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520.325.7925 /fax

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Practical Research and Grants Writing Strategies for Geriatric Care Managers

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GUEST EDITOR'S MESSAGE

Practicing Care Management in the Age of Accountability

Lenard W. Kaye, D.S.W./Ph.D.

Prepare yourselves for a different experience. This issue of the *Geriatric Care Management Journal* is unlike any other issue you have previously received. It does not address a particular practice issue confronting the field of geriatric care management. Nor does it consider any of a wide range of real life challenges confronting older adults and their families such as Alzheimer's disease, institutionalization, family caregiving, disability, or elder abuse.

Rather, this issue provides you with the rationale and some basic tools needed for donning a very different hat in your work as geriatric care managers. Even though geriatric care managers are known to be able to multi-task with the best of them, the hat referred to here is not often worn given the everyday demands of maintaining the organizational integrity and health of care management practices. Yet, it is a role that can buttress in very important ways your professional work, insure that you will be an influential agent in the shaping of aging-related policy and practice in your community and beyond, and make more secure your organizational future. To put it in the simplest of terms, we will argue in this issue that adoption of a research mentality is good for your professional health and can do your business a world of good as well.

Entitled *Practical Research and Grants Writing Strategies for Geriatric Care Managers*, this issue aims to introduce some of you for the first time and refresh the memories of still others to the benefits and approaches to incorporating a research perspective, evaluation technique, and grants writing effort in your daily work. In

doing so, our intent is not to suggest that such functions become necessarily a dominant part of your daily care management work. It is suggested however, that there is real value in carving out a place in your practice experience for such activities.

Oh yes, fear not, come the next issue of *GCMJ* you can rest assured that we will return to much needed discussion of substantive clinical and administrative topics that impact profoundly on your good work with clients.

**Why an Issue of GCMJ on
Research Methods, Policy Analysis,
and Grants Writing?**

There is no doubt in my mind that the strength of a helping profession (as measured by its standing, respect, and legitimacy in the larger interdisciplinary professional community) is ultimately measured by the scientific knowledge and theory base that it can lay claim to and the extent to which that profession can document in convincing fashion its practice efficacy – namely the extent to which it is changing people's lives for the better. You and I both know that geriatric care managers contribute in magnificent fashion to the well-being of older adults and their families. But how can we transmit that in convincing ways to

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GRAPHIC DESIGNER

Kristin L. Hager
Tokyo, Japan

Guest Editor's Message

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our colleagues situated in the more traditional domains of the helping professions and, for that matter, to the general public. Being able to document the effectiveness of what we do in systematic and authoritative fashion drives home best what we intuitively know to be the case. Adopting evidence-based practice interventions is critical to responsible practice. Evidence-based practice is, by definition, confirmed by way of sound clinical research.

It is likely that the majority of geriatric care managers never sat through a course on grants writing or remembers much of what transpired in their courses in research methods and statistics during their professional education. Consider this issue of *GCMJ*, then, our effort to offer a refresher course on such matters.

And, if we increase the likelihood that some of you will, as a result, consider ways to engage in policy formulation and refinement or add an ongoing research and evaluation component to your daily program activities we will be satisfied.

Living in the Age of Accountability

The rationale for incorporating greater doses of research mentality in geriatric care practice revolves around six basic assumptions:

- Resources are scarce
Scarce resources, whether in the form of more stringent third part reimbursement formulae or hesitancy on the part of individuals to draw down their personal assets for purchasing marketplace services, translates into the greater likelihood that both organizations and individuals will be increasingly cautious in terms of where and when they are willing pay for private geriatric care management services. It stands to reason that a care management practice that is able to document its effectiveness and positive impact on people's lives

in convincing fashion is in a stronger position to compete for scarce dollars.

- We are a results-oriented society
A society that increasingly expects "more bang for its buck" can be expected to feel the same about the human services it consumes. And, if a service doesn't measure up, one can assume that the consumer will turn elsewhere to realize more value for his or her dollar.
- Facts are very influential in the decision-making process
Hard facts speak for themselves and are exceedingly influential in the decision-making process. Being able to document the efficacy of your efforts is most immediately accomplished with quantifiable data. Counting solely on descriptive, ad hoc stories and vignettes of your good work to convince the public that you deliver a quality service is risky business.
- Clients have higher expectations as to the goods and services they purchase
Clients are increasingly well informed consumers. The elders of tomorrow will evidence inevitably greater increments of sophistication, education, and savvy when it comes to the decisions they make about which marketplace services they select and consume.
- It is assumed that service provision is based on community needs and resources
The justification of service offerings is increasingly tied, as it should be, to consumer need and demand. Measuring and interpreting community need and demand accurately requires a research mentality.
- It is increasingly a given that the services we provide will be evaluated for their efficacy
The attachment of an evaluation component to service provision is now virtually a given and sound, objective evaluations require

adherence to proven research methodology.

Our refresher course in research methods and grants writing begins with an article by *Barbara Hermann*, at the Department of Psychology at the University of Maine who considers the benefits and approaches to incorporating client satisfaction assessment tools in geriatric care management practice. *Joan K. Davitt*, *Karen Zurlo*, and *Heather A. Klusaritz* at the University of Pennsylvania School of Social Policy and Practice address a dimension of research perhaps less frequently considered as they discuss the use of policy and program analysis principles in understanding the practice issues confronted by care managers. *Helen B. Miltiades* at the Health Science Department at California State University Fresno considers (in user friendly language!) the various statistical procedures that can be used when analyzing and reporting on geriatric care practice data. Finally, *Jennifer A. Crittenden* and *Jason C. Charland* provide readers with a great deal of valuable practical advice to consider for those embarking on grants writing activities.

Of course, in the end the extent to which a research dimension is permanently integrated into your practice world likely will be determined by the degree to which those activities are practical and purposeful. For a research mentality to flourish amidst the pressing demands of daily professional life, the procedures you adopt must be minimally intrusive and burdensome and respond to questions and ideas that arise naturally out of your practice. Adherence to these principles will increase significantly the likelihood that such a perspective will be enduring.

Lenard W. Kaye, D.S.W./Ph.D., is the Director of the Center on Aging and Professor at the School of Social Work at the University of Maine.

GCMJ Special Issue Editor and Contributors

EDITOR

Lenard W. Kaye, D.S.W./Ph.D.
Director and Professor
Center on Aging
School of Social Work
University of Maine
5723 D.P. Corbett Bldg.
Orono, ME 04469-5723
207 581-3483 (voice)
len.kaye@umit.maine.edu

CONTRIBUTORS

Jennifer A. Crittenden, M.S.W.
Research Associate
University of Maine Center on Aging
5723 D.P. Corbett Bldg.
Orono, ME 04469-5723
207 581-2249 (voice)
len.kaye@umit.maine.edu

Jason Charland
Graduate Research Assistant
University of Maine Center on Aging
5723 D.P. Corbett Bldg.
Orono, ME 04469-5723
207 581-2249 (voice)
jason.charland@umit.maine.edu

Joan K. Davitt, Ph.D.
Assistant Professor
School of Social Policy and Practice
University of Pennsylvania
3701 Locust Walk
Philadelphia, PA 19104-6214
215-898.5512 (voice)
jdavitt@ssw.upenn.edu

Barbara Hermann, M.S.
Research Associate
Department of Psychology
University of Maine
301 Little Hall
Orono, ME 04469-5742
207-581-2030 (voice)
barbara.hermann@umit.maine.edu

Heather A. Klusaritz, M.S.W.
Research Associate
School of Social Policy and Practice
University of Pennsylvania
3701 Locust Walk
Philadelphia, PA 19104-6214
215-898-5512 (voice)
hklusaritz@ssw.upenn.edu

Helen Miltiades, Ph.D.
Assistant Professor
Health Science Department
California State University, Fresno
2345 East San Ramon Avenue M/S MH30
Fresno, CA 93740
559-278-7253 (voice)
hmiltiades@csufresno.edu

Karen Zurlo, M.S.W.
Research Associate
School of Social Policy and Practice
University of Pennsylvania
3701 Locust Walk
Philadelphia, PA 19104-6214
215-898.5512 (voice)
kzurlo@ssw.upenn.edu

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Measuring Client Satisfaction in Geriatric Care Management

Barbara Hermann, M.S.

Why Measure Client Satisfaction

The measurement of client satisfaction is a relatively novel endeavor for care management programs and so discussion of concepts related to methodology and implementation of findings draw largely from research examining settings in which initiatives designed to assess patient satisfaction first evolved, namely hospitals, long-term care, and private practice. As these concepts become increasingly examined and disseminated within the geriatric care management field, specific variations in methods, implementation, and consequences will become apparent. As such, it is proposed that a well-designed, implemented, and utilized system that assesses client satisfaction can help geriatric care managers just as well as it can traditional health care professionals to improve the quality of their client-directed and administrative activities.

