexican-Americans in InterCare's service area have very low incomes, live a migratory lifestyle, and have limited English-language skills, any one of which can inhibit the ability of a diabetic to access appropriate medical care and support for preventive self-care.

Barriers to Proper Diabetes Management

Approximately forty-eight thousand migrant workers come to Michigan annually for farm labor jobs. The Mexican-American population served by InterCare is primarily composed of migrant farmworkers, and over nine thousand annually use its services. Almost all of the summer migrants in southwest Michigan follow the "Midwest stream," coming from south Texas, the Rio Grande valley. Michigan's Department of Social Services estimates that the average family size of those coming to Michigan is 4.4 persons, with an average annual income of \$6,800, and with limited educational levels (an average sixth-grade education for the adults and eighth-grade education for older youth).

A migratory lifestyle presents unique barriers to diabetes management. The low socioeconomic status of this group impacts their access to medical care and proper nutrition. Farmworkers often delay visits to medical clinics in order to maximize their incomes. Transportation to the clinic is a problem for some, who work and live at a considerable distance from town. The migratory lifestyle impacts the medical community's ability to maintain thorough contact and follow-through with identified diabetic patients. The limited educational levels affect the patient's ability to understand and maintain the numerous precautions and treatments needed to manage the disease. And for those who have a limited understanding of the English language, this problem is exacerbated.

In addition to the challenges these diabetic patients face in their own environment, the medical providers face challenges, which prove to be one more barrier to treatment for this population. Community and Migrant Health Centers operate on very restricted budgets, having experienced substantial reduction of federal support dollars within the past decade. The focus of the agency personnel at this time must be on primary health care. Patient education programs are limited although the need for them is greater than ever. Studies over the past two decades have shown that for every health care dollar invested in diabetes education, two to three dollars can be saved by avoiding future hospitalizations (National Institutes of Health, 1988).

InterCare's management information system (MIS) documents 357 patients whose procedures within the last year were attributed to diabetes. Clinical staff believe that the true number of the agency's diabetic patients is much greater. The MIS is not currently designed to obtain primary and secondary diagnosis information on the agency's patients. Staff believe that the diabetic patients are equally composed of adult males and females. The number of migrant InterCare patients with a diagnosis of diabetes could be as high as 550, as estimated by medical staff members. An equal number of migrant farmworkers in our service area may have diabetes and have not yet been diagnosed, based upon national studies of the prevalence of undiagnosed diabetes among this population (Michigan Department of Public Health, 1988; National Institutes of Health, 1988). Without including an estimated large number of undiagnosed individuals, diabetes currently ranks as the most prevalent chronic disease among migrant and seasonal farmworker adults served by InterCare and ranks second among geriatric migrant and seasonal farmworkers.

Every year, all three InterCare migrant centers face key challenges during the migrant season, when the clinic begins to see increased numbers of diabetic Spanish-speaking patients.

- The limited amount of time staff members have to provide extensive diabetic patient education

- The difficulties encountered when the brief patient education presently provided can only be done with a translator
- The severity of complications when diabetic patients present for treatment very late in the progression of the disease
- The inability of InterCare staff to provide follow-up support to migrant patients to reinforce maintenance of the diabetic treatment, diet, and lifestyle changes

Currently, diabetes control activities consist of completion of a pertinent health history, performance of diagnostic lab work, and initiation of a treatment plan. The patient education that is done is, of necessity, presented during a busy clinic period when the physician sees thirty to forty patients. The nurse assisting the physician must squeeze patient education into her workload as she continues to assist the physician and dispense medications and treatments. Diabetic patients are given the booklet "Cuando Uno Tiene Diabetes" and an exchange list and diet, also in Spanish. These materials are donated to InterCare by pharmaceutical companies.

Little time is available during a primary care visit to explore the patient's lifestyle, eating habits, family support system, understanding of the suggested lifestyle and diet changes, willingness to take a proactive role in disease management, and the feelings the patient may be experiencing. When migrant patients are asked to set an appointment time to receive diabetic assessment and education, very few follow through due to transportation and scheduling difficulties. Migrants work extremely long hours in locations far from the clinic. Health professionals must put forth an effort to take the information to those living a migrant lifestyle. Such early intervention on the part of the health establishment is crucial to the healthy management of the disease, especially for those who have limited access to medical care and support throughout the year.

A problem that invariably arises with diabetic patients is that a high percentage of diagnosed patients are unable, for a variety of reasons, to follow through with their treatment plan. Clinic staff report several cases each year in which diabetic patients were hospitalized due to the severity of complications upon presentation.

The State of Michigan Department of Public Health's Task Force on Minority Health Affairs has recommended that diabetes outpatient education be established as a basic health service in Michigan. This has not yet come to fruition. The need for such education, especially in an accessible, culturally sensitive, and understandable form, is very great for the Spanish-speaking Mexican-American service population of InterCare. The agency's staff has the language skills, the medical and dietetic knowledge, the cultural sensitivity, and the facilities to provide diabetic patient education. Implementation of such a program, however, depends on funds to provide staffing and resources to serve this vulnerable population.

Goals and Objectives

InterCare's overall goal is the reduction of the incidence and severity of diabetic complications among Spanish-speaking residents and migrant farmworkers in the agency's service area. This effort will focus on the provision of diabetes education in an accessible and linguistically and culturally appropriate format for this target population.

Operational Goals and Objectives

Goal #1: To increase the availability and accessibility of diabetic education services for Spanish-speaking diabetics and their families.

Objective A: To develop and implement diabetes-screening protocol in all InterCare clinic sites for all current and new patients.

Objective B: To serve 30 percent of InterCare's currently identified diabetic Spanish-speaking patients with individualized diabetic education using a set curriculum.

Objective C: A minimum of 50 percent of these patients will complete the curriculum.

Objective D: To implement biweekly evening group diabetic education and support classes in four out-clinic locations throughout the months of May through October.

Objective E: To invite all newly diagnosed diabetic patients within two weeks of their diagnosis to begin patient education sessions.

Objective F: To achieve an enrollment rate of at least 50 percent of InterCare's newly diagnosed diabetics between May 1 and September 30.

Goal #2: To maximize Medicaid reimbursement and program quality by obtaining certification as state MDPH-approved diabetic education providers.

Goal #3: To increase knowledge of diabetes and its symptoms among non-diabetic farmworkers and those with ties to the camps—for example, camp aides, priests, and crew leaders.

Objective A: To provide twenty-four two-hour educational sessions, focusing on the symptoms, risks, and treatments of diabetes, to laypersons working with migrant workers and to interested camp residents between the dates of May 1 and October 30.

Program Outcome Goals and Objectives

Goal #1: All individuals completing the diabetic education curriculum shall have increased knowledge of diabetes mellitus, its risks, and treatments necessary for good health. Knowledge of these areas will be measured by the Diabetes Education Profile (pretest) and the Diabetic Knowledge Test (posttest).

Objective A: Ninety-five percent of those completing the curriculum shall show understanding of the disease by doing the following:

Explain what diabetes is in own words.

State symptoms.

State that glucose testing is used to diagnose and assess the control of diabetes.

State that the normal fasting serum glucose is 70–115 mg/dl.

Name the two types of diabetes mellitus.

Name at least two factors related to the development of diabetes.

State that diabetes is not curable.

State in own words that the goal of treatment is control of blood sugar.

List the three components of treatment of diabetes—diet, exercise, and medication.

Describe the importance of self in diabetes control.

Objective B: Ninety-five percent of those completing the curriculum shall show a basic knowledge of the diabetic exchange system and a beginning ability to apply that system to a variety of settings that pertain to the individual's lifestyle. This includes the ability to do the following:

Select food to avoid in the diabetic diet.

Select foods appropriate to each of the six diabetic exchange groups.

Determine the appropriate exchange of a variety of foods.

Utilize the exchange system in a variety of situations appropriate to the individual's lifestyle.

Objective C: Ninety-five percent of those completing the curriculum shall show understanding of the role of medication (oral hypoglycemic agents and insulin) in diabetes control, including skills on insulin preparation and administration when warranted.

Objective D: Ninety-five percent of those completing the curriculum shall show knowledge and skills to assess blood glucose control and to interpret and treat situations of noncontrol.

