# PERFORMANCE MEASUREMENT FOR PROGRAM MONITORING AND EVALUATION

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### PLANNING, ACCOUNTABILITY AND CUSTOMER SERVICE

### DATA TO ENHANCE EFFECTIVE PRACTICE WORKGROUP

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DATA TO ENHANCE EFFECTIVE PRACTICE

Department of Health and Human Services
Planning, Accountability and Customer Service
Data to Enhance Effective Practice Workgroup
Telephone: (240) 777 1098
Email: DHHS.PACS@MontgomeryCountyMD.gov
Website: www.montgomerycountymd.gov/HHS/



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This document is part of ongoing series of reports to inform management, frontline staff, community partners and the public about the Department of Health and Human Services' efforts to make data informed decisions.

The aim of this work is to identify needs and provide practical responses for frontline practitioners in support of that mission and to support long term strategic solutions which improve individual, family and community health and social outcomes, to deliver more equitable services which reduce disparities, and to be a responsible steward of the public resources.

## ACKNOWLEDGEMENTS

The Department of Health and Human Services (DHHS) is among the largest agency in Montgomery County government and is responsible for public health and human services that help address the needs of the community's most vulnerable children, adults and seniors. DHHS has a staff of 1,600 professionals, provides more than 130 programs and delivers services at more than 20 locations, with many more school-based health and wellness centers, in addition to 700 contracts for services with community providers located throughout Montgomery County.

DHHS provides services through several service areas: Aging and Disability Services (ADS); Behavioral Health and Crisis Services (BHCS); Children, Youth and Family Services (CYFS); Public Health Services (PHS) and Services to End and Prevent Homelessness (SEPH).[1] The Office of Community Affairs (OCA) provides direct services through several programs. In addition, DHHS administrative functions include budget administration, fiscal administration, contract management, facilities, grant acquisition, human resources, information systems and performance management.

The Department's core services protect the community's health, protect the health and safety of at-risk children and vulnerable adults and address basic human needs. Planning, Accountability and Customer Service (PACS) operates under the Office of the Director, to ensure efficient, effective and high-quality delivery of services and to measure the goals of the organization and focus on results in line with the organization's values. A key component of the two-year transition workplan is to develop and deliver standardized staff training to improve measurement of program performance, client and community outcomes. This document sets the foundation for a sustainable and consistent approach.

The Department's Data to Enhance Effective Practice (DEEP) workgroup's mandate includes, among others, streamlining processes for planning, measuring, and reporting on the outputs, outcomes, and quality of DHHS programs and services. The following DEEP representatives are recognized as having provided substantive input on this document, its templates and subsequent training materials: Nicki De La Rosa, Rita Deng, Michelle Gallipoli, Chunfu Liu, Matthew Nice, Nouné Sekhpossian, Erin Smith and Lisa Stafford. There work aligns with training on performance measurement, evaluation and monitoring efforts from Department's Empowering Community Health Organizations (ECHO) Project; Non-Profit Montgomery's Metrics, Outcomes, and Responsible Evaluation (MORE) program; and the training efforts from the Collaboration Council.

This document draws from the following acknowledged sources: Performance Measurement Manual, Multnomah County, Budget Office; Measuring What Matters in the Public Sector by Mary Campbell; Performance Measurement Challenges and Strategies by the White House Office of Management and Budget; Not a Tool Kit by the Institute of Governance, Ottawa, Canada; Urban Institute's Transforming Performance Measurement for the 21st Century; and the United Nations Development Programme Handbook on Planning, Monitoring and Evaluating for Development Results. Other resources that were used in development of this document are listed in the annex.

Graphic design and covers provided by Sean Clark, Office of Public Information, Montgomery County, Maryland.

[1] This service area is currently in-process to change its name from Special Needs Housing (SNH).

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## EXPLANATORY NOTES

This report relies upon the following acronyms listed below.

| | |
|---|---|
| ADS | Aging and Disability Services |
| BHCS | Behavioral Health and Crisis Services |
| CYFS | Children, Youth and Family Services |
| DEEP | Data to Enhance Effective Practice |
| DHHS | Department of Health and Human Services |
| ECHO | Empowering Community Health Organizations |
| eHR | electronic Health Records system |
| eICM | enterprise Integrated Case Management System |
| eSAR | expert Service Area Representative |
| ICMA | International City/ County Management Association |
| IT | Information Technology |
| MORE | Metrics, Outcomes, and Responsible Evaluation |
| MTR | Monthly Trend Report |
| OMB | Office of Management and Budget |
| OCA | Office of Community Affairs |
| OCOO | Office of Chief Operating Officer |
| OESS | Office of Eligibility and Support Services |
| PACS | Planning, Accountability and Customer Service |
| PET | Practice Enhancement Team |
| PHS | Public Health Services |
| QSR | Quality Service Review |
| SEPH | Services to End and Prevent Homelessness |
| SNH | Special Needs Housing |
| SMARTIE | Specific, Measurable, Achievable, Relevant, Timely/ Timebound, IT-Ready, Equity Informed |

## EXECUTIVE SUMMARY

The Department of Health and Human Services (DHHS), one of the largest government agencies in the County, is responsible for public health and human services that help address the needs of our community's most vulnerable children, adults and seniors. DHHS has a staff of 1,600 professionals, provides more than 130 programs and delivers services at more than 20 locations—with many more school-based health and wellness centers—throughout Montgomery County. DHHS regularly evaluates service delivery and outcomes to identify gaps and equitable service solutions, which reduce disparities and improve individual, family and community health and social outcomes. Customer focus is essential to managing performance.

A shared framework and nomenclature of performance measurement for program monitoring and evaluation among leaders, managers, staff, and providers that focuses on outcomes and more systematic monitoring and reporting fosters an organizational culture of learning, transparency and accountability. Programs are investments in outcomes purchased with the taxpayers' money and managers have a responsibility to reliably tell their story related to the value in achieving the desired results.

A key strategy of the Department's Planning, Accountability and Customer Service (PACS) two-year transition workplan is to develop and deliver standardized staff trainings to improve program performance and client and community outcomes. PACS and the Department's Data to Enhance Effective Practice (DEEP) workgroup, developed this document, its templates and subsequent training materials to align with on-going accreditation processes, training efforts offered by and to the County's non-profit provider partners, and the more than 700 service contracts.

Through its technology modernization efforts, nearly every DHHS program now enjoys access to real-time client and program performance data. In addition, every provider contract awarded from DHHS requires the collection and reporting of related performance data. The processes outlined in this document allow for the development and utilization of meaningful, objective program indicators that can be systematically tracked to assess progress made in achieving and sustaining predetermined goals for clients and communities.

# 1. INTRODUCTION

The demand for effectiveness is based on the realization that producing good "deliverables" is simply not enough. Efficient, well-managed program outputs lose their relevance if they yield no discernible improvement in conditions and lives of people. A shared framework and nomenclature of performance measurement, monitoring and evaluation among leaders, managers, staff, non-profit outside providers, and the public that focuses on outcomes and more systematic monitoring and reporting fosters an organizational culture of learning, transparency and accountability.

The National Performance Management Advisory Commission's performance management framework was developed to move governments beyond measuring and reporting metrics to managing performance toward improved outcomes. The framework included several fundamental components, *among other things*, performance measurement for program monitoring and evaluation. The process develops and utilizes meaningful, objective indicators that can be systematically tracked to assess progress made in achieving predetermined goals for individuals and communities through an organization's programs.

Assessing progress requires articulating the problem and its programmatic response into quantitative metrics, monitoring those metrics against expectations, and ultimately evaluating the extent to which the need for the program was adequately addressed.

Fundamental to this process is the development of key quantitative and qualitative program metrics and ongoing data collection to determine if a program is implementing activities and achieving objectives. Metrics typically quantify resources used, activities performed, and results over time. The data are used to identify the difference between what customers and stakeholders expect and what programs deliver.

**Box 1. Defining performance measurement**

Performance measurement is a process in which a public service organization undertakes regular collection of output and outcome data throughout the year for most of its programs and services. It differs from performance management, which is the practice of public service managers using performance data to help them make decisions that continually improve services.

Source: Harry Hatry, The Urban Institute

The development of sound performance measures that clearly define the problem and solution are critical components. Programs provide performance indicators as a part of sound management practices and through their program budgets. The Executive, County Council, citizens and others use the information annually to aid their understanding of the problem's magnitude and how the program addresses that problem.

Administrators, managers and frontline staff utilize performance measures to determine the efficiency and effectiveness of practices and how well the program mitigates risk, improves health and wellness and/ or improves self-sufficiency for clients.

**Anti-poverty strategies**

Greater attention is being paid to how the performance individual programs impact the larger strategic goals that alleviate two generation poverty and address the social determinants of health.

Two-generation poverty programs focus on disrupting the cycle of poverty by

serving parents and children together as a family unit. These programs are individualized and focus on economic stability, and program outcomes guided by an understanding of the interrelationship between the home environment, individual successes and family outcomes.

The social determinants of health are the economic and social conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of resources from the at global to the local level. The social determinants of health are mostly responsible for health inequities which are the unfair and avoidable differences in health status seen within and between communities. These include, access to care, insurance, employment, education, income, housing and transportation.

