

Developing Community-wide Outcome Indicators FOR SPECIFIC SERVICES



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FOR SPECIFIC SERVICES



This guide is part of a series on outcome management for nonprofit organizations. Other guide topics include

- keys steps in outcome management
- surveying clients
- using outcome management
- following up with former clients
- analyzing and interpreting outcome data

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Preface

A growing concern for nonprofit organizations providing health and human services is balancing the need for accountability to funders and the community with the providers' need for information that can help them continually improve their services. This need for accountability has led to a proliferation of competing outcome-reporting requirements from governments, United Ways, and foundations that provide funding. If service organizations and funders can agree on a common core set of outcome indicators to report on, this problem can be alleviated.

In addition to more focused, efficient outcome reporting, agreement among service organizations and funders on common outcomes has other advantages. Services can be improved if reasonably comparable outcome information is available from nonprofit organizations delivering similar services. Such improvements can occur both by identifying successful practices used by local organizations and then sharing these with other service organizations, and by motivating service organizations with less successful practices to improve.

This guide focuses on how local community funders and service providers can work together to develop a common core set of indicators that each provider would regularly collect data on, for its own use and to provide to funders.

Even if the process does not yield a core set of indicators, getting service providers together, along with funders, to discuss outcome measurement and identify appropriate outcome indicators seems likely to be useful. It will at least encourage some providers to improve their own outcome measurement efforts for internal use.

How funders use the outcome information from the service providers is critical. Funders can cause more harm than good if they use the data primarily to decide who to fund. Instead, the data should be used constructively; for example, to identify best practices that are then disseminated among the providers, or to identify programs that could be improved with better staff training or more technical assistance.

As the guide notes, the suggestions provided should also be useful to service providers in a community who themselves decide, without funders, to cooperate to identify basic outcome indicators. This cooperation is likely to produce a better product for each of them and help them subsequently to identify best practices.

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This guide is one in a series to help nonprofit organizations that wish to initiate or improve their efforts to measure the outcomes of their programs. Harry Hatry and Linda Lampkin are the series editors. We are grateful to the David and Lucile Packard Foundation for their support of this series.

Introduction

Most communities have many service organizations providing similar services to residents, and multiple funders for these services. As outcome-reporting requirements from governments, United Ways, foundations, and other funding sources increase in number and complexity, providers may be overburdened collecting the information they need for accountability to funders and the community and what they need to help improve their services. Agreement between funders and service providers on a common core set of outcome indicators for reporting can greatly help balance these needs.

In Maryland, the Montgomery County Department of Health and Human Services (DHHS), the local United Way, and the cities of Rockville and Gaithersburg all fund health and human services in Montgomery County. Because of their ongoing interest in outcome measurement, this group of funders brought together providers of homeless services, adult mental health services, and child and family mental health services to seek agreement on a common core set of outcome indicators. This guide describes what was learned from this experiment to develop community-wide outcome indicators for these specific services and provides suggestions for other interested communities.

This type of effort might be initiated by one or many funders, such as a local government agency, the United Way, or a foundation. It might also be initiated by the nonprofit service providers themselves. If service providers develop a core set of outcome indicators on which they would regularly report, then multiple funders might not each request different outcome information. An important added advantage is that each provider does not have to develop its own outcome measurement process, but instead can receive guidance from other providers and perhaps funders.

A word of caution: Funders that initiate this effort need to use the resulting outcome data carefully. Funders can cause more harm than good if they use the data primarily to decide who to fund. This focus would inevitably lead to game playing with the data, and perhaps destructive competition among the providers. Instead, the data should be used constructively, such as to identify best practices to disseminate among the providers or to identify programs that could be improved with additional staff training or technical assistance.

About This Guidebook



Key Steps to Developing Community-wide Indicators summarizes the key actions needed to undertake such an effort.



The Montgomery County Experience describes how the funders and service providers in one Maryland community worked together to identify outcomes and develop core indicators for each of three services.



What Leads to Success: Process Factors discusses the process elements that contribute to the success of this type of cooperative effort.



What Leads to Success: Content Factors discusses a number of specific content issues involved in selecting outcomes and core indicators.

Key Steps to Developing Community-wide Indicators

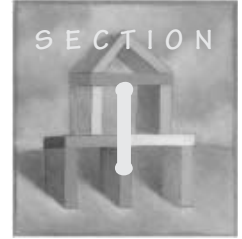


Exhibit 1 lists key steps for efforts to develop a set of outcomes and core indicators involving various funders and providers of similar services in a community. This process requires effort from all stakeholders. The steps listed here are divided into four stages: planning; meeting; finalizing outcomes as well as core indicators to measure progress toward those outcomes; and implementing.

The goal is to have the various service organizations regularly report on the core indicators for specific services. Service organizations and funders can use the resulting information to help improve services, identify best practices, and provide information on accomplishments to the community.

PLANNING

Step 1. Obtain Funder Support and Participation

If funders are sponsoring the outcome measurement process, their actual participation is crucial to success. Active involvement will provide incentive for the providers to reach agreement on appropriate indicators and data collection procedures.

Step 2. Select Services for which Community-wide Indicators Will be Sought and Identify the Providers

These services might include homeless shelters, food banks, or counseling for drug addiction, for example.

