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Results-Based Systems For Public Health Programs

Volume 1: Lessons From State Initiatives

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EXECUTIVE SUMMARY

PURPOSE

This report describes initiatives underway in 11 States to implement results-based systems for managing public health programs. It draws on the experiences of these States for insights into the development and implementation of such systems.

BACKGROUND

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. Some proposals call for combining several categorical and block grants together and replacing them with performance partnerships. Performance partnership grants would be negotiated between Federal Government agencies and the States.

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. These arrangements would combine various categorical grants into performance partnerships and would reshape several of its block grant programs.

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.

This report is 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. A companion volume contains brief descriptions of these States' initiatives.

STATE INITIATIVES

The results-based accountability initiatives we examined are generally of two types: (1) broad efforts at Statewide strategic planning and priority setting, and (2) systems focused on target populations and specific program interventions.

These States, in initiating their results-based systems, have several characteristics in common: public pressures for better government, top-level commitment, and extensive stakeholder involvement.

State officials see many benefits from development and implementation of results-based systems and are using data in various ways. However, data from these systems are unlikely to become the sole criteria or driving force for programmatic, budgetary, or contracting decisions.

CHALLENGES FOR THE STATES

In developing their results-based accountability systems, States face several significant challenges: issues with the measures themselves, data concerns, the use of results, and system capacities.

Measurement: States must ensure that measures are related to program missions and goals, adopting a mix of different kinds of measures in order to balance the limitations of outcomes, output and input measures. They must also ensure that measures are appropriately focused on true priorities.

Data: In considering measures, State officials struggle with whether the necessary data are available and reliable, as well as whether the data can be obtained in a timely manner in order to make necessary programmatic adjustments.

Standards: States must consider whether, and how, they will adopt standards associated with the measures they select. If they adopt standards, what are the penalties or results if the standards are not met, and what conclusions can be drawn about program or contractor performance?

Capacities: States must also fairly assess the capacities within their system to analyze and interpret the information they obtain through their measurement and data collection systems.

CHALLENGES FOR HHS

There are significant challenges facing HHS as it considers future directions for its performance partnership grant initiative. The ability of HHS to address these challenges timely and effectively will affect the success of its efforts to implement meaningful performance partnerships with the States. These challenges include:

Usefulness to States: How can HHS ensure that its performance partnership approach, relying on results-based systems for accountability, will be integrated with the State's own performance management efforts?

Effectiveness of Partnerships: What kind of administrative infrastructure can best support the inter-agency partnerships?

Information Exchange: How can HHS best support an exchange of information among Federal and State agencies and with the research and academic communities?

Data Collection: How can HHS maximize the usefulness of its current data collection systems to enhance the effectiveness of its performance partnerships with the States?

Research Agenda: How can HHS best leverage its resources to ensure a research agenda that addresses the major information needs of the States and its own agencies?

Evaluation Capacity: How can HHS ensure that its agencies and the State agencies with whom they partner have adequate capacity to evaluate the performance-based data emerging from these systems?

CONCLUSION

This report documents some important initiatives that are underway across the country to develop more meaningful approaches for managing public health programs. Developing these systems is inherently messy, difficult and time consuming. It involves multiple stakeholders with complex, sometimes competing, agendas. It is an expensive endeavor and can make heavy demands on limited resources. Progress is neither straightforward nor single-tracked. Yet, as is clear from the initiatives described here, States are making serious efforts to develop results-based systems and are moving forward.

We document in this report a number of benefits State officials we interviewed see emerging from their efforts. They bear repeating here. These benefits include: (1) obtaining information efficiently, which can be used to improve program performance; (2) empirically demonstrating program results; and, (3) obtaining consensus among stakeholders on program missions and goals. We believe that these are significant benefits to program managers and strategic planners.

The ultimate determinant of whether these systems succeed, however, may well be their usefulness to those most vested in the programs: legislators, administrators, providers, advocates, and consumers. The challenge facing these stakeholders will be to achieve an appropriate balance when using the data from these systems to enhance decisionmaking about program improvements, budgets and contracts, and feedback to providers and consumers.

AGENCY COMMENTS

We received very positive comments from the Assistant Secretary for Planning and Evaluation, the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control, the Health Resources and Services Administration, and the Secretary for Health. Their comments offered further insights on such matters as: the impact of the Government Performance and Results Act in helping shape performance partnerships; the data and performance measurement problems facing States; the importance of information exchange; and, the role of Federal agencies in performance partnerships. We were also informed that the National Research Council's Panel on Performance Measures and Data for Public Health Performance Partnership Grants has

recently issued its first report entitled "*Assessment of Performance Measures for Public Health, Substance Abuse and Mental Health.*"

Based on these comments, changes were made to the report as appropriate. The complete text of these comments can be found in Appendix B. We regard them as an integral part of the report and recommend them to the attention of the reader.

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INTRODUCTION

PURPOSE

This report describes initiatives underway in 11 States to implement results-based systems for managing public health programs. It draws on the experiences of these States for insights into the development and implementation of such systems.

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.[4] 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, have formed a backdrop for HHS efforts on performance partnership grants in its public health programs.[5] Federal initiatives, such as the Government Performance and Results Act, seeks to improve agency performance and results through results-based management. This technique uses the same process of engaging stakeholders, identifying goals, and formulating performance measures as that employed by the States.