Although progress has been made in integrating meaningful performance measures into program design, a *2017 Program Measures and Quality Awareness Survey* of DHHS managers found that 56% used their program's performance measures on a regular basis, or at a minimum, within the last six months. A similar figure was found for purposes of contracted programs.

Montgomery County is one of the most diverse in the nation with 55% of the population identifying as a racial or ethnic minority and 40% of residents speaking a language other than English at home. The DHHS mission and values statement holds equity as a critical value necessary to guide the way services are delivered and is reflected in the organization's policy, budget and program decisions. However, only a third of managers surveyed in 2017 indicated that their program measures provided the level of detail necessary to assess service access and outcomes by race, ethnicity, language, country of origin or similar appropriate variables.

With recent significant investments in technology modernization projects, such as the NextGen electronic Health Records (eHR) and the enterprise Integrated Case Management (eICM) systems, DHHS positions itself to improve its program performance measures, measure service integration and equitable service outcomes. Additional refinements of various quality initiatives—Community Review, Quality Service Reviews (QSR), Practice Enhancement Teams (PET)—align with and reinforce those investments.

### Box 2. Quantitative versus qualitative data

Quantitative data express a certain quantity, amount or range. Usually, there are measurement units associated with the data, e.g. inches, in the case of the height of a person. It makes sense to set boundary limits to such data, and it is also meaningful to apply arithmetic operations to the data.

Qualitative data describe the attributes or properties that an object possesses. The properties are categorized into classes that may be assigned numeric values. However, there is no significance to the data values themselves, they simply represent attributes of the object concerned. They are a categorical measurement expressed in terms of a natural language description.

Source: Economic Commission for Europe of the United Nations

Efforts to take advantage of all our technology modernization and data analytics capacity and become more efficient, effective and more outcomes focused demonstrate a strong return on investments as outlined in the two-year

(2017-2019) transition strategy.[2] Included herein are detailed instructions, examples, templates, and additional resources to improve upon or develop new program performance measures.

### Box 3. Equity in program performance

Equity refers to fair policies, decisions, and practices when we interact with staff and community. Equality does not necessarily equate to equity. Equity principles address five major areas: dignity, elimination of disparities, access, resource distribution, and community engagement.

**Dignity:** all individuals should be treated with dignity and respect.

**Elimination of Disparities:** preventing and eliminating social and health disparities to achieve optimal health and well-being.

**Access:** ensuring access to effective and high-quality services that meet people's needs, when they need them, delivered by a professional workforce which is competent to provide those services in a caring and respectful manner.

**Distribution of Resources:** the resources of DHHS should be distributed in a manner that maximizes the health, safety, well-being and self-sufficiency of the community.

**Community Engagement and Participation:** our diverse communities should be meaningfully engaged in providing input and feedback on policies, practices and services.

Evaluation is an objective, independent and systematic examination of the extent to which a program or project has achieved (or is achieving) over time its stated objective and, therefore, is meeting the needs and priorities of the community. Evaluation assesses the efficiency, effectiveness, relevance, impact, and sustainability of a program or project.

Organizations of all shape and size measure performance. The United Nations expends significant resources monitoring and evaluating development and poverty alleviation programs, worldwide. The UN defines monitoring as a continuous function to inform the program or managers and stakeholders of progress achieved against planned results (outputs, outcome and objectives).[3] Data on specific, pre-determined indicators are systematically collected and analyzed to track actual program performance for management decision making. Monitoring generally involves collecting and analyzing data on implementation processes, strategies and results.

## 2. HISTORY OF PERFORMANCE IN MONTGOMERY COUNTY

In 2006, the newly elected County Executive invited 135 residents to serve on a large and diverse transition team of business and community leaders. A panel of experts provided an overview of the demographic, economic, and social opportunities and challenges that faced the County as it moved to over one million people. The result was a transition document which outlined, among other things, priorities and strategies for Montgomery County, and how government would be accountable.

The document outlined that government be responsive to the changing cultural paradigm and establish a tracking system to ensure prompt and appropriate follow-up to needs of residents, community organizations, and businesses. Processes that responded to these needs had to

[2] www.montgomerycountymd.gov/HHS/Resources/Files/Reports/DHHS%20STRATEGIC%20ROADMAP%20(4)%202016_2018.pdf

[3] Monitoring and Evaluation Guidelines: Technical Cooperation Projects. International Atomic Energy Agency. Vienna. 2013.

ensure that budget and policy decisions were based on the core values of the community, the long-term interests of the County, and the **outcomes** deemed most important to its residents, community organizations, and businesses.[4] From that document, eight County Priority Objectives were identified, and in 2007, the Chief Administrative Officer established CountyStat to use data strategically to monitor, assess, and improve the effectiveness, efficiency, and performance of County services.

In 2009, the DHHS Director, through the Planning, Accountability, and Customer Service (PACS) unit, mandated comprehensive leadership and direction for those three areas that constitute the unit's name. To fulfill its mandate related to planning and accountability, PACS convened a workgroup comprised of a representative from each of DHHS' Service Areas and from the Office of the Chief Operating Officer (OCOO) and the Office of Community Affairs (OCA), entitled Data to Enhance Effective Practice (DEEP).

DEEP enables DHHS to improve its competencies and capacities to:

- Manage common and streamlined processes for planning, measuring, and

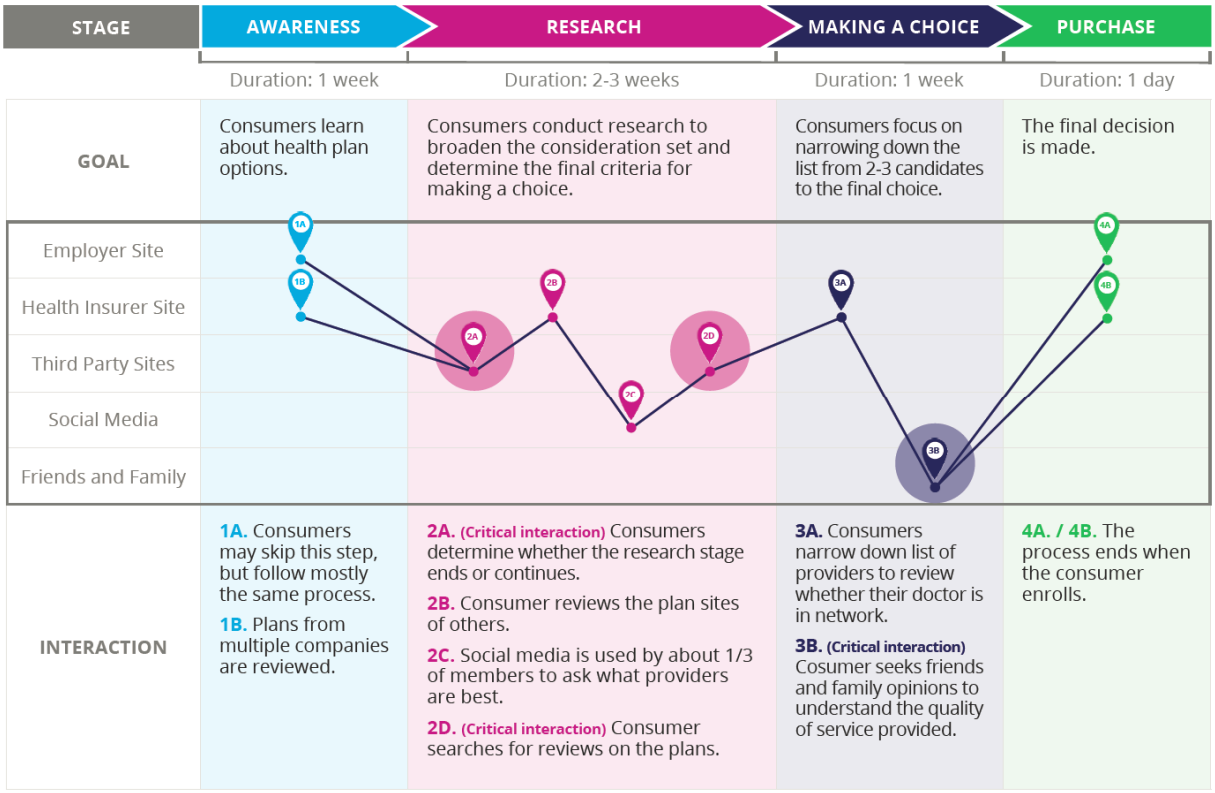



*Figure 1. A client journey map is a logical decision model from the client perspective. Adapted from Jim Tincher, Heart of the Customer.*

[4] Office of the Executive (2006). Taking Charge… Making Change. Montgomery County, MD

reporting on the outputs, outcomes, and quality of its programs and services;
- Utilize empirical evidence for planning and managing programs and services;
- Understand the concepts, issues, methodologies, and implications of data-driven performance management;
- Reduce disparities and improve the equity of health and social services outcomes for minority populations;
- Analyze the linkage between its performance measures, the achievement of its strategic goals and objectives, and the attainment of the County Executive's priorities; and
- Inform technology modernization, IT infrastructure development and database content to reflect the needs and expectations of the Service Areas and Offices of the Department.

Annex VI provides for the DHHS Service Area DEEP representatives and additional Department expertise. [5]

## Community Assessments

Assessments by, and for, the community are critical to monitoring DHHS performance. The Community Review is a process of structured program self-assessment and subsequent independent review that informs DHHS on how well aligned a program's service delivery is with the Department's objectives.

