JDC PARTNERSHIPS
INQUIRY
ASSESSMENT
DECISION-MAKING

# BRINTON HOMELESS PROJECT
# EVALUATION FRAMEWORK REPORT

PREPARED FOR

BOARD OF DIRECTORS

PYCHIATRIC FOUNDATION OF NORTHERN CALIFORNIA

BY

JDC PARTNERSHIPS

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## INTRODUCTION

In MONTH 2003, the Psychiatric Foundation of Northern California (PFNC) engaged JDC Partnerships to guide them in the development of an evaluation framework that would allow them to document the reach, scale and effectiveness of the Brinton Homeless Project (BHP). Over the past several months, JDC Partnerships has been working with the PFNC Board and the BHP Staff in the development of program outcomes, objectives and the beginning of tools and processes to that end.

### *Purpose of the Report*

The purpose of this report is to provide 1) an overview of the development of the evaluation framework and 2) recommendations for next steps in designing and implementing an information management system to support on-going data collection, program monitoring and evaluation.

### *Structure of the Report*

The evaluation framework report is comprised of several sections. Section 1 presents an introduction outlining the purpose of the evaluation framework. Section 2 provides a detailed description of the Victims of Crime Initiative, its components, activities, outputs, and intended impacts. Section 3 identifies the evaluation issues that ideally should be addressed over the course of the Initiative, and Section 4 discusses potential methodologies and performance measurement strategies.

### *Need for an Evaluation Framework*

In a time of diminishing resources, the importance of effectiveness and accountability have become increasingly important. As such, the terms evaluation and performance measurement have become mantras in the world of non-profit, public and philanthropic organizations. An evaluation framework provides just that, the framework for determining if the intended purpose and objectives of a program are being met. It is an explicit articulation of a program's impact (intended change) aligned with measurable objectives (tied to activities) in support of that impact. It sets up clear targets (expectations for performance) for staff and the program which allow for more informed decision-making around resource (i.e., time, money, people) allocation which also serve as indices along the way as to how well the program is working (implementation) and what is happening as a result (short and longer term impact).

### *Approach*

The primary goal of the evaluation framework is to develop a monitoring system to assess implementation, document client demographics and services, and assess and evaluate effectiveness and impact. The process for developing the framework was built on two previous phases: 1) the articulation of the Brinton Homeless Project design model and 2) the assessment of the Brinton Homeless Project to date. These two efforts were extremely informative and provided insight to the Psychiatric Foundation of Northern California Board as well as to the Brinton Homeless Project staff. However, because of the developmental/transitional nature of the project, several of the assessment findings and subsequent recommendations are programmatic in nature and thus preclude certain steps in the evaluation implementation.

JDC Partnerships has worked closely with the PFNC Executive Director, Board and BHP staff in designing and evaluation framework that reflects the current developmental status, resources and intent of the Brinton Homeless Project. To that end, the Evaluation Framework seeks to answer a set of questions at four levels: client, program, project and foundation/board level. The questions are designed to provide information to inform real-time decision-making at both the practice level (with clients) and with regard to resource allocation and effectiveness (program impact) and are presented later in this report. Recommendations for next steps are included in this report as well.