Step 3. Establish an Overall Schedule

For each service, this schedule should include sessions for introductory training. If the nonprofit participants have some introductory training on outcome measurement

EXHIBIT 1

Key Steps to Developing Community-wide Indicators



Planning

- Step 1.** Obtain funder support and participation
- Step 2.** Select services for which community-wide indicators will be sought and identify the providers
- Step 3.** Establish an overall schedule
- Step 4.** Consider having “experts” assist



Meeting

- Step 5.** Select the facilitator(s) for each service
- Step 6.** Develop agendas for each session
- Step 7.** Send formal invitations to all providers of the service
- Step 8.** Send summaries of each meeting to all participants



Finalizing the Outcomes and Indicators

- Step 9.** Schedule and hold subcommittee meetings when necessary
- Step 10.** Seek consensus on core indicators
- Step 11.** Develop a manual



Implementing

- Step 12.** Work with providers not participating in the workshop
- Step 13.** Provide technical assistance
- Step 14.** Start with a pilot period
- Step 15.** Annually review the process and make improvements

and management, the meetings to develop the indicators will probably be considerably more productive. Support from funders could cover such training as well as funding for facilitation of the workshops.

Several workshops to develop the indicators should be scheduled. Subcommittee meetings between workshops to work out details that cannot be adequately covered at the workshops may be very helpful.

Each service needs a separate schedule of meetings. However, training in outcome measurement and management could be provided simultaneously to staff from more than one type of service provider. Probably at least six months is needed to develop indicators for each service.

Step 4. Consider Having “Experts” Assist

These experts might be staff from a local or state government agency, consultants, or faculty members from a local university. Whomever is asked to help should be highly pragmatic. A regional or national perspective on outcomes and indicators within the particular service area of interest may be valuable.

MEETING

Step 5. Select the Facilitator(s) for Each Service

The facilitator should be familiar with outcome measurement and management and able to work with groups to develop consensus.

Step 6. Develop Agendas for Each Session

Agendas for a particular service should include both plenary sessions and smaller group sessions. Sample agendas are provided in appendix D.

Step 7. Send Formal Invitations to All Providers of the Service

If the sessions are sponsored by funders, the letter should explain that all service providers funded by any of the groups co-sponsoring the workshop will be required to report regularly on the agreed set of outcomes and core indicators. This requirement is a powerful incentive for current grantees, as well as those who might seek future support from the funders, to participate. Providers should be asked to respond in advance about their participation.

If the sessions are sponsored by the service providers themselves, the letter should emphasize the value of the cooperative effort to the community and providers.

Step 8. Send Summaries of Each Meeting to All Participants

Shortly after each workshop session, participants should receive a summary, including the latest draft of outcomes and core indicators.

FINALIZING THE OUTCOMES AND INDICATORS

Step 9. Schedule and Hold Subcommittee Meetings When Necessary

For issues that need in-depth attention, a subcommittee can be created for more detailed discussion. The results of such meetings should, of course, be reviewed by all workshop participants.

Step 10. Seek Consensus on Core Indicators

Drafts of the common outcomes and indicators should be circulated for comments and suggestions until consensus is reached on what providers will report to funders and each other.

Step 11. Develop a Manual

This manual should include full definitions for each core indicator and clear guidance on how each indicator is calculated.

IMPLEMENTING

Step 12. Work with Providers Not Participating in the Workshop

Because these providers will also be required to collect and report on the information, it is important to familiarize them with the core outcome indicators and data collection procedures.

Step 13. Provide Technical Assistance

Identifying outcome indicators is only the beginning. Technical assistance is likely needed to help some service providers implement the new data collection and reporting procedures.

Step 14. Start with a Pilot Period

This pilot could be a six-month or one-year period when service providers will begin providing data on each agreed-on outcome indicator. This time allows for any problems in the process to be corrected. Funders should view these data as preliminary and not as a basis for any action.

Step 15. Annually Review the Process and Make Improvements

The indicators and data from the service providers should be reviewed on a regular, probably annual, basis. This review should consider the accuracy, reliability, and usefulness (to both funders and service providers) of the information provided. Appropriate modifications should be made, such as changing or deleting indicators or data collection procedures that provided inaccurate data or data that were not used by anyone, and improving the measurement procedures.



The Montgomery County Experience

In Montgomery County, Maryland, the county Department of Health and Human Services (DHHS), Montgomery County United Way, and the cities of Rockville and Gaithersburg have been working together to improve how the county measures health and human service outcomes. These organizations established the Montgomery County Organizational Development Group (MODG) to create a culture of measurement and evaluation to improve services and results; to apply a common evaluation and reporting system to reduce redundancy and inefficiencies; and to improve accountability.

First, MODG contracted with Montgomery College to provide basic outcome measurement training to all nonprofit service organizations funded by MODG members. Representatives from more than 100 service organizations attended these sessions between August 2000 and November 2001.

Next, MODG held a series of separate working sessions with the providers of homeless services, adult mental health services, and child and family mental health services to select core outcome indicators for reporting. These meetings were facilitated by Montgomery College faculty members.

MODG contacted all organizations that provided services in any of these three areas and were funded by one or more MODG members. Organizations were notified that they would be required to report using the agreed-upon set of indicators, even if they did not participate in the workshop. They could also report on additional indicators, if desired.

Homeless Services

A five-hour workshop was held in January 2002. Seventeen representatives from 12 providers of homeless services in Montgomery County attended, as well as two MODG representatives who participated actively. One major provider not funded by any member of MODG chose not to attend the session. The DHHS administrator for the countywide Homeless Tracking System, a web-based system to facilitate data collection on homeless clients, attended to discuss whether the system could collect data for at least some of the outcome indicators developed in the workshop.

Participants were divided into two breakout groups, one focusing on core outcomes for emergency shelter services, the other on services provided by transitional shelters. Two follow-up meetings were held to refine and detail the outcomes and indicators drafted during the initial workshop. These meetings involved only funders of homeless services and one workshop facilitator. The results, however, were shared with all workshop participants for further input and comment, to ensure that the final product represented their thinking.

The two sets of outcomes and core indicators (for emergency shelters and transitional shelters) were adopted by all the participating providers and funders of homeless services in Montgomery County in May 2002 (see appendix A). Providers began reporting on these indicators annually in FY 2003.

