Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Results-Based Systems For Public Health Programs

Volume 2: State Case Studies

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INTRODUCTION

PURPOSE

This report contains brief descriptions of selected initiatives underway in 11 States to implement results-based systems for managing public health programs.

BACKGROUND

Federal Approaches to Grantmaking

The Federal Government currently administers both categorical and block grants to the States for the purposes of addressing public needs. Categorical grants are for specific and narrowly defined purposes, and generally include federally-specified eligibility and reporting requirements. Block grants are broader, encompass a larger range of purposes and goals, and contain fewer Federal prescriptions.

Government-wide interest in enhancing the performance and accountability of government programs, including its grants programs, intensified with the publication, in 1993, of the Vice President's Report on the National Performance Review. As a result of this and other governmental and nongovernmental influences, policymakers have been actively considering changes in Federal grantmaking and oversight authorities.[1]

Some proposals call for combining several categorical and block grants together and replacing them with performance partnerships. These grants would be negotiated between Federal Government agencies and the States. They would allow States greater flexibility in meeting key national and State objectives. In return, States would provide the Federal Government with performance data and work with the Federal Government to establish goals.

Performance Partnerships and Public Health

The United States Department of Health and Human Services (HHS) has been considering performance partnership grants for some of its public health programs for several years.[2] (See Appendix A for a fuller description of the Federal block grants for preventive health, maternal and child health, substance abuse and mental health.)

Over the past several years, the President has included provisions for performance partnership grants in his budget. Several legislative proposals to create such grants have also been introduced in the Congress.[3] While not yet enacted, these proposals reflect the growing consensus about the need to improve the management and structure of Federal-State grant programs for health.

The concept of performance partnerships for public health is also rooted in, and made possible by, activity at all levels of government and in the private sector to assess the

impact of various health care interventions on health status and clinical outcomes. Spurred on by high costs, quality concerns, technological advancements in data storage and processing, increasing penetration of the health care marketplace by managed care organizations, and consumer demands for information, Federal, State, local, nonprofit and private organizations have been working to improve the way health status and outcomes are measured and used. This movement was given added impetus by the adoption of Total Quality Management principles by many healthcare organizations likewise seeking to introduce, within the confines of their own systems, the collection and use of meaningful data on patients and providers in order to identify and implement system improvements.

These developments, along with other Federal initiatives such as the Government Performance and Results Act, have formed a backdrop for HHS efforts on performance partnership grants in its public health programs.[4]

In mid-1995, HHS requested the National Academy of Sciences to examine and make recommendations for specific performance measures that could be used in public health performance partnerships over the next few years. In 1996, HHS, in collaboration with several national health organizations, convened a series of regional meetings with States to discuss current activities in developing performance measurement systems for public health programs.[5] The results of these meetings were provided to the Academy to assist in its analysis. The Academy issued its draft report in the fall of 1996.[6] It is now assessing further developmental work needed in data systems to support performance measurement systems.

This Inquiry

The Assistant Secretary for Planning and Evaluation asked the Office of Inspector General to identify and examine State initiatives that use outcomes measures to assess the performance of their public health programs. Its primary interest lies in knowing more about the nature, extent, and uses of these outcomes measurement systems, and lessons learned and challenges faced by the States, building upon information supplied at the regional meetings sponsored by the Department.

We contracted with Penny Thompson, a principal in Management Evaluation Training, LLC, an evaluation and management consulting firm, to undertake this study. The Office of Inspector General staff were project officers and participated in all phases of the study.

In this report, we describe selected initiatives in 11 States. We intend this report to serve as a resource document that offers insight into the experiences thus far of a number of States that have engaged in the process of developing outcomes measurement systems for public health. It is not an assessment of the outcomes measures themselves, their appropriateness, or adequacy. It is not exhaustive of all State efforts or even all efforts in States we examined.

A companion report, *Results-Based Systems For Public Health Programs, Volume 1: Lessons From State Initiatives, OEI-05-96-00260*, discusses common experiences of the States we selected in developing and implementing results-based systems, and draws on these experiences to identify challenges facing States and the Federal Government as they proceed with these initiatives.

METHODOLOGY

This report, and its companion volume, are based on a review of results-based initiatives in the preventive health, maternal and child health, substance abuse and mental health programs of 11 States. We conducted onsite discussions in seven of these States: Florida, Illinois, Massachusetts, Nebraska, New York, North Carolina and Washington. We interviewed officials by telephone in four other States: Georgia, Minnesota, Ohio and Oregon. Two other States included in our first round of State contacts, Colorado and Texas, were dropped from our interviews due to resource constraints.

We initially wrote to all officials in all the States mentioned above and requested available documents on their efforts. These documents served to confirm the presence of reported efforts and to form the basis for additional discussions with State officials. As we interviewed State officials onsite and by telephone, we often received or requested additional documentation which we then reviewed as well.

The criteria we used in selecting the State initiatives described here included: (1) suggestions from government and non-government experts, researchers, and analysts identifying States with positive experiences in developing and implementing results-based systems; (2) our own review of documents associated with individual State initiatives; (3) geographic representation and program balance to reflect the areas of maternal and child health, substance abuse, mental health, and preventive health; and, (4) our own judgments about whether particular initiatives were sufficiently different from, and less well known than, others.

We developed these summaries based on our interviews and visits with State officials. To ensure accuracy, we shared our summaries with our key contacts in the States for review and comment. All 11 States responded and their comments have been incorporated into this report.

We conducted this study in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

Definition of Terms

As we reviewed the available literature on this subject, designed this study and conducted these interviews, we became increasingly sensitive to the importance of consistent, clear terms in describing efforts in these areas. Terms and definitions used for the purposes of this report and its companion volume include the following:

Results-based System: An initiative focused on using measurement systems to gauge program outcomes and effectiveness, with accountability attributes which might include public reporting, goal setting, and standards or requirements for meeting goals applied to program officials, providers, contractors or grantees.

Outcomes Measures: Measures reflecting ultimate programmatic results, including health status and risk behaviors.

Performance Measures: Measures reflecting a program's more immediate effectiveness or efficiency, including activity levels and direct accomplishments as a result of services rendered.

Standard: A measure set as a requirement and expected threshold for States counties, providers, or other partners in the results-based system.

Goal: A measure representing the end to which efforts by States, counties, providers or other partners in the results-based system are aimed.

FLORIDA

FLORIDA

Division of Alcohol, Drug Abuse and Mental Health

Department of Children and Families

Overview

The Division of Alcohol, Drug Abuse and Mental Health (ADM), Department of Children and Families, is the first State health office to develop a performance measurement system for budgeting purposes, according to the requirements of the Government Performance and Accountability Act (The Act). The Act was passed by the Florida legislature in 1994 and agencies are being phased in to the new system over a period of 8 years. At the present time, the State legislature is reviewing the Division's proposed system which could result in minor or significant changes to the program.

Nature, Extent and Uses of Performance Measures

The Government Performance and Accountability Act requires agencies to submit performance measures and standards in their budget submissions. In return, agencies would be given flexibility for the reallocation of dollars among categories and programs. The Act requires agencies to submit input measures, output measures, and outcome measures.

The Act vests oversight authority in both the executive and the legislative branches. According to the Act, evaluation of State programs would be undertaken by the Office of Planning and Budgeting (OPB) in the Executive Office of the Governor. The Office of Program Policy Analysis and Government Accountability (OPPAGA) is responsible for conducting program evaluations and reporting to the OPB and legislature.

In the phase in schedule for the Act, the Department of Health and Rehabilitative Services, Division of Alcohol, Drug Abuse and Mental Health was scheduled to begin performance-based program budgeting in Fiscal Year 1996-1997; that schedule slipped 1 year for reasons discussed below.[1] The Division is now submitting its performance-based budget request to the Legislative Budget Committee.

In July 1996, as the Division finalized its performance accountability system, it placed parallel performance measurements in provider contracts and required providers to report data on all measurements. The purpose of this approach was to ensure accountability throughout the system for the same outcomes, and to provide a continuous source of data for all ADM measures approved for use in performance-based budgeting.

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[1] Since the passage of the Act, the Department of Health and Rehabilitative Services has been reorganized. The Division of Alcohol, Drug Abuse and Mental Health now operates within the Department of Children and Families.

Process for Developing the Performance Systems

The Act arose from the combined efforts of the Governor and key House and Senate committees responsible for oversight of government operations. The impetus to the Act included: (1) low public confidence in State programs and operations; (2) performance-based management approaches gaining acceptance in private sector management theory and practice; (3) national support for performance-based public administration, including the National Academy of Public Administration/American Society for Public Administration 1991 statements in support of performance measurement; and, (4) the Government Performance and Results Act of 1993.

The Act built on prior efforts in Florida as well, including the Frederick Commission, which in 1991 recommended community-oriented, customer driven, results focused management in public programs.

To implement performance-based budgeting according to the Act's provisions, the Division developed target populations, established an overall goal, and worked with stakeholders to identify measures. In focusing on target populations, the Division ensured that measurement would be oriented towards people rather than services, believing this to be a key to effective and innovative program operations as well as to creating opportunities for services integration. The Division also established a "core" goal for its target populations: self-sufficiency. The consideration of factors which contribute to self-sufficiency drove the development of performance indicators. The Division used workgroups with stakeholders--providers, clients, legislative staff, OPAGA staff--to develop measures. These workgroups were arranged around target populations, consisted of 15 to 30 people, and met according to their own needs and schedules (some for a full day, some for two full days).

Within the workgroups, providers and client or client representatives often had different perspectives on appropriate measures and outcomes. Providers generally wanted more controllable, limited measurements connected to outputs and the results of particular services (e.g. day treatment). Clients and their representatives were often forceful in agitating for broader outcomes and measurements to reflect what they considered their true needs and requirements (e.g. for obtaining sustained work and income levels). Even State employees brought their own perspectives: our informants characterized employees with backgrounds in mental health as more accepting of the work on outcomes measurement than their colleagues who had worked in the substance abuse arena.

In June 1995, the final set of performance measurements were approved. However, the Division lacked baseline data for measures relating to persons with mental illness. As a result, the schedule for performance budgeting was delayed one year while these data were collected. The State contracted with the Florida Mental Health Institute (FMHI) to develop survey instruments and train district staff and volunteers on data collection. Through this mechanism, in May 1996, the State was able to successfully survey a sample of individuals in provider agencies representing people in crisis, children with severe

emotional disturbances, children at risk of service emotional disturbances, people with forensic orders and adults with a mental health disability.

In July 1996, the State placed performance measurements in provider contracts to provide a continuous source of data for all its ADM measures approved for use in performance-based budgeting. All of the measures included in the Division's submission to the legislature as reflective of its performance are also included in provider contracts.

In attaching the same set of performance measures to its contracts, the Division wrestled with a number of questions, including: (1) whether data would be collected on all clients, (2) whether providers would be responsible for all data required, and (3) how the results would be used in assessing provider performance. Ultimately, the Division decided to require reporting on all clients, not just a sample. They decided to require providers to report on all data (not just data related to the particular service they delivered). Providers preferred that the Division use collateral data sources, such as other State databases (from the Department of Corrections, for example), but the Division rejected this option because they feared such data would not be timely, and because they wanted providers to become responsible for knowing key data on their clients. Finally, the Division set fairly loose performance standards--provider performance targets are based on obtaining results within two standard deviations of a performance goal for all providers, and a failure to meet that standard does not automatically trigger contract termination. Failure would trigger further inquiry, and initiate a series of questions about service delivery, population demographics, and management and administration.

Sample Performance Measures

As discussed above, the Division identified target groups and developed outcome statements for the group. It then identified subpopulations within the target group and performance measures for each group.

Example: Substance Abuse

Target Group: Adults who abuse drugs and/or alcohol.

Outcome: Will be drug free upon completion of treatment; will reduce substance abuse.

Subpopulation: Adults abusing substances involved in the criminal justice system community.

Measures: (number served, substance abuse, arrests, individual satisfaction, employment)

Subpopulation: Parents abusing substances putting children at risk.

Measures: (number served, reduced substance abuse, arrests, individual satisfaction, substance free newborns, employment)

Subpopulation: All other adults abusing substances.

Measures: (number served, substance abuse, arrests, individual satisfaction, employment)

Example: Mental Health

Target Group: Children with, or at risk of, serious emotional disturbances.

Outcome: Will function appropriately and live in stable settings.

Subpopulation: Children at risk of developing severe emotional disturbances.

Measures: (number served, community days, functional level, family satisfaction, percent school days attended, arrests)

Subpopulation: Children with severe emotional disturbances.

Measures: (number served, community days, functional level, family satisfaction, percent school days attended, arrests)

Management Challenges

Data challenges, as described above, remain significant. Contractor performance standards are quite broad for several reasons, including program managers' understanding that forces outside the control of a particular provider can impact results; but it is also a reflection of the limitations of the data. In particular, the time lag in contractor reporting and State response can cause the State to question performance that occurred 2 years earlier, at a time when staff, management, and service delivery methods at a provider could have been quite different than at present.

Perhaps the most significant question facing the Division in the future as it moves ahead with performance-based budgeting is the response of the legislature to the Division's plans. In responding to its budget submission, the legislature could decide to allocate funds based on strict categories of funding, without flexibility to the agency, outside the Government Accountability and Results Act. It could appropriate the Division's $500 million budget based on its own targets. It is not certain that the legislature is willing to appropriate large amounts of dollars, and give program managers flexibility to move resources, based on a few performance measurements; in fact, the Division expanded its original list of 24 key measurements for 13 target populations to 52 measurements in response to legislative concerns about sparse data.

Lessons Learned

The Division identified several factors important to the progress that has been made in implementing a performance measurement system:

Starting from "ground zero" in developing measures. The Division did not simply adopt measures from academia or other sources and assume they would meet the expectations of the key stakeholders.

Forming key alliances. In particular, the Division worked closely with, communicated regularly with, and sought comment and advice from legislative stakeholders and their agents.

Focus on target populations. The Division focused on the client populations they serve directly, with the idea that once effectiveness is demonstrated with these populations, the legislature might expand the Division's responsibilities to encompass other groups.

The balance and competition between client and provider interests. The full participation of both sets of stakeholders was considered critical in forming a meaningful set of measures.

Understanding the concept that knowledge often raises more questions than answers. Data collected as part of the performance measurement system will create discussion, debate, and the need for additional analysis. Instead of reducing the resources needed for monitoring, it may well increase the resources needed as more and more questions are raised about provider performance, client needs and experiences, and the validity of data.

For Further Information

Contact information not available.

FLORIDA

Department of Health

Overview

The Department of Health, reorganized as such effective January 1, 1997, consists of a number of agencies that have been involved in performance measurement efforts over a period of years. While part of the Florida Department of Health and Rehabilitative Services (HRS), officials now in the Department of Health (as well as the Department of Children and Families) developed strategic plans for Floridians' health. A quality improvement process was also used to assess the performance of local health units responsible for preventive health, maternal and child health, environmental health, and disease control.

Nature, Extent and Uses of Performance Measures

The Department issued its latest strategic plan in January 1997. The plan consists of priority service areas, one priority indicator for each area, a set of key indicators for each area (no more than 10, composed largely of outcome measures or measures for reducing risk), and intervention strategies. Baseline data for 1995 are included for a number of measures.

The Department also released an evaluation of their success in meeting objectives outlined in a 1994 strategic plan. Based on this experience, it also modified some of the indicators.

The State reviews District and County level performance based on a series of indicators. It conducts a quality improvement peer review process in which indicators, structure and process are reviewed for county public health units. The Public Health Indicators Data System (PHIDS) contains data available for use in constructing indicators and measuring results, based on data from vital statistics, trauma, census, epidemiology programs, and other sources.

Process for Developing Performance Systems

The Department's work on strategic planning began in 1976, when staff codified local health department activities and developed a comprehensive reporting system and initial plan. In 1988, the Department initiated a series of regional meetings to develop health status and outcome indicators and process measurements. That effort was largely based on the national *Healthy People 2000* effort.

The effort in developing a quality improvement (QI) process began in 1990. State and local health officials worked together to develop a program structure, system, and indicators, through a Public Health Services Council. The Council used *Healthy People 2000* and *Healthy Communities 2000*, in addition to other documents such as the HRS

strategic plan and State Health Plan, to develop its indicators. The criteria developed for indicators was that they would be: understandable, acceptable to a wide range of stakeholders, measurable using data that was available or could be made available, and influenced by the activities of public health units.

In the past, local health units, district offices, and the State had discrete roles in the system.[2] Local health units establish their targets for each indicator and conduct ongoing analysis of results. Districts provide technical assistance. The State establishes Statewide goals. Both the district and State staff have been involved in onsite peer reviews of local units.

Sample Performance Measures

Departmental Strategic Plan

Priority Service Area: Preventing Infectious Disease

Priority Indicators:

- Reduce rubeola (measles) case rate per 10,000 children under age 18 from 0.038 in Calendar Year (CY) 1994 to zero by CY 2000.
- Reduce HIV seropositivity per 1000 women giving birth from 4.26 in CY 1994 to 3.69 by CY 2000.
- Reduce incidence of tuberculosis cases per 100,000 persons from 12.65 in CY 1994 to 11.05 by CY 2000.

District Performance Measures

Area: Maternal and Child Health

Measures: (resident live births, infant mortality, neonatal mortality, low and very low birthweight, births to mothers 15-19, repeat births to mothers 15-19, births to children 10-14)

[2] As part of the departmental reorganization, the new Department of Health no longer has district offices, which were assigned to the Department of Children and Families. There will be no comparable replacement for the districts. To manage 67 CHDS, the central office is developing a comprehensive performance measurement system encompassing outcomes, the quality of service delivery, and outputs. The performance reports will be generated on a routine schedule and the measures, or a subset, will be used for performance reporting. This includes Agency Strategic Indicators and Performance Based Budgeting indicators.

Area: Infectious Disease Control

Measures: (congenital syphilis, HIV seropositivity in childbearing women, tuberculosis, tuberculosis in children under 15, measles in children under 18, haemophilus influezae type B in children under 5, high risk infants beginning immunizations)

Area: Chronic Disease Control

Measures: (metastic breast cancer at diagnosis, metastatic cervical cancer at diagnosis, years of potential life lost under age 65)

Management Challenges

Our informants in the State office generally spoke very positively of the QI effort, but noted several factors which make optimal use of the system more complicated. First, local public units differ substantially from county to county in their roles and capacities. Generally, public health units in Florida (as in many other parts of the country) saw their role in the 1970s and early 1980s as one of ensuring overall community public health. In the mid-1980s, many units reoriented their services towards the provision of direct primary care to indigent or at risk populations. Today, some public health units see themselves as needing to move away from the primary care model and back towards the earlier model of assuring community health. Such a transition requires shifts in resources that may not be available. In less densely populated areas with few providers, the pressure for the local public health unit to focus on delivery of primary care to clients is significant.

These differences in how units see their mission makes development and use of performance indicators and data very difficult. Some units accept accountability only for their own client base, rather than the general community. Some units, more focused on direct provision of care, may lack the analytical capacities to use and apply data they receive. Differences in the size and population base of local health units also create significant variation in the orientation to and use of data. Our informants at the State level characterized local health units as still very process oriented and driven, with a focus on patient care rather than data.

A further complication is the absence of some types of data. There can be a significant time lag in receiving certain data, depending on its source. Our informants described the data from vital statistics as very timely; but noted that data from cancer registries can lag behind as much as 3 years. The absence of good child morbidity data was mentioned. The difficulty in obtaining data from other departments--Medicaid, highway safety and motor vehicles, corrections--was identified as an obstacle. And, informants also noted that the spread of managed care might well complicate further their ability to obtain important data. Nonetheless, it was the effective exploitation and use of existing data, rather than the need for additional data, that was identified as the most significant challenge remaining within the QI process.

Lessons Learned

Among the lessons learned by Department of Health officials as developing performance measurement systems are:

Avoid overbuilding the system. In its first attempt at an overall health-oriented strategic plan, officials believe they made the mistake of "including everything." The initial plan was deemed too massive for actual tracking and follow up purposes; subsequent iterations of the plan were more streamlined. Officials now see a need to expand the number of measures.

Process is still important. Despite the emphasis on results, officials believe that measurement systems are not well enough developed to substitute entirely for process measurements. "Process" is still important for accountability purposes in many policymakers' minds. "Performance" means different things to different people.

Indicators should be reviewed continuously. Officials mentioned that they recently deleted a measurement, "access to care," because appropriate data was not available at the local level. In 1994, officials made a series of changes in indicators, combining some, adding a dental indicator, and adding administrative outcome indicators to the list of health status indicators (e.g. client satisfaction, employee productivity and retention). Other changes were made in 1995 and 1996.

For Further Information

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GEORGIA

GEORGIA

Georgia Policy Council for Children and Families

Overview

Georgia has decided to adopt results-based accountability to improve results for the health and welfare of its children and families. The five results Georgia seeks for its children and families are: (1) healthy children, (2) children ready for school, (3) children succeeding in school, (4) strong families, and (5) self-sufficient families. The corporate benchmarking approach is now being used to help measure the extent to which these results are being achieved. The State is planning on implementing results-based budgeting within the next 2 years.

Nature, Extent and Uses of Performance Measures

Since 1991 community and State partnerships have evolved, engaging in collaborative planning and integrated service strategies designed to strengthen the family and improve the well-being of children. The State has developed a broad framework for achieving the above mentioned results, the essential elements of which are:

Results Accountability: Reform strategies will be designed to address specific benchmarks (the ends), so that communities can develop strategies (the means) that target their most prevalent problems.

Community-Driven Decisions: The State Policy Council and local Community Partnerships have inclusive, legal structures that are recognized by both public and private sectors as the change agents for children and families.