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.[6] 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.[7] 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 focus on 11 States' initiatives. 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 the States we examined.

A companion report, *Results-Based Systems For Public Health Programs, Volume 2: State Case Studies, OEI-05-96-00261*, contains short, descriptive summaries of the State initiatives we examined.

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 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 of performance 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.

STATE INITIATIVES

The results-based accountability initiatives we examined are generally of two types: (1) broad efforts at Statewide strategic planning and priority setting, and (2) systems focused on target populations and specific program interventions.

Broad Efforts

Some States are developing results-based systems to assess progress towards broad, health-related goals for the States' populations. The development of measures in these cases is usually connected with strategic planning efforts designed to identify Statewide priorities and sometimes with reorganizations of health functions within a State. These efforts may also be duplicated at the local level, where officials adjust goals, priorities and measures based on their own assessments of local populations' health status and needs. We found examples of such efforts in Georgia, Florida, Minnesota, New York, North Carolina, Oregon and Washington State.

Georgia's efforts are illustrative of State efforts of this type. In 1994, the State's Governor appointed a 21 member Policy Council for Children and Families. The following year, the Georgia legislature statutorily established the Council as a 19 member panel composed of leaders in business, child and family advocacy, local government and religion along with State directors of cognizant agencies. The Council issued a report in 1994 outlining five results areas that it seeks for children and families, including healthy children. The Council established a Results Accountability Task Force which established 26 benchmarks for the five results areas identified by the Council. Benchmarks for healthy children include: (1) reducing the percentage of children who have untreated vision, hearing or health problems at school entry; and, (2) reducing the pregnancy rate among school age girls.

New York's efforts are also illustrative of State efforts of this type. In the past year, New York's 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.

Program Specific Efforts

Some States are developing results-based systems to assess the effectiveness of particular interventions and programs. In these cases, measures are often developed in connection with efforts to develop consensus and agreement on program missions and expected results. Program specific efforts are generally focused on the target populations actually receiving some kind of service from the program. We found examples of such efforts in Florida, Illinois, Ohio, Massachusetts, New York, North Carolina and Washington State.

Ohio's efforts in its Early Start Initiative are illustrative of State efforts of this type. Ohio's Early Start Initiative is focused on providing integrated, preventive services to families with infants and toddlers at high risk for abuse, neglect or developmental disabilities. Currently, 30 of Ohio's 88 counties are participating in the Early Start initiative. An essential part of the project was the development of performance goals and data collection protocols.

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

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.

As evident from the above, often both kinds of efforts are taking place at once, but they may or may not be explicitly linked. We found an example of an explicitly linked effort in Nebraska, where program officials have designed a system to use outcome measurements in conjunction with program specific performance measures. 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.

In examining State efforts, we are able to categorize systems into two broad classifications. Beyond that, because of the limited scope and duration of our visits, document reviews and telephone interviews, we cannot present more refined models or typologies of States' efforts. Within the two broad classifications presented here, the variety of efforts reflects a wide range of choices available to State and local authorities in developing systems they consider appropriate to their needs, available resources, and other legislative and administrative imperatives.

In describing the State efforts, the data presented here should be emphasized as a snapshot in time in a constantly changing environment in which State efforts will certainly evolve. Perhaps even dramatic changes in direction will occur with significant changes in State and local leadership, resources and other legislative and administrative imperatives.

(For a more detailed description of these initiatives, see the companion report, *Results-Based Systems For Public Health Programs, Volume 2: State Case Studies, OEI-05-96-00261.*)

These States, in initiating their results-based systems, have several characteristics in common: public pressures for better government, top-level commitment, and extensive stakeholder involvement.

Public Pressure

These results-based initiatives have been influenced by: the performance measurement movement that has become increasingly influential throughout government; the demands of State legislators and the public they represent for more evidence of results and program achievements; and, the interest in health reform at both State and Federal levels. Many State public health programs have been particularly influenced by the Healthy People 2000 initiative that established national public health objectives, goals, and standards for the nation to achieve by the year 2000. This document has served as a critical foundation and framework for several of the State efforts described here. It has helped the States to refocus their public health programs to achieve specific outcomes. It has also served a larger purpose of familiarizing those outside the public health community with a different approach for thinking about accountability in these public services.

Top-Level Commitment

Most of the State initiatives described here were either initiated or strongly backed by top-level State or agency officials. Sometimes, this commitment was in the form of a catalytic event, such as the major reorganization of a department or a major piece of legislation that required results-based systems. Other times, the commitment came from a newly elected Governor or a newly-appointed department head.

Stakeholder Involvement

All the State initiatives described here have involved a wide variety of stakeholders in the development of their systems and measures (e.g. providers, beneficiaries, program officials, advocates, and citizens). The development of partnerships with stakeholders was identified by respondents as one of the key aspects of their success, albeit one that was logistically difficult, time-consuming, and challenging.

For example, New York's State Department of Public Health sponsored a series of six, 1-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, representing local health care providers, government officials, community-based organizations, educators, advocates, and business and labor.

Florida's Division of Alcohol, Drug Abuse and Mental Health used workgroups with stakeholders--providers, clients, legislative staff, oversight 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).

For the Massachusetts Department of Mental Health, developing standards and indicators for residential services 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.

State officials see many benefits from development and implementation of results-based systems, and are using data in various ways. However, data from these systems are unlikely to become the sole criteria or driving force for programmatic, budgetary, or contracting decisions.