Adult Mental Health

Two three-hour workshops were held in February 2002. About 25 people participated in the sessions, including representatives from eight of the nine nonprofit outpatient service providers in the county, as well as one for-profit agency. Even though the workshop focused on outpatient services, residential providers were also invited, and seven such agencies participated. A number of contract monitors from DHHS also attended.

Between the two workshops, held one week apart, the workshop facilitators summarized the first session and shared results with the participants via e-mail.

A member of MODG convened two follow-up meetings with a small number of volunteers from the original workshop participant group. These meetings focused only on the outpatient adult mental health services, refining the outcomes developed during the workshops. After soliciting input and feedback from all the agencies affected, a core set of outcomes and indicators was finalized (see appendix B). All eight providers of outpatient adult mental health services in the county began providing quarterly data on these indicators in FY 2003.¹

Outcomes and indicators for residential treatment services were not addressed.

Child and Family Mental Health

Two three-hour workshops were held two weeks apart in April and May 2002. Approximately 30 representatives from 18 providers of child and family mental

¹ The mental health field was under considerable stress at the time. Major financial pressures had forced several of Montgomery County's largest outpatient mental health service providers out of business. Montgomery County partnered with the State of Maryland to provide additional funding to help the remaining mental health providers continue to provide services. Along with this funding came the expectation that outpatient service providers would pay greater attention to client outcomes.

health services in the county attended these sessions. Between the two workshops, the facilitators shared a summary of the first workshop via e-mail.

A small group of workshop participants volunteered to continue developing the core outcome indicators. This group, facilitated by a member of MODG, met twice during the early summer and reached consensus on a set of indicators and the data collection instrument. As with the other two service areas, this information was shared by e-mail with the original workshop participants for feedback before the core set of indicators was finalized and adopted (see appendix C).

Implementation for child and family mental health services has been delayed because funds to purchase the data collection instrument and train providers on its use are not available. A different instrument may be chosen at the state level, so the delay in purchasing may be prudent. In the meantime, one agency secured grant funds to purchase the instrument, so there is an ongoing pilot program for the core indicators.

More to Come

Because consensus on core outcome indicators in each service area was very important to both funders and service providers, early work focused on identifying a few basic but meaningful outcomes and indicators. Participants feel that the resulting core sets are not comprehensive and do not address some of the more challenging, difficult-to-measure long-term outcomes. But participants expect that these core outcomes and indicators will be expanded, modified, and improved in the future.



What Leads to Success: Process Factors

Many factors contribute to the success of efforts to develop community-wide indicators for individual services, some related to funders and some to the nonprofit service providers. These are discussed below and summarized in exhibit 2. The factors discussed in this section relate to the process of selecting indicators. Section IV discusses characteristics of the indicators themselves.

WHAT FUNDERS NEED TO PROVIDE

Commitment by Major Funders to Form a Partnership

The participation of multiple funders supports and validates the effort to develop common outcomes. It also ensures that requirements for outcome measurement from the various funders will be compatible. In Montgomery County, the coalition of funders included both city and county governments, as well as the United Way. Leadership was largely from the United Way and the Montgomery County DHHS, in part because they provided most of the funding for these services.

Active Support

The coalition of funders in Montgomery County provided both funding and personnel. In addition, coalition members were familiar with outcome measurement principles, and actively and openly supported the value and importance of measuring outcomes. These funders attended the homeless service provider and mental health service provider workshop sessions. This visibility indicates to providers that funders are very interested in the success of the outcome measurement process.

EXHIBIT 2

Factors Leading to Success in Developing Community-wide Indicators

What Funders Need to Provide

- Commitment by major funders to form a partnership
- Active support
- Funding for training and facilitation
- Existing outcome measurement efforts in the community
- Careful selection of services
- Reasonable expectations about initial results

What Service Organizations Need to Provide

- Support for the concept of community-wide indicators
- Willingness to form a partnership with funders
- Some experience in outcome measurement
- Understanding that this undertaking is complex

Funding for Training and Facilitation

In Montgomery County, MODG funded a third party to administer and facilitate the effort, including both initial training in outcome measurement and the second phase workshops to develop the core indicators. This approach reinforces the funders' commitment to making outcomes measurement a partnership effort with the providers, with no financial burden.

Existing Outcome Measurement Efforts in the Community

DHHS and the United Way had been working with their grantees on outcome measurement for several years and had created an atmosphere that encouraged the service providers to participate in workshops. Without such a history, there might have been more resistance to starting a new outcome measurement process or changing the existing one.

In addition, the performance measurement process in the Montgomery County government encouraged DHHS to participate in the partnership.

Coordination with related or parallel efforts in the community is also important. For example, Montgomery County and the State of Maryland had separate efforts for developing outcome indicators for child and adult mental health. Partnering these efforts more closely could have made the work more efficient and broader in reach.

Careful Selection of Services

The choice of the size, scope, and particular services to be addressed in each workshop is very important. The services selected should be broad enough to include a number of providers, but focused enough that the outcomes are likely to be reasonably clear and common to the service providers. Services with large amounts of funding and numerous providers are natural candidates. In Montgomery County, the efforts with homeless services and adult mental health services were the most successful. In the third area, child and family mental health services, participants in the workshops found it difficult to develop indicators that addressed both children individually and whole families.

Reasonable Expectations about Initial Results

It is impossible to cover all services, all possible outcomes, or even all the programs provided within a particular service area. In the Montgomery County workshop on child and family mental health, for example, common indicators were developed for only one or two critical services. Programs such as parenting education and early intervention services were not addressed in this first effort.

WHAT SERVICE ORGANIZATIONS NEED TO PROVIDE

Support for the Concept of Community-wide Indicators

Initial skepticism about the validity and wisdom of creating a useable set of common indicators is likely. The Montgomery County nonprofit representatives, however, were reasonably supportive of the effort and participated actively and constructively. In addition, some volunteered to meet after the adult mental health and child and family mental health workshops to further refine and finalize the set of indicators.