Innovative Strategies: Community Partnerships will develop new strategies focusing on: early and ongoing contact with children and families to prevent problems from occurring, improving access to family-friendly services, and expanding comprehensive services with a bias toward prevention.

Government Streamlining: The State will "...reinvent its systems and the ways that people and organizations think, behave, and apply their resources." For example, processes and procedures will be streamlined for efficiency, new forms of frontline practice and more effective ways to evaluate performance will be instituted.

Redirecting Resources: "State and community partners will develop specific agreements on how dollars will be invested to support the agreed-upon results and the innovative community strategies."

Definitions for the terms results-based and performance-based were developed as they are often confused. In essence, results and benchmarks have to do with "ends," while

performance measures and the programs they describe have to do with "means." For example:

A Result is a condition of well-being for families, children or communities, such as children succeeding in school.

A Benchmark is a measure for which data are available that help quantify the achievement of results, such as the percentage of students graduating from high school on time.

A Performance Measure is a measure of effectiveness, such as the percentage of students enrolled in an alternative school program who are promoted to the next grade.

Georgia has selected 26 benchmarks as indicators of the broader results. The benchmark data are designed to be used as a planning and evaluation tool by the Community Partnerships and the State. These benchmark data are expected to: provide a general sense of the well-being of children and families over time, signal whether strategies are making a difference, and serve as a catalyst for change.

However, these benchmarks are not all inclusive. As a result, the State has decided not to set Statewide goals because of the possibility that some of the benchmarks may not be relevant in some communities. When this situation occurs, the Community Partnerships/Family Connection Collaboratives are encouraged to develop other benchmarks as measures of progress.

Results-Based Budgeting

Results-based budgeting is another component of Georgia's results-based accountability system for children and families. Program results will be linked to budgets, thereby creating a system of accountability that explicitly works towards achieving agreed upon goals. Both the starting and the ending points of the budget process will become the results. Thus, budgeting begins with the desired results, systematically derives spending plans based on the results expected, and then measures success by demonstrated progress toward achieving the results.

The State is not yet using a results-based budgeting process. They are just beginning to implement this effort. The State plans, over the next 2 to 3 years, to move all its programs from line item budgeting to one that is linked to results. The 1995-1996 budget represents the first time State agencies have budgeted on a "program" basis rather than on a line item basis. Agencies' budgets are expected to be tied to performance beginning next year.

Barriers Busting Process

The Community Partnerships and Policy Council have also developed a process they hope will effect policy change. This mechanism is called the "Barriers Busting Process."

It was designed to: (1) focus on results, (2) promote top down and bottom up problem solving, (3) use common sense, and (4) be flexible and accountable. For each barrier, a lead State partner (e.g. the Georgia Child Care Council or the Departments of Human Resources or Medical Assistance) is assigned the responsibility for working with communities and other State partners to resolve the problem. Such actions may involve something complex and time consuming (such as new State and/or Federal legislation), or something more simple (such as a change in procedure that would eliminate one or move levels of management review).

This process is currently being tested. In May 1996, the Policy Council adopted Starting Points, a model system for prevention and early care designed to support families from birth to pre-kindergarten enrollment. In September 1996, participating communities were asked to identify any policies hindering their development of this model system. The Policy Council determined the top six priority barriers and decided to test the barriers busting process and its effectiveness in resolving these obstacles. An example of one of the barriers identified is: multiple intake and eligibility requirements whereby families have to complete different forms for every service.

The Department of Human Resources has the lead responsibility for mitigating this barrier. Resolution of this problem will involve streamlining intake and eligibility through its Common Intake and Eligibility and Integrated Computer System Initiatives, which will be no easy task as this effort could involve dealing with as many as 40 different funding sources.

Process for Establishing Performance Measures

The impetus for this effort began in 1991, when Governor Zell Miller challenged the State Departments of Human Resources, Education and Medical Assistance to work together to address the needs of Georgia's children. During that same year, The Joseph B. Whitehead Foundation provided funding to help 95 selected Georgia communities work in partnership with the State to test new and innovative approaches to the way services were reaching children and families. These efforts have evolved over the years into 86 partnerships/Family Connection Communities engaged in collaborative planning and integrated service strategies that revolve around: community-based decisionmaking, a focus on families, an orientation toward results, intense planning, creative strategies, and an emphasis on prevention and early intervention.

Policy Council for Children and Families

In 1994, by executive order, the Governor established the interim Policy Council for Children and Families, a 21-member panel composed of: elected and appointed officials; various State agency department heads; and, community, advocacy and business leaders. This interim Policy Council issued a report in December 1994 titled: "*On Behalf of Our Children: A Framework for Improving Results.*" The basic premise of this report calls for the State to:

- Focus on mutually agreed-upon results as the measure of success;
- Implement a community-based family-focused, and prevention-oriented services strategy;
- Eliminate the policy and system barriers that interfere with achieving results;
- Invest local, State and Federal funds in a cost-effective service strategy; and,
- Authorize new governance structures with the authority and responsibility needed to make improvements for children and families.

This interim Policy Council also challenged communities to develop prevention-minded services, new approaches to systems change, creative financing, collaborative planning and local decisionmaking.

In response to the interim Policy Council's recommendations, the Governor successfully sponsored a legislative bill that established new forms of State and local governance needed to implement the new framework. This legislative bill was: *The Georgia Policy Council for Children and Families Act of 1995 (Senate Bill 256)*. This bill authorized the:

- **Georgia Policy Council for Children and Families:** A permanent, 19-member panel, composed of leaders in business, child and family advocacy, local government and religion together with State agency directors from the Departments of Human Resources, Education, Medical Assistance, Children and Youth Services and the Office of Planning and Budget. The Policy Council serves as the State's focal point for planning and results-based accountability for children and families and for supporting the development of community partnerships.

  The Policy Council is responsible for: (1) defining the core results to be achieved for children and families, (2) developing a comprehensive State plan, (3) evaluating implementation of the State plan, (4) initiating needed changes in State or Federal laws or regulations, (5) reviewing and approving strategic plans of community partnerships and agencies, and (6) providing leadership training and other training and technical assistance to communities and agencies.

- **Local Community Partnerships:** Community level partnerships designated by local government and the Policy Council to serve as the focal point at the community level for planning and improving results for children and families. These partnerships are responsible for: (1) achieving a core set of results defined by the community partnership and the Policy Council; (2) developing a comprehensive plan for public and private agencies; (3) coordinating, evaluating and providing assistance in implementing and carrying out the comprehensive plan; and, (4) contracting with public and private agencies to provide programs and services for children and families.

The Results Accountability Task Force:

In May 1995, the Governor's Policy Council commissioned a Results Accountability Task Force to: (1) establish clear benchmarks of progress that will assist communities and the State in tracking the extent to which results are being achieved, and (2) develop a framework and recommendations for how to use results and benchmarks for policy and budget decisionmaking. This 15-member Task Force was comprised of leaders from business, education, health care, human services, philanthropy, government and the community.

Benchmarking

It took the Results Accountability Task Force about 6 months to develop 26 benchmarks for the Policy Council's 5 results areas. The following process was used to develop the benchmarks:

Setting criteria for selecting benchmarks.

In the first meeting, the Results Accountability Task Force decided upon four criteria for selecting benchmarks (measures). Staff were instructed to compose a list of possible benchmarks for the Results Accountability Task Force to review based on the following criteria:

(1) Measures indicating where early intervention can prevent later problems took precedence.

(2) Measures should demonstrate a link with desired results.

(3) County-level data, updated regularly, should already exist for the measures.

(4) Measures should build on existing work with Kids Count, Council for School Performance, Savannah Youth Futures Authority and the Governor's Council for Economic Development.

Reviewing the literature and meeting with experts.

Prior to presenting the list of proposed benchmarks to the Results Accountability Task Force, staff refined the list through an extensive literature review and discussions with subject area experts. A draft of 40 benchmarks were proposed for the 5 results.

Prioritizing the Benchmarks.

The Results Accountability Task Force determined that each result would have no more than five benchmarks. They used the critical factors analysis methodology to prioritize the proposed 40 benchmarks according to the following 3 standards:

(1) Magnitude of the problem - How prevalent is the problem? How much of the State budget is affected?

(2) Seriousness of the consequences of the problem - What are the consequences of not correcting the problem? Would other problems be reduced by correcting the problem?

(3) Feasibility of correcting the problem - Can the problem be solved with existing knowledge, technology and resources?

Each Task Force member rated the 40 benchmarks using the above criteria. These ratings were then aggregated and discussed until a consensus was reached on a preliminary list no more than five benchmarks for each result.

Presenting the preliminary list for community review.

The preliminary list of benchmarks was reviewed by the directors of the Georgia 2000 communities and with participants at the Family Connection Summer Institute. Five Community Partnerships conducted focus groups to review the proposed benchmarks also using the critical factors analysis methodology.

Revising the benchmarks.

The Results Accountability Task Force met to revise the proposed benchmarks to take into consideration community comments, data collection issues and the age group affected. Ultimately, 26 benchmarks were selected.

Results-based budgeting

The Budget Accountability and Planning Act of 1993 (Senate Bill 335) provides for outcome-based budgeting, which is defined "as a process by which selected agencies will be provided more expenditure flexibility when they agree to systematically assess progress toward outcome measures." Upon completion of its first charge, benchmarking, the Results Accountability Task Force focused its energies on what a results-based accountability system would look like.

The Results Accountability Task Force reviewed various models of outcome-based budgeting, both in the private sector and that occurring in government systems across the country. The framework they recommended links results to budgets. The budgets are developed according to the likelihood that they will yield improved results for children and their families. Results-based budgeting has yet to be implemented in the State.

Sample Performance Measures

The following provides examples of two benchmarks for each of the five results:

Result 1. Healthy Children

- Reduce the percentage of children who have untreated vision, hearing or health problems at school entry.
- Reduce the pregnancy rate among school-age girls.

Result 2. Children Ready for School

- Increase the percentage of low-income students in Head Start or pre-kindergarten programs.
- Increase the percentage of students passing the Georgia Kindergarten Assessment Program.

Result 3. Children Succeeding in School

- Reduce the percentage of students who are absent 10 or more days from school annually.
- Increase the percentage of students who graduate from high school on time.

Result 4. Strong Families

- Increase the percentage of stable new families (with the first birth to a mother who has completed high school and is age 20 or older, and with the father's name recorded on the birth certificate).
- Reduce the incidence of confirmed child abuse or neglect.

Result 5. Self-sufficient Families

- Increase the percentage of welfare recipients leaving public assistance because of employment or higher incomes.
- Increase affordable, accessible, quality child care.

Management Challenges

Limited resources. The State is ever being asked to do more with less resources (e.g. to increase county participation in Community Partnerships, to increase the number of clients served, to train community partnership staff). The Policy Council does not have the resources to be there for the Community Partnerships 100 percent of the time. As a result, the Community Partnerships have begun to formally establish peer-to-peer networks and are now assisting each other. For example, staff training is one area where the networks are working together to help each other.

Lessons Learned

Involve all stakeholders from the beginning. Making this effort community based and moving quickly to engage all stakeholders in the process was critical in the development of the system.

Do not get caught up in the political rhetoric. Take the time to think about what you want to accomplish and then determine how this can be achieved in a results-based accountability framework.

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ILLINOIS

ILLINOIS

Department of Alcoholism and Substance Abuse

Overview

The Illinois Department of Alcoholism and Substance Abuse (DASA) has two efforts underway to evaluate the impact of its treatment and prevention programs. Prevention providers have been using an assessment process to also target their efforts more efficiently. An outcome-based performance measurement client survey is currently being developed for use by treatment providers.

PREVENTION PROVIDERS

Nature, Extent and Uses of Performance Measures

"Community Focused Prevention Through Risk Reduction" (CPRR) is a five-step process used by prevention providers to aid in targeting their efforts more efficiently and to help document the impact of prevention programs.

The CPRR five steps are:

1. Assess Community Risk Factors
2. Target Desired Outcomes
3. Develop and Implement Programs
4. Review Program Implementation
5. Measure Outcomes

To assess their community's risk factors, step 1, prevention providers use the Illinois Risk and Resiliency Assessment (IRRA) tool. The IRRA tool is a database of archival data from many Illinois agencies and organizations that has been collected for the 104 counties of Illinois to identify or rate what the highest risk factors are for each county. The IRRA risk factors are:

1. Availability of ATOD (alcohol, tobacco and other drugs)
2. Stresses associated with transitions and mobility
3. Unsafe neighborhoods and community disorganization
4. Parental drug use and pro-ATOD family norms
5. Early initiation of ATOD use
6. Latch-key status and unsupervised time among youth
7. Lack of family resources or supports
8. Family management problems and stressful home environments
9. Pro-ATOD media messages
10. Community laws and norms favorable toward ATOD

11. Lack of education readiness and school success
12. Lack of child/family attachment to schools
13. Developmentally and physically hazardous school environments
14. Anti-social youth behavior

Prevention providers use the IRRA data in tandem with community input (e.g. parents, teachers/schools, business owners, local organizations/groups, pastors/churches and local law enforcement) when choosing the risk factor on which they will focus their prevention efforts. Prevention providers in each of the 104 counties, Chicago's 77 neighborhoods and 177 municipalities with populations over 10,000 use the assessment tool in addition to nine protective factors which are used to help identify existing community resources. Based on the IRRA results, knowledge of their community's resources and feedback from community stakeholders, prevention providers determine which outcomes to target, step 2.

In order to develop and implement programs, step 3, providers develop and test strategies or program interventions that will lead to the desired outcomes or community changes, ensure that those strategies or interventions build on community resources, research and experience; and, finally, implement strategies and programs.

Following that, step 4, review program implementation, involves: evaluating the implementation of the strategies or programs with key stakeholders; determining the quality of implementation, customer satisfaction, resource availability and unresolved issues; and, recommending modifications for improvement.

The University of Illinois' Center for Prevention Research and Development has developed 18 outcome measurement surveys that prevention providers can administer to their clients to complete step 5 of the CPRR process. Prevention providers may also develop their own evaluative tool should they wish to do so. The University wil' provide data entry and analysis support to prevention staff when they use one of the University's 18 survey tools. The University will also provide technical assistance to those providers that cannot use one of the 18 survey tools.

Process for Developing the Performance System

The DASA has come to view "prevention" as the long-term solution to ATOD abuse. The impetus for such a philosophy began in 1986, sheparded through the State legislature by, then Illinois Speaker of the House, George Ryan. In 1986, the State legislature appropriated $12 million for DASA's ATOD prevention activities and has continued to support and fund such efforts.

During this time, a sort of "brain trust" was created involving key State officials within DASA and among academia. These ties are still strong today. Prevention efforts at this time, being activity driven, provided data based on outputs rather than results, consequently, the impact of these programs was unknown. So it was decided that a new

outcome based performance accountability program was needed, and thus was born the "Community Focused Prevention Through Risk Reduction" process.

This process was derived from more than a decade of research conducted by Drs. Catalano and Hawkins and colleagues at the University of Washington and other universities around the country and is an adaption of work performed under DASA contract by:

- Prevention First, Inc.,
- Lighthouse Institute, and
- University of Illinois Center for Prevention Research and Development.

The reasons for implementing and maintaining a performance accountability system are even more imperative in today's environment of Federal and State government cost cutting. Prevention providers are under pressure to demonstrate the impact of their programs in an environment where: (1) ATOD abuse is a central factor in crime, school dropout and workplace under-performance; (2) the public is growing increasingly frustrated at the continuing degradation of the quality of life in their communities; (3) legislators and the public are focusing more on punishment versus cost of prevention programs; and, (4) government funded programs are under intense scrutiny to demonstrate efficiency and effectiveness.

Pilot projects testing the CPRR process began in 1991, prior to implementing the new system Statewide between 1992 and 1993.

Prevention providers are aided in their efforts by the InTouch System, a statewide prevention network that offers technical assistance and training to enhance prevention efforts funded by DASA and by other sources. InTouch coordinating offices bring together community prevention activities to ensure that these efforts complement one another without unnecessary duplication.

Sample Performance Measures

The outcome measurement surveys used to assess prevention providers' programs may address one or a number of the risk factors and may be used for children, youth or adults, or any combination of the three age groups. For example, the survey tool "Attitudes and Beliefs About Alcohol," is given to adults or youth. The IRRA risk factors this survey addresses are: (1) availability of ATOD, (2) parental drug use and pro-ATOD family norms, and (3) community laws and norms favorable toward ATOD. The survey uses a Likert scale of 1 to 5 inwhich clients are asked to indicate a level of agreement or disagreement to a series of statements or indicators. Some sample indicators from this survey tool are:

- It is OK for anyone to drink if they are not driving.
- Alcohol use is a way to appear more adult.

- Youth who violate an alcohol law should be treated differently from adults who violate the same law.
- Penalties for alcohol law violations are lenient.

Data from this survey is used to determine such outcomes as an increase or decrease in:

- Pro-alcohol attitudes among adults or youth.
- Beliefs about appropriate consequences for underage alcohol use.
- Acceptability of underage alcohol use.
- Beliefs regarding individual and community responsibility for preventing underage alcohol use.

This information would indeed have relevance for prevention providers, community leaders and other policymakers alike.

Management Challenges

The State faces the following primary challenges in using performance measures for its prevention providers.

Measurement philosophy. The concept of outcome performance measurement is new for almost all prevention providers. And, the learning curve involved in understanding the system takes time.

Provider understaffing. Currently, most of Illinois' prevention providers are not yet ready to produce outcomes. Many community prevention providers are staffed by just 1 or 2 people, who usually do not have a degree in the prevention area and must learn the job more or less on their own. Also, most have not been formally educated in evaluative techniques or sampling methodologies. Further complicating the readiness of prevention providers to produce results is a 25 percent staff turnover rate.

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TREATMENT PROVIDERS

Nature, Extent, and Uses of Performance Measures

The Illinois DASA has been working on the development of an outcome-based performance measurement survey for ATOD treatment providers. The survey will be client focused and used to help assess the impact of the treatment provider's program on ATOD abusers. Scheduled to begin in July 1997, providers will administer surveys to clients upon admission to a treatment site and when the client leaves a treatment site.

The primary user of the survey data is the State. Providers will transmit the raw survey data to DASA who will use it, along with other quantitative and qualitative data already being collected. This will give the State global oversight of the myriad services DASA clients receive and will be able to better assess the impact of treatment providers' programs.

The State is depending on providers to administer the survey, collect and report back the data in an unbiased manner. Providers will use a standard script or questionnaire. The DASA plans to conduct random field audits to check the accuracy and reliability of the data. In addition, DASA has hired a private consultant to conduct random surveys of clients 6 months after they have been treated. As a means of facilitating these client surveys, provider contracts include the stipulation that they must participate in this study.

Process for Developing the Performance Systems

The impetus for this new assessment program was the passage of State legislation (about 2 years ago) that called for the State's departments to conduct a yearly assessment of the impact of their programs. In an era of cost cutting, government downsizing and limited budgets, legislators wanted more definitive information about the effectiveness of State programs to help them decide where funds should be allocated.

Currently, there are about 200 corporations offering 600 ATOD treatment programs throughout Illinois. Most have been under State contract for many years, some since the 1950s. State officials met with 400 providers, 5 focus groups and 75 organizations (including advocacy groups) to both inform and solicit comment about the new outcome-based performance measurement program, and the outcome measures and survey instruments. The DASA's performance measurements (data) were developed in-house by DASA, though treatment providers ultimately agreed upon the script to be used for the client interview survey.

However, treatment providers have not been as receptive to this new process as the State would have liked. Providers have expressed concern with meeting standardized performance measures. They believe that there will be factors beyond their control that may negatively impact the success of their treatment program(s). And, they fear the DASA may not take these factors into consideration when evaluating their performance.

Sample Performance Measures

The scripted client interview survey will be used by the DASA to help assess the impact of treatment providers' programs. These surveys may also be client self-administered. The surveys will provide outcome baseline data from all clients upon admission (except those under age 18 or undergoing detox) and outcome follow-up data from all clients when they are discharged from the treatment program.

The scripted survey, still in draft, currently consists of about 23 questions or indicators. The indicators ask for personal information about the client's: alcohol and drug use; family, education, health and mental health, financial and employment status; health care utilization; living arrangements; and, interaction within the criminal justice system. Some examples of the indicators are:

- How old were you the first time you tried alcohol or drugs?

- Which item from the following list best describes your current status with the legal system?

  - Not currently involved with the criminal justice system
  - In jail or prison
  - On probation
  - On parole

Treatment providers already collect client demographic data (e.g. name, address, age, gender, race, referral source) and payment and eligibility data (e.g. family income and size, insurance coverage) from all clients upon admission into their treatment programs. In addition, a clinician or counselor must conduct a clinical assessment of the client upon admission.

Management Challenges

Although this system will not be implemented until July 1997, officials have found several aspects of the process, to date, to be particularly important.

Provider acceptance of new process. The DASA has found that the concept of evaluation through results versus outputs is so foreign to many providers and even some State officials, that informational meetings early on with stakeholders, about the new process and outcome measures, were indispensable in the development of the survey interview script. However, today (1 1/2 years into the development of the performance system) DASA still does not have full provider buyin. In hindsight, the DASA believes they should have developed the performance system in house but then spent more time soliciting feedback on how the process should work.

Management information system. The DASA has come to believe that the management information system is the most critical element in a results-based performance

measurement system. Unlike its own system, it should be an online, user-friendly system with language that works in modules so that changes can be processed without undue down-time. Also, minimum data entry and coding standards should be established at the outset, provider staff trained in these standards and field tests should be conducted prior to implementation. The DASA has found that there is a need to involve other State departments' in the development of the management information system and data collection process, as well, so that various department data systems can interface.