## BHP PROGRAM AND LOGIC MODEL

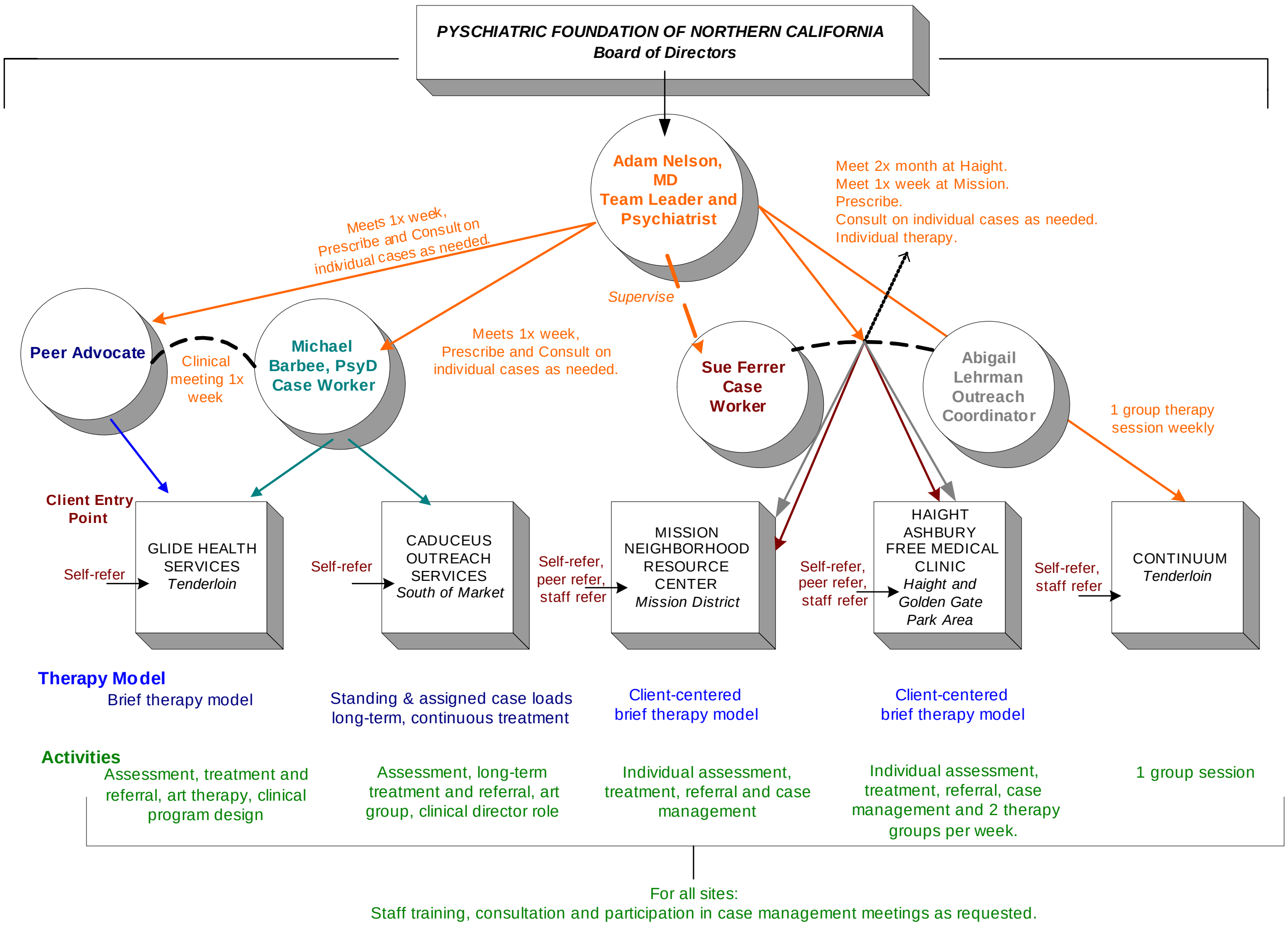
In this section, two models are presented program and logic. Program models are a helpful tool in illustrating the organizational and staffing structure, relationships with other stakeholders and the flow of clients in and out of the program. The core premise and purpose of the logic model is represented by a quote by Yogi Bera, “If you don’t know where you’re going, how are you gonna’ know when you get there?” Often used in both program design and evaluation, the logic model demonstrates the relationship between program objectives (measurable changes) with the key activities of the program, necessary inputs (resources) and the outputs and impacts of the work.

### *Program Model*

The Brinton Homeless Project Model presented in the graphic below depicts the interaction between the PFNC Board, BHP staff, clients and the partnering agencies. The model was developed with the input of partnering agency and BHP staff. Included in the model are the following elements: 1) staff positions, names and “relationship”, 2) partnering agency names and geographic locations, 3) client entry point, 4) therapy model and 5) shared and core activities. Since this model was crafted a Project Coordinator has joined the staff and will start work in mid-to-late March. As a consequence, there may be changes to the model.

**Figure 1.**

**Brinton Homeless Project Model**




As the model demonstrates, the *Team Psychiatrist* provided general oversight to the other BHP staff through weekly meetings to discuss cases, prescribe medication and to engage in on-sight client counseling services. The Team Psychiatrist is also the only member of the staff who meets regularly with all the other BHP staff members. Full team meetings are scheduled as needed.

