Bernalillo County Behavioral Health Initiative

Technical Assistance: BHI-Wide Metrics Evaluation

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Contents

Introduction

What is BHI?

The current Bernalillo County Behavioral Health Initiative (BHI) developed out of the collaborative efforts between the Department of Behavioral Health Services (DBHS) and the City of Albuquerque, via their joint strategic plan to address behavioral health in a shared geographic jurisdiction. The BHI is funded by a small sales tax addition and generates over $20 million dollars per year. The BHI manages contracts that fund several behavioral health services providers in the County, and contracts with external evaluators to conduct process and outcome evaluations regarding service provider metrics, objectives, and goals.

What is behavioral health?

The American Medical Association defines behavioral health as "mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms." Behavioral health is not only mental health (internal feelings of wellbeing) but the manifestation of our mental experience in our behavior and its health consequences. BHI's purview therefore includes mental illness as well as substance misuse, housing insecurity, unemployment and poverty, and suicide. In this report we refer to "substance misuse" (as opposed to "substance use") as BHI services engage people who misuse substances in an unhealthy or unsustainable way, or are in recovery from such misuse.

It is important to note that while all these conditions involve crises in an individual's mental or behavioral experiences, they are often not within an individual's sole control or responsibility to solve. Predatory opioid prescribing victimized patients who became addicted while thinking they were taking care of their health. Economic and housing inflation and crashes threw many into poverty and housing insecurity despite their precautions and best efforts. Trauma-induced PTSD can create mental and behavioral challenges that exacerbate the hardships of people who have already been though violence and abuse. As these social issues are beyond any one person to fix, BHI facilitates social services at the systems level, to give many individuals an opportunity to heal.

Report Purpose

BHI Staff contracted with Pivot Evaluation to provide program evaluation services for several of their service provider recipients. BHI Staff also contracted with Pivot to evaluate its system-wide metrics (sometimes referred to as technical assistance), the purpose of this report. Pivot participated in regular meetings with BHI administrators,

contracted providers and committee members to help inform all its work, including this report. However, the answer to "what should we measure?" requires investigation from the current metrics up a chain of logical questions that all require discussion. Said another way, evaluators had to develop questions that looked backwards at the logical chain that led to current metrics.

How to Read This Report

To present findings clearly and concisely, this report begins with a look at BHI's mission and vision, and then proceeds to the solutions BHI developed. This report refers to those solutions as **intervention strategies**. After describing those intervention strategies, the report uses that list to highlight distinctions between **strategic approaches** and **functional operational management**. Next, the report discusses community capacity in the context of relative scarcity of resources available to address BHI's mission and vision along with a grass-roots community building commitment. Finally, the report details a new framework for metrics development BHI Staff may adopt moving forward. Pivot presents evaluation findings within the above contexts throughout this report, finally concluding with all findings presented together in a summary narrative.

This report sets out a process for determining effective Behavioral Health metrics. As such, the report exemplifies each step. Pivot developed the examples adhering as close to the inferred mission and vision they constructed. BHI program Staff should consider revising examples that better fit their understanding and context by substituting their own text elements. Therefore, this is more like a cookbook that BHI Staff can follow and adjust the recipe as they proceed.

Please note that some of the points discussed in this report are ideas for future development, while others are strategies BHI already employs, either partially or fully. This report provides both suggestions for potential action and support for current practices. Additionally, this report restricts its review to BHI contracts, without regard for other services offered under the County's Department of Behavioral Health Services (DBHS).

Start Here: BHI Mission, Vision, Values

What are BHI's foundational mission, vision, and values, and how do they drive BHI activities?

Pivot has decades of experience with innovative social problem solvers. The most creative and effective often have difficulty answering simple questions about goals, mission, and vision. Our observation is that innovative social problem solvers ultimately know the answers but have moved on and are enmeshed in daily operations. When we ask a lot of questions, review materials, describe activities, we can infer goals, mission, and vision. Upon writing those down and presenting them to Staff, invariably, the response is something like Well, of course! That is what we have been telling you all along!" Rather than assume County Staff lacked understanding and insight, the following report resulted from attempts to infer County plans from data available publicly. In this case Pivot looked at County website pages, documentation presented to the NM Legislature, and relied on direct observations of social conditions within the county. While Pivot may have made incorrect inferences in places, the steps that follow offer County Staff to clarify and correct Pivot's inferences. The goal is for the County to document each step in their own words, which Pivot offers to facilitate.

Source: County Website

While the County lists general vison and mission statements, Pivot found no specific reference to vision and mission relative to the BHI.

County Vision: Resilient, healthy, safe community with a vibrant economy rich in opportunities that provides the best quality of life now, and for future generations.
County Mission: To provide welcoming, professional, exceptional public service to the community we serve.

As mentioned before, this is a common finding in innovative contexts.

Source: NM Legislature

A document found online apparently presented to the NM legislature titled ALFC 071019 Item 4 Bernalillo County's Behavioral Health Initiative - PRESENTATIO....pdf shows four subcommittees: crisis services; community supports; supportive housing; prevention, intervention, and harm reduction.

These areas may be part of BHI's mission to improve categories of county residents' wellbeing.

Source: Community Observations

Based on reporting in the *Albuquerque Journal*, homelessness and crime concern residents most. Police officers who have worked for decades have grown weary of crime driven by substance misuse and addiction producing a revolving door of expensive Law Enforcement and criminal justice interventions producing recidivism rather than reduced criminal involvement. While newspapers and critics often call for evaluations of social interventions, rarely do they require the same of criminal justice interventions. Pivot observes there are three major problems in which the community wished to see solutions: homelessness, unemployment, and crime, each driven by behavioral health challenges of one sort or another.

BHI can use the discussion above to formalize its own vision, mission, and organizational values. In addition to developing the guiding language of mission, vision, and values, BHI may ensure these concepts are operationalized in policies and practices by reviewing how BHI activities and funding align with guiding language. BHI already employs aspects of these strategies relating to language and practice, with current BHI challenges and successes further detailed in the following sections of this report.

It appears that BHI follows some implicit mission and vision but would benefit by formalizing those statements.

Steps to Create Custom Outcome Measures

1) Formalize Vision & Mission statements.

Develop BHI Domains & Organizational Approach

BHI as an organization addresses several different social issues that influence county behavioral health outcomes. The challenge ahead of BHI Staff is to standardize concepts and language in a way that helps plan effective interventions and communicate to various community stakeholder groups the details of implementing complex interventions.

To explore BHI's areas of involvement, Pivot reviewed all active BHI service provider contracts. After reviewing 36 contracts provided by BHI Staff, Pivot categorized them based on contract management terms as follows:

- Adverse Childhood Experiences interventions (ACEs)
- Capital Funding & Start-up
- Community Supports
- Housing
- Peer Case Management
- Senior Peer Case Management
- Suicide Prevention

The following Table 1 lists BHI's contract categories, its subcommittees, and community concerns discussed in the previous section of this report.

Table 1: BHI contract categories, subcommittee topics, and community priorities.

Contract Categories	Subcommittees	Community Observations
Adverse Childhood Experiences interventions (ACEs)	Prevention, intervention, and harm reduction	Homelessness
Suicide Prevention	Crisis services	Crime
Community Supports	Community supports	Unemployment
Housing	Supportive housing	
Capital Funding & Start-up		
Peer Case Management		
Senior Peer Case Management		

Some may characterize the above classifications of the BHI work as uncoordinated; however, it takes very little imagination to connect topics across columns. Pivot suggests developing the following distinctions to help BHI approach projects across topics, audiences, and working groups.

Renaming the contract categories so they clearly align with and meet needs that subcommittees address will help the public understand the purpose of the contracts.

Figure 1 shows one option for renaming support services offered to the public. The goal of the new categories is to clarify the public's understanding of the complexity behind the services offered.

Figure 1. Example of community support areas offered and their multiple purposes.

Differentiate three levels of analysis: individual, program, and system.

It is rare that metrics for any one level would be appropriate for any other level of analysis. While individual outcomes of interest may be some behavior change such as reduction in substance use, improved social interactions, or improved housing arrangements, none of these would be appropriate measures for the organization implementing the intervention. Organizations implementing interventions need to measure number of clients served, amount of time (or at least number of visits) devoted to each client, and how effective the treatment was over time after services ended. At the system level, county Staff need to know how effectively clients are referred around the system. Few of these metric examples are technically outcomes. Most are outputs to monitor as a means of understanding what needs improvement (and perhaps for contract monitoring).

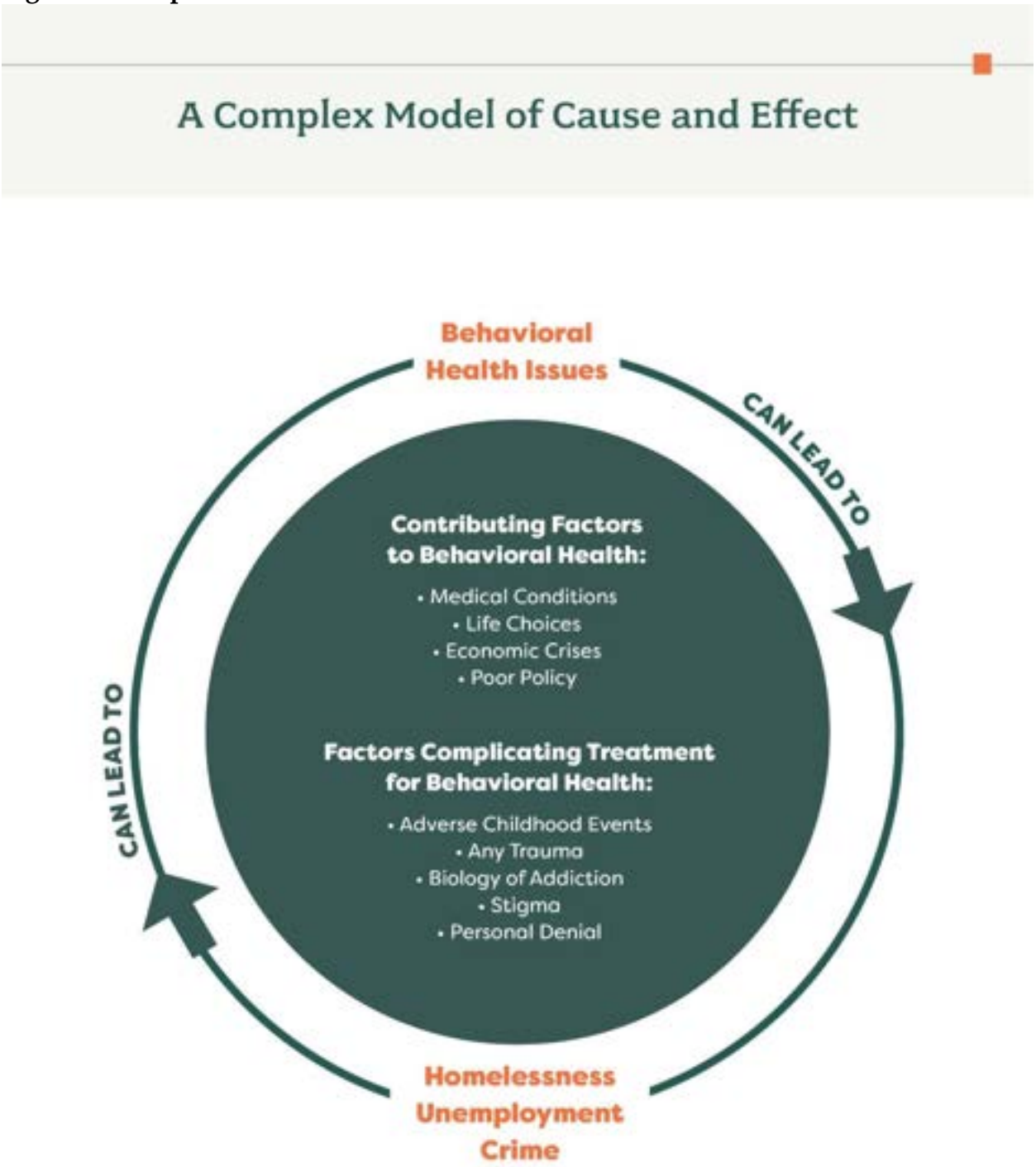
In the field of evaluation, you will find as many definitions of outputs and outcomes as there are evaluators. This truism paints a poor light for our field of program evaluation. However, there is an approach called Outcome Harvesting (Ricardo Wilson-Grau) which standardizes outcomes to mean some behavior change associated with an ultimate goal. Outcomes can be relevant either for a single individual (program participant), for the organization/program overall, or for the entire population. The most relevant outcomes for BHI-funded service providers are individual and program level. Population-level outcomes are influenced by myriad factors outside a single service provider or participant's control. BHI overall, however, is concerned with outcomes that affect the entire county, and tasked with synthesizing service provider contributions at the individual and program level to effect population change.

Consider causal antecedents versus population outcomes.

Behaviors (outcomes) that are often credited to intentional plans or motivations are often actually better explained by environments, circumstances, and conditions that prompt certain actions. For example, people who can walk to work are likely to get more daily exercise than driving commuters, even if both care about fitness. To extend the example on a macro scale, more walkable cities are likely to have more physically fit populations, regardless of their health departments promoting fitness education and awareness. When BHI Staff consider which casual precursors result in desired population outcomes for behavioral health, they build testable systems with clear metrics. Asking questions like those that follow and producing multiple answers begins a process for finding long-term solutions. Which conditions exacerbate public behavioral health challenges (Adverse Childhood Experiences (ACEs), drug availability, lack of insurance coverage)? Which conditions facilitate recovery and stabilizations (affordable housing, healthcare access, education)? Addressing issues

"upstream" from behavior health crises helps set people experiencing challenges up for success while simultaneously improving quality of life for everyone in the community.

Figure 2. Complex Causal Antecedents



The issues and topics listed in Table 1 above (including homelessness, crime, suicide prevention, case management, etc.) may be part of the experience of someone dealing with behavioral health challenges and fall within the activities of BHI. However, these issues and initiatives do not directly cause or resolve behavioral health issues. People experiencing homelessness or substance misuse disorder likely had very different causal trajectories to get to the same resulting state of affairs.

Behavioral health issues themselves often cause the homelessness, unemployment and crime BHI seeks to address. However, it is also true that the experience of homelessness (or poverty, or other social hardship) causes behavioral health issues (Figure 2). One pattern exhibited by BHI service recipients demonstrates initial behavioral health issues, followed by their additional resulting challenges. These challenges include maintaining relationships, housing, employment, potential self-medication with substance use, and finally outcomes of homelessness, unemployment, and crime. While it may be tempting for BHI Staff to prescribe causal models associated with interventions, the following sections suggest that BHI Staff organize their work in portfolios and MONITOR the effectiveness of models contractors develop to change client behavior and meet community need (demand). Monitoring effectiveness of contracting agencies that have developed their own causal models would help BHI adjust approaches, improve outcomes, and better communicate with the public.

Monitoring effectiveness of contracting agencies that have developed their own causal models would help BHI adjust approaches, improve outcomes, and better communicate with the public.

Consider mechanisms of change.

BHI projects employ various mechanisms of change to address hypothesized causal models. For example, some projects fund supplemental services known to improve outcomes for primary services. Peer drop-in centers, and Peer Case Management, are two such examples. Neither are considered therapies on their own but are designed to add value to other therapeutic interventions and activities. Other BHI projects fund crisis management, housing, and case management to help people experiencing behavioral health and resulting hardships recover, get off the streets, and take care of themselves. These are direct quality-of-life services to limit or reduce other more expensive outcomes such as visits to the emergency room, dangerous interactions with Law Enforcement, and death. The BHI also funds preventive activities to help reduce the number of people experiencing new behavioral health concerns.

At times evaluators will talk about theories of change or mechanisms of action. When we have a flat tire, we can all think of a tool to lift a car so we can remove a tire. However, we are less practiced at describing the tools we use to do work in social contexts. For example, most behavioral health therapies are considered talk therapies. The implication is that talking about various behaviors helps change people's behavior. Some therapies depend on logically working through changing behaviors, while others rely on insight. However, talking is the mechanism of changing behavior in both cases.

Evaluators can identify what current mechanisms of change the County employs but have not found them stated explicitly.

Three identified mechanisms so far include the following:

- increasing service capacity of existing organizations through capital investment;
- increasing capacity through establishing new service agencies;
- and increasing the efficacy of current service providers.

Keeping a short table or list of such mechanisms will allow the County to examine where its system of projects can be improved or adjusted. Note how this classification is very different than measuring outcomes. Understanding mechanisms of change allows BHI to adjust funded project priorities based on outcomes.

Occasionally, obtained outcomes call for modified mechanisms of change due to factors within or outside of BHI's control. For example, BHI can control which organizations it funds to best achieve positive population outcomes. But if these organizations are highly successful at addressing behavioral health, they could see an influx of people seeking help from outside Bernalillo County or the state of New Mexico — a situation outside BHI's direct control. Similarly, economic tumult can impact outcomes outside BHI control.

Grouping contracts together for management purposes may save some administrative work, but developing a presentation based on mechanisms of change (i.e., theories of change), would show the grouped contracts address different populations and solve different problems. For example, when thinking about funded programs, BHI Staff conceptualize them as similar based on an intervention method, such as Peer Drop-In (PDI) or Peer Case Management (PCM). However, the application of methods such as PDI and PCM differ so dramatically they would rightly have very different outcome measures (well described in Pivot's PDI report to Bernalillo County).

Understanding mechanisms of change associated with residents' recovery and reintegration into society and the workforce will help the county develop a portfolio of contracts that address community concerns.

Consider how behavioral health resources function.