Objective E: Ninety-five percent of those completing the curriculum shall show understanding of the importance of exercise in the treatment of diabetes, the benefits of activity, and the potential consequences of inactivity.

Objective F: Ninety-five percent of those completing the curriculum shall demonstrate knowledge of self-care techniques and preventive efforts relating to limbs, vision, kidney, and circulatory systems.

Methodology

(Organized According to the Proposed Operational Goals and Objectives)

Goal #1

Objective A: InterCare's Clinical Director will convene a Diabetic Advisory Committee, composed of the Medical Director and the Clinic Supervisors. The committee will review available literature and InterCare's former diabetes protocol before drafting a new protocol to be

performed on each Spanish-speaking patient over the age of twenty seen at InterCare's clinics between May and October.

Objective B: Diagnosed diabetic patients will be identified with the agency MIS at each site. Diabetic Education Program (DEP) nurses will be responsible for contacting each of these individuals, either by letter or phone, during a clinic visit, or by home/camp visits to present information and encouragement for the individuals to enroll in the program. The rate of positive response will dictate the total number of patients contacted.

An enrollment rate of 30 percent from this group is predicted. When InterCare's Holland clinic implemented a similar diabetic education program for Spanish-speaking diabetics, a number of patients chose not to enroll. Two main reasons noted were the patients' nonacceptance of the diagnosis of diabetes and the unwillingness to modify dietary habits unless a health crisis occurs. The nurses will attempt to address instances of noncompliance in several ways.

For those patients who deny the diagnosis of diabetes, the nurse will refer those patients to the site social worker. The social worker will make a contact with the patient. If the social worker can assist the patient in accepting the diagnosis and feels the patient is willing to consider participating in the DEP, the nurses will explore with the patient any perceptions of diabetes control that may be erroneous.

Those others who are concerned about dietary changes or any other reasons for noncompliance will be contacted by the nurses to explore any perceptions of diabetes control that may be erroneous or any other perceived barriers (that is, transportation problems, inconvenience, and lack of child care). All patients contacted will not be pressured or coerced to enroll in the DEP.

The DEP has the goal of enrolling 120 of the currently identified diabetic InterCare patients.

Objective C: The nurses will be responsible for monitoring attendance and completion of diabetic education requirements. All visits will be logged, both in the program statistics on the agency MIS and on the patients' charts. The nurses are assigned to patients geographically and will use phone calls, home visits, and letters to maintain contact with patients in the program. The DEP nurses will also monitor the appointment schedule to make contact with diabetic patients.

It is estimated that a large number of patients, once enrolled in the program, may not complete the entire curriculum due to the transitory nature of the migrant lifestyle, the occurrence of denial often seen with diabetic patients, and any number of other factors that have affected the participation of migrant patients in education programs in the past. The DEP nurses will make assertive efforts to maintain patient program participation, but staff members have learned from past experience that such efforts do not ensure success. Nonetheless, the DEP has set a goal of maintaining the participation, through to completion, of at least half of the enrollees.

Objective D: The nurses will, together, hold evening group diabetic education meetings biweekly in four rotating locations. These meetings may be held at large camps, churches, or schools. Location will be determined by the nurses' assessment of the targeted audience, its size, and location. The meeting topics may be varied but will focus on the emotional and lifestyle supports needed by the diabetic individual. The meetings will begin with a brief informative presentation about one aspect of the condition. Following questions, the group will break up into two groups, with one nurse meeting with diabetic individuals to talk about problems, concerns,

and emotional issues, and the other nurse talking with family members and significant others about similar issues, including ways they can support the diabetic individual.

Objective E: Upon positive diagnosis during a clinic visit, staff will provide to the patient information regarding available resources and that the patient will be contacted soon by a DEP nurse. The DEP nurses will contact all new diabetic patients by phone or in person, when possible, to invite their participation in this program. Clinic nursing staff will gather information at the diagnosis visit, which will help facilitate the DEP nurse's contact.

Objective F: The implementation of the new screening protocol will facilitate the identification of previously undiagnosed, untreated diabetic patients. This screening protocol is a crucial component of the DEP. Newly diagnosed diabetic patients are often more open to diabetic education programs than are patients who have had diabetes for a period of months or years. Nurses will contact the new patients, offering flexibility in the provision of the assessment and educational sessions at a location and time that are possible for the patient. It is estimated that the agency, through screening, may identify over 150 new diabetics in the duration of the DEP. Of this number, it is hoped that over half will enroll and complete the diabetic education curriculum.

Goal #2

Application will be made for certification as an MDPH-approved Diabetes Education Program. The Clinical Director will ensure that the INTERCARE diabetes education program meets the following state standards for certification:

Philosophy and rationale for program are defined.

Program has policies to ensure optimal patient access.

Program is based on a written plan.

A designated person is responsible for program management and quality.

There is a team approach to curriculum planning.

Curriculum and lesson plans are designed to promote appropriate self-care.

Individual learning needs are assessed.

Behavioral objectives are established for each area of self-care.

Learning experiences are designed to facilitate learner involvement and participation.

The instructional process is evaluated and modified.

Postprogram referrals are made based upon the individual participant's needs.

Educational follow-up is initiated with each patient after discharge or completion of the program.

Permanent records of program participants are maintained.

The program is evaluated at least annually, and modifications consistent with the findings are made.

Receipt of MDPH certification will enable InterCare to bill Medicaid for the nurse educator's services. It is anticipated that MDPH certification could take from four to six months from date of application. InterCare will apply for such certification within three weeks of the notification of funding for the Diabetic Education Program.

The funding that InterCare currently seeks for this program should be viewed as start-up funds for a program that will be self-supporting during the second season.

Goal #3

The DEP nurses will schedule informational meetings with camp aides, priests, and crew leaders in the four-county area in the spring before the major influx of migrants. The informational meetings will focus on several topics: (a) monitoring patients with diabetes; (b)

treatment of acute and chronic complications, for example, hypoglycemia and hyperglycemia; (c) reduction of risk factors, including cholesterol, smoking, hypertension, obesity, and stress; (d) pregnancy and prepregnancy counseling; (e) benefits and responsibilities of self-care; and (f) use of medical and social support services.

Because of the highly mobile lifestyle of the target population, it is anticipated that as many as 50 percent of those beginning the program will exit before completion of the curriculum. Therefore, information will be presented early in the curriculum regarding the access and use of health care systems in the Midwest. Patients exiting the InterCare service area will be given a portable diabetic patient record, including all clinical data, educational records, pre- and posttest results, and information regarding contacts for more information. All pertinent information will be submitted to the National Migrant Resource Program.

Task Analysis: DEP Program Coordinator

Program Development Tasks

Establish protocol for clinical referrals at each InterCare site.

Formulate referral process for community/layperson referrals.

Participate in DEP curriculum formulation.

Conduct in-services regarding DEP for InterCare staff at all sites.

Research, review, and order all diabetic education written and audiovisual materials.

Formulate and conduct training sessions for camp health aides and laypersons to provide screening and educational assistance.

Establish protocol for contact of potential program participants.

Establish enrollment protocol.

Establish record-keeping system for all aspects of DEP.

Program Management Tasks

Ensure proper documentation on all DEP forms/records.

Monitor progress toward attainment of DEP goals and objectives.

Gather and analyze DEP statistical data.

Submit monthly and season-end reports of program activities and results to Clinical Director.

Develop and administer patient satisfaction questionnaire.

Provide orientation and training to DEP nurse.

Serve as supervisor to DEP nurse. Write work schedule, evaluate DEP nurse's performance.

Communicate with Clinical Director regarding any conflicts needing intervention and resolution.

Direct Service Provision

Evaluate potential program participants. Refer to social worker when necessary.

Enroll new patients in DEP, completing in the process the assessment of patient's health status, acceptance, understanding of the disease, willingness to participate, and support systems.

Provide individual diabetic education sessions in patient's home or other off-site locations.

Provide evening group diabetic education sessions in off-clinic locations.

Coordinate referrals to other service providers when necessary.

Provide on-site nursing support services as needed.

Provide to patient termination support services, including provision of patient records and referral support, when possible, if patient leaves the InterCare service area.