The *Case Workers* split their time between two agencies each, Glide/Caduceus and Mission Neighborhood/Haight Ashbury. The services provided by the case managers at the sites are similar with some distinction based on the specific skills of the staff and the needs of the clients. For instance, art-therapy services are provided at Caduceus whereas at Mission and Haight " street-based" services are provided to clients, as that is often where the clients are best served. In addition, an *Outreach Coordinator* works in partnership with the Case Worker at Haight and Mission. This additional support allows the Case Worker to link clients with the Outreach Worker who provides specific case management and service navigational support thus allowing the Case Worker more time for individual and group counseling.

The *Peer Advocate* position is solely based at Glide Memorial. The Team Psychiatrist meets once a week with the Peer Advocate, as does the Case Worker assigned to that agency.

The *Team Psychiatrist* is the only member of the BHP team who has regular contact with all five (5) partnering agencies with time distributed equally among the sites with specific time set aside for administration and community education activities. The *Case Workers* both work approximately 30 hours per week with that time allocated between their two sites. The *Outreach Coordinator* works primarily at Mission Neighborhood Resource Center and spends the rest of her time at Haight Ashbury. The *Peer Advocate* works solely at Glide Health Services.

***Logic Model***

In December 2003, BHP strengthened its program model through the development of a program outcome and a set of related objectives. This framework provides a reference point for all of BHP's efforts in that each activity would now be aligned with an objective, which in aggregate contributes to the achievement of the outcome. The program outcome is stated as "Homeless individuals with mental health needs are stabilized." The related objectives are "targets" for staff/activity efforts and can be characterized in two groups:

1. Outreach and Referral – Activities performed by staff, which focuses on the identification and referral (both to BHP and to other resources) of homeless individuals with mental health needs.

   - *Outreach and Referral Objectives:*
     - To identify 1000 homeless individuals with mental health needs, in particular those that would benefit from medication.
     - To provide information and referral for 100% of identified clients.

2. Stabilization – Activities performed by staff that focuses on both clinical and psychosocial symptom stabilization defined as follows:

   - *Clinical Stabilization Objective*:
     - To provide 100 individuals with necessary mental health treatment including psychiatric counseling and medication.
   - *Psycho-Social Stabilization Objectives:*
     - To obtain state and federal benefits (e.g., SSI, MediCal) for 30% of those clients who are eligible and are in treatment.
     - To obtain employment for 5% of those clients who are capable of retaining a regular position.
     - To house 10% of clients (those in treatment and receiving public benefits) in housing environments within San Francisco (e.g., supportive SRO's, Board & Care).

Figure 2. is a draft logic model that reflects the flow of current activities and how they contribute to accomplishing particular measurable objective. Objectives are a step along the path to achieving the program outcome. In this example, it is the efforts of the Outreach Worker who has been identified as the primary point of entry for clients in to the BHP network of service and care which are the focus. A similar process should occur for all objectives and include the role of all staff in accomplishing that objective.

**Figure 2.**

**Draft BHP Logic Model**

| Outcome | Objectives | Activites | Outputs | Impacts |
|---|---|---|---|---|
| Homeless individuals with mental health needs are stabilized. | To identify 1000 homeless individuals (annually) with mental health needs (in particular those that would benefit from medication) | Outreach Worker develops relationships with key organizations around SF whose client base may benefit from BHP services (partnering agencies). | Memorandum of Understanding and/or Contract drafted and completed. | |
| | | Outreach Worker schedules regular hours at partnering agencies to increase accessiblity. | Outreach Worker spends Xhours weekly at Partnering Agency A | |
| | | | Outreach Worker spends Xhours weekly at Partnering Agency B | |
| | | | Outreach Worker spends Xhours weekly at Partnering Agency C | |
| | | | Oureach Worker completes Intake for X number of individuals | |

Finalizing the logic model should include all BHP staff and perhaps be led by the Project Coordinator. This process would serve as an excellent opportunity to refine the program model based on the addition of new staff as well as to clarify roles, responsibilities and the interactions between staff and other stakeholders (Partnering Agency).

## PERFORMANCE MEASURES AND EVALUATIVE INDICATORS

An effective evaluation framework includes both short and long term indices of success. A helpful strategy in determining those indices is to ask a series of questions to guide and inform day-to-day performance and practice as well as longer-term impacts of the program's efforts.