Training provider staff. Some of the data DASA receives from its treatment providers is unreliable. Generally, this occurs because of differences in interpretation of the data or data entry errors. Officials commented that, to minimize this error, they would require that each piece of data be individually confirmed.

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MASSACHUSETTS

MASSACHUSETTS

Youth Programs Prevention Services
Bureau of Substance Abuse Services

Department of Public Health

Overview

The Massachusetts Department of Public Health is moving to develop results-based accountability systems across its many programs. This effort is consistent with the Commonwealth's interest in moving all State agencies in this direction.

During the past year, the Prevention Unit of the Bureau of Substance Abuse Services initiated a process to develop outcome measures for its Youth Programs. As such, it is among the first of the Department's programs to begin outcomes planning. The Bureau's initiative is currently known as the Pilot Outcome Project (POP). It is the first phase of a larger effort to implement outcomes systems for all its Youth Programs.

The Pilot Outcome Program presently involves 18 local program sites among the Bureau's 50 Youth Programs. The Bureau contracts with these local programs, which focus on substance abuse prevention services directed to youth in high-risk environments. The programs provide services primarily in the areas of youth development, student assistance, court diversion, or street outreach.

Nature, Extent, and Uses of Performance Measures

The Bureau notes that using outcome measures for assessing the performance of prevention programs poses particular difficulties. The development of reliable models and valid ways of measuring results is in its infancy and therefore is not well established.

The Bureau is focusing on the use of intermediate outcomes, defined as "...a specific proposed program result relating to a risk or protective factor for substance abuse...[it] should relate to your overall program goal of reducing the percentage of youth who engage in the use of alcohol and other drugs. The outcome does not need to be a large part of your activities; it may represent a piece of your plans."[3]

The Bureau has distributed to all programs a menu of standardized outcome measures used in substance abuse prevention programs by other States and by academic researchers. These measures focus on community as well as individual factors. In addition, the Bureau plans to draw on outcomes materials being prepared by the Federal Government as soon as they become available.

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[3] Kathleen Herr-Zaya and Homer Rahn-Lopez, Memorandum to Executive Director and BSAS Youth Program Director, "Requirements and Highly Recommended Outcomes Planning," May 30, 1996, 1.

The Bureau is allowing the sites to develop and/or choose a measure of their own; they need not select from the Bureau's menu. It also is allowing sites considerable latitude to determine approaches to measure their performance in achieving the outcome. Among the approaches are: standardized surveys and questionnaires, problem-solving scenarios for youth that are presented both pre- and post-intervention, focus groups, and interviews with youths' parents.

The Bureau is encouraging the pilot sites to use this outcome process to improve their programs. In its communications with the Youth Programs, it has emphasized the importance of the process for identifying the most effective program activities and for demonstrating the value of prevention efforts from a broad perspective. While not holding the sites accountable for results during the pilot phase, the Bureau has communicated its intention to use the outcomes data to monitor program performance and that "eventually programs' demonstrated ability to achieve outcomes may strengthen their funding requests."[4]

Process for Developing the Performance Systems

The impetus for the specific POP initiative derived largely from the Director and staff of the Bureau's Prevention Unit. Work began in early 1996. By year's end, the 18 participating sites had been selected and the process of identifying outcome measures for each was well underway.

The primary actors in the process have included the Bureau's Prevention Unit staff, a private research firm that contracts with the Bureau, and providers from the local prevention projects. The process involved several major steps:

Seeking Input from Other States

Early on, the Bureau staff participated in a regional meeting of States, convened by the Federal Center for Substance Abuse Prevention, to share their experiences in developing outcome measurement systems and information on research tools for measuring outcomes in prevention settings.

Collaborating Closely with the Research Community

The Bureau's research contractor has played a central role in the process of developing measures, defining the strategy for implementation of the system, and working with both the Unit staff and the providers during this pilot phase.

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[4] Herr-Zaya and Rahn-Lopez, May 30, 1996.

Involving Local Youth Programs Directors

Staff from the community-based Youth Programs projects have been involved from the beginning of the process. Some are members of the Unit's Youth Programs Outcome Committee, which spun off from a larger advisory group to the Bureau. It focused on developing a menu of outcome measures for the prevention programs.

All Youth Programs Directors were surveyed for input into the measures development process. In mid-summer 1996, they were invited to participate in a day-long training and orientation session to become familiar with outcomes planning. The Bureau's orientation session included discussion of the potential benefits as well as costs, requirements, and responsibilities associated with being a pilot site.

Program sites interested in participating were asked to volunteer. In so doing, the Bureau asked each to agree to certain responsibilities, such as regular data collection and attendance at various POP-related meetings.

Implementing the Pilot

The site application and selection processes occurred during August 1996. The Bureau sought balance among the pilot sites in terms of geographic location, size, and type of program. Important to the Bureau, too, was the willingness of each site to share its experiences during the Pilot with other Youth Programs.

Eighteen sites volunteered. The Bureau divided them into two groups. Eight sites, those assigned to the Individual Technical Assistance (ITA) group, receive individual technical assistance from the Bureau's research consultant. The 10 other sites, assigned to the Group Technical Assistance (GTA) group, work with the quality improvement sub-unit of the contractor.

During the fall of 1996, the sites began working with their respective groups to identify and select appropriate outcome measures. The two groups are operating somewhat differently at present. A primary difference is that each ITA site selects its own specific outcome measure(s); the GTA sites are working to develop a common outcome measure to be used.

Sample Performance Measures

The Bureau distributed to the Youth Programs a menu of options for outcomes measurement related to alcohol, tobacco, and other drug use. It included some used by the Illinois Department of Alcoholism and Substance Abuse and the Institute for Prevention Research, Cornell Medical Center. These measures are derived from surveys of children and youth that focus on topics such as substance use, coping and problem solving skills, attitudes about substance use, and sense of community.

The Bureau-sponsored school survey questions can be used to address substance availability and frequency of use over time. For example, one section of the survey asks about use of drugs other than alcohol:[5]

How often have you used psychedelics LSD, mescaline, PCP)?

	TIMES						
	Never	1-2	3-5	6-9	10-19	20-39	40+
In your lifetime (ever).	A	B	C	D	E	F	G
During the last 12 months (past year).	A	B	C	D	E	F	G
During the last 30 days (past month)	A	B	C	D	E	F	G

Management Challenges

Among the challenges facing the Bureau, as it proceeds with its implementation of the Pilot and subsequently the expansion of the system to other Youth Programs, are:

Defining outcomes measures for prevention programs. Outcome measures need to be valid and consistent across programs; they need to reflect outcomes for individuals but also ideally to address the programs' basic prevention activities in the community.

Planning to involve programs in data collection and analysis issues. Plans are being developed to address the different levels of technological sophistication among the program sites, and changing attitudes and practices towards using data as tools for program improvement; and to identify resources for supporting data collection and computer analysis.

Expanding the Pilot Outcome Project to additional Youth Programs sites. The Pilot Outcome Project is regularly informing the non-pilot sites of the progress of the project. Also, the lessons learned from the ITA and GTA sites are being documented, while the project is exploring methods for effectively using pilot sites to assist new sites and for developing more formal systems.

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[5] Commonwealth of Massachusetts, Department of Public Health, "Tobacco, Alcohol, and Other Drug Use Survey," prepared by Health and Addiction Research, Inc., 3-5.

Lessons Learned

Bureau staff recognize they are in the early phases of a long-term process, but think these beginnings have been positive and augurs well for the future. They consider several aspects of the process to have been particularly important. For example:

The process has been inclusive. Local programs have been involved from the beginning in the initiative. They have had multiple opportunities for input along the way and have had maximum discretion in deciding whether to participate in the pilot and which outcomes measures to adopt. The Bureau included in the Pilot all sites that had expressed interest in participating. Bureau staff think including input from other States and from the research community has been particularly valuable.

The process has been a partnership. From the beginning, the Bureau has assigned high priority to making the initiative meaningful and non-threatening to participants. The Pilot is conceptualized and discussed largely as an effort to help improve programs. The initiative is separate from the sites' contracts with the Bureau. The sites are not being held accountable for results during the Pilot.

Participation in the Pilot was encouraged, but voluntary. The Bureau pursued several strategies for educating its Youth Programs about the initiative. It conducted mailings and meetings, and identified and publicized the potential benefits, costs and the responsibilities associated with participation in the Pilot. Ultimately, each program decided for itself whether to participate.

The initiative is being planned and implemented incrementally. The chances of success are maximized by beginning with several pilot sites, each of which adopts only one or two outcomes measures. This allows for learning throughout the process.

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MASSACHUSETTS

Department of Mental Health

Overview

The Massachusetts Department of Mental Health contracts with local provider agencies to deliver a majority of its service programs. Its Area Offices, with their citizen advisory boards, both negotiate with, and monitor, inpatient and community-based services providers. The Department uses a system of results-oriented performance measures with its local providers of services.[6]

Nature, Extent, and Uses of Performance Measures

Since 1992, the Department has been engaged in an intensive process to develop and implement standards and performance indicators for the services provided by its contractors.

The process is complete for emergency, residential, respite, day programs such as clubhouses, rehabilitation, partial hospitalization, and some inpatient services for adults, children, and adolescents. Standards and indicators for other inpatient and outpatient services are currently being developed.

The overall objective is to improve providers' performance through a process that articulates expectations and identifies standards for each type of service that apply to all contractors. The process also involves developing performance indicators (of both process and outcome) and, as appropriate, clinical indicators.

These standards and their performance indicators are incorporated into the Requests-for-Proposals made available by the Department to potential vendors. Eventually, the standards and indicators are incorporated into the contracts the Department negotiates with the service providers. The Area Offices work with their providers to establish specific targets that become terms of the provider's contract.

The Department expects that, ultimately, these data will be useful in helping the providers monitor their own performance. The Area Offices, and their citizen advisory boards, are beginning to use these data in monitoring contractor performance, e.g. identifying gaps in service and areas of less than satisfactory performance and in reviewing and awarding contracts. Although the Area Offices aggregate the data from providers in their areas, they do not routinely provide the data to the Department's central office.

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[6] The Department also has Department-wide objectives, measures, and outputs for which it prepares quarterly reports to the Legislature. It also has defined objectives and indicators for its annual community mental health services block grant plan and progress report for the U.S. Department of Health and Human Services.

Process for Developing the Performance Systems

The impetus for developing program standards and performance indicators to be used Statewide for all the Department's programs originated largely with the appointment of a new Commissioner in 1991. She and her top staff were committed to this effort during her almost 5-year tenure, during which time the process became institutionalized. The commitment to monitoring provider performance continues under the current Commissioner, who was appointed in February 1996.

Developing the standards and indicators for each type of service has been a time-consuming, resource intensive, broadly-based effort. Because all contracts for a given type of program (e.g. respite or residential services) are bid during a particular year, the Department anticipates each program cycle and engages the process before the contracts for each type of service are re-bid for their 5-year contract periods.

Developing standards and indicators for residential services, the largest undertaking so far, involved participation of Department staff, providers, consumers, and family members. The Department used focus groups to solicit feedback from these stakeholders on draft proposals it had initially prepared. The Department then considered the recommendations of the stakeholders as it modified the drafts. Final drafts were ultimately reviewed by a senior Department policy group before being approved by the Commissioner for implementation.

Sample Performance Measures

The Department has published its program standards and indicators for emergency services in a 28-page document that includes: (1) an overview defining psychiatric crises and describing emergency programs; (2) the clinical and programmatic standards for emergency programs and crisis stabilization; (3) the performance indicators; and, (4) sections on definitions of, and qualifications for, professional staff and guidelines for working with deaf and hard-of-hearing clients. Examples of performance indicators for the emergency programs include:[7]

STANDARD: Emergency Program services are provided in the least restrictive, clinically appropriate setting using the least intrusive interventions. The Program has the ability to triage, assess, and make appropriate clinical disposition decisions, including the capacity to access inpatient services or less restrictive alternatives.

Indicator 1: Percent of individuals evaluated and hospitalized.

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[7] Massachusetts Department of Mental Health, "Emergency Program Standards," approved 8/6/96.

Formula: Number of individuals hospitalized who meet the DMH clinical criteria for inpatient admission.

Total number of hospitalizations after evaluation by the emergency screening team.

Indicator 2: Percent of individuals evaluated and appropriately admitted to the crisis stabilization unit.

Formula: Number of individuals admitted to the crisis stabilization unit who meet the DMH clinical criteria for crisis stabilization services admission.

Total number of admissions to the crisis stabilization unit after evaluation by the emergency screening team.

STANDARD: When a face-to-face evaluation is clinically indicated, the face to face evaluation begins within one hour of initial contact.

Indicator 1: When a face-to-face evaluation is clinically indicated, the face-to-face evaluation begins within one hour of initial contact.

Formula: Number of evaluations that were begun within one hour of referral.

Total number of face-to-face evaluations.

Management Challenges

The Department staff describe data-related issues as their most significant challenge. The contractors have primary responsibility for data collection and reporting in this system. Issues of data availability and validity, consensus on which data to collect and how to collect them, definitions of terms, and changes to the contractors' systems for collection have been significant. Other complicating factors include orienting contractors new to the system and continually changing the contractors' data collection systems due to the inevitable changes to the indicators themselves.

Another major challenge facing the Departmart will be changing contractors' orientation from one of simply collecting data to one of using data to improve their performance.

Lessons Learned

The Department identified several factors important to its progress to date in developing results-based accountability systems. These include:

- gaining sustained commitment from the Department's top leadership;

- developing partnerships and relationships with a wide range of stakeholders both inside and outside government; and,

- developing, for each of its programs, standards of care as well as performance indicators.

The Department recognizes that achieving consensus from a broad spectrum of stakeholders on the standards and indicators has been a time-consuming process. It recommends that other States may benefit from establishing definite timelines for decisionmaking and clearly defining the steps and responsibilities in the process.

For Further Information

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MINNESOTA

MINNESOTA

State Public Health Goals

Minnesota Department of Health

Overview

Minnesota's Public Health Goals provide an overall framework for the many entities that are working to improve the public health. Organizations (e.g. health plans and medical providers) are encouraged to examine the goals to determine how they can contribute to the achievement of selected goals and objectives.

Nature, Extent, and Uses of Performance Measures

Since the early 1980's, Minnesota's community health service districts have been statutorily required to develop comprehensive health services plans every 4 years. However, with the advent of State health reform and a push towards managed care, the need for Statewide, comprehensive public health goals as an overall framework to guide these activities soon became evident. Minnesota's 1995 Public Health Goals are "...intended to provide a common direction for the many entities that are working to improve the public's health... . [and] It is hoped...will stimulate and encourage further voluntary efforts toward the development of healthy communities."

Each of the 17 public health goals (including 3 system development or infrastructure goals) has one or more objectives that were selected to serve as indicators of progress toward the goals over time. Some of the objectives were chosen, in part, based on the availability of baseline data; some currently have no baseline data available.

The intended use of the data is to see what public health improvements have been accomplished over time. The data will not be used for compliance purposes. Rather, the State hopes that stakeholders (e.g. health plans, providers and private insurers) will use this data to voluntarily initiate program improvements.

Process for Developing the Performance Systems

Development of the State's public health goals was coordinated through the Minnesota Department of Health. The process for developing these goals builds upon the mission and strategy laid out in "*Minnesota Milestones*," the Governor's initiative to develop a long-range plan based on Minnesotans' vision for their State. This strategic planning document draws upon the work done by the State of Oregon in setting benchmarks and encompasses all of Minnesota's State agencies. The Federal *Healthy People 2000* goals were also canvassed by the Department of Health for inclusion in the State's public health goals. Input on the proposed public health goals was then sought from public health agencies, medical care providers, health plan companies, voluntary organizations,

private insurers, academia and Regional Coordinating Boards. In 1994, Regional Coordinating Boards were statutorily established to serve as forums for the discussion and identification of those public health goals that are amenable to efforts by health plan companies and medical care providers. A draft of the goals was also sent to over 700 individuals and organizations, including consumer and advocacy groups, for comment.

Sample Performance Measures

Each of the public health goals has one or more objectives that were selected to serve as indicators of progress toward the goals over time. In the following goal example, one objective for each of the four subject areas within GOAL 1 is shown:

GOAL 1: Encourage and support community norms, practices, and policies that will reduce the behavioral risks for chronic diseases and minimize the impact of chronic disease and disability when it occurs.

OBJECTIVES (by the year 2000):

Tobacco Use

1.1 Reduce the percentage of adults who smoke from 22.5 percent to 15 percent. (Information will be received from the Behavioral Risk Factor Surveillance System [BRFSS], 1993.)

Physical Activity

1.8 Increase the percentage of children and adolescents reporting moderate daily physical activity to at least 50 percent. (No Minnesota baseline data available.)

Alcohol Use

1.9 Reduce from 41 percent to 35 percent the proportion of high school seniors who have used alcohol at least once a month for the past 12 months. (Information will be received from the Minnesota Student Survey, 1992.)

Nutrition

1.12 Increase the percentage of people 18 years and older who report consuming five or more servings of fruits and vegetables daily. (BRFSS, 1994.)

Management Challenges

Development of data systems. The State believes that: "Ultimately, limited resources must be prioritized and allocated to those activities that have the greatest impact on improving or maintaining the health status of the population." The development of systems to collect reliable and current health data has been identified as a critical need in

the Minnesota Public Health Goals document. Currently, the State has data for between 50 and 80 percent of the goals. The data systems needed to develop and manage this effort will be an ongoing challenge for the State. At this point, the Department of Health is working on strengthening the data sets they already have in place (e.g. looking at more disease registration and specific morbidities). The Department of Health is also reviewing what data is available and the resources needed to acquire it.

Timeliness of data. With a lag time of 1 to 2 years (data due in January 1997 represented data for January 1995), timeliness of the data is a great challenge to the State. Providers submit their data to the State and then to the counties. Once the State receives the data, it must then: (1) code the data, (2) put the data in a uniform standard, (3) send the data back to the provider to verify its correctness, (4) make any coding changes to the data based on provider comments, (5) input the data, and ultimately (6) analyze the data.

Lessons Learned

The Department of Health identified several aspects of the process to date that have been particularly relevant in developing results-based public health goals.

The State received less stakeholder feedback on the proposed public health goals than expected. Stakeholder's lack of response may have been the result of a relatively passive process whereby stakeholder comments were solicited after the goals had been chosen by the State. Another reason may be that some stakeholders may not have seen the need to comment on goals that they are not mandated to meet. In hope of achieving greater stakeholder "ownership" of the public health goals, the State plans to be more proactive in the future and include stakeholders at the beginning of the process when it reassesses the public health goals in 1998-1999.

Resources (funding for staff, hardware and software) and time must be committed for the research, development and maintenance of a management information system to ensure an effective results-based accountability system.

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NEBRASKA

NEBRASKA

Nebraska Partnership for Health and Human Services

Overview

The State of Nebraska has initiated an ambitious project in which, within 1 year's time, a complete reorganization of State health functions will have been designed and implemented. As part of this effort, a performance accountability system has been developed to identify outcomes, outcome indicators and performance measures for programs supported by the new Health and Human Services organization.

Nature, Extent and Uses of Performance Measures

The mission of the Nebraska Partnership for Health and Human Services is:

> To create and sustain a unified, accessible, caring and competent health and human services system for each Nebraskan that **maximizes local determination to achieve measurable outcomes** [emphasis added]. To this end, the state will work in partnership with communities and their public and private sector entities.[8]

Exhibit 1, on the next page, outlines the relationships between outcomes, indicators, performance measures, analysis, and systems or strategies, for performance accountability proposed for the Nebraska Partnership. Nineteen outcomes have been developed thus far. A series of possible indicators have also been developed, which are expected to be refined by agency professional staff based on data availability (meaning that data is now available, or could be made available). Performance measures, which focus on efficiency, quality and effectiveness and more directly relate to system or strategy under scrutiny, will be customized for each program or strategy. In order to apply the data to improve programs and interventions, analysis of data from the "outer loop," or systems level, together with data from the "inner loop," or program level, would occur. This allows for evaluation, interpretation and understanding of the system and program interactions and dynamics within a larger context.

According to the implementation plan, the Performance Accountability Team (PAT) will consist of members from all three HHS agencies, reporting to the Director of Regulation and Licensure. Other members from programs, the community and technical side are brought in as necessary. The Community/State Support and Technical Assistance Team (TA Team) works closely with communities to develop capacities, as well as providing leadership for the feedback, analysis and evaluation of the data obtained. The PAT drives much of the development and recommendation of measures, as well as analysis of the data obtained.