State officials who have implemented results-based systems point to two key benefits from their efforts: (1) obtaining information efficiently, which can be used to improve program performance; and, (2) empirically demonstrating program results. State officials also point to significant benefits from the process of developing results-based systems. Officials frequently mentioned the value of obtaining consensus among stakeholders on program missions and goals, and establishing lines of communication with key stakeholders.

Other benefits may become apparent from further experience. Some of the initiatives we examined are still in the early stages of implementation and are not fully operational. As a result, we can not yet draw conclusions for these programs as to how information obtained through results-based systems ultimately will be applied. Too, we did not interview other potential users of these data--planning staff, legislators, and stakeholders, among others--and so we cannot draw conclusions about how they might apply data from these systems.

State officials we interviewed, who have had experience applying data from results-based systems, indicate that performance and outcome data are most often used as part of a larger mix of information and interests which determine how: (1) programs are managed; (2) providers, contractors, and local offices are assessed; (3) budgets are allocated; and, (4) contract decisions are made. For example, officials in Washington State's alcohol and drug abuse program indicated that they had used data from their results-based system to refocus priorities and interventions, but only after further research and analysis. In Massachusetts, the mental health program uses results-based data in its contracting process, but does not rely exclusively or even primarily on these data to make its decisions.

One interesting development is the requirement by some State legislatures or executives for agencies to submit outcome and performance data with their budget requests. This suggests that executives and legislators might be increasingly inclined to make budgetary

and allocation decisions which at least take results-based data into account. The systematic collection of this information across all State programs, in addition to spurring activity to develop goals and measures, also allows executives and legislators to compare mission statements, goals, outcomes and performance across agencies and programs.

Washington State, for example, is requiring each agency to submit 6-year strategic plans as part of their 1997-99 biennium budget submissions. The plans must include the agency's mission description, strategies, goals, objectives, timeliness, and performance measures and standards. Florida is implementing its Government Performance and Accountability Act of 1994 over an 8-year period. Agencies must submit performance measures (input, output, and outcome) and standards in their budget submissions. In return, they will have flexibility to reallocate dollars among categories and programs.

The use and focus of these results-based systems makes the case for a broad definition of accountability, in which mission definition, public reporting, consensus building, partnering, and the use of information to engage partners, target technical assistance and close performance gaps are the key ingredients. This type of use is different from a definition of accountability in which the results-based data are seen as a clear and precise road map by which program managers can make clear distinctions between good and poor program providers, effective or ineffective program interventions, or adequate or inadequate budgets.

MAJOR CHALLENGES FACING STATES

In developing their results-based accountability systems, States face several significant challenges: issues with the measures themselves, data concerns, the use of results, and system capacities.

These challenges are complex and not subject to quick solutions. Many overlap and reinforce one another. Yet the extent to which States will be able to translate their efforts into improved program effectiveness or more efficient targeting of public dollars will largely depend on how they address these challenges and answer the questions they pose.

Measures

Are measures related directly to program missions and goals?

In order to develop appropriate measures, States must reflect on, and make decisions regarding, their primary missions and focus. In the areas of preventive health and maternal and child health, for example, the consideration of measurement systems has stimulated an ongoing debate about the role and mission of local public health programs. Is their mission one of providing primary care to the underserved; or assessment, policy development, and assurance oriented towards improving the infrastructure for an entire community; or some combination, and if so, with what balance? Likewise, in the substance abuse and mental health areas, the question is similarly put: is the orientation towards the community at large or towards target populations (e.g. those with current problems or those at risk of developing them) which are served by the programs?

In addition, States must struggle with the questions of what outcomes are really desired and how desired outcomes relate to accountability. For example, is a provider responsible for treatment only, regardless of whether the mode of treatment is effective? Or, more than that, is the provider responsible for whether or not the client obtains employment and is able to become self-sufficient?

What is the proper mix of different measures?

States must struggle through questions of the proper mix of measures: those that are end outcomes, others that are "intermediate" outcomes or risk behavior-oriented, and others that are capacity- or process-oriented performance measures.

Many experts consider the use of systems that are purely outcomes-based to be inadequate. It can be difficult to hold program officials accountable for outcomes that can be influenced by a wide range of factors. Results obtained through outcomes measurement systems often raise a host of questions that require process and capacity oriented data to help answer. Indeed, the use of outcomes measures in some of the States we visited has increased the visibility and need for research, evaluation, and

analytical support to interpret the data and conduct follow-up inquiries, rather than supplanting the need for such analytical support.[8]

Appreciating limitations of systems relying solely on outcomes measures, the National Academy of Science recommended that HHS combine outcomes measures with process and capacity measures in its performance partnership grants with the States.[9] The States, too, are adopting approaches which include a mix of measures.

In Nebraska, for example, State officials have made an explicit distinction between performance measures and outcomes measures, where the former is programmatically oriented towards measures of effectiveness, efficiency and quality; and the latter is oriented to broad health status measures. They believe this mix of measures will help focus on end results while providing more direct goals and measurements towards which program officials can work.

In North Carolina, at the Department of Environment, Health and Natural Resources, planners developed "Level I" indicators (health status indicators) and "Level II" indicators (output, capacity, risk behavior and process measures) which augment the information available through the Level I indicators.

Are the measures appropriately focused?