In 2016, the Community Health Needs Assessment for Montgomery County mapped out how conditions in the places where people live, learn, work and play affect a wide range of health risks and outcomes that lead to need for health and human services.

- What does a resident do when they need help?
- How does the person feel?
- What service or information does the person expect when they engage with the program from an interaction?

By continuing to map the journey[6] for diverse clients in Montgomery County, providers and service areas are better able to understand what the community needs as articulated by the community members themselves. By sharing the community's values, needs, and resources, journey mapping empowers residents to be more engaged and help inform ways in which DHHS and partners move toward prevention and earlier intervention focused on better client outcomes that also address root causes of health inequities, and streamline and coordinate services offered through integrated practice and intensive case teaming.

Currently, DHHS is undergoing a public health accreditation process to promote higher performance through a continuous effort to achieve measurable improvements in the efficiency, effectiveness, outcomes, and quality in services which attain equity and improve the health of the community.

Accreditation provides a framework for a health department to identify performance improvement opportunities, to improve management, develop leadership, and improve relationships with the community. The process is one that will challenge the health department to think about what

[5] DHHS Data to Enhance Effective Practice Work Group Charter, June 15, 2009 (Revised April 21, 2011). Montgomery County, MD

[6] Customer Journey Maps. The Top Ten Requirements. https://heartofthecustomer.com/customer-journey-maps-the-top-10-requirements-revisited/

business it does and how it does that business.

Domain 9 of the Public Health Accreditation Board's Standards and Measures focuses on quality improvement and includes standards, such as using performance management analysis tools to monitor achievement of organizational objectives and develop and implement quality improvement processes integrated into organizational practice, programs, processes and interventions.

This manual aligns DHHS using the standards and measures from the Public Health Accreditation Board[7] to evaluate areas and ways in which DHHS delivers essential public health services[8] and address social determinants of health inequities. Processes involved in program performance monitoring are covered in other series.

## 3. ALIGNING PERFORMANCE

Measuring performance is important for many reasons—improve productivity and mission effectiveness, support better budget decisions, permit benchmarking of process performance, allow DHHS to learn from our processes and outcomes—but overall, to relate to accountability to the citizens, representatives, staff and clients of Montgomery County.

**Programs are investments in outcomes purchased with the taxpayers' money and managers have a responsibility to reliably tell their story related to the value in achieving the desired results.**

With limited resources, priority must be determined, and programs aligned to meet those priorities. DHHS aligns its services to six of the eight County Priority Objectives, including:

- A Responsive and Accountable County Government
- Affordable Housing in an Inclusive Community
- Children Prepared to Live and Learn
- Healthy and Sustainable Communities
- Safe Streets and Secure Neighborhoods
- Vital Living for All of Our Residents
- Individual program measures link to 19 DHHS programmatic Headline Performance Measures reported to CountyStat. The Headline Performance Measures are those high-level organizational metrics specifically selected to reflect movement towards DHHS priorities.

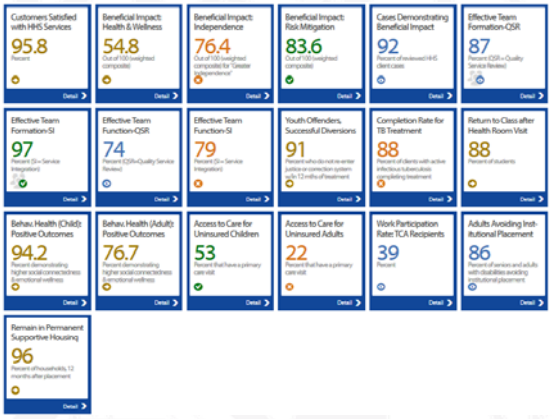



*Figure 2. DHHS Headline Performance Measures available publicly on the CountyStat website*

The Urban Institute points to major advancements that have occurred, and continue to occur, in areas of "Data Analytics, "Data Visualization," and "Big

[7] Public Health Accreditation Board Standards and Measures Version 1.5. http://www.phaboard.org/wp-content/uploads/PHABSM_WEB_LR1.pdf

[8] Ten Essential Public Health Services. https://www.cdc.gov/stltpublichealth/publichealthservices/essentialhealthservices.html

Data."[9] The use of these management systems for enhancing the value of the performance information opens new opportunities for public and non-profit organizations to improve quality and timeliness of information provided by their performance measurement systems.

The County too, is progressively moving towards democratizing data to elevate community empowerment and engagement and collaborating with diverse stakeholders. Increasingly, "Big Data" are becoming more transparent and readily available through efforts such as, openMontgomery and dataMontgomery, CountyStat and Healthy Montgomery. The availability and transparency of performance measures will serve to encourage communities to stay engaged with their government.


*Figure 3. Conceptual performance pyramid, with individual outcomes rolling-up into bigger societal outcomes*

A program's design and its metrics should align with the Department's priorities represented by the Headline Performance Measures that align with the Priority Objectives, even if only indirectly. For example, one of the Headline Performance Measures for DHHS is *"Students that return to class and are ready to learn after a health room visit."* School Health Services staff assess the health needs of students, provide immediate sick care and emergency care, administer medications and treatments to students who have physician's orders, and maintain student health records. This directly aligns with the *"Children Prepared to Live and Learn"* Priority Objective.

**Measures help decision-makers align strategies**

The use of performance measurement information helps in developing budget priorities and in setting overall performance goals for the organization. This is done through the allocation and prioritization of resources and by informing policymakers, so they can either confirm or change current policy direction to meet those goals.

**Box 4. Telling a Services Story**

Performance measures articulate a complex story more easily. For example, ADS Adult Protective Services caseload metrics have grown 24% in the past five years driven by growth in financial exploitation cases, which have since doubled. In anticipation of the growing senior population—projected to grow 36% by 2025—ADS responded by shifting staff to address these types of cases.

**Measures help align community support for programs**

Citizens are primarily interested in results or outcomes. An implicit aspect of the

[9] Transforming Performance Measurement for the 21st Century. Urban Institute, July 2014

budget process is the "justification" which is where performance measures provide a strong empirical and factual basis for programs and services that clearly deliver measurable results. Without transparent outcome measures, programs run the risk of more intense public scrutiny and losing support from citizens. Clearly specified performance measures can stimulate the public to take a greater interest in and provide more encouragement for staff to provide quality services, improve civic discourse and foster trust and public understanding of specific government service.

**Measures help managers deliver expected results**

Having valid and reliable performance measures increase attention to program results and customer satisfaction. Applying performance measures to all programs will foster greater understanding, responsibility and accountability on the part of program managers since they are the ones who are responsible for attaining the program's performance targets. Without that accountability, the measures will do little to improve performance. On the other hand, measures can be a manager's tool to keep their focus and help achieve their desired results.

**Measures help managers tell their success story and can justify resource re-alignment**

Managers can use valid and reliable performance measures to help tell their story: identify a new problem, promising areas and demonstrate results over time.

**Measures can motivate**

What gets measured gets managed and is also important for motivating staff and staying focused on the program's mission and helps to reduce ever present *scope-creep*. Most employees don't want to feel as though their program's performance is sub-standard and will rise to the challenge when presented with accurate information that shows opportunities for performance improvement.


*Figure 4. Aging and Disability Services (ADS) financial exploitation cases as a proportion of all senior abuse cases*

# 4. STARTING OUT

## New programs

The natural point to determine appropriate measures for programs is when the program is first designed to address a specified problem. Montgomery County's partner, the Pew-MacArthur Results First Initiative, established a process to ensure that new funding requests are backed by strong evidence demonstrating a program's effectiveness. DHHS adapted

this into our local tool entitled, the *Seven Elements of Quality Program Design*.

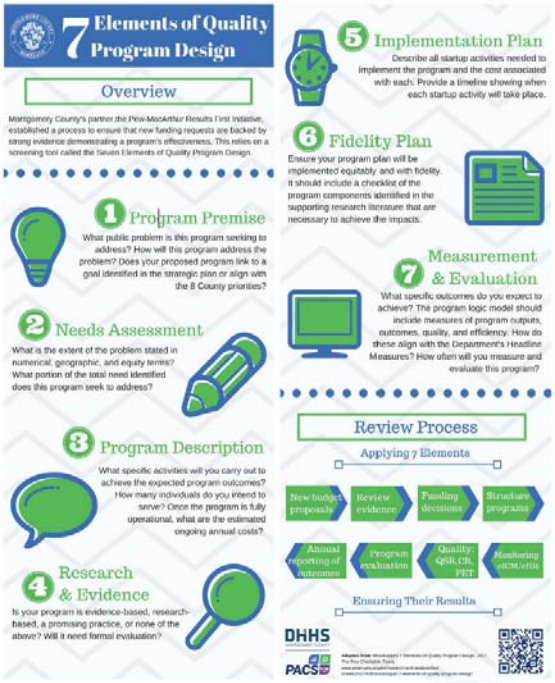



*Figure 5. Seven Elements of Quality Program Design adapted for DHHS*

The elements include developing a program premise, needs assessment, program description, research and evidence, an implementation plan, fidelity plan and on-going measurement and evaluation (Annex I).