Budget Summary

Expenses

Personnel

Salaries and wages: \$36,000

Fringe Benefits: 9,360

Total Personnel Expenses: \$45,360

Nonpersonnel

Mileage: \$2,340.00

Supplies: 352.23

Educational Materials: 875.00

Equipment: 1,725.00

Postage: 87.00

Total Nonpersonnel Expenses: \$5,379.23

Total Program Expenses: \$50,739.23

Budget Narrative

Personnel: DEP Program Coordinator

Salaries and Wages: (.84 FTE x (\$14.00/hr x 40 hr./wk. x 42 wks)) = \$23,520.00

Fringe Benefits: (26 percent of \$23,520.00) = 6,115.20

Total \$29,635.20

Explication. Two Nurse/Educators will be hired, one for a ten-month, forty-hour-per-week position and the other for a six-month, forty-hour-per-week position. The ten-month RN/LPN will work full-time from February 1 to November 30 each year. This individual will hold the position of DEP Coordinator and will be responsible for program start-up activities, training laypersons and staff, coordinating program activities, collecting data, leading group and individual education sessions, and supervising the six-month RN/LPN. This individual must be bilingual and familiar with and sensitive to the migrant lifestyle and culture.

Justification. The DEP Coordinator must not only be skilled in providing educational and nursing services to diabetic patients but must also have the administrative skills necessary to organize and operate this program.

Required Job Qualifications

Possession of RN or LPN degree and current license to practice nursing in the state of Michigan

Bilingual (Spanish speaking)

Ability to work flexible hours

Use of vehicle, willingness to travel throughout four southwest Michigan counties

Knowledge of, and sensitivity to, migrant lifestyle and culture

Knowledge, Skills, and Abilities Desired:

Excellent organizational skills

Effective verbal and written communication skills

Supervisory experience

Knowledge of current diabetes education models and curriculum

Personnel: DEP Nurse/Educator

Salaries and Wages: (.50 FTE x (12.00/hr. x 40 hrs/wk. x 26 weeks)) =	\$12,480.00
Fringe Benefits: (26 percent of \$12480.00) =	3,244.80
	<hr/>
Total	\$15,724.80

Explication. This nurse will be employed from April 1 to September 30 and will be primarily responsible for providing individual and group diabetic education. The two nurse educators will divide the patient load geographically when possible to minimize mileage costs and travel time.

Justification. The expected patient load requires that the DEP Coordinator have a full-time nurse educator to provide the patient assessments and individual education sessions and co-lead the evening group sessions.

Required Job Qualifications

Possession of RN or LPN degree and current license to practice nursing in the state of Michigan

Bilingual (Spanish speaking)

Ability to work flexible hours

Use of vehicle, willingness to travel throughout four southwest Michigan counties

Knowledge of, and sensitivity to, migrant lifestyle and culture

Knowledge, Skills, and Abilities Desired

Excellent communication/teaching skills

Knowledge of diabetes mellitus and its treatments

Nonpersonnel

Mileage

Home visits: (7900 miles x .26/mile) = \$2,054.00

Evening group presentation (800 miles x .26/mile) = 208.00

Training for laypersons (300 miles x .26/mile) = 78.00

Total \$2,340.00

Explication. This program will be very mileage intensive, due to the four-county area to be covered. The home visit mileage estimates were derived from a comparison to the InterCare Outreach Program mileage for one season. To optimize mileage dollars, nurses will attempt to schedule numerous individual sessions at camps and housing projects during a single trip.

Justification. The nurses must go to the patients' homes for individual instruction sessions. In past experience with a group diabetic education session approach, few of the diabetic patients were willing or able to attend all sessions scheduled in the clinic. For this reason, InterCare has designed this program to be more readily accessible to migrant patients.

Supplies

One Touch strips (350 @ \$33.79/50) \$236.53

Lancets (350 @ \$11.80/50) 82.60

Band-Aids (1000 @ \$2.03/100) 20.30

Cotton balls (4000 @ \$5.60/case) 5.60

Alcohol pads (800 @ \$1.80/200) 7.20

Total \$352.23

Explication. These are clinical supplies, which the nurses will need to provide patient glucose testing during the home visits. By doing the glucose testing at each visit, the nurses not only can assess the patient's management of the disease but can also reinforce for the patient the necessity and ease of self-performance of this important procedure.

Justification. Glucose monitoring is an easy, low-cost procedure in the management of diabetes mellitus, which can alert the patient to potential problems. This simple procedure empowers patients to monitor their management of the disease. It is also a necessary part of any clinical assessment of a diabetic patient.

Educational Materials

Meal Planning Books (350 @ \$2.50)	\$875.00
------------------------------------	----------

Explication. The National Migrant Resource Program has published an excellent, seventy-two-page paperback entitled *Meal Planning for People with Diabetes (Planificacion de Comidas para Personas con Diabetes)*. This booklet was developed by three InterCare staff persons following the receipt of grant monies for this purpose in 1984 from the Michigan Department of Public Health. Since that time, the National Migrant Resource Program, with funding assistance from the U.S. Department of Health and Human Services, has made this booklet available to health providers nationally, charging a nominal \$2.50 per booklet. The booklet was updated in 1990 and remains a very culturally relevant material available regarding management of diet for Hispanics with diabetes.

Justification. Culturally relevant materials regarding diet are crucial when educating a patient about dietary matters. This booklet contains information about common foods in the Hispanic and migrant cultures.

Other educational materials will be an important part of the educational sessions. Booklets explaining the disease and necessary lifestyle adjustments are available, in Spanish, from pharmaceutical companies and are provided, gratis, upon request. InterCare has utilized this service in the past and will access high-quality materials, in Spanish, for this program from several pharmaceutical companies. Videos are also used in the diabetic education curriculum, including Spanish-language videos provided gratis by several pharmaceutical companies.

Equipment

Glucometer: Portable One Touch II System (2 @ \$137.50) \$275.00

Explication. Glucometers are necessary for the determination of blood glucose levels. This will be done in the patients' homes during each assessment/education session.

Justification. Each nurse will be covering a separate geographical area, thus two glucometers are needed.

Panasonic 13" color TV w/ VCR (2 @ 725.00) =	\$1,450.00
Total	\$1,725.00

Explication. The nurses will carry the portable TV's into homes that have electricity. When none is available, other arrangements for video viewing will be made. The monitors will especially be useful for the evening group sessions, which will be meeting in buildings most likely to have electricity.

Justification. Video instruction has become an effective part of health education. Many fine videos are available in Spanish with characters with whom patients may more easily identify.

Postage \$87.00

Explication. The nurses will be sending correspondence to patients who are not accessible by phone.

Justification. It will be necessary for the nurses to establish and maintain contact with the potential, current, and past program participants. Many migrant dwellings do not have phone service. Contacting patients by mail will be one way in which contact will be maintained, the others being phone and personal visits.

Program Evaluation

The Clinical Director will evaluate the program two times, in June and in October. Data will be collected about the following: (a) previous InterCare diabetic patients solicited for program participation; (b) newly diagnosed diabetic patients invited to participate; (c) patients who agreed to participate; (d) patient assessments completed; (e) patients who left the program after assessment but before curriculum completion; (f) patients who completed the educational program; (g) patients who showed increased knowledge of diabetes mellitus as indicated by pre- and posttest scores; (h) patients who received referrals to health providers elsewhere; (i) training sessions for laypersons in the communities served, and the attendance figures; (j) evening group sessions held and the number of diabetic patients and family/support/community members who attended.

Qualitative data will also be gathered through patient surveys to assess attitudes regarding the quality of the Diabetic Education Program. These assessments will be solicited

from patients upon completion of the diabetic education curriculum. Feedback will also be acquired informally through conversation with family members and patients during visits in the home.

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SECTION 4

CHART 4.1 GUIDELINES FOR EVALUATION OF PROGRAM PROPOSALS

(Parts of the structure of this chart and some guidelines were extracted or adapted from the Grantsmanship Center's

Guide to Proposal Writing by Norton Kiritz, 1979.)

Introduction

Student work groups should use these guidelines to prepare for the simulation during the final class focused on the evaluation of program proposals. Work group members should assume that they are officials who are meeting to review program proposals and make a recommendation for acceptance, resubmission with modification, or rejection. (These guidelines may also be used to develop and evaluate your own program proposals that must be submitted no later than one month before you plan to graduate.)