A long list of measures may cause those within the system to lose focus on what really matters and to confuse priorities. A short list can provide too little data on which to assess performance or make funding decisions. In Oregon, State officials are being criticized in some quarters for measuring too much and losing sight of real priorities. In New York, an earlier effort in strategic planning in the late 1980s was derailed by too many measures and data points that prevented adequate tracking and accountability. Officials now express concern that they have focused too much on a few goals and a few measures and are not capturing all the health priorities of the State.

Data Concerns

Are the data available?

Most State efforts are intended to be practical and, therefore, use data availability as a key criterion for the acceptance of a measure. However, this practice may compromise the reliability and validity of the data. If States select measures primarily for the current convenience and accessibility of data, important results may not be measured and decisionmaking based on the measures will be inadequate and flawed. Yet, if States identify important measures for which data are not available, or cannot be made available, the system will be theoretical only.

Many States are facing a paucity of needed data, particularly at county and local levels. In these situations, States must ask hard questions about whether funds are available to collect additional data and who will collect them. If the States use funds to develop

Statewide management systems or impose data collection responsibilities on providers, they must assess whether or not the collection of additional data will be seen as an administrative burden or as a crucial responsibility of program management.

Our conversations with State officials confirmed the urgency of investing in focused systems that can provide the core data necessary to support State-, county-, and provider-level measurement efforts. In Illinois and Washington, officials responsible for alcohol and substance abuse prevention and treatment programs emphasized the importance of systems which can be altered easily, and unique identifiers to facilitate data analysis, validation and matching.

A particularly thorny issue facing States is the lack of data available to properly assess the impact of managed care arrangements on enrollee health and States' budgets. Almost all of the States we contacted have yet to address this question, though many are taking steps to do so. North Carolina does include requirements for data reporting in managed care contracts and several other States mentioned that they intend to do the same.

Are the data timely?

Even when data are available, the timeliness of obtaining them can present significant problems. While the usefulness of data may be dependent on the rate of change of the problem or environment, often data that are 2 or 3 years old cannot be used effectively to assess current program performance, to sanction providers, or to allocate scarce funds. In part, for this reason, Florida's alcohol, drug abuse and mental health program office requires providers to collect and report on data. These data could be obtained by matching data files with other State agencies, but would take considerably more time to obtain using this method.

Use of Results

How will States develop and use standards?

The States we examined are generally far away from the use of standards to require accountability among providers or contractors. States have not been reluctant to develop goals for broad health status measures, but have proceeded much more cautiously in developing standards for measures applicable to specific programs or interventions. Even when included in provider contracts or requests for proposals, standards tend to be broad, flexible, used to trigger further discussions and analysis when not met, and used to promote emphasis on results.

For example, Washington's Division of Alcohol and Drug Abuse has not implemented standards for its performance accountability system. This decision was very purposeful. The Division believes that without baseline data and more experience with the system, it is unwise to develop standards. State officials report that providers there continue to be wary about the development and use of standards.

Florida's alcohol, drug abuse and mental health providers are given two standard deviations as a range of acceptable performance. In the integrated services proposal being prepared between New York State and its Monroe County, county officials are expected to obtain goals with ranges of acceptable performance. In both of these cases, performance outside the range would trigger additional validation, analysis, research and discussions, rather than automatic sanctions.

How will the public, State legislatures, or other key stakeholders respond when program officials fail to meet benchmarks?

Officials in several States expressed concern about their exposure in reporting outcomes and performance data. They are particularly concerned about public and legislative reaction when goals are not met. They believe the data can be used inappropriately by stakeholders to assume that program managers have simply mismanaged or misdirected their efforts, when, in fact, failure might be attributable to unanticipated or uncontrollable external influences. These concerns of the State officials in many ways mirror those of the programs' providers. In Nebraska, for example, the development of standards was purposely set aside in order to make program officials feel "safe" as they worked on developing a performance measurement system.

Some officials noted the difficulty of responding appropriately to the data in the following way: does failure to achieve goals mean that the program should receive more money (in order to help it achieve the goals) or less money (because it is a poorly performing organization)? To answer this question, significant analysis and interpretation of data must take place with a depth of understanding of environmental complexities that these officials believe State legislatures and the public may not possess.

How do States balance accountability with partnership?

The above examples also reflect the difficulty States are facing in developing measurement systems with the assistance and active participation of those whose performance is being or will be measured. In Illinois, for example, officials observe that their partnership with providers has not evolved as they would like because of concern about how standards might be applied in evaluating their performance, particularly how external factors beyond the providers' control might be considered. We found that this concern was not exclusive to health care providers. To deal with this problem, some States have downplayed standards, as discussed above.

<u>System Capacities</u>

Will resource investments in data systems and analytical evaluation be adequate?

As discussed above, the collection of key data on outcomes and performance only **begins** a process of assessing performance, not ends it. In Nebraska, for example, officials believe their future success depends on whether the necessary investments in these capabilities will be made. And Washington's alcohol and drug abuse program officials

attribute their success in large part to having made adequate investments in non-mainframe data systems and a research capability to support focused reviews based on results.

How will States address the wide variation in local level infrastructure and capacity?

Many States noted in their conversations with us the wide differences among their local partners in staffing and expertise, as well as in mission definition and demographics. In Florida, New York, North Carolina, Ohio, Washington, and Nebraska, officials pointed out the variation in funding and density among the most populated and the least populated counties in their States. These State officials pointed out that the ability and interest within each of these counties to collect data, interpret it, and use it to manage programs varies widely.