Willingness to Form a Partnership with Funders

In Montgomery County, because specific outcome indicators were not imposed by the funders, providers were willing to participate in the process and now feel a sense of ownership about the results.

Some Experience in Outcome Measurement

Many of the nonprofit representatives came to the Montgomery County workshops with previous basic training in outcome measurement, and some had experience in outcome management. The greater the level of familiarity with and understanding of outcome measurement and outcome management, the easier reaching consensus on a set of common outcomes will be.

If, for example, many mental health service providers already collect data on a variety of outcomes to help assess client practices and meet funding or accreditation requirements, there is a precedent for outcome data collection. Such experience shows that outcome measurement can be done.

This factor has a potentially negative side; those with outcome measurement procedures already in place may be reluctant to alter them. Many Montgomery County mental health providers were already collecting data on a variety of outcomes and using specific data collection instruments. Reminding providers that the core outcome indicators could be supplemented with their own important indicators helped alleviate this concern.

Understanding That This Undertaking Is Complex

Complex and wide-ranging services may require a variety of outcome indicators. For example, some providers in Montgomery County primarily provided emergency shelter for the homeless, while others provided a set of transitional housing and supportive services. In the homeless services workshop, there were separate discussion

sessions for emergency and transitional shelters that led to separate outcomes and indicators.

For mental health services, some organizations provided outpatient therapy sessions while others provided residential assistance, and many provided both. In the adult mental health workshops, the areas of outpatient services, rehabilitation services/assisted living, and residential services needed to be addressed separately. The initial effort concentrated on outpatient services.

In the child and family mental health workshops, several client services were identified, but not all were addressed equally. Screening/assessment, outpatient services, and counseling were fully discussed, but early intervention and outreach programs were only briefly explored.

Another concern is the variety in the clients served by providers. The target populations are often different, and the potential inability of common outcome indicators to reflect these differences fairly was of particular concern in the Montgomery County workshops. It is important to identify characteristics of clients that may make them more or less easy to serve and then track their outcomes separately.

ENSURING EFFECTIVE MEETINGS

The workshop sessions that bring together the funders and the providers are also very important in these efforts. Exhibit 3 provides a list to help ensure the best results.

Logistics

Capable and Knowledgeable Facilitators

The Montgomery College faculty who facilitated the effort were an important asset in the process because of their knowledge of outcome measurement and their expertise in workshop facilitation.

Preselection of Specific Activities for Developing Indicators

A draft list of specific programs that discussion might focus on will help make the workshop more efficient and productive. Approximately two to three weeks before the workshops in Montgomery County, participants completed a brief questionnaire on their familiarity with outcome measurement, types of services offered, and client population served. The workshop facilitators reviewed the responses, along with the organizations' mission statements and previous reports on outcomes, to prepare for the workshops. Obviously, there should be flexibility to make changes to this list during the workshop if needed.

EXHIBIT 3

Ensuring Effective Meetings

Logistics

- Capable and knowledgeable facilitators
- Preselection of specific activities for developing indicators
- Planning of discussion groups
- Participative approach

Content

- Identification of a manageable number of indicators
- Adequate time in sessions
- Focus on use of data to help improve services and outcomes
- Discussion on presentation of comparisons among providers

Follow-Up

- Technical assistance
- Pilot period to test procedures and make modifications
- Ability to report explanatory information
- Communication of reporting requirements

Planning of Discussion Groups

Careful thought should be given to the composition and organization of discussion groups at the workshops. The Montgomery County workshop for the homeless shelter services divided the participants into two groups, one discussing outcome indicators for emergency shelter services, the other indicators for transitional housing services.

On the first day of the adult mental health service workshop in Montgomery County, there were three discussion groups. Two discussed indicators related to outpatient services, while the third covered residential and day provider services. On the second day, the participants were divided into two groups, one for outpatient services, and the other for residential and daily services. Smaller groups of workshop participants met after the workshop to further refine the indicators.

The child and family mental health service providers split into two groups for the first workshop. One group discussed outcomes for client screening and assessments, as well as for outpatient services. The other focused on individual and group therapy and briefly touched on early intervention programs and outreach. The participants received a summary of the first workshop session and then came back for the second workshop session to refine a set of indicators for family and youth counseling therapy services.

The assignment of workshop participants and facilitators to discussion groups should also be considered in advance. In Montgomery County, participants were given their choice of group. Pre-assigning participants to groups is another option.

Participative Approach

All attendees should be encouraged to participate fully in the discussions. In Montgomery County, the facilitators successfully ensured that the service providers had a major role in identifying the outcome indicators.

Content

Identification of a Manageable Number of Indicators

As the discussion of outcomes proceeds, it may go from not wanting to measure anything to trying to measure everything. If too many indicators are identified, the burden of collecting and reporting data will overwhelm providers, while funders will have difficulty interpreting all the information reported. A general guideline is to keep the total number of core outcome indicators for each service under a dozen (including both intermediate and long-term indicators).

Adequate Time in Sessions

Both funders and providers may want to agree quickly on a set of common indicators. But dealing with these complex issues and obtaining consensus on indicators requires some time and a number of meetings, not just one, two, or even three workshop sessions. The Montgomery County session times were productive but still too short to fully cover the issues. The session for homeless providers was a total of five hours including lunch. While sufficient for an initial discussion of indicators, it left many issues unresolved.

The Montgomery County workshop sessions for adult mental health and child and family mental health providers were spread over two days. The first sessions were three and one-half hours; the second sessions were two and one-half hours. Between the first and second session, participants received a list of preliminary outcomes and indicators developed in the first session. The group refined these preliminary outcomes and indicators during the second session. However, this was still not enough time to address the many issues involved in selecting operational outcome indicators.

