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## Candidate Outcome Indicators: Health Risk Reduction Program

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Implementing an outcome monitoring process enables organizations to track progress in achieving the program's mission. With this information, program managers can better develop budgets, allocate resources and improve their services. This document includes the following suggestions for starting or improving outcome measurement efforts:

1. **Outcome sequence chart** – *Identifies key outcomes presented in the sequence that are normally expected to occur.* The chart illustrates how one outcome leads to the next and identifies specific indicators that might be used to track each outcome. Intermediate outcomes tend to be on the left, and end (or final) outcomes are on the right. The program description at the top of the chart is meant to encompass a range of similar programs.
2. **Candidate outcome indicators** – *Lists outcomes and associated indicators as a starting point for deciding which outcomes to track.* They were chosen based on a review of the program area and consultation with program experts. Only outcome indicators are included (not physical outputs, such as number of classes held; not efficiency, such as cost per counseling session; and not organization issues, such as success in fundraising or staffing). The focus is on program beneficiaries (clients, customers, citizens, participants) and what has been accomplished for them. A data source or collection procedure is suggested for each indicator.

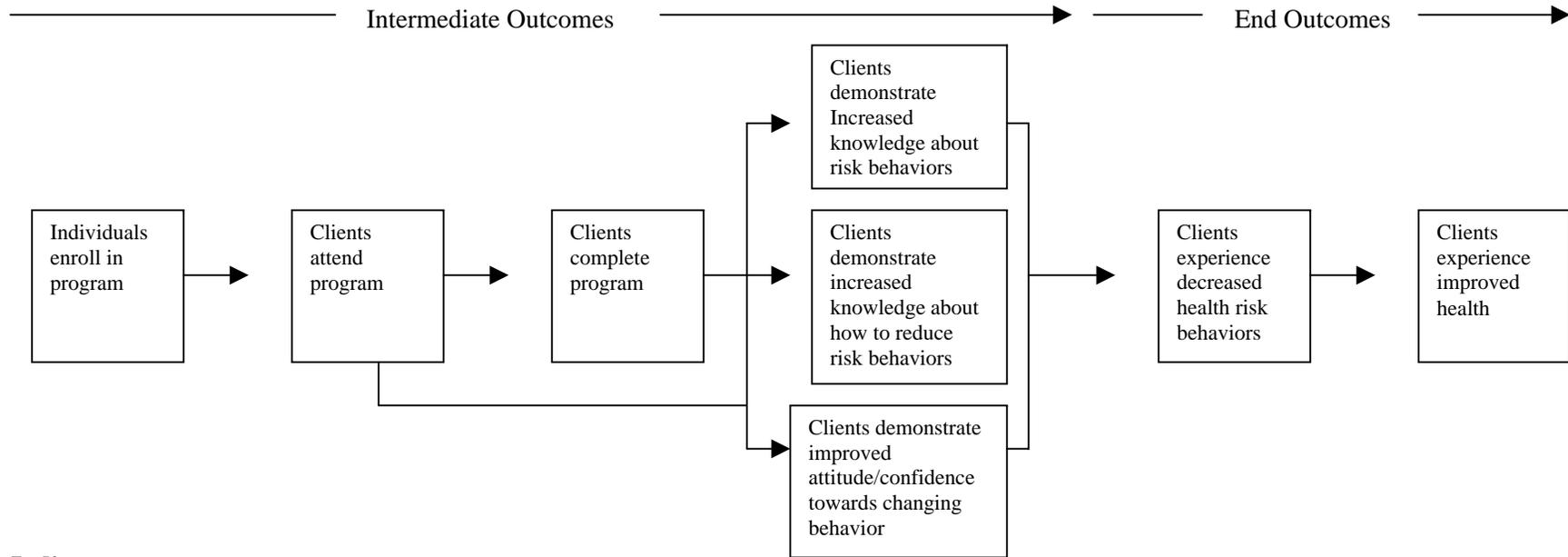
### Suggestions and Limitations for Use of the Materials

- Involve others in deciding which outcomes and indicators to track. Obtain input from staff, board members, and clients. As an early step, prepare your own version of an outcome sequence chart—one that you believe fits the needs of your program.
- Review the project report for additional ideas on relevant indicators and additional resources: *Building a Common Framework to Measure Nonprofit Performance.*
- Tabulate the outcome information by various categories of clients to see if outcomes are different for different clients (e.g., gender, age group, income level, handicap level, and race/ethnicity). Use that information to help better target your efforts.
- Start with a small number of the indicators, especially if you have had only very little experience with such data collection and have very limited resources. Add more outcomes and indicators to the performance measurement system later, as you find that information is likely to be useful.
- Outcome information seldom, if ever, tells *why* the outcomes have occurred. Many internal and external factors can contribute to any outcome. Instead, use the outcome data to identify *what* works well and what does not. Use the data to determine for which *categories of clients* your procedures and policies are working well and for which they are not working well. To the extent that the program is not working as well as expected, then attempt to find out the reasons. This investigation process leads to continuous learning and program improvement.