It may be helpful to think about how BHI expects participants to interact with behavioral health (BH) services. Currently, it appears services are conceptualized somewhat like a college class: you sign up, complete the program (i.e., service plan), and graduate (are discharged). It would sound odd to say participants achieve health after completing a course, but rather results from ongoing checkups and lifelong maintenance. Perhaps it would help BHI to conceptualize BH services less like a discrete class or module and more like primary healthcare services. This would change the metrics monitored from completions and exit to something more like level of care required for ongoing independent living.

Pivot observed some program materials and approaches that could discourage participants from continuously engaging, or re-engaging, in BH services, such as aforementioned program discharge or service plan completion. Instead of feeling empowered to maintain behavioral health through service follow-up (as with a primary physician), participants may feel they have "failed" if they return to services (and they may not return at all). Given the nature of behavioral health challenges, even the best providers cannot offer a service that will "fix" participants in one shot forever. Instead, service providers exist as consistent underlying supports that periodically alternate in the foreground or background of a participant's experience, depending on fluctuation in participant needs across one's lifetime. Intentionally considering framing BHI services as level of service required for independent living can help empower participants to follow up in maintaining their behavioral health and inform BHI monitoring and program evaluation.

Given the nature of program planning and funding cycles, administrators have tended towards binary success or failure type metrics. Throughout the service provider program evaluation, Pivot observed metric challenges such as: is someone a program member or not, are they an active member or discharged, or did they complete a service plan. While these related metrics may provide measurable quantitative data, they misalign with actual participant needs and service experiences. By identifying levels of care required for ongoing independent living, it would be possible to monitor program success by reduction in service

Metrics relying on levels of care may replace old success failure models of therapeutic outcomes.

needs over time without requiring a complete discharge or exit.

Ultimately, BHI still has to measure participation and outcomes and make funding decisions and schedules. Instead of a specific suggestion, this section provides a conceptual basis for other topics explored throughout this report so that BHI may consider many facets of its organizational structure as a whole. Sections that further explore how BHI conceptualizes and manages services include Types of BHI-Funded Service Providers & Funding Rationales, Applying Public Health Models to BHI Processes, Opportunities for Developing Capacity , etc.

BHI can compare the conceptual considerations in previous sections with current actual organizational processes and documentation to identify opportunities for alignment and clarification. The next step would be to align BHI language (terms and definitions) and graphics (logic models and mechanism of change diagrams) with the strategies, goals, and outcomes it seeks to communicate to the media and Albuquerque/Bernalillo public.

Steps to Create Custom Outcome Measures (continued):

2) Rename contract categories to align with intervention strategies.
3) For each strategy, identify the level of analysis that the intervention is designed to change (some interventions may impact more than one level)
4) For each strategy and level of analysis, articulate the hypothesized mechanism of change (these will be testable hypotheses later).
5) Use the various BHI Subcommittees to critique proposed mechanisms of change and expected "in the field" operations.

Identify Public Perception and Plan Communication

BHI is accountable to various stakeholders in the community that have different interests and perspectives regarding BHI's approaches and outcomes. BHI program Staff are responsible for communicating about BHI and receiving feedback and input with various stakeholder groups. Each stakeholder group brings different attributes and interests to the discussion and has diverse and at times even contradictory interests in BHI. The following Table 2 illustrates aspects of different key stakeholder groups for BHI.

Steps to Create Custom Outcome Measures (continued):

6) Use Table 2 as a worksheet with updated BHI STAFF generated content to begin planning comprehensive public communication strategies.

Table 2: BHI Stakeholder Groups Description

Stakeholder Group	Role Description	Interest/ Key Question	Communication Strategy
The Albuquerque/ Bernalillo County public	• Live in the community impacted by BHI interventions and the behavioral health issues BHI seeks to address. • Pay taxes that fund BHI operations, including its plans, developments, and service provider contracting. • Often receive information and respond with feedback via local news media representation. • Participate in BHI topical subcommittees (listed in Table 1 above) addressing "Prevention, intervention, and harm reduction," "Crisis services," "Community supports," and "Supportive housing."	The main question from the general public regarding BHI's activities to reduce behavioral health crises such as substance misuse and homelessness is: what actions is BHI implementing to address the issues?	When addressing the general community, public health practices suggest keeping materials at or below a 5th grade reading level. Using images and infographics is also an engaging way to communicate important ideas. BHI can use reading level (readability) checkers/calculators online, or Microsoft Word will score document readability under the menu File>Options>Proofing>Show Readability Statistics. BHI may consider contracting with a graphic designer and/or data visualization specialist to routinely generate charts, images, and infographics for public media. Sharing information across diverse media such as radio, TV, events, Reddit, social media, etc. can help BHI updates reach more people, and can often allow for two-way feedback communication.
Local News Media	May strive for impartiality but nevertheless be biased toward sensationalism of events or criticism/negative tone.	The main question of news media is: what narrative does information about BHI paint about its success or failure?	BHI may consider using information in this report to prepare a brief regarding its significant actions and rationales, to be ready with responses to news media inquiries or critiques. BHI can also proactively respond (and has already done so) via its own editorials, press releases, interviews, etc.

Stakeholder Group	Role Description	Interest/ Key Question	Communication Strategy
BHI Topical Subcommittee members	Contribute to BHI oversight, review proposed BHI strategies and projects, and facilitate feedback.	The main question from subcommittees is: what are the social implications of BHI-funded projects and how can subcommittees inform funding implementation?	Subcommittee members have more time and energy dedicated to reviewing BHI materials than the general public and are responsible for contributing to BHI decision-making. Subcommittee members prefer to receive all the information available about a proposed initiative in advance of BHI decision-making, so that they have time to process the information and critically respond. This is a sympathetic audience vested in BHI success. Their critique will likely be the best BHI gets before program implementation.
Albuquerque/Bernalillo local government representatives	Look to BHI for information and answers regarding community health and improvements.	The main question from local government is: are we seeing community improvements in behavioral health outcomes?	BHI representatives may wish to prepare information in advance tailored to folks in the public, media, and subcommittees, especially local government representatives. By having various communication approaches prepared, BHI can respond with agility to different audiences and information requests.
Local Law Enforcement	Engage with people in crisis and need to know which policies and resources apply to the situation.	The main question from Law Enforcement is: how do I connect people with services and know what's available and appropriate for them?	Law Enforcement personnel and service recipients may both benefit most from having an easy, accessible way to get information about services currently available. This can be in the form of an informational or supportive phone number like 311 or 988, or via online information available to anyone with a smart phone. BHI should also communicate with the newly implemented Albuquerque Community Safety team (https://www.cabq.gov/acs) to make sure they are aware of BHI resources when responding to mental health situations in the Albuquerque/Bernalillo area.

Stakeholder Group	Role Description	Interest/ Key Question	Communication Strategy
Service Provider Organizations	Understanding community needs from the grass roots. Sometimes they rely on BHI for funding and support, and potentially provide BHI with critical perspectives on direct engagement.	The main question from service providers is: what programs will BHI fund, and why, and for how long?	Service providers on the other hand need to know how BHI can support them through funding and technical assistance, and whether their services align with BHI plans and projects. Streamlining and standardizing BHI RFPs where possible would help providers understand their relationship with BHI and help them respond to RFPs with less burden on their time and administrative capacity. Pivot includes ideas regarding RFP improvements in the following sections of this report.
Behavioral health service recipients	Access BHI-funded resources to cope with and recover from behavioral health disorders.	The main question from service recipients is: does BHI facilitate the services, resources, and opportunities I'm looking for?	People seeking services, whether for themselves or others, would benefit from resources that provide an overarching summary of BHI services, as well as results that can be filtered to specific situations. For example, if BHI could populate a website with comprehensive service listings and also enable filtering the list by age, gender, need, location, open hours etc., it would help connect people with what they need in the moment.

Each of these stakeholder groups brings different perspectives, interests, questions, and requests to BHI conversations. Table 3 shows potential conflicting perspectives the BHI must manage. Each cell in the matrix identifies first a possible conflict, and then its suggested solution. Solutions that apply to multiple conflicts in perspective are bold**.** Providing a comprehensive public communication strategy is beyond the scope if this report; however, following the steps in this section to build a foundation for such a plan will ensure the public understands the County's efforts after an effective public messaging campaign.

Steps to Create Custom Outcome Measures (continued):

7) Use Table 3 as a worksheet with updated BHI Staff observations and concerns to identify potential conflicts they can address proactively when addressing public perceptions.

Table 3: Matrix of Potentially Conflicting Stakeholder Perspectives

	Local News Media	BHI Topical Subcommittees	Local Government Representatives	Local Law Enforcement	Service Provider Organizations	Behavioral Health Service Recipients
General Public (residents, taxpayers)	The public wants things to be good, but sensationalism/ criticism sells newspapers. **BHI can promote its own narrative in local media.**	Subcommittees want the best long-term improvements, but the public may not like how that looks in the short-term (example: building shelters in their neighborhood). Subcommittees want organizational diversity (new/small orgs), public wants old reliable. BHI can communicate subcommittee plans & rationales, and also use public feedback.	The public wants answers, the gov't might not have them. BHI communicates to gov't (county manager, governor, city mayor, etc. as needed).	Law Enforcement wants their safety, community safety. Public pressures Law Enforcement to perform, but also high scrutiny regarding excessive force. **Use the new CABQ Community Safety branch instead of police for mental health situations.**	Providers want to increase reach while public might be resistant ("NIMBY"). Providers work with neighborhood associations	Recipients trying to survive/recover, public may have stigma. Promote outreach, awareness, opportunities for working together (like needle cleanups, community events).
Local news media		Subcommittees may make choices that the media spins negatively. Addressed through subcommittee role clarification and improved meeting agendas and minutes.	Media wants to communicate sensations while gov't wants to communicate progress. **BHI promotes its own narrative directly to affected communities.**	Law Enforcement protects property, media provides scrutiny of methods. **Law Enforcement uses multiple methods according to context.**	Organizations want positive publicity; news tends to report negative. **Organizations use BHI evaluation results when interacting with the local media.**	Recipients want representation but local media offers negativity and perpetuation of stigma. **BHI uses evaluative comparisons to lack of program availability.**
BHI Topical Subcommittees			Subcommittees have grass roots knowledge, while local government representatives need to understand their communities to effectively lead. Formally engaging the groups with one another will improve Government decision making.	Subcommittees improve BHI decision making, Law Enforcement has to work with the results of those decisions. Subcommittees partner with Law Enforcement (some already doing this).	Orgs each wants to succeed, subcommittees influence overall decisions. Subcommittees inject grass roots knowledge that improves service provider functioning.	Subcommittees make the decisions; recipients have the lived experience. Subcommittees use participant input and may include participant members.

	Local News Media	BHI Topical Subcommittees	Local Government Representatives	Local Law Enforcement	Service Provider Organizations	Behavioral Health Service Recipients
Local government representatives				The government representatives want to increase Law Enforcement effectiveness and reduce abuse of power, but Law Enforcement has safety concerns for its officers. **Proven Community Safety branch effectiveness should aid Police adoption and use.**	Organizations want financial support, but government representative make decisions based on casual observations when evaluations are absent. Gov't support organizations evaluations of funded projects and process improvement efforts.	Recipients want representation, the government representatives want results. Government representatives search for venues to hear service recipient experiences with funded services.
Local Law Enforcement					Organizations want areas to be safe for participants, Law Enforcement wants it safe for everyone else. Local understanding of community stewardship between orgs and Law Enforcement	Recipients wants to be safe and treated well by Law Enforcement. Law Enforcement feels pressure to control BH situations. **Proven Community Safety branch effectiveness should aid Police adoption and use.**
Service provider organizations						Recipients want services now, but organizations have administrative responsibilities and are looking to future sustainability. BHI trust based contracting may stabilize the funding opportunities.

To facilitate sharing information and soliciting feedback, BHI may wish to consider the different stakeholder groups listed above, along with their essential questions and contexts for communication.

When BHI combines use of concepts levels of analysis and mechanisms of change to carefully plan interventions and to clarify and tailor communications with different stakeholder groups, communications will increase awareness about BHI initiatives and outcomes, maintain accountability, and promote service access.

Tailoring communications with different stakeholder groups will increase awareness of BHI initiative complexities.

The next sections of this report expand on topics and strategies to inform and improve BHI's internal organization.

Clarifying BHI Contracting Processes

Types of BHI Contracts & Considerations

BHI engages service providers in either capital contracts, which provide one-time start-up funding for non-service expenses such as facilities, or contracts for ongoing direct services such as Peer Case Management, suicide prevention, and housing.

Types of BHI-Funded Service Providers & Funding Rationales

How does BHI select providers to contract with and characterize the funds it allocates? When selecting service providers to fund, BHI often has choices between new grantees versus organizations that have been funded in the past, and small organizations versus larger providers. Understandably, some community members have voiced preference for funding smaller organizations that have not received funding previously, to give them a chance and further diversify local service provision. However, BHI has strong rationale to select established providers with existing organizational infrastructure like human resources practices, payroll, established leave policies, accounts receivable and payable, benefits, and facilities availability.

Implications of these business infrastructure includes the following:

- Funding new organizations may be criticized as risky, since all new businesses (for profit and especially nonprofit) have high rates of failure in the first few years. If capital contracts for new organizations fund their start-up, that is essentially using taxpayer dollars to start new businesses that may have high volatility, a potential point of criticism for wasting money. Conversely, organizations that already exist due to grassroots, volunteer, or additional funding resources, and that need BHI contracts to expand their services, display less volatility.
- Economy of scale: the more infrastructure an organization has already established, the less overhead is required to scale up programming. Instead of funding necessary but costly activities like setting up buildings, hiring Staff, or creating documentation, developed organizations can use BHI funding to prioritize increases in actual service provision. Considering that BHI is often under scrutiny for the ways it manages expenses, the concept of economy of scale is particularly relevant for public communication.
- Social capital, networking, and name recognition: longstanding organizations have more connections to other agencies, ideally comprising of trusting teamwork relationships. People seeking services are more likely to know of long-standing organizations. While an admirable administrative goal of conducting fair contracting that includes smaller providers, ultimately funding organizations with well-known track records may limit BHI criticism for wasted financial investment. This concern of course must be balanced by the pressure to start up new organizations.
- Sustainability: established organizations are more likely to have multiple and more robust funding options, enabling them to sustain programs after BHI funding. Agencies with less resources risk having to downsize or discontinue programs if they don't receive ongoing BHI support. While determining what it means to have a well-established organization goes beyond the scope of this report, Pivot is happy to offer technical support on the topic.
- High return on low investment: A small class of investments can have large low-level impacts. For example, the unhoused population has few options for addressing bodily functions which frustrates and angers neighbors. Similarly, dumpster availability could facilitate the unhoused contributing to their own cleanliness. Strategically investing in supervised portable restrooms that add to various existing shelter capacity may help ease some neighbor concerns. At minimum this would be a proactive public health feature (c.f Hepatitis A in cities). An example of the affordability came from a single phone call to Stanley Portable Jons which offers these for $125 per 4 weeks with weekly cleaning. It's a

small investment for human dignity and public health. Shelter Staff report being able to supervise them and ensure respectful use. Considering the likely use, county Staff may consider adding an additional premium for the extra clean option. These small investments in human dignity have the potential to solve or avert multiple problems at once.

Considerations on New Provider Success

BHI may wish to consider the following points when considering funding start-up organizations in terms of supporting them and communicating to the public:

- Consider targets for rates of new organization success or in this case failure in advance. What failure rate would the county consider an acceptable risk of investment? Around half of small businesses fail within 5 years (Forbes). With support from BHI, could the county expect only 25% of new providers to fail? That would be 50% better than national rates, but still provide a basis for criticism of the 25% waste.
- Consider funding incubator organizations in which to support new providers. For example, WESST (wesst.org/) incubates new businesses.
- Offer entry-level funding opportunities so grass roots organizations can build the organizational infrastructure and track record to participate in larger contract opportunities.
- Describe BHI as funding the **process** (which naturally will include some organizations being more successful than others), not just funding successes. Narrowly defining success by a business's operating cash flow does not acknowledge the learning and social capacity building that result from organizational approaches that faltered. Of course, this concept may also receive criticism from a public used to appreciating only one kind of success outcome.

Considerations on Sustainability

BHI also receives community questions regarding its choices to grant some organizations repeat funding. Some questions raise concerns about whether BHI-funded providers can continue their services after BHI contracts end, by utilizing other funding streams. The implication in these queries is that organizations should diversify funding sufficiently to ensure the sustainability of their services without long-term BHI financial support. This logic is based on assumptions that it is better business, and perhaps more in the American spirit of bootstraps individualism, to use local government funding as a steppingstone to self-sufficiency instead of an ongoing reliance. One could argue that when service partners graduate from BHI funding, they free up more funding for new programs or less resourced organizations that need it more.

However, Pivot offers the following additional implications to consider:

- There is no business model for community-based behavioral health management. Or homelessness, or poverty, or addiction. Companies can make money from pharmaceuticals, but the legwork of direct services resists the common market-based model because these direct service recipients lack the sufficient financial resources. They are social services that all taxpayers elect to pay for in hopes of avoiding other more costly solutions. As such, community service providers will never be sustainable in the business sense, because they will always rely on someone other than their service recipients to pay for their programming.
- The reason why BHI would provide consistent ongoing funding for select service organizations is to prevent more costly and problematic outcomes. The public wants folks off the streets enough to tax themselves, and the county has determined that providing social services is a worthwhile investment in our shared community. Evidence is building that costs resulting from the lack of these interventions compound dramatically. Crime increases, businesses close, neighborhoods become blighted. Law Enforcement, justice, and incarcerations systems become overburdened, risking civil litigation with massively increasing costs relative to those of behavioral health.
- Medicaid is usually cited as an avenue to sustainability (sourced from federal instead of local funding) but can be problematic for organizations and service recipients. Billing Medicaid or any other insurance is time consuming and burdensome for many organizations. Billing for small organizations proves unsustainable financially due to staffing scale-up challenges. Most organizations would require an administrative Staff person whose whole job would be to operate the Medicaid billing process.