Before presenting an overview of approaches to the process of client satisfaction measurement, it is best to consider the most common reason health organizations have pursued client satisfaction measurement, that of improving quality of care (Strasser & Davis, 1991). Understanding such motives helps to motivate and to clarify the pursuit of how to best go about such measurement. The notion of "quality of care" has evolved into a multidimensional concept, defined in terms of multiple indicators. In recent years, client satisfaction has been added to this list of quality indicators for a number of reasons. For one, and particularly salient for care managers, the definition of quality has been

expanded to include many of the service delivery aspects of care, including responsiveness, courtesy, flexibility, maintenance of confidentiality, and sensitivity to preferences (Strasser & Davis, 1991). Given that offering support as well as validation of needs and difficulties is a significant part of a geriatric care manager's role (Gassman, 2001) and that the interpersonal aspect in receipt of care is a key quality issue for clients (Attree, 2001), care managers need to attend to and assess how their clients are perceiving and evaluating such interpersonal experiences and the impact their evaluations have on their overall satisfaction with care management services received.

Secondly, asking clients to evaluate their health care experience formally legitimizes them as active members of the health care delivery team, making them more involved and informed in all aspects of their care. This serves to encourage them to report health or treatment issues more readily (Strasser & Davis, 1991) and influences their use of adjunct health care services (Bear & Bowers, 1998). Given the traditional passive stance toward health care taken by many older clients, this last point is particularly salient for geriatric care managers, in that how they interact with the client, the client's treatment providers, and family members in providing their services represents an opportunity to empower their older clients in their own care.

What is Client Satisfaction?

With a better understanding of the role of client satisfaction assessment in quality of care and its

provision, the next task is to identify the concept of client satisfaction itself. However, though the concept may make intuitive sense, there remains little consensus regarding a definition of the concept of client satisfaction (Avis, Bond, & Arthur, 1995; Merkouris, Ifantopoulos, Lanara, & Lemonidou, 1999). Most definitions of *patient* satisfaction as it relates to medical care include subjective elements of values, expectations, and perceptions of both the technical care received and the interpersonal manner of care provision (Mahon, 1996). As geriatric care management stresses the provision of services such as assessment, planning, referral, and coordination of services more than direct client care, care managers may want to focus satisfaction assessment on clients' expectations and perceptions of the care manager's provision of such services in terms of such factors as quality and comprehensiveness of the assessment and treatment plan, attentiveness and availability of the care manager, and other aspects of the manager's interpersonal manner throughout the process. Should direct services, such as counseling or education be provided, assessment of the client's expectations for and perceptions of those services can also be specifically examined.

An important factor that influences clients' expectations and perceptions and so necessitates consideration in satisfaction assessment is individual differences (Stesser & Davis, 1991). These differences include factors such as dispositional makeup, personality, needs, values, beliefs, lifestyle, and prior health care

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experiences. For research methodology and statistical analyses of client satisfaction measurement, Stresser and Davis suggest that clients' dispositional and experiential characteristics serve as moderator variables. Asking about clients' demographic information and the health care values they hold is one way to attempt to identify how certain groups of clients respond to questions about satisfaction (White, 1999). Client satisfaction, then, can be viewed as involving numerous factors, many of which service providers have control over and can change, and many of which they cannot but need to incorporate in their approach to assessing client satisfaction.

In pursuing efforts of client satisfaction measurement, defining client satisfaction is also contingent on identifying and learning about the clients who use geriatric care management services. Different types of clients may have different needs and expectations of the service and its providers (Applebaum, Straker, & Geron, 2000). In the case of geriatric care management, customers may include not only the care service recipient, but also their family members, as well as funding agencies and regulators. In long-term care, for example, there may be situations when the family would like more hours of care than the direct recipient would, as family members are quite concerned about health and safety issues, while care recipients are generally more worried about protecting their privacy and autonomy. Such conflicts require that agencies balance the needs of various consumer groups, while maintaining a commitment to the primary client, the service recipient. Assessment of client satisfaction can be done for various consumer groups, but the method and questions asked will have to be construed to fit within that group's values, expectations, and characteristics.

Approaches to Assessing Client Satisfaction

Choosing a method for measuring client satisfaction should largely be guided by the needs and resources of the individual geriatric care management organization or manager. The questions chosen to ask, the approach used to ask them, the number and kind of clients asked, and the way the findings are used are determined by a number of choices and constraints. Understanding various strategies, their advantages and disadvantages, allows care managers to make informed choices in developing an approach.

Small-scale, or qualitative, approaches, in which one probes deeply into the experiences of a few individuals, and large-scale, or quantitative, approaches, in which one asks the same questions across a large number of individuals, necessarily result in different kinds of information and each method has its merits. A combination of small-scale and large-scale approaches provides complimentary information. The recommended recipe for a useful assessment of consumer satisfaction is one that incorporates several data-collection strategies so that one approach may make up for the limitations of another (Applebaum, Straker, & Geron, 2000).

Small-Scale, Qualitative Methods. Realizing the many dimensions of client satisfaction, one key avenue for determining what domains of satisfaction are worth assessing is to begin by seeking general input. Small-scale qualitative approaches to assessing client satisfaction rely on gathering in-depth information from a small number of clients. Questions that are best answered with such methods include those pertaining to vague or subjective issues, such as what it means to be a service recipient and the values that clients place on different aspects of services. Small-scale approaches are also valuable for exploring variations among ethnic groups and socioeconomic strata among clients. Among the array of strategies, two that are commonly utilized are the focus group and the individual interview.

Focus groups allow for an interactive and in-depth approach for gathering information in order to explore a large overall question. One particular function that focus groups can provide a care management agency is as an aid in determining which aspects of its service provision should be covered in a more extensive or quantitative survey. A strength of the focus group is the way in which group interaction by its very nature may produce insights which might not come about otherwise. Moreover, sharing opinions with others and being part of a peer group may reduce anxiety in some older adult participants (Applebaum, Straker, & Geron, 2000). Focus group participants can also be recruited to elicit a broad range of viewpoints. One might recruit a group from clients who had complained about their services, a group from informal caregivers of clients, a group of new clients, or a group of long-term clients.

Focus groups do have inherent drawbacks to consider, however. For the management agency, a group may be costly depending on logistical demands, time-consuming, and labor-intensive with regard to hosting the group and analyzing the data (Ford, Bach, & Fottler, 1997). With regard to the data outcomes, the size and specificity of groups make them susceptible to the influence of a few dominant participants or views. Focus groups as a data assessment approach are not designed to be reliable or valid, nor be a substitute for quantitative data (Merton, 1987).

The second qualitative method to elicit feedback from individual clients is the use of in-depth interviews. Interviews can be conducted in person or over the telephone. As with focus groups, the qualitative reasons for satisfaction or dissatisfaction can be explored. The advantages of individual interviews are several. For one, they may allow some clients to express themselves more honestly in a one-to-one setting. Secondly, they lessen some of the difficulties that those with hearing, speech, or other types of impairments, may have when

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interacting in a group. Lastly, they can explore the issues relative to an individual client in greater depth than would be possible or even desirable in a group interaction. Compared with focus groups, individual interviews may be easier to manage with regard to the logistics of securing a time and place to meet, but they are a more costly way to collect data due to the time involved.

Viewed as a step in the client satisfaction assessment process, individual interviews can aid in refining open-ended questions first posed in a focus group that will then be used to develop a quantitative consumer satisfaction survey. Interviews may help in wording questions appropriately and in understandable language, provide information about the range of responses that will later be developed into response categories, as well as relevance of the questions for the client group. Important to consider, however, is that the time and effort required to recruit present or past clients, complete multiple interviews, and train interviewers may represent significant monetary drawbacks.

Large-Scale, Quantitative Methods. The quantitative measurement of client satisfaction may be defined as the measurement of the services and environmental stimuli clients come into contact with, as well as their value judgments and reactions to their health care experience, through numerical representation (Applebaum, Straker, & Geron, 2000). Quantitative methods based on the use of a satisfaction questionnaire may be the most frequently used approach for measuring client satisfaction among health care organizations (Avis, Bond, & Arthur, 1995; Teems & Stanley, 2001). A number of satisfaction instruments for health services are available, though ones specific to care management are scarce. However, problems with such

instruments have been voiced. One issue is the present lack of well-standardized, psychometrically sound questionnaires (Yellen, Davis, & Ricard, 2002). Another is the criticism that data from satisfaction surveys are not reliable, though methodological guidelines to reduce this possibility in an assessment endeavor have been offered (White, 1999). Although satisfaction questionnaires provide ease of measurement, they also serve to channel client concerns into avenues pre-defined by providers, and so do not allow a full range of perceptions, values, and experiences to be expressed (Avis, Bond, & Arthur, 1995).

Should satisfaction questionnaires be used, consideration should be given to a series of issues when deciding whether to use an existing instrument or to develop a new one (Applebaum, Straker, & Geron, 2000; White, 1999). For one, an existing satisfaction questionnaire may have the advantage of having been developed and honed via previous use and so may offer better psychometric properties than one without such history. Moreover, if an existing measure does have established validity and reliability, little or no input is needed from the care manager or agency, resulting in lower cost than if a measure were to be developed and pilot tested. On the other hand, an established questionnaire may not capture all areas of interest, or may address services or issues that are not applicable. When a care management agency has a specific area of interest, such as assessing the impact on clients of a change in service provision, designing an original measure may be worth the time and effort required.

