EVALUABILITY ASSESSMENT OF A NATIONAL REHABILITATION AGENCY FOR THE BLIND USING A QUALITY ASSURANCE APPROACH

BY

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JANET MARY HANEVELT

A Practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

ABSTRACT

Evaluability Assessment has made it possible for those agencies which are not prepared for a program evaluation the opportunity to develop program models in which all stakeholders may benefit. The Quality Assurance Approach has challenged and motivated service providers within the human service field to address issues associated with service quality. Interventions from these program evaluation approaches were utilized for the purpose of developing a program logic model and analyzing the service delivery process within the Canadian National Institute for the Blind (CNIB) Manitoba Division, Client Services Department.

Results indicate that CNIB direct service staff valued this opportunity as demonstrated by their participation, their ability to analyze individual practice skills within the broader context of service delivery, and their expressed desire to replicate this specific aspects of this research in order that all (staff and consumers) would benefit. Consumer participants reported that immediate contact and client centred goal formulation were critical issues in the promotion and enhancement of service quality. Differences in consumer responses revealed that seniors valued an empathetic approach, while younger clients considered service accessibility and self-determination as key elements in the provision of high quality service. Comparisons between staff and consumer input indicated that improved skills and a greater

understanding of the techniques associated with assessment and intervention strategies are needed to ensure that "quality of care" issues are addressed in a more effective manner.

In summary, this process demonstrated the importance and relevance of having key stakeholders (staff and consumers) as participants during the evaluation process. As well results from this practicum research demonstrate the need for continuous evaluation in order to enhance service accountability and improve strategic and program planning.

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Without the love, understanding, patience and support of my husband, Manford (Manny) and my two beautiful children Emma and Andrew, I would not have achieved my Master of Social Work degree. I love you!

It was only because of the endorsement and support of Mr. G. Dean Cousens, Executive Director of CNIB Manitoba Division, and the commitment and dedication of the CNIB Client Services Department direct service staff that this research project became a worthwhile and beneficial success.

Finally, to my friends and family members from near and afar, thank you so much for your faith, encouragement and support. I knew you were all behind me!

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CHAPTER 1

Practicum Overview

The Canadian National Institute for the Blind (CNIB) is a national not-for-profit human service agency which provides rehabilitation services to blind and visually impaired Canadians. The CNIB offers these services through nine divisional offices including, British Columbia - Yukon, Alberta - Northwest Territories, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, Nova Scotia - Prince Edward Island, and Newfoundland - Labrador. The research conducted for this practicum report is focused on the program model and service delivery process within the Canadian National Institute for the Blind (CNIB) Manitoba Division, Client Services Department which is located in Winnipeg, Manitoba.

Specifically, two types of program evaluation techniques were used for the purpose of developing an understanding of the relationship of services to the divisional and national organizational mandate. The first program evaluation approach used was that of evaluability assessment. Techniques within this approach assist agencies in preparing for future program evaluation. As such evaluability assessment is said to be a pre-evaluation approach. The second program evaluation approach used within this practicum research was that of Quality Assurance. The quality assurance approach of program evaluation within the human

service field is relatively new. Its success in the Japanese marketplace and in North American health care has been encouraging thus examples of quality assurance programs are becoming more commonplace across Canada and the United States. The theory and applications of these approaches are discussed in **Chapters 2** and **6**.

During the past four years, I have been employed with the CNIB Manitoba Division in two management portfolios: District Administrator of North District and, more recently, Director of Client Services of CNIB Manitoba Division. During this time frame, considerable changes have occurred within the rehabilitation services area.

Within Manitoba, CNIB has been forced to make difficult decisions affecting service, based on limited information. This being the case, it seemed timely to utilize this research opportunity along with the knowledge and experience gained as a manager of client service, to examine the service delivery process so that future decisions could be made with more knowledge, confidence, and expertise.

In preparing for this research, it was evident that a clearly defined program model did not exist within CNIB Manitoba Division. While agency documents define standards for each "core" service discipline and national policies guide several service practices, well

defined program goals and objectives were and are not present. As a result, an evaluation of program effectiveness is not seem feasible or practical at this time. It was also evident from interviews with other service managers and direct service staff that the association between direct service activities and the organizational mandate, i.e., goals and objectives, was not easily explained or understood. As will be discussed, in **Chapter 2**, evaluability assessment allows agency staff to participate in activities which result in the development of a clearly defined program model, thus forming the basis on which this practicum is conducted.

In **Chapter 2**, a presentation of relevant literature pertaining to program evaluation, evaluability assessment, and quality assurance, is provided. An overview of program evaluation, its purpose and functions, is discussed. Second, techniques associated with evaluability assessment are described. Specific attention is focused on the development of definitions of a mission statement, goal(s), objective(s), and activities(s). Third, a discussion of literature pertaining to the use of quality assurance techniques, with specific emphasis on the evaluation of standards of practice through a "peer review" process, is presented. In addition, with the recent focus on consumer feedback, motivated by the implementation of the CNIB National Core Services Review, it seemed essential to obtain client comments relative to their experiences with this agency.

In **Chapter 3**, a description of the CNIB national and divisional organizational structures is presented. A recent history of structural changes within CNIB Manitoba Division is given as these changes have had an impact on service delivery.

In **Chapter 4** personal learning and service objectives for this practicum research, are outlined. In addition, a rationale for this practicum research is provided.

In **Chapter 5**, the interventions used to complete the evaluation experience within CNIB Manitoba Division, Client Services Department are outlined. Interventions included, qualitative interviews and questionnaires, focus groups, peer review techniques, and consumer feedback.

In **Chapter 6**, a description of the findings in association with each phase of the practicum is discussed followed by analysis from an evaluator's perspective. At the end of the chapter conclusions relative to my performance are discussed in accordance with the achievement of the learning objectives as outlined in Chapter 4. Finally additional comments regarding my performance are shared using statements from the "Utilization Enhancement Checklist" (Brown and Draskamp, 1980).

In the final chapter, conclusions regarding the relevance and applicability of the evaluation techniques used to complete this practicum research are presented. In addition, statements regarding the overall learning experience are offered. Recommendations relative to the effective use of evaluation for the purpose of promoting quality service delivery within the agency are also discussed.

CHAPTER 2

Literature Review

Within this chapter the literature reviewed in support of the evaluation at CNIB Manitoba Division, Client Services Department is presented. The first part of this chapter is focused on a discussion of program evaluation and its particular relevance to this organization. To ensure evaluation success specific organizational considerations must be addressed in preparing the evaluator for the negotiation and implementation of an agreed upon evaluation plan. Factors such as organizational climate, structure, evaluator expertise, and costs, are discussed in preparing the foundation and rationale on which this evaluation is conducted.

Second, evaluability assessment, a specific evaluation approach in which techniques are applied for the purpose of conducting a pre-evaluation are discussed. Once the evaluator has a basic understanding of the organization, an assessment of the organization's readiness for a program evaluation must be determined. Evaluability assessment was developed to assist established programs in creating a favourable climate for future evaluation by acquiring "an intimate acquaintance with an agency or program that would aid in the evaluation design" (Rossi and Freeman, 1985, p. 99). In developing an understanding of the

organization, the evaluator must involve management and staff in formulating a model in which official agency documents are developed in conjunction with the described experiences of staff and management involved in providing the service.

Finally, quality assurance literature is reviewed with particular emphasis on the role of "Peer Review" and consumer satisfaction from which CNIB's service delivery process is defined and analyzed. In the current economic climate, attention to issues related to "quality" service as opposed to "quantity" service is considered vital to organizational survival. Increased pressure is forcing agencies like the CNIB to be more accountable as donors and supporters who ask tough questions about service provision. Furthermore, the techniques associated with quality assurance make it possible for agencies to develop internal evaluation mechanisms in which those who provide the service are expected to continually evaluate service delivery in order that issues of "quality" are maintained or improved.

The literature pertaining to program evaluation, evaluability assessment, and quality assurance was selected because of its particular relevance to the evaluation conducted with CNIB Manitoba Division. It is reviewed, critically analyzed and utilized to provide support for the specific approaches used in conducting an

evaluation of the existing program model and service delivery process within the Client Service Department of CNIB Manitoba Division.

PROGRAM EVALUATION

Program evaluation techniques have been utilized within the human and social services as far back as the 1930's. However, it was not until after World War II in response to a dramatic increase in social programming, that formalized and recognized evaluation techniques were universally applied (Rossi and Freeman, 1985). These authors state that evaluation research ". . . . is the systemic application of social research procedures in assessing the conceptualization and design, implementation, and utility of social intervention programs" (p. 19). After the evaluator determines the class in which the particular program fits, selecting the appropriate evaluation approach and methodology becomes challenging as managers of human service agencies try to: 1) define the evaluation problem; 2) identify evaluation questions; and 3) determine who within the agency should be involved.

Getting Started

Program managers, decision-makers, policy-analysts, direct service staff and others must answer several questions before an evaluation plan can be negotiated and implemented. Herman,

Morris, and Fitz-Gibbon (1987) recommend that managers follow four phases in preparation, implementation, and completion of a program evaluation.

In **Phase A** the evaluator is to "set the boundaries" of the evaluation including: 1) determining the purpose of the evaluation; 2) gathering information about and describing the organization; 3) focusing evaluation questions; 4) negotiating the evaluator's role; and 5) developing a tentative agreement about the evaluation plan.

In **Phase B** the evaluator is to select appropriate evaluation methods including: 1) refining the program description; 2) assuring that correct questions are being asked; 3) determining the course of action that will result after data is collected; 4) designing a plan for program implementation; 5) designing a progress monitoring system; 6) consolidating evaluator's concerns; 7) estimating the cost of the evaluation; and 8) drafting a final agreement.

Phase C is focused on the collection and analysis of data including: 1) developing or purchasing of evaluation instruments; 2) setting deadlines for data collection; 3) determining expectations for interpretation of data; 4) ensuring that the data collection plan is implemented appropriately; and 5) that data is analyzed in accordance with the plan.

Finally, **Phase D** outlines steps associated with the reporting of findings including: 1) a discussion about the appropriate communication of research findings; 2) determining a follow-up plan; and 3) leaving a record of the evaluation.

While all of the above phases are seen as being critical in ensuring that an evaluation is carried out from beginning to end, in an effective manner, the steps outlined in Phase A of this process are of particular relevance to this practicum evaluation. Setting the boundaries on which an evaluation is focused provides direction for the evaluator and assures managers that the evaluator understands the organization and its needs. In determining evaluation parameters, information must be gathered about the program through an understanding of the client population, program goals, objectives and activities, the mandate of the organization, the history of the program and/or the organization and the service delivery process. In addition, the evaluator must gain an appreciation of the general purpose of the program and organization, expectations of clients and/or staff relative to evaluation, the views of other stakeholders as well as any concerns (Stecher and Davis, 1987).

In addition, Rossi and Freeman (1985) state that agency decision-makers or managers must reach agreement on the following points:

"(a) the program components to be analyzed, the design of the evaluation and priorities for understanding the work;

(b) the commitment of required resources and agreement on necessary cooperation and collaboration;

(c) a plan for utilization of the evaluation results; and

(d) a plan for efforts required from program staff to strengthen the evaluability potential of program components not usually amenable to evaluation, and an approach to subsequently building them into the evaluation effort" (p. 90).

Other factors which must be considered before an evaluation plan can be finalized include: 1) an understanding of organizational structure and climate; 2) identifying evaluator expertise; 3) identifying evaluator constraints and agency costs; and 4) an understanding of the politics which influence decision-making, and program and strategic planning (Gerloff, 1985; Robbins, 1983; Herman et al, 1987; Rossi and Freeman, 1985; Patton, 1978; Weiss, 1973; and Neugeboren, 1985).

It is through the assessment of the above factors that the evaluator makes his/her final judgement as to the type of evaluation approach best suited to meet the agency's needs. Herman, Morris and Fitz-Gibbon (1987) state that organizations preparing for evaluation may be conceptualized within four classifications. They are: 1) **program initiation** which applies to those organizations in which new program initiatives are being

developed; 2) **program planning** in which established programs are being changed or altered; 3) **program implementation** applies to those organizations in which new initiatives have been recently installed and require assessment; and 4) **program accountability** applies to those established programs in which issues of efficiency or effectiveness are being questioned.

Rossi and Freeman (1985) conceptualize organizations preparing for evaluation within three phases: 1) **program conceptualization and design** in which interventions are examined in terms of their ability to respond to the identified social problem as originally intended; 2) **monitoring and accountability of program implementation** in which the organization is concerned with measuring its efficiency relative to defined goals and in response to stakeholders perceptions (p. 38-39); and 3) **assessment of program utility** in which it "is critical to know both the degree to which a program has an impact and its benefits in relation to its costs" (p. 40).

From the literature pertaining to organizational classifications, CNIB Manitoba Division falls within the **conceptualization or design stage** of Rossi and Freeman's (1985) process or within **the program planning phase** of Herman, Morris and Fitz-Gibbon (1987) process as both schema require that a program be previously established. Although by definition, the program planning phase refers to those established programs in which

particular aspects of the program are being changed or altered, in the case of CNIB, structural changes have resulted in changes within specific activities performed by many CNIB direct service staff thereby having an impact on the manner in which service is provided. In applying the schema in accordance with Rossi and Freeman (1985), it is concluded that CNIB may fit within the first phase, **conceptualization and design**, as a portion of this evaluation is concerned with assessing agency interventions, i.e. the CNIB service delivery process, relative to its responsiveness to the social need which in the case of CNIB is that of assisting blind and visually impaired people to lead satisfying lives.

Having gathered the necessary background information about the organization and decided in which phase the organization fits, the evaluator must select in cooperation with decision-makers the evaluation approach to be used in response to identified evaluation questions. Stecher and Davis (1987) identify five evaluation approaches. The **experimental approach** emphasizes research design and is focused on the effects that result from program activities. The **goal-oriented** approach emphasizes goals and objectives and focuses on the definition of program goals and objectives and their measurement. The **decision-focused** approach emphasizes decision making and is focused on which decisions need to made and the relevance of those decisions. The **user-oriented** approach emphasizes the information users and focuses attention on the intended users of the services and

the usefulness of those services. Finally, the **responsive** approach emphasizes personal understanding and is focused on people who have a stake in the program and their points of view.

Thus far it has been stated that an evaluation of CNIB must address factors associated with program planning or changes in service activities which have had an impact on service delivery, and conceptualization or design in which questions regarding the appropriateness of agency interventions must be asked in association with program goals and objectives, in this case, assisting blind and visually impaired people in achieving personal independence. As stated above the next phase in setting an evaluation plan is the selection of the evaluation approach. From the description of the five evaluation approaches above, a combination of the goal-oriented and responsive approaches is most relevant to CNIB. Within the goal-oriented approach, the evaluator must determine the agency's program goals and objectives before measurement of their effectiveness can be analyzed. Within the current evaluation only the identification of program goals and objectives are addressed. Measurement of goal and objective effectiveness will have to be evaluated at a later date. The responsive approach is relevant to CNIB as both staff and consumers have a considerable stake in the program or services. Because of their intense involvement, it is suggested that their points of view must be considered should further changes within the Client Services Department be implemented.

From the literature presented above, the program evaluator receives guidance relative to the factors for consideration in preparation for the implementation of a successful evaluation plan. In addition, the evaluator obtains knowledge relative to the conceptualization of organizational classifications. Knowledge gained through a review of these readings is of assistance in organizing the plan of action in terms of gathering the necessary data to negotiate a final agreement with agency decision-makers.

As a student and a beginning program evaluator, the above information has helped to organize my thinking and prepared me for the negotiation of a relevant evaluation within the context of CNIB Manitoba Division. Furthermore, the conceptualization of evaluation phases has guided my decision regarding the selection of the specific evaluation approaches from which an evaluation of CNIB Manitoba Division would benefit. And finally, the framework presented by Stecher and Davis (1987) pertaining to evaluation approaches has enabled me to focus the evaluation plan.

In critically analyzing the literature presented, the information provided by Herman, Morris and Fitz-Gibbon (1987) is basic yet critical to evaluation success. However, more emphasis aimed at discussing the importance of gathering information pertaining to organizational structure and climate would be of assistance to evaluators embarking on a review of large and complex organizations. Herman, Morris and Fitz-Gibbon (1987) and Rossi

and Freeman (1985) provide useful conceptualizations of evaluation phases, however, their frameworks do not address the complexities of organizations in which evaluations are being considered. As a result it was a challenge to determine which classification best pertained to the CNIB experience. In fact, in both cases the current situation at CNIB may cross more than one phase. Future work by these authors may indicate a more systemic view in presenting these concepts. Finally, Stecher and Davis (1987) suggest that in deciding the appropriate evaluation approach, a choice of one may be preferred. However, in considering the particular needs of CNIB more than one approach is relevant. Again, more emphasis on the process of selecting an approach or a series of approaches is seen as necessary especially in the case where stakeholders viewpoints are varied.

Data Collection Phase

After gathering basic information about the organization a detailed review of factors such as the organizational climate and structure, views of the stakeholders, cost and evaluator's role must be conducted. An analysis of this data will assist in determining the methodologies or interventions from which evaluation questions will be answered. However, prior to gathering this information it is necessary to determine with managers or key decision-makers what program component will be evaluated, who will be involved, and from whom information will be collected.

The decision regarding the evaluation at CNIB Manitoba Division was negotiated between the Executive Director and the District Administrators of Winnipeg and South/east districts. A review of program evaluation literature in conjunction with practical experience with this agency revealed that staff would develop a better understanding of their roles and functions through the clarification of program goals and objectives. It was also noted that through a review of cases using pre-determined service delivery criteria, CNIB staff would increase their understanding of the relationship between service delivery and the organizational mandate. In addition, it was also decided that a review of specialized programs such as Service to Deaf-Blind People, the Recreation Program, the Peer Group Program, and Occupational Therapy for Pre-Schoolers, be excluded from the current research as the future of these programs are more vulnerable to the affects of fiscal restraints than those programs mandated by National Office. Therefore it was decided that direct service staff who represent the seven "core" service areas should be involved. In addition, consideration of consumers points of view were seen as enhancing results.

With the evaluation focus determined, an analysis of the organizational structure, climate (including politics), resource allocation and evaluator's role can be completed.

Organizational Structure

In reviewing the organizational design literature there are three structural configurations which form the basis on which conceptualization of the CNIB's organizational structure may be understood. Within this section the characteristics of bureaucracy, adhocracy (matrix structure), and the divisional form are discussed.

When considering the characteristics of the bureaucratic structure, one must delineate between traditional or classical **machine** bureaucracy and the **organic type** of bureaucracy which is referred to as **professional** bureaucracy. Max Weber was the original writer and developer of **traditional** or **machine** bureaucracy. "In his work we find the first comprehensive definition of bureaucracy as a form of organization that emphasizes possession, speed, clarity, regularity, reliability, and efficiency achieved through the creation of a fixed division of tasks, hierarchal supervision, and detailed rules and regulations" (Morgan, 1986, p. 17). In his book **Organization, Policy, and Practice in the Human Services**, Neughboren (1985) states that the machine bureaucracy has the following characteristics: 1) a system of rules which are defined in the policies of the organization; 2) sphere of competence in which performance is measured against organizational rules; 3) hierarchy; 4) knowledge base which emphasizes the use of technical skills; and 5) exclusion of personal considerations (p. 93).

In response to many of the limitations of the **machine** type of bureaucracy, a more contemporary type of bureaucracy has emerged, the **professional bureaucracy**. The **professional** bureaucratic form has many characteristics of traditional Weberian bureaucracy with some distinct features. Morgan (1986) states that the "professional bureaucracy modifies the principles of centralized control to allow greater autonomy to staff and is appropriate for dealing with relatively stable conditions where tasks are relatively complicated" (Morgan, 1986, p. 56).

Structurally, the professional bureaucracy is flat. The strategic apex (decision-makers of the organization, e.g., executive directors, boards), middle line (middle managers, such as the Director of Client Services) and technostructure (manager consultants within the organization, such as the Director of Finance and Adminstration, the Director of Development) are relatively small in size while the operating core (the staff who provide the primary service in association with the organizational mandate) is large. The support staff area (clerical positions, policy analysts) is larger than the strategic apex, middle line, and technostructure, however, it is smaller than the operating core. Standardization of skills is emphasized through training. Agency policies and procedures are developed out of the knowledge and expertise brought into the organization through professional education. Functionally, decision-making authority is determined by members of the operating core rather than the strategic apex.

The administrators' role (strategic apex, middle line, and technostructure) is to buffer the operating core from outside interference rather than to direct the activities of the workers. The purpose of the support staff function is to provide support to the operating core. The **professional bureaucracy** is seen most in hospitals, social work agencies and engineering firms (Robbins, 1983, p. 195).

The second major structural form is called **adhocracy**. **Adhocracy** is defined as a "rapidly changing adaptive temporary system organized around problems solved by groups of relative strangers with diverse professional skills" (Robbins, 1983, p. 210). Organizational structures of this kind are said to have moderate to low complexity; the hierarchy is relatively small and simple, few formal rules and policies, and low centralization, in other words, decentralized decision making.

Although there are several types of adhocracy, including task forces and committees, the most dominant type is the **matrix structure**. "There is a normal vertical hierarchy, within functional departments, which is "overlayed" by a form of lateral influence" (Robbins, 1983, p. 214). Unlike a bureaucracy, the matrix has a dual chain of command. Employees who work within this type of organization have two bosses, a functional supervisor and project supervisor. The functional supervisor has responsibility for all performance related issues. The project supervisor has

supervisory responsibilities for employees relative to specific activities relating to the completion of the project.

The final structural form is the "**divisional structure**." The **divisional structure** is characterized by the following: 1) it is designed to foster well contained units; 2) each division is autonomous being responsible for its decisions and performance and; and 3) central office oversees the whole operation relative to the development of performance standards and strategic planning (Robbins, 1983, p. 232).

Although the CNIB clearly defines itself as a bureaucracy, characteristics of both the traditional and professional bureaucratic models are present. In addition, characteristics inherent in adhocracy, specifically the matrix structure and the divisional structure are present. It is apparent that the administrative sector of the CNIB operates like a traditional bureaucracy while the service area has more of the characteristics of professional bureaucracy. This is in part due to the fact that administrative tasks require traditional knowledge to perform clearly defined tasks while service provision requires social skill to perform more abstract duties.

Characteristics associated with adhocracy and in particular, matrix structures are present within the service, fund development, and communications departments of CNIB Manitoba Division. CNIB

Manitoba Division has two offices, the Divisional Service Centre, located in Winnipeg, and the West District Office, located in Brandon, Manitoba. The manager, namely the District Administrator of West District, reports directly to the Executive Director. As such, this position is parallel to the positions of Director of Client Services, Development, and Communications. However, the latter three positions have the additional responsibility of overseeing operations for the province as it relates to the specific program area.