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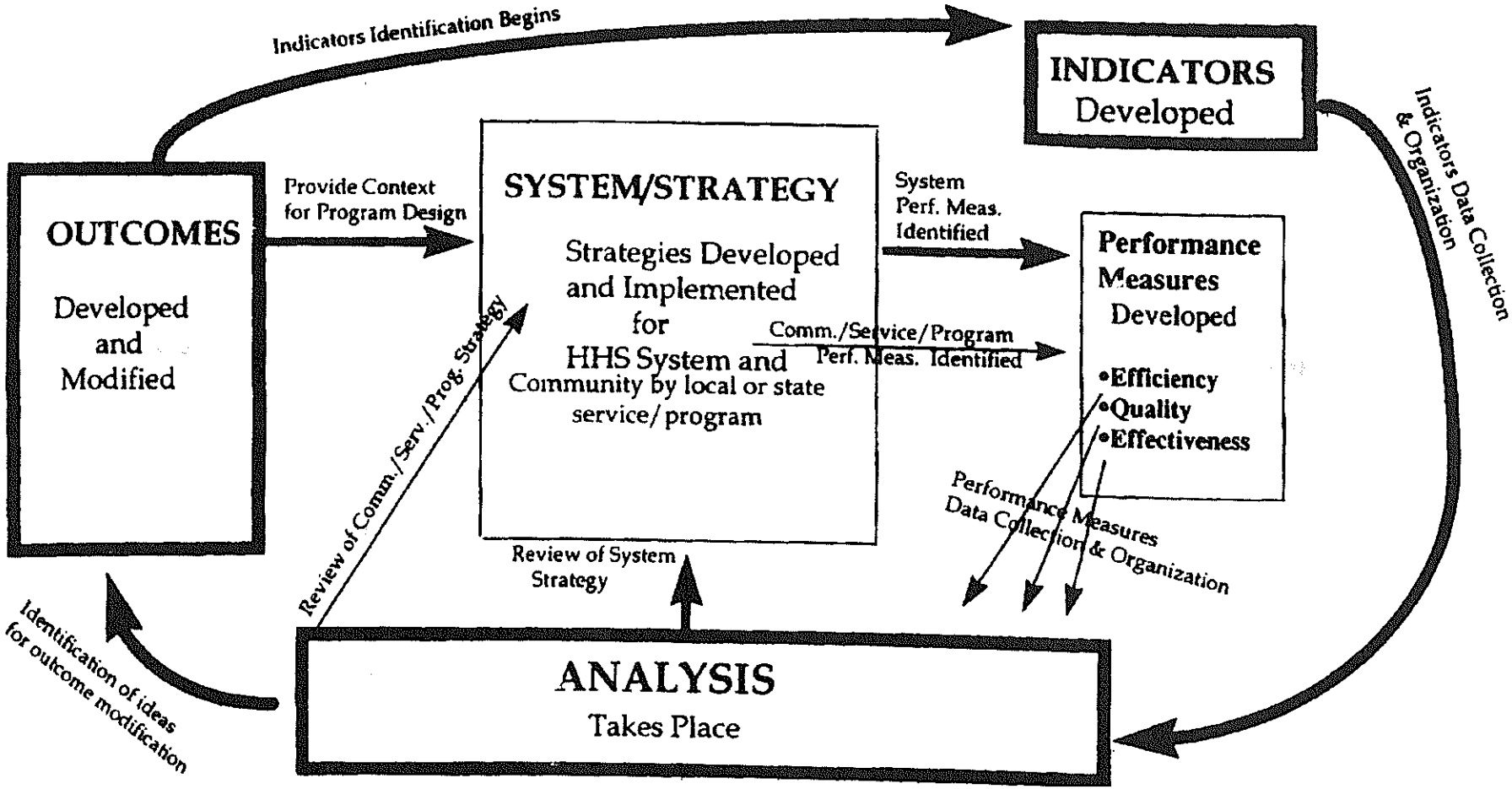
[8] Nebraska Partnership Project, "Unified Health and Human Services for Nebraska's Future: A Blueprint for Action," 1995.

PERFORMANCE ACCOUNTABILITY SYSTEM **

The Mission and Vision are considered throughout the Performance Accountability System

Stakeholders have a valuable role at each point in the Performance Accountability System and will be consulted thoughout



**Cite: Nebraska Partnership for Health and Human Services

Exhibit 1

To develop outcomes, PAT collaborates with communities and organizations to develop recommendations, and makes recommendations to the Partnership Council, which then makes recommendations to the Policy Cabinet. To develop indicators, PAT works with TA Team and community workteams, and reviews literature to develop recommendations for indicators. It then solicits feedback from the Partnership Council for feedback; identifies data needs, requirements, availability; and takes recommendations to the Policy Cabinet. To develop performance measures, PAT collaborates with TA Team, providers, program, customers, and communities (using, in part, focus groups). To support program leaders and staff in the analysis of data, PAT relies on assistance of information systems experts and the TA Team. The analysis includes indicator and performance measurement data as well as consideration of external variables and feeds information back to the system.

While this system is not yet in place, Nebraska is in part basing this system on its experience with strategic management of public health. The Nebraska Department of Health issued a report in May 1996 entitled, "*Strategic Plan for Public Health for Fiscal Years 1998-1999,*" which outlined a series of outcome measures and indicators, many of which are based on *Nebraska Year 2000 Objectives*, patterned after *Healthy People 2000.*

Process for Developing Performance Systems

The genesis of Nebraska's Partnership for Health and Human Services was an executive order signed by Governor Benjamin Nelson in January 1995. Executive Order 95-2 instructed Lieutenant Governor Kim Robak to carry out a review of the State's health services infrastructure, processes and goals and determine ways in which to increase State capacity.

The task force determined that current organizational configurations stood in the way of a unified, results oriented approach. Legislation was prepared for introduction in January 1996 which would sunset five separate agencies in 1997--the Department of Aging, the Department of Health, the Department of Public Institutions, Department of Social Services and Office of Juvenile Services--and establish in their stead:

- a Health and Human Services Policy Cabinet with responsibility for strategic planning, budgeting and allocation, and evaluation;

- a Health and Human Services Partnership Council, an advisory group to assess achievement and communicate with the community; and,

- three new agencies focused on function rather than population (services delivery, regulation and licensure, and finance and support).

As part of the reorganization plan, communication strategies with stakeholder groups were identified. Among other things, employee feedback was solicited and analyzed. Citizen/community input was obtained through public forums and meetings. A newsletter was distributed to approximately 17,000 individuals on a State mailing list, every 3 to 4

weeks, reporting on progress. A web site on the reorganization experienced about 400 visits a month.

In April 1996, a performance accountability work group was convened and identified four tasks for itself to accomplish by November 1996 to: (1) develop a system of performance accountability, (2) develop a starting list of outcomes desired by program interventions, (3) develop a starting list of indicators for those outcomes, and (4) develop a focus for performance measures. Work teams were established to accomplish these tasks.

The performance accountability work group was co-chaired by a State employee and stakeholder (a beneficiary advocate). This work group, as well as the work teams, were composed of strangers, from a variety of different private or public sector backgrounds, with expertise and experience in a variety of different areas.

With such an imposing task and with no preexisting relationships to use as a foundation, the steering committee relied heavily on facilitative leadership to ensure constructive and productive conversations. The group spent time developing a set of principles to guide their discussions together and the tasks they were assigned. The committee, and all three work groups, were each assigned a team leader, facilitator, and support staff.

To develop a performance accountability system, the committee members first attempted to obtain information from recent research literature, other States, and the agencies which were being reorganized to form the Department of Health. Committee members found helpful the work of several academics and writers in the field, who provided them advice. The team found no useful models to follow within the Nebraska State agencies they examined.

Work team members focused on outcomes went through an iterative process, using the community and employee forums at which the reorganization of health functions was also discussed, to generate discussion and input on outcomes. Based on a series of initial forums, the work team formed an initial list of 80 outcome statements. The list of 80 was shared at four new community and four employee sessions, for reaction, consolidation and categorization, and priority setting. The team is now in the final stages of testing 19 outcome statements, along with suggested indicators for each outcome statement, as their final product.

Work group members agreed that the performance accountability system they wanted to develop would have a number of different characteristics:

- It would not be a rule based performance accountability system. It would have to apply throughout the organization, from the top down.
- It would be simple.
- It would be efficient.
- It would be cost effective.
- It would encourage accountability.

- It would address the two key issues of lack of stakeholder confidence in programs, and limited or declining resources available for programs, by providing measurable, objective feedback on the results achieved and the use of those resources.
- It would renew itself as a dynamic system, rather than a static model.

Sample Measures

As discussed above, new tiers of measures will be put in place by the new system: outcome level goals and indicators, and performance level goals and indicators. For example, a series of outcome level goals and indicators have been drafted for various "cluster areas." A partial listing of outcomes and suggested indicators in the cluster area, Health and Well Being are:

Outcome: ***Nebraska residents are free from preventable disease.***

Indicators: (incidence of sexually transmitted disease, HIV infection, cardiovascular disease, cancer, type II diabetes, vaccine preventable disease, tobacco related deaths)

Outcome: ***Nebraska residents are free from substance abuse.***

Indicators: (percent of teens who report binge drinking, percent of adults who report binge drinking, percent of teens who report substance abuse, percent of adults who report substance abuse, percent of teens using tobacco, percent of adults using tobacco, number of deaths and injuries related to alcohol use, number of deaths and injuries related to substance abuse)

Outcome: ***Nebraska residents do not experience death, disease or injury related to lack of appropriate treatment.***

Indicators: (percent of residents who reside in medically underserved areas, percent of deaths due to lack of emergency treatment)

Performance measures will be developed on a program by program basis.

Management Challenges

Once implemented, officials we interviewed believe the success of the system will rely heavily on several key factors: (1) the constitution and competence of the performance accountability team (including its support from departmental leadership), which would facilitate efforts on performance reporting; (2) the availability of needed data; and, (3) the investment in analysis and evaluation capability.

Team participants believe that it will take another 2 1/2 years for everyone within the Department to be in the performance accountability system, at some point in the cycle.

A series of initial pilot programs to enter the cycle have been identified and should be underway by early 1997.

Among the most significant future challenges:

Improved information systems. Data is currently available for about half of the indicators identified to date. The development of improved data systems will take both money and time.

Sufficient staff for analysis. The commitment to, and investment in, analysis is critical for the proper interpretation of data and the use of data for program improvement and reform.

Proper use of data on indicators. The developers of the performance accountability system do not intend that indicators be viewed in isolation. Factors external to Health and Human Services interventions often impact the indicators. They argue that, in order to interpret such data, one must also review data from other sources and assess the impact of factors outside the system upon the indicators. The system is designed to protect against the isolated use of indicator data by including performance measures and context analysis; but, as one representative said to us, "We know there may be political considerations which impact this system."

Lessons Learned

The representatives we spoke to about the development of the performance accountability system were mixed in their assessment of the short timeframe in which they had to complete their work. "I can't tell you what a tornado this felt like," said one official. Nonetheless, the timeframe to which so much else was tied was never renegotiated by any party, and no motion was made to attempt a renegotiation. The timeframe might have helped to concentrate the attention of the work group and work team members, but combined with the reorganization being planned at the same time, it caused problems for team members in a number of different ways. Team members were often in too many meetings. Plans were in flux because of parallel processes and developments affecting performance accountability occurring in other reorganization teams. And team members still struggle with a persistent fear that some of the buyin to the performance accountability system was superficial and that key stakeholders were too distracted by other reorganization issues to pay close attention to, and reflect thoughtfully on, their efforts.

Nonetheless, the participants in the performance accountability work group believe that they were remarkably successful in forging consensus among their members. They point to several factors contributing to their success: (1) a strong facilitator; (2) a shared (among a third or so) grounding of the work group members in facilitative leadership; (3) implementation of facilitative leadership principles, [such as "going slow to go fast", agreeing on ground rules, balancing the building of relationships with content]; (4) stable

membership of the team; and, (5) a single sponsor. Reorganization teams without such characteristics, these members believed, were not as successful.

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NEW YORK

NEW YORK

Department of Public Health

Overview

In the past year, the New York State Department of Public Health has initiated a process to develop results-based accountability systems for its Statewide public health programs. As a first step, it initiated a comprehensive review process that identified 12 public health areas of high priority for future action. Each priority area has measurable objectives to guide State and community actions for improving the health of New Yorkers.

Nature, Extent, and Uses of Performance Measures

The Department recently completed work on a year-long effort to identify goals and measurable objectives for high priority areas of opportunity to improve the health of New Yorkers. This review process culminated in the publication of "*Communities Working Together for a Healthier New York*" in September 1996. This report, directed to local communities, focuses on prevention. It establishes priority areas for action over the next 10 years. This priority-setting was the first step of a long-term process to improve public health through partnerships among State programs and communities, guided by specific, quantifiable objectives for measuring progress along the way.

Rather than focusing on health problems directly, the process emphasized the causes of poor health and other adverse outcomes. It also searched for effective interventions appropriate for both communities and individuals. From this process, according to the report, emerged:

> Twelve priority areas of opportunity for public health action (listed alphabetically, not by importance): (1) access to, and delivery of, health care; (2) education; (3) healthy births; (4) mental health; (5) nutrition; (6) physical activity; (7) safe and healthy work environment; (8) sexual activity; (9) substance abuse, alcohol and other drugs; (10) tobacco use; (11) unintentional injury; and, (12) violent and abusive behavior.[9]

The report describes at least one quantifiable objective (and, where available, baseline data and references) to be achieved over the next 10 years for each of the 12 priority areas.

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[9] New York State Public Health Council, *Communities Working Together for a Healthier New York: Opportunities to Improve the Health of New Yorkers,* September 1996, 1.

Process for Developing the Performance Measures

A new Commissioner was appointed to head the New York State Department of Health in mid-1995. She immediately sought a review of the Department's health goals and priorities with a view to developing a comprehensive plan for action.

Building on a model she had implemented in another State, the Commissioner wanted the review process to be public, community focused, holistic, and one that would identify key areas of opportunity for the Department in the years ahead. The effort was to be grounded in the Department's ongoing emphasis on using the *Healthy People 2000* objectives for its individual program areas, particularly programs supported with Preventive Health and Health Services block grant funds, as required by the Federal Department of Health and Human Services.

The review and priority-setting process included several major steps:

Broadening Support at the Top

Early on, the Department involved the State's Public Health Council, a statutory body that advises the Commissioner and performs certain regulatory functions, such as approving certificates of need. The Council became a key partner for the Department. It guided the overall process of establishing goals, objectives and indicators for high priority public health needs.

The Council, in turn, created a Public Health Priorities Committee to focus exclusively on directing the effort and producing a plan for action. Its 19 members represented State and local government, academia, business, unions, providers, and consumers. The Committee relied on the Department of Health to provide staffing and other services to support the task.

Clarifying Purpose, Scope, and Ground Rules

The Committee established a series of understandings about the nature of its task. They included:

- The foundation of the new plan would be the national *Healthy People 2000* objectives. But these would be reexamined and possibly modified through the review process.

- The planning and priority setting needed to cross the organizational boundaries of State agencies.

- The process needed to establish approaches for examining the State's progress towards meeting its objectives.

- The process needed to pay attention to differences in priorities that would inevitably occur among communities and agencies.

- The review process needed to be concluded and a plan prepared within one year, in accordance with the Commissioner's priorities.

Learning from Key State and Local Government Officials

New York health officials were surveyed by mail early in the process as an initial needs assessment. They ranked the priority of the *Healthy People 2000* goals on a scale of one to five. Criteria included the size of the problem, the seriousness of the problem, the effectiveness of known interventions, the relevance of the goal to public health, and the degree of community consensus about the importance of the goal. This exercise served as a useful springboard for subsequent discussions. Most program staff identified goals and priorities in light of their own responsibilities. For example, for individuals working in State laboratories multiple drug-resistant organisms were a key public health priority; for those in community health, low birth weight babies were a significant public health issue.

Other New York State agencies, such as Education, Social Services, and Mental Health, met with the Committee to discuss their efforts and the cross-cutting issues.

Other States were surveyed to identify those who had undertaken similar efforts. Officials from several States briefed the Committee who was interested in learning about others' experiences concerning such issues as: (1) the process they had used in developing Statewide health goals and performance measures, (2) whether they had focused on diseases or on risky behaviors, and (3) whether the processes had been driven largely by the State departments of health or by local communities.

Seeking Input from Communities Across the State

The Committee sponsored a series of six, one-day regional workshops across the State during May 1996. Participants identified serious health problems in their communities, causes of those problems, and effective interventions. An estimated 1,400 participants attended: local health care providers, government officials, staff from community-based organizations, educators, advocates, and business and labor representatives. The comments and input from these local communities largely formed the final report, *Communities Working Together for a Healthier New York.*

Publicity

In organizing the workshops, which were the backbone of the review and priority-setting process within the States, the Department publicized the workshops widely through: direct mailings to individuals and organizations, an internet web site, newspaper and magazine articles, press releases, and use of an existing toll free phone number. In combing through mailing lists provided by numerous agencies and organizations, the

Department identified more than 35,000 individuals who were invited to participate. Local workshop coordinators also sent invitations. An estimated 1,400 individuals actually participated in the one day sessions.

Professional Facilitation

The Department arranged with a local university to facilitate the regional workshops. The basis for each workshop were small group discussions. These groups were pre-arranged by Department staff to ensure a mix of backgrounds and interests among participants. The discussion, led by the facilitators, focused on identifying: (1) the ten most significant adverse health outcomes in the communities, (2) the ten most significant risk factors contributing to these adverse health outcomes, (3) effective interventions now being applied in their communities, and (4) new interventions that might be effective.

Synthesizing the Input

The Department analyzed and summarized the input received from the regional workshops and from other State and local government agencies. Staff reviewed this information in the context of the *Healthy People 2000* goals and of the availability and validity of data available to monitor progress in improving health outcomes. This process culminated in the identification of the 12 "priority areas of opportunity for improving community health." For each of these areas, Department staff developed specific, quantifiable objectives to allow for monitoring progress. The rationale for the specific target levels for the objectives in each priority area were published in a separate document prepared by the Department and the Priorities Committee.[10]

Decisionmaking at the Top

The Public Health Priorities Committee directed the decisionmaking about the priority areas, and the objectives and target levels for each. It actively guided preparation of the report, *Communities Working Together*, which was submitted to the Commissioner in September 1996. The Commissioner distributed the report widely this fall, indicating that her "personal goal is that this landmark report be used as a blueprint for public health action in communities throughout the state."[11]

Beginning the Implementation

The Department is now considering its next steps for translating the document into community action. Many communities are seeking guidance and technical assistance from the Department about how to use the report in their local efforts.

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[10] New York State Department of Health, "Rationale for the Selection of the Target Levels for the Year 2006 Objectives for New York State," internal document.

[11] Barbara A. DeBuono, M.D., M.P.H., Commissioner of Health, State of New York Department of Health, letter to colleagues, November 1996.

As initial steps, the Department is making available to the counties $750,000 to stimulate follow up on areas of opportunity within the plan and to encourage efforts of local planning groups. The Department, too, is seeking for the counties $1 million to support a behavior risk survey to gather data on key behaviors at the county level; at present, all the behaviors data are available only on a Statewide basis.

Sample Performance Measures

The 12 priority areas identified through New York's review process offer the communities in New York opportunities for improving the health of their residents. Action in these areas by communities across the State could reduce the major causes of death, disease, and disability.

The Department's report, *Communities Working Together for a Healthier New York,* includes, for each priority area, objectives and indicators, a rationale for the particular area, and descriptions of the size of the problem and of possible interventions.

The Nutrition priority area, for example, has the following objective:[12] By the year 2006, reduce the prevalence of overweight to no more than:

- 20 percent among adults 18 years of age and older (baseline: 27%, Behavioral Risk Factor Surveillance System, 1994); and,

- 15 percent of second and fifth grade school children (baseline: 34.5% New York City, 27.9% Rest of State; New York State Department of Health Nutrition Survey, 1990).

The Mental Health priority area's objective is that: By the year 2006, reduce the rate of hospitalizations due to self-inflicted (intentional) injuries among persons aged 10 years and older to:

- no more than 50 per 100,000 persons (baseline: 62.5 per 100,000, Statewide Planning and Research Cooperative System, 1991-93).

Management Challenges

The challenges facing the Department in implementing its plan for action, *Communities Working Together*, include:

Encouraging community action. The emphasis is on community action for addressing public health problems. The Department needs to articulate ways of developing and maintaining "buyin" from local health jurisdictions and of supporting their efforts to

[12] Communities Working Together, 39, 36.

identify which areas have priority for action in their communities and which measurable objectives can be used to monitor progress.

Coordinating the Department's planning and program efforts at the State level. Once communities engage in local prioritization and planning activities, it will be incumbent on the State to direct resources to support community-identified priorities rather than Federal or State-identified priorities, as reflected by categorical funding streams. Coordinating and integrating the results of community-based planning with ongoing Statewide program planning by the Department will be a challenge. In particular, providing communities with flexible funding while assuring some level of accountability for outcomes will be key to the successful implementation of "*Communities Working Together.*"

Using results-based goal setting for decisionmaking. While the MCHSBG's application for the past 2 years has included results-based goals, objectives and implementation objectives, as required by HRSA, State MCH staff indicate that the results-based goal setting and reporting are not used as much as interventions. Often other criteria influence program decisions (e.g. media-led, stakeholder-led, legislature-led). The Department and local health units are likely to face similar challenges in implementing "*Communities Working Together.*"

Data issues. Among the significant issues are gaps in available data and a lack of valid data important for practical, valid assessment of problems and needs and for monitoring program accomplishments. As noted above, most data in New York are now available at a State-level only. Further, the State lacks data on children and adolescents and no population-based measures for assessing mental health problems, such as depression, at the community level.

The potential for others to misuse program performance data is another important issue facing program administrators. The challenges are: (1) to educate other potential users about the limits of the data so they avoid policy and budget decisions based on raw numbers taken out of context; and, (2) to avoid penalizing programs without first having had all partners working together to improve performance.

Lessons Learned

Department staff identified several factors important to the successful completion of the review.

Process-related factors. Relying on the Public Health Council and its Priorities Committee, which were knowledgeable, capable, well-respected, and external to the Department, to give direction to the process enhanced the legitimacy of the effort. Further, the Commissioner made the effort a top priority with a tight deadline for completion and redirected Department resources to support it. Finally, the extensive involvement of communities across the State encouraged their support for the overall process and enhanced the relevance of the final plan to their local needs. For example,

mental health and education are two priority action areas as a direct result of communities having articulated these as areas of great concern and need.