The hallmark and strength of a quantitative measure is that it asks the same questions of all respondents in the same way and so reduces measurement error via standardization. Usually, respondents are asked to choose their answers from a set of response categories. Items often use a Likert format, providing a range of responses rank-ordered from most positive to most negative for the

individual to choose from. An effective satisfaction measure ought to contain items that fully describe the attributes of client satisfaction (Applebaum, Straker, & Geron, 2000). A single-item measure such as "Overall, how satisfied are you with the services you are receiving?" is not recommended, as satisfaction as a concept is too subjective and complex to be expected to be stable from one individual to another (Geron, 1998). Most instruments use many items to cover a wide range of service areas and facets of each service. Multiple items may increase reliability and validity, and when both favorable (positive) and unfavorable (negative) statements or questions are asked, they are useful in preventing individual tendencies to simply indicate agreement, regardless of the item content (Geron, 1998).

Although, in general, items should be brief, clear, and address only a single topic, to gain additional interpretive information within an instrument, the option exists to supplement quantitative forced-choice responses with open-ended questions. For example, a question can be directed to those who chose a response indicative of dissatisfaction by asking those responders to briefly explain why they were dissatisfied. Such an approach can also provide valuable information for applying the results to quality improvement. It does, however, increase the length and difficulty of the questionnaire and may increase the number of non-responders (Ford, Bach, & Fottler, 1997).

After an instrument is developed or an existing one obtained, gathering client satisfaction information can occur via several approaches. The most commonly used method is to administer a written survey, either via mail, over the telephone, or in person. As in qualitative approaches, in-person administrations are the most expensive, followed by telephone interviews (Applebaum, Straker, & Geron, 2000). Telephone and in-person surveys do allow the respondent to clarify unclear answers and

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offer the interviewer the opportunity to clarify the questions they are asking. When different sets of questions are to be asked depending upon certain response categories, interviewers can negotiate the questions to be skipped and reduce the complexity of an instrument. Lastly, potential advantages of face-to-face administration, particularly for older clients, are that it allows for the establishment of rapport and may be less stressful than a telephone survey.

Written self-report surveys administered while the client is readily available (such as during a service discontinuation session) are the least expensive method for gathering quantitative information. If questionnaires are mailed to clients, assessment accrues cost in terms of the needed mailing materials and postage. Compared with in-depth interviews or questionnaires verbally presented to clients, written self-report surveys also allow for relatively quick output, ensure that all questions are asked in the same way of all respondents, and allow respondents anonymity and confidentiality. Issues of confidentiality can be particularly salient for older individuals who depend upon the services they are being asked to evaluate and so these clients may be reluctant to voice criticism without anonymity while still receiving services (Ford, Bach, & Fottler, 1997). Self-report questionnaires also alleviate, though do not eliminate, the problem of pressure to give socially desirable responses often found in interviews, particularly for questions assessing sensitive topics or criticisms of the agency. Self-report questionnaires, however, pose their own problems, particularly when used with an older population. Written surveys can be intimidating and complex. In addition, clients with vision problems, cognitive impairment, or difficulty writing may find a written survey impossible to complete.

Conclusions

As has occurred in other health care fields, measurement of client satisfaction needs to play a significant role in the process of continued quality improvement among geriatric care management agencies. It should be embraced and understood by staff and explained to clients as much as possible. The choice of strategies for assessing client satisfaction is influenced by expertise available, time and cost constraints, and the kind of information the agency or care manager is interested in. More than likely, a combination of strategies will be more helpful than relying on only one approach. The age of neglecting client input in care management is long past and agencies that choose to remain blind to the uses and impact of client satisfaction measurement do so at their own and their client's peril.

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Barbara Hermann, M.S., is a doctoral candidate in clinical psychology at the University of Maine at Orono. She served as a research associate at the UMaine Center on Aging during the 2004/2005 academic year. Her research, teaching, and clinical interests include mindfulness meditation, biopsychology, and health psychology. She earned her bachelor's degree in psychology and master's degree in kinesiology from The Pennsylvania State University.

Applying Techniques of Policy and Program Analysis in Geriatric Care Management

Joan K. Davitt, Ph.D.

Karen Zurlo, M.S.W.

Heather A. Klusaritz, M.S.W.

Introduction

Although the state legislated the economic well-being of older Americans with the passage of the Social Security Act in 1935 (P.L. 271-74) it was not until the second half of the 20th century that legislation was passed addressing the physical and emotional well-being of older persons. The Older Americans Act (OAA) of 1965, its subsequent amendments, as well as additional pieces of federal legislation, represent key policies that regulate the health and well-being of older Americans. (See Exhibit 1 for a list of these amendments.) As a result, the OAA has direct impact on the work of Geriatric Care Managers (GCM) and the care they provide older Americans. The OAA established a network of providers from the federal (Administration on Aging), to the state, (State Units on Aging) and to the local level (Area Agencies on Aging). The provision and oversight of federal monies through the Administration on Aging to local agencies facilitates programs such as in-home services, nutrition programs and care management for older Americans. GCMs and their ability to provide comprehensive services are influenced by these regulations and funding from the OAA (Administration on Aging, 2004). These policies and their historical development are a critical body of knowledge for geriatric professionals that inform and guide everyday practice.

Such policies both define and regulate the role of GCMs, their practice environment, the type of clients they care for, the resources

available to them, and facilitate as well as constrain the ability of GCMs to meet client needs. Therefore, GCMs are key players on all sides of the legislative and administrative policy process. In order to successfully provide services to clients, it is important for GCMs to stay abreast of policy that impacts their practice. Additionally, GCMs are the front-line workers who deal with the real world of policy and program implementation enabling them to identify gaps in services, unintended consequences of policies, or new problems/areas of

need and to advocate for change. In order for GCMs to be active participants in policy development, it is necessary to have an understanding of what the process entails and how to effectively promote change. We outline this process below while elaborating on the techniques relevant to policy and program analysis.

Policy and Program Development Process

In order to choose the appropriate tools and intervention strategies, it is
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EXHIBIT 1

Key Amendments to the Older Americans Act of 1965

Year	Amendment & Significance
1972	Title VII authorizes funds for a national nutrition program for the elderly.
1973	Area Agencies on Aging are established through the Comprehensive Services Amendments. Title V authorizes grants for multi-purpose senior centers.
1974	Title XX authorizes state grants for elder protective services, nutrition and health assistance, homemaker and adult day care services, transportation, and employment training.
1978	New Title III consolidated former Titles regulating Area Agencies on Aging, nutrition, and multi-purpose service centers. Long-term care ombudsman program created.
1981	OAA reauthorized with an emphasis on independent community living and the necessary supportive services. Expansion of ombudsman program to board and care homes.
1984	OAA reauthorized with an emphasis on State and Area Agencies on Aging coordination of community-based services
1987	OAA reauthorized with appropriations for multiple services and emphasis on serving the elderly in greatest economic and social need.
1992	OAA reauthorized with emphasis on caregivers, elder rights, and intergenerational programs. New Title VII further established the protection of elder rights and the prevention of abuse, neglect and exploitation through the "Vulnerable Elder Rights Activities."
2000	National Caregiver Support Program established

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essential to understand the stages in the policy and program development process, which are as follows: recognition of a problem, understanding and defining need (the problem analysis), creation of a sanction (the formal response plan), implementation of the policy/program, and evaluation and modification. The process outlined here can be thought of as a circular process. (See Exhibit 2 for a diagram of the process.) Interaction with this process can begin at any stage.

Recognition of a Problem

Initial recognition of a social problem can be generated via a variety of sources. However, care managers can play a critical role in this process given their immediate contact with clients and thus more direct understanding of the needs of clients, especially needs not currently being

met. It is important to note that an unmet need could result from the lack of policy or be due to adverse effects of an existing policy. When an unmet need is identified, it must be documented in such a way as to convince policy makers and the public at large that a problem exists and warrants further attention. Not all harmful conditions or unmet needs become defined as social problems; they must go through a collective process of recognition, definition, legitimation and action (Blumer, 1971). First and foremost the problem must be defined in such a way as to achieve social endorsement (legitimation). In this phase the care manager must be concerned with documenting the problem, its severity, incidence, prevalence, who it affects, how it affects them and developing a clear definition of the problem. If society does not agree that the condition is a social problem then little will be achieved in the way of response.

The Problem Analysis

Problem analysis is a political process where various vested

interests may vie for control. It is not as simple as documenting a need, rather the need must be constructed in such a way as to generate the greatest interest in responding to the problem (Rocheft and Cobb, 1994). GCMs therefore must take into account competing values, stakeholders, definitions and assumptions. The care manager must be cognizant of this political process to ensure that the problem is not co-opted by powerful forces wishing to derail the development process (Pressman and Wildavsky, 1984). See Exhibit 3 for a list of questions to be considered when analyzing a social problem.

