Performance Management Self-Assessment Survey, June 2021
Assessment of Performance Goals and Measures, Domain-9 Reaccreditation Requirement

This report provides a summary of the process adopted by the Office of Performance Management Quality Improvement and Evaluation (PMQIE) to assess components of Performance Management System (PMS) in the Arkansas Department of Health (ADH). To accomplish that, the OPMQIE implemented Performance Management Self-Assessment Survey (PMSAS) in June 2021. The survey tool was developed by the US Public Health Foundation and recommended by the Public Health Accreditation Board (PHAB) for public health agencies who were working toward meeting the specific reaccreditation requirements.

Twenty-nine senior ADH managers including executive team members, Center directors, and administrative officers took the survey in June. Results are presented in the Appendices on pages 3-9. Table 2 shows number of respondents and response rates for each section of the survey. Table 3 provides detailed survey results and Table 4 presents goals selected based on the survey results.

After the completion of PMSAS, the OPMQIE team continued to investigate to come up with measures appropriate for the performance goals. In the end, the team decided to adopt the ASTHO dashboard model with a set of measures specifically developed to assess core performances of public health agencies. These measures were tested and approved by an advisory group of state public health leaders. More importantly, the measures were simple and attainable. The team consulted key ADH staff members who represented the eight performance areas and used their input to tweak the measures.

Table 1 represents eight performance areas and twenty-five related measures adopted from the ASTHO Dashboard Model. Performance areas are akin to several goals ascertained through the PMSAS in Table 4. During the consultation with area experts, an understanding emerged that the data for many of these measures were already being collected by the ADH and tracked periodically.

After the completion of the review and approval of this document, the OPMQIE will move to complete the following steps.

- Finalize performance goals and measures,
- Develop Performance Management System (PMS) Dashboard,
- Formalize PMS committee, and
- Provide orientation to the committee members about their roles in their performance areas

The PMS Dashboard will be a live system with ongoing updates and improvement.

Table 1: Performance Management System focus areas and indicators, Arkansas Department of Health

Performance Area I: Customer Satisfaction: These indicators assess agency's engagement in seeking customer feedback and responsiveness to customer concerns.
Indicator: Proportion of ADH programs conducting a systematic process to assess external customer satisfaction
Indicator: Proportion of ADH programs conducting a systematic process to assess external complaint
Indicator: Average number of business days required for health department to respond to customer complaints
Performance Area II: Financial Management: These indicators measure the capacity to manage finances.
Indicator: Annual ADH expenditures
Indicator: Annual ADH revenue
Indicator: Proportion of purchase requisitions processed on time according to ADH policy
Indicator: Proportion of purchases that are changed due to cost error corrections for using "wrong funding codes".
Performance Area III: Grants and Contracts: Assess the ability to manage grants and contracts in an efficient and timely manner.
Indicator: Proportion of contracts executed according to established ADH policy
Indicator: Proportion of grant dollars expended on time
Indicator: Proportion of submitted grant applications that are funded
Performance Area IV: Human Capital: Assess the efficiency of the hiring process and the experience, satisfaction, and retention of ADH's workforce.
Indicator: Proportion of authorized ADH staff employment positions filled
Indicator: Proportion of ADH employees who "strongly agree" or "agree" that they are satisfied with ADH employment and would recommend the organization as a good place to work
Indicator: Proportion of ADH employees leaving the agency
Indicator: Proportion of ADH employees performance evaluations completed on time
Performance Area V: Information Services and Technology: Demonstrate the capacity to assess internal responses to IT issues and plan to advance and build agency's IT infrastructure.
Indicator: Average number of days to resolve internal ADH helpdesk tickets
Indicator: Development of ADH Information Technology Strategic Plan
Performance Area VI: Process Improvement: Inform on the extent to which the agency is implementing strategies for process improvement.
Indicator: Proportion of ADH programs using evaluation methods to improve processes for program activities
Indicator: Proportion of ADH programs using a proven Quality Improvement (QI) model
Performance Area VII: Program Development: Assess the extent to which the agency establishes internal and external partners to maintain best practice.
Indicator: Proportion of ADH programs utilizing performance targets for continuous program improvement
Indicator: Proportion of ADH programs that are currently implementing evidence-based interventions
Indicator: Proportion of ADH programs that have internal partnerships
Indicator: Proportion of ADH programs that have external partnerships
Performance Area VIII: Vital Statistics and Request for Records: Assess capacity of ADH to accurately maintain information and process requests for information.
Indicator: Proportion of ADH birth certificates filed electronically
Indicator: Proportion of ADH death certificates filed electronically
Indicator: Average number of days for ADH staff to process citizen's vital statistics records for any kind of request

APPENDICES:

Appendix 1: Table 2: PMSAS sections, number of participants, and response rates.