The table was designed to be comprehensive and to serve as a handy reference in writing and evaluating program proposals. However, in evaluating any proposals, you must know the particular documentation requirements of officials or external funders, because they vary markedly. Small local foundations may have a two-page application, whereas other foundations may have a substantial application and narrative requirement. In general, federal and state applications for funds are more extensive than local governments. Thus, you cannot just take the guidelines presented here and expect every proposal in the course pack to address all the elements. For purposes of the course, students who are officially completing short applications for local foundations or governments are required to provide more detailed documentation to the faculty. Nevertheless, do not use the comprehensive guidelines to "nuke" a proposal to a local foundation or government that has a short application form and minimum documentation requirements. To help you maintain perspective, the forms and documentation

requirements of funders are on reserve and should be scanned before you critique the proposals.

If the proposal assigned to your work group pertains to a new program, and the proposal will be submitted to external funders, most if not all elements usually have to be addressed, but again that depends on the funder. Some elements of the guidelines may not have to be addressed if your work group is assigned an in-house proposal pertaining to program changes. For example, you may skip the Introduction section of the guidelines under the assumption that the proposal will not be submitted to external funders. If the proposal pertains to program changes, students may have to add or substitute elements in the table and ignore others. If necessary, students should feel free to customize the table to conform to the aspects of the proposal that require evaluation.

Here are some suggestions for using the guidelines:

- Keep the guidelines handy as you begin reading the proposal.
- As you read through each section of the proposal, decide whether the required elements are addressed.
- If an element is not addressed, insert a No or an N in the cell.
- If the element does not apply, jot DNA in the cell or leave it blank depending on your coding preferences.
- If an element is addressed, insert the page number in the appropriate cell.
- Then assess whether the element meets or exceeds expectations or needs further development.
- If the element meets or exceeds expectations, insert a check mark in the appropriate cell.

- If the element needs improvement, insert a check mark in the appropriate cell.

Flagging elements that need further development enables you to monitor your work and facilitates backtracking through the proposal. The table facilitates systematic evaluation of the proposal. Your ratings and comments then facilitate decision making about the proposal and next steps.

Summary	Ratings		
Elements	Element Addressed Yes/No/DNA (if yes p. #)	Meets or Exceeds Expectations	Needs Development
Appears at the beginning of the proposal			
Identifies the entity submitting the proposal			
Problem/condition/needs			
Goals and objectives			
Project/service/program/benefits			
Funding			
No more than one page in length			
Comments:			

Description of the Agency Submitting the Proposal. This should provide convincing evidence that the agency is worthy of the confidence of the funders.	Rating		
Elements	Element Addressed Yes/No/DNA (if yes p. #)	Meets or Exceeds Expectations	Needs Development
Identifies entity submitting the proposal			
Describes mission/purposes and goals			
Describes auspices			
Describes years of service			
Describes governance and authority structure			
Identifies current sources of support			
Describes programs and activities			
States size of staff and describes staff qualifications			
Describes the service population and includes service statistics			
Provides evidence of accomplishments, support, endorsements, awards, accreditation, certification, licenses			
Demonstrates that agency and staff are qualified in the area of activity discussed in the proposal. Cites agency or staff experience with the topic of the proposal or similar topics			
The introduction ends with an appropriate transition to the problem statement			
All of the above are succinctly presented			
Comments:			

Problem Description/Needs Assessment	Rating (if applicable)		
	Elements	Element Addressed Yes/No/DNA (if yes p. #)	Meets or Exceeds Expectations
Is within the purview of agency purposes and its range of operations			
Describes the nature/features of the problem, condition, needs			
Describes factors that contribute to the problem or barriers to problem resolution			
Describes how the problem/condition affects those who are experiencing it			
Describes the consequences of the problem/condition			
Describes the characteristics of those who are experiencing the problem			
Addresses magnitude			
Need is supported by evidence, authorities/experts			
Statement is directed toward needs and problems of the target population and not just the need for services			
The narrative is persuasive that problems/needs exist and are worthy of attention			
Describes the target population and its selection and the scale of the problem and needs to be addressed			
Addresses diversity issues			
Comments:			

Program Objectives	Rating		
Elements	Element Addressed Yes/No/DNA (if yes p. #)	Meets or Exceeds Expectations	Needs Development
Outcome objectives are stated.			
Process objectives are stated.			
Output objectives are stated.			
Objectives are well formulated .			
Comments:			

The next four sections are adapted from Table 7.1, Master Chart for Monitoring Development of Elements of the Four Phases of Service Programs, in E. J. Pawlak and R. D. Vinter, *Designing and Planning Programs for Nonprofit and Government Organizations*. San Francisco: Jossey-Bass, 2004. Depending on the nature of the proposal, some elements may not have to be addressed. The table can also be used to assess whether diversity issues are germane to the proposal. Diversity is an umbrella concept and includes gender, age, race, ethnicity, religion, social class, and sexual orientation. If diversity is germane to the program design, planners can flag the relevant elements with a highlighter and assess whether the proposal adequately addresses diversity issues.

ADMISSIONS PHASE			
Elements of Service Programs	Element Addressed Yes/No/DNA (if yes p. #)	Meets or Exceeds Expectations	Needs Development
A. Dissemination of information about services			
B. Qualifying criteria for admission			
C. Admission process			
1. Initiation of the admission process			
2. Information to be sought in processing admissions			
3. Management of admission information			
4. Sources of information about applicants			
5. Management of the admission process and decision			
6. Site of the admission process/accessibility			
7. Duration of admission process			
8. Frequency of contacts			
9. Admission procedures			
10 .Completion of admission			

ASSESSMENT PHASE			
Elements of Service Programs	Element Addressed Yes/No/DNA (if yes p. #)	Meets or Exceeds Expectations	Needs Development
A. Purpose and focus of assessment			
B. Sources of assessment information			
C. Who conducts assessments?			
D. Means of assessment			
E. Duration of assessment process and frequency of contact			
F. Timing of the assessment			
G. Site of the assessment/accessibility			
H. Analysis of findings and development of service plan			
I. Management of assessment information			
J. Completion of the assessment process			

INTERVENTION PHASE			
Elements	Element Addressed Yes/No/DNA (if yes p. #)	Meets or Exceeds Expectations	Needs Development
A. Staff participant activities in the provision of services/interventions/benefits			
B. Recipient/significant others participant activities in the service program			
C. Service roles			
D. Duration or time span of service delivery			
E. Length of contact with recipients			
F. Frequency of contact with recipients			
G. Location of service provision /accessibility			
H. Timing of the intervention/service provision			
I. Procedures for recording benefits, interventions, and transactions.			
J. Units of service			
K. Staffing plan			

TERMINATION PHASE			
Elements	Element Addressed Yes/No/DNA (if yes p. #)	Meets or Exceeds Expectations	Needs Development
A. Termination policies and procedures			
B. Participants in the termination process			
C. Staff/recipient/significant others participant activities			
D. Duration of termination phase			
E. Frequency of contact between staff, recipients, and others during termination			
F. Timing of termination			
G. Location of termination process			

Budget		Rating (if applicable)	
		Meets or Exceeds Expectations	Needs Development
Elements	Element Addressed Yes/No/DNA (if yes p. #)		
Estimates are made for every program element			
Each element is explicated and justified in the budget narrative			
Delineates budget estimates for personnel according to positions			
Details fringe benefits separately from salaries			
Separately details nonpersonnel costs			
Indirect costs included when appropriate			
When necessary, estimates start-up costs			
Includes sources of support from other funders and in-kind contributions of agency			
Is congruent with what is promised in the program description, especially the staffing plan			
Comments:			

SECTION 5 GUIDELINES FOR AUDIOTAPED EVALUATION OF STUDENT WRITING ASSIGNMENTS

Edward J. Pawlak, Professor Emeritus, Social Work, Western Michigan University (WMU)

Dean Tyndall, Professor Emeritus, Occupational Therapy, Western Michigan University

Tracey Mabrey, Director, School of Social Work, DePaul University

Introduction

Courses in graduate professional programs usually require the completion of challenging written assignments or projects that entail a significant investment on the part of students. The investment is intellectual and emotional and involves substantial time and effort. This investment shapes students' expectations concerning the kind and amount of feedback they receive about their work products. Students want substantial and timely feedback, and we believe they deserve it. Furthermore, in professional health and human service programs, such evaluation is necessary to ensure that essential competencies are acquired by those who provide services to recipients. From the standpoint of the faculty, demands for instructional effectiveness, and research and scholarly productivity, require the efficient use of time without sacrificing student development.