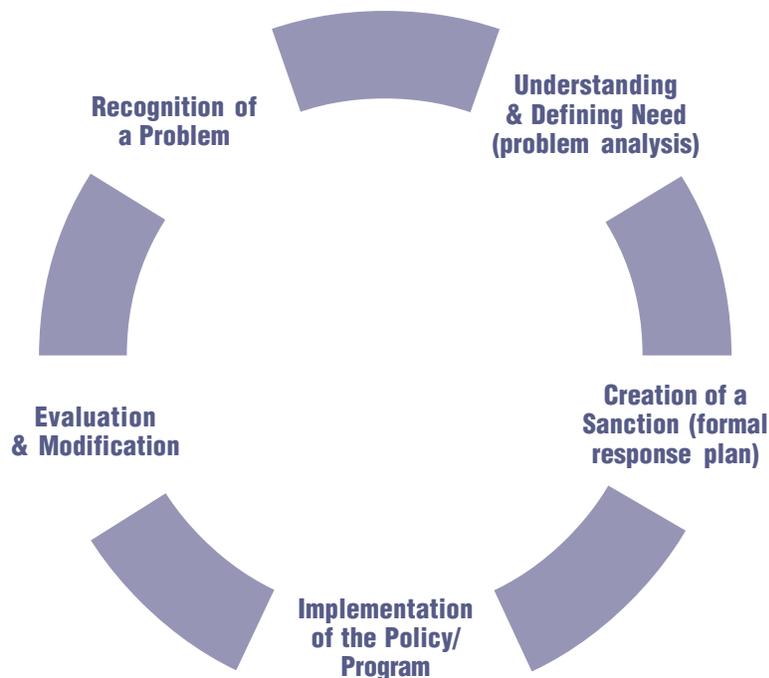
Critical to any assessment process is the ability to break down the problem/need. That is, one must understand the contributing factors to the problem and the consequences if the problem is left unaddressed (Kettner, Moroney and Martin, 1999).¹ The contributing factors will later be targets for intervention, those things that must be changed to alleviate the problem. The consequences will aid in establishing the outcomes that must be measured to document program effectiveness. In other words, the program will be focused on reducing negative outcomes and increasing positive outcomes. Of course this cannot be done without an articulation of clear and concrete definitions of the problem (Chambers, 2000).

The first step in conducting a needs assessment or problem analysis is to determine what is known and unknown about the problem. What key questions should define the needs assessment? Once the questions for study have been outlined, sources of this information must be identified. The first source is the empirical literature. This can place the problem in a context regarding the state of the art in knowledge of that problem. For example, existing studies of other communities/agencies struggling with similar problems can shed light on the contributing factors to the problem as well as the consequences. This information can be critical to one's understanding of the problem and can prevent the collection of unnecessary data.

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EXHIBIT 2

Policy and Program Development Process



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Next, we look to existing sources of information in order to save time, energy and money, thus reducing the overall burden of the assessment on staff and the agency. Such sources might include agency records, county level social indicators, census data, local, state or national surveys already completed, and other agency records. Once the key questions are defined, it will be easier to determine whether existing data will answer these key questions or whether new data must be collected. See Exhibit 4 for a list of questions to ask before using existing data and Exhibit 5 for the advantages and disadvantages to using existing data.

In some cases existing data sources may be limited, inaccessible or non-existent requiring the collection of new data to truly understand a given social problem. There are several tools for collecting data including observational techniques, such as single subject design, and survey procedures. We will focus our discussion here on survey procedures as this is the most widely used methodology in needs assessment.

Survey procedures include mailed or telephone surveys, in-person interviews, focus groups, public forums or town meetings, and specialized surveys such as the Delphi or nominal group techniques. Each of these techniques has its own benefits and drawbacks as does the use of existing data. (See Exhibit 6 and 7 for a list of the advantages and disadvantages of each technique.) The choice of technique depends on a series of critical questions. First, what are the key questions for which you seek answers? What technically will allow you to answer these key questions (the questions should drive the method)? What are the cost/resource constraints and what technique is feasible given these constraints? Are there any ethical considerations to using this technique? Do we have the

expertise to implement this technique?

In many cases you may need to use a combination of techniques including using existing data first and only collecting new data where there are gaps in the existing information. Finally, it is important to realize that every problem analysis will have limits. These limits should be recognized openly to ensure that inappropriate assumptions are not made about the problem, the population, or the needs (Rubin and Babbie, 2001).

Formulating the Response

Legislation is not the only way that policy gets created, although it may be the most widely recognized and understood form. Policy can also be generated via the courts, through administrative rule-making, by executive order, or via agency-based decisions. Regardless of the source, in an ideal scenario, the policy or program response would be driven by a sanction that was based on a comprehensive assessment of the problem or need.

The multiple sources of policy can be seen in the recent history of the Medicare home health care benefit. The home health benefit was originally

created via the 1965 amendments to the Social Security Act (P.L. 89-97). Eligibility for the benefit was gradually expanded via the legislature for the first 10 years of the program. However, benefit utilization did not expand significantly during this time. The main reason for this lack of expansion in use was a change in the administrative rules generated by the Health Care Financing Administration (HCFA)², the Medicare oversight agency, which tightened eligibility. Advocates brought a class action lawsuit (Duggan v. Bowen) in 1987 challenging the restrictive interpretive rule established by HCFA. The courts not only ruled that the eligibility limits were arbitrary and capricious, and contrary to legislative intent, they noted that in creating the rule HCFA had not followed the requirements of the Administrative Procedures Act of 1974 for public notification regarding changes in the regulations. Needless to say, the program expanded rapidly after this court decision (Davitt, 2003). Thus all three branches of government, legislative, executive and judicial were involved in designing policy to establish the eligibility criteria for the home health benefit. This example demonstrates the critical need to

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EXHIBIT 2

Policy and Program Development Process SOCIAL PROBLEM ANALYSIS

1. How is the problem being defined?
2. How are key concepts being defined?
3. What values underlie this definition?
4. Who defines it as a problem, and what are their interests in defining it this way?
5. Has the condition achieved widespread recognition as a problem?
6. Who is affected by the problem, how are they affected, who benefits and who suffers from the problem?
7. How are these different groups perceived?
8. Who are the targets for change?
9. What assumptions are being made about the problem and those affected by it?
10. Is this a growing problem, is it a crisis?
11. What is the prevalence/incidence rate?
12. How did the problem arise, what are the contributing factors?
13. What are the potential consequences if we do nothing about the problem?
14. What tentative solutions are being recommended?

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understand the policy making process from all angles as policy can be generated or modified via a variety of government sources that can all have a hand in the process at any given point in time.

Implementation of the Policy

Once the sanction has been established, the policy is prepared for implementation. This generally requires some type of rule-making process whether it be a federal, state or agency-based sanction. This phase of the process should not be overlooked as much new policy can be generated here (as was shown in the home health care example). Thus care managers need to continue to monitor this process and advocate for necessary changes in the policy or interpretive regulations. As previously mentioned, the Administrative

Procedures Act of 1974 established the criteria which federal-level administrative agencies must follow in developing the specific components of a program. The key requirements include: publication of an interim rule with comment period, review of and response to all comments received, and publication of a final rule with discussion of changes made or not made based on these public comments.

In an ideal situation, the program response would be designed to meet those needs identified in the needs assessment. Contributing factors would clearly be identified and goals and objectives would reflect both the contributing factors and the related consequences that need to be alleviated. In order to evaluate the program response both as proposed or as implemented, care managers would want to look at several key criteria. We discuss these criteria in the next section.

Criteria for Policy and Program Analysis

The fundamental question that must be asked when evaluating a

particular policy or program is whether or not it actually can have an impact on the social problem it was originally meant to address (Chambers, 2000). To be more specific, one would want to show that the program/policy targets and actually serves those client groups identified as suffering from the problem. Likewise, the program's goals and objectives should clearly be related to the problem as defined in the problem analysis/needs assessment. Finally, it should be clear that the actual benefits offered can have an impact on the contributing factors identified in the needs assessment/problem analysis (Chambers, 2000; Kettner, Moroney, & Martin, 1999). Several specific criteria can help in evaluating an existing program or proposed policy.

The first criterion is program effectiveness. Does the program have a clear plan of action that will enable us to measure its effectiveness? Or in the case of an existing program, is the program effective? In order to measure effectiveness one must articulate goals and objectives. The goals establish broad aims and purpose for the program or policy whereas the objectives must be clear, concrete, specific and measurable. There are two types of objectives, the process objective and the outcome objective (Kettner, Moroney, & Martin, 1999). Process objectives deal with what has been done or proposed to be done, e.g. how many clients served, how many hours of care manager contact with clients, etc. The outcome objectives deal directly with effectiveness (e.g. reduction in premature institutionalization among the client population).

In order to measure effectiveness, one must be able to show that certain identified contributing factors have been addressed and that this has generated key positive outcomes (or at least reduced negative outcomes) for clients. Thus the care manager's role in developing/modifying programs is to be able to articulate clear and measurable objectives which will enhance understanding of the program's effectiveness by providing

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EXHIBIT 3

Social Problem Analysis

1. How is the problem being defined?
2. How are key concepts being defined?
3. What values underlie this definition?
4. Who defines it as a problem, and what are their interests in defining it this way?
5. Has the condition achieved widespread recognition as a problem?
6. Who is affected by the problem, how are they affected, who benefits and who suffers from the problem?
7. How are these different groups perceived?
8. Who are the targets for change?
9. What assumptions are being made about the problem and those affected by it?
10. Is this a growing problem, is it a crisis?
11. What is the prevalence/incidence rate?
12. How did the problem arise, what are the contributing factors?
13. What are the potential consequences if we do nothing about the problem?
14. What tentative solutions are being recommended?