Finally, CNIB Manitoba, being one division among eight others across Canada, by design, has the characteristics of divisional structures as described above.

Although CNIB's organizational structure is not being analyzed within this research, it is essential that the primary features of the bureaucratic model be understood. Since most direct service staff have been trained professionally in human service professions and taught to regard professional autonomy, exposure to traditional bureaucratic processes has been somewhat challenging. Fortunately, within CNIB Manitoba Division there is a high regard for the ideas and concepts expressed by direct service staff as evidenced by comments shared by other professionals and CNIB management. As such, professional autonomy is permitted, in

practical terms, as direct service staff are perceived as having "expert" knowledge and skills in the field of blindness and visual impairment as well as client service.

An understanding of organizational design theory is critical within this evaluation because of the nature, size and complexity of the CNIB organizational structure. It is essential that an understanding of the type or types of structure(s) which influence organizational function be considered before evaluation implementation. What is noted, through the literature described above, is that CNIB's national and divisional organizational structures are defined and typically operate like traditional bureaucracies. However, within the Client Services Department of CNIB Manitoba Division the manner in which direct service staff report to their respective supervisors demonstrates the characteristics commonly associated with that of a professional bureaucracy as defined above. Furthermore, it is important that an understanding of the divisional structure form be achieved as CNIB Manitoba Division is one of several other divisions. Although divisional offices are given the discretionary powers regarding procedures and program planning, policy and financial decisions must be made with the endorsement of CNIB National Office staff and/or the National Council.

It is however noteworthy, that the authors cited within this section, do not state that organizations may have the characteristics of several organizational structural forms. This may be due to the

fact that an explanation of these theories is too difficult and examples of multiple organizational design structures may be too complex to illustrate.

Organizational Climate

The researcher must also understand the organizational climate. Knowledge of organizational changes and political factors which influence organizational functioning should be assessed before evaluation commences. Over the past four years, CNIB Manitoba Division has undergone two significant structural changes. These changes have affected service provision and individual work patterns of several staff members.

Furthermore, internal politics influence program evaluation. Weiss (1973), Campbell (1986), Stecher and Davis (1987), and Herman, Morris, and Fitz-Gibbon (1987) stress the importance of attending to organizational politics. According to Weiss (1973), not only are politics inherent in the evaluation process, but the political influence of organizational decision-makers is seen as having a direct relationship to evaluation success. She states that the further removed decision-makers are from the evaluation itself, the more dispassionate they may be. Second, Weiss (1973) states that decision-makers are primarily concerned that the values of the organization are upheld. Third, she advises that the value and belief systems of decision-makers must be acknowledged if results are to judged as credible.

In the case of the CNIB, while the Executive Director was involved during the negotiation phase of the proposed project, he was not directly involved with the project during its implementation. It is therefore anticipated that the Executive Director may not be concerned with all of the detailed results; rather he may be more concerned with the final results and their relationship to improved service quality.

Second, in CNIB Manitoba Division, quality service provision is highly valued by the Executive Director, the Divisional Client Services Committee, and the Divisional Board of Management. As a result any improvements to service quality which do not represent additional cost to the agency are expected to be viewed positively. It should be noted that the Executive Director and all Divisional Board of Management members are primarily concerned that service provision to clients be handled in a prompt, respectful, and effective manner. In addition, strict adherence to national and/or divisional policies and procedures pertaining to client service are considered to be an important attribute of service quality.

An appreciation of the political factors which influence evaluation success are seen as relevant to the current research as the approval of the Executive Director and members of the Client Services Committee is required before staff or clients can be

involved in research activities. This reality coupled with knowledge of the organizational structure are critical if evaluation findings are to receive serious consideration by decision-makers.

Considering Stakeholders Views

Campbell (1986) stresses the importance of tailoring the evaluation to meet stakeholder demands. She recommends that the evaluator involve agency decision-makers during the evaluation process, present a clear and well organized description of the project, assess face validity of all evaluation instruments, articulate a plan for the use of the results, and plan a strategy for dissemination of the final report. In the early development phases of this practicum the Executive Director and the District Administrators of Winnipeg and South/east Districts were involved with the negotiations of this practicum. To ensure that management and staff understood the parameters and purpose of this project, a written document describing the evaluation process was distributed to managers and staff.

To encourage the cooperation of agency stakeholders, a "responsive" (Stecher and Davis (1987), or "action-oriented" (Hudson, Mayne and Thomlison, 1992; Whyte, 1991) approach was used. These authors state that clients, staff participants, and middle line and senior managers, viewpoints must be considered if evaluation results are to be viewed as credible. Myers (1992) states that, "Whatever the type of program . . . . they [participants]

have the right to expect a safe and beneficial program (p. 294). She further states that involving service staff and managers of direct service in the negotiation and evaluation plan will aid in its success as quality of information gathered throughout the evaluation may be better. Third, Myers (1992) states that administrators and senior managers must: 1) be involved in the planning process; 2) understand the uses and purposes of evaluation; 3) be given recognition for their efforts; and 4) have the support of other organizational stakeholders (p. 299).

These approaches involve users in all phases of the evaluation including: 1) design development; 2) formulating questions; and 3) analyzing the results and disclosing research findings. Because of the organizational structure and climate of the CNIB and the high regard that staff hold relative to participation, incorporating the characteristics of these approaches was seen as critical to the success of this evaluation.

Evaluator's Role

Managers must consider evaluator expertise before an evaluation plan may be implemented. Should an external or an internal evaluator be employed? The advantages of contracting an external evaluator are that: 1) evaluation expertise may be more advanced; 2) objectivity or distance from the organization may be seen as necessary; 3) organizational human resources may not be available; and 4) cost may not be a factor. The advantages of

internal evaluation are that: 1) the evaluator has a longstanding relationship with the organization; 2) recommendations have better chance of being implemented; 3) the evaluator usually has a good generalist knowledge; and 4) it is an investment within the organization (Love, 1992). In addition, to the advantages stated above, internal evaluation does not produce any additional costs to the agency and the agency can agree to re-evaluate program components whenever it is deemed necessary.

Costs

In any program evaluation there are direct and indirect costs associated with the completion of this type of project. Contracting with external evaluators results in high direct costs for any agency. In many cases it is not necessary that an agency employee an outsider unless the expertise is not available within the organization or the perceived problem is too broad to be addressed by internal human resources. It is suggested that decision-makers consider the cost factor before finally deciding who should do the work.

As part of the negotiation process it was stated that a clearly articulated program model was not in existence within the Client Services Department. It was also stated that criteria on which the service delivery process could be evaluated was not present. Because CNIB managers in conjunction with the Executive Director viewed these issues as important, conducting an

evaluability assessment using techniques from quality assurance evaluation were selected as the approaches through which the above issues would be addressed.

EVALUABILITY ASSESSMENT

Before one can conduct a program evaluation, it is critical to assess the agency's readiness for such an endeavour. The researcher must have an understanding about the organization's history, structure, climate and mandate. Obtaining and reviewing information pertaining to the organizational chart, agency policies, and additional documentation stating the agency's mission, goals, and objectives provide a basic understanding of the agency from which the evaluator can proceed (Stecher and Davis, 1987; Rutman, 1980; Rutman, 1984; Kellberg, 1989).

As this term suggests **Evaluability Assessment** is referred to as pre-evaluation process aimed at determining whether or not an organization is ready for an evaluation. Identification of gaps in the definition and understanding of the specific program help the evaluator prepare the organization for future evaluation(s). (Rutman, 1980). The primary purpose of Evaluability Assessment is to "determine whether the program's objectives are conceptualized and operationalized in a way that would permit meaningful evaluation" (Gabor and Grinnell, 1994, p. 19).

Evaluability Assessment Process

Rutman (1980) states that there are four phases of Evaluability Assessment. These include: 1) preparation of a "Program Documents Model"; 2) interviewing program personnel for the purpose of defining a Program Manager's Model; 3) collecting data form the field to determine what really is happening; and 4) preparing an "Evaluable Program Model" for the purpose of depicting program components, goals/effects that may be considered for inclusion in an evaluation.

To develop a Program Documents Model, it is necessary to gather all agency documentation which describes the agency mission, goals, objectives, activities. In addition, policy and procedures documents and memorandums should be reviewed for the purpose of gaining an understanding of service provision.

The second stage of Evaluability Assessment as articulated by Rutman (1980) is interviewing program managers and staff for the purpose of defining a Program Manager's Model. Interviews are intended on eliciting detailed and descriptive information for the purpose of "filling the gaps" that may exist after a review of formal documents is completed.

Stage Three of the Evaluability Assessment process is to go out into the field for the purpose of finding out what is really happening. "The aim is to better inform the evaluator about the

program, not to draw definitive conclusions about the program's operation or impact" (Rutman, 1980, p. 106).

The primary purpose behind Stage Four of the Evaluability Assessment process is to develop an "Evaluable Program Model." Within this phase the evaluator combines all previous data to decide what program components are to be evaluated.

The literature described above has particular relevance to this evaluation as it defines the process within which an evaluator may guide his/her data collection about the organization. In addition, the literature points out the significance of the views and experiences held by stakeholders who may be impacted by evaluation findings. However, it is unclear from the literature reviewed thus far, what characteristics are needed to define a program model from which future evaluation can be implemented. Within the next sections, through the work of Gabor and Grinnell (1994) and Unrau (1993), an understanding of the attributes of a program logic model are described. These attributes are seen as fundamental to the development of a well conceptualized program model from which definitions and clarifications of service delivery may be formulated.

Definition of Mission Statements

An agency mission statement must be broad enough to meet the ongoing need of a large enough population of individuals in order

to sustain the agency's existence. Therefore, an agency's mission statement must be worded such that it will require only minor changes over time. It is intended to be broad in scope such that on a year by year basis the organization is legitimized. In the case of non-profit human service agencies, mission statements are scrutinized by funders, donors, and consumers. If the public perceives that the mission is out of date or the agency is not fulfilling the mandate as articulated, organizational survival may be jeopardized (Neugeboren, 1985).

After an organization is established it is necessary to clearly define and articulate, in the form of a philosophical statement, whose need will be met and what outcome(s) is expected or anticipated. From this statement all goals, objectives and activities should be logically linked. "In short, mission statements guide the conceptualization and operation of the program within the agency so that the programs will help the agency work towards its goals" (Gabor and Grinnell, 1994, p. 45).

In the case of the CNIB, according to historical agency documents, the CNIB established itself as a voluntary agency with the basic aim of helping blind and visually impaired people find ways to lead satisfying lives. Underlying all CNIB services is the belief that blind and visually impaired people can be integrated into the mainstream of community life, according to their ability to function within that community (CNIB, Manitoba Division, Client Services

Handbook, p. 4). In other words, CNIB's mission is to help blind and visually impaired persons, through its rehabilitation services, to become as independent as their abilities allow or permit.

An understanding of the theory behind the development of agency mission statements was seen as relevant as it assists participants in their thinking and helps guide the process of program goal and objective formulation. Discussion about the definitions of mission statements in the literature is relatively brief and concise. In most cases there are no right or wrong rules relative to the clarification of agency mission statements; rather they requires a lot of discussion among decision-makers and stakeholders in order that the best and most appropriate words are chosen to describe the work of the organization.

Definition of Program Goals

From the mission statement, agency goals are defined. Organizational goals are broadly defined statements which should be logically linked to the mission statement. Generally goals highlight "the nature of the problem to be tackled, the client population to be served, and the general direction of anticipated client change" (Unrau, 1993, p. 122). Goals are not measurable statements; rather they serve "as a focal point to navigate the entire scope of the program operations in a specified direction, and, function as an umbrella under which all other program elements are logically assumed" (Unrau, 1993, p. 122).

According to CNIB National Office and CNIB Manitoba Division, program goal statements, as defined above, are not recorded in any formal agency documents. Rather descriptions of the primary functions of each of the "core' services are presented on "Fact Sheets".

Definition Program and Practice Objectives

Unrau (1993) in her article defines two types of objectives, **program** and **practice**. **Program objectives** must have the following properties: 1) they are the intended and measurable results that all clients in a program must strive to achieve; 2) they identify the general intervention approach offered to clients at a program level; 3) they capture the essence of the overall practice approach to working with a particular client group; 4) they are based on empirical knowledge and thus serve as the foundation of the program's service delivery system; and 5) they imply that without the aid of the program service, clients would not show improvement on the dimension targeted (p 123-124).

Gabor and Grinnell (1994) state that a **practice objective** is "referred to as the personal objective of an individual client, whether that client is a community, couple, group, individual, or institution" (p. 59). Practice objectives are also known as treatment objectives, therapeutic objectives, and client goals. As with program objectives, practice objectives must logically link to program goals and the mission statement. "The function of

measuring practice objectives is to provide indicators of change for a particular client on a specified dimension of behaviour, knowledge, or feeling (p. 60). This definition is consistent with Unrau's (1993) definition of practice activities. She states that "practice objectives are constructed by each practitioner in consultation with his/her client" (p. 125). From this literature it is evident that the characteristics of program and practice objectives are similar with one exception; program objectives are focused on program outcomes while practice objectives are intended to be formulated in cooperation with the client. As such, practice objectives are focused on client outcomes.

According to CNIB National Office, there are three primary (program/agency) objectives. They are:

1) to ameliorate the condition of the blind of Canada,
2) to prevent blindness, and
3) to promote sight enhancement services. (CNIB, Manitoba Division, Client Services Handbook. p. 5)

The first two objectives were developed and documented during the early developmental stage of the CNIB in response to the expressed needs of war blinded veterans in 1918. The third objective was added after the Sight Enhancement Enterprises (SEE) Program provided the necessary base funding to allow divisions across Canada to provide low vision services to Canadians. This objective was added in the 1980's. The addition of sight enhancement services expanded the target population of

clients such that anyone who perceived their visual loss as having an impact on daily activities could refer themselves or be referred to the CNIB. Those people with visual acuities greater than 20/200 (6/60) or with field diameters of greater than 20 degrees could now benefit from CNIB assistance.

From this literature, it is apparent that the three CNIB objective statements do not meet the definitions provided above. First, the statements are not measurable thus program effectiveness can not be evaluated. Second, these statements do not clarify the type of intervention to be used to move the client towards problem resolution, (i.e. client independence). Third, the statements do not make any reference to rehabilitation which is the practice approach on which CNIB's service structure was designed. Fourth, while historically within each division empirical research may have been conducted, knowledge acquisition was and is not a requirement in the development or establishment of new service initiatives at least at a divisional level. Fifth, although there is evidence to suggest that without CNIB services blind and visually impaired persons, in some cases, would have extreme difficulty in achieving independence, to date, formal evaluation of the effectiveness CNIB services has not demonstrated this to be a fact.

Definition of Activities

Activities are understood to be the final stage of the conceptual framework. Unrau (1993) defines activities as "actions or behaviours that move a client and practitioner toward the accomplishment of an objective" (p. 129).

CNIB National Policy does not provide clear guidance with respect to the fulfilment of primary activities within each core service area except through the CNIB National Service Standards, Positions, and Systems and Procedures Manual. Each division has the discretion to actualize how these activities will be achieved through job descriptions and program planning.

The literature presented above provides the evaluator with the necessary theoretical knowledge in the formulation of mission statements, program goals, program and practice objectives and program and practice activities. It is seen as relevant to this research as it is has been confirmed by management and staff that clear goal and objective statements are not in existence at the divisional level.

In conducting this research it was noted by participants that a distinction between program activities and practice activities be made. It may be of benefit to the agency to highlight its primary activities while having direct service providers articulate specific activities associated with client service.

QUALITY ASSURANCE

Quality assurance evaluation originated from the Japanese manufacturing sector (Fricke, 1991). Three strategies were employed for the purpose of competing against other countries in the market place. These strategies included: 1) upper management took charge of leading the new approach; 2) all levels and functions underwent training in quality management; and 3) quality improvement was pursued continuously (p. 437). The primary objective of this approach was to measure quality after the product was completed.

Interest in quality assessment in health care has evolved since the 1960's in the United States and later in Canada in response to rising costs in health care. In the past hospital administrators made decisions about medical social work programs based on the numbers of patients seen (service quantity) rather than on "quality of care." Over time systems and techniques were developed to allow the analysis of service quality.

Coulton (1979), a pioneer of quality assurance evaluation in the health care field, has been instrumental in applying quality assurance techniques to medical social work practice. She states that quality assurance "refers to activities designed to assess service systematically, to determine whether they comply with what are believed to be adequate service and to correct any observed differences" (p. 10). This definition suggests that quality

assurance can be applied as a continuous measure. Thus it is presumed that not all issues related to "quality of care" are resolved after one evaluation. Therefore, once deficiencies are corrected, evaluation of their effectiveness is assessed and further deficiencies are identified for resolution.

Osborne (1992) states that the quality assurance approach within the human service sector is to "to develop mechanisms which minimize the likelihood that poor quality services are provided" (p. 441). In his proposed model of quality measurement, Osborne (1992) distinguishes between quality assurance and quality control. "Quality assurance allows for the development of services rather than simply the correction of faults as they may occur. Quality control allows one to pick up on any problems which do occur and feeds them back into the quality assurance system for elimination" (p. 441). He proposes a three stage process for a program evaluation focused at service quality. **Stage One** requires that a clear service philosophy and a strategy which links this with identified needs be articulated. The primary purpose within this stage is to define the program model and ensure that service outcomes relate logically to program objectives. **Stage Two** is concerned with the process of service provision and outputs. Are the needs of the target populations being adequately handled? **Stage Three** is concerned with the relationship between service outputs and consumer outputs (p. 449-450).

In a subsequent article, Coulton (1982) defines five interrelated areas of quality assurance. When assessing "**input**" the primary question is, "Are services being delivered by qualified staff working in acceptable organizational structures?" "**Process**" answers the question, "Are service being delivered in accordance with accepted beliefs about what constitutes good practice?" "**Outcome**" answers the question, "Are services having the desired affects on clients?" "**Output**" answers the question, "Are services being delivered in sufficient quantity?" And finally, "**access**" answers the question, "Are clients who need services actually receiving them?" (p. 399-401). Coulton (1982) lists the appropriate techniques which will help evaluators assess a program based on these suggested questions. In addition, she identifies the limitations of evaluating practice process within each of the areas defined above.

The five interrelated questions described above can be located within the three foci of quality assurance. First, Coulton (1979) and Campbell (1986) state that quality assurance techniques can be applied in assessing the "**structure**" variable. The purpose of evaluation is to look at the adequacy of training, staff resource allocation, materials, and time. Questions relating to "input" and "output" are likely to be related to structure. The "**process**" variable assesses service provision by answering the question, "Are services being provided in accordance with acceptable beliefs about what constitutes good practice" (Coulton, 1982, p. 400).

The third foci of quality assurance is "**outcome**." Questions relative to the impact of service and whether or not services are provided in sufficient quantity are addressed. Thus questions related to "outcome" and "access" can be assessed through an analysis of the "outcome" variable.

In the evaluation of CNIB service provision, techniques were applied in association with what has been defined above as the "**process**" variable or focus. Although it may be argued that in all five conditions the questions relate to process or the various stages and/or factors associated with service delivery, "process" as defined by Coulton (1979) refers to the flow of the defined service. Issues relating to service provision, as defined by Coulton's (1979) third question, are of most concern to CNIB management at this time.

The reasons other questions were not identified is due in part to perceptions based on experience as an employee of the CNIB First, questions related to professionalism and competence have direct bearing on service quality, however, within the CNIB, because of the current organizational climate, focused attention on job performance is considered to be sensitive by those who provide client service.

Second, questions associated with the impact of service are seen as being critical to program effectiveness. As stated previously, it seemed necessary to develop a clearly defined program model from which a future evaluation of service impact could follow. Although feedback from consumers has been gathered, a more extensive review would be of benefit in assisting agency decision-makers in identifying strategic and program planning issues. While outcome evaluation questions complete the picture, given time constraints this has not been included as part of this research.

Third, questions related to service sufficiency and access also provide vital information about service quality however time did not permit an analysis of quality of service relative to adequacy. In negotiating a realistic evaluation plan, given the time constraints of both staff and the evaluator, the organizational climate, and after consultation with CNIB management, focusing on issues related to "process" were considered to be of most benefit at this point.

Coulton (1982) recommends that several techniques be considered when answering the question associated with "process." **Direct service audits** allow the evaluator to analyze service provision through case records using agency standards of practice as the guide. **Peer review** is a professional group process in which participants define criteria from which performance is evaluated. **Utilization reviews** judge "whether

particular services are justified based on criteria that define when a particular service is needed" (p. 399). **Client satisfaction surveys** determine whether on the basis of consumer feedback, service was provided appropriately. **Profile analysis** compares summary information, such as information from an automated service tracking system, against defined standards of practice. And finally, **direct observations**, allow the evaluator to observe practice skills of professionals to determine whether the application of skills flow from predetermined standards. With the exception of peer review many of these techniques have been borrowed from program and clinical evaluation research. However, peer review, qualitative interviews, focus groups, and client satisfaction interviews were seen as being of most importance and relevance to the current research within the CNIB.

The literature reviewed above provided the theoretical base on which an understanding of the quality assurance approach is achieved. This literature is very thorough in its explanation of the quality assurance process thereby increasing my knowledge and understanding of some of the specific techniques utilized within this type of evaluation approach. I was able to conceptualize, organize, and select the appropriate techniques from which research questions could be answered.

As with much of the literature presented within this chapter it was difficult to select the most applicable interventions as comparisons between the CNIB experience and those articulated within the articles did not easily coincide. Because the application of techniques associated with the quality assurance approach in the social work field is still at the early developmental stages, examples in the literature are difficult to find. This is not seen as a weakness of the literature, rather it reflects a lack of experience in applying this approach to date.

The Peer Review Process

The peer review process or technique is critical to quality assurance evaluation. Application of this technique has moved quality assurance evaluation to the forefront of evaluation research within the health care and more recently the social service field. Utilization of the peer review process has enhanced the program evaluation process because it may be used with existing staff, rather than an external evaluator. In addition, a number of secondary gains can be achieved by the agency employing this technique (Fricke, 1991). First, through the peer review process, professionals evaluate their own practice performance based on agency standards. One byproduct of this activity is that individual and group accountability is enhanced. Performance is not based on supervisory feedback which is frequently the case. Second, through this process, professionals define the standards of practice, or in the case of CNIB, the service delivery process,

based on the goals of the agency and activities associated with their positions. Finally, issues pursuant to service quality are addressed rather than attention being focused on service quantity. In general, through the peer review process motivation may be enhanced as professionals critique their own performance within their peer group. From information gathered through peer review other issues relative to service provision may be addressed by management, such as sufficiency, professionalism, program planning, and service costs.