  Billing Medicaid also increases the burden on service recipients, as it is one more administrative hoop they need to jump through and adds documentation they need to produce. For service providers striving to be low/no barrier and service recipients who may be justifiably wary of government documentation, Medicaid poses a challenge. BHI can consider supporting providers' Medicaid process in a couple different ways. BHI may keep a support person on Staff to advise and assist service providers with Medicaid challenges (while still leaving the actual Medicaid billing tasks to providers). This option avoids concerns about sharing confidential service participant health information but may leave providers wanting for more support. BHI may consider hosting a dedicated Medicaid staffer in their own administration to actually process provider billing, potentially easing the process for service providers, but also requiring logistics

for data sharing. Finally, if Medicaid-billable services are undervalued, BHI could advocate for increasing the reimbursement amount. Higher reimbursement would allow service providers to dedicate more Staff time to Medicaid billing and make the process more financially sustainable.

Everyone wants BHI-funded programs or organizations to succeed even if their contract isn't renewed. BHI funding provides more Staff hours, a new program, or more facilities. Perhaps replacing descriptions of sustainability with **scalability** in the event of discontinued BHI funding would help the county understand the extent of outcomes funding provides. In this case, the question wouldn't be whether organizations can continue services indefinitely at the same scale regardless of funding, but whether they can be flexible to changes in funding. Such a shift would require service organizations to think about scalability and help BHI Staff understand actual capabilities outside of the county's funding opportunities.

When BHI funding ends, organizations must consider responsibly reducing hours without layoffs, integrating program features into other services, or renting some of their space to another service provider to keep and share the facility while seeking resources or funding to replace or supplement BHI funding. Regardless of how BHI chooses to address provider sustainability, Medicaid use, or scalability, addressing the above assumptions and implications will help facilitate productive communication among BHI and its stakeholders.

Current BHI Progress & Options

BHI already funds some newer and smaller service providers along with the larger organizations that win repeat funding. BHI builds a sustainability expectation into service provider contracts. BHI already implements processes and uses decision-making rationale that address service recipient needs and stakeholder interests. To facilitate ongoing decision-making and communication around funding opportunities, this section aims to illustrate the considerations and implications that go into the work BHI already manages. Additionally, the categories of service providers and funding opportunities described above are not mutually exclusive. BHI can and does fund a combination of more and less established organizations and programs, each of which may receive one-time capital funding and/or ongoing direct service funding.

Describing BHI funding rationale by setting benchmarks (ratios) for the amount of each organization type (new versus established) and contract type (capital start-up versus program funding) to which it allocates funding may answer many of the publics' questions in advance. For example, Table 4 shows a breakdown of divisions in funding allocations starting with service category as the biggest bucket on the left and increasing

in granularity moving to the right. Of course, if BHI wanted to formalize allocations, they could start with whatever they consider to be the largest buckets (least granular categories) and go from there, whether that would be capital versus ongoing funding (and then break down subcategories from there) or new versus established providers, etc.

Table 4 show all possible funding categories, but BHI Staff may determine not to fund certain categories at all due to sufficient community capacity or lack of need in the community. Also, Table 4 shows an equal weighting, but unequal weighting could align with community needs if those were better known. For example, there may be no need for capital investment in youth serving organizations, though there is a need for more youth focused housing options.

Additional consideration include:

- To improve funding partner understanding and expectations, BHI may wish to formalize its allocation ratios to different types of service providers and contract funding.
- To facilitate effective communication addressing which kinds of organizations it funds, BHI may wish to clarify its funding priorities and practices by identifying which types of BHI funding provide one-time versus ongoing support and why.
- To improve the County's understanding of provider capabilities, BHI may wish to adopt the concept of provider **scalability** (program scope flexibility in the face of uncertainty) as an alternative to its current approach to sustainability.

Table 4: Illustration of current funding process options.

Service Category (6 funding categories for contracts)	**Provider Type** (2 options per service category)	**Contract Type** (2 options per provider)
Community Supports (including Senior Case Management)	New Providers	Capital
		Ongoing Service
	Established Providers	Capital
		Ongoing Service
Early Prevention (ACEs related interventions)	New Providers	Capital
		Ongoing Service
	Established Providers	Capital
		Ongoing Service
Housing	New Providers	Capital
		Ongoing Service
	Established Providers	Capital
		Ongoing Service
Therapeutic Support (Peer Drop-in & Peer Case Management)	New Providers	Capital
		Ongoing Service
	Established Providers	Capital
		Ongoing Service
Crisis Teams	New Providers	Capital
		Ongoing Service
	Established Providers	Capital
		Ongoing Service
Suicide Prevention	New Providers	Capital
		Ongoing Service
	Established Providers	Capital
		Ongoing Service

Applying Public Health Models to BHI Processes

Employing public health models and terminology to describe population behavioral health principles and interventions may help communicate complex contexts to the public.

BHI is a public health organization, as it addresses behavioral health issues and interventions at the population level (the Albuquerque/Bernalillo community). BHI can further apply public health strategies to describe its initiatives and support its mechanisms of change.

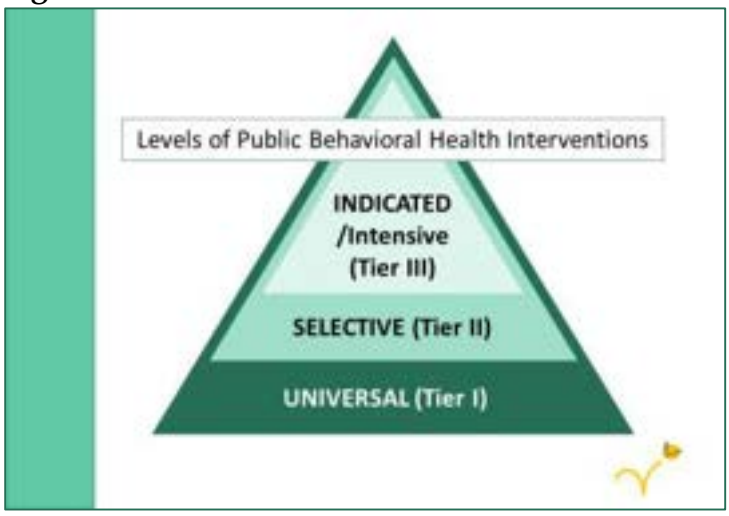
Intervention Scope for Behavioral Health Organizations

Figure 3 illustrates the different levels or tiers of public health intervention strategies. Interventions may address issues or improvements that apply to everyone in a population (Universal, or Tier I), a significant subset of the population (Selective, or Tier II), or a highly specific subgroup (Indicated/Intensive, or Tier III). The tiers represent both the proportion of the population an intervention applies to, and the intensity of the issue/intervention being applied. (Note that some models use the term "targeted" instead of selective; however, Pivot uses the above terms in alignment with nonviolent language and does not refer to people as being targets.)

For example, regarding BHI initiatives:

- Universal interventions could include increasing the availability of housing, gainful employment, and healthcare services, as well as increasing awareness around behavioral health issues, anti-stigma concepts, and wellness approaches. These practices benefit everyone in a community, whether they are experiencing an acute behavioral health challenge or not, and broadly apply to behavioral health in general, regardless of specific issues or diagnoses.
- Selective interventions could address behavioral health resourcing in a more specific way, for people who struggle with behavioral health on a regular basis. Selective interventions could include support groups, peer support services, medication assisted treatment (MAT), etc. Not everyone in a community would use these resources, but they would be generally applicable across different behavioral health needs.
- Indicated/Intensive interventions address the more specific needs of people experiencing an acute issue that requires tailored and rigorous resources. For example, this could include in-patient psychiatric care, crisis services, or detox facilities for specific substance use.

Figure 3: Intervention Levels of Public Behavioral Health Scope (Pivot Evaluation)



Organizations may use the intervention levels described above in the program planning process, to ensure that the programs they implement align with the scope they intend. Applying this model can help identify duplications or gaps in overall service coverage. BHI is involved in every stage of behavioral health prevention and can use this model to map different funded organizations and strategies onto the prevention continuum, and to communicate BHI's work in context to the public and media.

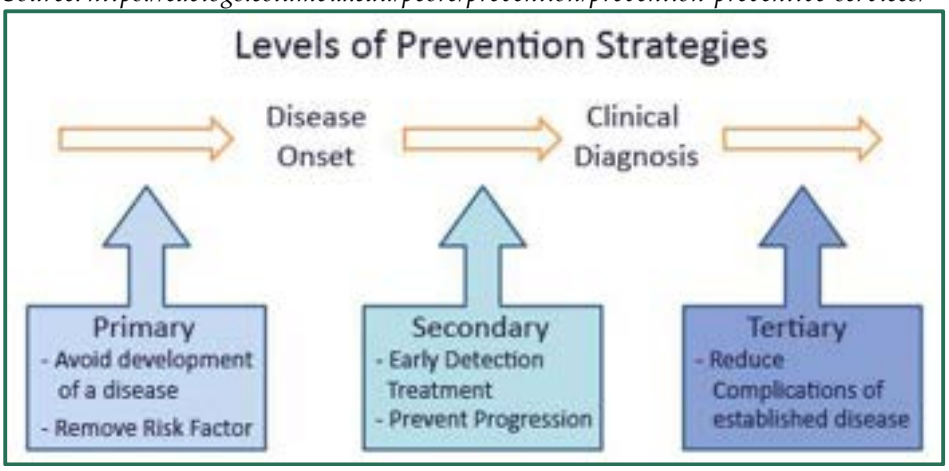
People experiencing behavioral health issues may benefit from program planning that accounts for levels of intervention scope. On the other hand, the tier labels of intervention services they access are unlikely to be relevant to their personal perspective. The intervention scope model is more relevant from an organizational perspective, while the public health models of prevention stages better illustrate the service population experience.

<u>Prevention Stages for Public Behavioral Health</u>

Figure 4 illustrates a typical public health model for applying different prevention intervention strategies to progressive stages of illness in an individual or population.

Figure 4: Stages of Prevention Strategies (Public Health model)

Source: https://edblogs.columbia.edu/pcore/prevention/prevention-preventive-services/



For Behavioral Health, Figure 4 may be more appropriate modified as seen in Figure 5.

Figure 5: Prevention Levels of Behavioral Health (Pivot Evaluation)

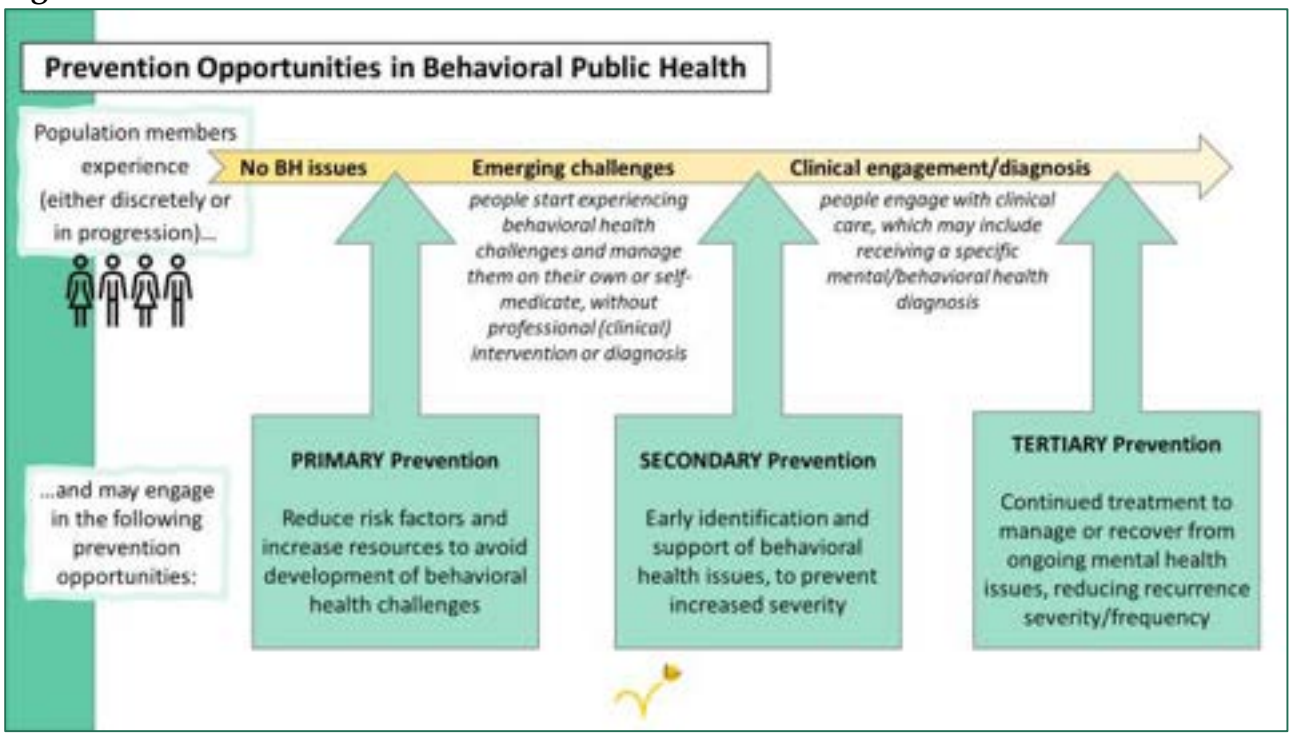


Figure 5 illustrates the opportunities for prevention that populations experience as they go through behavioral health issues. This model is more relevant to a service population perspective, as it focuses on the experience of health issues and treatment among the population. It describes opportunities for the public to engage in

interventions, at their discretion and volition. Ultimately, agency lies with the people experiencing issues, as they may or may not choose to engage in prevention options available to them. Organizations can therefore use this model for reference and context regarding their initiatives, but it describes the actions of a population instead of an organization.

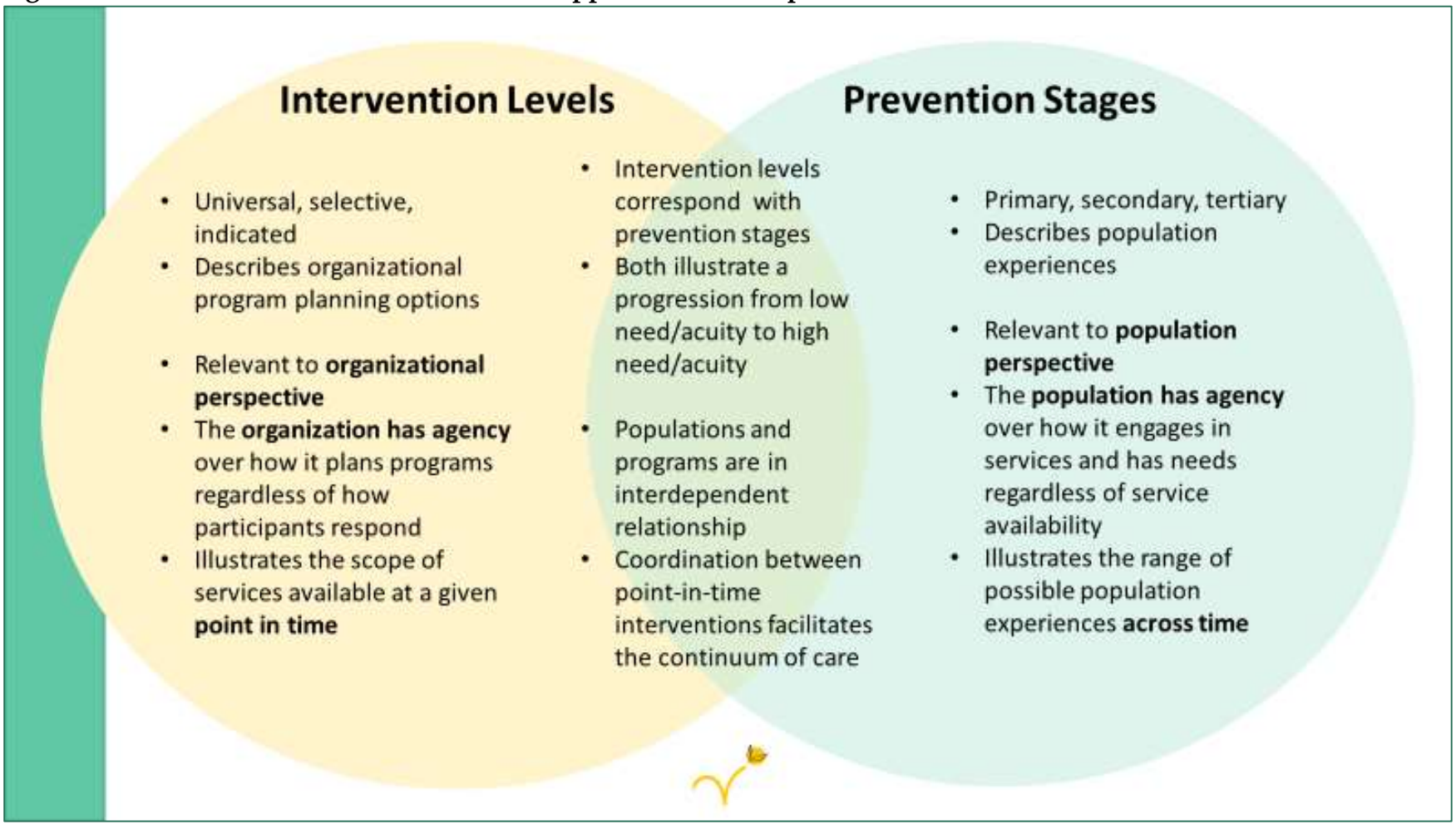
The previous intervention level model illustrates categories of organizational actions, while the prevention model describes population experiences. Ultimately, organizations have control over program development but less control over how a population receives or utilizes them. Populations experience health issues and needs regardless of whether services exist to support them at critical opportunities for preventing further declining public health outcomes.