CHALLENGES
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Our inquiry has examined the initiatives of several States in implementing results-based accountability systems in their public health and mental health programs. Our primary focus has been on the States rather than on any efforts of HHS as it moves forward with its performance partnership initiative.

At the same time, from our conversations with many State officials, we have come to appreciate the challenges facing HHS as it considers future directions for its performance partnership grant initiative. The ability of the Department to address these challenges timely and effectively will affect the success of its efforts to implement meaningful performance partnerships with the States.

Since we have not examined Federal initiatives, we can not say to what extent agencies are already addressing these challenges. In some cases agencies may have moved well beyond some of these challenges or are well underway in addressing them. Nonetheless, we present them here as important questions for Federal agencies that are working with States to develop performance partnerships.

To varying degrees, States raised these questions with us as indicators they will use in assessing the success of Federal-State partnerships. We do not intend the mere exposition of these challenges to reflect on the progress Federal agencies are making in pursuing performance partnerships. Rather, we intend them to reflect only the complexity of the enterprise.

Usefulness to the States

How can HHS ensure that its partnership approach, relying on results-based systems for accountability, will be integrated with the States' own performance management efforts?

The initiatives we examined confirm the seriousness and intensity of the States in implementing results-based systems for their programs. The State programs described here, for example, have already moved beyond the early talking stages and are deeply immersed in the nitty-gritty work of planning, implementation, and refinement.

As with all intergovernmental initiatives, performance partnerships require accommodation and consensus, as well as recognition of both common and different needs, goals missions, capacities, and Federal and State environmental pressures. As HHS works with States in developing performance partnerships, what are the lessons HHS can learn from States ongoing experiences with results-based accountability systems. Given the numerous efforts underway in the States, how can the Federal-State partnership accommodate and even support the variation in State approaches?

To what extent will State and local officials be receptive to Federal leadership in light of their own unique and established methods, partnerships, resources, capabilities, and commitments?

Effectiveness of Partnerships

What kind of administrative infrastructure can best support inter-agency partnerships?

A critical underpinning of the partnership grant approach is effective working relationships among numerous government stakeholders. The complexities of these relationships go far deeper than a casual reference to "Federal-State partnerships" may suggest. The experiences of the States described here indicate the essential cross-cutting nature of many important public health goals and the need for clear roles, consistency of requirements, and appropriate resources among the Federal agency partners, and regional and headquarters offices. What are the roles for the Federal agencies involved? Should one Department or agency have the lead, or should all those affected be equally involved? What are the roles for regional offices? What staffing resources are necessary for the technical assistance and dialogue essential for this new partnership approach?

Information Exchange

How can HHS best support an exchange of information among Federal and State agencies and with the research and academic communities?

As HHS and the States move forward with results-based accountability systems, they will have a continuing need for information and expertise. Open dialogue among stakeholders will greatly benefit the performance measurement efforts within the Department. Such exchanges could lead, for example, to standard definitions to be used across HHS, as well as models and best practices on working with States on performance partnerships.

In its leadership role for performance partnership grants, the Department will need to address many issues. For example, how can HHS learn from others about emerging developments that can enhance continuous improvement among Federal agencies and those of the States? What mechanisms, such as clearinghouses, advisory groups, or Federal-State meetings, are appropriate for giving the Department essential feedback and for informing itself, the States, and others with evolving knowledge, new ideas, and new approaches?

Data Collection

How can HHS maximize the usefulness of its current data collection systems to enhance the effectiveness of its performance partnership grants with the States?

The HHS supports extensive, significant collections of health and health-related data that are critical to the success of States' efforts to develop results-based systems for

accountability. The States already rely heavily on Federal survey and epidemiological data for their own purposes as well as for comparisons across States based on aggregated data. Because these systems are complex and expensive to operate, it is important that the Department ensure that its efforts, in so far as practical, meet the major, common needs for data among the States.

Agenda for Research

How can HHS best leverage its resources to ensure a research agenda that addresses the major information needs of the States and its own agencies involved with partnership grants?

Significant questions, both theoretical and practical, about results-based systems remain unanswered. These have been identified and described in other sources.[10] There is obviously a clear role here for HHS in the evaluation of these efforts. From the perspective of the States, however, it is important for the Department to appreciate the significance of the States' research needs for informing their ongoing efforts to implement effective systems.

Adequate Evaluation Capacity

How can HHS ensure that its agencies and the State agencies with whom they partner have adequate capacity to evaluate performance-based data emerging from these systems?

It will not be sufficient for HHS, or others, to rely primarily on performance data reported by the States for its critical decisions about program effectiveness, allocation of resources, and policy changes. These data should be considered only the raw materials for subsequent evaluation and analysis, essential for informing deeper understandings of what is actually going on. The data help frame the questions to ask; they, in themselves, do not provide the answers. A significant threat to the long-term viability of performance partnership grants and other results-based systems will be the failure to link them with sufficient systems for analysis and evaluation that will adequately provide for informed decisionmaking by the Federal Government, the States, and the general public.

CONCLUSION

This report documents some important initiatives that are underway across the country to develop more meaningful approaches for managing public health programs. Developing these systems is inherently messy, difficult and time consuming. It involves multiple stakeholders with complex, sometimes competing, agendas. It is an expensive endeavor and can make heavy demands on limited resources. Progress is neither straightforward nor single-tracked. Yet, as is clear from the initiatives described here, States are making serious efforts to develop results-based systems and are moving forward.