Content-related factors. The Priorities Committee and the Department were guided by the principles of emphasizing a community orientation and focusing on behaviors rather than specific diseases. These principles guided the framework of the report and its recommendations. Finally, while the report emphasizes community action in priority areas, it also addresses the importance of maintaining the public health infrastructure across the State. One section of the report focuses on this infrastructure and its importance to the public's general health and to successful implementation of specific actions as called for in other sections of the report.

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NEW YORK

Monroe County Department of Health

Overview

New York's State Department of Health is working with Monroe County health officials on an initiative to: (1) support child and family health services through a single funding stream of combined State and Federal funding sources, and (2) rely on results-oriented objectives and indicators for ensuring accountability for performance. The Department submitted the proposal to the Federal Government for review in late summer 1996.

Nature, Extent, and Uses of Performance Measures

The proposal calls for consolidating the contracts supporting eight child and family grant programs into a single, integrated grant. The services would be supported by a budget of $3.4 million, resulting from combining State and Federal funds for several categorical programs administered by several State and Federal agencies. These include, for example, the United States Departments of Agriculture, Education and Health and Human Services (the Centers for Disease Control and Prevention and the Health Resources and Services Administration), and New York's Medicaid program and various programs of the Department of Health.

The proposal calls for a single work plan and budget, streamlined administrative processes, and maintaining current reporting requirements of all funding agencies. The proposal also calls for relying heavily on outcomes measures to assure accountability for the program's performance.

Fiscal Accountability

Issues of fiscal accountability require the State to seek approval from the Federal Government for the proposal. The Department is asking that Circular A-87, issued by the President's Office of Management and Budget, be interpreted similarly by the Federal Departments and that it emphasize results-based accounting rather than program-specific accounting.

Performance Accountability

The outcomes-based system for accountability includes several program goals with indicators and targets for each. The proposal states that the program goals are "based on federal and state grant objectives and the Healthy People 2000 goals. The goals include: healthy births, optimal healthy development of children, enhanced development

and function for those infants and children with special health care or developmental needs, and effective and responsive systems to support maternal and child health."[13]

Indicators and targets are mutually negotiated by a team of county and Department staff. For the first grant year, these are based on 1995 baseline data to the extent possible. The team also defined "mutually acceptable **ranges** [emphasis added] of success" for progress in meeting each target to avoid inappropriate focus on a precise figure. Results outside the variance will trigger discussion, review, and technical assistance.

Health officials will monitor the program's progress in reaching the targets. "Should Monroe County's progress in achieving the Child and Family Health grant's stated goals be deemed unsatisfactory, State and County staff will review the County's strategies and efforts to determine if programmatic changes should be made... . If the County were found to be ineffective in achieving substantial progress toward one or more goals, the allocation of funding in future grant years associated with those goals could be affected."[14]

The State will continue to monitor the program in ways that go beyond review of data collected for performance indicators. The Department will conduct onsite visits and provide technical assistance. It also plans to hire an outside evaluator to assess the program.

Process for Developing the Performance Systems

County health department officials have spearheaded the effort to consolidate funding. They have long had an interest in trying out such a consolidated approach, having been frustrated over the years with meeting the different contract requirements of multiple categorical funding sources that support their child and family health programs. And, the county had gained some experience with consolidation under an earlier service integration grant from the Robert Wood Johnson Foundation, funded at 10 sites across the country in 1993, to integrate children's health services.

The county had unsuccessfully sought support for the initiative from the Department in earlier years. In 1996, however, the environment for pursuing such an approach was more favorable. The Department, for various reasons, was more receptive to trying consolidation. And it, together with the county partner, were encouraged by the Vice-President's National Performance Review, which supported efforts to consolidate grants and to develop results-based systems for accountability. The initiative is similar, in many respects, with the performance partnership grants envisioned by the Federal Government.

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[13] New York State Department of Health, "New York State/Monroe County Child and Family Health Grant: Executive Summary," internal document, 1-2.

[14] "New York State/Monroe County Child and Family Health Grant: Executive Summary," 13.

By 1996, much of the infrastructure necessary to support the initiative had already been developed: a single point of entry into the system for care, common assessment tools, cross-training programs for staff, and a central registry for data.

During 1996, county and State officials worked intensively to refine the proposal. A State-level Department team (composed of about ten members) met weekly; State and county partners met monthly, and intensive staff work supported the development of the proposal throughout the year. The proposal has been under review by the Federal Government since late summer 1996.

Sample Performance Measures

The initiative identifies four operational goals, each with multiple indicators. The indicators focus on outcomes for the Monroe County community and for the target population served directly by the county health department. For example, one of the goals is "healthy births." Examples of shared indicators for both community and target populations for "healthy births" are the following:[15]

- low birth weight births
- early entry into prenatal care
- infant mortality

Examples of indicators focused on the target population, defined as: families with pregnant women at moderate to high risk for poor pregnancy outcomes based on influence of environmental, economic, or educational factors; psychosocial, mental health, or developmental factors; risk behaviors (such as substance use, violence, sexual behavior); or, health issues (access to care, compliance, nutrition, previous fetal/infant death, premature birth) are:

- pregnant women entering WIC in the first trimester
- pregnant women who delay subsequent pregnancy for at least 1 year
- pregnant women who smoke
- women who report using family planning
- consumers satisfied with Monroe County Health Department Services

Management Challenges

The most immediate challenge facing the Department of Health is securing approval from the Federal Government for the initiative. Subsequently, it anticipates myriad challenges as the initiative is implemented. For example, performance monitoring, both through review of written reports and onsite visits, will be conducted in an integrated fashion. Department staff view the project as a pilot effort from which they hope to

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[15] New York State Department of Health, "Monroe County Child and Family Health Grant, Goals and Indicators" internal document, October 30, 1996.

learn lessons about what to do and what not do as they consider the feasibility of pursuing this approach with other counties.

Lessons Learned

Among the important lessons learned by those involved in advancing this initiative are:

Be tenacious and prepared to seize the moment of opportunity. County officials have pursued this idea for consolidation of funding for several years. They did their homework and prepared administrative systems that would support a transition from categorical to consolidated funding. They did not give up; they were ready to move when the climate for change became hospitable.

Bring all partners into the picture sooner rather than later. Officials believe that earlier communication with cognizant Federal agencies could have made the process more efficient.

Plans should be locally conceived. This particular package of categorically funded grants works well in a consolidated approach for Monroe County. Another county might select a different package of children and family health grants or focus on a different public health issue such as Disease Control and Prevention grants.

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NORTH CAROLINA

NORTH CAROLINA

The Department of Environment, Health and Natural Resources

Overview

The Department of Environment, Health and Natural Resources (DEHNR) is in the process of developing a public health accountability system for its local health departments. This system will allow DEHNR to employ performance-based management to measure local health department progress in applying health outcome standards and achieving health outcome objectives established by the State's Commission for Health Services.

Nature, Extent and Uses of Performance Measures

The DEHNR's proposed Accountability System consists of three levels of assessment. The design of this system was stratified to take into consideration those areas where the local health departments have a limited or negligible impact. While Level I and II indicators are still in the draft stage, data for these indicators are now being collected for the counties and local health departments. There are 86 local health departments (or jurisdictions) in the State, some encompassing more than one county. Level III assessment, as currently proposed, will consist of monitoring activities currently being carried out by the health divisions.

Level I consists of a Community Wellness Index, a "snapshot" of 8 health status indicators for each of North Carolina's 100 counties. These indicators were selected because it was believed they represented the most pressing public health problems in the State. Each of these indicators also has two or more population-based health outcome measures (rather than local health department-specific measures) on which counties are ranked against each other. These data are easily accessible to DEHNR and will be updated annually. The data will provide a "sound bite" measure of health status in the county while, at the same time, avoid measuring local health department performance in an inappropriate way.

The 32 Level II indicators add process measures to outcome measures in an attempt to answer questions about the nature, quality and quantity of public health services being provided and, in some cases, the impact of these services on health status. They examine, in greater detail, the areas addressed in the Level I indicators. In some instances, Level II data may be qualitative in nature, such as that derived from surveys. A decision has not yet been reached as to whether the data for Level II indicators will be updated yearly or biennially.

The DEHNR is just completing (January 1997) its data collection for Level I and II outcome measures. These benchmark data will provide the State with a score card assessment of the status of public health in individual counties and within local health

departments. The local health departments in the most populace counties will be ranked against each other. The other health departments will be ranked against others in their region. Each county and local health department will be informed of its ranking in relation to the other counties and local health departments, respectively. (As of February 1997 all counties and local health departments have received their ranking status.)

The DEHNR plans to use the Level I and II data to help pinpoint deficiencies in public health programs. The low ranking (bottom 10%) performers will be identified, and the DEHNR will work with these poor performers to improve their public health programs. The DEHNR sees itself in partnership with the counties and local health departments. A "support" position within the State Health Director's Office has been created and is now being filled. This individual will have the day-to-day responsibility for overseeing the accountability effort and will act as liaison between DEHNR and the local health departments to improve public health programs. The plan is to send out a review team composed of DEHNR staff to help the local health departments formulate corrective action plans to improve the effectiveness of their program(s).

Process for Establishing Performance Measures

The Proposal

The DEHNR's move towards a results-based accountability system began in late 1992 under the direction of the State Health Director, Dr. Ronald Levine. The impetus for this endeavor was the following two pieces of legislation passed by the State General Assembly in 1991, which called for enhanced monitoring efforts by DEHNR:

- House Bill 499, (An Act to Establish the Mission and Essential Services of the Public Health System) "...directs DEHNR to: attempt to assure, within the context of available resources, that a wide range of public health services are available to all citizens of the State."

- House Bill 183, (An Act to Require the Department of Environment, Health and Natural Resources to Conduct Various Health Related Projects) directs DEHNR to: "implement a monitoring and evaluation program to measure local health department progress in applying health outcome standards and achieving health outcome objectives established by the Commission for Health Services...and to provide assistance to local health departments that are having difficulty meeting objectives."

The DEHNR appointed a 20 member Accountability Task Force to "...propose a public health accountability system." Members of the Task Force were State and local officials with backgrounds in a variety of public health disciplines. Meeting 12 to 13 times in 1993, the Task Force issued its report in January 1994 proposing an accountability system that attempts to determine whether the resources appropriated to public health are being used in an effective and efficient manner. The Task Force viewed the purpose of this

document as one that would serve as a starting point for discussion of a public health accountability system, rather than the end result.

However, the recommendations of the Task Force were not immediately acted upon. State legislators, pressed to reduce spending and cut taxes, were wary of appropriating funds for new projects. Without additional resources to carry on this effort, development of an accountability system took a back seat to the current needs of established DEHNR programs.

A New Beginning

In early 1996, the Deputy State Health Director, refocused DEHNR energies once again on the development of an accountability system. A second task force was formed, informally known as Accountability Task Force II, with the expectation that its efforts would begin where the first Task Force left off. For the most part, this expectation was met. However, many members of Task Force II had not served on Task Force I. As a result, the DEHNR found that new members needed to be informed of, not only what decisions were made, but the reasoning behind the decisions in order for new members to concur with the first Task Force's results and to proceed with the new endeavor. Task Force II was smaller in number with more representation from the State's health divisions.

Task Force II pared down the number of Level I and II indicators developed by Task Force I, ultimately selecting 8 Level I and 32 Level II indicators. Such documents as the national *Healthy People 2000* objectives and the *Healthy Carolinians 2000* objectives were reviewed to help identify possible indicators. Members determined that the outcome measures for Level I and II indicators would be those for which: (1) data was already being collected, and (2) data was accessible to the DEHNR at no extra cost.

The DEHNR is proceeding with implementation of its proposed accountability system, though it is just now getting feedback from the counties and local health departments regarding the selected Level I and II indicators. Level I and II indicators were sent out to counties and local health departments in November 1996 for comment. In January 1997, a meeting of the Association of Local Health Directors was held and Level I and II indicators were discussed. About 45 to 50 of the 86 health directors attended this meeting (there were 12 or 13 health director vacancies at this time). For the most part, feedback to date has been largely accepting.

Sample Performance Measures

Data for Level I indicators are provided on a county basis. The 8 Level I indicators, and an example of one of their population-based health outcome measures, are:

1. ***Maternal and Infant Health***
   Measure: Infant mortality rate

2. *Child Health*
   Measure: Child (ages 1-9) fatality rate

3. *Heart Disease and Stroke*
   Measure: Heart disease rate

4. *Cancer*
   Measure: Breast cancer death rate

5. *Diabetes and Other Chronic Disease*
   Measure: Diabetes-related death rate

6. *Injury*
   Measure: Motor vehicle injury rate

7. *Communicable Disease*
   Measure: AIDS case rate

8. *Adolescent (ages 10-17) Health Status*
   Measure: Adolescent fatality rate

Data for Level II indicators are provided on a local health department basis. Some examples of the 32 Level II indicators include:

- Percent of live births with adequate/adequate plus prenatal care.
- Percent of mothers who smoked during pregnancy.
- Percent of Medicaid children utilizing health check preventative care.
- Percent of inspections completed on food, lodging and institutions.
- Public schools are smoke-free.
- Rate of unsatisfactory pap smears submitted to State laboratory.

Management Challenges

Understanding the data. The DEHNR believes it will be a challenge to accurately assess the impact local health departments have on their communities.

Level I and II outcome measures may not always be accurate indicators of poor health status in a community or of deficient local health department performance. These measures will probably not definitively identify a problem. Rather, they are intended to "red flag" an area where some evidence of a problem exists. It is then the responsibility

of the DEHNR to work with local representatives to determine if a problem really does exist and, if so, to develop a corrective action plan.

The DEHNR further cautions that ranking performance can be misleading as one may put greater confidence in the ability of one data to discriminate among counties then they deserve. For example, consider a county/local health department ranked 23rd out of 100 versus one that is ranked 26th: the difference between these entities' performance, depending on their confounders/variables, may be negligible and the county/local health department ranked 26th, upon further analysis, may actually be the better performer.

Lessons Learned

Do not reinvent the wheel. For those States just starting to develop a results-based accountability system, the DEHNR advises that they first review as many models of such systems as they can find. Also, invite another State(s) to talk about the pros and cons they experienced in the development of their own system(s). This will help expedite the development process, decrease the frustration that inevitably comes with this effort, and may help in avoiding some of the pitfalls another State experienced.

Identify the players. Make sure you have the right people around the discussion table. Know to whom they are accountable and for what they are accountable. Members who are the decisionmakers help speed up the development process.

Appoint a mentor. When Accountability Task Force I issued its report in January 1994, there was no one to mentor this evolving accountability system. Consequently, development of the accountability system stagnated until it was resurrected through the interest of the Deputy State Health Director in 1996. To help ensure the viability of this new effort, the DEHNR intends to institutionalize it by creating a "support" position within the State Health Director's Office. This individual will have the day-to-day responsibility for overseeing the accountability effort.

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NORTH CAROLINA

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Department of Human Resources

Overview

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) is developing a proactive "continuous quality improvement" approach to assess the efficacy of its public mental health, developmental disabilities and substance abuse service system. Consumer satisfaction surveys are conducted in all area programs and institutions. Client outcome assessment instruments are now being tested by a few area programs.

Nature, Extent and Uses of Performance Measures

Consumer Satisfaction Surveys

The DMHDDSAS uses consumer satisfaction surveys as part of its quality improvement process, to help determine that basic consumer needs are met and to identify possible deficiencies in service. These surveys are administered twice a year in all 41 Area Programs and 16 Institutions, with the exception of Developmental Disability Residential Centers where they are conducted annually. The survey consists of ten questions that focus on consumers' satisfaction in the areas of quality of services, meeting of service needs, staffing and facilities. The DMHDDSAS operated facilities, area programs and contracted providers administer consumer satisfaction surveys to all their active clients during a one week period specified by the DMHDDSAS.

The first time these surveys were administered was in November 1995 when 29,896 surveys were collected. To date, the consumer satisfaction surveys have been administered three times, with a fourth administration scheduled for May 1997. Approximately 75,000 such surveys have been collected thus far. Analysis of this data is ongoing. Currently, the survey results are distributed to the Area Program Directors, Institutional Directors, Executive Staff and the Advocacy Advisory Committee for informational purposes.

Client Outcome Assessment Surveys

The DMHDDSAS is piloting mental health, developmental disabilities and substance abuse client survey instruments in 3 of its 41 area programs prior to Statewide implementation which will begin in 1997. Separate survey instruments were created for: child and adult substance abuse services, perinatal/maternal substance abuse services,

child mental health services, adult mental health services, child developmental disabilities services and adult developmental disabilities services.

These survey instruments will furnish identification and descriptive data for program performance and client outcome measures. Some examples of the type of data to be collected (depending on the age of the client and the type of services required) are: client record number, Medicaid eligibility, hospital admissions and care days, current substance abuse use, academic enrollment and GPA, prior arrest record, client housing status, and services needed and received.

Data will be collected by the provider on a sample of their clients (selected by the DMHDDSAS) and subsequently furnished to the DMHDDSAS. These sample clients are given an initial assessment, status surveys (every 6 months for almost all client types) and a final outcome survey upon discharge from the provider's program. These survey instruments are easy to complete and color coded to distinguish between both client type and an initial assessment versus a status or final assessment.

The DMHDDSAS expects to have benchmark data in 1998-1999. It believes it will take that long to collect and properly and fairly analyze the client outcome assessment data.

Continuous Improvement

The DMHDDSAS plans to create liaison positions to help coordinate working relationships where by the 41 area programs can seek help and feedback from the State to improve their programs. By July 1997, the DMHDDSAS hopes to have about eight division staff persons solely dedicated to this effort. Data analysis of the client outcome assessment survey data and the consumer satisfaction survey data will emphasize the continuous improvement of all services throughout the State regardless of the current level of functioning. The DMHDDSAS plans to use the data collected from these survey instruments as a tool to help them identify those program providers with any deficiencies or problems with services or consumer satisfaction. The DMHDDSAS does not plan to use this data in a punitive way, it will not "play gotcha," but will work with the provider to help build a "self-correcting" quality improvement plan. Down the road (about 5 years) it is possible that the data may be used for policy purposes; to defend policy or redirect efforts or decrease or increase funding.

Process for Establishing Performance Measures

Phase I

The impetus for this undertaking was the Mental Health Study Commission's quality of services initiative, which began in 1991. The Mental Health Study Commission, a bipartisan commission created in the 1970's, studied issues and made recommendations to the legislature and Governor concerning mental health, developmental disabilities and substance abuse services provided to the public.

In March 1992 the DMHDDSAS formed a 22-member Quality Improvement Committee charged with making recommendations to the Mental Health Study Commission for the development of, and transition to, a quality improvement system for the DMHDDSAS. The Quality Improvement Committee was composed of DMHDDSAS staff and representatives from client advocacy groups, the Area Programs and The Commission for Mental Health, Developmental Disabilities and Substance Abuse Services. (Members of this Commission were appointed by the Governor and General Assembly. Their mission was to adopt rules to be followed in the conduct of State and local mental health, developmental disabilities and substance abuse programs. The Commission also acted in an advisory capacity to the State's Secretary of Human Resources.)

Believing that the DMHDDSAS had put too much confidence in structure and process inputs as adequate measures of quality, the Quality Improvement Committee determined that a continual assessment of the performance of the service delivery system and its impact on client care and client outcomes was needed. In addition, the Committee felt that the streamlining of administrative rules was absolutely necessary to the success of this endeavor. By 1992, the DMHDDSAS had lost any funding for research contracting and most of its internal evaluation staff due to legislative budget cuts. Without this expertise to draw on, the Quality Improvement Committee realized it needed to develop a quality improvement process that was neither too costly or onerous to implement.

The Quality Plan was developed, approved by the Mental Health Study Commission in December 1992 and subsequently endorsed as policy guidance for the DMHDDSAS in February, 1993 by the State Legislature. A significant portion of the plan involved changing from a prescriptive, procedures-oriented regulatory system for the public behavioral health system to a simpler, outcome-oriented approach that is focused on consumers and reduces administrative complexity.

The Committee developed seven working principles by which the new quality improvement system was to be guided. These principles are:

Accessibility: Consumers will have convenient and easy access to services;

Early Intervention & Family-Centered: Consumers will be more likely to succeed when services are provided at the earliest possible time in the onset of need and when family consumers are involved from the onset;

Consumer-Driven: Services will be designed and delivered to meet the needs of consumers;

Empowerment of Consumers: Consumers will be able to make choices concerning services, lifestyle and supports;

Empowerment of Providers: Service providers will be able to remove service barriers;

Outcome-Oriented: Service effectiveness will be determined through the measurement of appropriate outcome indicators; and,

Simplicity: The quality improvement system will be clear and direct. It will not be added to existing processes but will reduce or replace them.

With these guiding principles in mind, the Quality Improvement Committee conceived the following five, very broad outcomes for their primary consumers:

Education/Habilitation: Each primary consumer should have age-appropriate education/habilitation experiences.

Health: Each primary consumer should be physically and mentally healthy.

Housing/Support: Each primary consumer should have basic food, clothing and shelter in his natural home with his own family or in similar, safe living arrangements in a community of his own choice.

Social: Each primary consumer should have relationships which contribute to his well-being and foster trust, self-esteem and social competence, Each primary consumer should also exercise social responsibility.

Vocation/Avocation: Each primary consumer should have gainful employment or a productive activity appropriate to his age and capabilities.

