The Assessment Plan\(^1\) (i.e., Evaluation Plan) is a written document used to clarify how program activities will be assessed and monitored, as well as how the results will be used to make program improvements and demonstrate impact. An evaluation plan describes evaluation activities including overarching evaluation questions, indicators for measurement, data collection and communication strategies, timelines, and costs. It is a living document and may be revised over time to reflect changes in program strategies and work plan activities. The evaluation plan submitted for your Care Coordination grant includes the following sections:

I. Introduction/Evaluation Purpose
II. Logic Model
III. Evaluation Questions
IV. Data Collection
V. Analysis
VI. Dissemination & Utilization
VII. Evaluation Work Plan

2015 Rural Health Care Coordination Network Partnership (i.e., Care Coordination) grantees are encouraged to involve consortium partners in the process to develop the evaluation plan. This evaluation planning process provides the opportunity to engage your consortium partners in thinking about what direction your evaluation plan should take given program priorities, resources, capacity, and time. Involving consortium partners and other key stakeholders in the development process can foster transparency and ensure that everyone is on the same page.

Your evaluation plan should align with the work you proposed in your grant application. During the evaluation planning process, it will be necessary to revisit your program’s logic model, goals, objectives, and work plan. This will ensure better alignment of your program’s strategies and activities with the evaluation. If during the process you find that certain goals and objectives need to be rewritten, or you need to add new goals and objectives, you should adjust your work plan accordingly. Please remember, any major changes/adjustments will need prior approval from your Project Officer.

\(^1\)“Assessment Plan” is the official title of this reporting requirement. For the purposes of this document and other related resources, we will interchangeably use the term “evaluation plan” in referring to this same deliverable.
Your 2015 Rural Health Care Coordination Network Partnership Program Assessment Plan is due on March 16, 2016 as a deliverable of your grant. You will submit your plan in the HRSA Electronic Handbook under the “Submissions > Other Submissions > Assessment Plan” placeholder. You are required to adhere to the following format in writing your evaluation plan. Use the fillable template document to complete your plan. The text boxes will expand as text is inserted into the fields. Ensure that you adequately address the content in each section based on the guidance provided in this Assessment Plan Instructions document.
Assessment Plan Instructions

I. Introduction/Evaluation Purpose

The introduction should provide an overview of the program that covers the following:

- A brief description of the program and primary strategies to be implemented. This should include a discussion of the evidence-based model(s)/promising practice(s) being adopted and/or adapted for your Care Coordination grant program. Also describe the stage of development of the program (i.e., planning, early stages of implementation, expanded implementation of original pilot program, etc...).
- A short overview of the need that informed the project.
- The overarching purpose/goals of the evaluation (i.e., Why are you doing the evaluation?). Is it to monitor and improve program activities, be accountable to the funding agency, gain new knowledge or insights about implemented strategies, or demonstrate program impact to the community? Describe the overall approach to the evaluation process, including how the evaluation and its findings will be used.

II. Logic Model

A logic model is a graphic depiction of a program that shows the connection between the different components of a program from the activities implemented to the anticipated impacts of the program. They are effective tools for organizations because they present a simplified picture of a program; show the logical relationships among resources invested, the activities that take place, and the outcomes that occur as a result; and they help explain the “theory of change” (i.e., how and why we expect a program to produce results). On a tactical level, a logic model helps you focus your evaluation questions based on the different components of your program indicated in the logic model and prioritize where to invest limited evaluation resources.

Review and revise, if needed, your logic model that was originally submitted with your grant proposal. Insert it into this section. If additional information and guidance are required regarding logic models, refer to the CHSD e-Learning module on Logic Models that can be found here on www.ruralhealthlink.org. In addition to the e-Learning module, there is a Quick Course – Developing a Logic Model – that can be used by you and your partners in the creation of your own logic model.

III. Evaluation Questions

Your plan should focus on both process and outcome evaluation. In this section, provide the primary evaluation questions that you will seek to answer through the program evaluation, including those that focus on both implementation (i.e., process questions) and the impact of the program in the community (i.e., outcome questions). These are not to be confused with the questions on a survey or other measurement tool used for assessing a particular indicator. They represent the larger questions that help you understand the extent to which
activities were implemented as planned and if your program had an effect, positive or negative, on its participants.

**Process questions** focus on a program’s operations and seek to better understand how a program is being implemented. They help you understand some of the following:

- Were program activities completed as originally intended? Did we reach the number we expected in the timeframe we proposed?
- Are those served by our program satisfied with the services they receive?
- What progress has been made in the implementation of our program?
- How well were program activities implemented? What level of fidelity did we have to the proposed evidence-based model that we implemented?

**Outcome questions** focus on showing whether or not a service achieves the desired changes for patients, providers, network members, or the community. They are concerned with the effects or impact of your program. Some examples include:

- To what extent did individuals’ ability to manage their diabetes improve as a result of our disease management services?
- Have we been successful in increasing the prescription of inhaled bronchodilators for patients diagnosed with COPD?
- What percent of patients are now receiving a reconciled medication list upon discharge compared with before?
- To what extent did hospital readmissions rates decrease?