### *Day-to-Day Program Performance and Practice*

There are multiple levels of stakeholders' involvement and interest in the Brinton Homeless Project ranging from the client to the Board of the Psychiatric Foundation of Northern California. At each level, there are a set of questions that provide different types of information ranging from client demographic information that informs BHP staff practice and treatment to information on revenue and expense as well as how well the program is doing in reaching its stated objectives. Figure 3 presents a set of draft questions per the four levels identified: client, program, project and PFNC Board. The questions in the matrix reflect a core set of information, that is the minimum, needed for staff to practice and for the Board to understand how PFNC resources are being spent and on whom.

**Figure 3.**
**Practice and Program Performance Questions**

| | |
|---|---|
| **Client Level Demographics** | |
| 1. | What is your ethnicity/race? |
| 2. | What is your age? |
| 3. | What is your housing status? |
| 4. | What is your income source? |
| 5. | What is your preferred language? |
| 6. | What is the primary presenting issue/condition? |
| 7. | Where is the client service performed? |
| **Program Performance** | |
| 1. | How many clients were seen? |
| 2. | What is the demographic summary of these clients? |
| 3. | How many clients were referred by (what partnering agency)? |
| 4. | How many internal referrals? |
| 5. | How many external referrals (and to what types of agencies)? |
| 6. | How many clients were seen per quarter per partnering agency? |
| **Project** | |
| 1. | What is the avg. time spent per client per staff person? |
| 2. | What is the avg. duration of client relationship with BHP staff? |
| 3. | What is % of clients referred by each Partnering Agency? |
| 4. | Partnering Agency contract compliance |
| **Foundation/Board** | |
| 1. | Staff Performance |
| 2. | Revenue Expense Ratio |

### *Longer-term Evaluation Indicators*

To assess the effectiveness of the BHP project in reaching its stated outcome and objectives, a different set of questions is posed. This is not a comprehensive set of questions, but rather the core. Answers to these questions are compiled annually, although they can be tracked quarterly, and they will help BHP staff and PFNC Board understand what type of effect its services are having on the client population and for how long.

**Figure 4.**
**Longer-term Evaluation Question**

| | |
|---|---|
| 1. | How many/% of total clients obtained benefits? |
| 2. | How many/% of clients obtained housing (for how long)? |
| 3. | How many clients/% of adhere to treatment (3,6,12 mos)? |
| 4. | How many clients/% total incarcerated/not incarcerated during past 6 months? |
| 5. | How many clients did not receive any emergency care (during duration of BHP relationship)? |
| 6. | What is the avg. # of hospital days spent (prior and post)? |

In time, more questions will arise and thus the need for more data and information. In addition, if new funding sources come to fruition, they are likely to have reporting requirements that differ from BHP. The challenge for BHP will be to balance what it "needs to know," and "needs to show" with what it "would like to know" within the limits of its resources.

## IMPLEMENTING AN EVALUATION FRAMEWORK

Since its inception, all data collected for BHP has been through the forms and processes of the Partnering Agencies. The shift from BHP staff being responsible for collecting, storing and sharing data is a significant paradigm shift. Currently, there is very little infrastructure in place to support such an effort and the mobile nature of the work in the field makes the central housing and sharing of data challenging. To ensure that it can answer the questions it deems important and in the time frame required, BHP set upon developing its own data collection tools, processes and protocols.

### *Data Collection Tools*

An initial set of tools was developed with the BHP staff in order to provide 1) information to BHP staff with regard to their treatment of clients and 2) aggregate information to the Board and PFNC staff with regard to client served, primary presenting conditions and overall impact of BHP efforts in relation to stated outcomes and objectives. The following forms are to be administered by BHP staff.

- <u>Client Intake Form and Instructions</u> - This form serves as the intake/registration form and the information collected will provide an overview of the client's strengths/assets including housing status, preferred language, income source…etc. It also provide a record of which BHP staff served as the "first contact" for the client as well as the referral sources (how did the client get to BHP) which can be beneficial in terms of understanding the referral network between BHP and its' partnering agencies as well as other sources.