The objectives of the Program Planning course provide opportunities for individualized plans of study. Thus, a mentoring approach is used. Also, some of the planning skills that students are expected to acquire often are not easily mastered in one trial. Consequently, assignments are sometimes viewed as educational assessments, and students are given opportunities to remediate their initial work products. Audiotaped feedback facilitates both mentorship and the remediation of work that needs further development. Based on our experience, audio recorded evaluation of student assignments and projects is an approach that

satisfies student expectations, promotes their professional development, and enables faculty members to carry out their responsibilities for evaluation effectively and efficiently. Although students are initially anxious about receiving audiotaped feedback, postevaluation reviews conducted anonymously and in focus groups indicate that they favor and appreciate such methods.

Advantages of Audio Feedback

Audio recordings can be used to coach students through a problem and into corrective action. For major assignments that require developmental work over an extended period (for example, program proposals or grant applications), audio recording enables easy documentation of detailed instructions about complex matters that require further attention.

Upon acquiring skill in audiotaping evaluations, faculty members can provide substantial high-quality feedback in less time than through written comments. Instructional points about the student's paper can be made easily by referencing an item from the readings or a lecture.

There are unanticipated benefits: students have shared their audiotaped evaluations with parents and spouses, and they have expressed appreciation and respect for the level of effort given to reviews of written work. Students who are in distance education programs, or who travel long distances to the campus, have expressed appreciation for the opportunity to listen to audiotaped reports while they are en route to and from the campus.

The only disadvantage we have experienced pertains to students who want to challenge the evaluation. Without a written record, some elements of the critique may not be easily recalled. However, students have rarely challenged an audiotaped evaluation.

Recommended Approaches

Instruct the Students to Use Line Numbering

Tell students to activate page and line numbering on their word processor and print the assignment accordingly. Numbering facilitates your and the student's location of the matters that are being addressed on the tape.

Use a Voice-Activated Recorder

As you review a student's written work, there are likely to be many pauses to ponder and comment on particular passages. Manual manipulation of the pause or microphone switch is awkward and tiresome. A voice-activated recorder enables you to begin and end a dictation without having to diddle with the switches. Furthermore, the instructor's hands are free to highlight passages, write notes in the margin, or leaf through the document.

Location of Dictation

Conduct your dictation where intrusions are unlikely or will be limited. The tape recorder might pick up ambient conversation and noises. (For example, one student discovered the following on her cassette: "Grandpa, do you want scrambled eggs for breakfast?")

Scan the Document Quickly to See What You Have

Scan the document quickly to gain an impression of the quality of the work. For example, Is it well written? Does it appear to meet assignment objectives? Did the student follow instructions? Does the paper meet expectations? Is it well done? Is it poorly done? Your impression of the paper should shape your approach to the critique.

We have found that well-written documents do not require substantial line-by-line, paragraph-by-paragraph commentary. Thus, we read through such documents and then dictate comments on the overall quality of the paper, perhaps calling attention to particular sections to illustrate the points we want to make.

If the document requires substantial line-by-line or paragraph-by-paragraph detailed comments, we dictate an opening statement that informs the student of our approach to the critique. For example, “I’m going to walk you through your paper—section by section, page by page—to call your attention to parts that are well done, and parts that need further development.”

When Is It Inadvisable to Dictate a Critique?

Do not dictate a critique if the student performs so poorly that the work has little or no redeeming value. The voice of a faculty member, citing a litany of failures, chapter and verse, can be disheartening.

Make Sure Your Comments Are Being Recorded

At the beginning of each student’s evaluation, dictate a few sentences, rewind, and make sure your machine is recording.

Direct the Student’s Attention

Begin each dictation by directing the student’s attention to the page and line numbers that you intend to comment on. (For example, “Mark, please turn to page 2, line 31.”) Use highlighters or code numbers in the margin of the document to call attention to patterns or linked topics within the document. If you see a pattern distributed across several pages, you might say,

“Examine the yellow highlighted sentences on pages 3, 4, and 5. What do you see?” Let the student engage in critical thinking and figure it out, or you can point out the pattern. It is helpful to use highlighters with different colors. You can use one color to call attention to problems with composition and grammar and other colors to focus on substantive matters.

Take a Developmental or Coaching Approach

We recommend that instructors follow a developmental approach and dictate in a positive encouraging tone. Suggest what could or must be done. For example, “Melanie, examine the highlighted statements on pages 3 and 5. In both instances, you introduce sound recommendations, but you must follow through. Develop and explain your ideas.” “Mark, see line 455. You missed an opportunity to apply one of the dimensions from the framework we discussed in class. Here is what you could have done.”

Don't Wing It

Develop a work sheet with a list of evaluative criteria that can be used as a guide to cue the students to the learning outcomes they are supposed to demonstrate in the assignment. You can also use the work sheet to cue your dictation as you encounter elements of the paper that warrant a comment. It is also useful to codify the common problems that students have with a particular assignment. Both will facilitate recognition of satisfactory and unsatisfactory performances and ease of dictation. For example, one of the authors relies on a work sheet that has these items: (a) demonstrates skill in structuring an analysis with a conceptual framework; (b) shows understanding of the framework's dimensions; (c) demonstrates skill in values clarification. These and other items on the list serve as cues to guide the focus of the critique.

Also, this facilitates your composition of the message in that you can incorporate the language

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of the items on the work sheets in your message. For example, “Mary, the program description section of the proposal requires attention to service roles, and that has to be connected to the staffing plan and the program budget. Your narrative shows your ability to integrate essential components of the proposal, and your budget estimates are justified.”

Summarize the Critique

When you are finished with the critique, summarize the positive features of the student’s work first and then your main concerns or instructional points, perhaps followed by suggestions for one or two developmental goals that the student should pursue further.

Afterword

Dean Tyndall, one of the authors, used audiotaped evaluations with his graduate students in occupational therapy, who were required to write a daunting program development proposal. They did a role reversal and gave *him* an audiotaped evaluation of his course, including his positive performance and aspects of the course that they believed needed further development. Don’t say we didn’t warn you.

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SECTION 6 OTHER EXERCISES AND CASE EXAMPLES

Goals and Objectives Exercise

Matching Exercise

- | | |
|------------------------------|----------------------|
| a. program outcome goal | b. process goal |
| c. program outcome objective | d. process objective |

1. ____ Elderly patients will acquire skill in talking with their doctors about medication.
2. ____ Senior Center will establish a program to coach elders in how to manage discussions about medication with their doctors.
3. ____ Elders who participate in the training program will acquire assertiveness skills (for example, develop a list of questions and phone the doctor about the medication) and will be able to identify the key questions that should be asked about prescribed medications (for example, What is the purpose of the medication? What are the side effects? Can the medication be taken with OTC or other prescribed drugs? How many times can the prescription be refilled?). Elders will acquire such skills at the end of the training program.
4. ____ The Senior Center in consultation with the staff of the Hospital Geriatric Unit will develop and implement a training program on doctor-patient relationships that includes assertiveness training and information about medication management within two months of the approval of the program.
5. ____ The incidence of hospital admissions and visits to the public health clinic for adverse drug reactions and interactions will be reduced.

6.____ By the end of the fiscal year, the number of hospital admissions and visits to the public health clinic by elders due to adverse drug reactions or interactions involving tranquilizers, cardiovascular drugs, and sleeping pills will be reduced by 50 percent.

7.____ Senior Center will collaborate with local pharmacies and the local Academy of Medicine in developing a medication management program.

True or False. Statement # 8 has the essential properties of a well-formulated human behavior program outcome objective. Place a T or an F on the line adjacent to # 8.

If you answer True, justify your conclusion. If you answer False, then critique the statement and improve the objective so that it has the essential properties of a well-formulated outcome statement.