There is a relationship between the two models, in that **universal, selective, and indicated interventions often meet population needs for primary, secondary, and tertiary prevention, respectively**.

I. The aim of **primary prevention** is to reduce risk factors and avoid the development of health issues, which may be achieved through **universal interventions** such as those that reduce the incidence of Adverse Childhood Experiences (ACEs), substance use, discrimination and stigma. Universally preventive programs may also add or improve protective factors such as education and healthcare services.
II. The aim of **secondary prevention** is to identify issues early and provide support to mitigate further problems. Needs for secondary prevention may be met by **selective interventions** of non-clinical resources that help people manage their behavioral health and prevent progression, such as peer support services or community activities. People may also replace or supplement organizational interventions with self-management strategies, which can be sustainable and stabilizing (exercise, reducing lifestyle stressors, meditation etc.), or less sustainable and stabilizing (substance use, isolation, aggression, etc.).
III. The aim of **tertiary prevention** is to manage or recover from ongoing health issues, to reduce the severity and/or frequency of reoccurrences. **Indicated interventions** that support tertiary prevention may include specific clinical services or rehabilitation. In tertiary prevention, individuals continue managing their behavioral health, informed by their diagnosis and accessing both clinical and non-clinical resources as applicable, with the goal of minimizing complications/progression. This stage of prevention can also include recovery, and the re-building of foundational knowledge, attitudes, and behavior for ongoing wellness.

The following diagram illustrates the relationship between organizational intervention levels and participant prevention opportunities.

Figure 6: Intervention Levels and Prevention Opportunities Comparison



Implications for BHI Regarding Continuum of Care

Public health officials often use the expression **continuum of care**, which is a coordinated spectrum of services interconnected so people at any stage of behavioral health needs could access services, and then progress from one resource to another toward greater health as circumstances evolve. The prevention stages and intervention scope models are similar in that they both describe a progression from less acute/lower need conditions to more acute/higher need situations. Universal interventions can often be described as forms of primary prevention, with selective and indicated interventions analogous to secondary and tertiary forms of illness prevention. However, the models have two key differences. The prevention model illustrates a **progression through time** for the person or population **experiencing the condition**. The intervention model illustrates **point-in-time** options for **service organizations** to implement their treatments. So, the prevention model describes the experience of the populations BHI seeks to serve, those who go through various stages of behavioral health challenges over their lifetime. The intervention level model illustrates BHI's organizational perspective regarding strategic options for aligning funded services with focus population needs.

This is significant because BHI seeks to use funding not only to support individual organizations but to enhance an overall **continuum of care.** BHI wants to fund service engagement that moves with the participants, so that participants can continue accessing services appropriate for them as they age, change, relapse, recover, etc. Yet BHI does not fund a handful of organizations providing cradle-to-grave programming, they fund dozens of individual agencies that each provide tailored resources for specific populations and needs (as illustrated by the intervention model above in **Error! Reference source not found.**). BHI funds these diverse services so that at any given **point in time**, people seeking behavioral health resources can find the program that meets their needs, helping them *progress through time*, as illustrated in the prevention model above. People engaged along the continuum move through different programs instead of one program moving with them. BHI funds the points along continuum, to connect residents between points on the continuum of care. Table 5 illustrates how BHI could conceptualize funding the continuum by ensuring that each category below has adequate service provision. Compare this table to the current conceptualization in Table 4. Which is easier to follow?

Table 5: BHI Continuum Funding Example

BHI Focus Issues	Intervention Level
Housing	Universal
	Selective
	Indicated
Employment	Universal
	Selective
	Indicated
Crime	Universal
	Selective
	Indicated

Given this structure, the connections between BHI-funded organizations (the points across the continuum) are an essential part of BHI's strategic plan. BHI administrators have discussed wanting to learn more about how behavioral health organizations work together and how recipients access services between organizations. BHI currently collects counts of the number of total referrals made each month for individual organizations in funded agencies' monthly performance reports. While BHI Staff have expressed interest in other measures as suggested below, organizations resist sharing successful referral hand-offs due to HIPAA concerns.

BHI may additionally want to know the following:

- Which services do BHI-funded organizations refer their participants to, and which or how many referred services do those participants actually end up accessing?
- Which different types of referrals get made (cold call, warm handoff, etc.), how many of each type get made, and at what rates do participants follow through on accessing services referred in these different ways?
- Aside from referrals, how do service organizations connect with each other via sharing information, asking/answering questions, joint advocacy initiatives, stakeholder meetings, social/recreationally, etc.?
- Which organizations are better networked, in which of the above ways?
- Does stronger inter-organizational networking result in more coordinated care for participants?
- What are the barriers and facilitators of connections within a behavioral health continuum of care?
- What do providers and recipients think about the current continuum of care and its potential?

Given the existing data collection responsibilities on service providers and recipients (and the burdens these can entail, discussed elsewhere in this report), BHI may consider ways to explore the above points if desired, without directly questioning funded personnel. One point for BHI's internal consideration is how BHI defines connections within the behavioral health continuum. Connections could mean anything from regular meetings referrals to joint memorandum of understanding (MOUs) or data sharing agreements. Determining how to define and measure BHI's continuum of care is an integral part of developing its potential for supporting behavioral health service recipients.

BHI may also consider using software such as the Unite Us platform currently being implemented in Santa Fe, NM as an option for expanding data networking across service providers. Networking programs can enhance the care continuum and improve collaboration between service providers without exacerbating their data collection and sharing burdens.

Steps to Create Custom Outcome Measures (continued):

8) Use Table 5 as a worksheet to determine what areas to fund according to known needs and resource availability. (Remember to substitute updated service categories. Funding decisions reserved for a later step.)

Additional Applications for Criminal Justice

These models can also be used for criminal justice application. For example, in the prevention model, **primary prevention** can be thought of as community safety and enrichment processes that deter crime and provide alternative gainful opportunities (i.e., Tier I interventions). **Secondary prevention** would include behavioral correction and incarceration deferment programs to help people stop problematic activities and stay out of jail (Tier II). **Tertiary prevention** would involve addressing behavioral issues with people once they are involved in the criminal justice system, to reduce re-offense and recidivism (Tier III). One could also conceptualize a crime prevention model regarding the age/lifespan of the individuals involved, (i.e., primary prevention involves supportive resources during childhood to set kids up for success including education, community safety, role models, etc.). Secondary prevention could involve programs aimed at youth and young adults at-risk for criminal justice involvement, to help them correct course. Tertiary prevention involves adults already implicated in criminal justice systems to reduce involvement for the rest of their adulthood.

By adopting existing public health models and principles to conceptualize its behavioral healthcare continuum, BHI Staff can map their programs onto its framework for service availability/provision, make associated funding decisions, and communicate BHI's process concisely to the public.

Adopting public health model concepts will help BHI Staff plan, communicate, and measure their efforts.

Current BHI Intervention Strategies and Solutions as they relate to Contracting Practices and Principles.

How do the considerations detailed in previous sections of this report inform BHI's current contracting practices and principles?

Social vs Physical Infrastructure

For decades, county governments have seen their role as managers of shared infrastructure, such as roads and storm runoff. Failure to act at all regarding physical infrastructure leads to devastating and tragic loss of life. While many states and counties have developed social infrastructure it is rarely conceptualized as the same sort of essential infrastructure as physical. More often social infrastructure is conceptualized as a luxury and often the first to receive cuts in times of budget shortages. After the pandemic that began in 2020, it should be clear that public health and behavioral health infrastructure are every bit as important as physical infrastructure.

Social infrastructure as a set of essential services is different than social capital (which the Oxford Dictionary defines as "the networks of relationships among people who live and work in a particular society, enabling that society to function effectively") from. The two are related in the sense that the social network defines and implements the social infrastructure. Government agencies at many levels are always part of the social network because they have various responsibilities toward the public as a matter of law. Agencies that make up the social infrastructure only provide niche services; however, combined they become more holistic. Government agencies never receive adequate funding to solve social problems that have endured for thousands of years (e.g., homelessness, poverty, and crime). Nevertheless, community members expect government agencies to make a dent in the size of the problem.

As populations increase, the range of human marketable skills may not fit within current economic structures. For example, some individuals may not be employable for

reasons of educational or economic injustice, or due to some inherent behavioral health conditions. Therefore, developing social infrastructure that can recruit from the edges of the range of employability (i.e., provide interventions to improve functioning), helps reduce the size of the population that depends entirely on public support.

Since 2000, the U.S. has experienced at least two economic storms. One began at the end of 2007 and the other resulted from the Covid pandemic. These economic storms threw numerous individuals out of work and strained low-income housing markets. By providing infrastructure to facilitate preventing homelessness, or to arise from being unhoused, the county would expect to reduce some dependence on crisis resources (e.g., emergency room visits, Law Enforcement intervention, etc.).

Intervention Strategies vs Contract Management

BHI is involved in behavioral health interventions across the entire span of a project's scope. This involves strategic planning and conceptualization before a project even exists. BHI then must conduct the RFP process including review and selection of providers for contracting. BHI oversees and manages the contracts throughout a project's duration, using monthly Performance Reports (PRs) to monitor progress via project outputs. BHI contracts with program evaluators to measure overall outcomes regarding improvements in programs and their participants' experiences, health, and behaviors. BHI facilitates all these provider- and participant-facing activities and then has to turn around and communicate the results outward to public stakeholders.

Managing contracts internally, including developing provider relationships and monitoring incremental progress and specific activities, requires a completely different approach than synthesizing all those data points into cost analyses or outcome results for the public. To communicate effectively with stakeholders who are not intimately engaged in the service provision process, BHI must pull together the details they've collected into comprehensive summary results. If they try to communicate information that is too granular or specific, they risk confusing and alienating public stakeholders, and losing the story or point of BHI's overall impact on public behavioral health.

Evaluations likewise contribute to the story BHI communicates to public stakeholders but are tasked with approaching program information from yet another angle. Evaluations seek to connect the activities or measurements for each program (the granular data reported in PRs) and the overall outcomes (BHI's story or impact) by finding evidence for the causal links between the two. Comprehensive evaluations focus on complete intervention outcomes rather than individual provider contracts, but at minimum on intervention strategies. For example, BHI contracted Pivot to evaluate multiple providers' contributions to the intervention strategies of Peer Drop-In Centers

and Peer Case Management. However, evaluation methods inherent in the field can't determine outcomes based on a portion of an intervention without access to the remainder of the intervention.

Steps to Create Custom Outcome Measures (continued):

9) Consider developing a community-wide infrastructure map, comparing it to community needs, to identify features that need funding.
10) Fund organizations to strengthen strategic features of the infrastructure.

The following sections describe additional considerations for BHI's current intervention strategies and contract management.

Current BHI Capacity and Limitations

BHI Background Capacity

BHI is a relatively new and compact department of the Bernalillo County government, having operated for four years initially under the DBHS title before the County and City's strategic reorganization. BHI manages significant amounts of funding procured through local taxes. BHI has allocated funding of $22,098,787 in recurring dollars annually, $46,783,749 in one-time dollars, and $7,728,530 earmarked for upcoming projects/programming. Organizational BHI Staff consists of three groups: Administrative/ Contract Management, the Resource Re-Entry Center, and Tiny Homes Village.

BHI currently manages over 60 contracts across 20+ service providers in eight contract categories:

1. Capital (one-time funding for non-service provision costs such as new buildings)
2. Housing services
3. Community Engagement Teams
4. Suicide Prevention services
5. Adverse Childhood Experiences (ACEs) services
6. Peer Drop-In Services
7. Peer Case Management Services
8. Senior Peer Case Management Services

Table 6 shows Pivot's attempts to organize funding opportunity types by the organizations the BHI funds. While the table shows multiple organizations receiving funding, it is not clear what social challenges the county is addressing.

Table 6. Organizations by Funding Type

	ACEs	Capital Funding & Start-up	Community Supports	Housing	Peer Case Management	Senior Peer Case Management	Suicide Prevention
Albuquerque Center for Hope and Recovery					X	X	
Albuquerque Public School							X
All Faiths	X						
AMIkids	X	X					
ARCA		X					
CASA Q				X			
Centro Savila	X				X		X
Children's Grief Center & Grief Resource Center		X					
CLNKids (Cuidando de los Ninos)	X						
Crossroads for Women		X		X	X		
CYFD/ Bernalillo County				X			
Endorphin Power Company		X					
First Nations Community Healthsource		X					X
Heading Home						X	
Los Puentes Charter School		X					
New Day	X	X		X	X		
New Mexico Veterans Integration Center		X					
PB&J	X						
Recovery Services NM		X					
Serenity Mesa				X			
UNMH				X			
UHM Office of Community Health				X			
YDI	X		X	X			

BHI's developmental stage both accounts for some of the current limitations described in this report regarding organizational structure, documentation, and communication, and allows for flexibility and opportunities regarding its growing capacity.

BHI Limitations and Barriers

BHI is understandably under scrutiny from taxpayers and other public stakeholders, to use funding wisely in addressing major community concerns. BHI has received some criticism in local news media regarding productivity and outcomes, with complaints about the state of current social issues given the working timeframe BHI has had so far.

However, these critiques fail to account for several factors that influence BHI's operations and outcomes, described as follows:

BHI addresses problems that have no known solutions.

The criticisms levied against BHI regarding its handling of behavioral health crises, homelessness, and substance misuse take issue with BHI's progress so far on solving or fixing the presentation of these social issues in Bernalillo County. However, such a stance implies that these problems have known solutions and that BHI simply isn't applying solutions effectively to the situations at hand. Reminding the public that the issues BHI seeks to address do not have known solutions helps set realistic expectations for outcomes of the funded interventions. Some intervention strategies have proven more effective than others for different populations and geographies, but successes elsewhere are not necessarily generalizable to solutions here in Bernalillo County. Many proven successful intervention strategies are also often met with public controversy or resistance. Harm reduction approaches including drug decriminalization, needle exchanges, and supervised injection facilities have proven success, but still receive public pushback due to moralizing about their non-punitive nature. Community members often endorse the idea of more housing for people experiencing homelessness, but then balk at where to put it since nobody wants it in *their* neighborhood (referred to as NIMBY—Not In My Backyard).

BHI is not in the business of applying easily matched solutions to surface issues. Instead, BHI is part of a developmental process to identify, tailor, and measure potential successful interventions in our specific local context. They can reasonably expect to reduce unhoused populations by some unpredictable degree. This context is also constantly changing. For example, the increasing prevalence of Fentanyl in non-medically prescribed drugs has transformed the experience of substance use, overdose mortality, and associated issues like job and housing stability in our county even within the last year. While it is appropriate to hold BHI accountable for its use of taxpayer dollars, it is unreasonable to criticize BHI for grappling with

intractable entrenched social crises that do not have readily identifiable, applicable, or publicly palatable solutions.

There is no business model for solving poverty.

…Or homelessness, or substance use, or serious chronic mental illness. As discussed, some strategies and methods are effective in reducing or managing these population issues. However, there is no business model for solving them. That is, there is no profitable enterprise to address poverty, or other chronic complex social problems. When the population receiving services is not in a position to pay for or otherwise exchange value for those services, then by definition there is no profit or business model. Instead, as a society we may decide that everyone is better off if people with more resources contribute to nonprofit social services. Essentially, without government support, the business model for poverty is philanthropy.

Some countries institute from the top down, taxpayer-funded social safety nets that provide services to under-resourced individuals, in the best interest of the general population. While these services are provided at no or low cost to direct recipients, they are *not* free; they are paid for in taxpayer dollars democratically allocated in the public's best interest. Where taxes don't support social safety nets, many communities find themselves cobbling together solutions from the bottom up. In philanthropic-based systems the money still comes from the population. Time to raise money for non-profits takes away time that could be spent on gross domestic product, which raises taxes itself.

This distinction between direct taxes and indirect taxes is important. Critics of social safety net services, and other proposed taxpayer-funded social resources such as healthcare and education often mischaracterize and feel free to disparage their viability. Saying it's unreasonable or unsustainable to get something for nothing politicizes and oversimplifies the causal conditions leading to the social challenges people face. In reality, these goods are paid for by the communities they benefit, and the relevant issue is not free versus paid but a matter of how the public prefers to spend its money. BHI and other such local initiatives evidence specific communities' interest in allocating resources to social safety net services, however this approach is only partially reflected at the national level. In the extreme, a community that refuses to address issues directly will pay for them in other ways: through crime, increased costs associated with Law Enforcement, judicial and incarceration, and missed business opportunities.

There isn't sufficient large-scale support from national social safety nets.

BHI's efforts are complicated by the fact that BHI cannot look to national models for guidance or funding. In a country as large, populous, and ideologically diverse as the U.S., there are few examples of large-scale social safety net programs in place. Efforts to expand taxpayer-funded public services (such as healthcare and education) are met with high controversy, and even established programs such as Medicaid are regularly threatened. BHI and other locally funded programs are all pioneers in the environment of public social projects, attempting to solve difficult problems without the unified support of functioning large-scale models.

Not everyone can be helped.

The reason that the issues BHI addresses have no known solutions is that despite the public's best interest and providers' best efforts, the social services currently available are not sufficient to enable every individual to recover from their situations. One individual could experience, and many BHI service recipients, do experience, the entirety of substance dependency, history of abuse or neglect, serious mental illness, physical illness or disability, intergenerational trauma, institutional oppression, systemic barriers, and lack of resources. In urban communities such as Albuquerque, individuals with severe behavioral health challenges can end up so isolated and incapacitated that no good model for how to care for them exists, even with no-cost services available. Many who are involved in BHI's other branch of criminal justice are acting out of survival. Crime is one of the more drastic examples of a behavioral disorder.