Section	Number of responders	Response Rate
Section I: Visible Leadership	14	48.3%
Section II: Performance Standards	11	37.9%
Section III: Performance Measurement	11	37.9%
Section IV: Reporting Progress	11	37.9%
Section V: Quality Improvement	10	34.5%

Appendix 2: Table 3: PMSAS Responses

Section I. Visible Leadership - *Senior management commitment to a culture of quality that aligns performance management practices with the organizational mission, regularly takes into account customer feedback, and enables transparency about performance between leadership and staff.*

Performance areas for self-assessment	Never/ Almost Never	Some-times	Always/ Almost Always	# of Responses
1. Senior management demonstrates commitment to utilizing a performance management system	0%	64%	36%	14
2. Senior management demonstrates commitment to a quality culture	0%	43%	57%	14
3. Senior management leads the group (e.g., program, organization or system) to align performance management practices with the organizational mission	0%	57%	43%	14
4. Transparency exists between leadership and staff on communicating the value of the performance management system and how it is being used to improve effectiveness and efficiency	7%	71%	21%	14
5. Performance is actively managed in the following areas (check all that apply)				
A. Health Status (e.g., diabetes rates)	0%	29%	71%	14
B. Public Health Capacity (e.g., public health programs, staff, etc.)	0%	43%	57%	14
C. Workforce Development (e.g., training in core competencies)	14%	50%	36%	14
D. Data and Information Systems (e.g., injury report lag time, participation in intranet report system)	0%	46%	54%	13
E. Customer Focus and Satisfaction (e.g., use of customer/stakeholder feedback to make program decisions or system changes)	0%	57%	43%	14
F. Financial Systems (e.g., frequency of financial reports, reports that categorize expenses by strategic priorities)	14%	36%	50%	14
G. Management Practices (e.g., communication of vision to employees, projects completed on time)	14%	50%	36%	14
H. Service Delivery (e.g., clinic no-show rates)	0%	43%	57%	14
I. Other (Specify):	0%	3%	3%	6
6. There is a team responsible for integrating performance management efforts across the areas listed in 5 A-I	14%	57%	29%	14

Performance areas for self-assessment	Never/ Almost Never	Some-times	Always/ Almost Always	# of Responses
7. Managers are trained to manage performance	21%	57%	21%	14
8. Managers are held accountable for developing, maintaining, and improving the performance management system	21%	43%	36%	14
9. There are incentives for effective performance improvement	36%	36%	29%	14
10. A process or mechanism exists to align the various components of the performance management system (i.e., performance standards, measures, reports, and improvement processes focus on the same things)	7%	64%	29%	14
11. A process or mechanism exists to align performance priorities with budget	14%	50%	36%	14
12. Personnel and financial resources are assigned to performance management functions	14%	57%	29%	14

Section II. Performance Standards - *Establishment of organizational or system performance standards, targets, and goals to improve public health practices. Standards may be set based on national, state, or scientific guidelines, by benchmarking against similar organizations, based on the public's or leaders' expectations, or other methods.*

Performance areas for self-assessment	Never/ Almost Never	Some-times	Always/ Almost Always	# of responses
1. The group (program, organization or system) uses performance standards	0%	55%	46%	11
2. The performance standards chosen used are relevant to the organization's activities	0%	36%	64%	11
3. Specific performance targets are set to be achieved within designated time periods	0%	45%	55%	11
4. Managers and employees are held accountable for meeting standards and targets	9%	55%	36%	11
5. There are defined processes and methods for choosing performance standards, indicators, or targets				
A. National performance standards, indicators, and targets are used when possible (e.g., National Public Health Performance Standards, Leading Health Indicators, Healthy People 2020, Public Health Accreditation Board Standards and Measures)	0%	36%	64%	11
B. The group benchmarks its performance against similar entities	18%	64%	18%	11
C. Scientific guidelines are used	0%	27%	73%	11
D. The group sets priorities related to its strategic plan	0%	55%	45%	11
E. The standards used cover a mix of capacities, processes, and outcomes	9%	55%	36%	11
6. Performance standards, indicators, and targets are communicated throughout the organization and to its stakeholders and partners				
A. Individuals' performance expectations are regularly communicated	18%	45%	36%	11
B. The group relates performance standards to recognized public health goals and frameworks, (e.g., Essential Public Health Services)	0%	55%	45%	11
7. The group regularly reviews standards and targets	27%	55%	18%	11
8. Staff understand standards and targets	18%	36%	45%	11