The most crucial point is in defining exactly who the program will serve (targeted need), how much services they are to receive (dosage) and how this will address the problem identified. For example, a program that targets at-risk youth to reduce delinquency does not provide the level of specify to determine the population age, the risks and which manner of 'delinquency'. Without a clear definition, how will one know whether progress towards the problem has been made?

**National program clearinghouses**

New (and existing) programs can draw upon evidence-base social programs already shown effective from national clearinghouses. Montgomery County has partnered with the Pew-MacArthur Results First Initiative (Results First) to ensure the use of evidence-informed approaches.


*Figure 6. Clearinghouse results from a program search*

The Results First Clearinghouse Database consolidates evidence and information on over 1,000 different programs in several policy areas. The online database provides an easy way to find information on the effectiveness of various programs as rated by eight national research clearinghouses.[10] Each program is rated on effectiveness, using a simple red, yellow

[10] www.pewtrusts.org/en/multimedia/data-visualizations/2015/results-first-clearinghouse-database

and green light notification system harmonized across databases.


*Figure 7. Performance measurement development nexus and review cycle*

## Existing programs

Most of the 130 DHHS program have been on-going for years, as few programs either emerge or sun-set in a given year. Additionally, more than 700 external provider contracts also exist, making a meaningful review of their performance metrics challenging.

Even so, there are several opportunities where managers can examine an existing program such as, a program transfer, change in scope, change in funding source, or during the annual budgeting process. Online tools, like national program clearinghouses, can aid in that review to ensure the appropriate, benchmarks and metrics are considered.

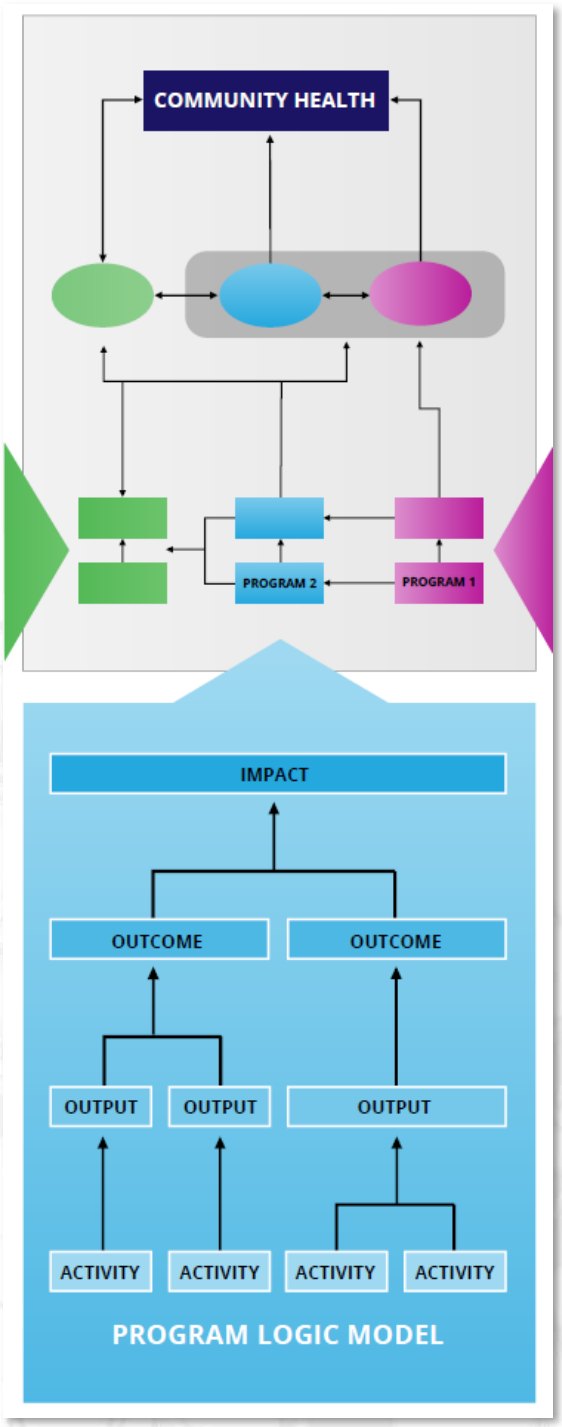



*Figure 8. How multiple logic models (bottom) fit in the overall theory of change (top), adapted from www.tools4dev.org*

## The team approach

The development or refinement of a program's performance measures benefits greatly when they are determined in

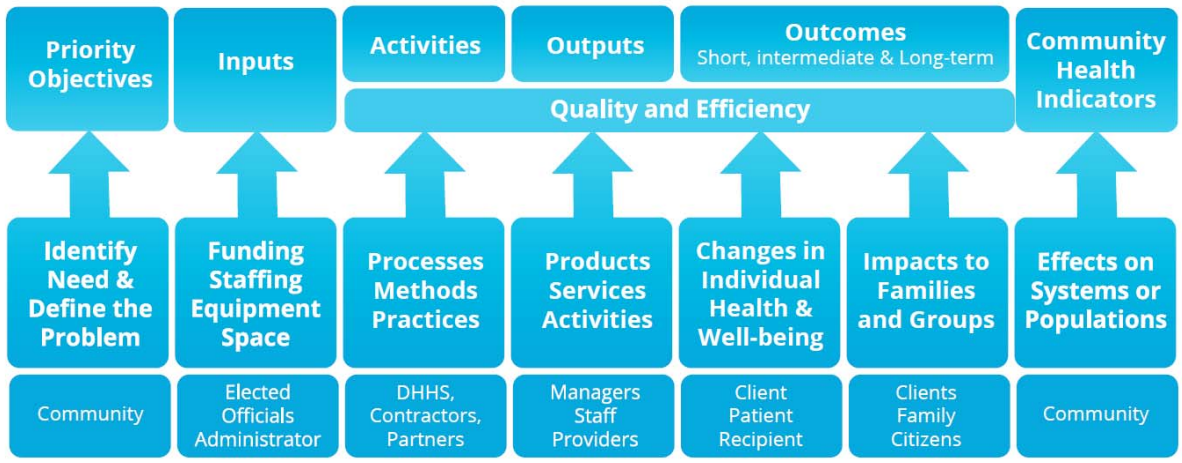



*Figure 9. Program logic model, performance measures and to whom they matter most (adapted from Mary Campbell, 'Driving Changes and Getting Results' )*

conjunction with the program manager, frontline staff, substantive experts (e.g., researchers), and various analytical experts.

A program manager, contract monitor, and frontline staff should be at the forefront in the discussions about performance measures. Their knowledge, input and ultimate buy-in ensures that the data will be used. Analytical staff should include the service area's DEEP representative. In addition, a representative from budget, PACS and possibly practice management teams may be of value.

Planning and cooperation are necessary for creating performance measures because a program's description (its activities and what it is trying to accomplish), budget determination (staff levels and funding needs) and service levels (inputs, outputs and outcomes, etc.) are highly interconnected.

For example, a new program should clearly define the goals (change from current state), the eligible population, the delivery system and specific activities (managers and program staff expertise); the requested resources needed to accomplish the activities (budget and finance staff expertise); and the evaluation of program progress and ultimate success (analytical staff expertise).

An established program might have a reduction in funding (e.g., grant loss), which in turn may reduce the service levels through lower volumes, longer wait time, or decreased customer satisfaction. This may ultimately lead to reengineering of the program.

On the other hand, a program experiencing increased wait times or customer dissatisfaction may warrant increased funding needed to continue delivering services at the appropriate level. These interactions affect the variety and type of performance measures selected and their subsequent results.

## 5. PROGRAM METRICS

### Modeling programmatic change

Developing meaningful performance measures depends on understanding and clearly defining the problem to be addressed. The theory of change and logical framework approaches are two

methodologies used for the design of program measures.

According to the Harvard Family Research Project, a theory of change is a "strategic picture of the multiple interventions required to produce the early and intermediate outcomes that are a precondition of reaching an ultimate goal." A logical framework model is a specific explanation of the process of producing a given outcome. It outlines the program inputs and activities, the outputs they will produce and the connection between those outputs and the desired outcomes.

The framework simply structures what the program is trying to accomplish; where the resources come from and how they are allocated; the program's target population (e.g., clients); what activities are being performed (i.e., outputs); and what results (i.e., outcomes) are expected.

Inputs and resources are put into place and are converted into activities; activities implemented will produce outputs; the outputs achieved will, in turn, result in the desired outcome. A logical framework template is available in Annex II.


*Figure 10. Results perspective (adapted from Mary Campbell 'Driving Changes and Getting Results')*

## Measuring what matters

It is important to measure what matters, not simply what is convenient. Jim Clemmer, a bestselling author on performance management, wrote, that *"crude measures of the right things are better than precise measures of the wrong things."*

Thinking about what matters means considering what matters to whom. Some measures might matter to staff but not necessarily to the client. In determining performance measures, consider the following questions:

- Who are the customers or beneficiaries (internal and external) of the program?
- What are the significant performance measures valued by these customers or beneficiaries (e.g., outcomes, timeliness, effectiveness, quality, satisfaction)?
- What performance standards would clients, managers, citizen, like to see achieved on these measures?
- How might management and program staff explain what the program accomplishes numerically to someone on the street?

The questions are about identifying who expects what results from the program service and bringing their results perspective in the performance measure process.