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measurable standards against which actual performance can be evaluated (Chambers, 2000). When analyzing proposed policies, the role of the care manager is to critically evaluate the potential effectiveness of the program by examining the stated goals and objectives or participating in defining clear outcome objectives. Ideally, the outcome objectives should be directly related to the program's goals which should be directly related to the purpose of the sanction which should be derived from the problem analysis/needs assessment.

The second criterion of concern in analyzing a policy or program is appropriateness, that is, the "fit" between client need and the providers' services (Rose, 1992; Chambers, 2000). For our purposes, appropriateness and inappropriateness are derived from clients' goals and needs, from the problem analysis/needs assessment. The care manager must be knowledgeable of the current service offerings of the provider and whether these fit with the definition

EXHIBIT 4

Questions for Using Existing Data

1. What do we know already, what do we need to know?
2. What data do we have already that can be used to support our understanding of the problem?
3. Can we get what we need from existing sources of data and if so which ones?
4. Can we get access to those existing sources? Will there be a cost to access or analyze such data?
5. What is the quality of these existing data, how are they collected and maintained?
6. Are there concerns regarding confidentiality and how can we protect client confidentiality?
7. If using our own records, are there gaps in the information available? If so, can we modify the system to fill in these gaps?
8. Can we compare our data to state or national data? Are there comparable variables at these various levels?

(Adapted from Witkin and Altshuld, 1995)

and understanding of the problem. Can the problem be alleviated through the provider's services? If not, then this may warrant advocacy to modify the existing program or to develop a new program. This is also an area where GCMs can begin to identify new problems in their current case load by recognizing incongruity between their clients' needs and the current service package.

The third criterion, adequacy, is both a measure of the quantity of services available as well as the fit between the services and the client's needs. Adequacy refers to the desirability of the care manager to provide a reasonable standard of service that ensures well-being of his/her client (Frankena, 1962). It can be

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EXHIBIT 5

Use of Existing Data

Advantages

1. Lower Cost
2. Less time to produce useful information as data collection time is eliminated
3. When using agency records, staff familiarity with the data will reduce time and expense
4. Allows for analysis of patterns of service use over time and changes in the population served
5. Can help us to understand who is or is not using the existing services, what services are being used most, and thus get a better picture of agency capacity and gaps in service delivery.

Disadvantages

1. It is never free of time and resource constraints
2. Because the data were collected for other purposes originally, there may be limits as to what the data can tell you about your population or problem area
3. Depending on the data source, it may require special expertise to use (e.g. national surveys or census data)
4. Special consideration must be given to the quality of the data, how they were collected and maintained
5. Existing data cannot always be considered valid and reliable measures of the population or problem area, especially if the data were collected for other purposes

(Adapted from Witkin and Altschuld, 1995; Rubin and Babbie, 2001; and Devaney and Rossi, 1997)

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applied to resources, benefits, or services and is often measured in quantifiable terms. To ensure adequacy of a benefit, the care manager may ask: how adequate is the service level provided to my specific client, to the average client or to all clients? If the benefit is not adequate, it should alert the case manager to take action to expand the program, or to seek other benefits for clients. In addition, the care manager needs to ask whether the benefits offered are in line with the needs of the clients and with the problem as specified in the problem analysis/needs assessment. In other words, can

the program, as it is designed alleviate the contributing factors identified in the assessment. Is it adequate to do the job?

The fourth criterion, accessibility, refers to the ability of clients to utilize available services. There are two components to accessibility. The first deals with the overarching question of who should be eligible to use the care management service. Thus in most programs, limits are established around who will be allowed to access that service. These are generally referred to as eligibility criteria and may include such factors as age, income, geographic location, diagnoses, etc. These limits are generally set by the sanction. However, again the GCMs' direct contact with the community may result in identification of additional subgroups with needs similar to those currently eligible for

services. Thus advocacy may be necessary to expand eligibility criteria as in the home health example mentioned previously.

Accessibility also relates to the ability of an eligible client to avail themselves of the care management services. In other words, are all those who are eligible equally likely to use the service or are there some barriers preventing certain subgroups from using the service, barriers that are unrelated to the eligibility criteria? Although the client may qualify for the service, he/she may be unaware of his/her eligibility, unable to benefit, and/or uninterested in benefiting from the service. For example, a care management agency serves a geographic area with a large elderly Hispanic population but they have no bilingual staff or outreach materials.

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EXHIBIT 6

Advantages & Disadvantages to Conducting Mail Surveys

Advantages

1. Ease of administration
2. Low cost of administration compared to other survey forms
3. Can gather much information in short period of time
4. Less time consuming than other forms of survey research
5. Can achieve greater specificity and thus enhance reliability

Disadvantages

1. Lack flexibility in responding to unique situations
2. Incomplete responses can affect the validity of the results
3. Standardization can reduce individual difference
4. Cannot measure action, only self-reports
5. Loss of context
6. Weak on validity
7. Must have a minimum degree of literacy of respondents

EXHIBIT 7

Advantages & Disadvantages to Interview Surveys

Advantages

1. May motivate respondent to give more accurate and complete information
2. Interviewer control may ensure fewer non-response
3. Can gather more detail through probing
4. Eliminates literacy problem
5. Greater flexibility than questionnaires
6. Can add observations to data collection

Disadvantages

1. Added cost and time
2. Potential for interviewer bias
3. Need to train staff or hire specialized staff to conduct the interviews

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Few older Hispanic adults take advantage of the service even though they meet the eligibility criteria. The lack of bilingual resources makes the program inaccessible to this sub-population which would otherwise be eligible for care management services.

The next factor, equity, relates to fairness in the distribution of services. This includes questions related to overall eligibility for a program as well as concerns about the distribution of services to those who are eligible. Distributive justice concerns arise when resources to support a program are limited, thus generating constraints on the amount of service available. For example, services can be distributed in an equitable manner by giving proportionally based on need. Alternatively, clients can be given an equal amount of service regardless of need (Chambers, 2000) or services can be delivered according to one's ability to pay. In fact, the OAA emphasizes "providing services to older individuals with the greatest economic and social need, with particular attention to low-income minority older individuals and older individuals residing in rural areas" (AOA, 2004, p.3). In considering equity factors the care manager must look beyond the individual needs of his/her client, to consider the needs of all who are served by his/her organization. Any program or policy will have to take into account the fact that services are limited and that the provision of service to one client may preclude service to another. Thus there must be a clear rationale for using proportional or absolute equity calculations in distributing services.

Efficiency is another factor that care managers need to consider. The key question here is whether a service or program can be provided in any other way making it more cost effective. Is there a more cost effective way (identified through the

process objectives) to achieve the specified outcomes? Efficiency is more directly tied to questions of process and the means used to reach the specified ends. This criterion, efficiency, in conjunction with the other five, effectiveness, appropriateness, adequacy, accessibility, and equity, can be used to stimulate the feedback loop, the final stage of the development process.

Feedback Loop/Evaluation

The final stage in the program/

policy development process is ongoing monitoring and evaluation. The problem analysis/needs assessment is critical to both the design of policies/programs, and to ongoing evaluation.

"In fact, one of the most important functions of a social problem analysis is to provide an internally consistent, solid basis for judging whether the policy/program design....is a "good" one"

(Chambers, 2000, p. 75). Goals and

objectives must fit the social problem. Fit is demonstrated through clear connections between the terms in the problem definition and the terms in how goals and objectives are defined. Likewise there must be a clear relationship between the process objectives and the identified contributing factors to the problem as well as between the outcome objectives and the identified consequences. This can be thought of as a series of if-then (means-ends) statements. In designing a new program these if-then statements become the hypotheses on which the program is built and they are derived directly from one's understanding of the problem (Kettner, Moroney, & Martin, 1999). In evaluation they are the tools to measure whether the program has done what it said it would (process

objectives) and whether the program has achieved success (outcome objectives have been met). By understanding both the process and the outcomes one can not only demonstrate effectiveness, but also why the program was effective (or not), the adequacy of the services, accessibility for subgroups as well as program efficiency, that is, the cost to deliver the service per unit delivered.

Conclusion

Policy that directs the work of GCMs is well-documented and

grounded in theory, research, and practice. Yet, as the demography of the aging population changes, Geriatric Care Management will also change. A new directive will arise, which will challenge existing policies and GCMs to recognize the evolving nature of need for the world's aging population and to advocate for an overall higher standard of care. GCMs will play a

critical role in this change process. Thus, the circle continues.

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The problem analysis/needs assessment is critical to both the design of policies/programs, and to ongoing evaluation.

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Joan K. Davitt, Ph.D. is an Assistant Professor at the School of Social Policy and Practice at the University of Pennsylvania.

Karen Zurlo, MSW is a Research Associate at the School of Social Policy and Practice at the University of Pennsylvania.