From the literature two examples of the utilization of peer review were identified. Coulton (1979) conducted a comparative analysis of several hospital social work programs across the United States. She suggests that Quality Assurance Programs should have the following attributes established: 1) an identified patient information system; 2) a peer review process; and 3) a Guaranteed Access System which assesses service coverage. While several programs did not report the existence of all three attributes, many used the peer review process to define the general and specific criteria on which effective service quality was evaluated. Several programs used agency documentation, knowledge from the profession, and standards of practice information from accredited bodies to define "general criteria." Professionals defined general criteria as initial referral/intake, assessment, goal formulation, service delivery/intervention, and termination. From this

framework professionals provided examples of the specific tasks associated with this classification system. Examples include the following:

1) Initial Contact
    * Time frame between initial contact and visit.
    * Statement of problem.
    * What service is being offered?

2) Assessment
    * Has a pyscho-social assessment been completed?
    * What are the workers impressions?
    * Is there a diagnosis?

3) Treatment Plans/Goals
    * Is the treatment plan adequate?
    * Does the plan reflect patient participation?

4) Service Delivery
    * Was social modality specified?
    * Was intervention consistent with the plan?

5) Termination/Outcome
    * Has case been closed appropriately?

Specific criteria are defined by the professional and based on his/her area of expertise.

Ferguson (1977) presents an example of the application of peer review in which professionals defined general and specific criteria within a hospital social work department. Faced with possible service cuts, hospital Directors of Social Work used peer review to clarify the purpose of hospital social work and define the activities

performed by this professional group. Social workers were asked to define the primary functions associated with their area of expertise. A Review Committee was established for the purpose of collating the information and developing a framework for understanding practice. Each specialty was provided with criteria relative to the intake function, and protocols were drafted including criteria relative to assessment, goal setting, implementation of plan, and recording. In addition, in the framework, criteria relative to unanticipated complications and termination were gathered. Ferguson (1977) noted that there was some reluctance during the initial developmental stages of this process, however, once professionals had used the framework to evaluate their performance positive experiences were reported.

The articles discussed above describe a framework within which human service managers can apply as guide for the purpose of assessing service quality. In Ferguson's (1977) article an example of the application of this framework developed by Coulton (1979) is successfully implemented. While the general criteria proposed by Coulton (1979) is considered to be universal within the field of social work, specific criteria may be redefined so that it is relevant to the specific setting. This literature was particularly helpful because it provided an illustration which was shared with CNIB staff and used in explaining the validity of the peer review process.

As with the earlier literature on quality assurance, there is little written regarding the success or failure of this specific technique therefore, it is also difficult to evaluate its effectiveness until more illustrations or examples are publicized.

Utilizing Clinical Evaluation

Another way in which service provision can be assessed is through the employment of clinical practice evaluation techniques. Neubring and Pascome (1986) discuss the application of single-subject design measures as a tool for quality assurance. Through the utilization of this technique, interventions can be analyzed statistically, professionals can evaluate their own practice, service provision can be easily explained to non-professionals, empirical research can be conducted, and cost-benefit analysis can conducted for program planning purposes.

Although clinical evaluation techniques are not utilized as a regular part of direct service practice, the merits of utilizing this type of technique is worthy of note. Successful application of single- or multi-design methodology would require experience and guidance by a knowledgeable evaluator. Furthermore it would require a work environment in which staff felt confident to have their work analyzed in this fashion. Therefore, implementation of type of

clinical evaluation methodology would be seen as an advanced application to be employed after a peer review process was underway.

SUMMARY

As stated earlier the literature pertaining to program evaluation, evaluability assessment, and quality assurance has provided the theoretical basis and rationale from which a selection of particular interventions was rationalized and supported. These interventions include qualitative interviews, questionnaires, focus group sessions, peer review and consumer feedback. Through these interventions, agency participants have developed an understanding of the relationship of client service delivery to the CNIB mandate.

Because of the many changes that have occurred within CNIB over the past three years coupled with increased pressure relative to service accountability, the need for a clearly defined program model was seen as one way to help staff understand the relationship between client service and the organization. Through the process of goal and objective setting staff would have an opportunity to make a contribution to the development of this model. Once goals and objectives were determined staff would have another opportunity to analyze service delivery. These activities are seen as essential to the improvement of inter- and intra-agency relations.

It is important that an understanding of the relevance of quality assurance evaluation be achieved. First, financial supporters (government, service clubs, United Ways, private donors) have begun to ask questions relative to the allocation of service costs and professional accountability. As an example, donors from rural communities have expressed interest in knowing about service provision. Questions such as who receives service, by whom, how frequently, and for what costs, are being asked. In other words, how does CNIB allocate its funds to ensure that services are provided equally? Second, given workload pressures as a result of human resource cutbacks and increased service requests, issues relating to service quality must be addressed in order that service efficiency and effectiveness are maximized. Third, quality assurance evaluation does not require the use of external resources. Through a peer review process, employees can evaluate their own performance and provide valuable information to management about service provision. This being the case, additional costs associated with the hiring of outside consultants can be virtually eliminated. Fourth, quality assurance techniques are relatively adaptable. Existing staff resources can be used in the development and implementation of a quality assurance program. An established quality assurance program would ensure that continuous rather than ad hoc evaluation is conducted. Finally, through an established peer review process, professional confidence would be enhanced and professional accountability achieved.

Within the next chapter a discussion of the practicum setting is provided. Because of the size and complexity of CNIB, a description of the divisional structure is described in relation to the national structure. The chapter concludes with a discussion about CNIB Manitoba Division's service delivery process as it provides background information in preparation for the later discussion about intervention approaches.

CHAPTER 3

Practicum Setting

The CNIB, as a national not-for-profit agency with nine divisions and 65 district offices, is extremely large and complex. Over the past seventy-seven years this agency has attempted to be responsive to changing needs expressed by its clients in a world which has presented considerable challenges particularly from a financial perspective. These factors have imposed extreme pressure at both divisional and district levels. In an effort to survive, it seemed timely and necessary that the CNIB Manitoba Division evaluate its current services as well as the manner in which those services are provided. Although a national willingness is required to effect change across all CNIB divisions, each divisional office has the discretion to deliver and evaluate the effectiveness of nationally mandated services. With the onset of Canadian social reform it makes sense to examine what and how services are offered at all levels. At this point, at the divisional level, service reform is being considered through this research opportunity. Perhaps experiences gained through this research may be considered useful to senior management at the national level.

Although this practicum research is focused on services provided through CNIB Manitoba Division, it is essential that a global description of the CNIB organizational structure, be presented. An appreciation of the history of this agency is also seen as necessary in order that readers understand the evolution of CNIB's complex service structure.

History of the CNIB - National

Before formally being established as the Canadian National Institute for the Blind, Edgar Robinson, a blind university graduate developed the Canadian Free Library for the Blind in 1906. Robinson loaned braille books from his home, through the mail, to any blind Canadian requesting this service. After his death, Robinson's wife obtained financial support through the Toronto Women's Musical Association to continue her husband's work. The library was moved into its own building in 1917.

As blind veterans returned home from the war, the library began receiving requests for other services. It was evident that the needs of blind persons were more profound than the availability of braille books. It was through the volunteer efforts of Captain Edwin Albert Baker (later Colonel Edwin Albert Baker) and Dr. Sherman C. Swift, blind veterans of World War I, and others, that the establishment of the Canadian National Institute for the Blind was made possible.

The CNIB received its charter from the Government of Canada on March 30, 1918. It was incorporated under the Dominion Companies Act as a non-profit philanthropic organization with its headquarters in Toronto, Ontario. The Canadian Free Library changed it's name to the Canadian Library for the Blind and joined the CNIB.

During its inception, the CNIB established and promoted itself as a rehabilitation agency concerned with service provision such that blind and visually impaired Canadians could become independent. In the early days the CNIB provided food, clothing and shelter for blind and visually impaired during a time when there were virtually no social programs. In addition, the CNIB began to educate the government about blindness and visual impairment. The agency was instrumental in lobbying for changes in federal legislation, such as the Blind Voter's Act and Income Tax legislation.

Following World War II, the CNIB began to broaden the scope of its services to include residential programs, career planning and re-training. Other services, such as orientation and mobility, rehabilitation teaching, and counselling and referral services were added by the 1960's. By the 1970's, the need for residential services had diminished, thus these programs were abolished. The A.W. Weir Building, the national training centre, was

renovated in order that National Office staff could be housed there. These events marked a significant change in the CNIB organizational structure.

History - CNIB Divisional Offices

Between 1919 and 1920, the CNIB divided the country into four divisions: Ontario Division; Maritime Division, including New Brunswick, Nova Scotia and Prince Edward Island; Central Western Division, including Saskatchewan and Manitoba; and the Western Division, including British Columbia and Alberta. Through a creating resolution in June, 1952, Ontario established its own divisional office. In 1930, although not a part of Canada, Newfoundland established its own divisional office becoming the Newfoundland and Labrador Division, as well the Quebec Division were established at this time. In 1956, the Western Division was dissolved and Alberta became a separate division. The British Columbia - Yukon Division was also established during the that time. In addition, the Central Western Division was dissolved and Manitoba and Saskatchewan were established as separate divisions. In 1982, the Alberta Division was renamed as the Alberta - Northwest Territories Division. Finally, in 1985, New Brunswick and Nova Scotia - Price Edward Island were separated into two divisions.

National Organizational Structure

As a not-for-profit agency, the activities of the CNIB are overseen by the National Council. National Council has 30 voting members, including the Chairperson, Vice-Chairperson, Secretary, Treasurer, Divisional Boards of Management Chairpersons, and members at large. National Council meets three times per year in Toronto and once per year in a divisional office. The responsibilities of National Council include;

* establishing policy in accordance with CNIB objectives,
* approving major plans and programs,
* reviewing and assessing operating results,
* overseeing financial affairs of the Institute, and
* approving budgets, accounting procedures and investments.

All positions on National Council are elected at the Annual General Meeting. The length of term varies depending on the position on the Council. The President and Chief Executive Officer, Dr. Euclid Herie, participates during National Council meetings, however, he does not have voting privileges.

There are a number of sub-committees of National Council. These include: Client Services, Finance, Communications, Fund Development, Personnel, and a variety of ad hoc committees organized to complete specific projects. The President and Chief Executive Officer, Dr. Euclid J. Herie assigns National Office staff to these committees.

National office staff include: the Directors of Finance and Administration, Human Resources, Marketing and Advancement, Government Relations and International Services, Planned Giving and Principle Gifts, Technology, and Rehabilitation and Program Planning, the Executive Director of the CNIB Library for the Blind, and the nine divisional executive directors. In addition, there are several support staff employed by National Office.

Divisional Organizational Structures

Like the national structure, all divisional activities are overseen by Divisional Boards of Management. The membership of the Board depends on the particular needs and characteristics of each division. Members of the Divisional Board are elected on an annual basis at the Divisional Annual General Meeting. Most terms are two or three years in duration. The Divisional Board of Management has many of the same powers as the National Council with the exception of policy development and implementation. These boards do have the power to make recommendations on behalf of a division regarding policy amendments. In Manitoba, only two paid staff attend and participate in board meetings, the Executive Director and Director of Finance and Administration. These staff do not have voting privileges.

In CNIB, Manitoba Division, the Divisional Board of Management has several sub-committees. These committees include; Client Services, Fund Development, Finance, and Communications. CNIB Manitoba Division staff are assigned to these committees. Ad hoc committees may be struck for the purpose of completing designated tasks. For example, in 1991. a committee was struck to develop a strategic planning process within CNIB Manitoba Division.

In addition to the Divisional Boards of Management, each district within a division may establish District Advisory Boards. These boards provide advice to the District Administrator on matters of public education, fund development and/or client service within the district. The Chairperson of each District Advisory Board holds a seat on the Divisional Board of Management.

History of CNIB Manitoba Division Organizational Structure

Within CNIB, Manitoba Division there are two offices, the Divisional office, or Divisional Service Centre, located in Winnipeg, and the West District Office located in Brandon, Manitoba. Until January 1992, the CNIB, Manitoba Division, had three service districts, South/east, North and West. Those clients who resided in communities such as, Brandon, Flin Flon, The Pas and other smaller western communities received service through the West District Office. In Winnipeg, clients residing in nursing homes south of Portage Avenue, and in communities south/east of

Winnipeg received service from staff assigned to South/east District. Northern clients and those in Winnipeg who resided in nursing homes north of Portage Avenue received service from staff in North District. All other referrals to North and South/east districts were assigned on an "ad hoc" basis. These three districts were managed by district supervisors. Overall management of rehabilitation services was the responsibility of the Director of Rehabilitation and this individual reported to the Executive Director.

In January 1992, a decision was made to restructure the rehabilitation services department. Rather than offering services centrally under the direction of the Director of Rehabilitation, the new district model took on more of the characteristics of a decentralized service delivery system. Several changes occurred. First the Director of Rehabilitation position was eliminated and replaced by the District Administrator of Winnipeg District. Second, two new district administrators were hired becoming the District Administrators of North and South/east Districts. Third, service boundaries were changed. Winnipeg became a separate district while North and South/east Districts became rural districts. Fourth, while West District boundaries and staffing resources did not change, the old district supervisor, renamed District Administrator of West District, reported directly to the Executive Director. Fifth, the District Administrators of Winnipeg, North and South/east Districts reported directly to the Executive Director.

Finally, with these structural changes came changes in work responsibilities. Rather than only assisting with the provision of direct service, the district administrators became directly involved in fund development and public relations activities within each of their districts.

As result of significant government cutbacks and increased dissatisfaction with the district model, the Executive Director and members of the Management Committee with the support of the Divisional Board of Management decided to dissolve this structure and re-implement a centralized model in 1994. The positions of District Administrators of North, South/east, and Winnipeg were eliminated and replaced by a Director of Client Services. (This position is currently filled by the writer of this practicum report). The position of District Administrator of West District remained. Both positions relate directly to the Executive Director.

Further cuts were felt by direct service staff within the Division Service Centre, as a rehabilitation teaching position and the Coordinator of Adaptive and Technical Aids were eliminated. Despite these cutbacks, staff are working hard at developing new strategies relative to service provision to ensure that service quality is maintained.

With these management changes came a new structure within the support staff area of the newly formed Client Services Department. One secretarial position was eliminated and replaced by an Office Manager position. This change is designed to allow a reduction in the administrative duties previously handled by the Director of Client Services.

In April, 1995, the Director of Client Services appointed two Coordinators of Client Service. Administrative and supervisory responsibilities previously handled by the Director of Client Services were added to two existing direct service positions. The Peer Support Coordinator's position, previously a 0.6 position was increased to a 0.8 position. The job title was changed to reflect the new responsibilities, namely Coordinator of Peer Group Programs and Client Services. In addition, the old position of Coordinator of Vision Rehabilitation was changed to Coordinator of Vision Rehabilitation and Client Services. This was and is still a full-time position. These two positions are responsible for the daily supervision of a variety of direct service staff leaving the Director of Client Services to focus attention on global service delivery issues.

In Manitoba Division, the Directors of Finance and Administration, Development, and Communication/Volunteers, similar to National Office, assume the roles of consultants to the Director of Client Services and District Administrator of West District. In addition,

the CNIB, Manitoba Division has a Library and Transcription Services Department managed by a director. Chaired by the Executive Director, all directors and the District Administrator of West District are members of the CNIB Manitoba Division Management Committee. These members are considered as senior management sharing equal responsibility across the division. Appendix A is a visual reflection of the CNIB Manitoba Division organizational structure.

CNIB Mission Statement

As stated in the previous chapter, when establishing an organization, it is usual that an agency mission statement be defined. This statement defines the general purpose of the organization.

According to historical agency documents, the CNIB established itself as a voluntary agency with the basic aim of helping blind and visually impaired people find ways to lead satisfying lives. Underlying all CNIB services is the belief that blind and visually impaired people can be integrated into the mainstream of community life, according to their ability to function within that community. (CNIB, Manitoba Division, Client Services Handbook, p. 4). In other words, CNIB's mission is to help blind and visually impaired persons, through its rehabilitation services, to become as

independent as their abilities allow or permit. This mission statement is articulated at the national and divisional levels (See Appendix B - CNIB Fact Sheet).

CNIB Agency Objectives

Although literature suggests that "program goals" logically follow from the mission statement, CNIB National Office states that it has three primary objectives and CNIB adheres to these. They are:

1) to ameliorate the condition of the blind of Canada;
2) to prevent blindness; and
3) to promote sight enhancement services. (CNIB, Manitoba Division, Client Services Handbook, p. 5)

The first two objectives were developed and documented during the early developmental stage of the CNIB in response to the expressed needs of war blinded veterans in 1918. The third objective was added after the Sight Enhancement Enterprises (SEE) Program provided the necessary base funding to allow divisions across Canada to provide low vision services to Canadians. This objective was added in the 1980's. The addition of sight enhancement services expanded the target population of clients such that anyone who perceived their visual loss as having an impact on daily activities could refer themselves or be referred to the CNIB. Those people with visual acuities greater than 20/200 (6/60) could now benefit from CNIB assistance. This change in the agency's objectives had an impact on the

organizational structure of every division across Canada as requests for service increased dramatically. CNIB Manitoba Division adheres to the above stated objectives.

CNIB Activities

The CNIB, nationally, through divisional service centres, developed and implemented several rehabilitation services aimed at assisting the blind and visually impaired persons to reach independence. As policies developed in the 1980's, CNIB stated that through the provision of seven "core" services, CNIB clients would achieve independence in accordance with the agency mission statement. Each division was, and is still, expected to provide these services to any blind and visually impaired person, of any age, culture, and/or geographic location across Canada who perceives that their vision loss impairs their ability to function in their home, school, place of employment, or the community at large.

The seven core services include the following: 1) counselling and referral; 2) rehabilitation teaching; 3) orientation and mobility; 4) career counselling; 5) adaptive and technical aids consultation; 6) sight enhancement services; and 7) library and transcription services.

In addition, the CNIB, nationally, requires that all divisions provide specialized services to seniors, children, and deaf-blind persons. Each division has the discretion to develop, implement, and

provide services to these target populations in whatever way makes sense. In most cases client needs, staff expertise, and financial availability dictate these program decisions. Divisional Board of Management approval is required before a new service is implemented.

In CNIB, Manitoba Division, services to children are provided through occupational therapy and counselling and referral; services to seniors are provided through peer support and recreation programs; and services to deaf-blind people are provided through intervenor services. In many cases clients who receive service through these specialized programs may also receive service from those staff who represent the seven "core" service areas.

CNIB Manitoba Division - Service Delivery Process

To receive CNIB services potential clients may refer themselves or be referred by family members, physicians, ophthalmologists, and/or other professionals. However, it is a requirement of the CNIB that all persons requesting service must have their eyes examined by an ophthalmologist. Once a report is received and the intake worker has explained CNIB services to the potential client, a contract between the client and counsellor may be determined. In some cases the potential client may decide that he/she does not wish to receive any service. The file is then closed.

It is generally the practice for clients who reside in Winnipeg, northern Manitoba, or south/eastern Manitoba, to be interviewed by the Client Services Department Intake Worker over the telephone. Once services needs are identified, the intake worker may interview the new client after a Sight Enhancement appointment to further assess needs. Referrals to other CNIB services will be made at that point. Rehabilitation counsellors assigned to rural Manitoba may interview clients after Sight Enhancement appointments as well. However, if a Sight Enhancement appointment is not required or if the travel distance is too great, the rehabilitation counsellor will interview the new client in their home. Once assessment information is completed and service goals are set, the client may be referred to any other service or group of services based on rehabilitation needs (see Appendix C - Service Delivery Flow Chart).

Summary

CNIB Manitoba Division is one of several divisions which is mandated by National Council through National Office to provide a range of rehabilitation services across Canada to over 80,000 blind and visually impaired and deaf-blind people. As the description above suggests, this agency is large and complex. Because of these factors, change can take time, however, divisional discretion allows those who work at the front-line the opportunity to respond to client demands effectively and efficiently.

Thus far a discussion of the relevant literature and a description of the CNIB has been provided. As such a foundation on which the current research is based is declared. In the next chapter a description of the learning objectives, service intervention, and rationale are presented in preparation for the description of the actual practicum process and results.

CHAPTER 4

Practicum Focus

Within this chapter, a discussion of personal learning objectives and the service intervention is presented. In addition, the rationale supporting the completion of this practicum research, is given. Since its inception, there have been some changes to the design of the proposed research as a result of personal and agency influences, this resulted in the addition of one new learning objective.

The later portion of this chapter is focused on a discussion of the rationale supporting the specific practicum approach. Because of considerable changes have been made over the past three years within CNIB Manitoba Division, revisions to the original evaluation plan were necessary. These changes have made the need for an evaluation of CNIB services even more essential than two years ago.

Personal Learning Objectives

In the original proposal, one of the primary objectives was, "the development of new skills acquired through the application of new techniques". Since the approval of this practicum and in re-negotiating the work involved in completing the research, one

learning objective was added: the ability to look objectively at the agency while working directly with other CNIB colleagues participating in the practicum research.

As a manager of client service and a graduate social work student, it has been my intention to learn more about the utilization of a variety of program evaluation techniques to assist in the workplace. Through practical application of a variety of interventions including qualitative questionnaires, focus groups discussion and interviews, I had planned to develop skills in implementing a program evaluation. Furthermore it was my intention to learn about a variety of evaluation approaches in which participation of stakeholders was required. Thus, it made sense to utilize intervention techniques associated with evaluability assessment and quality assurance.

First, the application of program evaluation techniques, in particular, evaluability assessment, were to lead to an increased understanding of the process and techniques used in developing a clearly defined program model. Second, the use of quality assurance techniques were to increase understanding in a more contemporary program evaluation approach. In particular, through the application of the peer review technique, skills in facilitating this kind of process were to be developed. Third, skills in using qualitative measurement techniques were to be achieved through

the development and administration of staff questionnaires, interviews, focus group and "peer review" sessions, and consumer feedback.

Finally, skills in the analysis, interpretation, and disclosure of findings were to be demonstrated. The ability to complete the above tasks and communicate results in an understandable fashion is seen as being critical to evaluation success (Hudson, Mayne and Thomlison, 1992).

As stated in Chapter 3, there have been significant changes within the service structure of CNIB Manitoba Division. At the approval of this practicum proposal, there were four managers assigned to client service, however two positions were eliminated in the summer of 1994. These changes prevented me from implementing this evaluation from an "arms length" position as was originally intended. It is for this reason that an another learning objective was added: the ability to look objectively at the agency while working directly with CNIB colleagues participating in the research, specifically those direct service staff with whom direct supervision is provided.

Because I am the only direct service manager remaining in Winnipeg, the importance of maintaining clear boundaries between my role as evaluator and manager were seen as critical to the successful outcome of the practicum research. In addition,

working effectively with a variety of direct service staff, some of whom had developed current service delivery procedures, necessitated that I implement evaluation techniques with sensitivity.