The population of people experiencing behavioral health challenges falls along a continuum ranging from those who manage self-sufficiently, to those who can recover with the help of public services, to some who may never be able to completely care for themselves. Many people experiencing behavioral health challenges or crises could regain stability when given the chance. BHI can provide these folks with avenues to self-sufficiency, a process which may be linear or nebulous, short or lifelong, discrete or recurring. BHI's charge is to facilitate enough of the right kinds of resources to provide individuals with the opportunity to recover if they are so able. While BHI strives to coordinate resources sufficient for all people struggling with behavioral health to heal, some conditions may nevertheless fall outside the scope of services BHI can provide. In characterizing BHI strategies and efforts, stakeholders do well to understand and acknowledge the limitations imposed by the severity of some behavioral health experiences.

BHI seeks to address intractable complex social issues without being able to rely on standardizable successful models or large-scale social safety nets. There is no business model for poverty or homelessness or substance use, and there will always be some people whose needs are beyond the ability of institutional services to address.

There is no business model for solving poverty or homelessness or substance use.

Intervention & Evaluation Scope

Under BHI's current intervention and evaluation structure, BHI funds specific programs that align with its intervention strategies. For example, BHI funded the peer drop-in (PDI) program component of New Day Youth and Family Services (NDYFS) and the Albuquerque Center for Hope and Recovery (ACHR). In this case, providing Peer Drop-In spaces is a BHI strategy for supporting behavioral health. NDYFS and ACHR are both local service providers that facilitate a variation of PDI. Because NDYFS and ACHR programs and service populations are significantly different, the current BHI model of grouping individual provider programs under a common intervention strategy impedes learning about actual outcomes.

ACHR has a more typical peer drop-in program, consisting of peer support workers in recovery from substance misuse and/or mental illness staffing a drop-in space for service recipients (members). ACHR provides services for adults, to help them re-build after behavioral health crises. On the other hand, NDYFS provides services to youth, primarily those experiencing homelessness and/or co-occurring challenges. They help youth build developmental skills and capacities, and provide a drop-in environment in The Space, their new BHI-funded youth activity facility. Aside from serving different ages and needs than ACHR, NDYFS also does not have peer Staff per se, as their clients are children/young people as practical and ethical concerns weigh in. Youth are among other recipient peers in The Space, and NDYFS hires adults with various lived experience.

It would be hard for BHI to characterize the scope and goals of its PDI intervention strategy in a way that accommodated both ACHR's and NDYFS' applications. Also, both ACHR and NDYFS run several other programs in addition to PDI, which are not funded under their BHI PDI contract or included in Pivot's evaluation, but presumably support the same goals for their service recipients as their PDI component. Evaluating ultimate (vs proximal) participant outcomes that can be attributed solely to their PDI participation versus organizational involvement overall is impossible due to practical methods issues. In conclusion, comparing ACHR's and NDYFS' evaluation results under the banner of PDI is like comparing apples to oranges. Managing them together

under a similar contracting scheme does make sense as they share similar contracting elements.

As an alternative to funding specific *methods* like PDI, BHI could consider funding overall *solutions* to identified behavioral health problems. For example, given the problem of adult substance use, BHI could fund overall organizations or even coordinated systems or networks of organizations that address adult substance recovery. Each organization would likely have several different program offerings. Each offering would fall under the banner of substance recovery services and contribute to BHI's overarching goal of improving outcomes for adults recovering from substance use. Likewise, the program evaluation would examine organizational efforts as a whole, and systems of organizations as a network when applicable. Because evaluators would be able to track the full effect of organizational engagement on participants, these evaluations would have stronger evidence for causal links between organizational activities and participant outcomes. This structure could also allow BHI to avail itself of the opportunity to practice alternative contracting methods that maximize community strengths, described in the following section of this report.

Table 7 illustrates an example of how BHI could plan to fund strategies within its continuum of care.

Table 7: Example funding breakdown for BHI continuum.

For this issue of focus…	and this intervention level…	BHI could apply strategies…	…by funding types of providers.
Housing	Universal	• Fund entire organization	% new providers
			% established providers
		• Fund network of organizations	% new providers
			% established providers
		• Etc. coordinated strategies	% new providers
			% established providers

Funding coordinated interventions, an overall organization, or network of organizations that address a main issue BHI seeks to improve, as opposed to portions of programs, will allow for improved evaluation, outcome descriptions, and community understanding of the funding opportunities.

Changes to funding schemes will improve outcome descriptions, evaluations, and community understanding.

Steps to Create Custom Outcome Measures (continued):

11) Consider funding strategic portfolios that can be modified depending on community needs.

Opportunities for Developing Capacity to Serve the Unhoused

To progress despite the challenges described above, BHI can help develop community capacity for addressing behavioral health problems by applying principles from trust-based philanthropy and a strengths-based, trauma-informed approach.

BHI faces significant challenges and limitations due to the nature of its work to address pervasive public behavioral health issues. However, transformative approaches to community networking, funding, and accountability can nevertheless support success among BHI contractors and populations of focus. BHI may consider the following approaches to inform its process and progress:

Trust Based Philanthropy (TBP) is "an approach to giving that addresses the inherent power imbalances between funders, nonprofits and the communities they serve" (www.trustbasedphilanthropy.org). In application, TBP emphasizes multi-year unrestricted giving, streamlined applications and reporting, and a commitment to building relationships based on transparency, dialogue, and mutual learning. **Participatory Grantmaking (PG)** shifts decision-making power to the communities impacted by funding decisions (https://www.trustbasedphilanthropy.org/resources-articles/participatory-grantmaking). Funders invite non-grantmakers (community stakeholders affected by the issues that include nonprofit organizations, family members, program participants, and other community members) to help set priorities, develop strategies, sit on boards/advisory committees, conduct research, inform theory of change goals, objectives and help define indicators of success. The process intentionally involves in decision making about the funding and evaluation the communities that the funders aim to serve.

BHI already employs some aspects of each and may consider a hybrid of these approaches to be beneficial for future contracting. The following lists detail foundational practices of TBP and PG:

Trust-Based Philanthropy Practices

There are six basic practices of TBP:

a) Give multi-year unrestricted funding that gives grantees/contractors the flexibility to assess and determine where grant/contract dollars are most needed, and allows for innovation, emergent action, and sustainability.
b) Do the homework that involves funders getting to know prospective grantees before they submit their proposals and thereby saving nonprofits time in the early stages of the vetting of proposal process.
c) Simplify and streamline paperwork by clarifying what funders (BHI) need to know and asking for only that information that serves the named values and mission of the work that is being funded.
d) Be transparent and responsive by being explicit about what would or would not be funded and openly communicating the decision-making processes and timelines, and reasons for non-selection. Be swift when needing to say no so that organizations are not misled; responding in a timely manner; and be receptive to feedback and learning about mistakes and misunderstandings.
e) Solicit and act on feedback through anonymous feedback surveys about the funders' practices and or performance; obtain grantee or contractor feedback before making major changes or updates such as revising strategic plan or theory of change; acknowledge and affirm feedback, how it may influence future actions to build trust and create accountability; and when asking grantees or contractors for a significant amount of time outside of their usual work, offer compensation in the same way you would for a consultant.
f) Offer support beyond the funding through making introductions to other funders, promoting grantee or contractor's work, providing mentorship, offering support through tough transitions, hosting retreats, offering meeting space, and writing letters of support. The support could be responsive, not prescriptive by listening to grantees' or contractors' needs, challenges, or opportunities; making such support optional, and showcasing grantees or contractors whose work may not be getting enough attention in the sector on websites, newsletters, and social media.

Participatory Grantmaking Practices

The core elements of Participatory Grantmaking are as follows:

a) People who are most affected by decisions have a right to influence funding decisions is a principle of participatory grantmaking. Their involvement in identifying community priorities and new ideas for addressing old problems in ways that build trust and advance equity is foundational to the process.

b) The process itself is an important outcome that offers opportunities for peers to increase knowledge and leadership about issues, build relationship with others, and ultimately, deepen their sense of agency to determine their own priorities. Important process outcomes could include democratizing the funding process by opening the decision-making process to those with lived experience that would lead to more informed and effective investments; promoting social justice and equity by encouraging participation of traditionally disenfranchised constituencies; and promotes community engagement.
c) Participatory grantmaking involves community in all parts of the grantmaking process, drawing on a wide range of participatory practices. Involvement could include designing strategies, stipulating program priorities, reviewing proposals, site visits, and conducting evaluation.
d) Simple and flexible reporting processes that encourage conversations with grantees/contractors to discuss the big issues and the challenges they are facing. Conversations could encourage real-time reflection and learning.
e) Participatory grantmaking is transparent with communication strategies designed to meet stakeholder group information needs.
f) Participatory grantmaking builds and strengthens larger social movements by building leadership, providing learning opportunities, and building capacity.

BHI Alignment: Trust-Based Philanthropy (TBP) and Participatory Grantmaking (PG)

While BHI already incorporates some of the principles of trust-based philanthropy and participatory grantmaking, it may enhance contracting practices to further engage stakeholders including contractors, service recipients, community members, and local organizations. Pivot considered the following examples of ways in which BHI already implements TBP and PG, and examples of potential further applications of TBP and PG in the BHI context. These examples are intended not as specific recommendations but as context to help BHI select their own applications of TBP and PG.

BHI already applies aspects of TBP and PG in the following ways:

1. *TBP: Do the homework that involves funders getting to know prospective grantees before they submit their proposals and thereby saving nonprofits time in the early stages of the vetting of proposal process.*
   BHI develops ongoing funding relationships with multiple providers based on previous trust and accountability. These relationships facilitate streamlined contracting, collaboration, and evaluation among BHI service providers.

2. *TBP: Simplify and streamline paperwork by clarifying what funders (BHI) need to know and asking for only that information that serves the named values and mission of the work that is being funded.*
   BHI reviews performance metric reporting with service providers when initiating contracts, to solicit provider feedback and confirm what will be measured and reported to BHI and evaluators.
3. *PG: People who are most affected by decisions have a right to influence funding decisions is a principle of participatory grantmaking. Their involvement in identifying community priorities and new ideas for addressing old problems in ways that build trust and advance equity is foundational to the process.*
   This PG concept is apparent in the way BHI conducts and receives input from its topical subcommittees. BHI topical subcommittees are comprised of individuals involved in planning and direct services, who review and inform BHI practices. BHI could further apply PG principles by involving service recipients and individuals with lived experience in subcommittees or other strategies of BHI decision-making.
4. *PG: The process itself is an important outcome that offers opportunities for peers to increase knowledge and leadership about issues, build relationship with others, and ultimately, deepen their sense of agency to determine their own priorities.*
   BHI contracted for the evaluation documented in this report, wherein Pivot observed, participated in, and evaluated BHI's administrative process. BHI could further apply this PG principle by evaluating its stakeholder engagement processes, including process and outcomes from subcommittee meetings, service provider communications, and service recipient relationships. As described in the PG principles above, *important process outcomes could include democratizing the funding process by opening the decision-making process to those with lived experience that would lead to more informed and effective investments; promoting social justice and equity by encouraging participation of traditionally disenfranchised constituencies; and promotes community engagement.*

In addition to the TBP and PG principles already enacted in BHI practices, BHI may consider ways to further apply these concepts by tailoring them into a hybrid model that matches BHI applications. Pivot considered the following examples to help guide BHI's process. As evaluators, Pivot does not have the full functional program knowledge to make specific administrative recommendations to BHI. Instead, evaluators hope the examples throughout this section will help BHI reach decisions regarding the best use of TBP and PG concepts.

Examples of potential further BHI applications of TBP and PG principles include the following:

1. *TBP: Give multi-year unrestricted funding that gives grantees/contractors the flexibility to assess and determine where grant/contract dollars are most needed, and allows for innovation, emergent action, and sustainability.*
   Providing ongoing flexible funding can help providers think outside the box and free them to consider new ideas, get creative, and reach new potential. The following boundaries could help make flexible funding feasible for BHI:
   - Offer flexible funding as an option only for providers who have successfully used traditional BHI funding in the past, with whom BHI already has a trusting relationship.
   - Set clear expectations at the beginning of the flexible funding period for what kinds of activities are appropriate for the funding (such as expanding or creating programs, increasing Staff hours or hiring, providing client resources, etc.) or inappropriate (such as padding Staff bonuses or doing projects unrelated to the provider's mission and goals).
   - Monitor and evaluate the *process* of how providers utilize the funding and associated *outcomes*.

2. *TBP: Offer support beyond the funding through making introductions to other funders, promoting grantee or contractor's work, providing mentorship, offering support through tough transitions, hosting retreats, offering meeting space, and writing letters of support.*
   BHI could consider offering a suite of supports to contracted providers including:

   - In-person social networking events at local restaurants, outdoor spaces, etc. to give service provider Staff a chance to relax and create more connections and relationships among the provider continuum
   - Subsidizing professional development trainings for contracted service providers (such as CPR, Mental Health First Aid, trauma-informed practices, CEU credits, etc.)
   - Supporting Medicaid billing, either through a help desk to help providers process their own billing, or by actually processing the Medicaid billing for providers

3. *PG: Simple and flexible reporting processes that encourage conversations with grantees/contractors to discuss the big issues and the challenges they are facing.*
   BHI may consider working with service providers to see if they can automate reporting with the databases they use (such as Apricot or Salesforce).

Simplifying and automating reporting lessens the administrative burden on service providers, freeing their time for direct services and, as the PG principle above describes, focusing on overarching issues or challenges.

4. *PG: Participatory grantmaking is transparent with communication strategies designed to meet stakeholder group information needs.*
   BHI accumulates a wealth of information about behavioral health service processes and outcomes. However, much of this information is presented in formats that are extensive and/or dense, such as lengthy written reports or service provider performance report spreadsheets. BHI may consider contracting with a specialist in data and information visualization and communication, to produce short reports, executive summaries, slide decks, infographics, and other media that could be easily shared and digested by stakeholders such as local officials, community members, and service recipients.

Involving stakeholders intentionally and proactively helps BHI foster foundational relationships among service providers, service recipients, and community members, strengthening social capital among those who are most invested and involved in BHI. The mutual understanding resulting from these relationships can help BHI better contextualize and integrate feedback from various stakeholders. Trust-based and participatory relationship development also supports tailoring interventions and communications regarding different stakeholder needs and perspectives. The collaborative principles and practices described above can help BHI align its intentions to be transparent and receptive with stakeholders in partnership with community priorities and institutions.

Pivot recommends BHI Staff consult with outgoing County community services Staff about identifying local organizations and building their capacity to accomplish community goals.

BHI Accountability: Client-Driven, Relationship-Centered, Trauma-Informed

Another opportunity for BHI alignment between values and activities involves the principles of client-driven, relationship-centered, and trauma-informed social services. Both BHI administrators, and especially service provider Staff, have voiced the importance of providing services grounded in the needs and sensitivities of service recipients, including the primacy of developing authentic supportive relationships throughout program engagement. Aside from offering a compassionate approach, centering these values is a practical consideration. Many BHI-funded programs are completely voluntary. Even if participants are in great need of services, they may

choose not to come back if they do not feel respected. The joint City/County Gap Analysis recently developed for BHI acknowledged the sobering reality that for many people struggling with behavioral health crises or complications, it can actually be more painful to seek help than to cope alone. Barriers to successful service provision can include logistics and bureaucracy such as paperwork, eligibility requirements, or physical access, as well as interpersonal issues such as stigma and discrimination, and re-traumatization.

All BHI personnel and BHI-funded contractor Staff with whom Pivot communicated in the course of evaluation activities spoke to the importance of meeting participants where they're at by centering participant needs and experiences. Some service providers described relationship development as the single most important aspect of program provision, beyond specific activities or issues without forming foundational relationships, none of the other work is possible. However, despite hearing these principles from BHI-involved personnel, Pivot's evaluations identified several areas in which BHI practices do not appear aligned with client-driven, relationship-centered, and trauma-informed care.

The following are examples of practices, mostly involving performance measure data collection, which prioritize institutional interests at the potential expense of service recipients' experiences and relationship development with care providers:

- Requiring data collection for service provision (i.e., participants must extend personal information to receive care) that would not be collected in fee-for-service contexts.
- Conducting surveys that ask about sensitive information (personal struggles, traumatic experiences, etc.) that would not be collected in fee-for-service contexts…
    - …if not in the context of a supportive interpersonal relationship (i.e., if at the very beginning of service provision before those relationships have formed)
    - …if the data collector is not trained in providing sufficient support (i.e., trauma informed care training, social work training, etc.)
    - …if the data collector is not prepared to provide actual help and resources for participant challenges if requested.
- Conducting surveys that ask for extensive personal documentation, such as social security number, ID, insurance information, etc. This point is particularly relevant among service populations likely to have suffered abuse or exploitation, as these folks may be highly sensitive to giving out personal documentation and understandably wary of institutional engagement.

- Conducting surveys that ask too much too often. Surveys that are too lengthy and or too frequent impose an undue burden on participants.
- Conducting surveys that are biased toward institutionally desired outcomes or culturally exclusive values. For example, the Social Determinant of Health (SDOH) form and Arizona Self-Sufficiency Matrix (ASSM) include several measures that indicate higher levels of independence as desirable. While self-sufficiency can be useful for survival, it may not be the best or only option for people whose ideal recovery includes reconnecting with family or requires ongoing service support. Over-valuing self-sufficiency can also lead to individuals feeling pressured to lessen or disengage from services prematurely to achieve this idea of success.
- Requiring extensive, time-consuming performance measure data collection and reporting beyond service organizations' regular data practices. This can take time away from program service provision and the flexible unstructured time required for authentic relationship development. Some service providers described trying to come up with creative alternatives or workarounds for getting information required by BHI but problematic for service recipients. Others discussed trying to get service recipients to increase program engagement, even though the program was supposed to be voluntary based solely on clients' preferences for engagement. All described challenges with reporting performance measure data to BHI, including questioning how the data was used and whether all data points were truly useful and necessary.