We document in this report a number of benefits State officials we interviewed see emerging from their efforts. They bear repeating here. These benefits include: (1) obtaining information efficiently, which can be used to improve program performance; (2) empirically demonstrating program results; and, (3) obtaining consensus among stakeholders on program missions and goals. We believe that these are significant benefits to program managers and strategic planners.

The ultimate determinant of whether these systems succeed, however, may well be their usefulness to those most vested in the programs: legislators, administrators, providers, advocates, and consumers. The challenge facing these stakeholders will be to achieve an appropriate balance when using the data from these systems to enhance decisionmaking about program improvements, budgets and contracts, and feedback to providers and consumers.

AGENCY COMMENTS

We received very positive comments from the Assistant Secretary for Planning and Evaluation, the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control, the Health Resources and Services Administration, and the Secretary for Health. Their comments offered further insights on such matters as: the impact of the Government Performance and Results Act in helping shape performance partnerships; the data and performance measurement problems facing States; the importance of information exchange; and, the role of Federal agencies in performance partnerships. We were also informed that the National Research Council's Panel on Performance Measures and Data for Public Health Performance Partnership Grants has recently issued its first report entitled "*Assessment of Performance Measures for Public Health, Substance Abuse and Mental Health.*"

Based on these comments, changes were made to the report as appropriate. The complete text of these comments can be found in Appendix B. We regard them as an integral part of the report and recommend them to the attention of the reader.

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

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

AUG - 7 1997

TO: June Gibbs Brown
Inspector General

FROM: David F. Garrison
Principal Deputy Assistant Secretary
for Planning and Evaluation

SUBJECT: Comments on the OIG Draft Report: "Results-Based Systems for Public Health Programs," OEI-05-96-00260

Thank you for the opportunity to review this draft report. We continue to believe in the importance of establishing performance partnerships for greater flexibility, improved accountability, strengthened relationships with States and other partners, and, ultimately, improved outcomes for our customers.

The report provides a comprehensive description of current state efforts to implement results-based systems and the challenges involved, both at the State and Federal levels. We were pleased to see that the report now includes examples of performance measures in each state case study. The report reinforces many of the challenges that we have tried to address over the past several years in our performance partnership efforts. For example, CDC and SAMHSA have each spent the last year working to integrate some aspects of performance measurement into their existing grants, have recognized the importance of conducting extensive stakeholder consultations as an integral part of this process, and have modified their proposals to be responsive to states concerns. The Department also recently commissioned the National Academy of Sciences to develop a report on performance partnerships, *Assessment of Performance Measures for Public Health, Substance Abuse, and Mental Health*, which provides guidance for Departmental efforts by laying out many of the same challenges with recommendations for addressing them.

We appreciate the opportunity to review and comment on this report. We believe that it will provide valuable guidance as programs at the Federal and State levels implement systems of outcome-based management, particularly as we move forward with our State partners on implementation of the Government Performance and Results Act.

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Substance Abuse and Mental
Health Services Administration
Rockville MD 20857

AUG 1 1997

TO: June Gibbs Brown
Inspector General

FROM: Administrator, SAMHSA

SUBJECT: Comments on Draft Inspector General Report, *Results-Based Systems for Public Health Programs*

Thank you for the opportunity to review this very valuable report. Not only did we find its conclusions sound, but the information on the States' efforts will be extremely useful to all of us -- Federal staff and the States -- working on SAMHSA's pilots on State performance measurement.

Our general comments on Volume I will be followed by specific comments on each section, as well as a few comments on Volume II. Also, attached are more detailed comments on States' concerns about the type of data required and the nature of accountability under a results-based system.

Volume 1. General Comments

As noted, we find the Report thorough and sound. We are particularly pleased that the Report stresses the importance of top-level commitment to and stakeholder involvement in results-based systems. States have indicated repeatedly that these two factors are critical to the success of these efforts. We are also pleased that, on page 9, the authors state that "the use and focus of results-based systems" calls for a "broad definition of accountability", which would lead to targeting technical assistance and closing gaps, as opposed to a more narrow definition that would provide clear distinctions between good and poor programs.

The Report could be even stronger, however, if it were updated in the following ways:

- **Reference to the National Research Council's Panel on Performance Measures and Data for Public Health Performance Partnership Grants**: This Panel recently issued its first report, *Assessment of Performance Measures for Public Health, Substance Abuse and Mental Health,* which provides a "framework" for performance measurement which clarifies that, often, a combination of process, capacity, and outcome measures is necessary as State and Federal officials seek to determine the contribution made by their resources, but that the link between process and capacity measures to outcomes must be well-documented. It also provides a set of "assessment guidelines" to assess the appropriateness of individual measures, including that they be: results-oriented;

meaningful and understandable; valid, reliable and responsive; and that data are available to "support the measure." It also calls upon the Department to work with the States "to identify and develop common definitions and methods that will contribute to standardizing measurements". Finally, we urge the Report's authors to adopt the National Academy of Sciences Panel definitions, which include terms such as "performance measure" ("a qualitative indicator that can be used to track progress toward an objective").