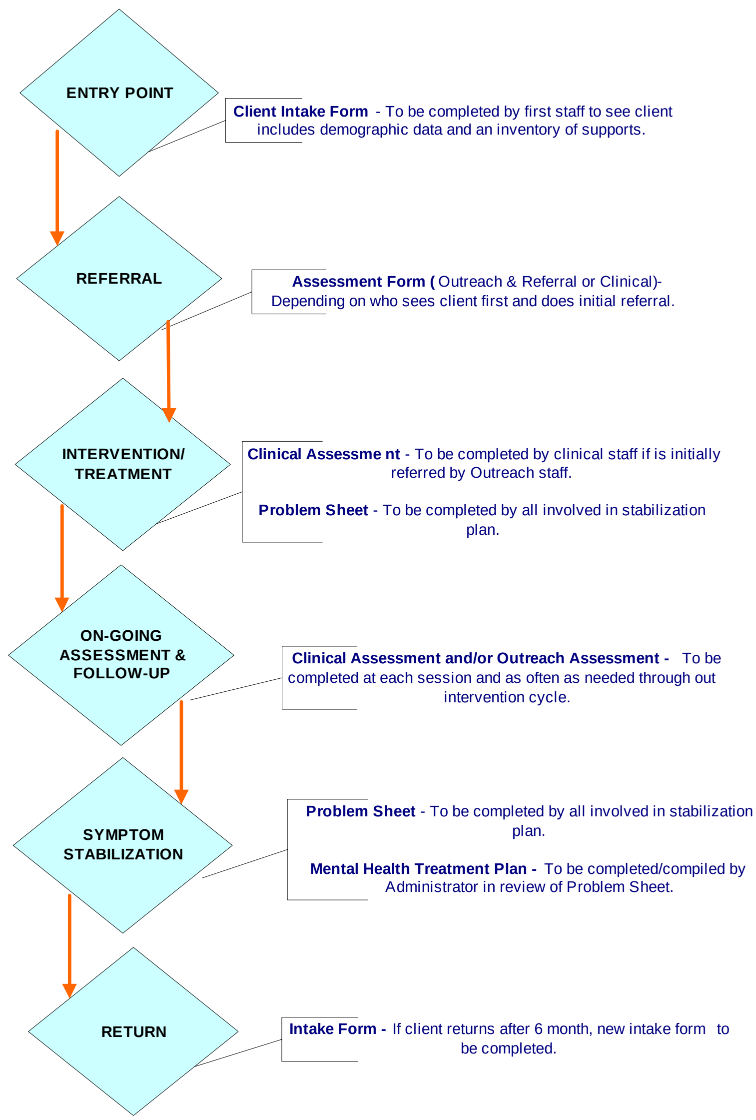
- <u>Assessment (Clinical and Outreach & Referral) and Follow-up Form and Instructions</u> - Administration of the Assessment is to follow the Client Intake and is designed to provide a standardized process (SOAP) by which BHP staff develops a treatment plan through both subjective and objective observations developed to assist clients in attaining both clinical and psychosocial stabilization. The Assessment Form also serves as a Follow-up form once treatment has begun and for the duration of that process.

- <u>Issue/Problem Sheet and Instructions</u> - The Issue/Problem Overview Sheet serves as a summary of the primary focus and related interventions that BHP staff will work to address in partnership with the client towards client and psychosocial stabilization. The following information is captured on the sheet:
  - Key issues/problems being addressed by BHP
  - Staff responsible/participating in treatment or other services (BHP staff initial)
  - Time period in which issues/problems are resolved (start and end date)
  - Primary interventions selected to target/address client issues-

***Data Collection Processes and Protocols***

Several issues are pending and thus prevent the development of a final set of data collection processes and protocols. These issues include: 1) staffing and clarification of roles and responsibilities, 2) re-negotiated contracts with the partnering agencies with regard to client data (HIPPA) and overall relationship with BHP and 3) a determination as to whether BHP will have a central office/location/infrastructure. However, Figure 4 below depicts how BHP staff while working with clients should use the various tools.

**Figure 5.**
Client Flow And Data Collection Process




In order to guide the future discussions on how information is shared, Figure 5 cross references the key evaluation questions with the appropriate data collection tools as well as presents a series of questions for consideration as to how the tools will be administered, data collected and subsequently shared. This table was originally presented to the Executive Director of PFNC in February 2004.

Figure 6.