All the service providers appreciate the importance of collecting performance measure data, and strive to meet BHI's requirements and requests, regardless of the time, effort, and flexibility needed to make it happen. All stakeholders agree that collecting and using information about the programs BHI funds is an important part of accountability, organizational development, and BHI's capacity to communicate with the public. However, it is also true that burdensome data practices can work against BHI's intended outcomes by infringing upon service provision capacity, harming participants' service experiences, and negatively pressuring provider-recipient relationships. Ultimately, BHI must practice trauma-informed and client-centered and set up processes (such as asking subcommittees to review practices) carefully examining how their performance measure data requests impact client experiences.

Here are some examples of what client-driven performance measure data processes could look like:

- Consider what information is absolutely necessary and useful to collect. Limit required performance measure data collection as much as possible while utilizing the data you do collect as much as possible.
- Consider which if any services must collect personal recipient information as a requirement for engagement, and which can be accessed anonymously or can use anonymous measures to count engagement such as tallies.
- Work with service providers to use data they already collect and/or modify and improve the instruments they already use, to get necessary information.
- Intentionally limit the length, frequency, and breadth of required performance measure data collection. Focus on information that will meaningfully inform BHI practices, reduce or eliminate service recipient burden, and be collected in a supportive context. A supportive context between service providers and recipients contributes to relationship development and requires that providers be appropriately prepared to address sensitive issues.
- Make sure that data collection instruments and personnel use accessible language (at or below 5th grade reading level) in participants' language of choice.
- Provide technical assistance and support. Providers stated that they appreciated BHI's audits of their existing data processes because it offered a fresh perspective and provided them with actionable ways to improve. Other technical support may include Medicaid billing, data system support, payroll system support, and accounting support (systems and standards).

Ultimately, ask yourself how you would feel about responding to the data collection asked of service recipients. Would you feel offended, violated, overwhelmed, or like a statistic, charity case, or failure? Would you feel seen, supported, included, and empowered, like a valuable partner?

The public asks a great deal of service recipients to engage in recovering from some of life's hardest challenges like homelessness, addiction, mental health crises, and then burden them with data labor that could easily overwhelm or offend the rest of us.

It is possible for data collection to be a mutually beneficial experience for service institutions and recipients. People want to share information when they understand how it is being used in their best interest.

People often share personal and extensive data when they know its use and implications, for example:

- People who record biodata using a tracker device like Fitbit and access the data analytics to understand and improve their own health/exercise/sleep.
- People who answer questions about their personal thoughts and feelings when filling out questionnaires like Meyers Briggs or the Gallup Strengths Finder to expand their own capacities and skills.
- People who volunteer sensitive demographic, health, or financial information when applying for health insurance or university financial aid, because they understand how their data will be used to benefit themselves, and the legal limitations on how their data will be shared.

Currently, most institutional performance measure data collection processes follow a top-down structure, in which the biggest and most resourced organizations (often the funders of service programs) decide what information they want and determine how it will be collected, used, and shared. Service organizations and recipients then do their best to accommodate institutional requirements, even if the process is cumbersome and taxing. They may or may not end up with any utility or insights from the data they harvested. Disproportionately, the benefits go to funder institutions and the burden falls on service providers and populations.

What would an opposite, bottom-up model look like? One in which the people directly providing and collecting information decided what got collected and how, how it was used, and who received the results. In this case, the greatest power and utility would rest with the people supplying the information, and institutions would have to work with what they could get. Modern evaluations have been including multiple stakeholder perspectives in their method designs for many years.

It may not be feasible to conduct a truly bottom-up performance measure data collection approach. For example, BHI drafts performance report requirements in tandem with service provider Staff, but this collaboration does not reach the level of service recipient input. Yet, by integrating concepts from trust-based philanthropy and participatory grantmaking and holding accountability for the alignment of BHI's actions and values, it is possible to find a middle ground. This would require flexibility on the part of both BHI and direct service personnel, to share the burdens, limitations, opportunities, and insights afforded by intentional data use practices. When BHI makes decision, they certainly consider critical observers, and must make difficult choices. Documenting and communicating how the decision was made may forestall some critics. The critics that persist, likely have points worth considering. BHI may

also choose to keep some of their current data practices with the acknowledgement that not all are ideally client-centered, but the information they collect is vital. BHI may also modify or limit performance measure data collection to prioritize trauma-informed care, and should be ready to unabashedly justify this decision, its rationale, its tradeoffs, and its benefits to the vulnerable populations BHI exists to serve.

Finally consider that sometimes, less is more. Collecting performance measure data selectively does not necessarily mean getting fewer or less meaningful results. Sometimes the opposite is true, where intentionally curating the breadth of data collection processes allows for more depth in the information that is collected. Getting clear about which information is not useful can focus the utility of the information that's really essential. Foregoing collecting a myriad of check-box style details can allow for refocusing on the bigger picture, more meaningful outcomes, and most insightful syntheses. In short, quality over quantity. BHI already collects performance measure data thoughtfully, mindful of its utility, communication, and impact. The considerations described above highlight opportunities for BHI moving forward, to further inform the sensitivity, value alignment, and rewards of its approach.

BHI can develop community capacity to address homelessness, unemployment and crime through applying principles of trust-based philanthropy and participatory grantmaking, promoting a strengths-based approach to funding decisions, funder relationships, and intervention approaches. BHI may consider developing processes like enlisting the subcommittees in reviewing practices for the practical implications of being client-driven, relationship-focused, and using trauma-informed practices. These principles pertain to BHI's performance measure data practices and the processes they require of awardees to facilitate continuous improvement of its approach.

Steps to Create Custom Outcome Measures (continued):

12) BHI may wish to sort through features of Trust Based Philanthropy and Participatory Grant making in order to develop a custom practice that fits the community and manages risks peculiar to the BHI context.
13) Use the BHI Subcommittees as to review strategies, RFPs, and proposals (responses to RFPs). Subcommittee members are uniquely qualified to critique assumptions behind strategies, implications of nuances affecting focus populations), identifying practices needing modification to improve participant experiences (being treated equitably).

Process as it Relates to Contracting

Concepts to Consider Before Contracting

Putting the concepts described above into practice of contracting and evaluation involves re-examining the outputs and outcomes that BHI measures. This section will review implications of discussion above and connect them from the most general to the most detailed.

BHI may consider applying the following operationalizations where applicable in its contracting process:

Conceptual Scope: From Broad to Narrow (Least to Most Granular)

This report previously describes the significance of BHI clarifying its vision, mission, goals, and objectives. The following text describes the relationship between these concepts once they are in place: namely, that they create a spectrum of broad to granular structures which all must be in alignment to create a cohesive population based intervention. Program planning perspectives often start with the broadest category (vision) and work progressively down to the most granular (objectives) to plan activities. In practice, some organizations may work backwards based on the activities they're actually implementing, to make sure they align with the broad-strokes vision and mission and reverse-engineer if necessary. Alternatively, organizations may find themselves in the between the two positions above, working practically and conceptually to ensure their organizational planning still resonates with daily operations, and modifying both as needed.

An organization's **vision** is the broadest indicator of its purpose, the improved imagined future an organization seeks to contribute to. Its **mission** is slightly less broad: the organization's own role in achieving the vision. From there an organization has **goals** that illustrate the changes in population conditions or behaviors it hopes to affect. The most granular category on this continuum is the organizational **objectives**, which describe specific actions the organization must facilitate to accomplish its goals. **Objectives describe *what* an organization does (or plans to do); goals explain *how and to what extent people benefit* (i.e., to improve peoples' health, wellbeing, etc.).**

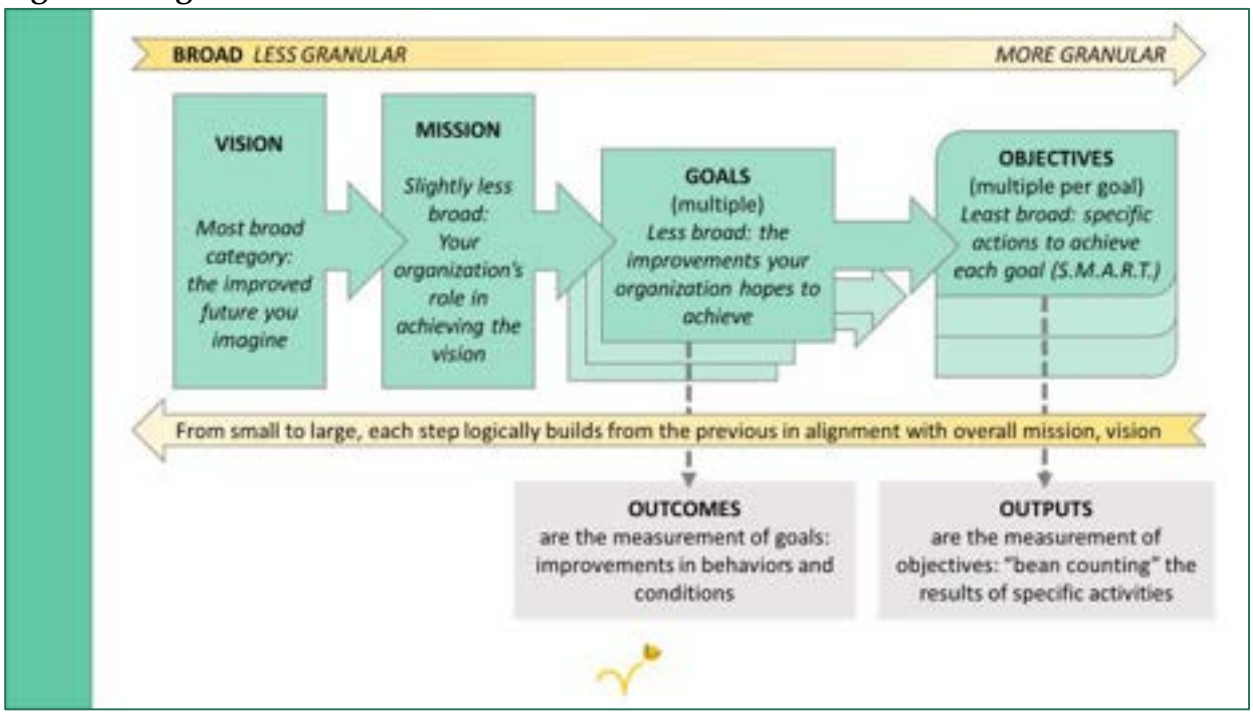
For example, an anti-smoking organization could have the following organizational structure:

- Vision: a smoke-free Albuquerque.

- Mission: empower all Bernalillo residents to quit or never initiate smoking through facilitating prevention education, community enrichment, and supportive policies.
- Goal (one of multiple organizational goals): reduce the rate of current smokers.
- Objective (one of multiple objectives per goal): within one year, supply 100 packages of Nicotine gum each to 25 nonprofit partner organizations throughout the Albuquerque area for service recipients to receive free of charge.

Along the continuum from vision (most broad) to objectives (most granular), each step narrows in scope as it progresses. Conversely, there should be a logical progression in which, starting from objectives and moving back up the continuum towards the vision, each step should build on the results of previous steps, to culminate in achievements that align with the overall mission and vision (see Figure 7 below).

Figure 7: Organizational Structure Continuum. (Pivot Evaluation)



<u>Outputs versus Outcomes</u>

Outputs and outcomes can logically be understood as the measurement of objectives and goals, respectively. Where objectives describe what an organization plans to do, outputs ask, "what did you do, when, and how much?" Outcomes measure, "who benefited? What changed?" To extend the example above, for the organizational objective "within one year, supply 100 packages of nicotine gum each to 25 nonprofit

partner organizations throughout the Albuquerque area for service recipients to receive free of charge", the organization may measure the following outputs:

- Program timeframe (i.e., start and end dates for the one-year program period)
- Number of nonprofit partner organizations involved
- Number of packages of nicotine gum provided to each partner organization at the beginning of the project
    - Sum of above: total number of nicotine gum packets distributed across all partners
- Number of gum packages that each partner organizations gave out to service recipients
    - Sum of above: total number of gum packages delivered to service recipients throughout the program,
- Demographics (if available from partners) of the service recipients who received nicotine gum. I.e. counts or percentages of different racial or ethnic groups, genders, income levels, educational levels, zip code etc. among gum recipients.

Outputs can also measure the number of people who attend an event or complete an activity like a survey. Outputs can even quantify survey results, such as the number or percent of respondents who rate program satisfaction at a given threshold, or number of respondents whose satisfaction improved from the beginning to the end of the program.

Once an organization has quantified outputs, now what? They did activities, measured attendance, resources, or feedback, and collected information about their service population. But ultimately, is that population better off, and how? Outcomes address the improvements that result from conducting programs. Outcomes are often qualitative, or quantitative at the population level instead of the individual level. (I.e., outputs may measure how many individuals attended an event while outcomes measure whether an overall community experiences lower rates of disease). Outcomes often describe changes in conditions and behaviors.

To use the smoking prevention example, outcomes could include the following:

- Albuquerque smoking rate decreases.
- Albuquerque residents feel more empowered to quit.
- New smoking regulations passed in the state legislature.

Evaluators may look at multiple outputs to synthesize an outcome measure, such as collecting data about program participation, survey results, and health measurements.

It may be necessary to synthesize multiple data elements to determine whether and how much population health improved. After measuring outcomes, evaluators then consider the evidence linking outcome improvements with program participation to validate an organization's causal models and mechanisms of change.

Objectives describe what an organization's plans to do. Outputs measure the discrete, quantifiable results of objectives. Goals answer how and to what extent a program improves conditions or experiences. Outcomes measure the success of organizational goals by describing qualitative and or quantitative population-level results. Developing sound organizational goals and objectives, and output and outcome measures, benefits BHI's internal structure and facilitates aligned contracting.

To develop effective outcome measures, mission and vision, goals and objectives must be clearly stated.

Campbell's Law: Performance Measure and Evaluation Implications

Campbell's law describes how using limited metrics to measure an incentivized outcome can create unintended biases that distort our understanding and decision-making (https://en.wikipedia.org/wiki/Campbell%27s_law).

> *"The more any quantitative social indicator is used for social decision-making, the more subject it will be to corruption pressures and the more apt it will be to distort and corrupt the social processes it is intended to monitor."*

Any single metric used to describe or incentivize a favorable condition can be manipulated to maximize that metric, even if it becomes counterproductive or detrimental to the intended impact. A common example is schools that "teach to the test". Standardized tests are supposed to measure real learning, but when test scores are used as a standalone rationale for teacher promotions, school funding, and student admissions, all of the above (students, teachers, and schools) are incentivized to manipulate the metric by teaching students how to ace the test. Test results no longer show what they were intended to indicate (i.e., educational progress); instead, they simply show how well students know how to take standardized tests. Metric manipulation can be conscious or unconscious, innocent or dishonest. For example, if a standardized test is significant for student college admissions and teacher salaries, teachers may emphasize information likely to be tested, or students may outright cheat to get a higher score. Either way, real education is sacrificed for test scores, creating the exact opposite result as intended or desired.

Any data collection that informs an incentivized outcome is subject to Campbell's Law. Regarding BHI activities, many metrics may influence whether BHI continues to award contracts to a service provider or increase their funding.

The following list shows examples of BHI metrics and how their measurement validity may be affected by Campbell's Law:

- Participation counts: If providers know that higher participation numbers make their organization appear more desirable to BHI, they may encourage service recipients to participate in activities that are intended as completely voluntary and recipient-directed. In this case, participation counts are no longer as accurate a measurement of participant agency.
- Satisfaction surveys: If participants believe that rating services highly may result in receiving better treatment themselves or securing ongoing funding for the provider, they may inflate positive responses and refrain from negative feedback, even if constructive criticism would actually help their experience and the organization. In this case, satisfaction surveys are no longer an accurate a measurement of how participants really feel about services.
- Participant progress. Likewise, if program participants perceive that when they report personal progress they get more positive feedback or help promote the service organization, they may be de-incentivized to share the extent of setbacks or challenges, even though doing so could help them more in the long run. In this case, measurements of personal progress would no longer be as accurate metrics for people's successes and challenges.

It is important to note that all of the above are examples of normal human response to incentivized measurements and describe people trying to do their best without any intention or harm or dishonesty. If you're measuring social conditions to inform decision making you can't get away from Campbell's Law entirely, but you can mitigate its effects in several ways.

Solving for Campbell's Law: Practical Examples

The following are examples of how to mitigate effects of Campbell's Law when using social measurements to make decisions:

- Collect multiple different kinds of data points to inform decision-making. The more influence a single metric carries, the more exposed it is to bias.
- When using self-report, define metrics that are more resistant to manipulation. For example, avoid framing data collection in ways that have obvious positive

and negative polarities. If people perceive there is one "right" way to answer or show up, they are more likely to bias their participation in that direction.

Solving for Campbell's Law: Conceptual Considerations

In addition to the specific suggestions above, keep in mind the following:

- Consider how setting targets for service provider activities can influence results. Funders may set benchmarks for service provider activities, while being mindful of how applying different targets and methods to the same activity can yield different outputs. For example, regarding targets, consider an organization that wants to increase service delivery and sets a benchmark for either increasing service hours or participants served. A benchmark around service hours incentivizes providers to spend more time with each recipient, while a benchmark around the number of people served incentivizes the opposite! For an example regarding methods, consider homelessness, a social condition notoriously difficult to measure. Homelessness is often estimated via a point-in-time count, which tallies all homeless individuals in a given place at a given time. However, differences in methodology could yield vastly different results, such as counting versus not counting people in shelters, tallying at different times of day, or employing community members for data collection versus police. In both examples, there is no one "right" way, and instead the best targets and methods for an organization depend on its context. It is helpful to recognize the strengths and limitations of different organizational practices, to account for them in fine-tuning data collection and acknowledge them in stakeholder communication.
- Consider alternative methods such as Trust-Based Philanthropy, in which funding decisions do not depend on specific provider or participant activities or behavior.