- **Clearer link to the Government Performance and Results Act**: Although GPRA is referred to in the Report's introduction (p.2), its conceptual link to State efforts (i.e., the Federal government is engaged in the same process of engaging stakeholders, identifying goals, and formulating measures as the States) and its impact on Federal receptiveness to State needs (i.e., better data on Federal programs) and "lessons learned" due to results-based management should be emphasized.

State Challenges

Attached is a background document prepared by the SAMHSA Center for Substance Abuse Prevention concerning data and measurement issues faced by States in implementing results-based systems. Three key points are made:

- **Level of accountability** (i.e., client, program, system): "Most States appear more comfortable with accountability being tied to changes at the program level.... The major problems associated with collecting this level of data include cost/manpower, programs that receive funding from multiple sources, and the fear of the providers that they will lose funding depending on the results."

- **National vs. State Data**: "...while national surveys can resolve the issues of variation in definition, design and methodology across States, the data are of little practical use at the State and sub-State level. They need data at the lowest common denominator possible to be useful for planning and funding. One suggestion is to provide States with sufficient funds to conduct surveys (much as in State needs assessment contracts) that provide data at a level useful for States, but require some common data collection (and provide consistent methodologies with training) so that they can be aggregated to the national level."

- "**State data infrastructure capacity** is a major issue. Most simply don't have sufficient funds, manpower, and or equipment to develop, implement, and maintain a performance measurement system."

Page 3 - June Gibbs Brown

Federal (HHS) Challenges

We are pleased that language has been added, on page 15, that acknowledges that "agencies may ... be well underway in addressing [these challenges]" because SAMHSA has been engaged in a true partnership with the States over the past 1 1/2 years to shape the performance partnership effort related to its block grants. As a result of this partnership, we have proposed legislation to provide State flexibility (waivers of certain conditions in exchange for measuring performance) and to strengthen State data infrastructure.

We have three minor comments on the challenges:

- Under "Information Exchange", we urge the authors to note the importance of information exchange on performance measurement efforts within the Department. Such exchange could lead, for example, to standard definitions to be used across HHS, as well as models and best practices on working with States on performance partnerships.

- Under "Agenda for Research", authors should note the role for HHS in evaluating and assessing these efforts as well.

- Under "Adequate Evaluation Capacity", we recommend that the specific importance of linking these efforts to GPRA be clarified (for example, through the block grants by ultimately using State performance indicators as block grant GPRA measures).

Volume 2. State Case Studies

Page 33 - Substance Abuse treatment is not noted for Massachusetts.

Page 43 - Minnesota has an outcomes monitoring system in place for substance abuse, but this was not noted.

Again, thank you for the opportunity to comment on this very worthwhile and timely Report. We look forward to receiving a copy of the Final Report.

Nelba Chavez, Ph.D.

Attachment

Attachment

CENTER FOR SUBSTANCE ABUSE PREVENTION
DISCUSSIONS WITH STATES ON RESULTS-BASED SYSTEMS
(FL, LA, GA, IL, MA, MN, NE, NY, NC, OH, OR, WA)

TYPES OF DATA
Statewide or program

States made it clear that, while it's easier to obtain State level data (e.g., using social indicators, or national or Statewide surveys), they have no confidence in their usefulness re: Performance Partnership Grants (PPGs) because the contribution of the effects of the programs they fund and the limited populations they serve on changes in State level data is likely to be nonsignificant. In addition, there is no controlling for the effects of other substance abuse prevention programs on those data. Therefore, it would seem futile to hold the single State agency accountable for changes in results at that level. This holds true, to a lesser extent, even at a county level for most States. The exceptions may be those States that have established State inter-agency coordination of programs and even pooling of resources. This is by far the exception, rather than the rule.

Most States appear more comfortable with accountability being tied to changes at the program level. The major problems associated with collecting this level of data include cost/manpower, programs that receive funding from multiple sources, and the fear of the providers that they will lose funding depending on the results.

Another problem is that, typically, States are unable (as opposed to treatment) to do long term follow-up. Therefore, while changes in risk factors/status may be detected after involvement in prevention programs, they will be unlikely to track long-term outcomes such as use 5-10 years later (e.g., programs for elementary aged children).

In the CSAP Minimum Data Set pilot, interested States have focused on data at the provider level. CSAP is currently modifying the system tested by eleven States in the Phase I pilot which was completed May 31, 1997, and pursuing the refinement of definitions, methodologies and procedures for the collection of five intermediate and outcome performance measures agreed upon by 27 States. These were identified using a multiple focus group approach and using selection criteria also identified via consensus of the participating States. It is important to recognize however, that participation is voluntary and, by the time the data collection phase begins, CSAP expects some States to drop out.

STATE ISSUES

Measures are another problem. Some valid data sources and/or instruments exist in some areas. There is much diversity among the States re: which measures to use, how they are defined etc. This is, therefore, a problem at the Federal level for the collection of the common core data. In fact, in our pilot, States used the National Academy of Sciences (NAS) criteria with the addition of the criterion "cheap and easy to use". Other considerations (discussed in NAS) of importance to States are the frequency of the data collection (especially if national survey); the speed with which results are obtained (a frequent criticism); and the ability of the measure to be impacted by an activity (e.g., not likely to affect divorce rates).