8.____ Adult residents with mental retardation who live at the Duke Road Group Home will learn to use public transportation without assistance within three months of their admission.

Initial Class Exercise in Identifying Participant Activities:

A Trip to the Zoo

The purpose of this exercise is to provide you an opportunity to practice the identification of participant activities. In preparation for the exercise, some elements presented in Chapter Seven are reviewed here. We stated that the design of service programs requires attention to program activity sequences, which leads us to concentrate on two types of participants: service providers *and* service recipients. Service providers necessarily include those persons who are in immediate contact with recipients—that is, those whose activities or interventions constitute the key process by which service is given. However, our perspective requires inclusion of *all* personnel who have contact with recipients, regardless of titles or others' definitions.

The prospective or current recipients who will be or are in contact with direct service staff must be considered in designing service programs. Likewise, attention must be directed to secondary or indirect recipients such as family members and significant others who may participate in some aspect of the program process or otherwise need to be considered as the service program is designed.

The required or expected behaviors of staff persons within activity sequences are generally known as tasks or procedures, which are sometimes specified in extensive detail regarding who should do what, when, and how. Note, however, that each of these terms is usually applied only to staff activities and thus tend to ignore or deemphasize recipient behaviors and decisions that are also relevant to the design and functioning of service programs. Recipient participant activities must be given at least the same attention as staff participant activities, because recipients are the reasons for the existence of service programs.

Activities refer to publicly observable behaviors, patterns, and decisions that guide actions and are documented (or that can be inferred from behaviors). Actual program sequences include not only participant activities that are planned and required but also behaviors that are discretionary, evoked, and sometimes even forbidden. Although we concentrate on the expected activities, still other probable behaviors of recipients and staff need to be identified (for example, in a school service program, classroom misconduct and absences of pupils, or irritable conduct by harried administrative or frontline personnel).

First Exercise

We present a common activity—an outing to the zoo—that many individuals and families experience on their own or that is often sponsored by church and scout groups, day camps, and recreation and community centers. An outing to the zoo is not a service program, but one activity in a service program. We have simplified this exercise to provide students with an opportunity to practice the identification of participant activities on a small scale, and one that could be engaged intuitively or based on experience. The example is presented in the form of the scoutmaster's initial jottings as he and his assistant planned the outing with a group of eight scouts. The jottings consist of a list of participant activities of the scoutmasters, scouts, and others, including planned and unplanned behaviors and decisions, as well as events that might significantly affect decisions and behavior during a zoo outing. As you read the list, you might conclude that some items need further detailing and that additional participant activities must be identified. Share these observations with the members of your work group.

Here are some tips on how you might develop your list of participant activities. Envision or anticipate the tasks, activities, decisions, behaviors that must occur during a zoo outing.

Envision or anticipate behaviors of the scouts that might be evoked by what is seen or

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experienced at the zoo. Deconstruct or disassemble a zoo outing. As you list scoutmaster activities and behaviors, are there reciprocal scout activities and behaviors?

Scoutmaster's Jottings

- (a) Call zoo officials. Determine visiting hours. Fees? Check into special requirements for groups.
- (b) Prepare information sheets. Include date and departure and arrival times. Essential clothing. Costs—meal, snacks, seal show, and admission fee.
- (c) Next meeting—inform boys about the trip. Hand out information sheets. Tell boys to give the sheets to their parents.
- (d) Distribute permission slips to boys. Tell them to have a parent sign the form. Slips need to be returned at the following meeting. That's Plan A. Develop Plan B for boys who lose forms or forget to bring them to the meeting.
- (e) Reserve the van from the main office. Arrange to pick up the key the night before.
- (f) What's the best route to the zoo? Avoid construction bottlenecks. Plan some car games.
- (g) Morning of the outing. On the way to the zoo, present the plan for the day. Present rules about staying together. Divide into subgroups. Assign buddies. Rules about going to the rest room. What to do if you get separated from the group. Emphasize zoo regulations about feeding animals, knocking or banging on glass partitions, staying behind barriers, and chasing the ducks and peacocks. Review the Scout's Code of Behavior.
- (g) At the zoo: Walk through the park throughout the day. Take the zoo train back to the parking lot at the end of the day. Lunch at the outdoor restaurant. Seal show after lunch. (Get seal show tickets ASAP on arrival.) Outdoor exhibits viewed in the morning while it is cool. Guided tour of the reptile exhibit will be the last activity of the day. Jim and Phil don't get along. Put them in the

same group (but keep apart in van). Work on their troubles.

You're probably wondering how things turned out. Overall, the outing went as planned, but one of the scouts fell off the slippery ledge of the water fountain (despite repeated warnings by the scoutmaster), and he had to be taken to First Aid, which caused both to miss half of the seal show. The scoutmaster had many opportunities to talk with Jim and Phil about their tiffs. At the petting zoo, Jim let Phil finish the feeding of a goat, which proved to be a turning point in their relationship. A flash thunderstorm knocked the power out one hour before closing, just as the boys were about to board the zoo sky train to head back to the parking lot one mile away.

Second Exercise

Let us change some characteristics of the participants and redo the exercise. This time let's assume that the outings to the zoo are being planned for the following groups : (a) a group of six emotionally troubled ten- to eleven-year-old girls in a summer day treatment program; (b) a group of six physically challenged twelve-year-old boys and girls who rely on wheelchairs for mobility; (c) a group of ten fifteen-year-old boys and girls from a church youth group; (d) a group of ten elders who are members of a septuagenarian club at a senior center. Each student work group will be assigned to a different recipient group. Each work group should write its jottings on the work sheets taped to the wall, and a spokesperson should present the work group's results. What did you learn from this exercise about designing service programs?

Project “Home Base”
Supporting and Sustaining Chronic Care Support Groups:
A Proposal

John P. Flynn

Foreword

This proposal was written by John P. Flynn, Professor Emeritus, Western Michigan University, who is a leader in a local Parkinson’s Support Group (PSG) and a capable and tireless contributor of community service. The proposal was funded for \$10,000 by a local foundation. I am grateful to Professor Flynn for giving permission to include his proposal in this manual.

This proposal was included in the manual for several reasons: (a) it pertains to a current health issue; (b) it is an example of a type of proposal that is often submitted to local foundations—that is, it pertains to a local small-scale project; and (c) it is an example of a problem statement and needs assessment that is qualitative in substance and that makes a compelling case without substantial quantitative data.

There are at least three ways that instructors can use this proposal. (a) Students can be assigned to evaluate the whole proposal, or one or two of its segments. (b) The proposal can be distributed to students with the section on the Coordinator’s tasks deleted, and the students can be assigned to develop the tasks based on the problem statement and the objectives. (c) Depending on how a particular department’s program and curriculum are structured, students can be assigned the task of identifying the material and staff resources needed to implement the program.

Executive Summary

The problem of instability and discontinuity of leadership is endemic to support groups associated with chronic health conditions. As a disease progresses, caregivers necessarily devote increasing time to management of the disease. There are consequently less and less personal resources available to continue to provide group leadership. Nevertheless, support groups in communities are an invaluable resource in helping any community to manage and cope with chronic illnesses. In addition, members of the community often do not receive (or sometimes reject) the necessary information or education on disease management and health promotion that is often available through support groups. Other individuals solely in need of mutual support that could be forthcoming from others in similar circumstances are left to their own devices as a result of poorly organized community care systems.

This project proposes to leverage the resources of a community agency having many years experience in providing supportive services to community citizens. It will also collaborate with the local PSG, which is relatively well intact, as a pilot/demonstration subject to identify how and what might best be provided by way of technical staff support in order to adequately sustain such groups. As a process-oriented project, members of other support groups facing problems in group development and maintenance will be included, where appropriate. The demonstration or pilot project is aimed at identifying what tasks must be performed, by whom, and in what measure, particularly in regard to what can/should best be performed by technical staff support, what by community volunteers, and what by support group members themselves. The project will also be guided by an Advisory Committee representative of the various community organizations that have a necessary interest in the well-being and optimum functioning of those

with chronic care needs and their caregivers, as well as the participation of representatives of the affected group members themselves.