Heather A. Klusaritz, MSW is a Research Associate at the School of Social Policy and Practice at the University of Pennsylvania.

Footnotes

- 1 The term contributing factors refers to the causal elements in the social problem. We use contributing factors as opposed to the term causes as most social problems have multiple factors which contribute to the problem.
- 2 HCFA is now referred to as the Centers for Medicare and Medicaid Services (CMS)

Using Statistics in Geriatric Care Management Practice

Helen Miltiades, Ph.D.

Statistics is the process of collecting, organizing, and interpreting numbers. Certain statistics are beneficial for practitioners. A basic knowledge of statistics allows you to interpret and apply the findings in professional articles to your own area of practice. It also allows for informed decision making and an understanding of market and client characteristics. Statistics can be used to describe a client population, determine relationships between client needs and community characteristics, and test whether provided services are beneficial. Statistics can be used to determine if a need exists, how broad the need may be, and which part of the population might best be served by new or modified services. Furthermore, statistics can be used to evaluate the benefits of a social program and determine whether or not the program has a significant impact on people's lives. It is not the goal of this article to provide extensive statistical instruction and formulas. Rather the goal of this article is to provide instruction on how to utilize basic statistical techniques that can improve geriatric care management practice. This article is based on the premise that not all readers have access to advanced statistical packages; therefore the statistical techniques are explained using Excel, a common spreadsheet package commonly found in Microsoft Office.

Statistics to Describe the Client Population Served

The easiest way to utilize statistics is to describe a client

population. The demographic characteristics of a client population can be used to predict service needs and identify potential clients. Demographic characteristics can also be used to compare the client population served to local, state, and national demographics on the older population. This section explains the purpose of and how to compute medians, means, and standard deviations. The median is the score that falls in the middle of the score distribution. Medians are used to describe typical values in a population. If the scores are ordered from smallest to largest, half of the scores fall above the median, and half of the scores fall below the median. Seventy-five would be the median of the following three ages: 69, 75, and 95. In samples where there is an even number of scores, the median is the average of the two middle scores. For example, in order to find the median of the following four ages 69, 70, 75, and 90, the scores 70 and 75 would be added and divided by two yielding a median of 72.5. The mean describes the average value of the population. The mean is computed by adding up all the scores and dividing by the number of scores. The mean of the four scores above would be derived by adding 69, 70, 75, and 90 and dividing by 4 (the number of cases). Thus, the mean or average would be 76. The standard deviation describes how closely clustered all the scores are to the mean. When comparing demographic characteristics for different client populations, the standard deviation will reveal how diverse the demographic characteristics are for each client population. The first step in computing the standard deviation is to compute the mean of all the scores. Second, subtract each individual score

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from the mean, and square the answers. Third, add all the sums from step two. Fourth, take the sum computed in step three and divide by the number of scores minus one. Lastly, calculate the square root of the number in step four. Here is how to find the standard deviation using the ages from the last example. The mean is 76. Second, each individual score would be subtracted from the mean and squared $(76 - 69)^2$ $(76 - 70)^2$ $(76 - 75)^2$ and $(76 - 90)^2$. Third, the answers from each equation 49, 36, 1, and 196, respectively, would be added yielding a sum of 282. The number 282 would be divided by 3 (the number of ages minus one) yielding the answer 94. Finally, the square root of 94 is calculated. The standard deviation is 9.69. The smaller the standard deviation is, the closer the scores are to the mean. A standard deviation of 9.69 is somewhat large, and occurred because age 90 is not clustered closely to the mean of 76, like the ages 69, 70, and 75. An easier way to compute the standard deviation using Excel is to type “=STDEV(A1:A99)” into the cell where the standard deviation is to be computed. A1 would indicate the cell where the first value is to be computed, and A99 would indicate the last cell.

Understanding Relationships Between Two Variables

The ability to compute the descriptive statistics, described in the first section, is a necessary precursor to understanding relationships between variables. If there is a relationship between variables, knowing the value of one variable will lead to an expected value on the other variable. For example, there is a positive relationship between education and income. Knowing that an older person has less than a high school education would lead one to expect that this older adult may be living in poverty.

Pearson Correlation

One of the most common measures used to determine if there is an associa-

tion between two linear variables is the Pearson correlation. The Pearson correlation can only be used with interval variables. Interval variables order data, and there is a precise numeric distance between data points. Age, education level, income, and counts of services provided are all examples of interval variables. The Pearson correlation also describes the strength of the relationship between two variables. The correlation ranges from -1 to +1. A correlation of 0 indicates that there is not a linear relationship between two variables, while a score greater than 0 indicates a positive relationship and a score less than 0 indicates a negative relationship. It is unusual for a correlation to be -1 or +1. An easy way to compute the Pearson correlation is to use Excel. The formula to type into an Excel cell is “=PEARSON(A1:A99,B1:B99).” In this equation, A1 indicates the first value of the first variable and A99 indicates the last value of the first variable. Likewise, B1 indicates the first value of the second variable and B99 indicates the last value of the second variable. It is also possible to compare two correlations to determine which one is stronger. For example, a geriatric case manager might be interested in determining whether a relationship exists between the number of informal caregivers an older adult has, and the number of social services an older adult needs. The number of services an older adult needs, however, may also be related to the number of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) that an older adult can perform. If the correlation coefficient between the number of informal caregivers and the number of social services needed is -.30, one can surmise that as the number of informal caregivers

increase, the need for social services decreases. If the correlation coefficient between the number of ADLs/IADLs and the number of social services needed is .50, one can surmise that as the inability to perform ADLs/IADLs increases, so does the need for social services. Since .50 is larger than .30, the relationship between health and need for services is stronger than the relationship between informal support and need for services.

Chi-Square Test of Independence

A Chi-Square test is used to examine relationships between two categorical variables. Categorical variables are variables that group people or cases into categories. Gender is a category where people are grouped according to being male or female. A Chi-Square test answers the question, “Are these two groups related?” A Chi-Square test could determine if there is a relationship between a client following a case management plan (yes, the client follows the plan, no, the client does not follow the plan) and gender (male, female). If women are more likely than men to follow a case management plan, then a case manager could focus efforts on creating strategies to emphasize the importance of following a care plan to male clients. Excel does compute the Chi-Square statistic, however, some computations must be made manually before using Excel. Consider the hypothetical situation proposed above. In order to determine if women follow a case plan more rigorously than men, a contingency table would be drawn up. Table 1 displays the hypothetical scenario of following a case plan.

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T A B L E 1

Following a Case Plan by Gender

	Men	Women	Total
Follow Case Plan	30 (57.6)	150 (122.4)	180
Do Not Follow Case Plan	50 (22.4)	20 (47.6)	70
Total	80	170	250

Using Statistics in Geriatric Care Management Practice

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In this table, 180 people follow a case plan. The top left cell with a “30” in it means that 30 men follow a case plan; 50 men do not. The table seems to show that more women than men follow a case plan. Thus, the row a person is in (follow a case plan or do not follow a case plan) depends on the column the person is in (men or women). After filling out a table of the observed results, the second step is to determine if the row variables are equally distributed among column variables. In other words, a calculation is conducted to determine what the table would look like if men and women equally followed a case plan. This simple calculation must be done manually. For each cell, the row total the cell is in is multiplied by the column total the cell is in, and then divided by the total sample size. In order to determine the expected frequency for cell 1 (men who do not follow a case plan) 180 (the row total) is multiplied by 80 (the column total) and divided by the total sample size of 250 yielding a result of 57.6. This means that if men and women equally followed case plans one would expect 57.6 men to follow a case plan. The same calculation must be made for the remaining three cells. The expected frequency is given for each cell in Table 1 in parentheses. Note that the expected frequencies are unique for each cell based on the row and column total. After constructing two tables in Excel, one with the observed results, and the other with the expected results (the numbers in parentheses in Table 1), the numbers can be entered into an Excel formula. The formula to type into an Excel cell is “=CHITEST(A1:B2,A3:B4)”, where A1 is the first cell and B2 is the last cell of observed frequencies, and A3 is the first cell and B4 is the last cell of the expected frequencies. Excel will return a statistic indicating the probability that the results observed (the row and column distributions) are independent or not related to each other. If the number returned by Excel is less than

or equal to .05, then the observed values are dependent. In the hypothetical example, Excel returns a number less than .05. The interpretation is that more women than men follow case management plans.

Two Sample Paired T Test

The paired t test is generally used when measurements are taken from the same person before and after they experience a different environmental condition. For example, paired t tests can be used to determine if an intervention or educational experience has an impact on a person. Paired t tests require measurement or testing prior to the intervention, and testing after an intervention. The testing instrument should be the same both times. For example, it is possible to test the effectiveness of a fall prevention program. A case manager might use a checklist of questions to determine a client’s knowledge regarding steps they can take to prevent falls. The intervention program might include reading material on fall prevention and a home safety assessment. The follow-up assessment would include the questions asked on the first assessment. Thus, each person would have two scores, a before and after score. The score can be as simple as a count of the number of fall safety prevention features in a person’s home. Determining if the intervention has an impact is simple to do in Excel. The text to type in is “=TTEST(A1:A40,B1:B40,2,1).” A1 is the start of the before measurements;

Certain statistics are beneficial for practitioners. A basic knowledge of statistics allows you to interpret and apply the findings in professional articles to your own area of practice. It also allows for informed decision making and an understanding of market and client characteristics.