As illustrated in the following chart, almost every program involves funders, managers and staff, providers, clients, and the community in which the program operates. Their perspectives and expectations on performance should be brought into the

process of building a program's performance measures.

After identifying who matters, it is possible to identify what matters and create measures that are meaningful. With careful thought, there is likely to be agreement on what matters from the various groups' perspectives.

# 6. MEASUREMENT INDICATORS

## Various types of indicators

Program metrics are comprised of several types of performance indicators. Well measured programs include a variety of meaningful measures and should include at a minimum indication of volume of work (output) and the results of that work (outcome).

Combinations of input, output (workload), outcome (results), efficiency and quality indicators draw upon a different aspect of the service that is being delivered and provide a more robust description of the result.

#### Input Indicators

An input indicator is descriptive, designed to report the amount of resources (e.g., financial, personnel, material) available or the context which a program operates. Financial and personnel data are the most common input measures and are typically reported in the revenue and staffing detail of a budget.

Service Areas may choose to report other program resources that are managed or consumed. The measure is helpful in illustrating the scope of work, but not the actual activities performed, particularly when a program is identifying the needs for services. The data are typically reported as numbers and not percentages.

Examples of Input Indicators

- Number of client referrals
- Number of treatment beds
- Number of clinic hours opened
- Number of calls received
- Number of restaurants and food carts operating in the county

#### Output Indicators

An output indicator is the most common type of indicator found in most performance measurement systems and reports the number units produced or services provided by the program. It describes the activities that a program has completed and can be thought of as, *"How much did we do?"* It does not necessarily show their results. It is common for programs to have more than one output indicator. The data are typically reported as numbers and not percentages.

Examples of Output Indicators

- Number of behavioral health treatment sessions delivered
- Number of client screened
- Number of public swimming pools inspected
- Number of information flyers distributed
- Number of vaccinations given to children
- Number of community forums organized to discuss community health improvement

#### Outcome Indicators

The outcome indicator is designed to report the results of the service. It can often

be described as an initial (e.g., successful treatment completion), intermediate term (e.g., success by 3 or 6 months), or long-term outcome (e.g., 1 year or more). It is often thought of as, *"How well did we do it?"* There should be a logical connection from outputs to outcomes, with activities supporting the results in a sequential fashion. The data can be reported as either numbers or percentages (typically percentages of the output). Examples of Outcome Indicators include:

- Percent of youth showing a decreased rate of violence-related arrests at discharge
- Percentage of youth living independently at discharge
- Percentage of clients that reduced drug use at discharge (initial outcome)
- Percentage of clients remaining drug-free at one year after discharge (long-term outcome)
- Percent reduction of emergency room visits due to specific health conditions

**Efficiency Indicators**

Efficiency measurement is a method for examining how effectively a program is delivering its activities. This is an indicator that measures the cost of resources (e.g., in dollars, employee hours, time) per unit of output (e.g., per call, per session).

Efficiency can also be qualified as a *productivity measure*. For example, *"labor cost per client telephone calls taken"* reflects efficiency, whereas *"percentage of call questions answered correctly at initial call"* (e.g., not returned or redirected) reflects outcomes, *"unit cost per client telephone successfully answered"* reflects productivity. The costs (or staff-hours) of incorrectly answered calls as well as the costs of properly answered calls are included in the numerator of such a calculation, but only properly answered calls counted in the denominator—thereby encouraging both efficiency and outcome by call-center staff. Examples of Efficiency Indicators include:

- Average number of minutes per client screening
- Benefits generated per staff
- Average number of days to close an investigation
- Cost per child vaccinated
- Average caseload per therapist

**Quality Indicators**

Quality indicators reflect effectiveness in meeting the expectations of customers and stakeholders. Measures of quality include reliability, accuracy, courtesy, competence, responsiveness, and completeness associated with the product or service. Customer satisfaction reflects the degree to which the customer's expectations of a service are met or exceeded. Lack of quality can also be measured. Such examples include rework, correcting errors, or resolving complaints.

Examples of Quality Indicators

- Percent of reports that are error free
- Percentage accuracy of information entered in a data system
- Percent of customers that rank service as exceeding their expectation (customer satisfaction)
- Percent of clients waitlisted more than a week


*Figure 11. SMARTIE acronym reminds staff that useful measures must be specific, measurable, achievable, relevant, timely or time-bound, IT-ready and equity informed.*

## Selecting appropriate measures

DHHS performance measures use the SMARTIE framework (Annex III). Performance measures are commonly associated with Peter Drucker's management by objectives[11] S.M.A.R.T measures, meaning they are: specific, measurable, achievable, relevant and timely or time-bound. DHHS program measures also prioritize those available through IT-ready investments, such as eICM and eHR. Program measures must also be Equity informed, consistent with the Department's principles of equitable service access and outcomes (Annex V).

Numerous variations on a performance measures are possible within the SMARTIE framework. Additional selection criteria should be used to help narrow down the multiple measures and determine the most meaningful measure.

- Meaningful and valid: The key to assessing program performance is measuring the right things with the right measure. If a measurement fails to measure what was intended, then this measurement is not valid.
- Consistent and reliable: The data used to generate the measurement must be consistently accurate and reliable. It is important that the data collected describe what is being measured. If other programs have similar services, can the same measures be applied universally (e.g., mentoring)?
- Understandable and clear: Think about whether a measure is simple enough to be understood by people who are interested in the program. Keep it simple, and ask, "would it pass the 'John Q. Public' test", being readily comprehendible by the average citizen?
- Comprehensive: Measures should capture the most important aspects of a program's goals. Where multiple facets of a program exist (e.g., nutrition, physical activity, self-esteem) consider using appropriate indices instead of reporting just one facet.
- Focused on the controllable facets of performance: Good measures should focus on the indicators that show individual, program or community change directly affected by the activities of the program/ service.

Well measured programs include a minimum combination of input, output, outcome, efficiency and quality indicators that draw upon a different aspect of the activities delivered to provide a more balanced description of the result.

Programs should also be aware of metrics which are costly, ineffective or counter-productive. For example:

- Not Redundant: It is reasonable for a program to have more than one output or outcome measure, but keep in mind that providing variations on the same measure can be redundant.
- Standardize: Often adopting a standard measure across similar services or industries would be advantageous, especially for comparative or benchmarking exercises.
- Sensitivity to data collection cost: For many programs, the data needed for performance measures are readily available, particularly

[11] Drucker, P., The Practice of Management, Harper, New York, 1954; Heinemann, London, 1955; revised edn, Butterworth-Heinemann, 2007

through new IT systems. However, data collection cost should be taken into consideration, especially when creating new measurement.

- Perverse incentives: Might the measure lead to behaviors that reduce quality or outcomes just so the "numbers look good"?

## Defining measures

For performance measures to be useful, elements of the selected measure must be clearly identified. This allows for both a consistent understanding of what is being measured and a consistent approach to collecting and reporting those data.

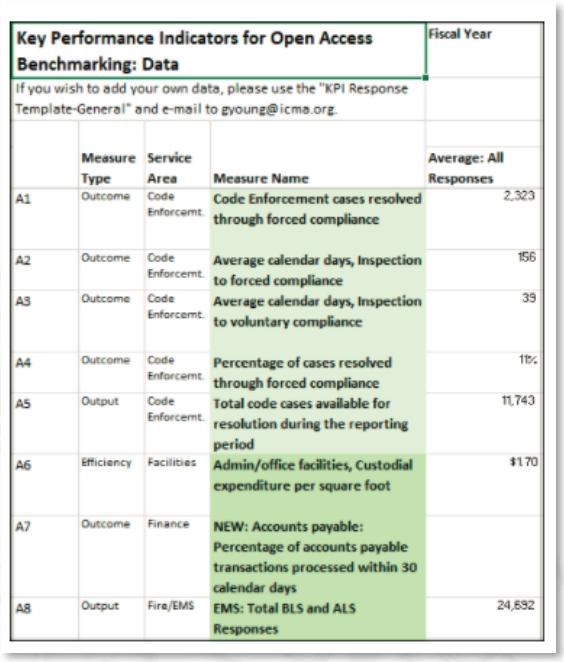
Annex IV provides the operational definition template for DHHS headline measures, OMB program measures, and Monthly Trend Reports (MTR)/ Chief's report data elements. The template identifies the type of metric, the county performance priority area, related DHHS beneficial impact (i.e., improved health and well-being, risk mitigation, greater client self-sufficiency), data characteristics, and factors contributing to or restricting performance. In addition, space for past and projected results is provided as well as how specific calculations for the measure should take place.