If small subcommittees can meet between sessions to work out particular problems, the time in the larger sessions might be more productive.

Focus on Use of Data to Help Improve Services and Outcomes

A major use of outcome information is to help individual providers improve their programs. It is important not to focus solely on accountability and external reporting, even though funders may be very interested in these areas. For an outcome measurement process to be really productive, the information collected should help service providers become continuous learning organizations.

While the internal use of outcome information to help improve programs was identified as a purpose of the outcome information in Montgomery County, it was only mentioned briefly. Participants discussed the potential value of sharing data reported on common outcome indicators to help providers benchmark their own results and identify good practices in the field. Most service providers in Montgomery County, and probably throughout the United States, have had little experience in outcome measurement, and even less in using the data to help improve services. More focus on how to use the data for this purpose will build support for the outcome measurement process.

Discussion on Presentation of Comparisons among Providers

A natural, and reasonable, fear for providers is that outcomes data comparing performance among providers will be misused. Funders should identify uses of the comparisons and safeguards for ensuring that outcomes are presented fairly. For example, there should be an opportunity to provide reasons for low or high outcomes

relative to other organizations (such as serving more difficult clients). Comparison reports should also report the limitations of the outcome information and what they show. These steps can help alleviate some provider concerns.

Follow-Up

Technical Assistance

Funding for technical assistance will probably be needed to help providers install and maintain the data collection and reporting procedures for the agreed core set of outcome indicators.

Pilot Period to Test Procedures and Make Modifications

It is good practice to allow a trial period for testing new outcome measurement procedures. If service providers are already familiar with the outcome indicators selected, this may not be necessary. However, if there are new data collection procedures, a trial period before official data reporting will ensure that the process works well.

Ability to Report Explanatory Information

If the indicators show surprising or disappointing values, it is important to provide an opportunity for explanations. Many factors outside of service providers' control can affect client outcomes, such as the characteristics of clients that come in for service. Formal provisions should be made that encourage service providers to provide explanations for unexpectedly weak or strong outcomes.

Communication of Reporting Requirements

Funders need to indicate the nature and timing of the outcome information reports they expect of service providers. Providers need to know what reports will be publicly available and to what extent outcomes will be compared among service providers. This major concern is especially likely if the funders do not make explicit provisions for information that explains important differences in clientele and other factors beyond the control of individual providers.

Some funders may want data on individual clients. For example, DHHS requires individual data on clients of homeless services, in part so that it can provide unduplicated counts of the number of homeless being served. In such instances, the reporting process must assure the confidentiality of the data and protect the privacy of clients.



What Leads to Success: Content Factors

This section discusses major factors relating to selection of outcome indicators.

Precise Definitions

Clear definitions of indicators are needed to collect comparable data from multiple providers. It is probably impossible for all providers to collect and report exactly the same information. Aggregations of outcome data across providers will inevitably include some comparisons that are not perfect. This imperfection needs to be acknowledged by all participants.

Nevertheless, reasonably precise definitions will help collect reliable and comparable data. For example, what does “achieve a stable environment” mean to the different homeless services providers? Ground rules and guidelines are needed to define such terms.

Montgomery County tackled definitions in various ways. The homeless indicators included guidelines. For the adult mental health indicators, a brief manual was created that explained how to measure the indicators. The child mental health training sessions will include finalizing a data collection instrument that incorporates definitions. All three approaches—attaching notes to individual indicators; preparing a manual that provides detailed definitions; and providing training sessions on the definitions—could be used.

Calculation of Changes in Indicators

What denominators should be used for calculating outcome indicators expressed as percentages? In Montgomery County, the homeless transition services group was concerned that using the “easy” denominator, one that includes all clients served during the reporting period, can distort the findings for some outcome indicators. The inclusion of all served means wide variation in the length of services received by the clients. Some might have just started services and could not be expected to

have improved when the measurement was taken. Preferably, the denominator would include only clients who began services at some pre-selected time before, such as six or 12 months before measurement.

For example, the core indicator for a homeless services program might be expressed as

percent of clients entering service in the last quarter of 2001 who, in the last quarter of 2002, showed significant improvement in their housing status

As noted above, a clear definition of “*significant improvement*” would also be needed.

Measurement of Difficulty of Serving Clients

Some clients are substantially more difficult to help than others. If one homeless or mental health service provider has a large share of difficult-to-help clients, it is likely to have a lower success rate than those with smaller proportions of difficult-to-help clients.

Client difficulty should be considered so that users of the outcome data do not misinterpret differences among providers, or across time from one reporting period to another period. If client difficulty is not taken into account, providers could be motivated to focus on serving easier-to-help clients in order to increase their success rates, especially if outcome reports focus on comparative data. Some providers in the Montgomery County effort were concerned that data taken out of context could negatively affect their organizations.

One way to approach this problem is to work on defining three or four levels of client difficulty that could be used to categorize clients as they begin service. A group drawn from the workshop participants or experts could help define the characteristics of “difficult-to-help,” “moderately difficult-to-help,” and “easy-to-help” clients. Outcome data would then be tabulated separately for each category of clients.

Breakouts by Client Demographic Characteristics

Outcome information will be considerably more useful if the data are broken out for different client demographic characteristics, such as age group, gender, race/ethnicity, and disability type. Such breakouts can be extremely important for identifying service areas that need improvement.

The workshop participants, or a subcommittee, should identify which breakouts would be useful to both funders and service providers for each indicator.

To permit reliable aggregations and comparisons across agencies, definitions for each category for use by each service organization (such as similar age group ranges or race/ethnicity categories) are needed.

If some providers find it difficult to reach consensus on indicators because of their unique client base, explaining and encouraging the disaggregation of the data according to key client characteristics may be helpful.