As the Quality Improvement Section of the DMHDDSAS and the Rules Reduction Task Force began to address the challenge of developing such a system, the rapid transition of the health care system to managed care and the increased pressure to reduce government spending and regulation impacted the rules development process. In addition, expected funding for this initiative failed to be passed. It took approximately 2 1/2 years, from the Quality Improvement Committee's initial recommendations to the Mental Health Study Commission in December 1992, to revise the State's administrative code and achieve rule reduction for mental health, developmental disabilities and substance abuse facilities and services. In the new rules standards are largely performance-oriented and specifically directed toward establishing and being accountable for client outcomes and consumer satisfaction.

During this time, the DMHDDSAS was also developing its consumer satisfaction surveys. November 1995 marked the first administration of the satisfaction surveys and the State General Assembly's vote to adopt the new administrative code.

Phase II

Once the administrative code had been amended, the DMHDDSAS proceeded to identify program area goals and objectives. Finally, client outcome assessment survey instruments were developed.

The DMHDDSAS Quality Improvement section staff began with lists of questions (outcome indicators) drawn up by the Quality Improvement Committee in December 1992 that evolved, over a period of about one year, into the draft client outcome assessment surveys currently being piloted. Development of these surveys was delayed until early 1996 for a variety of reasons. First, was the lengthy time it took to pass the administrative rule reduction legislation. Secondly, as no extra funding was appropriated for this effort, the DMHDDSAS had to shift funding and staff on an as needed basis to work on this initiative. Also, staff assigned to develop the surveys worked within the same section and had to fit this activity in with their other duties. Further complicating this endeavor was the delay caused by section staff turnover that allowed the effort to lie fallow until someone was available to work on the initiative. In addition, wanting the survey instruments to be as succinct as possible, every section within the DMHDDSAS had to justify the need for the information they wished providers to furnish. Finally, the implementation of the Program/Performance Budgeting System, beginning in 1994, changed the focus of the DMHDDSAS client outcome effort. Each Division of State government was required to develop a limited set of client outcomes for inclusion in the State budget. Both the requirements and limitations of the budgeting structure further postponed development of the more comprehensive effort directed toward client outcomes within the DMHDDSAS.

Sample Performance Measures

The DMHDDSAS has developed and identified program goals, objectives and qualitative and quantitative outcome indicators specific to the program areas of mental health, developmental disabilities and substance abuse. The following provides an example of a goal (including one objective and related outcome indicators) for the mental health program area in DMHDDSAS:

Goal #11: Maintain and improve health care access and treatment.

Objective #2: At least 80 percent of mental health clients and their families will be satisfied with the mental health services received.

> Outcome Indicators: Data from consumer satisfaction surveys, quantitative service data.

Some examples of data collected on the *Child Mental Health Update/Discharge Outcomes Assessment Survey* are provided in Section 4 of this instrument, which supplies data on the services needed and received by the client in such areas as:

- Social Services (i.e., protective services, family unification, family preservation, shelter, adoption, foster care);

- Mental Health (i.e., outpatient services, case management, day treatment services, residential group home, residential therapy home, emergency inpatient, non-emergency inpatient, family support, respite);

- Health Care (i.e., inpatient services, specialized, immunization, nutritional services, primary care physician);

- Juvenile Justice (i.e., court counseling, diversion services, multi-purpose group home, wilderness camp, adjudication, detention, training school);

- Community (i.e., sports/organized recreation, church, scouting, full-time employment); and,

- School/Vocational (e.g. Individual Family Service Plan-birth to 5 years, developmentally delayed, alternative school, vocational training, vocational counseling).

Management Challenges

Managing the data. The DMHDDSAS believes it will need to contract for data entry or provide data entry screens at the local level and specific file layouts so that the data can be submitted locally to the DMHDDSAS, especially once all 41 programs begin submitting their client outcome assessment data. Presently, data receipt from the three pilot programs has a time lag of about 4 months (October to January). It will be a challenge for the DMHDDSAS to obtain and/or redirect enough resources to process and manage the data once all 41 programs are up and running.

Understanding the data. Analyzing the client outcome assessment data, determining what the data means and understanding its limitations will be time consuming and a challenge for the DMHDDSAS. In addition, while the quality improvement initiative has the support of policymakers, sometimes the level of sophistication needed to understand the data and, more importantly, its limitations, is not what it should be. The DMHDDSAS plans to develop an education campaign to ensure that the data is properly understood.

Stakeholder buyin. Area program directors are troubled about the State's use of the data. They have some concerns that the data may be used for punitive purposes to defund non-performers. The DMHDDSAS did not involve the area program directors from the very beginning of the survey instrument design process. They believe that if they had done so, while it would have taken more time to develop the survey and they might have had to compromise on some of the selected data elements, they would have achieved greater buyin from these stakeholders.

Performance-based budgeting. The DMHDDSAS is currently submitting both a line item budget and a performance-based budget to the State legislature and Budget Office. The performance-based budget submitted was based on current data that could be translated into an outcome. It is the line item budget, however, that is still being used by the Budget Office and legislature for funding appropriations. Once all area programs are submitting the client outcome assessment data and the DMHDDSAS has analyzed the data, performance-based budgeting will be used.

Federal Challenges

NO to national performance standards. The setting of outcome measures or standards should remain at the State level. The Federal Government should not mandate national performance goals or standards. They believe this would be a mistake as State statutes differ and their local and county governments have varying degrees of autonomy.

Not all systems are equal. It has been suggested that a results-based outcome measurement system can be selected through a review of those systems in use by the biggest behavioral health organizations. The DMHDDSAS cautions the Federal Government against taking this course. They believe that these big organizations "cherry pick" their clients, selecting only those that can pay. Consequently, their client outcomes reflect very favorably on their client care system. State public health facilities, on the other hand, do not have the luxury of preselecting their clients relying largely on the State for reimbursement.

Lessons Learned

Identify all stakeholders. The DMHDDSAS believes it is critical to identify all the stakeholders and ensure that all are invited to the table to participate in the process. The move to outcome-based monitoring was too radical a change -- a paradigm shift -- not to include all who would ultimately be affected. For this process to succeed everyone must buyin to the philosophy and for this to occur, stakeholders must be included at the beginning of the decisionmaking process.

Understand the terminology. Before starting the process, everyone at the table must understand the terminology of results-based outcome measurement systems. All must learn and come to the same understanding of the meaning of: (1) an economic outcome, (2) a clinical outcome, and (3) a process outcome.

A facilitator/consultant should be able to explain the process and terminology in language that a lay person (not an academic) can understand. In fact, a consultant may only be needed for the first few days of the process once everyone has grasped the concept and the meanings of the terminology.

Do not reinvent the wheel. Research what other States and private industry are doing in the area of outcome measurement. Draft a proposed process based on your research and then set this draft aside. Do not be wedded to your first effort, review and reassess.

Adequate resources. The DMHDDSAS has had to develop their quality improvement process without extra funds. This process began in early 1992 and the DMHDDSAS is just ending the pilot phase of its client outcome assessment survey instruments. This data will be collected and analyzed in the near future. This process could have been much farther along if the DMHDDSAS had been authorized funds to hire and dedicate staff to this initiative.

Collect data that is necessary, not what is interesting. Take the time to identify the data that's needed. Confer with stakeholders and justify data needs. The process for developing the data elements on the client surveys has taken DMHDDSAS at least 1 year.

Concurrent processes. It took DMHDDSAS 2 1/2 years (from the December 1992 report to the Mental Health Study Commission) to get the administrative rule reductions passed by the State General Assembly. During this time, further development and refinement of the initiative (e.g. data needs, surveys, client outcomes) was put on hold. In hindsight, the DMHDDSAS would have run the two processes simultaneously. Two separate groups, one working on the rules reduction effort and the other working on developing the pilot programs would have been formed. These groups would have met periodically to coordinate their efforts. If this had been done, the pilot programs could have been implemented immediately upon passage of the new administrative rules, rather than over a year later.

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OHIO

OHIO

Department of Mental Health

Overview

The Department of Mental Health is involved in two assessment efforts using outcome-based performance measures. The first effort involves a Statewide development of outcome measures to assess the effectiveness of its mental health programs. The second effort, is a demonstration project to develop consumer-driven quality assessment data to help evaluate the success of Ohio's mental health systems.

Statewide Measures

Nature, Extent and Uses of Performance Measures

Ohio's Department of Mental Health is in the very beginning stages of developing client and system outcome performance measures for its mental health programs. As of February 1997, outcome measures had not yet been determined.

Process for Developing the Performance Systems

The Health Care Financing Administration's approval of Ohio's Section 1115 managed care demonstration was one impetus for this effort. Concerned about ensuring quality care in managed care programs the Program Evaluation and Research Office in Ohio's Department of Mental Health recommended to its director that client and system outcome measures be developed.

Dr. Michael F. Hogan, Director of the Ohio Department of Mental Health, formed a Blue Ribbon Task Force charged with developing client and system outcome measures for the Department's mental health programs. This 42 member Task Force is composed of: State and local government officials, consumers and family members, advocates for mental health, mental health care providers, case managers and local mental health board officials.

Formed in September 1996, the Task Force has until October 1997 to complete its mission. Scheduled to meet monthly, the Task Force has met four times as of February 1997. The first meeting's agenda focused on the importance of evaluating systems of care and on the mission of the Task Force. This meeting was presided over by Dr. Hogan. In the second meeting, members developed a set of values and rules and regulations of conduct to which all members are to observe. The third meeting involved a brain storming session at which all members were asked to first suggest client outcomes and then system performance outcomes. As expected, most (about 80%) of all suggestions related to system outputs rather than client outcomes. At its most recent

meeting, the Task Force determined that client outcomes will be measured in four domains: (1) clinical status, (2) functional status, (3) life satisfaction and fulfillment, and (4) safety and welfare.

Management Challenges

Stakeholder buyin. To date (after four meetings), some friction has been encountered. One source of friction is providers' concern that this process may be highly resource intensive. Providers are unsettled about the extra costs they may have to bear for data collection, new data systems, staff training and/or new hires. The other source of friction has been the different perspectives of various stakeholders about the appropriate outcomes to measure.

Consumer Quality Review Teams

Nature, Extent and Uses of Performance Measures

The Department of Mental Health is piloting three initiatives to develop consumer-driven quality assessment data for its mental health systems. Face-to-face interviews with randomly selected consumers, family members and providers will furnish information about the availability, accessibility and appropriateness of mental health services; the quality of these services; treatment results; and, consumer satisfaction. Consumer quality review teams (CQRTs) will conduct the interviews. The teams will consist of 50 percent consumer representation, 25 percent family member representation and 25 percent provider representation.

In June 1996, the State of Ohio's Office of Consumer Services awarded grants in three areas of the State. The Alliance for the Mentally Ill of Ohio and The Ohio Advocates for Mental Health will provide training and technical assistance to the consumer quality review teams. The pilot projects are under way in the following three areas:

- A six-county area (including cities of Akron, Youngstown and Warren);
- A region in western Ohio between Toledo and Cincinnati consisting of 18 predominantly rural counties; and,
- Hamilton county-(urban Cincinnati area where efforts are focusing on services for children).

The data collected from these interviews will be, for the most part, qualitative in nature. It will be used by the Department of Mental Health for informational purposes and not as a means of evaluating provider performance per se. Local mental health systems will have primary access to the data so that they might assess their own system's performance.

In addition, The Alliance for the Mentally Ill of Ohio and The Ohio Advocates for Mental Health will perform a meta analysis of the data collected by the three pilot projects. This report is due to the State by the end of June 1997. These data are expected to help facilitate policy, service planning and system improvement at the local and State levels.

Process for Developing the Performance Systems

The impetus for these demonstration projects came from the State's Office of Consumer Services and the Community Support Program Advisory Committee. Under State standards Ohio's local mental health boards are required to do outcome evaluations of the State mental health programs and are also responsible for gathering client feedback. In the past, the State has never really enforced the outcome evaluation requirement and client feedback usually consisted of client satisfaction surveys that have not been all that substantive.

The interview instrument was developed inhouse by the Program Evaluation and Research Office in Ohio's Department of Mental Health. Consumer satisfaction surveys used by the States of Georgia and Pennsylvania for their own clients of mental health services were reviewed as a starting point for Ohio's own model.

Management Challenges

Working together to effect improvements. The Department of Mental Health is encouraging its local mental health boards to use the "continuous quality improvement model." This effort will necessitate the local mental health boards working together to make this happen. This may be problematic due to the fact that the local mental health boards: do not all have the same service plan, are located in different geographic areas, and do not necessarily tend to share information.

Understanding the data. The plan is to interview clients, effect improvements and then interview clients to determine if improvements have indeed resulted. Determining how to use the data, how to improve the system and how to ensure the data is used by local boards to make a positive impact on consumers will be a challenge for the Department.

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OHIO

Early Start Initiative
Bureau of Early Intervention Services

Department of Health

Overview

The Ohio Department of Health's Early Start Initiative "...provides funding for direct services to infants and toddlers who are extremely vulnerable because their environmental, family or health circumstances place them at very high risk for developmental difficulties, abuse or neglect. [This] funding is intended to provide a collaborative, integrated system of services and supports to help strengthen and preserve families who may be experiencing problems before they become crises." The Department has developed outcome-based performance measures to help assess the success of this initiative.

Nature, Extent and Uses of Performance Measures

As of January 1997, 30 of Ohio's 88 counties are participating in the Early Start Initiative. These participating counties received their first funding in January 1996 and were expected to start serving children and families immediately. Participating counties were asked to provide:

- public awareness and ways to identify potentially eligible children;
- assessment of children (including health and developmental status) as well as the families concerns, priorities and resources;
- an interagency individualized family service plan;
- family support;
- home visits;
- training to staff from local service agencies;
- public awareness and child find; and,
- expansion, enhancement, or creation of services to meet the needs and build on the strengths of children and families in the program.

Providers are required to submit data on the above mentioned services (e.g. type and number of services provided, number of clients served) to the Department every 6 months. Some of the survey tools providers use to capture performance data are:

- The Nursing Child Assessment Satellite Training Feeding and Teaching Scales (NCAST). This data collection tool provides information on parent-child interaction during feeding and teaching interactions. Use of this tool requires 30 hours of training and certification to administer. Eleven Early Start counties use this tool as of October 1996.

- The Home Observation for Measurement of the Environment Scale (HOME). This tool provides information on the quality and quantity of the social, emotional and cognitive support available to young children in their home environment. All 30 Early Start counties are required to administer.

- Individual Family Service Plan (IFSP).

- Parent Satisfaction Survey.

- Data Collection Tool.

Providers' primary concern with the Early Start Initiative was its extensive data collection requirements and associated costs, which would involve the administration of surveys to all clients and data entry. Some of these concerns were assuaged when the Department assured providers that they would not have to collect this large amount of data indefinitely.

Currently, providers do not have the capability of submitting their data electronically. The Department is now working on purchasing computers and modems for the Early Start providers by combining this effort with the State's Early Intervention Initiative. The Early Intervention Initiative has been working for over a year to develop a data collection and reporting system for all 88 of Ohio's counties. In the meantime, providers submit their Early Start data to the Department on paper and the Department then hires temporary data processors to do data entry.

The primary users of this data will be the State. The data is not intended to be used for compliance purposes but as an aid to determine if counties are on target in reaching their goals and objectives and where program improvements might be made. A spin off of this effort, is that the Early Start staff will also be collaboratively working with The Temporary Assistance for Needy Families' JOBS (Jobs Opportunities and Basic Skills) program. In addition, it is believed that this data may support increased funding for the Early Intervention Initiative.

Process for Developing the Performance Systems

The Ohio Department of Health's Early Start initiative is actually an initiative of the Ohio FAMILY & CHILDREN FIRST (OFCF) INITIATIVE. Fully supported by the Governor, the OFCF initiative was formed in 1992 as a part of the National Governor's Association System Reform project to streamline State bureaucracy. A Cabinet Council was formed, composed of the Directors of the Ohio Departments of: Health, Education, Mental Health, Mental Retardation and Developmental Disabilities, Human Services, Drug and Alcohol, Youth, and the Office of Management and Budget. Each cabinet director was designated lead for a specific topic area and responsible for coordinating activities related to their topic area across all departments. (For example, the Director of the Department of Health's topic area is improving the public's access to services.) A State Action Team made up of State agency department or bureau chiefs was formed to

develop, coordinate and manage projects. To ensure that all stakeholders had a voice in these proceedings, committees (headed by State Action Team members) comprised of State agency staff, local providers, consumers and their family members were formed.

The State Action Team's realization of a need for improving access to services for children from birth to age 3 was the impetus for the Early Start Initiative. From concept (July 1995) to implementation (January 1996) the Early Start project took shape in just 6 months.

The performance goals were developed with input from the following sources and stakeholders: local providers and parents, State agency staff, Family and Children First State Team members, evaluators from the Healthy Start Program in Hawaii and the Smart Start Program in North Carolina, and research and evaluation experts from the University of Cincinnati, Ohio State University, the University of Washington (Seattle), and the University of Arkansas. Those State legislators with an interest in early childhood education and the Early Start Initiative were kept informed throughout its development.

Input from the Governor and Cabinet Council members provided four long-term performance indicators. However, these indicators could conceivably take 4 or more years to achieve. Realizing this, the State Action Team members decided that interim goals were needed to assess the progress being made towards achieving the long-term indicators. A two day retreat was held with a research and evaluation group to help facilitate in the development of the short-term goals. Ultimately, a set of three short-term performance goals with accompanying objectives/activities were defined.

The development of the performance measures began with a research design. The Department considers the research design as the one critical element that held the initiative together and kept the process moving along. From the very beginning, and throughout the development of the performance goals and objectives/activities, the Department focused on how they were going to evaluate the effectiveness of county programs and what data was needed to accurately assess their performance. Focus groups with State staff and some of the participating counties were held to determine counties' capacity to do data collection. The Department determined, upfront, data that currently existed and was readily available from data that needed to be created. In addition, prior to county implementation of the Early Start programs, consensus among stakeholders (e.g. State and county officials and participating providers) was reached as to: how the programs would be evaluated, what data would be collected, and how that data was to be collected and by whom.

The Department provided data collection and assessment skills training for provider staff, all of whom had to be certified in these skills before they were allowed to gather data. Two video teleconferences for providers, live and interactive, were held at six to seven sites across the State for further clarification and instruction and for those people that could not attend one of the regional meetings.

Sample Performance Measures

The four long-term performance indicators identified by the Governor and The Cabinet Council are:

1. To decrease the number of subsequent pregnancies for teen parents.

2. To decrease the number of substantiated/indicated cases of abuse and neglect among children age birth to three.

3. To decrease the number of children birth to three placed into out-of-home care.

4. To increase the percentage of substance abusing pregnant women and parents of children birth to three receiving substance abuse treatment.

The three short-term goals and one example of an objective/activity for each goal are:

Goal #1: ***To help create a family environment conducive to the growth and development of children.***

Objective/Activity: To increase parental knowledge and skills related to parent-child interaction and developmental expectations. [Data sources are: NCAST, HOME and the nutrition checklist information from the Data Collection Tool.]

Goal #2: ***To ensure children birth to three have proper medical care.***

Objective/Activity: To increase the percentage of children participating in Early Start with a primary health care provider. [Data source is: Data Collection Tool.]

Goal #3: ***To bring well coordinated services to children and families who need help.***

Objective/Activity: To increase identification and referral of eligible children and families. [Data sources are: BabyNet, intake forms, list of referral sources.]

An example of one of the data sources for goal #1 is the Home Observation for Measurement of the Environment Scale which is used for children from birth to age three. The original form was developed by the University of Washington, School of Nursing. The version used by the Bureau of Early Intervention Services has the following six sections: (1) Emotional and verbal responsitivity of mother, (2) Avoidance of restriction and punishment, (3) Organization of environment, (4) Provision of appropriate play material, (5) Maternal involvement with child, and (6) Opportunities for variety in daily stimulation.

Each section requires the observing party to indicate a yes/no response for a variety of possible caregiver-child interactions. Two examples of these interactions are:

Mother spontaneously vocalizes to child at least twice during visit (excluding scolding). (Section I, interaction #1)

Father provides some caretaking every day. (Section VI, interaction #41)

In some cases, a direct question may need to be asked of the caregiver. For example, "Does the family has a pet?" or "Does the child have a special place in which to keep his toys and treasures?"

Management Challenges

Understanding the new mission. The principle of the Early Start Initiative required counties/providers to think beyond the "quick fix" (e.g. providing money for food, rent or gasoline) to the long-term goal of behavior modification and the services needed to affect this change. One issue the Department has had to struggle with, is people's (e.g. legislators, providers and the public) need to simplify the Early Start program into a fixed package of services and related costs. The Department plans to conduct a public awareness campaign about the purpose of this initiative.

The Early Start Initiative is being administered by the State very much like a block grant. Not all Department staff have grasped the concept of block grant administration which involves a more "hands off approach." In the beginning stages of program development, the counties floundered a bit, thinking they had to invent new and different programs. They wished for the Department's feedback on the viability of various program concepts. However, the State, seeing its role in this initiative as primarily that of a funding agent, instructed Department staff to be helpful but not directive. Instead, counties were instructed to build on existing services and systems already in existence within the county and only create new services where no service existed. The counties were given free rein to develop their Early Start programs. Performance agreements, standard operating procedure in the past, may still be used by the counties but the Department will neither approve nor disapprove such agreements.

Expansion uncertain. Though the Ohio Family and Children First Birth to Three Committee has submitted a half dozen proposals to expand Early Start, it does not appear that the State legislature will increase funding for expansion. State resources are limited and while the Governor and the Office of Budget and Management are in general support of the Early Start Initiative, it is viewed as part of the State's abuse and neglect prevention effort. Also, the legislature has yet to see any data with which to gauge the effectiveness of this initiative. (As of January 1997, counties have submitted data but once to the Department. This first set of data will be used as a benchmark against which county programs' progress towards meeting their short-term goals and long-term indicators may be assessed.)