On the other hand, while national surveys can resolve the issues of variation in definition, design and methodology across States, the data are of little practical use at the State and sub-State level. They need data at the lowest common denominator possible to be useful for planning and funding. One suggestion is to provide States with sufficient funds to conduct surveys (much as in State needs assessment contracts) that provide data at a level useful for States, but require some common data collection (and provide consistent methodologies with training) so that they can be aggregated to the national level. State data infrastructure capacity is a major issue. Most simply don't have sufficient funds, manpower, and/or equipment to develop, implement, and maintain a performance measurement system.

States, while anxious, appear to see the importance and utility of performance measurement, especially for planning and resource allocation, and to tie to needs assessments. The issue here is whether the results will be used to provide technical assistance to those programs and States where results are disappointing, or whether the consequences will be punitive in nature.

Although several States have Statewide performance measurement models with required performance measures, more use a menu approach and several permit local development and identification of local performance measures as long as they address Statewide goals and/or objectives. The more the variation, however, the less likely the data can be supportive of the PPG concept.

Other related issues concern applying Statewide models to programs which, although targeting the same performance measure, often vary in intensity and scope.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Centers for Disease Control
and Prevention (CDC)

Memorandum

Date AUG 06 1997

From Associate Director for Management and Operations, CDC

Subject CDC Comments on Office of Inspector General (OIG) Draft Report, "Results-Based Systems for Public Health Programs" (OEI-05-96-00260)

To June Gibbs Brown
Inspector General

Thank you for the opportunity to review the draft report. Attached are CDC's comments. If you should have questions concerning these comments, please have your staff contact Carolyn Russell, Director, Management Analysis and Services Office, at (404) 639-0440.

Arthur C. Jackson

Attachment

CDC Comments on the Office of the Inspector General Draft Report, "Results-Based Systems for Public Health Programs"

Vol. 1, Pg. i, paragraph 3,

We recommend restructuring the last sentence as follows: These arrangements would combine various categorical grants *into performance partnerships and would reshape several of its block grant programs.*

Vol. 1, Pg. ii, Challenges for the States, Paragraph 3,

We recommend that the data objective refer to the need to take into consideration the availability of a system necessary to validate the data.

Change the first sentence to read, " ...the necessary data *are* available..."

Vol. 1, Pg. 8, paragraph 5, last sentence,

Change " . . . *this* data . . . " to " . . . *these* data . . . " The same change should be made in the last sentence of paragraph 6.

Vol. 1, Pg. 10-17, State and Federal Challenges,

There are many questions and issues raised regarding the implementation of performance-based measures. The format in which the sections were written is confusing, for example, questions are answered by other questions. We recommend explaining that the section only outlines the challenges and does not attempt to provide solutions.

Vol. 1, Pg. 11, paragraph 5,

The reliability and validity of the measures are a major issues not addressed here.

Vol. 1, Pg. 12, paragraph 3,

The paragraph states that the major problem facing states is the lack of data for persons enrolled in managed care; however, the real issue facing states is the need to provide health care coverage and the lack of data available to properly assess the impact of managed care. This point should be clarified.

Vol. 1, Pg. 12, paragraph 4,

The paragraph entitled, "Are the data timely?" refers to the reconsideration of the usefulness of data that are two or three years old. It is also important to consider the rate of change of the problem and the environment before making a judgement on the usefulness of data.

Vol. 1, Pg. 13, paragraph 4,

The problem seems overly simplified by focusing solely on health care providers. This paragraph does not reflect that problems resulting from the attempt to balance accountability with partnership, extend beyond health care providers participating in the development of measurement systems.

Vol. 1, Pg. 15, last paragraph,

Change the word, "extend" in the last sentence, to "extent."

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and
Services Administration
Rockville MD 20857

AUG 25 1997

TO: Inspector General, OS, DHHS

FROM: Acting Deputy Administrator

SUBJECT: Office of Inspector General Draft Reports "Results-Based Systems For Public Health Programs Volume 1: Lessons From State Initiatives" OEI-05-96-00260 and "Results-Based Systems For Public Health Programs Volume 2: State Case Studies" OEI-05-96-00261

HRSA has reviewed the subject draft reports and has no comments.

Staff questions may be referred to Michael Herbst on (301) 443-5256.

for Thomas G. Morford

APPENDIX C

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 Kassenbaum 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. The National Research Council's Panel on Performance Measures and Data for Public Health Performance Partnership Grants has recently issued its first report: *"Assessment of Performance Measures for Public Health, Substance Abuse and Mental Health."*

5. 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 set 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.

6. 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.

7. 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.

8. The U.S. General Accounting Office, which has written extensively on this subject, noted in a September 1995 report:

> While State efforts will certainly be closely tied to block grant results, outcomes will just as certainly be affected by factors outside the control of state administrators. *Because of the role that these variables may play, evaluation will need to isolate the effect of outside factors on state programs. [Emphasis added.]* For example, the incidence of low birth weight infants depends not only on the efforts of a particular state and local agency to fill the gaps in prenatal care, but also on many other demographic and situational factors, such as regional employment trends and demographic patterns...

See U.S. General Accounting Office, *Block Grants: Issues in Designing Accountability Provisions*, GAO/AIMD-95-226, September 1995.

9. National Academy of Sciences, Committee on National Statistics, *Assessment of Performance Measures in Public Health, Phase 1 Report.*

10. See, for example, Department of Health and Human Services, Office of Inspector General, *Federal Approaches to Funding Public Health Programs,* OEI-01-94-00160, July 1995.