To assist with the analysis of my effectiveness as an evaluator, a variety of informal feedback opportunities and one formal evaluation questionnaire were utilized. Direct service staff provided feedback after the focus group and "peer review" sessions by responding to one questionnaire and providing verbal feedback. In addition, employment of the "Utilization Enhancement Checklist" (Brown and Draskamp, 1980), a self-analysis tool, was used as a guide to formulate conclusions about evaluator effectiveness from a personal perspective (see Appendix Q - Utilization Enhancement Checklist).

Service Intervention

Within the proposed practicum proposal another objective was "the exposure of the agency to an evaluation process which has enhanced knowledge in a fairly contemporary evaluation approach". Through participation in the evaluation experience, CNIB direct service staff were to benefit.

Firstly, direct service staff were to develop an understanding of how specific discipline related service activities fit within the overall agency mandate. Secondly, direct service staff were to recognize

the benefits of analyzing casework practice through the utilization of quality assurance techniques, specifically, the utilization of a "peer review" process.

Finally, through the evaluation experiences discussed between direct service staff and senior divisional management, staff were to share and demonstrate the merits of program evaluation such that the adoption and incorporation of quality assurance techniques would become an ongoing process within CNIB Manitoba Division. As the literature suggests, implementation of continuous evaluation techniques would enhance the quality of program and strategic planning (Hudson, Mayne and Thomlison, 1992).

Rationale

Since the rehabilitation services were developed and implemented, a mechanism to evaluate their effectiveness has not been present. However, CNIB National Office staff evaluate the performance of each divisional office every three to five years. This review process is referred to as the "Comprehensive Audit". Its primary purpose is to ensure that national standards and policies are adhered to on a regular and constituent basis by all divisions. In addition to formulating recommendations regarding standards of practice and adherence to national policy, members of the Comprehensive Audit Team may make recommendations regarding structural design. In 1989, the audit team recommended that CNIB Manitoba Division change its centralized service

structure to a district model as it did not fit within usual agency standards at that time. In 1991, two district administrators were hired and the Director of Rehabilitation position was changed to the District Administrator of Winnipeg.

After financial cutbacks and staff departures, a Mini-Audit was conducted in 1994. Recommendations to eliminate the district model in favour of a centralized model were made. This decision was consistent with the manner in which other western divisions were structured. These significant changes have had an impact on the way in which services are delivered within Manitoba.

With the exception of the Comprehensive Audit process, CNIB Manitoba Division has not evaluated its client services within the Divisional Service Centre. However, financial restraints felt by the CNIB Manitoba Division, over the past two years, have forced management to make difficult decisions with respect to client service.

Since 1993, five direct service positions have been eliminated. Decisions regarding these changes were based on national service comparisons and divisional client service statistics. These statistics are quantitative and do not consider regional differences. Because of client and geographic differences, qualitative measurement techniques such as the kind utilized within this practicum research may have assisted management in making

decisions which were better understood or accepted by direct service staff. In addition, a well established quality assurance program may have encouraged direct service staff involvement thereby improving implementation efforts in response to these significant changes.

The above factors including: 1) the absence of past program evaluation; 2) increasing financial pressure; and 3) increasing client demands as a result of an increasing aging population supported the need for a program evaluation within CNIB Manitoba Division.

Because of the costs associated with the implementation of a program evaluation, it was advantageous for CNIB to use an internal evaluator. There are several advantages to internal evaluation. Love (1991) states that internal evaluators: 1) have longstanding relationships with their agencies; 2) can implement recommendations; 3) have a good generalist perspective; and 4) are a valuable investment to the agency.

In the case of CNIB Manitoba Division there several advantages to internal evaluation. First, given the financial climate, it is valuable for the agency to have an employee who can utilize research techniques to answer questions about standards of practice from a divisional perspective, at no direct or additional cost to the agency. Second, it is valuable to the agency to have an employee

evaluator who understands and appreciates the complexities experienced and challenges faced by the agency. Third, it is valuable for direct service staff to have a previously established rapport with the evaluator ensuring that comments will be understood and considered within the appropriate context. Fourth, using an employee evaluator has the potential of ensuring that the final results of the evaluation may be implemented. Finally, the employee herself has the "real life" opportunity of experiencing how evaluation results are interpreted and implemented after they are shared with the organization.

In summary, all direct service staff would develop an appreciation for ongoing or continuous program evaluation. By implementing a quality assurance process, within the CNIB, ongoing evaluation could be possible at a minimal cost to the agency, but at a considerable gain to the direct service staff and consumers in the main. Establishment of a program evaluation process will succeed if the experiences by staff are viewed as positive.

CHAPTER 5

Practicum Intervention

In considering a program evaluation of CNIB Manitoba Division client services, there were three primary objectives: 1) to define the program model; 2) to utilize quality assurance techniques to understand the current service delivery process within the seven "core " services of the Client Services Department within CNIB Manitoba Division; and 3) to assess whether or not there was consistency between staff and consumer perceptions about the service delivery process. To achieve these objectives, an understanding of program evaluation techniques was required. This provided background information, to decide the necessary evaluation approach from which a series of interventions were selected and used in answering research questions pertaining to service delivery. From the literature and practical experience as an employee of CNIB, it was concluded that the techniques associated with Evaluability Assessment would be of benefit in achieving the first objective as outlined above.

As discussed, in Chapter 2, before an analysis of established programs can be conducted, it is essential that the agency have a clearly defined program model including clarification of mission, goal(s), and objective(s) from which the activities of the agency are logically linked (Unrau, 1993; Gabor and Grinnell, 1994; Rossi and

Freeman, 1985). Most importantly, the design of an agency program model would help direct service staff understand the relationship of their work in the context of the larger organization. Participating in an exercise of this kind improves staff relations and enhances work relations within the larger system thereby resulting in a sense of purpose and meaning within the context of organizational life.

Secondly, it was decided that the actual research methods, should be qualitative rather than quantitative. Qualitative results would elicit more detailed and descriptive responses from staff and management participants. In addition, participants would feel more a part of the research. Patton (1987) states that qualitative measures are less intrusive than quantitative measures. In addition, qualitative measures rely on induction rather than the formulation of a pre-determined hypothesis. The qualitative approach is also consistent with the tenets of the "responsive" approach as defined by Stecher and Davis (1987). This approach allows participants, in this case CNIB direct service staff, the opportunity to participate in the development of the evaluation plan. As such this approach fosters a more interactive communication between the evaluator and participants.

Thirdly, a quality assurance approach was utilized for several reasons. First, quality assurance evaluation is a process oriented evaluation approach. Although program activities may be

analyzed and conclusions formulated about any aspect of program effectiveness, at any defined point, results are to be used, in subsequent analysis, after the implementation of recommendations has occurred. As such, quality assurance evaluation is seen as a continuous or dynamic approach in program evaluation.

Quality assurance evaluation is also cost-efficient. In times where not-for-profit agencies are facing financial challenges, program evaluation can be conducted internally, by those employees who actually perform the work (Love, 1991).

Furthermore, quality assurance evaluation can increase worker motivation. Through techniques, such as "peer review" staff have an opportunity to measure and analyze their professional performance against agency standards rather than having an external evaluator analyze their effectiveness. In addition, staff, through using critical analysis with the aid of specific criteria, may have an impact on program and strategic planning activities. The end result is that morale, motivation, and commitment to the agency may be enhanced (Coulton, 1982; Ferguson, 1977).

Through the utilization of Quality Assurance techniques, achievement of the second and third objectives as outlined above are discussed in the next chapter. The specific applications of Evaluability Assessment and Quality Assurance techniques are discussed in the following sections.

EVALUABILITY ASSESSMENT

The overall objective of Evaluability Assessment is to help the agency determine its readiness for evaluation and to prepare the agency for future evaluation. Rutman (1980) as stated earlier, defines three phases of program evaluability: 1) analyzing program characteristics; 2) determining the feasibility of implementation; and 3) preparing for evaluation. Within the first phase, the researcher is to define the program components through staff and consumer input and a review of agency documentation. Although CNIB Manitoba Division, Client Services Department does have standards of practice statements associated with each of the seven "core" services as well as several national policies which guide direct service practice, (e.g. the role of multi-disciplinary teams, file recording formats, access to information, file closure), a clearly defined program model, including the formulation of goals and objectives as defined in the literature, is not articulated in any divisional documentation. This being the case, this evaluability assessment is focused on the utilization of staff for the purpose of developing a program logic model as defined by Unrau (1993).

During the first phase of the Evaluability Assessment, a review of CNIB agency documentation including CNIB Service Standards, Positions, and Systems and Procedures, the organizational chart, job descriptions, and relevant office memorandums was conducted. Also informal discussions with CNIB direct service staff and management (in preparation for the formal process of

interviewing and the sending of questionnaires) occurred with the objective of developing a concept of how the newly defined program model would look. To obtain the formal or final information to define the CNIB Manitoba Division, Client Services Department program model, a variety of interventions were used, including: qualitative interviews; questionnaires; and focus groups. Each technique is described in detail in the following paragraphs.

Before the evaluation commenced, all direct service staff who represented the seven "core" service areas were advised of the steps which were involved in completion of the research. All staff were asked to participate, however, they were told that their participation was voluntary. Staff were also asked to sign consent forms stating that they understood the nature of the research and that their individual comments would remain confidential. Staff was told that any tape recorded sessions would be destroyed upon successful completion of the practicum.

Interviews

Although the original intent was to interview two direct service managers and two direct service staff, by the time the interviews were scheduled, only one manager in addition to the writer, remained on staff. One direct service staff was interviewed for the purpose of testing the interview guide, two direct service staff were interviewed as a part of the research. One manager, the District Administrator of South/east District was also interviewed.

Participants were asked several questions pertaining to their perceptions about the existence of agency goals, objectives, and activities. They were asked to: 1) define the goals and objectives they believed to be in existence; 2) to state their opinions in relations to whether or not the existence of goals and objectives were needed in order to conduct a program evaluation relative to effectiveness; and 3) identify any gaps or duplications in service delivery. Specific questions are outlined in Appendix D - Staff Interview Guide.

Obtaining responses from direct service staff and managers was intended to determine whether or not different views or opinions were held by these staff groupings. The selection of direct service staff was left to the discretion of their managers. Interviews were conducted after hours to ensure that direct service to clients was not disrupted. The interview process was used to provide a detailed account of staff opinions on the questions asked. This intervention assisted the evaluator in formulating questions aimed at obtaining general perceptions from all direct service staff (representing the "core" services) about the agency mission, goal(s), objective(s) and discipline specific activities.

Questionnaires

All direct service staff representing the seven "core" service disciplines were asked to respond to a questionnaire which asked their perceptions about the mission statement, goals, objectives,

and discipline specific activities. Only two direct service staff did not complete the questionnaire (see Appendix E - Direct Service Staff Questionnaire). Staff who agreed to respond to this questionnaire were asked to sign consent forms stating that they understood their participation was voluntary and that specific information pertaining to individual responses would remain confidential (see Appendix F - Staff Consent Form).

Focus Groups

After the responses to these questions were collated and a content analysis was conducted, direct service staff participants were brought together in a group for the purpose of re-defining the CNIB mission statement and defining program goals, program objectives and program activities clearly. A series of three sessions were used to define the agency program model. Between seven and nine staff members participated. Sessions involved one full day seminar and two additional sessions to refine definitions. Four staff did not participate as present workload demands made it difficult for their active participation. The results of these sessions are depicted in four flow charts (Figures 1 through 6) and are included in Chapter 6 within the discussion of evaluation interventions within the specific section titled "Focus Groups".

QUALITY ASSURANCE

The purpose of using quality assurance evaluation within CNIB Manitoba Division was to have staff participate in defining the service delivery process associated with their area of expertise. After service activities were defined, staff were to analyze their own performance using pre-determined criteria. Through this experience staff were to begin to see the relevance of looking at service provision by attending to service quality, (i.e. looking at the service delivery process), rather than quantity, (i.e. analyzing number of contacts with clients). As stated in the literature, through an exercise of this kind, professional accountability is increased resulting in a more positive outlook relative to service provision (Ferguson, 1977).

The Service Delivery Process

To achieve the objectives as stated above (an understanding of the difference between service quality and quantity, increased professional accountability) the following interventions were used. After reviewing the literature, general standards of practice were defined. This is referred to in the literature as "general criteria" (Coulton, 1982). General criteria includes: 1) initial contact/intake phase; 2) assessment; 3) goal formulation; 4) service delivery; and 5) termination. Through the questionnaire, described above, staff were asked to define activities (specific criteria) associated with each phase of the service delivery or rehabilitation process.

Responses were collated by the researcher and presented during the "peer review" group process (see Appendix G - Specific Program Activities).

The Peer Review Process

The second phase of the intervention was the implementation of a "Peer Review" process. A committee of 3 staff volunteers representing various service disciplines was established based on voluntary consent. A rehabilitation teacher, career counsellor, and vision rehabilitation specialist reviewed three cases presented by two direct service staff. Committee participants used the previously defined general and specific criteria, based on the work of Coulton, (1982), to evaluate the effectiveness of service delivery relative to the presentation of three problem cases.

The two staff who presented the three cases, represent two different disciplines. They were given the general and specific criteria in advance and were asked to review each client file in preparation for a discussion about the case(s) (see Appendix H - Specific Criteria - Service Delivery Process). Presenters were asked to select a case or cases which posed a problem from a service delivery perspective. They were asked to critique their performance in accordance with the prescribed criteria. Members of the Peer Review Committee and case presenters were advised that the purpose of the exercise was not intended to be a

performance appraisal rather its intent was to do a critical analysis of the service delivery process as understood by all who participated in the "peer review" process.

Consumer Feedback Survey

Six clients were selected by CNIB direct service staff to participate in a telephone survey. Blind and visually impaired participants representing a range of age groupings were given information about the rehabilitation process and its associated activities. Clients were asked which services they received and how they felt about or experienced these services. Clients were advised that their responses would remain confidential. They were also advised that their participation was voluntary (see Appendix I - Client Consent Form).

General criteria was used to guide the interview process. Questions used during the peer review process were re-formulated such that a comparison of staff and consumer perceptions could be analyzed at the conclusion of the practicum process (see Appendix J - Consumer Feedback - Interview Guide).

Six clients within three age groupings were selected. The first group was intended to include one blind and one low vision client under the age of 30. However, in the survey only one consumer interviewed was under 30 years of age. The second group included one blind and two low vision clients between the ages of

31 and 64. The third group included one blind and one low vision client over 65 years of age. Clients with severe disabilities other than vision loss were excluded from the evaluation. It has been demonstrated in practice that clients who have other mental and physical complications, such as head injury, Multiple Sclerosis, mental illness, etc., benefit minimally from CNIB services. These individuals rely extensively on other supports, such as community resources or family members to assist them in many areas of their lives. Because CNIB mandates its employees to work on issues related to blindness and visual impairment, and CNIB staff have previously never participated in this kind of "in depth" analysis of their professional practice, it seemed less stressful or complicated for staff to analyze cases which focused primarily on service delivery with those clients for which vision loss was their predominant need.

Results from this client survey were used to assist the evaluator in identifying any potential differences between client and worker perceptions relative to service delivery. This component of the research was intended to test a consumer feedback process in an exploratory fashion. If successful, it was felt that this process could be expanded and utilized as part of the CNIB National Core Services Review.

In the next chapter a detailed report of the occurrences, experiences, and findings are reported within each phase of the practicum process.

CHAPTER 6

Evaluation of Interventions

Within this chapter a critical analysis is provided of the practicum process from beginning to conclusion. After the findings within each phase are described, a analysis is provided from two perspectives: the role of objective evaluator, and the role of self, as an evaluator. At the conclusion of this chapter some general comments are made with respect to evaluation of self.

In Chapter 4, three objectives were presented; one was aimed at potential learning from an agency standpoint while the remaining two were aimed at personal learning. The agency objective was that of exposing "the agency to an evaluation process in which knowledge would be enhanced in a fairly contemporary evaluation approach." Individual learning objectives were: 1) the development of new skills acquired through the application of new techniques; and 2) the ability to look objectively at the agency while working directly with staff. My conclusions relative to the achievement of these objectives will be discussed at the end of this chapter.

At the Beginning

Because of workload demands and pressures coupled with the human resource reductions and structural changes experienced by staff and management within CNIB Manitoba Division, I wondered whether or not the completion of this practicum would become a reality. Although not fully appreciative of all the steps involved in this process, it was through the support of the Executive Director and colleagues that this project was completed.

Shortly after the announcement of this project, financial pressure was felt by the agency and plans to continue the research were put on hold for several months. A significant provincial reduction to CNIB's annual grant resulted in the elimination of several direct service positions including the two Winnipeg based district administrators. Just prior to the announcement regarding staff cutbacks, the first phase of the practicum, the interviews, was completed. However, it was evident that some modifications to the practicum plan were necessary. Revisions were made, discussed with and endorsed by the Executive Director, and re-presented to staff in written form. Once voluntary consent was received, the process began.

Interviews

Although the original plan was to interview two service managers and two direct service staff for the purpose of noting similarities and differences between these staff groupings, timing and

changes to CNIB's organizational structure eliminated this as a possibility. As a result one direct service staff was interviewed for the purpose of testing the interview guide. After some changes were made, three interviews, two with direct service staff and one management interview were conducted (see Appendix D - Staff Interview Guide).

When first asked to define the agency's mission, goals and objectives, interviewees stated the national mission statement as articulated in the Client Services Handbook and in the CNIB Fact Sheets. In all cases interviewees defined the goals using the three objectives as defined by National Office. However, when asked about objectives, interviewees had to re-refer themselves to the theoretical definitions provided in the article written by Unrau (1993). Once an understanding and integration of these definitions was achieved, in all cases, respondents reported that there were no clearly defined divisional objectives in existence. When trying to make the connection between agency activities, goals and objectives, all staff agreed that in their opinion the ability to conduct an evaluation of program without defined goals and objectives. Furthermore in all cases, interviewees reported that their participation during the interview process was worthwhile. They expressed support for the occurrence of a goal and objective clarification process.

From an evaluator's perspective, this intervention was most challenging. An experienced evaluator would have had to provide a lot of education regarding the definitions and conceptualization of goals, objectives and activities. Although all interviewees were provided definitions, it was difficult to integrate this highly conceptual material quickly. This process may have been more effective had the questions and definitions been provided in advance allowing interviewees the opportunity to prepare themselves for this intense interview process.

Although modifications were made to the interview guide after the pre-test interview had been conducted, using the definitions of mission statement, goals, objectives, and activities, I had difficulty guiding this process as the material presented is extremely theoretical. It was difficult to track the process, re-conceptualize the information and integrate responses. Tape recorded interviews assisted this process as it was necessary to refer to the content later.

Nonetheless, as a beginning step, this interview process was an excellent way to gain an initial understanding of employee perceptions. With more experience in the field of program evaluation, I may have been better equipped to manage this process more efficiently and effectively.

Questionnaires

After the original plan had been re-negotiated and endorsed and a revised outline of the practicum process distributed among direct service staff, questionnaires were distributed (see Appendix E - Direct Service Staff Questionnaire). Staff were asked to return their responses along with the signed consent form within a two week period. Responses to all questionnaires were collated and similarities and differences between responses identified for analysis.

Responses to the first question about the mission statement were varied, but differences were not major. In all cases respondents reported a variation of the content as articulated in the CNIB Fact Sheets or in the CNIB Manitoba Division, Client Services Handbook (see Appendix B).

Responses to questions two and three, where staff were asked to provide definitions pertaining to the goals and objectives of the agency, varied significantly. In all cases staff listed the three national objectives in response to either the question relating to goals or to objectives. For example, if one person listed the three CNIB national objectives in response to the question about goals, then individualized responses were given regarding their perception relative to objectives or vis-versa.

With respect to responses given about the agency goals, some similarities and several differences were noted. For those staff who did not list the three national objectives in response to the question about goals, two common themes emerged: independence and fostering integration. These themes are articulated in the existing CNIB mission statement. Other examples of responses included: 1) provision of emotional and practical rehabilitation; 2) to assess and determine needs of the client; 3) to provide full social, educational, and employment opportunities for the blind; 4) to make best use of their remaining vision; 5) to work together as a part of a multi-disciplinary team with the hope of enabling the client; and 6) to promote, maintain and extend the knowledge and use of braille.

Regarding the question about objectives, in fewer cases than above, staff reported the agency objectives as being the official CNIB objectives. Similarities between the responses given by participants who did not include national objectives within their answers, articulated the same themes as stated above, namely independence and fostering integration.

On the other hand, differences between responses was greater than in the previous question about goals. Staff reported objectives as being: 1) to integrate blind people into the mainstream of community life; 2) to teach people activities so that they could be independent; 3) clients could lead satisfying lives; 4)

to be educated, supported and rehabilitated to be independent; 5) to gain emotional support to enhance coping skills; and 6) to learn how to shop, cook and organize their personal possessions.

Staff were also asked to define their primary activities using the following criteria: 1) initial contact/intake; 2) assessment; 3) plans/goals formulation; 4) service delivery; and 5) closure. These responses were generally detailed demonstrating knowledge and understanding of specific roles and functions. These responses are included within Appendix G - Specific Program Activities.

In summary, staff responses to questionnaires were as varied as those received from participants during the interview process. Because of the wide discrepancy in responses to the questions pertaining to goals and objectives, it was concluded that the need for a clearly defined program model, in which staff would help define, was essential before an agreement regarding the definition of the service delivery process could be developed.

As an evaluator, this process was useful in capturing the perceptions of a large group of staff in an efficient manner. The information received supported my view that consistent responses relative to questions about goals and objectives were not evident. These findings were consistent with responses given during the interview process. It is noteworthy that staff were extremely clear

when asked what activities they perform within their own discipline, however, they were much less clear or consistent when questions about goals and objectives are asked. This suggests that the understanding of the relationship between specific activities and the organizational mandate is not evident.

In general the information gathered through these questionnaires was useful in preparing staff for the focus group sessions. Having had the opportunity to read and integrate the definitions pertaining to program goals, program objectives, and activities helped staff to conceptualize these program logic components before these sessions occurred.

The feedback received by staff regarding the content of the questionnaire was generally positive. Because staff were previously informed about the general content and had their questions answered before completing the questionnaire, the process was less intimidating than was the case during the interview process. In all but three cases the questionnaires were completed on time while others were reminded that the deadline had passed. Two staff did not respond as workload demands made this impossible. A total of 11 out of a possible 13 staff completed the questionnaire. When asked whether the time frame for completion was realistic, most reported that it was fair. However, five people commented that completion of the questionnaire was a time consuming and intense process.