Lessons Learned

Sooner rather than later. The Department believes providers would have benefitted more from the experience of people at the public health level at the very beginning of the initiative rather than later on in the process.

Consensus building. Reaching consensus from stakeholders at the beginning of the process in regard to outcomes, definitions and what data will be used to measure these outcomes is critical in the development and implementation of outcome-based performance measures.

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OHIO

"Five Point Plan For Strengthening Public Health in Ohio"

Department of Health

Overview

The Ohio Department of Health's Five Point Plan is a planning document offering a systematic approach to developing five program initiatives that together will strengthen public health leadership and collaborative relationships at the State and local community level. The five interrelated program areas targeted for development are: (1) Community Needs and Capacity Assessment, (2) Data System Development and Management, (3) Leadership Skill Development, (4) Healthy People Ohio, and (5) Performance Standards. Though not yet developed, the Department has decided that the performance standards will be outcome based.

Nature, Extent and Uses of Performance Measures

The Five Point Plan is still in draft as of February 1997. Performance standards will be developed for the other four program areas. These four interrelated program areas, and a brief explanation of what they are intended to accomplish, are:

Community Needs and Capacity Assessment: This initiative will provide methodology(ies) and tools for assessing and prioritizing community health problems and needs, and the community's capacity to address priority needs. A component of this program area, and the first step prior to the community assessment, is to examine the organizational readiness of local health departments.

Data Systems Development and Management: This initiative will provide State and local health departments with a Statewide, integrated public health data system.

Leadership Skill Development: This initiative will provide a continuing education program for public health professionals that will focus on developing skill improvement through practical training programs. The interdisciplinary curriculum will include the following skills: basic public health sciences, policy development/program planning, analysis, communication, cultural sensitivity and financial planning and management.

Healthy People Ohio: This initiative is modelled after *The Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. It is intended to provide State and local health departments with a tool to define public health priorities for policy development and program planning, implementation and funding. A structured approach will be developed which establishes objectives with measurable outcomes that are aimed at improving health status, preventing disease/disability and improving access to care while also controlling health care costs. The State plans to adapt the United States

Department of Health and Human Services' model of health promotion and disease prevention objectives to local public health issues.

The Department expects the performance standards to evolve from entities capacity to perform the core public health functions at desired levels. They are intended to "serve as benchmarks for determining what [State and local health departments] are expected to do or must do as part of their day-to-day operations to promote health and prevent disease, injury and premature death." The Department believes that the performance standard initiative will:

- provide for a more equitable system of accreditation, certification and subsidy determination, while assuring State and local health department accountability to the public.
- ensure that the State maintains a minimum public health infrastructure with minimum quality standards.
- enhance the ability of the State's public health system to ensure improved health outcomes for Ohioans.

The State will be the primary users of the data. Local health departments may be allowed access to their own data and aggregate data.

Process for Establishing Performance Measures

Self Assessment

The Ohio Department of Health (ODH) conducted a self-evaluation that ultimately led to the reorganization of its operations and the initiation of this planning process. The impetus for the assessment was the changing health care environment stimulated by the following trends:

- The belief that the health care system is in need of reform has created a demand for greater cost savings, coordination of services and outcome data;
- The pressure on Federal, State and local government programs to prove their effectiveness;
- The formation of partnerships and collaborative efforts among agencies that increases communication and coordinates services for greater efficiency;
- New and anticipated challenges in environmental and health threats; and,
- The advent of nationally accepted public health functions and models that assist State and local health departments handling of today's public health problems.

Phase I of the Five Point Plan

In February 1995, Dr. Peter Somani (Director of Ohio's Department of Health) created a core/steering committee composed of ODH staff and representatives from public health to re-evaluate the role of the State's public health system - a system that was service driven and fragmented. Believing that the public health system was not flexible enough to deal with the changing health care and political environment (e.g. the advent of managed care, a call for privatization, the maxim of doing more with less) Dr. Somani charged the core committee with developing a public health strategic plan that would focus on community needs and accountability rather than programs and perceived needs.

The development of the Five Point Plan was, and still is, a collaboration between the ODH, local health departments, local Boards of Health, public health associations, health care providers, academia and experts in the public health arena. A Steering Committee, consisting of ODH senior staff, hired a consultant (a research and planning organization) to facilitate the planning process. A Technical Advisory Committee consisting of representatives from public health associations was convened to assist in drafting the Five Point Plan. And, to ensure input from local health departments, health commissioners from each of Ohio's local health departments were asked to complete a survey designed to elicit their views and opinions on public health.

The Steering Committee and the Technical Advisory Committee met over a period of 9 months to develop the: Five Point Plan mission and vision statements; purpose and scope of the Plan; and, definition, goals, objectives, and strategies for implementation (action steps) for each of the five initiatives.

Phase II of the Five Point Plan

In February 1996, five workgroups were created (one each for the five strategic areas) to flesh out the elements to be included in each strategic area. Participants were asked to: (1) develop and shape the initiatives; (2) determine resources required to develop and implement the initiatives; and, (3) develop fiscal impact analysis for the respective initiatives, including funding options. This stage of the process has just been completed.

Each of the workgroups was comprised of 25 to 30 people, experts from Ohio's public health system. Members included ODH and local health department staff, representatives from the four major public health associations, and from universities and the private sector. The workgroups were further divided into four to five subworkgroups of four to five people. Because most of the workgroup members were strangers to each other, the first thing each workgroup did was to create a vision and values statement for its program area. This process allowed all involved to get to know and trust each other.

As of January 1997, performance standards have not yet been developed. This will be accomplished in the next phase of the planning process. However, during Phase I, "Essential Action Steps" for the development of new performance standards were outlined. These Action Steps are:

1. Determine whether existing laws/rules need to be modified to develop new performance standards.

2. Department staff assigned, work schedule developed, key participants recruited (e.g. representatives from local health departments).

3. Work group of State Department of Health unit staff convened.

4. Review existing standards and national approaches (e.g. Federal, other States, professional organizations) to the development and implementation of performance standards.

5. Initiate/oversee process of developing performance standards by:

    a. developing a mechanism for incorporating core public health functions into performance standards;

    b. determining the public health practices that fall under the three over-arching core public health functions;

    c. selecting those public health practices to be incorporated into the Department's performance standards; and,

    d. developing measurable performance standards which incorporate existing and new public health practices.

6. Develop a process/procedure for determining/measuring local health department compliance with performance standards.

7. Develop enforcement protocol.

8. Develop self-assessment standards for the Ohio Department of Health.

9. Determine existing authority; draft legislative changes required; draft proposed policies, legislation and/or rules specifying State and local health departments' responsibilities regarding the implementation of the new performance standards.

10. Implement new performance standards.

11. Develop and implement a plan for interpreting/communicating needs and benefits of performance standards. This is an on-going activity to be undertaken by State and local health department leadership.

The workgroup that will be in charge of developing these performance standards is to "...produce a written document describing topical areas for Performance Standards, how

the Performance Standards will incorporate essential public health practices, how compliance will be managed, including enforcement protocol.

Sample Performance Measures

The Five Point Plan defines performance standards "...as statutorily-based, standardized criteria for documenting levels of compliance with public health laws, rules and regulations, and professionally accepted public health practices." Though performance standards have not yet been developed, the Department has decided that Ohio's existing minimum standards will be updated and modified to focus on outcome-based performance measures for the three core public health functions. In addition, performance standards will be developed for each of the following 10 public health practices:

Assessment Standards

1. Capacity for assessing and monitoring health needs.
2. Capacity to investigate and to remedy health hazards.
3. Ability to analyze health determinants, barriers and needs.

Policy Developmemt Standards

4. Capacity to mobilize constituents, communicate and advocate.
5. Ability to establish priorities.
6. Capacity to develop and articulate policies.

Assurance Standards

7. Organizational and resource management capacities.
8. Ability to plan and implement programs.
9. Evaluation and quality assurance capacities.
10. Capacity to inform/educate the public.

Management Challenges

Data development and management is seen as the most critical area in the strategic plan. The Department plans a total systems improvement that will be funded over a 5-year period. Because of the possible changes in agency department directors and in the legislative and executive level of government that can occur during this period of time, a continuing education process to promote this effort will be implemented.

Keeping the effort alive. Recognizing the importance of providing accurate and consistent information about the Five Point Plan to the public health community, the Governor, legislators and other public officials, a short-term marketing plan (designed to interpret the purpose, progress, rational and expected benefits of the Plan) was adopted by the Steering Committee and Technical Advisory Committee. This marketing effort

will be an on-going process to be implemented and coordinated by these two committees and is key to the successful implementation of the Five Point Plan.

Stakeholder buyin. The Five Point Plan calls upon Ohio's 150 local health departments to reassess their public health programs and focus on community needs rather than programs and perceived needs. It also calls for performance standards that will hold local health departments and providers accountable for meeting community needs. Achieving stakeholder buyin for this philosophical change in the way of doing business will be a challenge for the Department.

A legislative mandate will be necessary for the implementation of performance standards.

Lessons Learned

Total Quality Management. Incorporating the Total Quality Management philosophy was critical in the development of the Five Point Plan. Steve Covey's models of circles of influence were used to focus the Department's efforts (e.g. being creative, adaptive, flexible and yet viable). The Department believes it is moving in the right direction as local health departments are beginning to see the value in the Five Point Plan.

Conduct an environmental scan. Because there will always be opposition to change, the first thing one must do when developing a results-based accountability system is to assess what the future may hold. Secondly, one must determine of what value the effort or results will have to stakeholders (e.g. executive and legislative branch, Department directors and staff, providers, advocacy groups and clients). And finally, one must be able to demonstrate effectiveness and efficiency.

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OREGON

OREGON

Division of Health

Department of Human Resources

Overview

As of 1991, Oregon has used benchmarks to assess its progress toward achieving a broad strategic goals set forth in the State's strategic plan, "Oregon Shines." Oregon's Department of Human Resources uses a Statewide system of outcomes and performance measures to evaluate its success in meeting the State strategic plans goals and objectives. The Department is composed of six divisions, among them the Division of Health.

Nature, Extent, and Uses of Performance Measures

The State has just revised its strategic plan (Oregon Shines II) to address the issues and concerns of Oregonians today. The new central vision for the State outlined in the strategic plan is that:

- Oregon will have a high-wage economy and an excellent quality of life.
- Oregon will be a place where all families and individuals can prosper.
- Oregon will balance demands of a vital economy with demands of health ecosystems.

Oregon's benchmarks have also been amended. The total number of benchmarks has been decreased from 259 down to 92 benchmarks that focus on measurable outcomes. The health related benchmarks have decreased in number to 23 and the Department of Human Resources and its Divisions are in the process of revising its outcomes and performance measures to correspond to the new benchmarks. Six of the 20 Department outcomes relate specifically to the Division of Health, which has developed 43 draft performance measures for these 6 outcomes.

Oregon Benchmarks is administered by the Oregon Progress Board. Through citizen opinion surveys and public review and comment, the Board scans trends to draw attention to opportunities and challenges within State programs that may be addressed in the Benchmarks. While this gives an overall direction to pursue in the Benchmarks program, historical data are used to establish a baseline for various target benchmark outcome and performance measures.

In response to each benchmark, Oregon's institutions (public, nonprofit and private) take periodic data measures that are then collected and compiled by the Progress Board in

biennial reports to the State legislature. One example of such a survey is the Youth Risk Behavior Survey which is administered every 2 years to a sample of students in grades 9-12. These surveys are used to monitor progress toward the Oregon Benchmarks and to track the health status of youth, in general, and in relation to such health risks as tobacco, alcohol and other drugs, for example.

Information collected in the form of the Oregon Benchmarks report is used in several capacities. Not only does it contribute to setting the legislative agenda in establishing budget priorities but it also helps focus management attention on high priority matters, useful in the community planning process. Overall, the Department of Human Resources and its Divisions use the data, not for compliance purposes, but as an aid in determining how well the State and county health department programs are performing so that the State may focus its attention on those areas that need improvement.

Process for Developing the Performance System

The Oregon Benchmarks program has been heralded as a pioneer in the move toward legislative enactment of measurement indicators to guide and monitor a State's progress. This model for a union between public, private, and nonprofit organizations in a shared vision garnered the State widespread recognition for its award-winning idea (e.g. 1994 Innovations in Government Award presented by the Ford Foundation and the Kennedy School of Government at Harvard University; included as a section in the 1993 report on reinventing government by the National Performance Review; featured in the National Governors' Association policy paper on the redesign of State government).

The idea for the Benchmarks program was hatched in the mid-80's by a group of corporate leaders as a response to Governor Neil Goldschmidt's request for an economic growth strategy. Oregon Shines, the State strategic plan, was issued in 1989. Later in that same year, the Oregon Progress Board was created and charged with: (1) taking the State's strategic plan to the public for review, (2) identifying key steps necessary to achieve the strategic vision, and (3) translating the strategies in Oregon Shines into measurable goals for the State.

The strategic plan's goals and strategies were the cornerstone for creating the Oregon Benchmarks. The actual beginning of the program is marked by the passage of the first 160 benchmarks into law during the 1991 legislative session. The program swelled to 272 benchmarks in 1993 when then Governor Barbara Roberts offered funding incentives to agencies that adopted benchmarks. In addition, all State agencies were directed to give priority to critical benchmarks in developing their budget proposals and to develop performance measures consistent with these benchmarks.

However, by 1995, with 259 benchmarks, many within and outside State government felt that the benchmarks had become unmanageable, many being unmeasurable or impractical. In fact, the 1995 State legislature declined to renew the program.

In April 1996, Governor John Kitzhaber, unwilling to abort the program outright, appointed a 45-member Governor's Oregon Shines Task Force to work with the Oregon Progress Board to reassess the State strategic plan and its benchmarks in relation to today's realities. Task Force members included legislators; county and local officials; and, representatives from business, labor, academia and the media. In addition, meetings were held across the State during 1996 to obtain input from Oregonians about the State strategic plan.

Based on the benchmark data gathered since 1991, the Task Force determined that the State strategic plan needed to focus more on: "...the well-being of families and communities and the condition of our surroundings." They found that Oregon's "...improved economy has not reduced some of [its] social problems as much as had been expected and that our economic expansion may be threatening the very quality of life that makes Oregon such a special place to live." New goals, objectives and key benchmarks were developed aimed at ensuring Oregon's economic success, improving the health of communities and citizens, and protecting the environment. The revised Oregon Shines II strategic goals are:

Quality jobs for all Oregonians;
Safe, caring and engaged communities; and,
Healthy, sustainable surroundings.

Each goal's objectives identified by the Task Force are projected out to the years 2000 and/or 2010. The Task Force also worked on decreasing and refining the 259 benchmarks into "statements of measurable, realistic outcomes" with more specific performance measures. Ultimately, all but 92 benchmarks were eliminated.

Prior to the establishment of the Task Force, the Department of Human Resources had initiated two efforts, working simultaneously, to reassess its progress toward meeting the strategic goals. These efforts are:

- The Department Director and the six division heads (The Cabinet) and the assistant administrators (The Department Policy Council) held focus groups to review the Department's status in meeting its objectives and the relevance of outcomes and key benchmarks.

- The Performance Measurement Committee (composed of performance measures coordinators for each of the six Divisions within the Department) has been meeting monthly for about 2 years to develop broader outcome measures and more specific performance measures.

The Performance Measurement Committee has just completed (February 1997) a draft of revised outcomes and performance measures, tailored to the 92 new benchmarks, for each Division in the Department. The next step in the process calls for a review of these revised outcomes and performance measures by the Cabinet for approval.

Sample Performance Measures

Each of the Division of Health's outcomes has three or more performance measures. An example of one performance measure for each of the Division of Health's six outcomes is provided below. The number in parenthesis represents the total number of Health Division performance measures for this outcome. These 6 outcomes and 43 performance measures are still in draft.

Outcome: ***Decrease the percentage of people using tobacco.***

Performance Measures (4): Increase the percentage of adults who do not currently smoke tobacco.

Outcome: ***Decrease the number of people at risk of alcohol and drug abuse.***

Performance Measures (3): Decrease the percentage of 8th grade students who used alcohol in the previous month.

Outcome: ***Increase the percentage of healthy babies.***

Performance Measures (5): Decrease the infant mortality rate.

Outcome: ***Decrease the number of deaths, illness, and injuries due to preventable environmental and personal causes.***

Performance Measures (21): Decrease the number of deaths due to AIDS.

Outcome: ***Decrease the teen pregnancy rate.***

Performance Measures (3): Decrease the rate of teenage pregnancy. (Pregnancy rate per 1,000 females age 10-17.)

Outcome: ***Decrease the rate of preventable deaths due to suicide and injuries.***

Performance Measures (7): Decrease the rate of deaths due to unintentional injuries.

Lessons Learned

Stakeholder buyin. In the beginning of the State benchmarking initiative, the effort was discussed and promoted in terms that led State officials and staff to feel that failure to achieve the benchmark(s) could result in the loss of their jobs. Consequently, many people were apprehensive about moving to an outcome-based performance system and development of such a system was slow to be achieved. It took about 2 to 3 years for people to feel comfortable with the new process and to work cooperatively with each

other and among different Divisions and Departments. Today, benchmarking is viewed as a partnership towards achieving the State's strategic plan goals and objectives.

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WASHINGTON

WASHINGTON

Public Health Improvement Plan

Overview

Washington State's Public Health Improvement Plan (PHIP) is a multi-year plan. To date, the efforts under the PHIP have focused on developing an understanding of the core functions and capacities of the State's public health system, including State and local jurisdictions. They have also included the development of outcome standards for improved health of the community, building on *Healthy People 2000.*

Nature, Extent and Uses of Performance Measures

The Department published its first Public Health Improvement Plan (PHIP) in 1994. It outlined core function capacity standards in "community health assessment, development of public health policy, assuring community access to quality health care within the community, and providing the leadership financial and organization administration required to integrate these functions into a coordinated, adaptive and effective public health system."[16] A total of 88 core function capacity standards were included in the 1994 plan.

The plan also included "long term objectives, or outcome standards for the improved health status of the people who live in Washington State, at the same time recognizing that the public health system is not, and should not be, solely responsible for achievement of these objectives. The outcome measures are...generally for the year 2000. They define optimal, measurable future levels of health status, maximum acceptable levels of disease, injury, or dysfunction, and in some cases the degree to which a particular service or program is operational. Many of the outcome standards...are identical in subject matter to the national year 2000 health objectives contained in Healthy People 2000. The actual quantitative objectives for Washington will most often be different from those for the nation, since the baselines are usually different."[17]

In September 1996, the Department of Health published, "*The Health of Washington State*," containing Statewide data on health status, risk factors, and year 2000 goals. All 33 local health jurisdictions have been working on reports on health status and risk indicators for their communities, though with varying results.

A 1996 PHIP report was finalized in December 1996. This second report focuses more on the development of measurement systems. Performance Measures Technical Advisory

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[16] Washington State Department of Health, Public Health Improvement Plan, November 29, 1994, p. 29.

[17] Ibid., p.84.

Committee members believed that they had taken a "critical step" when they differentiated "core functions" from "capacity". They defined capacity as: (1) the presence of supportive organizational structures and policies, (2) a skilled workforce equipped with necessary resources, (3) an effective information and communication system, and (4) an active involvement with the general public, community providers and elected officials. As outlined in the 1996 report:

> Separating the concepts of core function and capacity allowed for the development of a multi-dimensional tool--a matrix format--which could be used to measure the current status of both with a manageable number of indicators.[18]

Process for Establishing Performance Systems

In 1989, Washington State created a Department of Health. The divisions that comprise today's Department of Health were formerly divisions in a large umbrella agency which dealt with many health and social services issues. The State legislature formed the Department to bring some cohesion to health policy development and raise awareness of health issues. Local health jurisdictions were a key constituency in the creation of the Department.

In 1990, an association of local public health officials began work on reviewing the recommendations of an influential 1988 Institute of Medicine (IOM) report, "The Future of Public Health," and its applicability to Washington State. The IOM report identified assessment, policy development, and assurance as the core public health functions. The IOM report was used by the Health Care Study Commission whose recommendations resulted in passage of the State's Health Services Act in 1993.

The Health Services Act anticipated national health reform. The Act incorporated some of the work of the local and State health officials in devising a new vision of public health responsibilities for the State and local health jurisdictions, and allocated money for further work on the concept. The Health Services Act stated:

> The Legislature finds that the public health functions of community assessment, policy development, and assurance of service delivery are essential elements in achieving the objectives of health reform in Washington State. The legislature further finds that the population-based services are cost effective and are a critical strategy for the long term containment of health care costs. The legislature further finds that the public health system in the State lacks the capacity to fulfill these functions... .
>
> The department of health shall develop, in consultation with local health departments and districts, the State board of health, the health services commission, area Indian health service, and other State agencies, health services providers, and citizens concerned about public health, a public health services

[18] Washington State Department of Health, "Public Health Improvement Plan," December 1996, p. 36.

> improvement plan. The plan shall provide a detailed accounting of deficits in the core functions of assessment, policy development, assurance of the current public health system, how additional public health funding would be used, and describe the benefits expected from expanded expenditures.[19]

In 1995, the legislature, responding in part to developments at the Federal level where health reform had stalled, repealed health reform provisions for universal access and an employer pay or play mandate. However, the legislature strongly supported the PHIP initiative. The legislature appropriated funds to begin implementation of the PHIP.

The PHIP is a collaborative effort of State and local health jurisdictions. Throughout the life of PHIP, a steering committee with broad stakeholder representation, along with technical committees (one on performance measures) similarly constituted, have guided the work. Leadership often came from the local health jurisdictions themselves.