Evaluation Questions and Data Collection Implications

| | KEY QUESTIONS | DATA COLLECTION STRATEGY | IMPLICATIONS | | |
|---|---|---|---|---|---|
| | | | **Process/Protocol** | **Accountability** | **Infrastructure** |
| | | | **Client Level** | | |
| 1 | What is your ethnicity/race? | Client Intake Form | What staff collects which data?<br><br>How often will data be collected and submitted? | Who will monitor the data collection and the quality of the data? | How will data be compiled?<br><br>What staff will provide oversight on the data collection process?<br><br>What technology is needed to support data collection? |
| 2 | What is your age? | Client Intake Form | | | |
| 3 | What is your housing status? | Client Intake Form | | | |
| 4 | What is your income source? | Client Intake Form | | | |
| 5 | What is your preferred language? | Client Intake Form | | | |
| 6 | What is the primary presenting issue/condition? | | | | |
| 7 | *Other information from Clinical Intake Form if used.* | | | | |
| | | | | | |
| | | | **Program Level** | | |
| 1 | How many clients were seen? | Client Intake Form | Aggregation of client level data. | Who will aggregate the data?<br><br>How often will aggregated data be reported? | What technology is needed to support data collection? |
| 2 | What is the demographic summary of these clients? | Client Intake Form | | | |
| 3 | How many clients were referred by ? | Client Intake Form | | | |
| 4 | How many internal referrals? | Client Intake Form | | | |
| 5 | How many external referrals (and to what types of agencies)? | Client Intake Form | | | |
| | | | | | |
| | | | **Project Level** | | |
| 1 | Avg. time spent per client per staff person? | Staff time sheet/ invoice | Review of BHP staff time sheets and other administrative data sources<br><br>Establishing partnering agency reporting requirements.<br><br>Review of partnering agency contract compliance.<br><br>Quarterly reporting of aggregate data not reviewed at client level | Who will monitor/oversee Partnering Agency performance and provide information/ recommendations to Board?<br><br>Data Analysis (including findings from other projects) | Staff roles and responsibilities with regard to the project and to the Board.<br><br>Refinement to current staff performance review process.<br><br>Establish feedback process with partnering agencies regarding staff…etc. and data system to support process. |
| 2 | Avg. duration of client relationship with BHP staff? | Client Case Management Form | | | |
| 3 | How many/% of total clients obtained benefits? (annual) | TBD | | | |
| 4 | How many/% of clients obtained housing (for how long)? (annual) | TBD | | | |
| 5 | How many clients/% of adhere to treatment (3,6,12 mos)? (annual) | TBD | | | |
| 6 | How many clients/% total incarcerated/not incarcerated during past 6 months? | Client Case Management Form | | | |
| 7 | How many clients did not receive any emergency care (during duration of BHP relationship)? | Client Case Management Form | | | |
| 8 | Avg. # of hospital days spent (prior and post) | Client Case Management Form | | | |
| 9 | % of overall clients referred by Partnering Agency | Client Intake Form | | | |
| | Partnering Agency contract compliance | TBD | | | |
| | | | **Foundation/Board** | | |
| 1 | Staff Performance | TBD | Establishment of personnel performance objectives<br><br>Review of personnel performance and time sheets, feedback from partnering agencies<br><br>Annual analysis of aggregate data in comparison to program objectives. | Who will monitor/oversee personnel performance and provide information/ recommendations to Board?<br><br>Who will report annual findings? | |
| 2 | Revenue Expense Ratio | Adminstrative data | | | |
| 3 | How many/% of total clients obtained benefits? | TBD | | | |
| 4 | How many/% of clients obtained housing (for how long)? | TBD | | | |
| 5 | How many clients/% of adhere to treatment (3,6,12 mos)? | TBD | | | |
| 6 | How many clients/% total incarcerated/not incarcerated during past 6 months? | Client Case Management Form | | | |

***Information Management System***

An information management system is proposed to serve as a secure, online data collection/distribution repository, accessible via a variety of different methods and which can readily provide information and reports for staff, board, and funders. To that end, a 3-stage progression is proposed. This 3-stage process is proposed for two reasons: 1) to pilot the questions and the process for data collection, 2) the lack of a designated staff person to oversee both the data collection process as well as data input at the time of the writing of this report.

1. Paper filing system, housed at the current BHP office; information accessible by staff in office; and reports possible on demographics and staff caseload.
2. Computer filing system, housed at BHP office, and with information entered by remote dictation/transcription service; information accessible by staff in office; reports as above. Begin development of database for information access and complete reporting functions.
3. Online computer filing/database system, housed at BHP office, reports entered either by staff or by remote dictation/transcription service; and information accessible by staff in office or offsite via wireless connection.