Reviewing and redefining responses to the question pertaining to activities was not possible during the practicum process. This was primarily due to limitations in time both for staff and myself. Some attention was focused on discipline specific activities during the focus group sessions and Peer Review Process. This is discussed in subsequent sections.

Finally, staff were asked to share comments relative to the impact of change upon service delivery. The comments are general in nature and reflect the viewpoint that participation in the decisions relative to service cutbacks perhaps would have been better implemented had staff had input into the planning process. In general, staff expressed that in their opinion clients have been affected by changing roles within the Client Services Department. It was noted by the rehabilitation counsellors and rehabilitation teachers that staff cutbacks had reduced the availability of individual adjustment counselling services and home management instruction thereby resulting in increased waiting lists.

Although their responses relative to the impact of change were critical, it must be noted that the direct service staff at CNIB have a remarkable commitment to their work. It is because of this attribute that flexibility and creativity are evident. No one disputes the tremendous stress that staff feel when structural change occurs; unfortunately it is such a frequent occurrence within our

current economic climate that the impact of change should be discussed. However, in reality, these changes are rarely acknowledged (Bargal and Schmid, 1992).

Focus Groups

The third phase of this practicum involved the gathering together of those staff who represent the seven "core" service areas for the purpose of redefining the agency mission statement, goals and objectives. Staff were given a memorandum detailing the events that would occur during the full day session. Staff were also provided with the definitions and properties associated with the formulation of mission statements, program goals and objectives, as well as, copies of Unrau's (1993) conceptual framework of a Program Logic Model (see Appendix K). A total of 10 staff participated in the full day session.

The definitions and properties of mission statements, goals, objectives and activities were provided. Unrau's (1993) framework was reviewed for the purpose of explaining what a Program Logic Model would look like in theory. Staff were advised that by the end of the day, the group was to have developed definitions of the three program logic components as listed above, namely mission statement, program goals and program objectives. In addition, the similarities and differences were identified and shared from the responses given by staff who completed the questionnaire with the

objective of demonstrating the varied degree of responses. Staff were also given copies of their responses regarding specific discipline related activities.

The remainder of the morning was spent problem solving and re-formulating a mission statement. It was decided that a review of the agency mission statement would provide a foundation from which the program goals and objectives would follow. In addition, staff reported that they felt that the wording of the current mission statement was not relevant. Staff were given the option of working in small groups rather than as one large group. They preferred the later. At the conclusion of the morning session, it was recommended that the redrafted mission statement be incorporated or adopted as a divisional mission statement.

The afternoon was spent developing program goals, program objectives and defining primary activities. Again staff stated that they preferred to problem solve together. Through facilitation and the use of flip chart notes staff re-defined the mission statement, 2 program goals, 6 program objectives, and several of the primary activities associated with each of the objectives.

It was evident by the end of the day that the objectives as outlined within the agenda would not be achieved. Therefore the group was given the option to continue or have the facilitator complete the definitions. All staff participants expressed a desire to

complete the process. Two-hour sessions were scheduled. It was also agreed that in preparation for the second and third sessions, I would collate the responses and develop a flow chart to be circulated to all participants in preparation for the next session.

Finally staff were asked to complete a written questionnaire providing feedback about their experience of the session (see Appendix L - Evaluation). In general staff stated that the evaluator had a difficult time explaining the concepts, however, by the end of the day staff expressed that they found the experience extremely worthwhile and beneficial.

In preparation for the second session, copies of the re-defined mission statement, program goals, program objectives, and program activities were distributed. Staff were asked to review these charts so that any changes could be made during the second session.

In addition, a copy of Unrau's (1993) article was circulated to all direct service staff prior to the session. The entire second session was spent revising the charts previously distributed. Revised copies were circulated prior to the third and final session (see Figures 1 through 4, inclusive).

Figure 1

CNIB MISSION STATEMENT, PROGRAM GOALS, AND PROGRAM OBJECTIVES

The Canadian National Institute for the Blind is a not for profit agency whose aim is to improve the circumstances related to vision loss experienced by people of all ages, cultures, and locations across Canada
thereby enabling their inclusion in all aspects of society.

PROGRAM GOAL (1) To educate the public (including CNIB clients and families) about vision loss to ensure that the integration of their knowledge becomes an integral part of the community			PROGRAM GOAL (2) To work in cooperation with and/or on behalf of individuals who have experienced vision loss; to enable them to achieve their desired level of participation in the community		
PROGRAM OBJECTIVE (1.1A) To increase awareness and knowledge about eye conditions which result in significant vision loss	**PROGRAM OBJECTIVE (1.2A)** To increase awareness and knowledge of CNIB services offered to blind and visually impaired individuals	**PROGRAM OBJECTIVE (1.3A)** To increase awareness and knowledge of the implications resulting from blindness or visual impairment	**PROGRAM OBJECTIVE (2.1A)** To facilitate the development and maintenance of resources/services to benefit those individuals who experience vision loss	**PROGRAM OBJECTIVE (2.2A)** To assist the individual in adjusting to personal issues related to the loss of sight	**PROGRAM OBJECTIVE (2.3A)** To teach individuals who experience vision loss a variety of skills to enhance personal functioning in all aspects of life

NOTE: The mission statement, program goals, and program objectives were defined during the full day session. In addition, to reflect the logic of this model, the program goals are numbered (1) and (2). Program objectives follow a similar numbering sequence. For example the three program objectives which are logically linked with the first program goal are numbered (1.1A); (1.2A); and (1.3A). The alpha code "A" is used to reflect the order of logic used in the model. As such all program objectives are followed by "A".

Figure 2

CNIB MANITOBA DIVISION
PROGRAM ACTIVITIES FOR PROGRAM OBJECTIVES (1.1A) AND (1.2A)

PROGRAM OBJECTIVE (1.1A)		PROGRAM OBJECTIVE (1.2A)	
To increase awareness and knowledge about eye conditions which result in significant vision loss		To increase awareness and knowledge of CNIB services offered to blind and visually impaired individuals	
PROGRAM ACTIVITIES (1.1B)		**PROGRAM ACTIVITIES (1.2B)**	
Information is shared in the following ways:	Information is shared with the following recipients:	Information is shared in the following ways:	Information is shared with the following recipients:
- written documentation - media presentations - Audio/Visual aids - inservices - proposals - information giving - counselling - demonstration - instruction	- CNIB clients - schools - health care professionals - post secondary students - helping professionals & agencies - relatives of CNIB clients - researchers - insurance companies - employers - day care facilities - government - industry - volunteers - funders - medical facilities	- written documentation - media presentations - Audio/Visual aids - inservices - proposals - information giving - counselling - demonstration - instruction	- CNIB clients - schools - health care professionals - post secondary students - helping professionals agencies - relatives of CNIB clients - researchers - insurance companies - employers - day care facilities - government - industry - volunteers - funders - medical facilities

NOTE: Only two of the three program objectives and activities which logically link to Program Goal (1) are shown above. To reflect the logic of this model, all program activities are numbered using the same sequence as the program objectives. To reflect the hierarchal order of the model all program activities are followed by the letter "B".

Figure 3

CNIB MANITOBA DIVISION
PROGRAM ACTIVITIES FOR PROGRAM OBJECTIVES (1.3A) AND (2.1A)

<table>
<tr><th colspan="2">PROGRAM OBJECTIVE (1.3A)

To increase awareness and knowledge of the implications resulting from blindness or visual impairment</th><th>PROGRAM OBJECTIVE (2.1A)

To facilitate the development and maintenance of resources/services to benefit those individuals who experience vision loss</th></tr>
<tr><th colspan="2">PROGRAM ACTIVITIES (1.3B)</th><th>PROGRAM ACTIVITIES (2.1B)</th></tr>
<tr><td>Information is shared in the following ways:

- written documentation
- media presentations
- Audio/Visual aids
- inservices
- proposals
- information giving
- counselling
- demonstration
- instruction</td><td>Information is shared with the following recipients:

- CNIB clients
- schools
- health care professionals
- post secondary students
- helping professionals & agencies
- relatives of CNIB clients
- researchers
- insurance companies
- employers
- day care facilities
- government
- industry
- volunteers
- funders
- medical facilities</td><td>CNIB staff will develop any resource/service to respond to specified client need(s) by:

- assessing existing needs, skills and abilities
- identifying available resources
- implementing agreed upon instructional plan
- developing resource/service
- obtaining financial support
- implementing resource/service
- evaluating resource/service
- advocating for development of external resource/service</td></tr>
</table>

NOTE: Program Objective (1.3A) follows from the first program goal, whileProgram Objective (2.1A) follows from the second program goal (see Figure 1). To reflect the logic of this model, all program activities are numbered using the same sequence as the program objectives. To reflect the hierarchal order of the model all program activities are followed by the letter "B".

Figure 4

CNIB MANITOBA DIVISION
PROGRAM ACTIVITIES FOR PROGRAM OBJECTIVES (2.2A) AND (2.3A)

PROGRAM OBJECTIVE (2.2A)	PROGRAM OBJECTIVE (2.3A)
To assist the individual in adjusting to personal issues related to the loss of sight	To teach individuals who experience vision loss a variety of skills to enhance personal functioning in all aspects of life
PROGRAM ACTIVITIES (2.2B)	**PROGRAM ACTIVITIES (2.3B)**
CNIB staff will provide intervention through individual/group/family/peer counselling by: - assessing coping abilities - identifying specific emotional issues - developing an intervention plan - implementing agreed upon service plan - evaluating client progress/worker effectiveness - deciding future plan(s)	CNIB staff will provide individual/group/family instruction by: - assessing existing skills and abilities - identifying instructional needs - developing instructional plan - implementing agreed upon instructional plan - evaluating client progress/worker effectiveness - deciding future plan(s)

NOTE: Program Objectives (2.2A) and (2.3A) follow from the second program goal (see Figure 1). To reflect the logic of this model, all program activities are numbered using the same sequence as the program objectives. To reflect the hierarchal order of the model all program activities are followed by the letter "B".

It is important to note that after having completed this exercise and upon reviewing the definitions pertaining to Practice Objectives and Practice Activities, staff participants stated that the activities they had identified during these sessions should be referred to as program activities as they reflect the primary activities associated with all service disciplines.

In preparation for the final session, I had circulated proposed definitions of practice objectives and practice activities. Before discussing these, at the beginning of the session, all staff were asked to review the charts which had been re-distributed for final changes. Staff all agreed that the necessary changes had been included. Because time did not permit, staff were asked to review the practice objectives and practice activities which had been drafted and return any comments within a 10 day time frame. Upon receiving the feedback, it was agreed that I would make the necessary changes and distribute copies. Only two responses were received after ten days had lapsed. I completed the definitions and distributed them.

The following two figures are illustrations of two program objective statements, practice objective(s), and practice activity statements. As reported above, staff defined two program goal statements, six program objectives, and six lists of primary program activities during the focus group sessions. The practice objective and practice activity statements were refined by me.

Figure 5 shows the relationship between the first program objective (1.1A) and the practice objectives (1.1C) and practice activities (1.1D).

Figure 5

CNIB MANITOBA DIVISION
PRACTICE ACTIVITY FOR PRACTICE OBJECTIVE (1.1C)

PROGRAM OBJECTIVE (1.1A)
To increase awareness and knowledge of eye conditions which result in significant vision loss
PRACTICE OBJECTIVE (1.1C) All CNIB Core Services
To increase client's awareness and knowledge of specific eye condition
PRACTICE ACTIVITY (1.1D) All CNIB Core Services
Provide verbal and written information about the specific eye condition

NOTE: The above practice objective and practice activity statements pertain to all seven core services. To reflect the logic of this model practice objectives and practice activities follow program activities. As such they are denoted by the letters "C" and "D" respectively.

Figure 6 which appears on the next page shows the relationship between Practice Objective (1.2A) and the associated practice objectives (1.2C) and practice activities (1.2D).

Figure 6

CNIB MANITOBA DIVISION
PRACTICE ACTIVITIES FOR PRACTICE OBJECTIVES (1.2C)

PROGRAM OBJECTIVE (1.2A)
To increase awareness and knowledge of CNIB services offered to blind and visually impaired individuals.

PRACTICE OBJECTIVE (1.2C-a) Rehabilitation Counselling
To increase client's awareness and knowledge of all CNIB services which may be available to him/her.

PRACTICE ACTIVITIES (1.2D-a) Rehabilitation Counselling
Give information about each service area to allow client to make an informed decision regarding his/her service path.

PRACTICE OBJECTIVE (1.2C-b) Rehabilitation Teaching
To increase client's awareness and knowledge of a variety of rehabilitation teaching techniques in order that the client can choose.

PRACTICE ACTIVITIES (1.2D-b) Rehabilitation Teaching
Outline areas of instruction with relevant examples.

PRACTICE OBJECTIVE (1.2C-c) Orientation & Mobility
To increase client's awareness and knowledge of instruction plan and techniques necessary to safely and confidently travel independently.

PRACTICE ACTIVITIES (1.2D-c) Orientation and Mobility
Explain all phases of the instructional process.
Demonstrate techniques through simulation.

PRACTICE OBJECTIVES (1.2C-d) Career Counselling
To increase client's awareness and knowledge of all phases of career development in order that client can make an informed decision.

PRACTICE ACTIVITIES (1.2D-d) Career Counselling
Explain all areas of the career planning and development phases.
Share examples from other experiences of blind and visually impaired people.
Match client with peer to assist with illustration of examples.

Figure 6 (Continued)

PRACTICE OBJECTIVES (1.2C-e) Adaptive and Technical Aids
To increase client's awareness and knowledge of the availability of aids and appliances which may enhance visual functioning.

PRACTICE ACTIVITIES (1.2D-e) Adaptive and Technical Aids
Show and demonstrate aids and devices.

PRACTICE OBJECTIVES (1.2C-f) Vision Rehabilitation
To increase client's awareness and knowledge about services provided through the Sight Enhancement Centre.

PRACTICE ACTIVITIES (1.2D-f) Vision Rehabilitation
Explain clinic process.
Explain the necessity of understanding functional vision loss.
Explain and demonstrate magnifying devices.

PRACTICE OBJECTIVES (1.2C-g) Library Services
To increase client's awareness and knowledge of services available to enhance access to information.

PRACTICE ACTIVITIES (1.2D-g) Library Services
Explain library and transcription services.
Demonstrate TTB machine.

NOTE: All other examples of practice objectives and practice activities following from the remaining four program objectives are included within Appendices M through Q. Each core service is alpha coded to reflect the different objectives which link logically with the corresponding program objective.

From an evaluator's point of view, this exercise was again very challenging. In the verbal feedback provided by staff, at the conclusion of the two, two hour sessions, most said that examples were helpful, however they experienced the facilitator as having some difficulty in conveying the concepts clearly and easily. All staff commented that once immersed in the exercise, they learned a lot and saw this opportunity as a great team building exercise.

After the above interventions were completed the program model was defined. However, this process would need to be expanded to include the specialized services, namely Peer Group Programs, Recreation Program, Services to Deaf-Blind People, Occupational Therapy Services in order to truly reflect all service activities provided by CNIB Manitoba Division.

Furthermore, in accordance the final stage of the Evaluability Assessment framework as presented by Rutman (1980) management and other key stakeholders (board members; consumers) would have to review the contents of the program model before it would be officially endorsed.

While in theory a program model should be in existence before a review of service delivery is conducted, it was decided that this practicum provided a timely opportunity to at least begin a quality assurance evaluation. Peer review and consumer feedback were the interventions selected to answer questions about the service delivery model relative to its clarity and logic.

Peer Review Process

Peer review is a technique associated with the Quality Assurance approach to program evaluation. This technique is intended to use peer professionals within an agency to review policies, case

performance, service delivery, etc. Furthermore peer review is intended to be a continuous method in which ongoing evaluation of quality service is conducted.

The expectation of the specific application of peer review within this practicum was to have staff analyze how their specific interventions with clients fit within pre-determined criteria. It was intended that case presenters develop an understanding of the analytical process required to evaluate clinical practice. Through the utilization of this technique it was intended that staff evaluate performance using quality assessment criteria. Members of the Peer Review Committee were intended to use the service delivery criteria to facilitate discussion through which case presenters would be guided in their analysis of each case.

According to the literature (Coulton, 1979) one way in which service quality is measured is by asking questions about the relationship between defined standards of practice and what occurs in reality. In other words, do practitioners intervene with clients in accordance with agency expectations about what constitutes good practice? Although there are prescribed CNIB standards of practice about the intake process, file recording, and case closure, there is little guidance regarding the formulation of clinical assessment, plans/goals, or, in many cases, service modalities. Because these attributes are seen as critical within successful clinical practice and are recommended as a guide to

practitioners concerned with quality of care issues, I decided to use the general criteria defined by Coulton (1979) to structure this evaluation process.

Three staff volunteered to form the Peer Review Committee. I facilitated this process, however, I stated very clearly that this process was a new one for me. Two staff presented three cases for review. Definitions pertaining to general and specific criteria, as articulated by Coulton (1979), were used to guide this process. I reworded some of the questions as originally proposed by Coulton (1979) to correlate with CNIB's service delivery process (see Appendix H - Specific Criteria - Service Delivery Process). Committee members were asked to review the criteria in preparation for the case presentations. They were advised that this process was not intended to be a performance appraisal rather a critical analysis of CNIB's service delivery process.

The presenters were asked to present three different cases, representing young, middle, and senior age groupings. Presenters were given both the general and specific criteria as guides in preparation for their comments before the review committee.

Before reviewing the client cases, I outlined the purpose of the peer review process and provided basic background information about quality assurance evaluation. I clarified the purpose of the process and defined the roles and functions of committee

members and presenters. I asked that each presenter provide background on each client including their name, age, eye condition, and their role. I also stated that the service delivery process would be analyzed from the vantage point of the presenter. In other words, the presenter was not to comment on the involvement of other CNIB staff unless these staff were present during this review.

Case #1

The first case presented, involved a young male under the age of thirty years. This person had been a client of CNIB since his formative years. He is totally blind. His first "in depth" involvement with CNIB occurred after completion of his high school education when he was seeking help in planning for a future career.

With respect to the first phase of service delivery, that of initial contact, the worker reported he responded immediately to this client's request for service. The time span between the first call and first interview was one week. In terms of assessment, the worker determined that this client was clear about his career objective and had wanted assistance from the worker to continue post-secondary studies. After the necessary materials and equipment were purchased, the client ceased active involvement with CNIB. After two years of education were completed, the client dropped out due to the unavailability of materials in alternate

format. The client re-contacted the worker because he did not know where to go or what to do, vocationally. Plans and goals were re-established and the client participated in a work place assessment course leading him to eventual employment. At this point the presenter concluded his formal presentation and members of the Committee asked questions.

When asked about service delivery modalities or methods, the presenter said that this client was one who had a clear direction and was not wanting to consider other vocational possibilities. However, after the client left his education program, the worker felt that he had the opportunity to explore different possibilities one of which was work assessment. The worker was also asked about the assessment techniques used to arrive at a decision regarding career choice. The worker indicated that assessment tools are primarily subjective and based on previous experiences achieved by other blind people, previous school performance and stated interests. When asked about case closure, the worker indicated that this client had recently stated that he wishes to return to college to pursue a business diploma. This will necessitate a re-assessment of his abilities in preparation for provincial government support. Once this client is employed in a field of his choice, the case will be closed.

Case #2

The second case presented was by the same worker as above and involved a visually impaired male who had recently lost his position as a result of significant sight reduction. This individual requested CNIB service to determine whether or not he could continue his current vocation. He had also requested that a career counsellor explore other vocational possibilities with him. Because one of the Peer Review Committee, members had also provided service to this client, additional comments were added during the presentation.

This client had been referred by a CNIB rehabilitation counsellor to a rehabilitation teacher and career counsellor. All three professionals who had direct involvement with client were present during the Peer Review process. With regard to the time frame between intake and initial contact, all stated they had responded within a short time frame ranging from one to three weeks. The client after having had all CNIB services explained by the rehabilitation counsellor and determining a service plan, selected services typically provided by the rehabilitation teacher and career counsellor. An assessment conducted by the rehabilitation counsellor and verified by the rehabilitation teacher and career counsellor revealed that this individual seemed depressed as demonstrated by a lack of self-initiative in making commitments or decisions relative to career development, home management skills, and/or communication skills even though he had initially

identified these as areas of need. Appointments were scheduled in cooperation with the client, however within a short time frame, they were cancelled. As a result, the rehabilitation counsellor, the rehabilitation teacher and career counsellor reported that they were unable to provide any useful instruction or guidance in the areas identified by this client.

Upon completion of the formal presentation, committee members asked whether or not the client's failure to progress had been considered as a failure of the CNIB service delivery process. It was generally agreed that CNIB staff had gone out of their way to provide service to this client with no success. The progression of this case demonstrated the reality that clients cannot be assisted if there is no commitment on their part to the rehabilitation process.

Committee members and presenters expressed that they could not comment on service delivery methods and closure since this client did not engage in the rehabilitation process such that agreed upon plans or goals could be measured in terms of their success or failure. Nonetheless, committee members and presenters felt that a review of this case allowed them to analyze their involvement in the lives of clients especially those who would obviously benefit from CNIB intervention.

Case #3

The third case was presented by a rehabilitation counsellor and involved a visually impaired senior woman. This woman's vision loss was caused as a result of the aging process. She had been involved with the agency for eight years. The presenter had become involved with the client as a result of complaints she had lodged relative to CNIB building conditions. In terms of intake or initial contact, the worker had responded immediately. In talking with the client she did not express any specific needs beyond what had been stated above. The worker had recommended after an assessment of the client's current situation that she have a complete medical examination based on complaints about being cold while participating in CNIB activities. The worker had also noted that she was having a great deal of difficulty hearing normal conversation. Beyond assessment and referral to a medical facility, the client did not express an interest in any other service. She was participating in one of the CNIB peer groups and the CNIB recreational program. Because the client had not identified any rehabilitation objectives, services were provided on an as needed basis. Members of the Peer Review Committee did not have any questions to add to the case discussion. Committee members stated that a discussion of service delivery methods or case closure were premature as this client would receive service on an "as needed" basis for years to come.

Summary

As an evaluator of this peer review process it is difficult to identify the strengths of this process as my experience is so limited. As stated in Chapter 2, while the literature outlines the peer review process clearly, at this point, there is little empirical support for its effectiveness. The effectiveness of this approach would be clearly established once a quality assurance program was implemented and further empirical support for its merits documented. In addition, the success of the peer review process would be determined by the ability of the particular staff grouping to critique performance objectively and respectfully. In cases where communication is poor or ineffective, this process would not work. Furthermore, it would be essential that a clearly defined program model in conjunction with an established service delivery process be in place in order for standards of practice to be qualitatively analyzed or assessed.