# 7. OTHER CONSIDERATIONS

## Benchmarking performance

For performance measures to have meaning and provide useful information, it is necessary to make comparisons. The comparisons may evaluate progress in achieving set goals or targets, assess changes in performance over time, or weigh the performance of one organization against another.[12]

Benchmarks are a way to assess whether the program's performance is within limits given acceptable norms. One of the significant challenges to benchmarking is consistent nomenclature, what to measure, how to measure it, and how to collect and analyze the data.



| Key Performance Indicators for Open Access Benchmarking: Data | | | | Fiscal Year |
|---|---|---|---|---|
| If you wish to add your own data, please use the "KPI Response Template-General" and e-mail to gyoung@icma.org. | | | | |
| | Measure Type | Service Area | Measure Name | Average: All Responses |
| A1 | Outcome | Code Enforcemt. | Code Enforcement cases resolved through forced compliance | 2,323 |
| A2 | Outcome | Code Enforcemt. | Average calendar days, Inspection to forced compliance | 156 |
| A3 | Outcome | Code Enforcemt. | Average calendar days, Inspection to voluntary compliance | 39 |
| A4 | Outcome | Code Enforcemt. | Percentage of cases resolved through forced compliance | 11% |
| A5 | Output | Code Enforcemt. | Total code cases available for resolution during the reporting period | 11,743 |
| A6 | Efficiency | Facilities | Admin/office facilities, Custodial expenditure per square foot | $1.70 |
| A7 | Outcome | Finance | NEW: Accounts payable: Percentage of accounts payable transactions processed within 30 calendar days | |
| A8 | Output | Fire/EMS | EMS: Total BLS and ALS Responses | 24,682 |

*Figure 12. ICMA Open Access Benchmarking tools*

The International City/ County Management Association (ICMA) has been working to bring some consistency to benchmarking, while also limiting the need for centralized control and uniformity. The ICMA "Open Access Benchmarking" initiative removes the barriers to jurisdiction benchmarking by providing a set of definitions along with related data from those pilot communities who've participated in ICMA data gathering efforts.[13] Open Access Benchmarking provides benchmarks and definitions

[12] Poister, Theodore H. 2003. Measuring Performance in Public and Nonprofit Organizations. San Francisco, Calif.: Jossey-Bass.

[13] https://icma.org/open-access-benchmarking

across several government service areas, such as general government, health, jails, probations services, and youth services.

For example, the following indicator has been adopted by ICMA related to tuberculosis treatment completion: *Of those discontinuing treatment during the reporting period, report the percentage that did so after successfully completing their course of treatment. If a diagnosed individual refused treatment, count this as someone discontinuing treatment without reaching successful completion.*

Annex IV provides resources for programs that want to benchmark their performance against other organizations.


*Figure 13. Forecasting program performance using eICM*

## Forecasting performance

Forecasting is commonly reserved for revenues and expenditures; however most programs provide OMB with a projection of their expected outputs and/ or outcomes. One of the key purposes of developing a forecast is to identify potential actions necessary to balance program resources and activities over the long-term to ensure overall sustainability.

Forecasting can be done several ways, but each follow some basic steps. The simplest approaches start with actual program performance from the most recent years; not the previous projections. Determine if budget implications are expected, either in fixed or variable costs, that will increase or decrease resources. These might impact the programs operating hours, locations, staffing, activities, caseloads and outcomes.

Factor in changes to the service population, such as projected growth (e.g., increase aging or immigrant populations) or influx from other providers (e.g., service consolidations, closures). Are populations

### Box 5. Volume and complexity of interactions impact forecasts

Forecasting considers both expected changes in volume and complexity and how those impact service delivery. For example, a recent analysis by the Office of Eligibility and Support Services (OESS) identified a greater need for interpreters and materials translated to serve a decreasing number of in-person clients, as the number of non-English speaking clients have increased. Contrast this by the 2017 report by OCA that found that the number of client languages has also diversified in recent years; in 2017 Arabic and Russian calls for service and amount of times for such calls became the 5th and 6th most common languages, respectively. The amount of time spent on Arabic language calls was equivalent to Korean and Vietnamese, combined. Additionally, a small but increasing number of Swahili calls (0.6%) were required, but which accounted for 12th greatest amount of time on the call (2,425 minutes), reflecting their complexity. Forecasting service delivery that maintains or improves current equity service performance would need to account for more clients needing interpretations services for less common languages, which, all else being equal, impacts response time and costs.

sizes expected to become more challenging with their needs?

Consider how these changes may impact not only outputs but outcomes, and how the two may interact. For example, a grant loss may reduce the service levels through lower volumes, longer wait time, or decreased customer satisfaction. However, a program may choose to service far fewer clients but maintain the same level of outcomes.

More sophisticated models will factor in more variables, interactions and may use longer time frames. Forecast using the most likely situation, but also consider conservative and aggressive scenarios. It should be noted that a forecast does not necessarily relate to adequate service level based on a structured needs assessment.

## Refining measures

There are several suggestions that can make the process of developing or refining a program's performance measures easier.

- Many programs have several activities that encompass the same service. The measure should relate to the primary service or result that the program is attempting to accomplish. For example, a housing placement program may measure the number of pre-service screenings, applications created, or interviews scheduled, but the primary purpose is to place someone in a home and have that person remain housed. The last two measures—outputs and outcomes—are the measures of primary interest.
- There are cases where similar programs are offered (e.g., drug treatment, call centers, protective services investigations, gang services, etc.). In these cases, the various programs should attempt to use common measures where appropriate. This will move the DHHS toward more standardized reporting of outcomes and increase the ease and understanding of performance measures by citizens.
- Use the best available measures. Crude measures of the right things are better than precise measures of the wrong things. Not all measures may be readily available, especially if the program is new.
- Better to have several measures than only the bare minimum. A variety of measures communicates the value of the program. This is especially true when outcome measures or data may not currently be available.
- Select measures that are effectible and meaningful. Measures that are always at 100% suggest the bar is too low or the measure has little meaning from a program management perspective. This is also true of programs where failure is not an option. In these cases, proxy measures—measures closely tied to the outcome—should be able to demonstrate how the proxy ties to the eventual outcome of what the program does.
- Remember, developing appropriate performance measures is an iterative process subject to changes over time.

## Common reasons for not measuring performance

Some limits exist to what types of information performance measures can capture. Typically, these are limits found in cases where direct measurement is difficult, lack event frequency or are costly. Often however, measurement difficulties

are due to unclear program results. Clarifying the program objectives and who will benefit will go a long way towards developing meaningful measures. Below are several considerations when applying performance measures.

### Box 6. DHHS technology modernization

DHHS completed its three-part technology modernization initiative in 2017, culminating with the on-time launch of its enterprise Integrated Case Management (eICM) system. As one of the country's first fully integrated health and human services information systems, eICM provides nearly limitless access to a wide-range of program and client performance data accessible through many tools. eICM replaced hundreds of outdated databases, spreadsheets and shadow systems to become the backbone of DHHS' information systems. DHHS is now able to identify and better serve the 1 in 10 County residents who are active clients receiving services with the appropriate types of multiple services they need and can better measure the impact of services.

**Measurement is inaccurate as the program doesn't have control of all variables**

No program in the real-world has total control over the outcome. Often various programs contribute to achieving the same goal. However, if a program can't demonstrate any impact on the result, then why should the program exist?

The contribution of any one program may be relatively small or large, and multiple models may be at play. One approach to this situation is to develop broad, yet measurable, outcomes shared by a collection of programs, while also having program-specific performance goals.

**Measures lead to unfair comparisons**

Comparison is going to happen whether programs invite it or not. But programs never stand only on their performance results. Clearly articulating the context of the program, its target population and services, limit apples-to-oranges comparisons. Consider taking the initiative in selecting comparable organizations that can help your program by proactively comparing performance, benchmarking how well you are doing, and seeking ideas on how you can improve your performance.

**Performance data may be negative**

Like the stock market, a program cannot always improve year over year, and if it does, then something may be amiss. Demonstrating transparency and accountability, even when the news is not positive, inspires trust, gives the program performance data street credibility, and shows that the manager understands their program and the difficulties of providing social services. If programs are open about the need to improve, most people will give a program the benefit of the doubt if programs demonstrate improvement plans. Cynical manipulation of measures, for example selecting overly easy targets or ignoring relevant data, will lead to mistrust and question motives and credibility.

**Data capacity don't exist**

**Considering the investments DHHS has made in IT, every program has performance data available either through eICM or her or a State of Federal system. In addition, every contract also has**

**metrics. Remember, if a program is important enough to fund, staff should find ways to collect data and report on its effectiveness.**

Program managers are responsible for dedicating a percent of their time to collecting data on thoughtful measures and using the data to manage for results. However, there may be technical gaps between performance measures and technical outcome measures that leads to misinterpretation if the service area does not have staff that understands both. Therefore, the formation of a team utilizing expertise throughout the Department is essential.

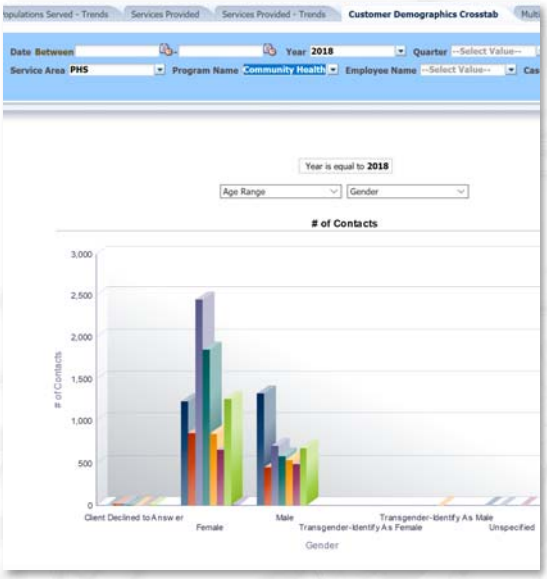



*Figure 14. eICM analytical tools provide customizable visualization of real-time program performance*

**The program is different and can't be measured**

Every program is measurable, and some such as prevention and education programs pose more challenges than others, particularly when looking at long term outcomes. Most jurisdictions have initiated performance measurement systems and more comparative information exists for staff to reference (see Annex VII).