There are several ways that funders can support data collection that is less susceptible to corrupted results. Ultimately, funders must trust the professionalism and goodwill of providers and service recipients to collect accurate and complete information. Funders must consider that honest reporting contributes to their knowledge base but does not in itself constitute a complete decision point. Funders may use provider data collection to inform decisions in combination with other contextual information such as community data, funder priorities, and relationship social capital among providers, funders, and community members. In this way, complications of Campbell's Law cannot be fully avoided, but can be mitigated to protect the quality of provider, recipient, and funder relationships and information.

Outputs and Outcomes in BHI Contracting

Working from the above definitions and examples of outputs and outcomes, BHI may take the following points into consideration when using outputs and outcomes for organizational structure and contracting:

Outcomes of interest vary for different stakeholder groups.

When consolidating organizational outputs and outcomes, keep in mind that different stakeholders will be interested in different outcomes. BHI may be invested in a range of potential outcomes, with each stakeholder group (described above in the section "Identify Public Perception and Plan Communication") interested in a select few. For example, BHI steering committees may be interested in methods and provider capacity development, where the public or local government are interested in results (i.e., what taxpayers are getting for their money). BHI has the opportunity to tailor outcome reporting to different stakeholder groups.

Consider outputs as contractual minimum requirements, and outcomes as population goals.

It is helpful for both contractors and funders to have clarity regarding which expectations are minimum requirements that must be met for contract compliance. Population outcomes will not be met by a single organization or program although they may contribute to them.

Factors that influence the breakdown between minimum requirements and population outcomes include the following:

- How much influence an organization or program has over its population outcomes of interest. Often, many factors outside an organization's control influence the outcomes of participant experience. For example, a program may help people develop their job application and interview skills. However, improvements in participant employment may also be affected by external factors such as the availability of jobs and living wage pay, access to transportation, crises or other conditions in participants' lives, discriminatory hiring practices, etc. In such cases, individual organizations, programs, or even participants can only be held partially responsible for intended outcomes.
- Outputs measure program activities that are usually under an organization's control (such as number of workshops conducted) whereas outcomes measure changes in behaviors and situations (often among service populations). It is appropriate for funders to hold funded organizations accountable for achieving objectives within their control. Requiring service providers to measure outcomes as a part of their contractual obligations leads to several problems for data

collection associated with Campbell's law. This scenario creates a potentially unhealthy and unbalanced relationship between service providers and recipients, in which the providers rely on recipients to secure what they need (funding), essentially flipping the relationship of recipients and providers! When providers unintentionally create any pressure around recipient participation in services, these services are no longer client driven.

Note that this can be an issue with outputs as well, such as with counts of people participating in an activity. Throughout evaluating BHI contractors, Pivot encountered instances of providers trying to enroll more people to participate in activities that were supposed to be completely optional and client initiated. The providers meant no harm but were concerned about participant counts regarding their contract compliance. **To avoid unintentionally manipulating service provider-recipient dynamics, funders should only set requirements regarding what providers do, not recipients.** Funders can still measure participant behavior without setting benchmarks or requirements around it.

Some contracts may only have outputs, not outcomes.

In consideration of the differences between outputs and outcomes, be aware that while many service contracts involve both, some may only have outputs. For example, a capital contract that provides funding for a new building may only have outputs: how long construction took, lists of facility features and amenities, number of new Staff hired for the facility, etc. These are all meaningful measures, but they are not outcomes regarding changes in client behaviors and conditions. For example, if BHI went on to fund services in the new facility under a new contract, it could include outcomes of interest such as improved community safety in the facility neighborhood, and improved health among people accessing facility services, etc.

Performance measures are likely outputs, not outcomes.

Contracting documents may use several different terms in addition to outputs and outcomes, such as performance measures. Bear in mind that performance measures are often analogous with outputs, such as the following examples from BHI RFPs:

- Percent of psychological distress reported during the previous 7 days
- Percent change reported in alcohol or drug use
- Percent change in days being housed over time
- Number of initial visits (members that come for the first time)
- Number of total visits (attendance)
- Number of return follow up visits (retention)

- Number of referrals to other programs

Outcomes can be considered relative to **time** as short-term, intermediate, or long-term.

Each program may define the timeframes of short, intermediate, and long for itself, depending on the program context. Considering outcome timing can help programs set realistic expectations and examine causal relationships between short-term outcomes that contribute to intermediate outcomes that in turn contribute to long-term outcomes. Pivot cautions that outcomes without measurement budgets should not be included in any planning. If you don't plan to measure outcomes, they literally do not matter.

Regarding long-term outcomes, consider also what timeframe you use to measure success. What would you consider to be successful program outcomes at the time of program exit versus at one year, five years, or 10 years? Ideally, validate long-term outcomes by conducting some kind of follow-up with program participants after program exit. It can be challenging to follow up with participants over time, but CPSWs provide an opportunity for convenient long-term outcome measurement since they are in recovery and networked with provider organizations. BHI could consider surveying CPSWs on their lived experience, past program participation, and outcomes over time.

Outcomes can be considered relative to **population** as individual outcomes, program outcomes, and population outcomes.

Considering whether outcomes pertain to individuals, programs, or populations can help BHI clarify which outcomes funded agencies are responsible for. Clarifying outcomes helps organizations navigate how to measure, which outside factors influence their outcomes, and how to communicate accountability to their funders.

Examples of levels of outcomes in the sense of behavior change include the following:

- Individual: reduction or cessation of substance use
- Program: increasing the size of the referral network, or changes in process that improve client engagement.
- Population: few people sleeping on the street at night.

Outcomes can be considered relative to **prevention stages** and/or **intervention scope.**

The section above in this report headed "Applying Public Health Models to BHI Processes" describes stages of prevention (primary, secondary, tertiary) and levels of

interventions (universal, selective, indicated). BHI may consider these categories when determining organizational goals and objectives to ensure coverage across them, also illustrated in "Table 7: Example funding breakdown for BHI continuum."

See the following Table 8 for an expanded example of aligning outcomes with intervention levels.

Table 8: Intervention Level Outcome Alignment Example

This table illustrates an example of how BHI may ultimately align outcomes with intervention scope levels. The following strategies and outcomes represent examples, not specific recommendations. This table expands an example across one intervention level (universal) and one topic (homelessness). BHI would expand across all topics (including unemployment and crime) and intervention levels to apply this framework for program planning.

Topic (BHI goals are to reduce these issues)	**Intervention Scope Levels**	**Strategies** (BHI objectives are to apply these strategies)	**Outcomes**
Homelessness	**Universal**	**Fund crisis services**	**Individual level outcomes…**
			Program level outcomes…
			Population level outcomes…
		Fund non-crisis services	**Individual level outcomes…**
			Program level outcomes…
			Population level outcomes…
		Fund entire organization	**Individual level outcomes…**
			Program level outcomes…
			Population level outcomes…
		Fund network of organizations	**Individual level outcomes…**
			Program level outcomes…
			Population level outcomes…
		Etc. prevention strategies	**Individual level outcomes…**
			Program level outcomes…
			Population level outcomes…
	Selective		
	Indicated		

The cumulative sum of outcomes.

Pivot has developed the concept of cumulative program effects that BHI Staff may wish to consider. Imagine, going to a video arcade, inserting your coin and beginning the game. Often there is a message from the FBI that exhort the player not to use drugs. If an evaluation of that anti-drug intervention were developed the chances of it being observed would be unlikely due to the small size of its possible effects. But then the same individual goes out for a burger and on the way sees the Lion's Club billboard that reads "Hugs Not Drugs". Again, the effect of that message is likely immeasurable. When the same individual goes to the restroom at the burger stand, another message is posted there. Likewise, it would have little possibility of showing any effectiveness. What if the constant messaging really was important? How would we know? What if the cumulative effect of all the messaging really reduced the number of individuals willing to try drugs or maybe encouraged them or reminded them to stay off drugs? It may be a mistake methodologically to evaluate each intervention separately for effectiveness and then eliminate them individually when the mechanism of change may be the cumulative effect.

In the case of BHI this could look like a program with limited participation, but where clients take the skills or information they learn back to their families or friends who also adopt the intervention without checking into the official program. Or they may check into the next step up the opportunity ladder. Eliminating the program due to lack of participation may then cause participation in the next step to drop off.

Consider alternative approaches to outcome measurement such as Outcome Harvesting.

Finally, instead of always pre-determining outcomes of interest, if BHI wants to explore the most possibilities regarding program results it may consider utilizing an alternative method such as Outcome Harvesting. A highly regarded evaluation method because of its highly informative approach, Outcome Harvesting entails observing all apparent program outcomes as they transpire, without pre-defining only a limited set to monitor. Harvesting a plethora of outcomes allows for findings regarding unintended (or even deleterious) program consequences that may otherwise be overlooked by evaluating only a predetermined subset of intended positive outcomes. Outcome harvesting can increase awareness of harmful program effects, including negative impacts of over-surveying participants and providers, and burnout. Outcome Harvesting may not be practical for all BHI projects, but it may be helpful when considering new or untested programs. Outcome Harvesting can also be used when changing organizational practices, as a way to take inventory of the full picture before selectively narrowing focus to various features of interest.

Pivot utilized an Outcome Harvesting approach when compiling this report. Instead of predetermining BHI outcomes to consider, Pivot noted interests and questions posed by BHI Staff at the beginning of the evaluation process, and then observed all possible information available about both successful and challenging outcomes.

Consider the applications and implications of outputs and outcomes in BHI contracting, especially regarding how BHI could standardize the outputs and outcomes it presents in RFPs to promote alignment and comparison among service provider funding applications and contracts.

Standardizing approach to outcome selection facilitates contracting clarity and communication with the public.

Contracting and evaluation timing.

Evaluation's utility is to provide information that helps people make decisions. To maximize this utility, BHI may consider contract funding and program evaluation timelines in tandem.

See the following Table 9 for a worked example of how to align BHI funding decisions with Service Provider and Evaluation contracts. This example shows the BHI timeframe of contracting for 2-year periods with an option to renew for an additional two years. The example illustrates the first two years of activity; to continue with additional renewals, BHI would simply duplicate the timeline. Note that this timeline includes 5 months of evaluation technical assistance, to account for the time necessary for BHI to make funding decisions after receiving an evaluation final report, but before the end of service provider and evaluation contracts. Technical assistance could include providing additional service to BHI (such as RFP/contract/PR review, methods research and literature review, etc.) as well as to service providers (such as instrument review/revision, internal evaluation capacity building, etc.). Pivot has so far experienced these needs from BHI and service providers through program evaluations and has endeavored to meet them while conducting process and outcome evaluation activities at the same time, which can create timing challenges. Experience and timeline planning suggest that some dedicated time for technical assistance would be mutually beneficial for BHI decision-making and operations.

Align service provider contract timelines with evaluation timelines to facilitate decision-making.

Steps to Create Custom Outcome Measures (continued):

14) Organize RFP intervention strategies and contract management independently.
15) Organize RFP and contract timelines to allow for BHI and service providers to review evaluation results and incorporate findings into evidence-based decision-making for program activities and contracted funding.
16) Be cautious about asking for data reporting elements that can be corrupted easily or that can corrupt the processes BHI is promoting.

Table 9: Timeline Alignment Example

Year 1 months 1-12 (Y1M1-Y1M12), Year 2 months 1-12 (Y2M1-Y2M12), year 3 months 1-12 (Y3M1-Y3M12).

YEAR 1	Y1M1	Y1M2	Y1M3	Y1M4	Y1M5	Y1M6	Y1M7	Y1M8	Y1M9	Y1M10	Y1M11	Y1M12
BHI	*Develop RFP*	*Collect RFP responses*	*RFP determination, contracts*	Review Performance Reports…	…	…	…	…	…	…	…	Review process report
Provider Orgs		*Respond to RFP*	*Sign BHI contract*	Begin BHI contract work…	…	…	…	…	…	…	…	Apply process findings
Eval Orgs		*Respond to RFP*	*Sign BHI contract*	Begin Process eval…	Process eval…	…	…	…	…	…	Process interim report	Tech support to providers, BHI
YEAR 2	Y2M1	Y2M2	Y2M3	Y2M4	Y2M5	Y2M6	Y2M7	Y2M8	Y2M9	Y2M10	Y2M11	Y2M12
BHI	Review Performance Reports…	…	…	…	…	…	…	…	…	…	Review outcome report	Funding decisions
Provider Orgs	BHI contract work…	…	…	…	…	…	…	…	…	…	…	…
Eval Orgs	Outcome eval/ tech support…	…	…	…	…	…	…	…	…	Outcome final report	Technical support …	…
YEAR 3	Y3M1	Y3M2	Y3M3	Y3M4	Y3M5	Y3M6	Y3M7	Y3M8	Y3M9	Y3M10	Y3M11	Y3M12
BHI	Renew contract OR distribute new RFP			*Continue with new OR renewed contract orgs…*								
Provider Orgs	BHI contract work…	…	Contract renewal OR termination	*Continue new OR renewed provider org…*								
Eval Orgs	Technical support…	…	Contract renewal OR termination	*Continue new OR renewed eval org…*								

Contract compliance and reporting.
Currently, BHI uses a Master Tracker spreadsheet to keep track of performance metrics across all contracted service providers. However, the current Master Tracker does not allow for easy data collection or comparison across providers or over time. BHI may consider alternate methods for metrics tracking and data visualization, to reduce data collection burden and human error, and increase data visibility, utility, and communicability.

Examples of alternative tools include the following:

- Google products such as Google Forms to collect standardized data from service providers. Google Forms also allows BHI to control the type of responses providers enter (such as multiple-choice vs short answer, specific character lengths or types, etc.), an option to reduce human error and data management.
- Dashboard tools such as Tableau, which allow for viewing and comparing data in real time. Dashboards are sometimes excessively complex options for datasets that do not change or compare with other information on a regular basis. However, such applications could be highly useful for BHI information, and could provide more visual data for BHI to communicate with the public.

Contracting Components
Consider incorporating the following components in service provider RFP responses and contracting:

1. Make contractor taxes explicit in budget documents.
   While some organizations may not pay taxes, those that do have no mechanism for making adjustments.

2. Include a simple needs assessment for BHI and service providers.
   Service providers already identify focus populations, behavior health issues to be addressed, and proposed programming in their responses to BHI funding RFPS.

   Include a grassroots needs assessment that addresses the questions:
   a) Is there a local (geographically or niche based) need for this service, and
   b) Is someone else already addressing that need? And what is their capacity to address that need.

   BHI must first answer these questions at the county level to justify distributing an RFP. In their RFP response, service providers must then answer these questions on the scale of their service geography/population/issue. Service

providers could include evidence of the need such as feedback from participants, a waitlist for services, etc.

3. Include a simple Mechanism of Change model for service providers.
   Service providers could include a simple Mechanism of Change model in their RFP responses by answering the following questions about their programs:

   a) What positive outcomes do program participants get?
   b) What does your program do?
   c) How does your program activity generate the participant outcomes?

   Providers should keep their responses brief (limited to one or two sentences per question). Note that some programs refer to Mechanisms of Change and "Theories of Change." This report uses Mechanisms of Change because it identifies testable methods as opposed to theories.

4. Commit to developing a data dictionary.
   Pivot observed that service providers and funders may have different conceptualizations of shared terminology; for example, how to define a program member versus non-member, a frequent versus infrequent participant, or an active versus inactive participant. BHI and service providers may include commitment to developing a data dictionary as a component of their contract agreement.
   If the service provider wants more support about how to delineate between metrics definitions, BHI and the provider could agree on a list of terms to be defined later with technical support from program evaluators. Defining metrics in a data dictionary is important for both monitoring (such as via BHI monthly performance reports) and evaluation. Creating working definitions can be challenging due to the flexible and personalized nature of many service areas.

   For example:
   a) An organization may have 100 drop-in sign-ins before they enroll 10 people in case management. It is important to count both the drop-ins and the case management clients, and keep the counts separate!
   b) Organizations may use reverse operationalism to "draw the line" regarding which clients are frequent versus infrequent participants. That is, instead of defining cutoffs for frequent versus infrequent participation at the program outset, measure actual participation frequency and then identify a cutoff that makes sense based on real results.

c) Program participants may have life experiences that create interruptions in service (such as a mental health crisis or losing/changing jobs). How can programs differentiate between people who want to continue services but must decrease participation due to crises, as opposed to people who decrease services due to a lack of interest/services not meeting their needs? Participant feedback could help inform the situation, but it would be particularly hard to get feedback from the people who *aren't* engaged! This is an elusive issue for all data management without an easy solution.

Defining terms in a data dictionary helps funders, providers, and evaluators understand service and participation metrics. It allows evaluators to analyze whether positive program outcomes follow particular participation patterns or correlate with a particular service amount ("dose"). Developing a data dictionary is a collaborative process that begins in the planning stage and continues to refine data element throughout the project.

Performance Reporting Implications

The concepts described above in this report apply to BHI contracting practices, which in turn dictate BHI Performance Report (PR) practices. This section describes specific implications for contractor performance reporting going forward.

Clarify the utility and audience of Performance Reports, as opposed to Service Provider Annual Report Slides, and Process/Outcome Program Evaluations.

Currently service provider PRs ask for extensive details across several different domains, such as service provision, case manager caseloads, organizational capacity building/training, and organizational community outreach and networking. BHI may reconsider which metrics are useful on an ongoing monthly basis, and which would be better communicated in summative provider annual reports or measured with process/outcome program evaluation.