When asked for feedback from the presenters and committee members, they all agreed that the process had merits. All participants stated that the peer review process had increased their skills in the area of clinical analysis. They also stated that it was useful and essential to look at cases systemically which, in their opinions, would lead to improved service quality. Finally they recommended that this method of evaluating client intervention be adopted within the multi-disciplinary team setting as more meaningful case discussions would occur.

The presenters stated that the process allowed them to re-conceptualize their involvement with clients in a well organized fashion. However, committee members had a difficult time asking questions using the pre-determined criteria because they found it difficult to objectively separate their roles as staff from peer review evaluators.

Perhaps the most difficult challenge was analyzing casework, using a linear framework while conceptualizing service delivery as a systemic process. Presenters, committee members, and I realized very quickly that it was very difficult analyzing the service delivery process in a methodical fashion. What seemed evident was that the presenters did not see their work with each client as following the five phases of service delivery. Rather, they looked at the history of each case within a global context. Once I became aware of this confusion, I attempted to re-define the criteria and the process, however, the presenters found it a challenge to re-conceptualize their involvement relative to the service delivery criteria I had provided. Committee members seemed to have similar difficulties.

Without defined standards of practice from which a complete service delivery process is articulated, it is difficult to answer questions regarding the achievement of good practice. It is apparent from the peer review process, that some staff do not have well defined skills in the areas of goal formulation and

service modalities, and case closure. A more extensive evaluation of all core service areas applying the criteria used within this process would reveal strengths and weaknesses within the current CNIB service delivery system. Once a review of this kind is completed, staff would participate with more confidence in peer review.

In addition to assessing the current service delivery system with CNIB, the peer review process was used as an educational tool for staff and myself in order that its merits could be evaluated from an experiential standpoint.

Consumer feedback Interviews

The final phase of the practicum involved the interviewing of six clients: three who were blind and three visually impaired. Two clients were selected representing young, middle, and senior age groupings. The interviews were conducted in three phases. Assigned workers called each client giving basic information about the project. I called each client and read the client consent information and a description of the purpose of the project. In all but one case, clients were contacted a few days later at a convenient time and the formal interview was conducted.

Each client was asked what services they had received. In all six cases, the clients identified services on the basis of workers names rather than position functions. Once I had matched the

worker's name with the appropriate position, I explained the role of those workers who had primary involvement with each client. Clients were asked to first give their general comments about the services they had received. During the next phase specific questions relative to the five phases of service delivery were asked. Questions were reworded in order that consumers understood their content. All but two interviews was conducted over the telephone and these were conducted in person. The results of the interviews are summarized under the following headings: 1) General Comments; 2) Intake/Initial Contact; 3) Assessment; 4) Treatment Plans/Goals; 5) Service Delivery; and 6) Termination/Outcome.

It is important to note that in every case the consumers interviewed have had involvement with several CNIB staff over varying periods of time. Those that participated in this research are at different points in the rehabilitation process. As such, in some cases these clients have not been seen by a CNIB staff member recently while in other cases clients are currently being seen by more than one CNIB worker.

Furthermore, although in most cases consumers had received between three and seven rehabilitation services, they only commented generally about their experiences with sight enhancement and library services. There were no criticisms expressed about either service.

General Comments

In every interview, consumers reported several positive comments relative to the services they had received. It was noted that younger clients had more criticism about CNIB services overall than did seniors. Seniors typically stated that their workers were responsive, kind, and empathetic or sympathetic. Middle and younger aged consumers reported that workers were knowledgeable about the services and skilful within their areas of expertise.

When consumers were asked if they had any criticisms of CNIB services, seniors expressed no concerns while younger clients expressed some. Examples included: 1) lack of knowledge in the specific field; 2) general unhappiness with the job resulting in lack of initiative and creativity; 3) concerned with own agenda rather than client needs; 4) failure to report rationale for the frequent change in workers; 5) lack of knowledge about other resources external to CNIB; and 6) lack of interest in client's problem.

Intake/Initial Contact

All interviewees were asked the following questions:

What is the time between initial contact and visit?
Was the time frame acceptable to you?

What is the presenting problem(s)?
Did you feel that the worker understood the problem?

What service(s) were offered?
How clearly was/were the service(s) explained?

In all but one case, clients stated that they were contacted within an acceptable time frame and appointments were scheduled promptly. One younger client indicated that he had to wait six weeks for an appointment. That same client stated that his counsellor does not return phone calls for several weeks. As a result he contacts other CNIB staff regarding service queries.

In all but two instances consumers reported that workers understood their problem(s). Senior clients indicated that they often did not know what they needed, however, their workers, through suggestions and guidance, helped them identify and clarify their needs. In all cases middle and younger aged clients said that once CNIB services were explained, they knew what they wanted.

In one case, a younger client stated that the worker did not understand or listen to his problems. He indicated that this worker ignored his views and asked irrelevant and inappropriate questions. Another female client stated that the worker seemed to understand her problem but did nothing to assist her.

Regarding the third question about the explanation and provision of CNIB services, in only one instance did a consumer indicate that CNIB services were not explained. In almost every case

clients reported that they were informed of all appropriate or relevant services during the initial phase. One younger client stated that no one explained the services to either his parents or him. He expressed that he had to become very assertive with some CNIB staff to achieve his desired objectives.

On the other hand, most clients stated that explanations relative to the specifics of each service provided were not given, with the exception of rehabilitation teaching and orientation and mobility instruction. Consumers generally reported that services provided by rehabilitation counsellors were rarely explained while services provided by career counsellors and adaptive and technical aids staff were explained on some occasions. Rehabilitation teachers and the orientation and mobility instructor were reported as being very clear about the services they provided.

There were no examples in which clients expressed that they had been referred to an inappropriate service. Some clients did indicate that they had been previously dissatisfied with particular workers, however, in all but one case, conflicts had been resolved as a result of worker re-assignment, staff turnover, or natural case closure.

In summary, the feedback relative to questions associated with initial contact are in most cases positive. Senior clients had very little criticism. This is perhaps due to the fact that most seniors

are not intensively involved with core services except rehabilitation teaching. library services and sight enhancement services. Senior clients needs are generally met through participation in CNIB peer groups or recreation programs. These programs were not included within this evaluation. Furthermore, senior clients rely on family members, volunteers, or external agencies for practical activities such as meal preparation, money management, ot transport to medical or other appointments.

Alternatively, younger clients are more critical of the CNIB and its services. This may be explained by the fact that they are typically intensively involved with several core services. In addition, these clients may be more invested in the receipt of quality services because they will utilize the CNIB for many years to come. Finally younger clients tend to experience more difficulty in adjusting to the loss of sight and as a result rely on CNIB for more emotional support. Because blindness is most commonly associated with the aging process and occurs gradually, the sense of loss for seniors is less dramatic than for younger people who typically experience intense emotional loss when blindness occurs.

Assessment

All interviewees were asked whether or not their workers had assessed their needs appropriately. With the criticisms reported above, all but one client did not have anything to all. One middle aged client stated that his previous career counsellor did not

explore different career options. As a result he felt that he only had one choice. This client did state that with his current worker he has learned that there are several related career directions within his previous field of expertise. This same client expressed concern for the lack of objective assessment techniques available to CNIB career counsellors. In his opinion, this individual stated that more resource materials and testing aids were needed within this service area.

Treatment Plans/Goals

Interviewees were asked the following questions:

> Was the treatment plan stated?
>
> Did the plan(s)/goal(s) reflect client participation?
>
> Were long and/or short range goals determined and articulated?

In most cases consumers reported that after the initial assessment which in all but one case were conducted by a rehabilitation counsellor, they were informed about who they would be referred to for future service(s). All clients indicated that they were either told that a specific worker would be in contact by telephone for the purpose of arranging an appointment. Typically younger clients were instructed to call the specific worker themselves. No one expressed any concern about this phase in the process.

In some instances consumers felt that plans or goals were not client directed. Criticisms included the following: 1) workers were too pushy seeming more concerned with meeting their needs than the client's; 2) workers made decisions for clients rather than considering the client's views; and 3) workers did not provide adequate information to clients to facilitate goal setting. These views were commonly held by middle or younger aged clients.

In general consumers reported that clear client centred goal planning occurred within the areas of career counselling, adaptive and technical aids consultation, and orientation and mobility. Clients felt that their wishes were respected, heard, and considered in service planning.

With respect to long and/or short range planning, consumers expressed that their workers (rehabilitation counsellors) in all cases explained the rehabilitation process clearly during the initial phases of service. Middle and younger aged consumers stated that they were informed of the necessary skills required in achieving independence prior to being referred to specific service disciplines. Senior clients were typically more focused on immediate issues thus no comments were shared relative to long range planning. Client directed short range planning occurred more with middle and younger clients than with seniors. In the case of seniors decisions tended to be made by the specific workers. Interviewees did not experience this as negative.

In summary, comments pertaining to the formulation of plans/goals were critical except in the case of senior respondents. As stated previously, seniors may be less critical because their involvement with specific core services is usually short term and focused. Middle and younger aged consumers tended to be more concerned with "client directed" rather than "worker directed" goal setting. This is perhaps due to the fact that their involvement is intensive and long term.

Service Delivery

Interviewees were asked the following:

> Was the service modality specified? (Systemic, Psycho-Dynamic, etc.)
>
> Were the intervention strategies clearly articulated to the client?

With the exception of rehabilitation teaching and orientation and mobility, clients were not informed about the specific techniques used to facilitate goal attainment. Within these services specialties consumers were told what knowledge and skills were required in order that independence could be achieved. Of those clients who had received career counselling services in all but one case consumers reported that assessment techniques would be explained. One client stated that she did not have the assessment phase explained. In the case of rehabilitation counselling services,

clients were not informed about the types of techniques used as part of the counselling process. This was only expressed as a concern by one client.

In summary, clients expressed little concern relative to whether or not service modalities were explained. Consumers generally are confident that CNIB staff are trained and knowledgeable within their specific areas of expertise. As stated previously clients tend to be more concerned that the services they receive are client rather than worker directed. Typically this was a concern raised by younger and middle aged clients.

Termination/Outcome

Interviewees were asked whether or not they had been informed about case closure. In all but two cases, consumers reported that case closure was not discussed by rehabilitation counsellors. One client was told that he was "doing well" and did not require any more counselling. This client expressed that he had felt abruptly "cut off" from his worker. Another client stated that she was advised that she was "doing well", however, she was also advised that she could contact her worker if she needed further assistance.

With respect to the other core services, namely orientation and mobility, rehabilitation teaching and career counselling, clients stated that they were advised in advance of case closure. Those clients who had sought the services provided through the Adaptive

and Technical Aids Centre, indicated that case closure had not been discussed. In all these cases clients reported that they anticipated ongoing contact with this service area.

In summary, with the criticisms noted above, consumers were not overly concerned about case closure. Younger and middle aged clients generally asked questions relative to case closure while seniors followed their workers direction and advice.

It should be noted that CNIB National Policy, at the present time, does not define case closure as implied within the criteria used to evaluate the service delivery process. However, it is recognized and supported by CNIB management and direct service staff that service with clients does come to an end. In Manitoba, with the exception of rehabilitation counsellors who do not close case files, all other direct service staff contract with clients for the receipt of service(s) which in all cases conclude because the client and designated staff member agree that service is no longer necessary. CNIB National Policy states that client files may be formally closed in cases where the client is deceased, the client relocates to an unknown address, or the client requests that their name be removed from client records.

Summary

As with all other phases of this research, conducting consumer feedback interviews proved to be both challenging and difficult. Although I had introduced myself as a student evaluator and an employee of the CNIB it was difficult for interviewees to separate my two roles. Because of the many stories that were shared throughout each interview, it was sometimes difficult to re-focus clients on the purpose of my contact with them. This was especially true with the senior participants as they had so many stories to share.

Conducting these consumer interviews further enhanced my understanding of CNIB's service delivery process beyond comments shared during the peer review process. Consumers were better able to objectify and focus their comments than were staff. Although personally impacted by the services they had received, consumers were able to critically evaluate and analyze each service area. Alternatively, staff had more difficulty separating and analyzing their interventions relative to the five phases of the service delivery process. This may have been due to the fact that directions relative to the type of cases selected for presentation may have been clearer. In addition, staff may have been better prepared by having more details, in advance, about what was expected relative to the analysis of each case.

In spite of these deficits several comparisons were made. First of all, it was noted that both staff and consumers had a lot to say about intake/initial contact and formulation of plan/goals. Both staff and consumers stated that the time frame between intake and initial contact was acceptable. Second, clients shared more positive comments about their experiences relative to goal setting while staff had more difficulty evaluating their performance relative to this phase. Staff seemed to associate successful goal formulation with the amount of client involvement or commitment to the rehabilitation process. On the other hand, clients stated that they were more concerned with the fact that goal formulation was client rather than worker directed. Third, staff had more difficulty articulating the activities associated with the assessment and service delivery phases. This was supported by consumer comments as clients could not define or evaluate interventions within these phases.

In general, little attention has been focused on the refinement of these five phases of service delivery at the divisional level. CNIB national policies provide little guidance except in the cases of rehabilitation teaching and orientation and mobility. Until four years ago, training for rehabilitation teachers and orientation and mobility instructors was provided by CNIB National Office. As a result CNIB staff have more knowledge and first hand experience with these two service disciplines. Finally, staff commented that in all service areas, except rehabilitation counselling, cases are

closed. CNIB staff indicated that they have developed their own practice guidelines for file closure. CNIB National Policy does not endorse case closure except in cases where the client moves, dies, or refuses service. Consumers comments support this practice as indicated above.

In the proceeding section I have analyzed the achievement of my learning objectives. In addition, I have evaluated the success of this practicum experience from an agency perspective based on my experience with the CNIB direct service staff and the consumers who provided feedback in the final phase of the research.

Self Evaluation

In Chapter 4 two learning objectives were outlined. The first objective was to develop new skills acquired through the application of new techniques. The program evaluation literature helped provide a framework for planning and implementing a successful project (Herman, Morris and Fitz-Gibbon, 1987). After reviewing this literature, I was made aware of the necessary preparation needed to ensure success, including a review of agency documents, awareness of the key service delivery issues expressed by direct service staff and concerns or issues articulated by the Executive Director and senior management. In addition, I was reminded that I had to carefully attend to the amount of staff time and resources required to ensure completion

of this project. Finally, I needed to comply with agency policies and agreements with staff to ensure that credibility of the findings would be achieved. Not only was it essential that I gain an understanding of all of the necessary steps and considerations in preparing for this practicum, I also had to be knowledgeable of the techniques used so that staff would judge the process as worthwhile. The specific skills developed through this practicum are discussed below.

Obtaining skills in evaluability assessment have helped me analyze the core services provided within the Client Services Department using a goal and/or responsive oriented approach. The process for conducting an evaluability assessment enabled me to conceptualize each step of this process using qualitative interviews, questionnaires and focus group sessions such that the necessary clarification around program goals and objectives were achieved. The utilization of these interventions were consistent with both the goal and responsive oriented approaches as they require detailed and descriptive information as part of the data collection process and they require involvement of stakeholders. With the information gathered through this phase, namely the evaluability assessment and with senior management endorsement, I am better equipped to replicate this process by including all direct service staff.

In addition, a beginning knowledge of quality assurance evaluation using techniques associated with the peer review process have increased my understanding of a dynamic program evaluation approach. Upon reflection of this phase of the practicum, I gained some skills in guiding staff through an evaluation and analysis of their performance. In addition, I learned that staff expertise can be used to critically review service delivery rather than having to rely upon external expertise.

My second learning objective involved the assessment of my ability to look at CNIB objectively while evaluating the service delivery system within the Client Services Department. As stated in Chapter 4 it was reported that there have been many human resources changes within the Client Services Department, over the past three years, necessitating changes in the manner and focus of this practicum. Because I am the only senior manager within the direct service area, it was necessary that I clearly separate my role as evaluator and as a staff member. Although this was a challenge at times, during the staff phases of this research, I was able to critically analyze the program model with sensitivity. For the most part, staff expressed that they found this evaluation experience positive, although they were careful in their analysis of my performance. This was expected as until very recently all staff involved in this evaluation were directly supervised by myself. Secondly, although I had clarified my agency and student roles

with consumers, the interviewees at times asked direct service questions and provided criticisms which they hoped I would address as the Director of Client Services.

Overall, while there were many changes during this practicum, as a student and an employee of CNIB, I learned a lot. Most importantly, I learned that it is essential for a person in my role within CNIB to have the necessary skills in conducting a program evaluation. In addition, I learned that it is essential to have the ability to objectify service practices in order that critical changes can be made ensuring that service quality is maintained. Finally, I learned that it is essential to involve both staff and consumers in program evaluation ensuring that proposed changes are implemented with success.

The final objective of this practicum was focused on the agency. In Chapter 4, I stated that I had wanted CNIB direct service staff to have exposure to a contemporary program evaluation approach as I believed that an evaluation of this kind had not been previously conducted within the division. Although National Office staff audit agency performance every three to five years, the nature of this process is to determine whether or not divisional service practices comply with national policy. However, in 1989, an evaluation aimed at formulating recommendations relative to the organizational structure was conducted. Although staff had participated in this review, implementation of the results did not

occur with staff input. Because staff have expressed the need and desire to have input in service directions it was seen as essential that staff be involved in a process in which an evaluation of client service was the aim.

The final phase of program evaluation is that of reporting the findings and determining an implementation plan. While the staff involved in this practicum have been informed of some of the findings, senior management has not had the opportunity to discuss the results. A copy of this report will be given to the Executive Director for his consideration. Upon his review, an implementation strategy of the reported findings will need to be discussed before further research may be done.

In the final paragraphs of this chapter, I include share additional comments relative to my performance using statements taken from the "Utilization Enhancement Checklist" (Brown and Draskamp, 1980). The Utilization Enhancement Checklist is a grouping of statements organized into the following groups: 1) determining the evaluator's role; 2) understanding the organizational context; 3) planning the evaluation; 4) conducting the evaluation and communicating evaluation information. A series of statements are listed within each section and the evaluator is asked to rate his/her performance to determine his/her effectiveness (see Appendix Q). I have not used this checklist to rate my performance, rather I have used the content to enhance my analysis and organize my

thinking relative the typical phases of program evaluation as discussed in Chapter 2. The additional comments discussed below are critical and relevant to the work I have just completed.

The category referring to the evaluator's role, the evaluator is asked to rate his/her performance regarding personal commitment and the congruence of personal values with the objectives of the evaluation. In general, I saw myself as being committed to this process such that I was able to engage the interest of those staff who were involved. I believe that staff were pleased that I had spent the time and energy in focusing on the service delivery process using relevant techniques and a fresh approach. On the other hand, when considering my technical ability to complete the necessary tasks, I rated poorly. Because I was unfamiliar with the interventions used within this research, I felt that I may have been more respected had I exhibited more confidence when facilitating the focus group and peer review processes.

In the second category of the Utilization Enhancement Checklist, the evaluator is asked to assess his/her competence relative to his/her understanding of the organizational context. While I have a good understanding of the CNIB structure and service delivery process, the decision regarding the implementation of any of the evaluation phases conducted as part of this practicum, must be endorsed by the Executive Director, the Divisional Client Services

Committee, a sub-committee of the CNIB Manitoba Divisional Board of Management, the CNIB Manitoba Division Management Committee, and lastly, direct service staff.

In the next category of the Utilization Enhancement Checklist is focused on planning for the evaluation. Statements are aimed at preparing respective audiences for evaluation, awareness of political factors, and identification of sources of positive or negative resistance. As stated earlier all staff were made aware in writing and verbally of the evaluation process. The Executive Director verbally sanctioned this process, however, staff initially were reluctant to be involved because of time commitments and future implementation of results. It was noted previously that staff participants found most of the evaluation activities beneficial, however, they are waiting to find out whether or not implementation of a continuous program evaluation approach is endorsed by management.

In the fourth category is focused on conducting the evaluation. Specific statements are aimed at data collecting and analysis, responding to changing information needs and being responsive to participants needs. In all areas I would rate my performance high. Because I have discussed the evaluation process extensively in Chapter 5, further comments would add little to this component.

Finally, the last category of the Utilization Enhancement Checklist is focused on the communication of evaluation results. Thus far I have shared some of my results with staff who were involved in various phases of the practicum. I have been asked to share a written copy of this project with the Executive Director before staff review it. I will discuss my conclusions with the Executive Director in the hope that further work on the development of the program model may be conducted and a continued review of the service delivery process, implemented.

Chapter Summary

Within this chapter a detailed account of the evaluation findings was given along with an analysis of the evaluator's role. The last section included an analysis of my performance based on self perceptions and observations, written and verbal feedback received from staff and consumers, and guidance taken from the Utilization Enhancement Checklist. Although a challenging experience - in all I have increased my knowledge and developed skills in program evaluation. This growth can only be positive for the CNIB.

The final chapter of this document addresses the implications of adopting a strategy involving the use of approaches related in this practicum.

CHAPTER 7

CONCLUSION

Although there have been many challenges during the process of developing and implementing this research, the experiences have been beneficial both for me and CNIB Manitoba Division. From a personal perspective the knowledge and skills developed through this practicum have resulted in enhanced appreciation of program evaluation particulary the techniques inherent in Evaluability Assessment and Quality Assurance. While I would by no means consider myself an expert, I do know where to go for guidance and how to begin an evaluation process.

There are also significant benefits and implications for the CNIB Manitoba Division. Given the current changing economic climate, the role of program evaluation within the human services field is more important than ever. Agencies like the CNIB are required to be more accountable for the services they provide to their consumers. The old saying, "the public has the right to know" is applicable in today's world. Because of this reality it is the responsibility of key decision-makers to ensure that front-line staff are equipped with the necessary skills and expertise to analyze the efficiency and effectiveness of their programs and services.

It is also the responsibility of key decision-makers and volunteers to ensure that public funds are utilized to provide the best quality service. Financial supporters of non-profit agencies must be assured that their dollars are allocated to services aimed at addressing and resolving problems associated with human need in this case, the loss of sight. In addition, donors must be assured that services are provided in an effective and efficient manner. Donors, volunteers, concerned citizens, and consumers expect that the agency will be responsive to the wishes of those to whom services are provided. Organizational survival will be insured if key decision-makers and volunteers are responsive to consumer feedback.

With these factors in mind, how will CNIB Manitoba Division benefit from this research? Having supported my work and in my position as the Director of Client Services, management may be confident that the necessary skills to fulfil the obligations associated with that of an internal evaluator have been satisfied. Having a staff member who is knowledgeable about the organization and its service delivery process as well as one who is equipped with the necessary program evaluation skills will help to ensure that service quality is offered through the CNIB at no direct cost to the agency. Because service accountability must be assured by agencies like the CNIB, it is necessary that program evaluation aimed at assessing service quality become an integral part the service manager's position. It would be advantageous for

the CNIB to have a staff member with knowledge of the Quality Assurance Approach as current trends suggest that attention must be focused on "quality of care" issues if organizational survival is to be assured.