Project Goals

1. Leverage the experience and existing infrastructure of an established community agency to provide stability and continuity to essential functions of a chronic disease support group (that is, the local PSG) and subsequently additional support groups.
2. Identify the professional staff support tasks that would be fundamentally essential and those that would enhance the functioning of a local support group.
3. Use this demonstration project, both during the life of the project and in the subsequent postproject period, to contribute this project's and similar staff supports to additional groups as requested and as appropriate.
4. Strengthen the community's ability to offer pertinent and group-specific staff assistance that would maintain community support groups offering community-based extended care for those with chronic health conditions that sustain independent functioning.

The Problem

Many individuals and families who are faced with chronic care conditions are forced to go it alone in the absence of any organized and properly serviced support system. In addition, many community health and human service organizations are left without adjunct care systems to offer support for obtaining aids to daily living. This leaves patients or clients, or their

caregivers, to handle the necessary regimen of follow-up or chronic care. This is particularly problematic in the case of chronic and degenerative or progressive diseases in which the individual's or family's ability to cope is commensurately, over time, lessened. Fewer of their own energies or resources are available to sustain the needs of a support group, which may have heretofore filled some of the gaps in providing help.

Groups' Internal Resources Generally Insufficient to Sustain a Support Group

There are various support groups in communities that are self-organized and self-staffed. Examples are those groups devoted to management of Alzheimer's disease, fibromyalgia, stroke, muscular dystrophy, multiple sclerosis, mental health issues, pulmonary conditions, and the like. A major problem, with a few exceptions, is that the support groups themselves are subject to high rates of turnover and are lacking themselves in commensurate levels of support to sustain themselves as a viable group. Patient/client and caregivers predictably find less time or energy for maintenance of support groups. A common scenario is withdrawal of the person with the chronic condition followed by eventual withdrawal of the caregiver or care partner. This is frequently due to exhaustion or, at the same time, the progression of the disease and more attention needed for care. This results in constant drain on the pool of available leadership for the support group and the people power to sustain it.

Instability and Discontinuity in Leadership in Support Groups

The area PSG was originally established in 1984 by persons interested and invested in this problem. That original group was affiliated with a movement located in California called the Parkinson's Education Project (PEP). However, while PEP folded over the years, the local area group continued to provide education and support to many in the surrounding area. Generally,

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monthly meetings are held with presentations provided by relevant local professionals (for example, neurologists, speech therapists, pharmacists, music therapists, representatives of various social service agencies, nutritionists, and so forth). Other special symposia were also presented (for example, legislative updates, reports on current research trials). The general "membership" meetings (that is, persons with PD and those who accompany them to meetings) have usually been held monthly in the evenings, in recent years under the generosity of a residential community for elders. More recently, PSG has also provided separate small-group sessions solely for care partners or caregivers, which are led by a professional social worker. Funding for these support group activities generally comes from small grants, generally in the form of bequests by individuals following the death of individuals or families who request such gifts to be made in support of group activity. However, most bequest dollars go to larger foundations. Such a funding mechanism provides a very uncertain manner for funding group needs (for example, mailings of newsletters, program announcements, and telephone services).

It cannot be stressed enough that PD is a progressive disease that over the years consumes more time, effort, and energy of the person with PD, the caregiver or partner, and sometimes other family members. There is constant turnover in those who associate with the group. This turnover is particularly problematic when it comes to providing and maintaining leadership for the group. Consequently, an individual or family problem evolves into a community problem as a matter of course. *Put another way, this is a community problem to be solved inasmuch as the same pattern cuts across many disease groups needing care in the community.* Leadership is based largely on who will "do it." In the interim, there has been no institutional base to ensure continuity with this important function for a substantial part of the community. *This same scenario is surely played out within or among other groups. This*

phenomenon needs to be made known to the community of care so that efficient and effective responses may be designed and delivered.

Attaching a Chronic Care Group to an Ongoing Professional Institution

Over most of the last year, the PSG recognized the threat posed to its stability as a viable group and its constant turnover in available group leadership. Withdrawal from the group (and performance of tasks central to group function) is positively correlated to the progression of the disease. In the case of death of a member, caregivers are very likely to withdraw from further group responsibilities. The threat to care for this particular support group was seen as (a) the loss of stability evident in the lack of any institutional tie to service organizations in the community to sustain the group's efforts/tasks; and (b) the constant turnover in group leadership caused by the demands of a progressive chronic disease.

An extensive effort at exploring solutions via interviews with many community leaders in health and human services was conducted over the past ten months. The PSG received knowledgeable and skilled input and direction from a variety of community professionals. All confirmed the need for an institutional tie and professional and technical support to sustain our group, often with recognition of the fact that many other groups likely faced the same issues of stability and continuity.

The PSG was ultimately led to the local Advocacy Center, which, at the same time, was experiencing frustration in not having the staffing resources to respond to various requests from individuals or families for situations that likely could have been serviced effectively by an appropriate staff response. Having identified the mutual goals and similar problems (as well as limitations) placed upon both of our organizations, the Advocacy Center and the PSG have set about the task of mutually facing this problem. This proposal argues for a demonstration project

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in which the Advocacy Center would take the leadership in identifying precisely what staff activities would be needed to sustain such groups. With the PSG group having studied the matter and still being substantially intact as a support group for the present time, a partnership was formed to design a response to this problem. Hence, we are submitting this request for assistance.

Parkinson's Disease as a Subject Group for a Demonstration Project

The following information is offered solely to craft an image that, generally speaking, might be said to be characteristic of many chronic disease support groups. Each group may focus its interests and resources on a particular set of conditions and might be aimed at reaching a particular target area. Each tends to provide educational materials or information, often via the input of relevant specialized practitioners. Obviously, each group offers mutual support to one another and promotes awareness of its availability to the general community. In this context, the following section on PD is not meant to promote one particular disease issue but to show what is more or less easily translatable to other chronic conditions.

PD is a progressive disease, generally showing clinical symptoms of tremors, slow or inaudible speech, shuffling gait, facial masking, rigidity or freezing in place, and involuntary movements or dyskinesia. While PD is generally seen as a condition appearing solely among persons aged 60 or older, there are in fact a number termed as "early onset" PD. Consequently, it is difficult to estimate the prevalence of PD in any geographical area on the basis of age.

A conservative figure commonly used to indicate the prevalence of PD in the United States is 1,000,000 persons. With the U.S. Census of 2000 at 200 million persons (ages 20 or above), this would indicate a rate of 0.5 percent of the population. Including persons with PD and/or their families or caregivers in the region (who generally orient themselves to the local

PSG), one could roughly estimate that there are approximately 1,475 persons with PD in the locale of the PSG. The PSG presently has on its mailing list approximately 200 households having a person with PD. There are likely some persons in the locale of the PSG who may be attached to support groups elsewhere in the state. The PSG is only one of approximately 40 such support groups in the state affiliated with the State Parkinson Foundation. The Foundation provides excellent technical assistance but, logically, only of the type that is not “on-site” or not stationed in the local community. In addition, there are surely those who have no desire to be attached to or associated with a support group, for various reasons. On the other hand, there are likely others beyond the 200 known to PSG who would welcome assistance. Put another way, a support group is likely a failure in providing adequate case finding without staff support to take on leadership in that area.

Nevertheless, serving 200 out of an approximate number of 1,475 would suggest considerable failure in providing helpful information, education, and support to many that might benefit from such services. It never ceases to amaze many of us associated with PSG the extent to which persons with PD and their families and care partners or caregivers are so ill-informed about the management of their conditions. For one thing, many neurologists are not specialists in movement disorders such as PD, as is true of many physicians practicing in internal medicine and/or family or general practice. Oftentimes, little appropriate information, or even misinformation, is provided to those who suffer from or care for those with this progressively debilitating disease. It is for these reasons that the PSG is striving to offer a more adequate support base to the PD community. *The important question here is: To what extent are other chronic disease groups failing in their outreach to others in like conditions and how can the community fill that void?* A demonstration experience via this proposed project, “Home Base,” could provide valuable insight in this regard.