Frequency of Data Collection and Reporting

Funder requirements are likely to vary. In Montgomery County, DHHS wanted quarterly reports for adult mental health services, while they needed data for homeless services annually. The providers themselves may want more frequent data for internal use.

Timing of Outcome Data Collection

For some indicators, providers should obtain feedback from clients at a specific time after leaving service, such as three, six, or 12 months.

Many organizations now assess client status when the client leaves service. However, to assess outcomes and the sustainability of changes, measurements are needed after the client leaves service. Should that time be after three months, six months, 12 months, or some other interval? To make the outcome measurement system practical, probably only one time should be selected for community-wide reporting on each core indicator. Of course, each service provider can also track outcomes at other additional times of interest.

Follow-up information can provide vital insights about the success of the program and any needed corrective actions. Adding an “after-care” component to the program builds in periodic checks of clients and lays the groundwork for outcome assessment. More information on after-service follow-ups is included in another guide in this series.

How to Undertake Defining Indicators to Measure Levels or Changes over Time

Funders and providers should consider whether indicators should measure client status at the time of measurement or the change from client status at intake. An indicator expressing status at time of measurement is “*number of clients who at follow-up reported they were no longer drinking.*” The indicator expressed as a change might be “*number of clients who had reduced their use of alcohol from X times per week to Y times over the past three months.*”

Each measure provides a different but important perspective on outcomes. However, calculating the change outcome requires more work, since the information on alcohol consumption obtained at intake needs to be properly recorded and then compared with the information on alcohol use obtained at follow-up.

Referrals to Other Services

If clients are referred to another provider for additional services (such as substance abuse assistance), what are the appropriate outcome indicators, if any? For example, should the outcome indicator for a homeless provider only be the number of referred clients who enrolled in the referred-to agency? Or should it be client status after receiving the services from the second agency? If the second outcome is selected, then data collection for the first homeless service provider becomes more complicated. And users of the information need to recognize that the outcomes were a product of efforts by both providers.

From the viewpoint of the referring-provider, having clients use referrals is probably about as much responsibility as the provider wants to accept. For either option, the homeless service provider will need feedback from the referred-to agency, if only to determine whether clients used the referrals. In some instances, confidentiality issues may make such information difficult to obtain.

Use of Intermediate Outcome Indicators

It may be useful to include common intermediate outcome indicators that eventually lead to long-term or end outcomes. This issue arose in all three workshops in Montgomery County. Because of an emphasis on accountability, funders may only be interested in end outcomes. In Montgomery County, adult mental health providers felt that it was important to track an intermediate outcome, such as “*completing the planned set of counseling sessions,*” in addition to an end outcome, such as “*improved ability to function normally.*”

Use of Existing Data Collection Instruments

Data collection instruments that can provide data for one or more outcome indicators may already exist. Should these instruments be used to provide at least part of the common core set of outcome indicators? For example, many mental health and other service providers use Activities of Daily Living (ADL) scales. The providers are likely to be able to agree on common items to include in an ADL scale for reporting outcomes; however, they might be using different data collection instruments.

Unless the group can agree on using one instrument, compromises may be necessary to obtain agreement on a core set of indicators. Some indicators on different instruments may be reasonably equivalent. To achieve reasonable comparability, each organization needs to provide data on the core set, but can also add other indicators to a version of the instrument.

If new reporting requirements draw on existing data collection activities, developing community-wide indicators and data collection instruments will be easier.

Support for Software Development

Funding for software to help providers enter, tabulate, and report the outcome data may be necessary. Some small organizations may also lack computer hardware. If there are only a small number of clients, it may be feasible to process basic outcome information manually.

Appendices



APPENDIX A

Outcomes and Core Indicators for Homeless Service Providers: Montgomery County Workshops

A. EMERGENCY SHELTERS

INITIAL OUTCOME: *Clients receive emergency food and shelter.*

Indicator 1: Total number of different clients who received shelter.

This is an unduplicated count of all the individuals who received shelter at your location during the fiscal year. In the case of families, count each member of the family separately.

Indicator 2: Average number of bed-nights used per client.

Count the total number of bed-nights for the fiscal year and divide by the total number of different clients who received shelter during that fiscal year, i.e., the value for Indicator 1 above.

INTERMEDIATE OUTCOME: *Clients begin to access needed services.*

Indicator 3: Number and percent of clients who agree to a recovery/treatment/service plan by the end of their 30th day of shelter at that site.

In this indicator, “clients” refers to adult clients whose 30th day of shelter at your site occurs during the current fiscal year. These days do not have to be consecutive or all in the same fiscal year.

If the client’s first 30 days of shelter spans two fiscal years, that client should be included in the first fiscal year calculation (both numerator and denominator for the percentage) only if s/he agreed to a recovery/treatment/service plan during that fiscal year. Otherwise such clients should be included in the computation of this indicator for the next fiscal year.

Indicator 4: Number and percent of clients who, as a result of their service plan, connected with supportive services within 30 days of the start of case management.

In this indicator, “clients” refers to adult clients.

If a client’s 30 days following the start of case management spans two fiscal years, that client should be included in the first fiscal year calculation (both numerator and denominator for the percent) only if the client connected with supportive

services that fiscal year. Otherwise such clients should be included in the computation of this indicator for the next fiscal year.

Supportive services include any of the following:

- alcohol or drug abuse services
- mental health services
- HIV/AIDS-related services
- other health care services
- education
- child care services
- legal services
- housing placement services
- employment assistance services

LONG-TERM OUTCOME: *Clients move to more stable housing.*

Indicator 5: Number and percent of clients who move to a transitional shelter, long-term housing, a rehabilitative setting, or the home of a friend or family member.

In this indicator, “clients” refers to all clients, not just adults. Consequently, the denominator for the percent calculation will be the number of different clients who received shelter at your location during the fiscal year.

