Build Measurement In Before the Program Becomes Hard to Understand

How to design evidence into a new program or service — while you still can

FOR

executive directors, program directors, program designers, evaluation staff, and anyone building a new service, pilot, or initiative

INCLUDES

a measurement-design checklist, a baseline-data planning table, a say/cannot-say table, and guidance on when to get outside help

Your organization just received funding to launch a mobile health clinic serving three rural communities. The van is ordered. Staff are being hired. Community partners are excited. Someone at a planning meeting says, “We should probably figure out how we’ll measure this.”

That sentence — said casually, usually near the end of a meeting — is the moment this guide is about. Right now, before the first participant walks through the door, you have options that will disappear in six months. You can collect baseline data on the people you serve before the service begins. You can define what you will track and

how. You can set up your intake forms, your follow-up schedule, and your data systems to capture the information you will need later — when the board asks whether the investment was worth it and when you need to understand your own work.

Once the program is running, these decisions get harder. Staff are busy. Systems are set. Changing an intake form after two hundred people have already been through it means you have two hundred records that do not match what you are collecting now. Building measurement into the program before launch produces the clearest and most consistent record. Work begun later remains useful, with additional cost and less complete information.

The common mistake

The most common mistake organizations make with new programs is postponing measurement until after the work begins.

This usually looks like a program that launches, runs for a year, and then faces a reporting deadline. Someone pulls together whatever data exists — sign-in sheets, a few case notes, an output count. The numbers answer the question “How many?” but they cannot answer the questions that matter most: “Did anything change for the people we served?” and “What can we learn from the first year to make the second year better?”

The measurement decisions were left until they became difficult. Defining outcomes, building intake assessments, planning follow-up intervals, and choosing what to track are straightforward at the design stage and painful to retrofit.

A related mistake is over-measuring. An enthusiastic planning team creates a twelve-page intake form, a battery of validated instruments, and a follow-up schedule that requires staff to contact every participant monthly. Within three months, staff are overwhelmed, data quality collapses, and the organization has many incomplete records. Choosing Measures That Fit the Work provides a practical framework for selecting a smaller set that can be collected consistently.

What to prepare

Before the program launches, make five decisions. These do not require an evaluation consultant or a sophisticated data system. They require a conversation among the people who will run the program.

1. Define what success looks like — in terms you can observe

Write a concrete description of what you expect to change for participants. “Improved health outcomes” is a goal. “Participants report having a regular source of primary care at six months” is a measure. The second version tells you what to count, when to count it, and how.

Write down two or three outcomes that you believe the program should produce. Keep them specific enough that you could explain to a new staff member exactly how to check whether they happened.

2. Decide what you will collect at intake

The information you gather when someone first enters the program is your baseline. Without it, you cannot describe change. If you want to know whether participants’ access to care improved, you need to know what their access looked like before they received services.

Your intake does not need to be long. But it should include the starting-point measures for the outcomes you defined in step one. If you care about employment, ask about employment status at entry. If you care about housing stability, document housing status when the person first shows up. You will thank yourself later.

3. Plan your follow-up intervals

Decide now when and how you will check in with participants after they receive services. Will you contact them at three months? Six months? Twelve? How — phone call, survey, administrative data?

The most important thing is to choose intervals you can actually sustain. A six-month follow-up that you complete for 70 percent of participants is far more valuable than a twelve-month follow-up that you complete for 20 percent. Be realistic about staff capacity and participant accessibility.

4. Set up your data system before the first participant

This does not require expensive software. It requires a consistent place to record the information you decided to collect, with fields that match your intake questions and outcome measures. A well-structured spreadsheet is better than a sophisticated database that nobody uses consistently.

The critical requirement is that every record follows the same format from day one. If you change your intake form three months in, you will spend years trying to reconcile the two versions.

5. Decide what you will not collect

This is as important as deciding what you will collect. Every question on an intake form takes time — the participant's time and the staff member's time. Every data point you collect is one you must store, clean, and analyze. If a measure does not connect to an outcome you defined in step one or a genuine reporting requirement, ask whether you truly need it. Choosing Measures That Fit the Work offers a practical framework for making these choices.

A ready-to-use checklist: measurement design before launch

Use this checklist in a team meeting before the program begins serving participants. Check each item when it is complete.

1. We have written down two or three specific outcomes we expect the program to produce.

2. We have defined how we will measure each outcome — what we will count, observe, or ask.
3. Our intake form includes baseline questions that correspond to each outcome measure.
4. We have chosen follow-up intervals (e.g., 3 months, 6 months) and a method for each (phone, survey, records review).
5. We have estimated our realistic follow-up completion rate and accepted it as sufficient or adjusted our plan.
6. Our data system is set up with fields that match our intake and follow-up instruments.
7. Staff who will collect data have been trained on the intake form and data-entry process.
8. We have identified which data we will use for external reporting, which we will use for internal learning, and how the two overlap.
9. We know what we will not collect, and we have a reason for each exclusion.
10. We have a plan for when we will first look at the data together as a team — not at the end of the year, but at a mid-point that allows for course correction.

If you cannot check every item, focus on the first six. They represent the minimum foundation for being able to say something honest about your program's results when the time comes.

What not to say

INSTEAD OF THIS	SAY THIS
"We'll figure out measurement once the program is up and running."	"We are building our measurement plan into the program design now, so we have what we need when reporting time comes."

INSTEAD OF THIS	SAY THIS
"We'll track everything and sort it out later."	"We have chosen three outcome measures that align with our program goals. We will collect those consistently."
"We don't need baseline data — we'll just report outcomes at the end."	"We are collecting baseline data at intake so we can describe the change participants experienced, not just where they ended up."
"Our intake form covers all the validated instruments in the field."	"We selected the measures that match our outcomes and that our staff can administer consistently without overburdening participants."
"We'll use the data to prove the program works."	"We will use the data to understand what is happening for participants and to improve the program over time."

The language in the right column reflects a basic discipline: evidence is most useful when it is designed to inform specific decisions. A new program is the ideal moment to establish that discipline.

When to get help

Outside support may be useful when:

- You are launching a program with complex outcomes — behavioral health, workforce development, family stabilization — and you need help choosing measures that are both meaningful and practical for your staff and participants.
- The new program has specific external evaluation requirements, and you need help designing a measurement plan that satisfies them without overwhelming your team. Those expectations are easiest to resolve before the reporting period begins.
- You want to build in a comparison or baseline that would allow you to make stronger claims later — for example, collecting data on a waitlist group or documenting community-level conditions before the program starts — and you

need guidance on what is feasible and ethical.

- Your organization has launched programs before without a measurement plan and struggled at reporting time. An outside adviser can help you build a simple, sustainable system based on what went wrong last time, so you are not repeating the same pattern.
- You are designing a pilot that will need to demonstrate results quickly — within a year or two — to justify scaling or continued investment, and you need to make sure your evidence plan aligns with that timeline.

At this stage, an outside adviser can help you make a small number of sound measurement decisions before the program starts. Those decisions will matter every time someone asks, “What do we know about how this is going?”