It would be possible to move immediately to the stage 3 but that would require on-going support and supervision from a designated staff person such as a Project Coordinator. An implementation framework including requirements, functions, security and confidentiality considerations for the 3-stage process were presented to the Executive Director on February 17, 2004. The following summarizes that proposal.

- Stage 1:Paper Filing System Requirements of this stage include a central location to house files as well as a staff person to organize and maintain files. Forms will initially be handwritten and housed as such. Demographic data from *Client Intake* form can be put into a spreadsheet (computer or paper) and simple counts of types of clients served can be generated for reports. Other information available for reports includes number of referrals by/to agencies; number of clients seen by staff; number of encounters per client; number of new/discharged clients. For confidentiality and security reasons, a client code (or unique identifier) should be used to refer to the client in print, in files or on computer at all times. A client code might consist of the client's first initial, last initial, and date of intake, e.g., DZ021704.

- Stage 2:Computer Filing System Requirements of this stage include: finalized data collection forms and computer, software and designated data entry and management staff person. BHP staff in office on computer may view completed forms, or staff may make copies of printed forms to take away, in order to cover for one another. All reports mentioned in Stage 1 can be generated more easily with a spreadsheet. More complex reports, such as: types of clients referred by/to agencies; types of clients successfully completing intervention; types of presenting issues most frequently solved; may now be generated with comparative ease. A web site designer with experience in security issues should be consulted regarding the design of an accessible, confidential web site. A database developer should be consulted regarding the format of a database to hold, manage and present the information collected thus far and to be collected in the future.

- Stage 3: OnlLine Computer Information Management System Requirements of this stage include: remote access to the Internet for staff and a web site with secure access. Staff at any location, at any time, may view client information. Up-to-date reports (as mentioned in Stage 2 and more) may be generated and viewed with ease. Complex statistical reports can be designed and generated. Financial information may be entered/tracked/monitored in the database, increasing the number and types of reports possible, e.g.: Cost per client, Cost per intervention, Cost per successful "graduate" of program, Proportion of budget spent on each program aspect. Reports can be generated/viewed without making changes to the database. Staff can only access the web site with a password.

Once the pending decisions are made, BHP can consider implementation of an information management system based on the stages presented. And although it is likely that other issues and consideration will arise, these three stages provide a strong foundation for moving forward.

## NEXT STEPS AND RECOMMENDATIONS

The following summarizes next steps and recommendations with regard to fully implementing the evaluation framework and the supporting information management system.

### *Pilot Testing of Data Collection Tools*

Originally scheduled for launch March 1st, the Executive Director decided to postpone the pilot testing as a new staff person will be joining the team who will have significant responsibility for the new data collection process and will not start until mid March. In addition, issues with the Partnering Agencies regarding HIPPA and other contractual issues need to be explored, as the adoption of an internal data collection process will change the nature of the relationship between BHP and its partners. **It is recommended that these issues be addressed as quickly as possible with the understanding that it is a "testing" period to fine tune the tools, the data sharing protocol among staff and the new relationship with the Partnering Agencies.**

### *Review and Refine Program Model*

With the addition of new staff and the possibility of a central location, the BHP Program model may no longer be accurate. **It is recommended that the logic model process presented in this report be completed as a way to clarify the activities, roles and processes used to meet the newly identify program objectives.**

### *Information Management System*

The information management system is a support to the evaluation framework as well as to the overall management of the BHP. The information proposed for inclusion is based on tracking and monitoring the program's efforts in reaching its stated outcome and related program objectives. **It is recommended that a formal data collection system be instituted as soon as possible and starting with a hard copy process is appropriate.**

### *Partnering Agency Contract and Reporting Requirements*

Currently there are no reporting requirements in the partnering agency contracts. This presented a problem when data on BHP clients and staff activities was requested from the partnering agencies in Fall 2003 in order to prepare the BHP Assessment. Only 3 of the 5 partnering agencies provided information in a timely manner and for those who did not, there was little recourse for BHP to encourage them to respond. For that reason, **it is recommended that quarterly or semi-annual reporting requirements are included in the Partnering Agency contracts.** Information requested should be similar to that which BHP proposes to collect for its own clients so that it will be able to compare its client population against the overall Partnering Agency population. In addition, there may be other reporting requirements around staff performance and resource allocation that are more programmatic in nature (and thus the purview of the Executive Director or Program Coordinator) but which will help the project and the Board understand how BHP fits in to the system of care of its partners.