Evaluation questions should directly link to the main elements of your logic model and address what is happening at different stages in the program. Process questions will typically come from the left side of your logic model which includes the inputs, activities, and outputs of your program. The outcome questions are derived from the right side of the logic model and may be short, intermediate, and/or long-term in nature. As it is not possible to evaluate every aspect of a program, questions should focus on priority areas identified by your stakeholders.

When developing your evaluation questions, keep in mind the requirements of the Care Coordination grant which include both grant-specific outcome measures and Performance Improvement Measurement System (PIMS) reporting. All Care Coordination grantees are required to report on four outcome measures for each chronic condition (Type 2 Diabetes, CHF and COPD), for a total of 12 measures. Furthermore, all grantees are required to report at least three care coordination measures. Performance on these measures will be aggregated across the funded sites to measure program impact. Additionally, you will need to ensure the integration of the PIMS measures into your evaluation plan. Final PIMS measures will be shared by the Care Coordination program Project Officer in grant Year 1.

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2 As a result of potential changes to the measures since the FOA was written, your Project Officer will provide more details on the specific outcome measures required by the grant once finalized.
IV. Data Collection

Your evaluation plan should explain what data will be collected, how the data will be collected (methods, tools), who will collect the data, and the timeline for collecting data. This section should cover the following:

Describe the indicators (or measures) that will be used to assess each of the prioritized questions listed in the section above. Process measures assess how well a program is being implemented and can often be expressed in numerical counts. Examples include: # of participants attending class, # of brochures distributed, or # of educators trained on the curriculum. Outcomes measures examine the impact or effect that a program is having in the community. They may often be expressed in terms of a percent or other level of change. Examples include: % decrease in BMI, changes in emergency room admissions, or improved knowledge of diabetes risk factors. There may be more than one indicator/measure for any evaluation question.

Based on your evaluation questions and selected measures, describe the data sources you will use. There are two primary types of data: secondary data (i.e., existing data) and primary data (i.e., new data). For primary data collection, describe the tools or approaches you will use to gather that data. Examples include: surveys, focus groups, key informant interviews, and document analysis. For primary data collection, indicate who is responsible for administering a survey or measure and the proposed schedule of data collection for each measure.

V. Analysis

In this section, describe the techniques and approach that will be used to analyze the evaluation data, both quantitative and qualitative. This would include a discussion of any statistical methods and analytic tools (e.g., SPSS, SAS, ATLAS.ti) that might be used. Also discuss any potential limitations to the data (e.g., self-report bias, variability in data collection across sites, missing data). Describe how stakeholders will be engaged in the analysis and interpretation of evaluation data.

VI. Dissemination & Utilization

In order to ensure utilization of evaluation results, it is important to consider how findings will be communicated and used to inform program implementation decisions. Describe how evaluation data and findings will be shared with both internal staff and external partners, including the timing and/or frequency of reporting evaluation results. Identify any methods or approaches that will be used to disseminate the results of the evaluation. To help with this, think back to your original purpose/goals of the evaluation and the potential users of your evaluation. This will help you determine who the primary audiences are, the information to share with them, and approaches to sharing that information (e.g., 1 page brief, newsletter, formal presentation, etc...).

Discuss how data will be used to guide program improvement efforts. Describe your process or approach to engaging staff and/or other key stakeholder in the interpretation of data, including how often this will occur. Discuss how you plan to work with stakeholders to determine the implications of evaluation findings for your Care Coordination program. Describe your plan for revisiting (and updating) your evaluation plan.
VII. Evaluation Work Plan (see attached sample table)

Please note that you will complete a separate work plan table for each intervention or strategy to be evaluated. If any of the interventions or strategies represent specific Promising Practices/ Evidence-Based Practices/ Evidence Informed Practices, please indicate in the Intervention/Strategy section of the work plan table.
**Evaluation Work Plan**

[insert date]

**Intervention/Strategy:** Utilize community health workers (CHWs) to provide care coordination support to diabetic patients

- **Promising Practice/ Evidence-Based Practice/ Evidence Informed Practice (if applicable):**

<table>
<thead>
<tr>
<th>P/O</th>
<th>Evaluation Questions</th>
<th>Indicator(s)</th>
<th>Data Source/ Instrument</th>
<th>Methods</th>
<th>Target Population</th>
<th>Timeline</th>
<th>Individual responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>How many patients have the CHWs referred for health and/or other social services?</td>
<td># of referrals made by CHW’s to other providers</td>
<td>Electronic health records (EHR)</td>
<td>CHWs record referrals into EHR or tracking sheet</td>
<td>Data captured at time of referral, compiled monthly</td>
<td>Community Health Worker</td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>Are patients able to more effectively manage their diabetes as result of care coordination services?</td>
<td>% of patients achieving A1C control</td>
<td>Biometric testing</td>
<td>Patients tested at regular physician visits</td>
<td>Bi-annually</td>
<td>Clinic staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patients possess greater self-efficacy for managing their diabetes</td>
<td>Patient pre/post survey</td>
<td>Survey patients at intake and follow-up</td>
<td>Patients Survey at initial intake and then at each annual visit until discharge</td>
<td>Clinic staff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*In the first column, indicate whether each question is a process (P) or outcome (O) question*