## Health Risk Reduction Program Description

To promote health and quality of life through programs that help clients reduce health risk behaviors through health education and preventive programs. Examples include health promotion, STD-HIV prevention, stress management, substance abuse prevention and treatment (alcohol and drug), smoking cessation, weight loss, wellness, and nutrition programs.

### Outcome Sequence Chart



### Indicators

1. Number of individuals enrolled in program.

2. Number and percent of clients attending programs.

3. Number and percent of clients who complete the program.

4-5. Number and percent of clients with improved knowledge about a) the nature and consequences of risk behaviors, b) how to reduce risk behaviors.

6. Number and percent of clients indicating improved attitudes towards changing their behavior.

7. Number and percent of clients reporting a substantial improvement in their behavior, after the end of service.

8-9. Number and percent of clients who a) have improved health, b) report feeling healthier than before the service, six or twelve months after the end of service.

Participant satisfaction

Satisfaction with program services is an outcome that occurs within almost every program area, yet does not necessarily have a sequential placement. The indicator may be: Number and percent of clients satisfied with health risk reduction programs and services.

Sources consulted: Community Foundations; Outcomes Evaluation Technical Assistance Guide, Case Management Outcomes, Titles I and II of the Ryan White CARE Act; Colorado Prevention Resource Database: State/Federal Programs and Resources 2003.

**HEALTH RISK REDUCTION**

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	Common Outcome	Program Specific Outcome	Indicator	Data Collection Strategy	Note	Outcome Stage
1	Improved Enrollment	Individuals enroll in program.	Number of individuals enrolled in program.	Internal program records.	See Note #1.	Intermediate
2	Improved Participation	Clients attend program.	Number of clients attending program.	Internal program records of registered clinics.		Intermediate
3	Improved Completion Rates	Clients complete program.	Number and percent of clients who dropped out of service before the service was completed.	Internal program records.	See Note #2.	Intermediate
4	Improved Knowledge	Increased knowledge about risk behaviors.	Number and percent of clients with improved knowledge of the nature and consequences of risk behaviors.	Tests of clients' knowledge before and at the end of the service.		Intermediate
5	Improved Knowledge	Increased knowledge about how to reduce risk behaviors.	Number and percent of clients with improved knowledge about how to reduce risk behaviors.	Tests of clients' knowledge before and at the end of the service.		
6	Improved Attitude	Improved attitude/confidence towards changing behavior.	Number and percent of clients indicating improved attitudes/confidence towards changing their behavior.	Tests of clients' attitudes/confidence before and at the end of the service.		Intermediate
7	Improved Behavior	Decreased health risk behaviors.	Number and percent of clients reporting a substantial improvement in their behavior after the end of service.	Client survey.	Program may want to separately track those who report complete abstinence from risk behavior. This outcome may also be tracked at 6 and 12 months after the end of service. See Notes #3, #4, and #5.	End
8	Improved Health	Improved health.	Number and percent of clients who are healthy, or have improved health, 6 or 12 months after the end of service.	Client survey after program completion/Results of health testing.	See Notes #3, #4, and #5.	End

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	Common Outcome	Program Specific Outcome	Indicator	Data Collection Strategy	Note	Outcome Stage
9	Improved Health	Improved health.	Number and percent of clients reporting feeling healthier than before the service, 6 or 12 months after the end of service.	Client survey after program completion.	See Notes #3, #4, and #5.	End

Note #1: Outcome indicators are likely to be considerably more useful if they are broken out by client types as well, such as by age group, race/ethnicity, gender, handicap status, and specific geographic areas.

Note #2: When assessing client satisfaction, it is also likely to be useful to survey dropouts from the program to identify dropout reasons, where possible.

Note #3: Note that the same client survey can obtain information on several of the indicators, such as for indicators 7-9.

Note #4: Variations of outcome indicators may be used. For example, many of the indicators can be expressed either positively or negatively.

Note #5: People may not agree with designations presented here of "intermediate" or "end" outcome stage. While these designations are generally the common order of events for this program area, some organizations may order events differently. The important issue is what should be measured and its relative significance, not how it is labeled.

### Sources Consulted:

Community Foundations

Outcomes Evaluation Technical Assistance Guide, Case Management Outcomes, Titles I and II of the Ryan White CARE Act

Colorado Prevention Resource Database: State/Federal Programs and Resources 2003.