To clarify the utility of PRs and which information they measure, BHI may consider the following questions:

a) Who are PRs for? Who reads them?
b) How is the information from PRs used? When and by whom?

Pivot suggests that while several of the metrics may be useful for monthly monitoring and contract compliance, others may be more relevant in the contexts of service

provider annual reports, or contracted program evaluation. BHI may consider which information to continue collecting in monthly PRs and which metrics should be reassigned to annual reports and evaluations. Applying the same two questions listed above to annual reporting and evaluation may help BHI clarify which data to collect via each kind of report.

BHI may keep in mind the following considerations about PRs when deciding which data to collect via which reports:

- Collecting all the data currently included in PRs may be burdensome to service providers. It may benefit providers to collect fewer data points, less frequently.
- PRs are not a substitute for program evaluations. As they are currently written, PRs tally information about service recipients such as number of participants that month, percent of participants reporting satisfaction with the provider, and number of participants engaged in community activities. However, these measures do not replace an outcome evaluation. Totals and frequencies cannot be calculated from PRs, since each month clients are duplicated in the tallies. Evaluation can more comprehensively address the ways individuals or organizations engage in topical and/or geographic communities, and the results thereof.

Performance Report streamlining and standardization.

BHI may consider reducing and replicating PR metrics across all contractors, or across contractors in similar service types. The main goal in this process is to simplify the reporting process for all parties involved and simplify accountability statements. The BHI streamlining and standardization of service provider Performance Reports would result in increased data utility, BHI efficiency, and clearer communication with the public. The performance reports have the double goal of synthesizing the BHI provider outputs and showing tax dollars investment relative to those outputs. With data standardization, the goal is to decrease the burden for those doing the data synthesis for all the programs (usually BHI Staff). Similarly, decreasing the data point numbers to those applicable across the board will also decrease the data collection burden on service providers and recipients.

The FiguresFigure 8 and Figure 9 show an example of how BHI could reduce and reallocate PR metrics to produce a more specified and simplified monthly PR. In the following figures, red highlighting and text shows examples of metrics to change or

remove from PRs. Green highlighting and text shows Pivot suggestions and explanations.

Streamline and standardize service provider Performance Reports to increase data utility, BHI efficiency, and communication with the public, while decreasing the data collection burden on service providers and recipients.

Standardizing performance reports will produce benefits at every stakeholder level.

Figure 8: Example Changes to Monthly Provider Performance Reports

The following figure shows an example of a current BHI service provider monthly performance report, with examples of modifications in red (to remove) and green (to modify/explain).

Core Measure: Number of Clients Screened for Initial Intake

Performance target: Screen 425 clients annually

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL YTD
Total Number of Active Program Clients (New and Continuing)	58	64	65	30	61								65
Total of Newly Screened Clients (Monthly)	17	49	50	41	32								189
Total of Newly Accepted Clients (Monthly)	3	11	15	2	6								37
% of Screened Clients Accepted (Monthly)	18%	22%	30%	5%	19%	0%	0%	0%	0%	0%	0%	0%	20%
Number of New Clients Internally Referred	21	63	7	6	10								107

Notes: remove target around participant behavior, extraneous details, and duplicate YTD counts.

Number of Clients in Case Management- Active Clients

Performance Target: Staff-to-client ratio of 1 to 10-15 clients while providing 2,000 hours of PCM services to 325 unduplicated clients

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL YTD
Case Manager 1 # of new clients # of clients seen this month	0	2	2	0	0								4
Case Manager 1 number of returning clients	0	0	1	2	2								5
Case Manager 1 hours of PCM services	0	2	3	3	0								7
Total hours of PCM services													
Total unduplicated clients receiving PCM													
Total clients on active caseloads													

Notes: remove target around participant behavior, extraneous details, and duplicate YTD counts.

Community Engagement and Trainings

Performance Target: Attend 8-10 health fairs, community events, tabling opportunities per month. 15 clients per year will engage in civic opportunities.

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL YTD
Number of community events attended	4	7	2	5	1								19
Number of clients engaging in civic opportunities	3	2	4	6	6								21
Number of staff trainings	12	14	11	11	10								58
Number of case staffings	7	41	140	166	64								418

Notes: remove high target for org engagement, target for participant behavior, extraneous details.

Self-Identified Service Plan PCM Clients

Performance target: Create 325 service plans anually with 150 Clients reaching personal self-identified service plan goals, 150 clients reporting improved mental health, and 150 clients reporting decreased substance use.

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL YTD

Number of service plans initiated	25	29	30	22	11								117
Number of clients reaching personal self-identified goals	3	9	9	11	9								41
Number of clients reporting improved mental health	12	9	6	6	7								40
Number of clients reporting decreased substance use	7	0	1	0	0								8

Notes: remove target for participant behavior, data that would be better addressed in provider annual reports or program evaluation, and duplicate YTD counts.

Referrals - External Warm Hand Offs

Performance Target: 75% of clients are referred out

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL YTD
Number of active clients	58	64	65	30	61	0	0	0	0	0	0	0	
# clients referred to community resources with warm handoff	14	28	14		17								73
Percentage of clients referred out	24%	44%	22%	0%	28%	0%	0%	0%	0%	0%	0%	0%	
Number of clients who connect with community provider	8	4	10	9	12								43
# clients who began provider counseling this month	5	6	3	0	0								14
Number of clients who participate in provider counseling	5	6	2	0	4								17

Notes: remove target for participant behavior, extraneous info, and duplicated YTD counts.

Appointments with Peer Case Managers (PCM)

Performance Target: 2,000 PCM meetings attended annually - Clients attending more than one PCM meeting annually (only count each client the first time they attend their second meeting)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL YTD
Number of appointments scheduled with PCM	132	143	138	110	92								615
Number of appointments that were attended	91	101	108	107	57								464
Attendance Rate (Monthly)	69%	71%	78%	97%	62%	0%	0%	0%	0%	0%	0%	0%	75%
Number of clients that attended more than one PCM appointment	25	25	25	25	25								125

Notes: remove targets and duplicated YTD counts.

Client Satisfaction

Performance Target: 85% client satisfaction for clients that attended two or more PCM sessions, surveys administered quarterly.

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL YTD
Number of client satisfaction surveys sent (quarterly)	0	0	100	0	0								100
Number of client satisfaction surveys completed (quarterly)	0	0	17	0	0								17
Response rate for client satisfaction surveys (quarterly)	0%	0%	17%	0%	0%	0%	0%	0%	0%	0%	0%	0%	17%
Number of clients satisfied (quarterly)	0	0	10	0	0								10
Percentage of clients satisfied (quarterly)	0%	0%	59%	0%	0%	0%	0%	0%	0%	0%	0%	0%	59%

Notes: address this in program evaluation.

Number of Collaborative Community Partners

Performance Target: Establish and maintain four collaborating community partnerships for services and supports per quarter

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL YTD
Shared information and coordination of services	12	1	30	26	35								92
Established new partnership, cooperation and relationship	11	2	3	4	8								17

Figure 9: Revised Example of Monthly Provider Performance Reports

The following figure shows what BHI's current PR example would look like with the modification in Figure 6 above applied.

Core Measure: Number of Clients Screened for Initial Intake

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL YTD
Total Number of Active Program Clients (New and Continuing)	**58**	**64**	**65**	**30**	**61**								N/A
Total of New Clients (Monthly)	17	49	50	41	32								189
Notes:													

Number of Clients in Case Management- Active Clients

Performance Target: Staff-to-client ratio of 1 to 10-15 clients while providing 2,000 hours of PCM services

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL YTD
Case Manager 1 number of clients seen this month	0	2	2	0	0								N/A
Case Manager 1 hours of PCM services	0	2	3	3	0								7
Case Manager 2 number of clients seen this month													N/A
Case Manager 2 hours of PCM services													
Total hours of PCM services													
Total clients on active caseloads													N/A
Notes:													

Community Engagement and Trainings

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL YTD
Number of community events attended	**4**	**7**	**2**	**5**	**1**								19
Notes:													

Self-Identified Service Plan PCM Clients

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL YTD
Number of clients reaching personal self-identified goals	**3**	**9**	**9**	**11**	**9**								N/A
Notes:													

Referrals - External Warm Hand Offs

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL YTD
# clients referred to community resources with warm handoff	**14**	**28**	**14**		**17**								N/A
# clients who began provider counseling this month	**5**	**6**	**3**	**0**	**0**								14
Notes:													

Appointments with Peer Case Managers (PCM)													
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL YTD
Number of appointments scheduled with PCM	**132**	**143**	**138**	**110**	**92**								615
Number of appointments that were attended	**91**	**101**	**108**	**107**	**57**								464
Attendance Rate (Monthly)	69%	71%	78%	97%	62%	0%	0%	0%	0%	0%	0%	0%	75%
Number of clients that attended more than one PCM appointment	25	25	25	25	25								N/A
Notes:													

Number of Collaborative Community Partners													
Performance Target: Establish and maintain four collaborating community partnerships for services and supports per quarter													
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL YTD
Shared information and coordination of services	**12**	**1**	**30**	**26**	**35**								92
Established new partnership, cooperation and relationship	**11**	**2**	**3**	**4**	**8**								17
Notes:													

Contractor instruments and timing alignment.
Revising and standardizing the performance reports along with the regularity (monthly, quarterly, annually) that service providers employ for required BHI data collection will reduce the data collection burden on service providers. Currently, BHI uses a Social Determinant of Health (SDOH) questionnaires across many contracted service providers. However, BHI should clarify the instrument's role, as SDOH are inherently defined as precursors or proxies for actual health outcomes and cannot be used as direct measures of actual health outcomes. While the SDOH tool is standardized across service providers (which Pivot endorses), some BHI-funded service providers use their own instruments to measure actual health outcomes (such as substance use, mental health, etc.). BHI may consider keeping its SDOH instrument with the understanding that it measures changes in social conditions, not health. Alternately, BHI may replace or supplement it with a standardized actual health outcomes measure.

Aligning service provider instruments and/or data collection schedules can facilitate better data comparisons and program evaluations, public communication, and BHI decision-making. Consider revising and/or standardizing the instruments and/or timing that service providers employ for required BHI data collection.

Upgrading and standardizing reporting instruments will help BHI Staff report on progress toward population outcomes.

Contracted activities and outputs.
Programs may only effectively set target requirements around **activities** or **outputs** at a given time. Programs (and their funders) can control either what they do, and then measure the organic results of their actions, or determine what results they want, and then reverse-engineer the activities necessary. They cannot control both what they put into a program and what they get out of it (scientifically speaking, the independent and dependent variables of a program). BHI can consider which set of variables to control, i.e., which contract measures will be the required metrics. BHI may also consider using preexisting outcome statistics (such as substance recovery rates among various populations, including time to recovery and relapses during recovery) to contextualize BHI provider metrics and progress. Strategies such as considering which metrics are absolutely necessary and utilizing secondary information when possible can help BHI standardize and streamline performance reporting.

Steps to Create Custom Outcome Measures (continued):

17) Use minimal and essential outputs for contracting compliance.
18) Let evaluators manage detailed outputs and outcomes.

Evaluation Implications for BHI Going Forward

Based on Pivot's evaluation of BHI contracting processes detailed above, BHI may consider taking the following steps to improve its processes and practices going forward:

1) Formalize Vision & Mission statements.
2) Rename contract categories to align with intervention strategies.
3) For each strategy, identify the level of analysis that the intervention is designed to change (some interventions may impact more than one level)
4) For each strategy and level of analysis, articulate the hypothesized mechanism of change (these will be testable hypotheses later).
5) Use the various BHI Subcommittees to critique proposed mechanisms of change and expected "in the field" operations.
6) Use Table 2 as a worksheet with updated BHI STAFF generated content to begin planning comprehensive public communication strategies.
7) Use Table 3 as a worksheet with updated BHI Staff observations and concerns to identify potential conflicts they can address proactively when addressing public perceptions.
8) Use Table 5 as a worksheet to determine what areas to fund according to known needs and resource availability. (Remember to substitute updated service categories. Funding decisions reserved for a later step.)
9) Consider developing a community wide infrastructure map, comparing it to community needs, to identify features that need funding.
10) Fund organizations to strengthen strategic features of the infrastructure.
11) Consider funding strategic portfolios that can be modified depending on community needs.
12) BHI may wish to sort through features of Trust Based Philanthropy and Participatory Grant making in order to develop a custom practice that fits the community and manages risks peculiar to the BHI context.
13) Use the BHI Subcommittees as to review strategies, RFPs, and proposals (responses to RFPs). Subcommittee members are uniquely qualified to critique assumptions behind strategies, implications of nuances affecting focus populations), identifying practices needing modification to improve participant experiences (being treated equitably).
14) Organize RFP intervention strategies and contract management independently.
15) Organize RFP and contract timelines to allow for BHI and service providers to review evaluation results and incorporate findings into evidence-based decision-making for program activities and contracted funding.

16) Be cautious about asking for data reporting elements that can be corrupted easily or that can corrupt the processes BHI is promoting.
17) Use minimal and essential outputs for contracting compliance.
18) Let evaluators manage detailed outputs and outcomes.

These considerations are intended as a framework for BHI to define and implement its own specific organizational needs and characteristics. The following Table 10 below shows a worked example for the topic of homelessness. The following strategies and outcomes represent examples, not specific recommendations. BHI would expand across all intervention levels and topics to apply this framework for program planning.

This table provides an example of the framework BHI could use to clarify the following organizational structures: vision, mission, goals, objectives, outputs, and outcomes.

Table 10: BHI Full Framework Example

BHI's Vision	BHI's Mission	BHI's Goals	BHI's Objectives (strategies to achieve goals)	BHI's Outputs (measurements of objectives)	BHI's Outcomes (measurements of goals)
A Bernalillo County community where everyone can meet their behavioral health needs along a cohesive continuum of care.	Structure, fund, and support a comprehensive Bernalillo County continuum of behavioral health care providers, services, and strategies.	Reduce homelessness	Allocate funding $ amount to strategies: • Universal/ selective/ indicated scope of service • Crisis/ non-crisis services • New/ established providers • Organizations/ networks of organizations	Allocate funding $ amount fund intervention services: • # of crisis/ # of non-crisis services • # of new providers/ # of established providers • # of organizations/ # of organization networks	• Amount of people experiencing homelessness (homelessness rate) • Amount of resources available to people experiencing homelessness • Extent and effectiveness of the housing continuum of care
		Increase employment	Allocate funding $ amount to: • Universal/ selective/ indicated scope of service • Crisis/ non-crisis services • New/ established providers • Organizations/ networks of organizations	$ amount allocated to fund: • # of crisis/ # of non-crisis services • # of new providers/ # of established providers • # of organizations/ # of organization networks	• Amount of people experiencing unemployment (unemployment rate) • Amount of resources available to people experiencing unemployment • Extent and effectiveness of the employment continuum of care
		Decrease crime	Allocate funding $ amount to: • Universal/ selective/ indicated scope of service • Crisis/ non-crisis services • New/ established providers • Organizations/ networks of organizations	$ amount allocated to fund: • # of crisis/ # of non-crisis services • # of new providers/ # of established providers • # of organizations/ # of organization networks	• Amount of people involved in criminal justice (crime rate) • Amount of resources available to people involved in criminal justice • Extent and effectiveness of the criminal justice continuum of care

This framework also aligns with the foundational four questions of program evaluation:

1. What did the program plan to do? (Objectives)
2. What did the program do? (Outputs)
3. Who benefited? (Outcomes)
4. What evidence supports the causal connection between program activities and participant benefits? (This question can be answered using evaluation data collection methods and analysis techniques.)

Future Directions

This report represents not an endpoint but a pivot point for BHI structure going forward. To fully engage with the implications in this report, BHI may consider applying selected changes and then re-evaluating again after another few years.

Pivot offers the following additional considerations for BHI opportunities going forward. These suggestions do not pertain to BHI's inner workings (as in the rest of this report) but to opportunities for expanded future partnership, analysis, and investment:

1. Conduct an operational gap analysis.
   Gather a comprehensive list of all county/city behavioral health resources, public and private. For each, include their accessibility (i.e., requirements, cost, etc.), service capacity (how many people they can accommodate), and service scope of work (what they offer). Use this resource to identify and evidence gaps.
2. Conduct a synergistic meta-analysis of the BH continuum in the context of the city, county, and state's strategic plans.
   A continuum of care is worth more than the sum of its parts (synergy). Analyze the synergistic effect of Bernalillo's networked BH providers, and their alignment with city, county, and state overall strategies.
3. Consider additional area of investment.
   In addition to BH services for people currently experiencing homelessness, unemployment/poverty, or criminal justice crises, BHI may consider funding focused on:
   a) Basic material needs for people currently experiencing homelessness on the streets, such as portable toilets and handwashing stations, feminine hygiene products, and water fountains. These resources are essential for human dignity, a protective factor in further resource access and recovery.
   b) Expanding and encouraging the CPSW process to help more people with lived experience across any BH domain (homelessness, poverty, mental illness, substance use, criminal justice involvement, PTSD, etc.) get trained and gainfully employed in peer work. Financially incentivize community organizations to hire peers with lived experience.

Where BHI is already implementing aspects of the above ideas, this list can serve as confirmation instead of suggestion. The evaluation described in this report details ways in which BHI already implements many thoughtful and effective practices and has the opportunity to further expand its organization structure and capacity in the future.

While BHI has asked for guidance on developing outcome metrics, this report has described and detailed the process for arriving at them. BHI must make decisions and add their own content before determining absolute outcome metrics. Pivot offers a half to full day workshop (depending on vision/mission status) to finalize actual metrics. BHI Staff will be required to finalize vision and mission statements, as well as make decisions on characterizing intervention types and strategies. Pivot will lead discussion on other funding decisions mentioned in the report. Pivot will provide the worksheets, and the group will complete them by the end of the session.

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