In some cases, this can be addressed by identifying meaningful output-oriented milestones or short-term proxy outcomes that will lead to achieving the long-term outcome goal. For example, in a youth education program, the measures may focus on end of year test scores instead of high-school completion rates which may become available only many years later.

To address this issue, a program should refer to their logic model to define the specific initial short-term and intermediate outcomes to accomplish the long-term outcome goal. While these steps are likely to be output-oriented, they are modeled as a prerequisite accomplishment on the path toward the long-term goal.

**How to measure prevention**

Programs with a deterrence or prevention focus can be difficult to measure for a variety of reasons. Most importantly, deterrence measurements require consideration of what would happen in the absence of the program.

It may be difficult to isolate the impact of the individual program on behavior that may be affected by multiple other factors. If performance measures reflect a continuum from lower-level outputs to higher-level outcome measures related to the overall goal, it is important for deterrence programs to choose measures that are far enough along the continuum that they tie to the program's activity. This will help ensure that the measures are both meaningful and genuinely affected by the program.

**Programs where failure is not an option**

For programs where failure to prevent a negative outcome would be catastrophic,

such as programs to prevent a pandemic disease outbreak, traditional outcome measurement might lead to an "all-or-nothing" goal. If the negative outcome is prevented, the program might be considered successful, regardless of the costs incurred in prevention or any close calls experienced. In these cases, proxy measures can be used to determine how well the deterrence process is functioning. These proxy measures should be closely tied to the outcome, and the program should be able to demonstrate how the proxies tie to the eventual outcome. Because of the risk, multiple proxy measures should be used. Failure in any one of the safeguards would be indicative of the risk of an overall failure.

## Real limitations in measuring and using performance data

Notwithstanding the above perceived limitations, performance measurement systems do have real limitations, which include:

- Collecting metrics for the sake of measuring, and not used for managing performance.
- Collecting limited outcome information, or those outcomes which are not long-term.
- Reliance on aggregated data dashboards which fail to identify specifically strengths and weaknesses of the services.
- Failing to provide qualitative context to better tell the story of the data findings.
- Not providing the training and technical assistance to managers on how to access and use the performance information.

There are of course, may other limitations to capturing and using these data. The purpose of this manual is to address some of these very real limitations in practical terms, localized to the culture of doing business. The aim is to imbed the concepts of performance measurement practices into on-going work in a way that becomes sustainable and consistent over the long-term.

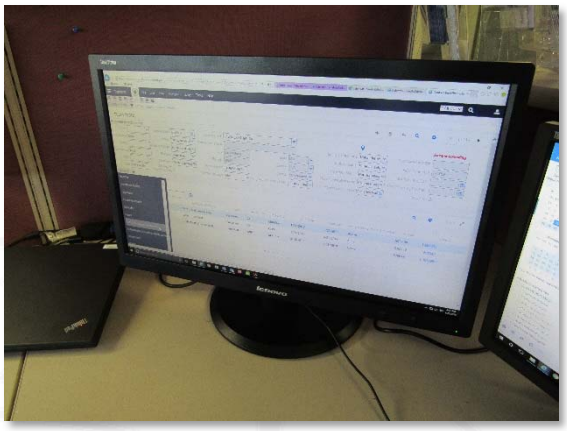
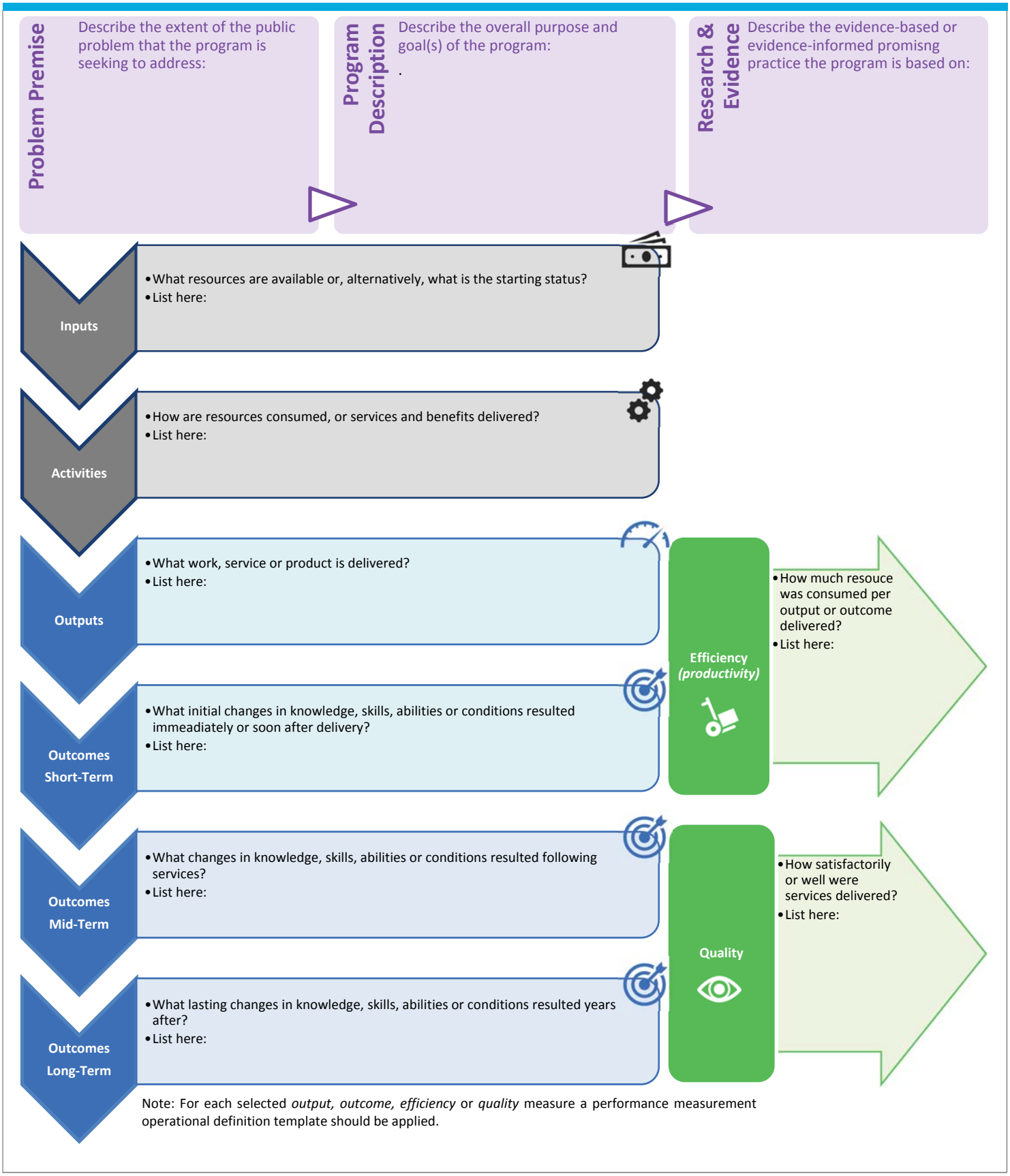


*Figure 15. DHHS eICM interface houses hundreds of millions of records and data points which can support program performance, forecasting, predictive modelling and more.*

# ANNEX I: 7 Elements of Quality Program Design

# ANNEX II: Program Logical Framework Template




Note: For each selected *output, outcome, efficiency* or *quality* measure a performance measurement operational definition template should be applied.

# ANNEX III: SMARTIE Framework for Measurement Selection

**SPECIFIC**
- Indicator is defined simply into observable and measurable elements free from ambiguity and jargon.

**MEASUREABLE**
- Indicator is tanglaible evidence that can be seen, heard, counted, reported, or otherwise enumerate d using a valid and reliable data collection method.

**ACHIEVABLE**
- Indicator provides a challenge to the program but is defined well enough so that it may be realized in the time frame.

**RELEVANT**
- Indicator make sense in relation to the activities but should focus on the results the program is designed to achieve.

**TIMELY**
- Indicator is inked to a timeframe that creates a sense of urgency between the current reality and the relevant outcome the program is designed to achieve.

**IT READY (eICM & eHR)**
- Indicator is readily linked to a reliable and valid IT system used by DHHS, preferably reportable via eICM or eHR systems.