In reviewing the experiences of staff and consumer participants, several pertinent issues have emerged. If management supports the notion that more attention be focused on service quality using program evaluation techniques, then direct service staff input is essential. Based on responses from the questionnaires, participation in interviews, focus group sessions and the peer review process it was evident that staff benefited. Many meaningful statements about the process were offered throughout.

Staff feedback suggests that implementation of a peer review process within the multi-disciplinary team would challenge them professionally thereby contributing to more effective decision-making about client service.

In addition, staff reported that all CNIB programs and services should be included in the final formulation of a divisional program model. While the experience of clarifying program goals and objectives was reported as challenging and intense, participants stated that this process forced them to analyze their individual practice skills within the context of the whole organization.

This phase of the practicum process was significant as the newly defined program and practice goals and objectives have formed the basis from which future program evaluation of outcome(s) may be possible. As expressed during the interview phase, participants stated that all direct service staff would benefit from an experience whereby the mission, goals, objectives and primary service activities were clarified. These views were supported during the comments shared within the focus group sessions.

In preparation for this formal research and throughout the staff components of the practicum, it was evident that direct service staff view the participatory approach to evaluation as valuable. Direct service staff believe that decisions regarding service delivery should be made with their input. It is apparent that a wealth of knowledge exists within the Client Service Department as direct service staff respond to consumer needs on a frequent basis. This reality coupled with the professional expertise required to intervene in the lives of blind and visually impaired people, have resulted in an understanding of the many challenges faced by clients as well as an understanding of the complexities associated with the provision of a variety of rehabilitation services. When asked to objectively analyze all aspects of service delivery, it was demonstrated throughout this research that direct service input is an essential component of quality assurance. There is little doubt that through an established quality assurance process within the CNIB Manitoba Division, consumers would ultimately benefit and

as suggested by Ferguson (1977) staff morale and motivation would improve as a result of having direct input into the development of a peer review process aimed at evaluating service delivery.

With respect to the feedback received through consumer interviews, several important points were raised. Overall younger and middle aged clients expressed more criticism of the specific services provided than did senior clients. This finding is attributed to the fact that blindness is typically associated with the aging process, thus seniors anticipate that vision loss may be a reality however, younger people typically experience more emotional trauma. In addition, younger and middle aged clients must make decisions relative to their personal and vocational futures while seniors are predominantly concerned with leisure and/or home management activities.

Differences in responses relative to the five stages of the service delivery process were also significant. In most cases seniors were concerned with the overall temperament of their workers. They reported that an empathetic approach was important. Younger and middle aged clients were more concerned with the receipt of service information. They wanted to know about the availability and accessibility of specific services. Furthermore seniors were more concerned with initial contact and goal formulation than other phases. Seniors wanted an immediate response to their needs.

They also wanted to know what service was being provided as well as the duration of service provision. While younger and middle aged clients were concerned with the immediacy of initial contact, regarding goal formulation, these individuals were primarily concerned with client centred goals. On the other hand, senior clients were more interested in goal attainment than the goal setting process. It is also worthy of note that seniors typically did not request counselling services rather they were primarily concerned with the achievement of practical skills such as those associated with home management instruction. Younger and middle aged clients expressed that counselling services were very important.

What are the implication of these findings for CNIB? It is apparent that younger and middle aged clients require a service delivery process in which client rights or choice are considered. It is also critical that "adjustment to blindness" group counselling continue to be made available as younger and middle aged clients need the expertise of professionals and the support of their peers during the initial stages. It is evident from senior responses that they are relatively happy with CNIB services at least in the "core" service areas. A review of senior feedback relative to the receipt of peer group and recreation services is recommended as this client population are frequently involved in these programs.

Overall most individuals stated that specific services were explained in a clear and understandable fashion. While most direct service staff explained the skills necessary to achieve personal independence, service modalities were rarely defined. Finally, with the exception of the rehabilitation counsellors, case closure practices were discussed with consumers.

From the analysis given by staff involved in the peer review process and the responses from consumers, some important themes emerged. Both staff and consumers offered more comments relative to the initial contact, goal formulation, and termination phases. Staff had more difficulty discussing key components associated with assessment and service interventions. Comments shared by consumers support this finding. It is concluded that more work is needed in these areas of the service delivery process as the ability to analyze assessment techniques and intervention strategies would assist staff in an eventual evaluation of service impact and/or outcome.

With an articulated program model, a clearly defined service delivery process and feedback from consumers, meaningful and relevant strategic and program planning may be more likely. All stakeholders will have had input into what and how CNIB services should be provided. As a result service quality will likely be assured.

Some of the recent activities within CNIB would suggest that from a national perspective, key decision-makers are concerned that more emphasis be focused on service quality. This is demonstrated by the fact that, in 1994, the President and Chief Executive Officer, Dr. Euclid J. Herie, directed his staff to begin a nationwide review of its "seven core" services. Staff, consumers, and collaterals have been interviewed and surveyed over the past six months. Although the preliminary report has not been drafted general feedback collated thus far indicates that changes are eminent. The overall objective of this review is to ensure that the CNIB is providing services which are responsive to the needs of its consumers.

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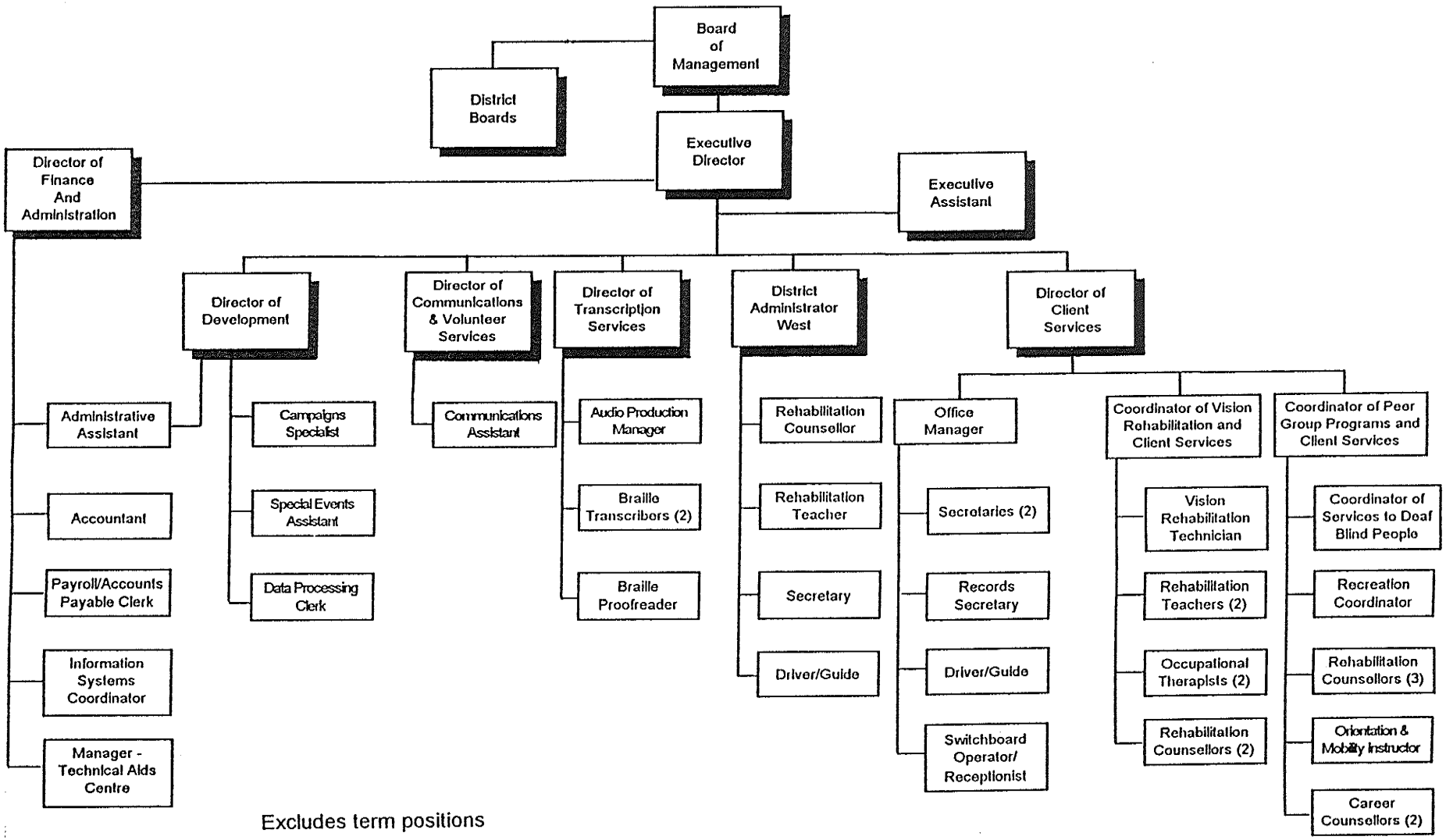
APPENDICES

The Canadian National Institute for the Blind - Manitoba Division

March 31, 1995

Organizational Chart

With Position Titles



Excludes term positions

Appendix A

Appendix B

CNIB Mission Statement

The Canadian National Institute for the Blind (CNIB) is a national voluntary agency providing services to individuals across Canada to whom loss of vision is a central problem in personal and social adjustment. The CNIB also acts as a consultant and resource agency to the helping professions, government departments and private industry.

The basic aim of the CNIB is to help blind and visually impaired people find ways to lead satisfying lives. Underlying all CNIB services and actions is the belief that blind or visually impaired individuals can be integrated into the mainstream of community life, according to their ability to function within that community.

The specific objectives of the CNIB are:

* **To ameliorate the condition of the blind of Canada;**

* **To prevent blindness; and**

* **To promote sight enhancement services.**

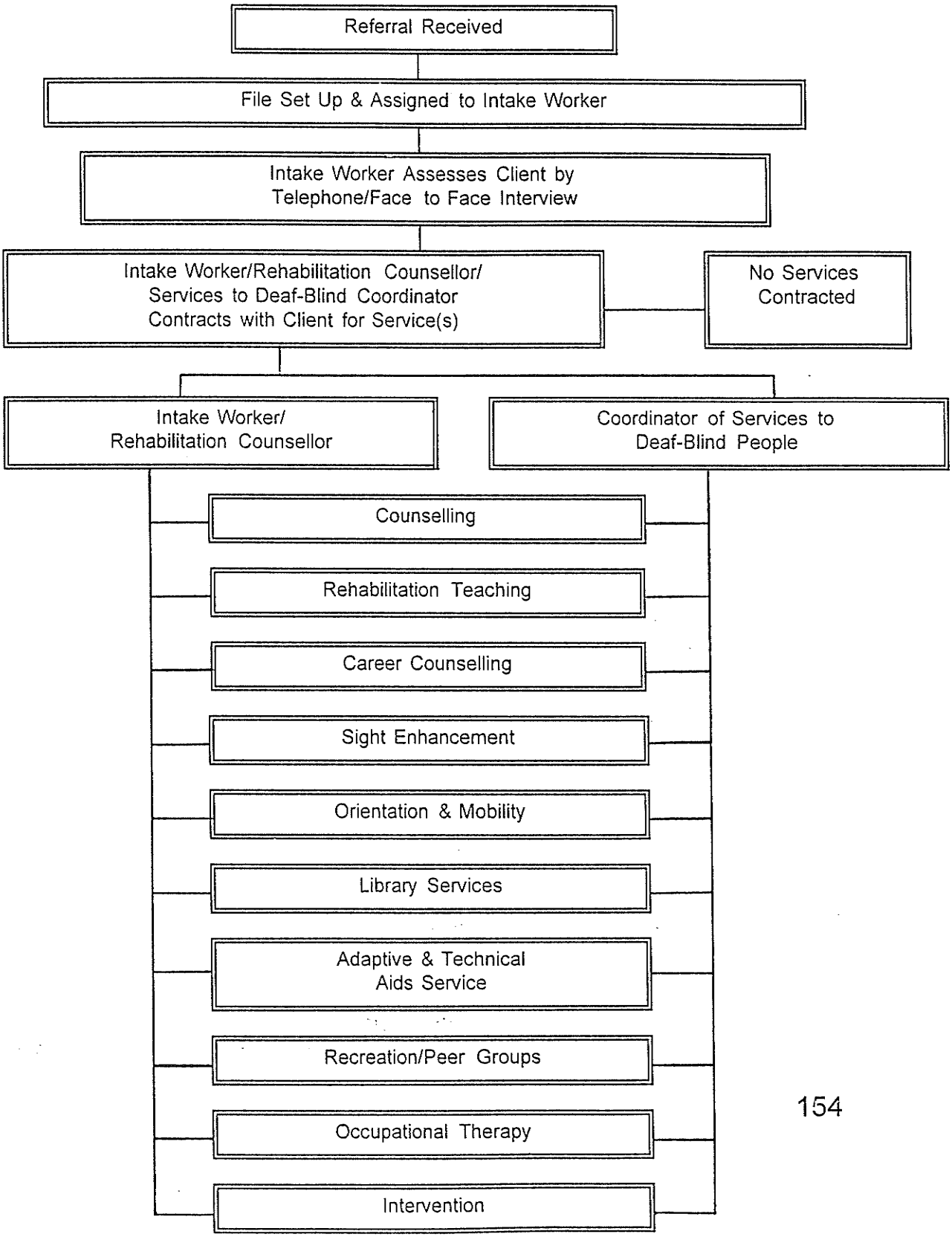
The CNIB is committed to helping anyone with a vision problem that cannot be corrected using ordinary lenses and that significantly affects the person's ability to function normally. The CNIB uses a team approach in which staff, volunteers and clients work together towards a set of common goals. Our purpose is to help blind and visually impaired persons achieve the lifestyle they want, both at home and in the community.

CNIB Manitoba Division
1080 Portage Avenue
Winnipeg, Manitoba, R3G 3M3

Telephone (204) 774-5421
Fax: (204) 775-5090

Appendix C

CNIB - MANITOBA DIVISION
CLIENT SERVICES DEPARTMENT
SERVICE FLOW CHART



Appendix D

Staff Interview Guide

Participants were asked the following questions;

1) What, in your opinion, is CNIB's mission statement?

2) What, in your opinion, are CNIB's goals?
(Note: Provide definition of program goal)

3) What, in your opinion, are CNIB's objectives in relation to direct service?
(Note: Provide definition of program objectives)

4) If no objectives are defined, ask the participant if he/she believes that with the absence of clearly defined objectives, can problems arise?

5) If the participant answers "yes" to the previous questions, ask him/her to outline the problems.

6) Are there any implications for the agency without having clearly defined program goals/objectives? (e.g program planning, evaluation, etc.)

7) How might the agency undertake an evaluation of services without clearly defined program objectives?

8) Note: Provide a definition of Program Activities. When you consider the linkages between goals, objectives, and activities, are there any gaps or problems, in your opinion? How might these problems be addressed?

9) What adjustments are needed in order for goals/objectives achievement to be made possible? How might these problems best be resolved? Can you give any concrete suggestions?

Appendix E

Direct Service Staff Questionnaire

Staff who agreed to participate in the evaluation were asked to respond, in writing, to the following questions;

1) By definition, a mission statement is a global, philosophical statement whereby the agency states who it will serve and what services it will provide. With this in mind, based on your understanding, what is CNIB's mission statement?

2) By definition, a "program goal" has a twofold purpose in guiding practitioners to accountable practice. "First the program goal serves as a focal point to navigate the entire scope of the program operations in a specified direction. Second, the purpose of the program goal is to function as an umbrella under which all other program elements are logically linked." (Unrah, p. 122). Based on your understanding, what is/are CNIB's goal(s)?

3) By definition, "program objectives are intended as measurable results that all clients in a program must strive to achieve. In general, program objectives identify the general intervention approach offered to clients." (Unrah, p. 123). Based on your understanding, what are CNIB's objectives?

4) By definition, "program activities are the actions or behaviours which move a client and practitioner towards the accomplishment of an objective." (Unrah, p. 129). Within your particular service discipline, (e.g. rehabilitation counselling, etc., what are the primary activities within each of the following areas;

a) Initial Contact Phase
b) Assessment
c) Goal Formulation (What the client wants to achieve)
d) Service Delivery (What interventions/techniques are used)
e) Closure (How is service completed)

5) In your opinion, how does change within the organization affect the way in which service is provided?

6) In your opinion, what does the agency need to do to ensure that service quality is maintained?

Appendix F

STAFF CONSENT FORM

Quality Assurance Evaluation of Service Provision

of The Canadian National Institute

for the Blind Manitoba Division

I,_____ agree to the following:

That

1) I have been informed of and understand the purpose of the Quality Assurance Evaluation.

2) I understand that all responses to questionnaires will remain in the possession of the evaluator, Janet Hanevelt, and

3) further, all copies of individual questionnaires will be destroyed upon completion of the research.

4) the identity of any person's response/opinions will not be identified in any written communication or during the evaluation or within the final report.

5) my participation is voluntary and I can withdraw from participating at any time during the course of the project.

6) my individual responses will not be identified in any circumstance or documented in the written report.

_____ _____

Date Participant

Appendix G

Specific Program Activities

Adaptive and Technical Aids

a) Initial Contact Phase

general welcome to CNIB
inquiry as to the client's needs or requests

b) Assessment

After consultation on and demonstration of a variety of low and high tech. devices, assessment is made to determine if client (consumer) can use the device and will it fit the need.
Certain devices may be loaned for trial and assessment at home and on the job.

c) Goal Formulation

The goal of the CNIB Technical Aids service is to provide consumers with information and guidance to make informed decisions about the availability, selection, use, and purchase of technical aids and devices.

d) Service Delivery

1) consultation on a wide range of products
2) product demonstration
3) information and referral including research on individual needs and referral to appropriate services on information and training and advocacy
4) product sales (over 600 products in inventory)
5) maintain up to date information on client files

e) Closure

There is rarely closure in the Tech Aids Centre as most clients return to the centre with further inquiries about products as their daily needs change.

Rehab. Counselling

a) Initial Contact

During the initial intake phase data is gathered in order to formulate an initial definition of the problem. In addition to the necessary "tombstone" information data is collected regarding eye condition, health problems, safety issues, personal functioning and family background and community supports. CNIB services are described and the client is encouraged to identify problems he/she is experiencing with regard to vision. This information is used to identify goals for the future.

The purpose of this phase is to alleviate anxiety and obtain basic information, clarify if there are any safety or risk issues for the client, provide any basic information re: client services provided by CNIB.

The purpose of this phase is to collect information about what areas the client is not able to currently manage on an independent basis. Review of medical referral form re: eye diagnosis.

b) Assessment

Information gathered in the intake phase, along with impressions formulated re: strengths and weaknesses in the client and in his/her formal and informal support systems. The client and worker begin to set goals and formulate service plan. As the client's situation changes reassessment is required.

Determine functioning in all areas of client's life and assess personal skills in activities of daily living including; cooking, cleaning, mobility, ability to be self sustaining re: banking, shopping, money skills. Determine social needs.

The purpose is to interview client (and family members (if appropriate) to assess current functioning. Consult with community collaterals re: needs identified.

c) Goal Formulation

The client is provided with information regarding CNIB services. He/she is encouraged to meld his/her particular needs with the services offered and a realistic plan/goal can be mutually agreed upon.

Determine with client ADL needs. Discussion re: skills with self medication, cooking, eating, shopping, banking, cleaning, socializing and family supports. Prioritizing with clients' their needs, greatest safety needs first, followed by other daily living activities difficult to perform and the need for teaching or assistance, as well as social needs re: loneliness and isolation. Determining education employment needs and goals.

Client should be asked what goals they have which will result in the achieve of personal independence.

d) Service Delivery

An eclectic approach is used which most frequently includes education, CNIB services, and other community services. I also spend time reframing situations and providing a safe avenue for clients to express feelings so they can begin to work through the grief process.

Discussions around feeling and fears and provide support and understanding that these feelings are normal.

Reinforcement re: skills that client does have. Have client demonstrate skills they use and instruct methods to facilitate in these areas (coin I.D., pouring liquids). This helps to build confidence and gives the client a feeling of continuing competence. Referral to other service providers within the agency, ex: R.T. mobility, advocacy and referral to agencies outside CNIB. Interpretation, education and support to client and other family members.

Referrals to other caseworkers to perform instruction in their speciality area re: O&M, rehab teaching, etc.

Counselling to help client adjust emotionally to their loss of vision.

e) Closure

When the worker and client agree that the agreed upon goals have been achieved then closure is appropriate. Client is informed that further service is available if his/her situation changes in the future.

When issues clients have been dealing with have become settled or manageable, and when all referrals have been made and followed through, client is informed that they can call us if and when they need further service. Their file is only closed when they are deceased.

Review outcome of activities to determine if goals have been met. Determine if any new needs or goals have arisen. If client feels the goals have been met or chooses not to pursue them further, then a mutual agreement is made that service is completed.

Appendix H

CNIB MANITOBA DIVISION

Specific Criteria - Service Delivery Process

1) Initial Contact/Intake

What is the time between initial contact and visit?
Is the time frame acceptable? to the client?, to the worker?

What is the presenting problem(s)?
Is the problem clearly articulated?

What service(s) is being offered?
How clearly is the service(s) explained stated?
What might the client say?

2) Assessment

Has psycho-social assessment been completed?
What are the worker's impressions?

3) Treatment Plans/Goals

Is the treatment plan stated?
Does the plan reflect client participation?
Are long term goals set and documented?
Are short term goals set and documented?
Do the above goal(s) reflect client participation?

4) Service Delivery

Was the social modality specified? (Systemic, Psycho-Dynamic, etc.)
Were the intervention strategies clearly articulated to the client?
Were the interventions used consistent with the stated plan/goals?

5) Termination/Outcome

Has the case been closed appropriately?

Appendix I

CLIENT CONSENT FORM

Quality Assurance Evaluation
Client Feedback about Service Delivery

The purpose of this interview is to ask for your general and specific thoughts about your experiences of the services you received from the CNIB Manitoba Division, Client Services Department since you have been a client. The evaluator is Mrs. Janet Hanevelt, Director of Client Services. This project is endorsed by the Executive Director, Mr. Dean Cousens. Both the National Director of Rehabilitation Services of CNIB and the Ethics Review Committee of the Faculty of Social Work, University of Manitoba are aware of the contents of this project.

Your participation along with CNIB direct service staff will provide feedback to CNIB Management regarding client service delivery. Your comments will be included within the final written document, however, any reference to your specific circumstances will be amended or altered so that confidentiality is maintained. Only the staff who contacted you directly to ask for your permission to participate in this evaluation are aware that your thoughts are being shared.

Do you have any questions at this point?