Practical Needs to Function as an Educational and Service Support Group

There are a number of tasks that this and similar support groups must provide to be in any way useful or effective. There are such matters as planning useful program activities or topics, publishing and mailing a newsletter, informing those whose presence or participation comes and goes by publishing notices or reaching out through a telephone tree, or maintaining a bank account or other bookkeeping records. Then there are other matters such as providing a routine greeter for meetings, preparing snacks or coffee or tea for a social time at meetings, maintaining and circulating educational materials such as booklets and videotapes, reporting on current events in pharmacological changes, information on clinical trials, and making arrangements for proper facilities for meetings or symposia.

In the case of the local PSG, the State Parkinson Foundation (SPF) has been very helpful in providing practical assistance to support groups, particularly through workshops for "facilitators" or those in leadership roles. However, the Foundation cannot fill roles at the local level—those must be filled by local people. While SPF provides assistance with medication costs, day-care expenses, and some financial aid with small grants, technical assistance is what is most helpful to the group's leadership. But the Foundation is not in a position, nor does it have the mission to replace leadership, nor does it have the capacity to run the organization of the local support group. This state of affairs likely is replicated with other chronic care groups, and this project will document what is actually needed in terms of staff support.

The central problem does not appear to be a lack of creativity at the local level (though outside input is often very helpful). The central problem appears to be a lack of continuity and instability, particularly in providing long-term leadership and guidance to the local support group. Every community finds the propensity for some people not to volunteer or come forward.

However, the very nature of this disease consumes many individuals and family members with coping with symptoms and disease progression, who would otherwise, in different circumstances, likely come forth. Consequently, the need is great for some type of institutionalized structure to "provide support for the support," so to speak. It is necessary that some elements of the community should come forward to assist with what is really a community problem. The next step should be to explore what alternatives might be reasonable, practical, and available.

Home Base: Leveraging an Existing Community Resource

The Advocacy Center agrees to provide technical staffing support to organized chronic disease support groups, employing for the present the PSG as the primary demonstration subject. Other groups could (and likely will) be added as appropriate. This is clearly an opportunity for the community to leverage a resource in which it has already placed considerable investment. The Advocacy Center brings some twenty years of experience and its existing infrastructure to take on this problem for examination and, perhaps, even remediation. This resource is fortuitously available to answer one chronic illness group's problem, and that might meet other chronic illness groups' needs in the future without having to duplicate the demonstration project.

As part of the demonstration project, staff time and resources will also be offered or allocated, as appropriate and feasible, to other support groups whose associated needs come to light during the project. The Parkinson's group will be the pilot test. That is, the demonstration will have goals, objectives, and an appropriately disciplined evaluation (to be described below), but flexibility and inclusion, where appropriate, will be another principle of the project. The project will also welcome other groups that might come forward with similar, or even new, additional needs that appropriately fit in with the project design and purpose.

The Differential Roles of Staff and Patients/Clients

It is important to recognize that any staff that might be assigned to a support group by the Advocacy Center be guided by a certain philosophy giving distinction to the role of a staff coordinator and a responsible member of a support group. *Tasks that might be appropriately performed with and on behalf of the support group by a staff person assigned by the Advocacy Center would not include all of the decisions that must be made and all of the work that must be done.* It must be stressed that the tasks would be performed by an agency staff person outside of but with the support group in the spirit of the coordinating staff member being an **auditor**, or **monitor**. That is, the support group would not surrender nor abdicate its responsibilities to give direction to and participate in the group's direction and functioning. In many instances, the actual work suggested by an activity would be performed by a volunteer from the support group or even by a volunteer from the wider community, but the staffer could serve as auditor or monitor by assuming responsibility over time to make sure that those tasks are performed. At other times, the staff person would actually perform necessary tasks. For purposes of this project, one might call this person the **Coordinator**. It is assumed that the Coordinator would be an employee of the Advocacy Center, having the responsibility to perform the role of Coordinator of the PSG (and other groups as the project develops).

The Coordinator's Task List

In the list of tasks that follows, the Coordinator and current leadership of the support group would ***negotiate the degree to which either*** the Coordinator or designated group members would be totally or only partially responsible. The leadership would ideally consist of six or more steering committee members, who would give feedback to the coordinator. The

following tasks to be provided by a group Coordinator serve, then, as the project's objectives. Each task (objective) is behaviorally observable, can be counted as to its frequency of need or appearance, as well as subjectively evaluated by such features as presumed need or utility for sustaining group functioning. Consequently, the Coordinator (that is, Advocacy Center staff person assigned to the project) will carry out the following tasks.

A. Education, Outreach, and Case Finding

1. Assure publication of and solicit copy/content for the support group newsletter (that is, such content to be the responsibility of designated group members).
2. Facilitate/execute any production mechanisms of such materials as newsletters, brochures, flyers, etc.
3. Work with group Program Planners to schedule interesting, topic-appropriate meetings for people with the chronic condition and their caregivers. The support group representatives would provide input regarding ideas concerning past meetings and ideas for future meetings/activities.
4. Assure that support group meetings are regularly publicized in local media.
5. Implement a public relations effort aimed at informing community members of the availability of support group functions relevant to chronic care needs.
6. Represent the Advocacy Center and participating support groups in various meetings of community professionals, as appropriate.
7. Oversee distribution of support group brochures to appropriate venues, aimed at broadening awareness of the availability of a support group in the community.
8. Assist in the development of a group-specific or general-application speakers' bureau.
9. Maintain library resources available to groups and families.

B. Group Maintenance and Development

1. Oversee and provide assurance that members of the group have fulfilled their functions in such roles as secretary, treasurer, and activities such as program planning, publicity, hospitality, and so on.
2. Maintain a brief historical record of each meeting in terms of the subject matter or main topic on any particular date, the name of the presenter, and the number in attendance.
3. Assure that thank-you notes are sent to guest speakers in a timely manner.
4. Oversee the accuracy of the group's mailing list.
5. Assure desired furniture or room setup for support group meetings.
6. Assure that sufficient name tags are available at monthly support group meetings, if desired.
7. Maintain contact/communication with the SPF (as well as other state/regional groups for other support groups as they are added to the project).

C. Program Support

1. Locate and arrange, when necessary, meeting sites for group activities/meetings.
2. Assure availability and provision of mechanical or communication devices, such as video projection equipment, portable speakers, and/or microphones for the hard of hearing and those whose speech is impaired (particularly in regard to volume or enunciation).
3. Before support group meetings, contact any speaker or presenter in order to confirm plans and identify any special equipment needs, etc.
4. Identify those functions not listed here or not anticipated that should be added as a result of the experience and the project evaluation.

Note on the Membership and Coordinator Task List(s)

There is surely much to be done to maintain a well-functioning support group beyond those tasks listed above. Much work is undertaken by the group's leadership (goal setting, program planning, fundraising, honoring specifics found in the affiliation agreements with state agencies such as the SPF). The important point here is not that the support group needs a designated person to do its own work or to perform tasks that are more appropriately done by the membership or its leaders. The most important point is that a Coordinator role, through its auditing and monitoring functions, will hopefully create an ongoing institutional attachment between the community and the support group, thereby minimizing the chronic problem of instability and lack of continuity of this group in our community. Otherwise, this disease group (and likely others as well) will continue to lose its limited human resources, which could result in the group's dissolution. Such an unfortunate outcome due to lack of any institutional community tie that is committed to the support group's continued contribution to the community-at-large would be unfortunate.

Project Evaluation

Project evaluation would use a formative approach (that is, a focus on observable process and required inputs) rather than a classical summative approach (that is, a focus on measurable outcomes and searches for cause-and-effect measurements). Each of the process objectives (stated in the form of tasks above) lends itself easily to counts of frequency of performance, length of time, and other resources required. The attainment of these objectives, being behaviorally specific and quantifiable, will be captured for frequency counts. However, the evaluation will go beyond mere staff activity reports and, in addition, will solicit the impressions of the Coordinator, Advocacy Center administrative staff, and support group members for such

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subjective expressions as perceived adequacy, relevance, and desirability. This aspect will be obtained via Likert-type scales of opinion (for example, soliciting an impression from key informants by recording expressed opinions on a scale of 1 to 5) and either/or scaling of forced choices of “not needed” versus “needed” in characterizing a particular task or activity. This evaluation can be done by an outside evaluator or by agency administrative personnel or a combination of available technical skills.