**EQUITY INFORMED**
- The indicator allows for the identification of disparities by race, ethnicity, age, country or origin, or other relevent socio-economic measure so as to improve the equity of health and social services outcomes for minority populations.

| | |
|---|---|
| Meaningful & valid | • The program performance is measuring what the program is trying to achieve and can be found in other jurisdictions. |
| Consistent & reliable | • The data used are consistently accurate and reliable. Where similar programs exist the same measure has been applied. |
| Understandable & clear | • The measure is simple enough to be understood by county residents interested in the program. |
| Comprehensive | • The measures captures the most important aspects of a program's goals, especially where multiple facets of a program exist. |
| Focus on controllable facets | • The measure shows individual, program or community change directly affected by the activities of the program/ service. |
| Unique & not redundant | • The measure is not a simple variation on another measure already being reported. |
| Sensitive to collection cost | • The data required are readily available, particularly through new IT systems. These data require little if any manipulation or shawdow system use to track. |
| Perverse incentives | • The measure will not lead to behaviors that reduce quality to improve the outputs or short-term outcomes, known as perverse incentives. |
| Variety of measures | • The measure supports a minimum combination of input, output, outcome, efficiency and quality indicators that draw upon a different aspect of the activities delivered to provide a more balanced description of the result intended. |
| Adopt a standard | • The metric draws upon similar program measures or industry standard. |

# ANNEX IV: Performance Measurement Operational Definition Template

| | |
|---|---|
| **Text of Measure:** | |
| **Metric is reported out as:**<br>*(Check all that apply)* | ☐ County Cross-Departmental Initiatives ☐ DHHS Headline Measure ☐ OMB Program Measure ☐ Monthly Trend Report/Chief's Report Data Element |
| **County Performance Priority Area:**<br>*(Applies to Headline Measures only)* | **Check only one, as appropriate:**<br>☐ A Responsive and Accountable County Government<br>☐ Affordable Housing in an Inclusive Community<br>☐ Children Prepared to Live and Learn<br>☐ Healthy and Sustainable Communities<br>☐ Safe Streets and Secure Neighborhoods<br>☐ Vital Living for All of Our Residents |
| **DHHS Beneficial Impact:**<br>*(Check all that apply)* | ☐ Improved health and well-being ☐ Risk mitigation ☐ Greater client self-sufficiency |
| **Service Area and Program:** | **Responsible Staff:** |
| **Program Description:**<br>*(from budget book)* | |
| **Program Goal(s):** | |
| **Why is this Measure Important?:** | |
| **Date of creation/ last approved:** | **Baseline, if any:** *(date)* |
| **Published in Budget Book?:** | ☐ Yes ☐ No |

| Data Characteristics | |
|---|---|
| **Type of Metric:**<br>*(Check only one)* | ☐ Input ☐ Outcome (Result) ☐ Output<br>☐ Efficiency ☐ Quality |
| **Data Source(s):**<br>eICM, eHR, other<br>*(be specific)* | |
| **Type of data:**<br>*(Primary vs. secondary)* | **Measure Type:** *(Percent, number)* |
| **How data are Collected:**<br>Instrumentation and collection methodology if primary:<br>▸ Tools/instruments used<br>▸ Sampling process<br>▸ Method of collection<br>*(e.g. self-administer, staff)* | **Source if secondary data:** |
| **Inclusion and Exclusion Criteria for Selected Data:** | |
| **Questions used to obtain the data:** | |
| **When data are Collected:**<br>*(Extraction time frame and/or collection periodicity)* | |
| **Population covered:**<br>*(inclusion/exclusion criteria and what data represent - include demographic or other relevant characteristics)* | |
| **Equity:**<br>*(There are many data that may be used to examine equitable service provision. These are examples of the types of data that may be considered when identifying disparities)* | **Are the following data available about the population served?:**<br>Race ☐ Yes ☐ No Preferred language ☐ Yes ☐ No<br>**At least annually, does the program use the above data to compare client outcomes and inform the development and/or refinement of services to address any identified disparities?**<br>☐ Yes ☐ No |

| | |
|---|---|
| **Factors Contributing to Current Performance:** *(Applies to Headline Measures only)* | |
| **Factors Restricting Performance Improvement:** *(Applies to Headline Measures only)* | |
| **Performance Improvement Plan:** *(Applies to Headline Measures only)* | |
| **Department Notes/ Comments:** *(internal to DHHS Only)* | |
| **Department Notes/ Comments:** *(for OMB/ CountyStat Only)* | |
| **Footnotes:** *(for public display)* | |

| Actual FY__ | Actual FY__ | Actual FY__ | Actual FY__ | Actual FY__ | Actual FY__ |
|---|---|---|---|---|---|
| | | | | | |

**Additional details:**

1. **If needed, specific instructions on:**
   - ▸ How data are collected
   - ▸ How to retrieve data
   - ▸ How data are analyzed and the measure is calculated
2. **Calculation for individual clients/ program outcome (imbed Excel, as needed)**

# ANNEX V: Equity Tool Framework

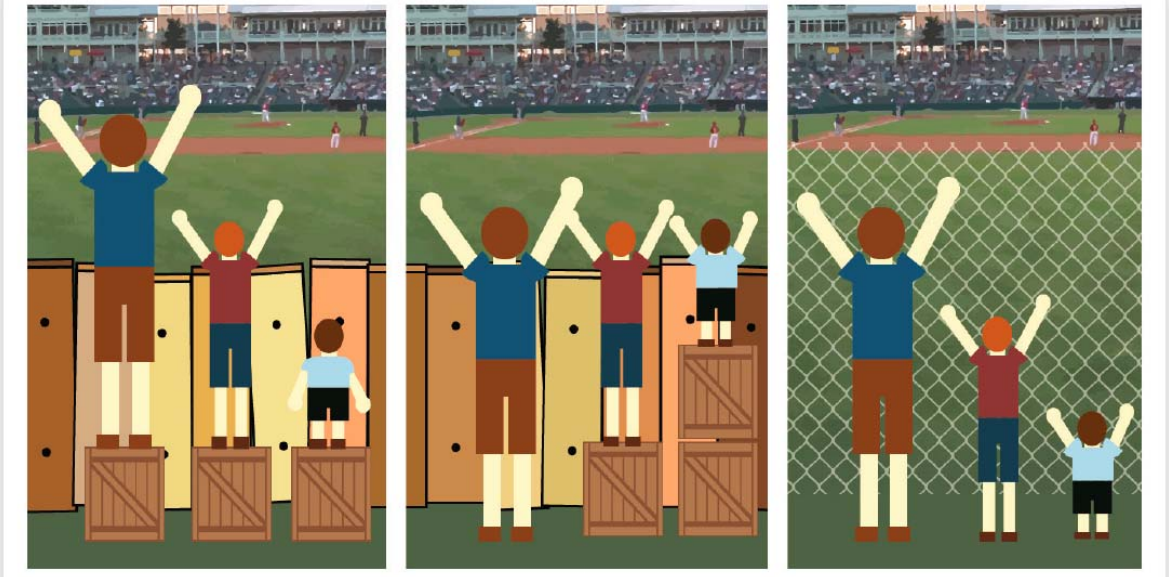
Equity refers to fair policies, decisions, and actions by DHHS when impacting the lives of people. Equity is a value of fairness that guides the way that DHHS works with customers, staff, and community to promote health, safety, well-being and self-sufficiency. Together DHHS builds a culture of inclusion and tailors its approaches to achieve the best possible outcomes for the communities and customers served.

**Our Equity Principles address five major areas:**

1. Dignity – We believe that all individuals should be treated with dignity and respect.
2. Elimination of Disparities – We believe in preventing and eliminating social and health disparities to achieve optimal health and well-being.
3. Access – We believe in ensuring access to effective and high-quality services that meet people's needs, when they need them, delivered by a professional workforce which is competent to provide those services in a caring and respectful manner.
4. Distribution of Resources – We believe that the resources of the Department should be distributed in a manner that maximizes the health, safety, well-being and self-sufficiency of the community as a whole.
5. Community Engagement and Participation – We believe that our diverse communities should be meaningfully engaged in providing input and feedback on policies, practices and services.

**Practical questions to ask related to equity:**

1. Are equity principles intentionally considered in the decision-making process?
2. If the decisions may cause negative impact on certain groups, have you considered any mitigation measures?
3. Are the decisions honoring the principles of treating people with dignity and respect?
4. Will the decisions help eliminate disparities? How?
5. Are your decisions supported by evidence or data, research and/or evidence based/promising practice? Which?
6. Does this policy decision promote or improve access to services for the community?
7. Have you considered who will be the most and least advantaged by your decisions?
8. How have you considered the interconnectedness with other systems and programs and the cumulative impact?
9. Are the voices of all groups affected by the decision at the table?



# ANNEX VI: Service Area Performance Measurement Resources

| DHHS Service Area | Data to Enhance Effective Practice (DEEP) Representative | eSAR |
|---|---|---|
| **ADS** | Erin Smith | Marsha Aaron (eICM) |
| **BHCS** | Vacant | Leon Suskin (eICM/eHR) |
| **CYFS** | Michelle Gallipoli | Richon Nembhard (eICM) |
| **OCA** | Vacant | Jose Amaya (eICM) |
| **OCOO** | Sommer Barnes<br>Lisa Stafford | Parinaz Barr |
| **PHS Healthy Montgomery** | Chunfu Liu<br>Rita Deng | Sheila Bermudez (eICM)<br>Nicholas Corraya (eHR) |
| **SEPH** | Eric Rickford | Denise Anderson (eICM) |
| **DO/ PACS** | Nicki De La Rosa<br>Abigail Hoffman<br>Matt Nice<br>Nouné Sekhpossian<br>Sarah Yaftali | |

# ANNEX VII: Resources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Montgomery County Department of Health and Human Services
Planning, Accountability and Customer Service (PACS)
401 Hungerford Drive, 7th Floor
Tel. (240) 777 1098
www.montgomerycountymd.gov/hhs/