As part of the PHIP process, a large group of individuals also identified 39 key public health problems in the areas of infectious disease, noninfectious disease, violence and injury, family and individual health, and environmental health. For each of these five areas, a subcommittee composed a variety of stakeholders was formed to discuss and research key problems, standards, and interventions.

These 39 key public health problems in infectious disease, noninfectious disease, violence and injury, family and individual health, and environmental health laid the foundation for developing *The Health of Washington State*. In each of these areas, outcome standards, threshold standards, and interventions are detailed. For example, in the area of noninfectious disease, six problems are identified: cardiovascular disease, female breast cancer, uterine cervix cancer, diabetes, tobacco use, and chemical dependency. In the area of female breast cancer, measures include: mammogram rates and breast cancer rates.

To develop performance measures for the core function capacities, the technical committee charged with developing performance measures established 20 standards of performance and 39 performance indicators. The assessment tool was sent to all local health jurisdictions. Twenty-eight of 33 LHJs responded. They all used the instrument to rate themselves on each of the 39 performance indicators.

The assessment tool sent to all LHJs for self assessment on a Likert scale of 0 through 5 included such indicators as:

- LHJ uses data acquired through the information systems in the development of health policy and the evaluation of prevention services.

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[19] Revised Code of Washington 43.70.520, contained in Washington State Department of Health, Public Health Improvement Plan, November 29, 1994, p. 247.

- LHJ provides coordination, direction and leadership within the community to improve the access to, and quality of, health services.

- LHJ has access to people technically skilled in carrying out policy development activities.

In its 1994 PHIP report, standards were included for core function capacities. For example, under health assessment, examples of standards included:

- All public health jurisdictions...must have access to an integrated, centrally managed electronic network that provides access to Federal, State, and local information systems.

- All public health jurisdictions...must develop, operate and assure the quality of data management systems which meet local needs in order to systematically collect, analyze, and monitor standardized baseline data.

- All public health jurisdictions...must conduct and publicize epidemiologic, sociologic, economic and other investigations which assess the health of the community and access to health care.

Management Challenges

Obtaining consistent data is a continuing challenge, and the Department of Health is leading an effort to assess data needs and sources for public health purposes throughout the State. To date, no Statewide system of data exists which can be easily used by State officials or local health jurisdictions to obtain key data on health indicators, risk factors, or outcomes. Officials also expressed concern about managed care organizations reluctant to share data that might give competitors a competitive advantage.

Those involved with PHIP continue to struggle with different capacities and needs of extremely different sized counties. Of 33 local health jurisdictions, 20 serve populations of less than 50,000. King County serves over 1.5 million people.

Key State and local officials working on PHIP believe they may be 3 years away from tying capacity to health outcomes. In the meantime, the use of assessment data (local communities' health status and risk factors) will be used to guide programmatic decisions on priorities and activities at the local level.

Independently, the State Office of Financial Management is pursuing goals that are compatible with the core functions approach. Washington State is encouraging the development of performance measurement systems within the State by requiring each agency to submit 6-year strategic plans as part of their 1997-99 biennium budget submissions. Among other things, strategic plans must include the agency's mission description, strategies, goals, objectives, timelines, and performance measures. A separate form for performance measures has been developed, in which agencies must

identify strategies and the outcome, output, and efficiency measures which relate to each strategy, as well as actual data from FY 1994 and 1995, and estimated achievements in FY 1996 through 1999.[20] Because of their prior work, the Department of Health was able to comply with this directive rather smoothly.

Lessons Learned

Officials we interviewed ascribed their success to date to leadership, stakeholder consensus, and support from the legislature.

Because of the historical support of LHJs for the Department of Health, State and local health officials enjoyed a good, constructive working relationship. Officials we interviewed thought that the inherent trust in this relationship made the process work: "The process was built on consensus. People have to brought along. When we were finished, we had consensus; we didn't have a product we had to market or sell."

Officials we interviewed told us they first tried another approach, and carried it out four or five steps, before abandoning it as too cumbersome and finding the right direction in developing the first PHIP. "Mistakes are inevitable," said one official. "That's not failure. Your tolerance for ambiguity has to be pretty high."

Officials who were responsible for guiding the development of the PHIP were particularly encouraged by the legislature's support of PHIP at a time when many other provisions in the original Act establishing the initiative were being repealed. They attribute this support to the emphasis they placed on accountability and the focus of PHIP on community empowerment.

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[20] State of Washington, Office of Financial Management, Operating Budget Instructions, 1997-99 Biennium, May 1996, B-96-01.

WASHINGTON

Division of Alcohol and Substance Abuse

Department of Social and Health Services

Overview

The Division of Alcohol and Substance Abuse in Washington State has developed a multi-tiered approach to performance measurement which began in the late 1980s, in response to a variety of pressures for increased accountability. Among the critical improvements made by the division were increases in data-base capacity to obtain relevant data and focused studies assessing outcomes for target populations.

Nature, Extent and Uses of Performance Measures

The performance accountability system for treatment programs at Washington State's Division of Alcohol and Substance Abuse (DASA) is composed of several key parts.

A **management information system** was developed with input from a variety of stakeholders to meet information needs of a variety of audiences. The new system, entitled TARGET (Treatment and Assessment Report Generation Tool), is focused on performance data. Providers are responsible in their contracts for entering data into the TARGET system. DASA reviews data continually, identifies delinquent reporting, and audits providers for compliance.

The DASA also developed a **performance accountability plan**, developed with input from a variety of stakeholders to identify expected outcomes from treatment.

Finally, DASA supports a **research agenda** to explore performance, through the strategic use and combination of TARGET data, data from other State agencies, and self reported information from the community. This agenda includes the reporting of data from TARGET; the matching of TARGET data to other State systems, including employment and earnings data, Medicaid data, welfare information, corrections data, and birth outcomes and costs; and the use of self reported data from program participants. Over the course of the last several years, DASA has conducted a series of evaluations, many of them focused on particular populations such as adolescents, pregnant women and substance abusers with mental illness, to assess outcomes. Information from TARGET and these evaluations have been used to shift dollars into program and service categories which would be a more effective use of funds.

As part of the division's research and performance measurement efforts, in 1993, Washington State published its first edition of "*Tobacco, Alcohol and Other Drug Abuse Trends in Washington State*," building on the health goals and objectives set out in

"Healthy People 2000: National Health Promotion and Disease Prevention Objectives," published in 1990. This trend report is updated annually.

Process for Developing Performance Systems

A number of factors influenced the development of DASA's performance accountability system. The most significant and immediate factor was a critical report issued by the Legislative Budget Committee (LBC), which conducted a routine review of DASA system operations and found them deficient. In addition to problems of data reliability and validity, the LBC criticized the systems for lacking the capacity to measure outcomes. The results of this review were widely publicized in the front pages of the Seattle Times. Around the same time, a new division director was experiencing his own difficulties with DASA data systems, finding them cumbersome, inflexible and expensive to use because they were mainframe based, and often lacked key data necessary to make good policy decisions.

In addition to these DASA specific issues, the larger environment also influenced a move to a more responsive, user friendly system. Beginning in 1988 and 1989, DASA officials observed intense discussion at the Federal and State level about program effectiveness, outcomes, and accountability. State economies were slumping, including Washington State, creating more pressure for budget tightening in State government. DASA officials believed performance information was critical for them to protect their program against unwarranted assault.

Ironically, budget pressures also led to more scrutiny of State spending for research and planning activities. State legislators and State budget officials were particularly sensitive to management systems procurements, and in fact had created a data oversight group to review and approve such investments. In a very concrete way, the problems identified by the LBC with regard to DASA's systems helped DASA officials convince legislators and budget officials to move forward on DASA's management system improvements. Advances in technology also made DASA's vision for a non-mainframe, user-responsive system possible.

TARGET Development

DASA officials submitted a plan to the data oversight committee, which was approved, which called for a two year time frame to design and implement their new system. They received approved for a $1.2 million investment in the new system.

After two false starts, DASA officials contracted with a small consulting firm with expertise in organizational development, training, and hardware/software expertise, to develop their data system. Their initial use of a departmental data team was unsuccessful because the expertise was exclusively mainframe, and the design plans submitted were not acceptable to DASA management. Their subsequent use of an independent consultant recommended by another program office proved unsatisfactory as well. By the time the final consulting team had been hired, a year had passed without

significant progress on the project. Nonetheless, matters moved quickly once this final team was on board.

The DASA also contracted with a quality assurance consultant, who was knowledgeable about program issues and served as a credible source of information about the project to a wide variety of audiences, including the legislature, program officials and program stakeholders. The DASA convened an executive management committee, composed of the project sponsor (DASA's director), the consulting team, the quality assurance consultant, county officials, providers and other stakeholders. The executive management team met regularly to discuss design and data plans, and defined how they would measure the success of the project. Weekly meetings were also held with the program staff, consulting team, quality assurance consultant, and sponsor.

To develop the items that would be collected within the new system, an advisory committee was formed. This advisory committee was composed of counselors, county staff, State researchers, and others. It met every month for a full day. The advisory committee agreed that the system would meet the needs of the Federal Government, State government, counties, legislature, and providers. Over 400 data items were identified through the deliberations of the advisory committee. The committee prioritized data needs and approved system screens.

Performance Accountability Plan

Parallel to its efforts on TARGET and the development of the report on Statewide trends, DASA developed a performance accountability plan for residential treatment service delivery. Using its quality assurance consultant, who facilitated and summarized results of meetings and prepared a final report on the consensus achieved, DASA outlined outcomes expected from residential treatment. Providers, who were reluctant initially to join the effort because of fear that unrealistic benchmarks would be set for which they had no control, were ultimately persuaded that the development of performance measures was inevitable, because of the budget pressures and demand for accountability discussed above. The DASA officials also believe that their own longstanding credibility and constructive relationships with the provider community assisted in creating the atmosphere of mutual regard and trust necessary for consensus building. The DASA's director commented, "We weren't trying to build new relationships at the same time we were trying to accomplish this task (of building a performance measurement system)."

In addition to coordinating a stakeholder group of providers and counties, DASA developed outcome measures by conducting surveys of other States and Federal agencies; reviewing the recommendations of the LBC; and conducting a review of the negative consequences of alcoholism.

Research Agenda

The DASA hired a full time researcher to help guide its research agenda. The DASA is assisted in this research agenda by two coordinating councils. The first, the Washington Interagency Network, is composed of representatives from 13 different State agencies having a role in or affected by alcohol and drug abuse, including corrections, education, law enforcement, prevention and treatment. Originally formed to develop consensus on responses to legislative proposals, the relationships formed over time and regular meetings have allowed joint projects to be pursued and data sharing facilitated. The second, a research committee composed of State and academic researchers, including representatives from the Veterans Administration, Washington State University and the University of Washington, meets three to four times a year to discuss research initiatives. Discussion within this group helps ensure research is conducted and supported which is relevant to program operations.

Sample Performance Measures

As indicated above, the Division uses various "tiers" of measures to report on performance.

For example, in its last report on tobacco, alcohol, and other drug abuse trends in Washington State (1995), the division reported on such outcomes as the percent of Washington State's high school seniors who had never smoked a cigarette, the percent of high school seniors who reported never having had a drink, deaths per 100,000 persons due to alcohol related motor vehicle accidents, rates of deaths due to liver cirrhosis and lung cancer, and arrests for drug abuse violations, and compared those results to the nation as a whole. The report also discusses policy questions and data needs arising from the Division's examination of these data.

The Division's TARGET data supports outcomes measurements more directly related to programmatic interventions. For example, the Division has developed outcomes measures for four programs: ADATSA ("a state funded program that provides a continuum of care to persons who are indigent and deemed unemployable as a result of alcoholism and/or drug addition"), detoxication, youth assessment and treatment, and treatment of pregnant and parenting women. A series of outcomes and measures have been developed for each program. The following provides some examples of ADATSA outcomes and measures:

Outcome: Reduction in alcohol and other drug use

Measures: (re-admissions to detox and inpatient treatment, abstinence or reduced use of alcohol and/or other drugs--tracked 12 months after discharge)

Outcome: ***Improvement in health***

Measures: (emergency room use, hospital inpatient admissions, hospital inpatient days, outpatient health/clinic visits, psychiatric hospitalization, psychiatric inpatient days--all comparisons between incidence during treatment to the year prior to treatment)

Outcome: ***Reduced crime***

Measures: (drug offenses, domestic violence, violent crimes, property crimes, driving under the influence, other public order offenses--all comparisons between incidence during treatment to the year prior to treatment)

Outcome: ***Improved Employment and Self Sufficiency***

Measures: (levels of employment, earnings, levels of public assistance, stabilized housing--with the exception of the last, where implementation of the measure is in progress, all comparisons between admission and discharge)

Management Challenges

Two unresolved issues remain on the horizon. For the moment, DASA has not developed standards for its performance accountability system. This decision has been very purposeful. The DASA believed that without baseline data and more experience with the system, it was unwise to develop standards. Providers continue to be wary about the development and use of standards.

Another factor affecting accountability measures is the use of managed care for Medicaid recipients in the State. The increasing use of managed care arrangements has an impact on data availability. The DASA officials also fear the impact of carveouts on performance accountability, since it might reduce the incentive to make investments in substance abuse treatment in order to recoup benefits outside the carveout.

Washington State is encouraging the development of performance measurement systems within the State by requiring each agency to submit 6-year strategic plans as part of their 1997-99 biennium budget submissions. Among other things, strategic plans must include the agency's mission description, strategies, goals, objectives, timelines, performance measures, and performance standards. A separate budget form for performance measures has been developed, in which agencies must identify strategies and the outcome, output, and efficiency measures which relate to each strategy, as well as actual

data from FY 1994 and 1995, and estimated achievements in FY 1996 through 1999.[21] The DASA's efforts thus far help position them to respond effectively to this charge.

Lessons Learned

Both consulting firms engaged by DASA to assist in the development of the TARGET system and in performance accountability plan produced internal reports outlining lessons learned from their efforts, which DASA officials shared with us. The DASA officials also shared with us the central lessons they have learned from these combined initiatives.

The key ingredients in all DASA's initiatives which led to success were leadership, commitment, and communication. The DASA's director commented that the initial difficulty in the development of the TARGET system demonstrated to him the importance of his personal, detailed attention to the project as its sponsor, to ensure decisions consistent with the vision of the project were being made and to help "cut through red tape" when obstacles presented themselves. The use of a variety of different committees, representing different constituencies, ensured involvement from key parties and widened the basis of support for DASA's various initiatives. Each initiative undertaken, as part of a whole effort to increase program accountability, supported each other initiative. Commitment occurred because of an increasing consensus of the need and urgency of developing good systems before a less favorable one was imposed from outside, or before the program suffered because it could not demonstrate what it believed to be true. Communication between leadership, staff, consultants, and stakeholders was critical to ensuring common expectations, alleviating fears, and finding optimal solutions.

Continuing threats present themselves, but the structure of leadership, commitment and communication helps allow responses to those threats. For example, DASA faced a legislative challenge to reduce its research investment, but was able to demonstrate the value of its investment and rely on support from widely different stakeholders to help make its case.

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[21] State of Washington, Office of Financial Management, Operating Budget Instructions, 1997-99 Biennium, May 1996, B-96-01.

APPENDIX A

Federal Public Health Block Grant Programs

Among the current block grants administered by the United States Department of Health and Human Services (HHS) for public health purposes are the Community Mental Health Services Block Grants, Substance Abuse Block Grant, Preventive Health and Health Services Block Grants, and Maternal and Child Health Services Block Grant.

Consistent with the character of block grants, the legislation establishing these grants specifies purposes, populations to be served, specific activities or processes to be carried out, reporting requirements, and limits or minimums on the uses of funds for particular purposes. A brief description of each of these block grants follows below.

Community Mental Health Services Block Grants

The Public Health Service Act provides for block grants for community mental health services. The Secretary of HHS, through the Director of the Center for Mental Health Services, makes grants to the States each fiscal year for the purposes of providing comprehensive community health services under a State plan, evaluating programs and services carried out under the plan, and planning, administration and educational services under the plan. State plans provide for the establishment and implementation of an organized community-based system of care for adults with serious mental illness or children with serious emotional disturbance. The plan must contain quantitative targets to be achieved, although the Act only specifies that such targets include the numbers of such individuals residing in the areas to be served under the system. Among other things, specific attention must be given to: (1) reducing the rate of hospitalization for eligible individuals, (2) providing outreach and services to eligible homeless individuals, and (3) estimating incidence and prevalence in the State of the conditions of eligibility.

States must establish mental health planning councils to review State plans, serve as an advocate for individuals with mental illnesses or emotional problems, and monitor, review and evaluate the allocation and adequacy of mental health services within the State.

No more than 5 percent of the total grant to a State may be used for administrative expenses.

Substance Abuse Block Grants

The Public Health Service Act provides for block grants for the prevention and treatment of substance abuse. The HHS Secretary, through the Director of the Center for Substance Abuse, makes grants to the States each fiscal year. States must allocate a specific minimum percentage of funds for alcohol prevention and treatment and for prevention and treatment activities regarding other drugs. States must also spend a specific portion of their funds to educate and counsel individuals not requiring treatment about abuse and provide for activities to reduce their risk of such abuse.

States must submit an assessment of needs to the Secretary in order to receive a grant. This assessment must include information by localities within the State on the incidence and prevalence of drug abuse and alcohol abuse; current prevention and treatment

activities in the State; the need of the State for technical assistance; efforts by the State to improve such activities; and, the extent to which availability of such activities matches the needs.

States must provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program.

No more than 5 percent of the total grant to a State may be used for administrative expenses.

Preventive Health and Health Services Block Grants

The Public Health Service Act provides for block grants for preventive health and health services. Allotments under this section are for preventive health services, comprehensive public health services, and emergency medical services. Payments to States may be used for activities designed to make progress towards *Healthy People 2000* objectives.

States must develop their plans in consultation with State Preventive Health Advisory Committees. They must specify strategies for making progress toward improving the health status of the population and establish reasonable criteria to evaluate the performance of entities receiving payments from the State. The statute also specifies that States must report to the Federal government on progress in meeting the year 2000 health objectives and use the uniform collecting and reporting formats developed by the Secretary for this purpose.

No more than 10 percent of the total grant to a State may be used for administrative expenses.

Maternal and Child Health Services Block Grant

The Public Health Service Act provides for funds to improve the health of all mothers and children consistent with the applicable health status goals and national health objectives established by the Secretary for the year 2000. The grants are to be used to provide and assure mothers and children access and quality health services, reduce infant mortality and incidence of preventable disease and handicapping conditions among children, reduce the need for inpatient and long-term care services, increase the number of immunized children, and other objectives.

States must report on a number of measures specified within the statute or by the Secretary, including rate of infant mortality, rate of low birthweight births, rate of maternal mortality, rate of neonatal deaths, and other such health status indicators.

APPENDIX B

Endnotes

1. For a detailed discussion of general concepts of accountability and specific issues of accountability in Federal block grant programs, see President's Council on Integrity and Efficiency, Committee on Inspection and Evaluation, *Accountability for Block Grants*, July 1996.

2. For a discussion of Federal grant approaches to funding public health activities, see U.S. Department of Health and Human Services, Office of Inspector General, *Federal Approaches to Funding Public Health Programs*, OEI-01-94-00160, July 1995.

3. The President's Fiscal Year (FY) 1996 budget included a proposal for 16 Performance Partnerships in the Public Health Service, including the consolidation of various grant programs within Centers for Disease Control (CDC), Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA). In the FY 1997 budget, the Administration continued to propose performance partnerships for CDC, HRSA and SAMHSA. In the FY 1998 budget, the Administration emphasized performance partnerships within SAMHSA only.

Both Representative John Dingell and former Senator Nancy Kassebaum introduced bills in the 104th Congress that would have implemented the performance partnership model for public health service programs, and specifically for mental health and substance abuse block grants.

4. A recent report by the Institute of Medicine, summarizing a workshop on performance monitoring for improving community health, identified a wide range of activities by Federal and non-Federal organizations. For example:

> The National Committee for Quality Assurance has developed the Health Plan Employer Data and Information Set to collect standardized information from health plans for their own use in assessing their performance, and to help purchasers make decisions among health plans. The Committee is also active in assisting health plans to improve their capacities for data collection, analysis and reporting.
>
> The Joint Commission on Accreditation of Healthcare Organizations is moving beyond standards to develop indicators for assessing the reliability of the standards in predicting actual performance. The Indicator Measurement System was originally developed for hospitals and is now being expanded.
>
> The HHS is responsible for Healthy People 2000, a set of objectives regarding the health promotion and disease prevention with goals to be accomplished by the issued model standards for translating those national year 2000. The American Public Health Association has goals into community action plans.
>
> The HHS, through the Agency for Health Care Policy and Research, funds research on health care outcomes and quality measurement.
>
> The HHS, through the National Center for Health Statistics, assembles vital statistics and conducts significant health related surveys.

For further information, see National Academy of Sciences, Institute of Medicine, *Using Performance Monitoring to Improve Community Health: Exploring the Issues, Workshop Summary*, 1996.

5. Among the national health organizations working with HHS were: the Association of State and Territorial Health Officers, the National Association of State Alcohol and Drug Abuse Directors, the National Association of State Mental Health Program Directors, and the National Association of City and County Health Officials.

6. National Academy of Sciences, Committee on National Statistics, *Assessment of Performance Measures in Public Health, Phase 1 Report, Draft: for Comment*, September 1996. The report proposed performance measures in the areas of chronic disease, HIV/STD/TB, mental health, immunization, substance abuse, sexual assault prevention, disability prevention, and emergency medical services.