B. TRANSITIONAL SHELTERS

INITIAL OUTCOME: *A client develops a treatment/recovery/service plan and implements it.*

Indicator 6: Number and percent of clients who have met with counselor/case manager and developed a plan within 30 days of entering program.

In this indicator, “clients” refers to adult clients only.

If the 30 days following admission to the program spans two fiscal years, that client should be included in the first fiscal year calculation (both numerator and denominator for the percent) only if s/he has developed a treatment/recovery/service plan during that fiscal year. Otherwise such clients should be included in the computation of this indicator for the next fiscal year.

Indicator 7: Number and percent of clients who within 30 days of agreeing to a treatment/recovery/service plan are involved in recuperative daytime activities related to that plan.

In this indicator, “clients” refers to adult clients only.

If the 30 days following the development of a treatment/recovery/service plan spans two fiscal years, that client should be included in the first fiscal year calculation (both numerator and denominator for the percent) only if s/he has become involved in recuperative daytime activities during that fiscal year. Otherwise such clients should be included in the computation of this indicator for the next fiscal year.

Recuperative daytime activities include any of the following:

- mental health or substance abuse programs
- psychiatric rehabilitation programs
- job skills training
- education or vocational education programs
- employment
- day programs

INTERMEDIATE OUTCOME: Clients diagnosed with substance abuse and/or mental health problems receive treatment.

Indicator 8: Number and percent of the clients diagnosed with substance abuse and/or mental health problems who are receiving professional treatment within 90 days of entering the program.

In this indicator, “clients” refers to adult clients only.

If the 90 days following the admission to the program spans two fiscal years, that client should be included in the first fiscal year calculation (both numerator and denominator for the percent) only if s/he begins receiving professional treatment during that fiscal year. Otherwise such clients should be included in the computation of this indicator for the next fiscal year.

LONG-TERM OUTCOME 1: Client’s income increases.

Indicator 9: Number and percent of clients whose income is greater upon discharge from the program than when they entered.

In this indicator, “clients” refers to adult clients only.

The denominator of the percent calculation is the number of adult clients discharged from the program during the fiscal year.

LONG-TERM OUTCOME 2: *Client moves to permanent housing.*

Indicator 10a: Number and percent of adult clients who moved to permanent housing.

Indicator 10b: Number and percent of child clients who moved to permanent housing.

This indicator measures the outcome separately for adults and children. Consequently, the denominator for the percent calculation for Indicator 10a will be the number of different adult clients who received shelter at your location during the fiscal year, and the denominator for the percent calculation for Indicator 10b will be the number of different child clients who received shelter at your location during the fiscal year.

For purposes of this indicator, permanent housing is one of the following:

- rental house or apartment
- public housing
- Section 8 housing
- Shelter Plus Care housing
- homeownership
- moving in with family or friends

In measuring this indicator a foster home for a child is not considered permanent housing.

LONG-TERM OUTCOME 3: *Client remains in permanent housing.*

Indicator 11a: Number and percent of adult clients who do not reenter the Montgomery County homeless system within one year of obtaining permanent housing.

Indicator 11b: Number and percent of child clients who do not reenter the Montgomery County homeless system within one year of obtaining permanent housing.

This indicator measures the outcome separately for adults and children. The numerators for the percent calculations are the number of clients who had obtained permanent housing during the previous year and as of one year later had not reentered the Montgomery County homeless system. The denominator for the percent calculation for Indicator 11a is the number of adult clients previously sheltered at your site who moved to permanent housing during the prior fiscal year. The denominator for the percent calculation for Indicator 11b is the number of child clients previously sheltered at your site who moved to permanent housing during the previous fiscal year.

APPENDIX B

Outcomes and Core Indicators for Outpatient Adult Mental Health Service Providers: Montgomery County Workshops

INITIAL OUTCOME 1: *Members of the community are aware of and are able to avail themselves of outpatient mental health services.*

Indicator 1: Number of consumers who received outpatient services during the quarter.

This is the total number of public mental health system consumers who received any type of service at your clinic at least once during the reporting period.

INITIAL OUTCOME 2: *Consumers take responsibility for their mental health problems.*

Indicator 2: Number and percent of consumers who had a treatment plan update this quarter.

INTERMEDIATE OUTCOME 1: *Consumers manage or reduce their presenting symptoms.*

Indicator 3: Number and percentage of consumers who managed symptoms or experienced a reduction in negative symptoms.

This is the total number of consumers who, with or without medication, reported an ability to manage their symptoms or had a reduction in negative symptoms as measured by a therapist using the General Assessment of Functioning (GAF) score.

Number of consumers with improved GAF score out of number of consumers for whom follow-up assessment was completed during the reporting period.

Each consumer should be assessed at intake and every six months and/or at discharge. There may be some consumers who happen to have two assessments in a quarter because case closure occurs a month or two after last assessment. In this case, report the case closure assessment.

INTERMEDIATE OUTCOME 2: *Consumers experience an improved level of functioning.*

Indicator 4: Number and percentage of consumers in an appropriate day program or other meaningful activity during all or part of the reporting period.

This is the total number of active consumers from your clinic that were attending an appropriate day program, such as school, community centers, group meetings, volunteer work, or engaging in other meaningful activity during all or part of the reporting period.

LONG-TERM OUTCOME 1: *Consumers do not require emergency hospital services.*

Indicator 5: Number and percentage of consumers who had a psychiatric hospitalization.

This is the total number of active consumers from your clinic that had to be admitted during this reporting period to a hospital for psychiatric reasons.

Indicator 6: Number and percentage of consumers who were treated in hospital emergency rooms.

This is the total number of active consumers from your clinic that were treated at a hospital emergency room during this reporting period.

LONG-TERM OUTCOME 2: *Consumers avoid first or new involvements with the justice system.*

Indicator 7: Number and percentage of consumers who were arrested, detained, diverted, or incarcerated.