A40 is the last case in the before measurements; B1 is the first case in the after measurements; B40 is the last case in the after measurements. The two (2) indicates a two-tailed probability, and the one (1) indicates that the data are paired (two measurements from the same person). Excel returns a probability statistic that indicates if the intervention had a significant impact. If the number is less than or equal to .05, then the intervention had a significant impact and was successful.

This brief article could not cover all the assumptions and variations in the statistical meth-

ods discussed. A brief overview of the procedures was provided. For more in-depth statistical guidance, one could turn to a statistical consultant, take a college level course in statistics, or purchase one of the recommended books in the bibliography.

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- Helen Miltiades, Ph.D. is an Assistant Professor with the Health Science Department of California State University, Fresno.

Writing Effective Grant Proposals: Guidelines and Strategies for Geriatric Care Managers

Jennifer A. Crittenden, M.S.W.
Jason C. Charland

Introduction

It is no secret that resources are scarce for social service agencies and geriatric care managers are not immune to this phenomenon. Stretching the proverbial dollar is indeed a necessary skill to operate effectively when funding streams tighten and reimbursement dollars are at a premium. It is important for geriatric care managers to consider exploring the realm of grantwriting as a way to finance new programmatic or research endeavors. There are numerous opportunities to seek federal, state, or foundation dollars for geriatric care managers and their collaborative partners. This article aims to enable geriatric care managers to utilize the grantwriting process by outlining: 1) strategies for identifying potential grant opportunities and 2) guidelines for putting together a competitive grant proposal.

Before You Get Started

First, put aside your fears and feelings of intimidation about the grantwriting process. Writing a grant proposal is both an art and a science (Carty & Silva, 1986). As a geriatric care manager you have three of the most important qualities needed to put together a competitive proposal: 1) hands-on expertise of geriatric issues in need of further development; 2) the ability to plan strategically and follow directions closely and; 3) access to potential collaborators in the field of aging.

The skill set that you have developed in your geriatric care

management career positions you will take on the task. You will need to add persistence, determination, a good idea, and sound planning to help turn your concept into a well formulated proposal. Be aware that it is not a process that yields success overnight and there are more rejected proposals out there than proposals that are funded (Lusardi, 1999). However, with thoughtful planning, strong partnerships, and a solid idea, grants writing can be a viable option for geriatric care managers to raise funds for programmatic or research endeavors.

Brainstorming and Idea Formulation

One way you can start the process is by brainstorming a "wish list" of potential program or research areas that you would like to pursue. Write them all down, no matter how big or small. This will allow you to list the topics that you feel are most important to you and the clients that you serve. Once listed, rank the items from most important to least. Next, circle the ideas that are the most realistic to accomplish while putting a line through the unrealistic ones. Rewrite the items that you circled on a new sheet of paper. Take the new list to the library or the nearest computer and you are ready to start on preliminary investigation of your topic.

Start out by looking at the topic broadly and learn more about it by investigating current and past efforts by others who have studied the topic. A thorough browse in an internet

search engine (examples: www.google.com or www.yahoo.com) will lead you to countless websites to investigate. Narrowing the search with more specific words will gradually help you come closer to your idea topic. It is easy to get "sucked in" to websites so you will want to exercise some discipline while balancing being exhaustive and thorough.

If you prefer the library, ask a librarian for assistance in locating the resources you need. If you live near a college or university, utilize the reference librarians who are experts in directing you to relevant holdings in their collection.

Avoid "reinventing the wheel"- It's a waste of effort, time, and money. Try to take the information from your broad investigation of the topic and piece together how you can incorporate a unique twist. In formulating ideas you are limited only by your creativity and the capacity you and your collaborative partners have to carry out your budding project.

Demonstrating Need

It is invaluable to separate the concepts of "need" and "solution" when drafting a proposal. Documentation and demonstration of "need" must be conveyed first followed by the proposed "solution" that the efforts of your project will bring to bear (Chavkin, 1997). Programmatic grant proposals should be based on documented need as well as realistic and feasible projections of utilization rates. Often the place to start is a small pilot grant to conduct a needs assessment that will yield such documentation of need. If you are pursuing a research-oriented grant it is important to have a well formulated research question that has relevance to your practice from which to guide your project. Regardless of the track taken, program or research, it is critical to have a solid plan in place.

Finding Grants

A crucial strategy to employ when finding appropriate grants is to stay informed of currently funded projects locally, within your state or

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region, and nationally. This information can be found by directly contacting the funding source, looking for news stories in local and national papers and on news broadcasts, visiting relevant social service agency websites, and being civically engaged in your community.

Knowing the political climate of your topic on all levels (local/state/national) can give you insight as to the popularity and timeliness of your project. Knowing your topic area well and seeking out local agencies, universities, or other practitioners can potentially expand your capacity as well as the scope of the overall plan. Remember, innovative ideas sell. Approaching a timely issue in an innovative manner can be an effective strategy by which to achieve success.

Do Your Homework

Review annual reports of funding sources (available online or in your local collegiate library) to see who was funded in the previous year, the amount of funding, and the type of project selected by the funder to become acquainted with the funder's priority areas. Keep track of the trends in funding and take note of popular topic areas among funding sources. Take the initiative and contact the grant recipient to learn about their project as well as to request advice they have for you regarding the process (Shaw, 2005).

Reading Requests For Proposals (RFPs)

It will save you time and unnecessary frustration to identify the key deadline dates and the eligibility requirements before you read through the text of a request for proposal. This will tell you loud and clear if you have time to initiate the process and if you are eligible to be considered for review.

Once you find a RFP that you have adequate time to prepare and are eligible for, read the RFP carefully

several times. Take notes while reading the RFP and keep a working log of your thought process; it will prove to be valuable for your future reference when you prepare the actual proposal. It can not be stated enough that following the directions dictated by the funding source is of the utmost importance. Good, great, and superior proposals alike are rejected without further review if the author does not follow the directions outlined in the RFP (Van Zant, 2003; Kurland & Malekoff, 2004; Carty and Silva, 1986; Chavkin, 1997).

Contact the Funding Source with Questions

During the writing process you may have a question that needs clarification. Contacting the grants officer is a great way to not only get questions answered but also to bring your name and agency to their attention. It is wise to be prepared and ask clear and concise questions. You can find the contact person for a grant within the RFP document.

Pre-proposal Planning

Writing a proposal is a time intensive process that can take several months to complete. Library research, consultation with colleagues to gain feedback, and assembly of a project team are some foundational steps in the process (Lusardi, 1999; Carty and Silva 1986; Hester, 2000). When working with others it is important to negotiate who will be doing what as well as the estimated costs of the effort. Figure 1 below provides a

starting point in your preparation.

Pre-proposal planning is an essential component of successful grants writing that entails mapping out your potential program, evaluating your capacity to carry out the proposed project and devising evaluation strategies. Before writing the proposal, re-read the RFP and prepare any additional items that may be needed including letters of support, documentation of non-profit status, etc. For those interested in pursuing a research project, the National Institutes of Health (NIH) suggest that applicants consider forming their own review committee to review your proposed plan before submission (NIH, 2005).

Choosing a Project Name

When you have crafted a sound argument demonstrating the need for the project and a well formulated plan from which to carry it out, you will next need to give it a name. Err on the side of economy when choosing your words- be descriptive but not wordy. The use of acronyms is one way to slice a long title into a single word or phrase. You will want to come up with something "catchy" that will stick in the minds of reviewers as well as future participants if funded (Nutt, 2001).

Assessing Capacity

Assessing capacity to carry out a project represents a challenge to you as a grants writer to be honest about your own abilities and what you can and cannot reasonably promise to deliver. For example, if the following events are

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FIGURE 1

Strategies for Successful Grant Acquisition

1. Locating funding
2. Understanding project guidelines
3. Establishing a plan of action
4. Addressing each grant proposal component
5. Soliciting letters of support
6. Building credibility
7. Justifying budget requests
8. Capture reviewers' attention, stand out

(Hester, 2000)

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occurring in your organization or a major project partner's organization consider postponing your grants writing efforts or examine the situation more carefully before submitting a grant:

- High turnover rate among board members
- A difficult executive director transition or vacancy is occurring
- When your agency or a partnering agency has been involved in negative press or scandal
- When there are inadequate staff and resources to meet the demands of planning and executing your new program or project (Clarke, 2001)

As an individual researcher and grants writer, your own assessment may include any of the following:

- Do I have adequate expertise in this area?
- Does my current level of experience meet the needs of the funding source?
- Do I realistically have the time to devote to this project if and when it is funded?

Logic Model

A logic model is a tool with which every grants writer should be familiar. In a time when local and federal budgets are strapped, logic models are being used more often to define, in a realistic fashion, how a program or project will unfold. A logic model outlines not only how a program will progress but it also requires thought on how you plan to measure the impact of your work.