Let me tell about the content of this review. Over the past three months staff have participated in a number of activities to develop an understanding of CNIB's Program Model for service. Specifically we looked at definitions of goals, objectives, and activities. In a group forum, staff were involved in discussing their perspectives about the management of specific cases. Now I would like to hear what consumers say about their experiences.

CNIB direct service staff were asked to select 6 clients, three who are totally blind and three who are visually impaired. Clients representing young, middle, and senior age groupings were selected. As stated above only the specific worker who has previously called you is aware of your participation in this evaluation. All notes regarding the contents of these interviews will be destroyed after final approval by the Faculty of Social Work, has been given.

Do you have any questions? Are you still interested in responding to questions regarding service?

I would like to schedule an interview with you of approximately an hour in duration to discussion your experiences? May we arrange a time?

End of Initial Contact.

Appendix J

Consumer Feedback - Interview Guide

Specific questions included;

1) How long have you been a client of the CNIB?

2) What services have you utilized within CNIB Manitoba Division? (Note: All services were outlined)

3) What has been your experience with each of the services you received? (Clients were asked to share both positive and negative experiences)

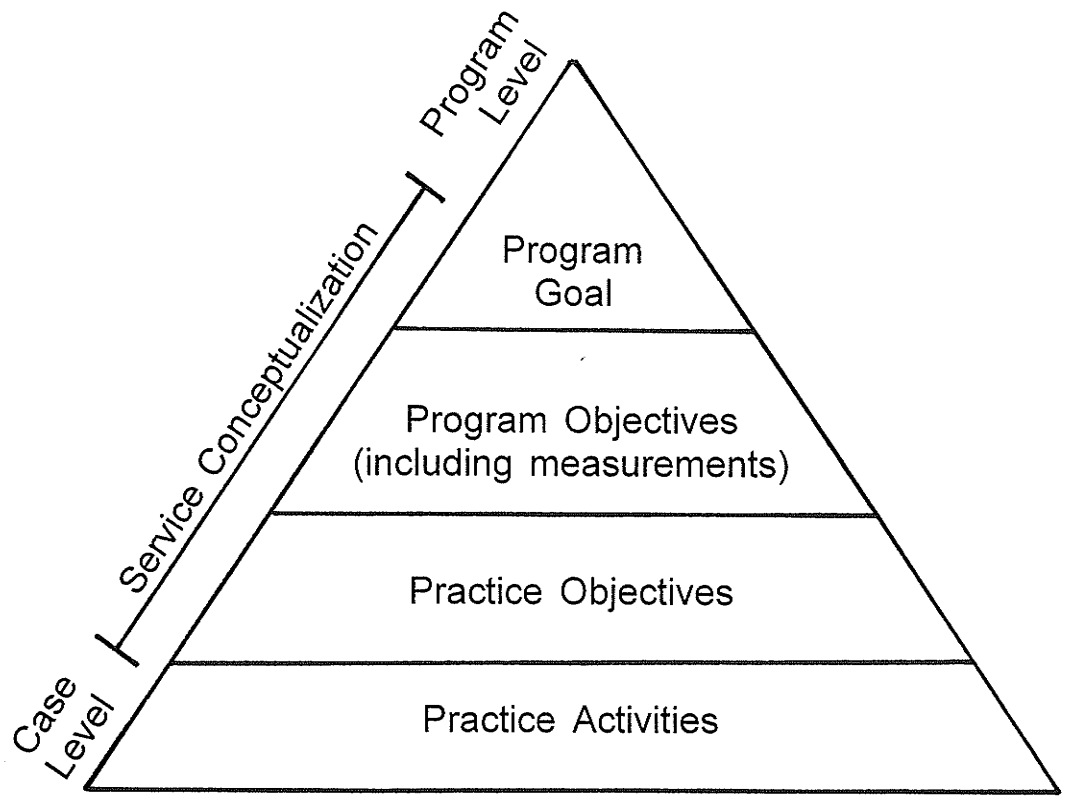
4) The specific criteria associated with those services received by the client, were shared. The client was asked to comment on specific experiences associated with each phase of the service delivery process.

5) All clients were asked to make suggestions or recommendations for future change regarding service delivery process (e.g. referral process, etc.)

6) All clients were told that they would be called and read the segment of the final report in which their personal comments were documented. This was offered to ensure that confidentiality was maintained.

Appendix K

Figure 1
A Program Logic Model for Conceptualizing Treatment Services



Unrau, Yvonne. (1993). A Program Logic Model, Approach to Conceptualizing Social Service Programs. **The Canadian Journal of Program Evaluation.** 8:1 (p 121).

Appendix L

EVALUATION

1. Comment on the Evaluators Presentation of Concepts

2. Comment on Process/Format of the Day

3. Do you feel that this activity was beneficial to your work?
   Yes _____ No _____ Comment

4. What did you find least beneficial?

5. Any additional comments for the evaluator.

Appendix M

PRACTICE ACTIVITIES FOR PRACTICE OBJECTIVES (1.3C)

PROGRAM OBJECTIVE (1.3A)
To increase awareness and knowledge of implications of blindness and visual impairment.

PRACTICE OBJECTIVES (1.3C-a) Rehabilitation Counselling
To increase client's awareness and knowledge of functional limitations of their specific eye condition.

PRACTICE ACTIVITIES (1.3D-a) Rehabilitation Counselling
Explain functional limitations present and future.
Match with peer for further education.

PRACTICE OBJECTIVES (1.3C-b) Rehabilitation Teaching
To increase client's awareness and knowledge of the implications of their specific eye condition relative to their ability to function in the home.

PRACTICE ACTIVITIES (1.3D-b) Rehabilitation Teaching
Provide information regrading functional vision loss with a corresponding adaptive technique such as a physical adaptation or device.

PRACTICE OBJECTIVES (1.3C-c) Orientation and Mobility
To increase client's awareness and knowledge of implications of blindness from a mobility perspective.

PRACTICE ACTIVITIES (1.3D-c) Orientation and Mobility
Explain how blindness affects the client's ability to move independently in familiar and unfamiliar environments without the use of mobility aids.
Demonstrate basic techniques.

PRACTICE OBJECTIVES (1.3C-d) Career Counselling
To increase client's awareness and knowledge of implications of specific vision loss on career planning and development.

PRACTICE ACTIVITIES (1.3D-d) Career Counselling
Explain how vision loss will effect certain career choices
Explain what other blind and visually impaired peers are doing
Match with peers who have similar eye conditions and career interests

Appendix M (Continued)

PRACTICE OBJECTIVES (1.3C-e) Adaptive and Technical Aids
To increase client's awareness and knowledge of implications of specific vision loss relative to their ability to use low and high end tech devices.

PRACTICE ACTIVITIES (1.3D-e) Adaptive and technical Devices
Explain availability low and high end technical devices.
Demonstrate simple devices.

PROGRAM OBJECTIVES (1.3C-f) Vision Rehabilitation
To increase client's awareness and knowledge of the implications of specific vision loss on daily functioning.

PRACTICE ACTIVITIES (1.3D-f) Vision Rehabilitation
Explain eye condition from a functional perspective.
Explain how magnification can assist in improved functioning.

PRACTICE OBJECTIVES (1.3C-g) Library Services
To increase clients' awareness and knowledge of the implications of specific vision loss relative to the ability to read regular print.

PRACTICE ACTIVITIES (1.3D-g) Library Services
Note: There are no identified activities associated with increased awareness and knowledge of the implications of specific vision loss.

Appendix N

PRACTICE ACTIVITIES FOR PRACTICE OBJECTIVES (2.1C)

PROGRAM OBJECTIVE (2.1A)
To facilitate the development of resources/services to benefit those individuals who experience vision loss.

PRACTICE OBJECTIVE (2.1C) All CNIB Core Services
To assess current skills of client; identify, develop, and implement resources/services needed by client so that personal goals (towards independence) can be achieved.

PRACTICE ACTIVITIES (2.1D-a) Rehabilitation Counselling
Assess client's current skills and abilities to determine the needs.
Explain CNIB or external agency resources/services which may meet needs.
If resources/services are not available, consult with other CNIB direct service staff to see whether of not a common need exists with other clients.
If the need is a counselling need, rehabilitation counsellors may work together to develop and implement a resources/service on behalf of the client(s).

PRACTICE ACTIVITIES (2.1D-b) Rehabilitation Teaching
Determine whether current client need(s) can be met through individual, peer or group intervention currently offered through CNIB.
If client need is common to a group of clients and is not being met through existing resources/services, then consult with CNIB direct service staff.
Develop and implement resource/service if client(s) need can be met within discipline.
If client need crosses discipline boundaries, then departmental strategic planning process should determine whether need can be met within CNIB or whether the need may be responded to by another external resource/service.

PRACTICE ACTIVITIES (2.1D-c) Orientation and Mobility
Determine whether current clients needs can be met through individual, peer or group intervention currently offered through CNIB.
If client need is common to a group of clients and is not being met through existing resources/services, then consult with CNIB direct service staff.
Develop and implement resource/service if client(s) need can be met with discipline.
If client need crosses discipline boundaries, then departmental strategic planning process should determine whether need can be met within CNIB or whether the need may be responded to by another external resource/service.

Appendix N (Continued)

PRACTICE ACTIVITIES (2.1D-d) Career Counselling
Determine whether current client needs can be met through individual, peer or group intervention currently offered through CNIB.
If client need is common to a group of clients and is not being met through existing resources/services, then consult with CNIB direct service staff.
Develop and implement resource/service if client(s) need can be met within discipline.
If client need crosses discipline boundaries, then departmental strategic planning process should determine whether need can be met within CNIB or whether the need may be responded to by another external resource/service.

PRACTICE ACTIVITIES (2.1D-e) Adaptive and Technical Aids
Determine whether current client needs can be met through individual, peer or group intervention currently offered through CNIB (e.g. computer training).
If client need is common to a group of clients and is not being met through existing resources/services, then consult with CNIB direct service staff.
Develop and implement resource/service if client(s) need can be met within discipline.
If client need crosses discipline boundaries, then departmental strategic planning process should determine whether need can be met within CNIB or whether the need may be responded to by another external resource/service.

PRACTICE ACTIVITIES (2.1D-f) Vision Rehabilitation
Determine whether current needs can be met through individual, peer or group intervention currently offered through CNIB.
If client need is common to a group of clients and is not being met through existing resources/services, then consult with CNIB direct service staff.
Develop and implement resource/service if client(s) need can be met within discipline.
If client need crosses discipline boundaries, then departmental strategic planning process should determine whether need can be met within CNIB or whether the need may be responded to by another external resource/service.

PRACTICE ACTIVITIES (2.1D-g) Library Service
Determine whether current client needs can be met through individual, peer or group intervention currently offered through CNIB (e.g. computer training).
If client need is common to a group of clients and is not being met through existing resources/services, then consult with CNIB direct service staff.
Develop and implement resource/service if client(s) need can be met within discipline.
If client need crosses discipline boundaries, then departmental strategic planning process should determine whether need can be met within CNIB or whether the need may be responded to by another external resource/service.

Appendix O

PRACTICE ACTIVITIES FOR PRACTICE OBJECTIVES (2.2C)

PROGRAM OBJECTIVE (2.2A)
To assist the individual in adjusting to personal issues related to the loss of sight.

PRACTICE OBJECTIVE (2.2C-a) Rehabilitation Counselling
To identify client's emotional and problem solving capabilities in responding to personal crisis and loss and provide agreed upon counselling intervention techniques in preparation for instruction in other areas of client's life.

PRACTICE ACTIVITIES (2.2D-a) Rehabilitation Counselling
Assess client's abilities or strategies in responding to and coping with personal crisis and loss.
Identify client limitations and explore options for resolution of these limitations (e.g. individual counselling, peer support, group intervention {Transition}, referral to external resource.
Determine with client the preferred intervention approach.
Contract with client (e.g. frequency of service, duration of service).
Evaluate service effectiveness through client feedback.
Refer to other CNIB service provider or community.

PRACTICE OBJECTIVE (2.2C-b) Rehabilitation Teaching
To identify client's emotional and problem solving capabilities in responding to personal crisis and loss and provide agreed upon instruction in home and personal management and alternate communication skills.

PRACTICE ACTIVITIES (2.2D-b) Rehabilitation Teaching
Assess client's coping strategies in responding to and coping with personal crisis and loss.
Identify client limitations in the home and personal management areas and in communication skills and explore options for resolution of these limitations (e.g. individual instruction, peer support, group intervention, referral to external resource.
Determine with client the preferred intervention approach.
Contract with client (e.g. priority, frequency, and duration of service).
Evaluate service effectiveness through client feedback.
Refer to other CNIB service provider or community.

Appendix O (Continued)

PRACTICE OBJECTIVE (2.2C-c) Orientation and Mobility
To identify client's cognitive and perceptual skills in response to visual loss and provide agreed upon instruction in orientation and mobility skills.

PRACTICE ACTIVITIES (2.2D-c) Orientation and Mobility
Assess client's cognitive and perceptual capabilities in response visual loss.
Identify client limitations in the above areas and explore options for resolution of these limitations (e.g. individual instruction, group intervention, referral to external resource.
Determine with client the preferred intervention approach.
Contract with client (e.g. priority, frequency, and duration of service).
Evaluate service effectiveness through client feedback.
Refer to other CNIB service provider or community.

PRACTICE OBJECTIVE (2.2C-d) Career Counselling
To identify client's educational experience, vocational aspirations, learning potential in response to visual loss and provide agreed upon counselling and guidance with the employment as the end goal.

PRACTICE ACTIVITIES (2.2D-d) Career Counselling
Assess client's educational experience, vocational aspirations,learning potential in response visual loss.
Identify client limitations in the above areas and explore options for resolution of these limitations (e.g. individual assessment, training-on-the-job, work assessment, re-education, volunteer work, neuro-psych. assessment, employment placement, peer mentorship, referral to external resource.
Determine with client the preferred intervention approach.
Contract with client (e.g. priority, frequency, and duration of service).
Evaluate service effectiveness through client feedback.
Refer to other CNIB service provider or community.

PRACTICE OBJECTIVE (2.2C-e) Adaptive and Technical Aids
To identify client's needs for and skills in utilizing a variety of technological devices in response to visual loss and provide agreed upon consultation and guidance so that the client can utilize these items.

PRACTICE ACTIVITIES (2.2D-e) Adaptive and Technical Aids
Assess client's technology or adaptive needs in response visual loss.
Identify client limitations explore options for resolution of these limitations (e.g. purchase of braille or audio watches/clocks to assessment and purchase of a computer with access devices, individual consultation/instruction in the use of. technology, referral to external resource
Determine with client the preferred intervention approach.
Contract with client (e.g. priority, and frequency of service).
Evaluate service effectiveness through client feedback.
Refer to other CNIB service provider or community.

Appendix O (Continued)

PRACTICE OBJECTIVE (2.2C-f) Vision Rehabilitation
To identify client's needs for and skills in utilizing a variety of low vision devices in response to visual loss and provide agreed upon consultation and guidance so that the client can utilize these items.

PRACTICE ACTIVITIES (2.2D-f) Vision Rehabilitation
Assess client's functional vision.
Identify client limitations explore options for resolution of these limitations (e.g. purchase of magnifiers, CCTV Reader, individual consultation/instruction in the use of these devices, referral to external resource.
Determine with client the preferred intervention approach.
Contract with client (e.g. priority, and frequency of service).
Evaluate service effectiveness through client feedback.
Refer to other CNIB service provider or community.

Appendix P

PRACTICE ACTIVITIES FOR PRACTICE OBJECTIVES (2.3C)

PROGRAM OBJECTIVE (2.3A)
To teach individuals who experience vision loss a variety of skills to enhance personal functioning in all aspects of life

PRACTICE OBJECTIVE (2.3C) All Core Services
To increase skill level of clients in order that they may function independently in their home, school, place of employment, and/or in public places.

PRACTICE ACTIVITIES (2.3D-a) Rehabilitation Counselling
Assess client's ability to function within their home.
Identify client needs (e.g. stove/microwave marking, etc.).
Explain and demonstrate possible adaptations/techniques.
Teach client how to use agreed upon adaptations/techniques.
Evaluate client's use of adaptation/techniques.
Refer to other CNIB services.

PRACTICE ACTIVITIES (2.3D-b) Rehabilitation Teaching
Assess client's ability to function within their home.
Identify client needs (e.g. meal preparation, etc.).
Explain and demonstrate possible adaptations/techniques.
Teach client how to use agreed upon adaptations/techniques.
Evaluate client's use of adaptation/techniques.
Refer back to rehabilitation counsellor.

PRACTICE ACTIVITIES (2.3D-c) Orientation and Mobility
Assess client's ability to function within indoor and/or outdoor environments. as selected by client.
Identify client needs (e.g. preferred indoor and outdoor routes).
Explain and demonstrate long cane techniques.
Teach client how to use long cane.
Evaluate client's integration of long cane skills.
Refer back to rehabilitation counsellor.

PRACTICE ACTIVITIES (2.3D-d) Career Counselling
Assess client's skill level in the area of career development.
Identify client needs (e.g. job readiness training, retraining, job search skills, etc.).
Explain possible options.
Teach client techniques in securing employment.
Evaluate client's integration of skills.
Refer back to rehabilitation counsellor.

Appendix P (Continued)

PRACTICE ACTIVITIES (2.3D-e) Adaptive and Technical Aids
Identify client needs (e.g. home, school, work, recreation, etc.).
Explain and demonstrate possible adaptations/devices.
Teach client how to use agreed upon adaptations/devices.
Observe client's use of adaptation device(s).
Refer back to rehabilitation counsellor or external resource for further instruction (e.g. computer training).

PRACTICE ACTIVITIES (2.3D-f) Vision Rehabilitation
Assess client's ability to function visually within their home, place of employment, etc.
Identify client needs for visual adaptation.
Explain and demonstrate possible adaptive solutions.
Teach client how to use agreed upon adaptive solution.
Evaluate client's use of adaptive solution.
Refer back to rehabilitation counsellor.

PRACTICE ACTIVITIES (2.3D) Library Service
Identify client's access to information needs.
Explain TTB service.
Demonstrate and teach client how to use TTB machine.
Evaluate client's use of machine as requested.

Appendix Q

UTILIZATION ENHANCEMENT CHECKLIST[1]

Directions: There are fifty items listed below which focus on self-analysis, understanding the organizational context, planning and evaluation, the evaluation process, and communication. You may wish to rephrase some of the items to fit your particular situation or to add items. The checklist can serve as a guideline as you conduct an evaluation or as a self-examination after you complete an evaluation. To serve these multiple purposes, all items are written in the present tense.

A. Determining the Evaluator's Role

1. Assess level of personal congruence with the program's general goals and consider withdrawing if the incongruity may result in unnecessary conflicts.
2. Determine extent of personal commitment to the importance of conducting an evaluation of this program.
3. Analyze degree to which personal values and opinions about the program are publicly advocated by the evaluator.
4. Determine appropriate share of the responsibility for utilization.
5. Specify activities related to an educational role as well as a data-gathering, information-providing role.
6. Make sure that consulting skills are sufficient to meet the demands and complexities of the evaluation for the program.
7. Ensure that sufficient technical skills, time resources, and personnel are available to conduct a utilization-focused evaluation.
8. Establish congruence between personal role perception (data-gatherer, consultant, expert, recommender, change agent) and audience expectations.
9. Determine willingness to spend time with program staff in activities that are not directly related to the evaluation (for instance, informal lunches).

1 From Brown, R., & Braskamp, L. (1980). Summary: Common themes and a checklist. In L. Braskamp & R. Brown (Eds). *Utilization of Evaluative Information.* San Francisco: Jossey-Bass. (p 94-97).

10. Establish a sense of credibility and trust with the program director, staff, and other audiences.

B. Understanding the Organizational Context

1. Obtain and study the organizational chart.
2. Identify the names of key people within and outside the organization.
3. Identify the decision makers and potential users of evaluation information within and outside the organization.
4. Understand the policy-making process of the organization.
5. Determine which decisions and policies are made as a result of the evaluation.
6. Know when decisions are made.
7. Determine which staff and other users should be consulted as the evaluation is planned and conducted.
8. Determine whether the sponsor of the evaluation is committed to the evaluation activity and uses evaluative information.
9. Determine the information sources and channels within the organization.
10. Trace the path and impact of previous evaluations in the same setting and determine how this affects this evaluation.

C. Planning the Evaluation

1. Make sure there is clear understanding of the evaluation role (that is, formative or summative).
2. Set up specific sessions in which the evaluation plan and its implementations are discussed with key persons.
3. Assess the implications of decisions based on the evaluation that affect personnel.
4. Assess the political implications of various evaluation findings.
5. Determine the likely sources of resistance to positive evaluation results.
6. Determine the likely sources of resistance to negative evaluation results.
7. Determine the freedom to provide evaluative information to various audiences.
8. Determine strategies for dealing with potential conflict and tension between program director/staff and evaluator.
9. Design an evaluation plan that will have technical credibility and provide needed information.
10. Establish a mutual problem-solving approach with the program personnel and decision makers.

D. Conducting the Evaluation

1. Make sure that everyone understands the purpose of the evaluation.
2. Involve key personnel in determining the purposes, issues, and general evaluation strategies.
3. Involve representatives of potentially affected groups in making decisions about instrumentation and data sources.
4. Be accessible to program staff during the evaluation to learn of and share perspectives from which each is interpreting the information.
5. Collect data from multiple sources.
6. Make sure the data collection instruments and procedures are understandable and relevant.
7. Have informal as well as formal meetings with key persons.
8. Maintain a mutual problem-solving relationship with staff and administrators throughout the evaluation.
9. Collect information needed, but only that.
10. Adapt the evaluation plan to meet changing information needs.

E. Communicating the Evaluative Information

1. Make periodic informal reports or presentations.
2. Ask program staff, especially those most affected, to assist in interpreting the findings.
3. Communicate major findings when available and considered appropriate; do not wait for the formal report deadlines.
4. Share rough drafts or preliminary thoughts with key persons before making a final presentation.
5. Write different reports for different audiences.
6. Make presentations understandable and easy to follow.
7. Link presentation to key issues and decisions.
8. Make sure that all audiences receive the evaluative information in sufficient time prior to key decision-making events.
9. Keep written reports brief.
10. Use several media (slides, charts) when making formal presentations.

Score Interpretation. Here are some rough guidelines for interpreting the results of your analysis. Allow two points for each question answered positively.

25 or less	Don't expect much to happen as a result of your efforts. Most likely your information will be ignored or gather dust on a shelf somewhere.
26 - 50	You may be called back later to do another evaluation, but don't count on it. Perhaps you might get a publication from your efforts, but the world won't change.
51 - 75	Somebody may actually do something different as a result of the evaluation, especially if it reinforces what they were already thinking.
76 - 100	Be careful! You may be so effective that someone may have you earmarked to be an administrator, even though you have no desire to be one.