This is the total number of active consumers from your clinic that were arrested, detained, diverted, or incarcerated at a correctional facility during this reporting period.

LONG-TERM OUTCOME 3: *Consumers do not require homeless services.*

Indicator 8: Number and percentage of consumers who were not housed in a homeless shelter during all or part of the reporting period.

This is the total number of active consumers from your clinic that were housed in a shelter during all or part of this reporting period.

LONG-TERM OUTCOME 4: *Consumers are employed.*

Indicator 9: Number and percentage of consumers who were competitively employed during all or part of the reporting period.

This is the total number of active consumers from your clinic that have been employed and earning wages during all or part of the reporting period.

LONG-TERM OUTCOME 5: *Consumers feel more positive about their lives.*

Indicator 10: Number and percentage of consumers who report an increase in well-being (life satisfaction).

This is the total number of consumers who during the course of their treatment at your clinic reported an increase in well-being (life satisfaction) as measured by the attached eight questions of the Maryland version of the Mental Health Statistical Improvement Program (MHSIP). (Questions beginning “As a Direct Result of Services I Received . . .” as rated by consumers on a scale of 1 to 5.)

The score is calculated by adding the eight scores and dividing by eight. So if a client checks “agree” for four questions ($4 \times 4 = 16$), “strongly agree” for three ($3 \times 5 = 15$), and “neutral” for one question ($1 \times 3 = 3$), the score would be 4.25. If a client scores 3.5 or higher, then the client is reporting an improvement in well-being/life satisfaction.

Each consumer should be assessed every six months thereafter and/or at discharge. Some consumers may have two assessments in a quarter because case closure occurs a month or two after last assessment. In this case, report the case closure assessment.

MARYLAND MHSIP FORM

Instructions to the Interviewer: Please give this to the consumer to fill out. In those instances when the consumer is unable to read the questions, please read them to the consumer.

Instructions from Interviewer to Consumer: In order to provide the best possible mental health services, we need to know what you think about the services you received during the past six months, the people who provided them, and the results. Please indicate your agreement/disagreement with each of the following statements by circling the number that best represents your opinion. If the question is about something you have not experienced, circle the number 9 to indicate that this item is "not applicable" to you.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
As a Direct Result of Services I Received:						
1. I deal more effectively with daily problems.	1	2	3	4	5	9
2. I am better able to control my life.	1	2	3	4	5	9
3. I am better able to deal with crisis.	1	2	3	4	5	9
4. I am getting along better with my family.	1	2	3	4	5	9
5. I do better in social situations.	1	2	3	4	5	9
6. I do better in school and/or work.	1	2	3	4	5	9
7. My housing situation has improved.	1	2	3	4	5	9
8. My symptoms are not bothering me as much.	1	2	3	4	5	9

Source: Extracted from the Mental Health Statistics Improvement Program's "Proposed Consumer Survey Items" for a consumer-oriented mental health report card, developed as of April 1996. Full report card available from <http://www.mhsip.org/reportcard/index.html>.

APPENDIX C

Outcomes and Core Indicators for Outpatient Child and Family Mental Health Service Providers: Montgomery County Workshops

INITIAL OUTCOME: Clients take responsibility for their mental health problems.

Indicator 1: Number and percentage of referrals who (do not) establish a treatment plan.

Indicator 2: Number and percentage of clients who (do not) discontinue services against provider's advice.

LONG-TERM OUTCOME 1: Clients maintain or increase their level of functioning.

Indicator 3: Number and percentage of clients who maintain or increase level of functioning on CAFAS/PECAFAS during this reporting period. (Short-term clients* at 90 days and/or discharge; long-term clients* at 180 days and/or discharge.)

Indicator 4: Number and percentage of clients who maintain or increase the number of strengths on CAFAS/PECAFAS during this reporting period. (Short-term clients at 90 days and/or discharge; long-term clients at 180 days and/or discharge.)

* Short-term treatment program: A treatment program of six months or less. Long-term treatment program: A treatment program of more than six months.

APPENDIX D

Sample Agendas from the Montgomery County Core Outcomes Workshops

HOMELESS SERVICES

9:00–9:15 Introduction to workshop; workshop objectives

9:15–9:45 Brief review of United Way Logic Model, outcomes, and outcome indicators

9:45–10:45 Defining a core set of common outcomes and indicators

Breakout groups: Emergency Shelter Activities Transitional Shelter Activities

Provision of emergency food
and shelter

Move to transitional shelter

Developing a recovery plan

Referrals to other recovery
services

Move to more stable housing

Developing a recovery plan

Case management

Recovery services

Employment readiness

Life/social skills

Housing readiness

Education

10:45–11:00 Break

11:00–12:00 Full group discussion: Barriers and challenges to implementing outcomes measurement; what's working and what's not; using the data to improve services

12:00–1:00 Lunch

1:00–2:00 The Homeless Tracking System, its current capabilities and potential use as a primary data collection resource for outcomes measurement

ADULT OUTPATIENT MENTAL HEALTH SERVICES

Day 1

- 9:00–9:30 Introduction to workshop; workshop objectives
- 9:30–10:15 “A Regional and National Perspective on Outcomes Measurement in the Outpatient Mental Health Community”—Dr. Vijay Ganju, Director, Center for Evidence-Based Practices, Performance Measurement, and Quality Improvement, NASMHPH Research Institute
- 10:15–10:30 Brief review of United Way Logic Model, outcomes, and outcome indicators
- 10:30–10:45 Break
- 10:45–12:15 Small group breakout discussions: Defining a core set of common outcomes and indicators
- 12:15–12:30 Wrap up; looking ahead to day 2

Day 2

- 9:00–10:30 Continued discussion on a core set of common outcomes and indicators
- 10:30–11:00 Wrap up; outcomes of the workshop; what to do next



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