Logic models come in various forms and some funding agencies may request a specific model for the purposes of the grant. One basic component of a logic model involves the resources that will be put into the project including time, money (from the granting source and other sources), expertise, education level of staff and partners involved, space for the program or project to happen, and even information that has been collected on the topic. Resources are then used in the project and incorporated in project activities or actions that will be taken to carry out the project.

Once you have mapped your resources and activities, conceptualize the outputs of the project. An output can be defined as a product or service that is delivered or developed as a result of your activities (McLaughlin & Jordan, 2004). Such outputs might include the development of a report, counseling services delivered to 60 older adults in your area, or the

creation of educational materials for consumers among many other possibilities.

The outcomes of your project represent the logical impact or effect of carrying forward your work. In designing your project or approach, you have some idea about what you want to accomplish. The outcomes portion of the logic model outlines the impact or result of your project into three levels: short-term outcomes, intermediate outcomes, and long term outcomes. Short-term outcomes are often the direct result of your intervention, project, or program and intermediate outcomes stem forth from the short-term outcomes. Long-term outcomes are the results of your short-term and intermediate outcomes over time (McLaughlin & Jordan, 2004). Often your long-term outcome will be very similar to the overarching goal of your program. Figure 3 provides some sample outcomes and demonstrates the change and impact of a program over time.

Elements outside of resources, activities, outputs and outcomes exist and you may wish to include some of these in your logic model including social climate, contextual elements that may impact your project or program, recent policies that impact your project, client perspectives on the issue you are addressing, or any other element that will aid in mapping out the "full picture" of your project.

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FIGURE 2

Sample Logic Model



FIGURE 3

Sample Outcomes

Goal: Older adults will have greater access to local resources available to them.

Short Term: Information about local resources will be more visible to older adults.

Intermediate: Older adults learn about local resources and how to access them.

Long Term: More older adults use local resources.

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Evaluation

A solid logic model will lead into a solid evaluation of your project or program efforts. To this end, whenever possible set benchmarks for yourself within your logic model. For example, how many older adults will receive counseling? How many trainings will be held? Quantifying results early on sets your project on a definable course with logical ends and goals. Evaluation information can and whenever possible, should be used to improve on program efforts.

Clearly defined activities, outputs and outcomes will make reporting and tracking your progress an easier task. Setting reasonable targets for your efforts can be difficult. Are you looking to increase knowledge about an area or topic? Are you looking to create a new service? Evaluation is increasingly becoming a requirement of many funders and some require that an outside evaluator be hired to carry out an evaluation of project outcomes and products.

8 steps of the evaluation cycle:

- Step 1: Conceptualize the evaluation
- Step 2: Design the evaluation and the methodology
- Step 3: Hire and train staff (if applicable, depending on the scope and size of your project)
- Step 4: Choose and test instruments and procedures (surveys, interviews, databases, etc.)
- Step 5: Collect data
- Step 6: Analyze and report data to funding agency and other stakeholders as needed
- Step 7: Modify your program based on the data
- Step 8: Prepare to re-evaluate

(Source: Substance Abuse and Mental Health Services Administration, no date)

Explore the following when creating your evaluation plan (Wholey, 2004):

- What information do you currently collect?
- What information could be collected?
- What analysis could be undertaken with the information available?
- How much will information collection and analysis cost?
- How much time is required for evaluation efforts
- What are the potential uses of the evaluation

Avoiding Common Pitfalls

Some of the most common pitfalls that result in a rejected proposal often stem from lack of planning and accurate assessment of capacity. Some of the frequently cited reasons for an applications failure revolve around project planning and include:

- Over-ambitious plan with an unrealistically large amount of work
- Direction or sense of priority not clearly defined
- Lack of focus in hypotheses, aims, and or research plan
- Lack of original or new ideas
- Evaluation plans that do not realistically match your program (National Institutes on Health, 2005)

Making Your Case: The Art of Marketing and Telling Your Story

Once your preparation has yielded a feasible plan, you should start in as soon as possible writing the narrative for your grant proposal. Writing is a difficult task that is best approached with time and patience. Grantwriting is much like writing in other venues however, there are some aspects of grantwriting that make it a unique art. First, grantwriting involves “telling your story”, that is, setting the scene by describing the who, what, when, where, how, and above all why (Clarke, 2001). Document the

information about the need for this particular program or service. Provide solid information about the need and the context of that need. For example, are you in a rural or urban setting? What makes your geographic location unique from other locations? How does this tie in with similar projects or programs? Why is this need so important? And why are you in a position to make this happen?

All the information you have gathered in your planning process about your program and your own capacity to carry out your proposed work should be highlighted within your narrative. Don't assume that a funder knows about your organization or the type of work you do. Avoid jargon or technical language that grant reviewers won't readily recognize (Gitlin & Lyons, 2004). Be clear and concise in your writing and document sources of information diligently. Avoid wordy writing, it may do more to distract rather than impress reviewers.

Follow the instructions set forth within the proposal guidelines. Nothing makes your proposal stand out in a negative way as does ignoring the grant guidelines. Abide by the font and margin sizes as if they were law! This is a simple point, but one easily overlooked in the rush to get your proposal out on time.

A good proposal markets your plan effectively. Understand, through research and getting to know your funding agency, what they are looking to fund and why. Give your own narrative that slant and make it relevant to the funding agency's efforts on a federal, local, or state level. Keep in mind that writing a grant and making your case are strategic activities.

Constructing a budget will also be necessary for your grant. Outline in great detail what types of equipment and services will be purchased with grant money. As with all other aspects of your grant, follow the budget rules set forth in the grant guidelines. If possible, demonstrate an in-kind match of funds from either

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yourself or another partner. This match can be through donated services, equipment, or even staff time. Some funding sources require such a match whereas others do not. However, providing an in-kind match can show commitment to making a project happen (Van Zant, 2003).

The Silver Lining: Making the Most Out of a Rejection or Acceptance

It is important to keep in mind that proposals are rarely funded on the first try and rejection can be expected initially. It also shows a great deal of professionalism to send a letter of thanks to the funding agency after a rejection. It is in this letter that you can ask for feedback from reviewers on how to improve the proposal (Chavkin, 1997). Keep in mind that foundations or corporate granters may not have the resources available to provide you with comments or feedback.

Federal granting agencies, on the other hand, will most often provide you with reviewer comments when available. If you were not funded this time around, use your thank-you letter to also inquire about future funding cycles and submission dates. Using reviewer comments to polish up a proposal can give you a competitive edge the next time around. It also bodes well to demonstrate that you listened to, and take seriously, comments that were provided. It is essential to implement feedback from the proposal rejection into your revisions for resubmission. Incorporating the reviewer's recommendations in resubmission demonstrates to the funder persistence and a determination to move further through the process (Lusardi, 1999).

Smaller local agencies and

organizations should be approached delicately as the politics of working and living in the same geographical area as a funding source provide unique challenges to grantwriters. How you handle a rejection notice from these funders will impact on further funding opportunities and it may impact on your practice or other collaborations and partnerships in your community (Bauer, 1994).

Whether it's a rejection notice or an award that you receive for your hard work, the message remains the same: use the notification process as a starting point for a continued relationship with that particular funder. If your request is funded, maintain positive communications with your funder including submitting all requested reports and updates on-time and in the format requested. Keep your funder informed of significant events and changes within your project or organization, send any relevant press releases that stem from your project, and be honest about the outcomes of your project (Clarke, 2001). It is also essential to keep your grants officer informed of any unintended results or goals that were not met as outlined in your proposal. Justify any changes that need to be made to your research or program.

Applying for a grant can be work intensive and intimidating. However, keep in mind that many small organizations and individual professionals have received grant money to carry out research and service programs. There are many resources available to aid you in your quest for funding including online modules, websites, books, and even your colleagues who may have valuable advice and experience to share with you about grantwriting.

Funding Sources to Investigate

FEDERAL

The grants.gov website is the single access point for over 1000 grant programs offered by all Federal grant-making agencies.

PRIVATE FOUNDATIONS (From Lusardi, 1999)

Alzheimer's Association

Medical and Scientific Affairs
9191 North Michigan Avenue,
Suite 100
Chicago, IL 60611
(312) 335-5779

AARP Andrus Foundation

601 E Street, NW
Washington, DC 20049
(202) 434-6190

American Federations for Aging Research (AFAR)

1414 Avenue of the Americas,
18th Floor
New York, NY 10019
(212) 752-2327

Commonwealth Fund

Harkness House
One East 75th Street
New York, NY 10021-2692
(212) 535-0400

Foundation for Physical Therapy (FPT)

1055 N Fairfax Street, Suite 350
Alexandria, VA 22308

Ittleson Foundation

15 East 67th Street, 5th Floor
New York, NY 10022
(212) 794-2008

STATE

Contact your state department of human services or conduct an internet search

LOCAL

Contact your local Area Agency on Aging to learn about grants that they are involved in to increase your professional "network" and brainstorm with colleagues.

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Jennifer A. Crittenden, M.S.W., is a Research Associate with the Center on Aging at the University of Maine.

Jason C. Charland is a Graduate Research Assistant with the Center on Aging at the University of Maine.