Performance areas for self-assessment	Never/ Almost Never	Some-times	Always/ Almost Always	# of responses
9. Performance standards are aligned across multiple groups (e.g., same child health standard is used across programs and agencies)	9%	55%	36%	11
10. Training is available to help staff use performance standards	27%	55%	18%	11
11. Personnel and financial resources are assigned to make sure efforts are guided by relevant performance standards and targets	9%	73%	18%	11

Section III. Performance Measurement - *Development, application, and use of performance measures to assess achievement of performance standards.*

Performance areas for self-assessment	Never/ Almost Never	Some-times	Always/ Almost Always	# of responses
1. The group (program, organization, or system) uses specific measures for established performance standards and targets				
A. Measures are clearly defined	0%	55%	45%	11
B. Quantitative measures have clearly defined units of measure	0%	55%	45%	11
C. Inter-rater reliability has been established for qualitative measures	27%	36%	36%	11
2. Measures are selected in coordination with other programs, divisions, or organizations to avoid duplication in data collection	18%	45%	36%	11
3. There are defined methods and criteria for selecting performance measures				
A. Existing sources of data are used whenever possible	0%	9%	91%	11
B. Standardized measures (e.g., national programs or health indicators) are used whenever possible	0%	27%	73%	11
C. Standardized measures (e.g., national programs or health indicators) are consistently used across multiple programs, divisions, or organizations	9%	36%	55%	11
D. Measures cover a mix of capacities, processes, and outcomes	9%	27%	64%	11
4. Data are collected on the measures on an established schedule	0%	45%	55%	11
5. Training is available to help staff measure performance	9%	73%	18%	11
6. Personnel and financial resources are assigned to collect performance measurement data	18%	45%	36%	11

Section IV. Reporting Progress - *Documentation and reporting progress in meeting standards and targets, and sharing of such information through appropriate feedback channels.*

Performance areas for self-assessment	Never/ Almost Never	Some-times	Always/ Almost Always	# of responses
1. The group (program, organization or system) documents progress related to performance standards and targets	9%	55%	36%	11
2. Information on progress is regularly made available to the following (check all that apply)				
A. Managers and leaders	9%	55%	36%	11
B. Staff	36%	45%	18%	11
C. Governance boards and policy makers	0%	55%	45%	11
D. Stakeholders or partners	9%	73%	18%	11
E. The public, including media	18%	64%	18%	11
F. Other (Specify):	67%	33%	0%	3
3. Managers at all levels are held accountable for reporting performance				
A. There is a clear plan for the release of performance reports (i.e., who is responsible, methodology, frequency)	18%	45%	36%	11
B. Reporting progress is part of the strategic plan	0%	55%	45%	11
4. A decision has been made on the frequency of analyzing and reporting performance progress for the following types of measures (check all that apply)				
A. Health Status	0%	55%	45%	11
B. Public Health Capacity	30%	30%	40%	10
C. Workforce Development	45%	27%	27%	11
D. Data and Information Systems	18%	45%	36%	11
E. Customer Focus and Satisfaction	18%	55%	27%	11
F. Financial Systems	9%	55%	36%	11
G. Management Practices	9%	73%	18%	11
H. Service Delivery	9%	73%	18%	11
I. Other (Specify):	25%	25%	50%	4
5. The group has a reporting system that integrates performance data from programs, agencies, divisions, or management areas (e.g., financial systems, health outcomes, customer focus and satisfaction)	9%	55%	36%	11
6. Training is available to help staff effectively analyze and report performance data	27%	55%	18%	11
7. Reports on progress are clear, relevant, and current so people can understand and use them for decision-making (e.g., performance management dashboard)	9%	55%	36%	11
8. Personnel and financial resources are assigned to analyze performance data and report progress	18%	55%	27%	11
9. Leaders are effective in communicating performance outcomes to the public to demonstrate effective use of public dollars	18%	55%	27%	11

Section V. Quality Improvement (QI) - *In public health, the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, that focuses on activities that address community needs and population health improvement. QI refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.*

Performance areas for self-assessment	Never/ Almost Never	Some-times	Always/ Almost Always	# of responses
1. One or more processes exist to improve quality or performance				
A. There is an entity or person responsible for decision-making based on performance reports (e.g., top management team, governing or advisory board)	10%	30%	60%	10
B. There is a regular timetable for QI processes	30%	30%	40%	10
C. The steps in the QI process are effectively communicated	40%	30%	30%	10
2. Managers and employees are evaluated for their performance improvement efforts (i.e., performance improvement is in employees' job descriptions and/or annual reviews)	40%	20%	40%	10
3. Performance reports are used regularly for decision-making	10%	70%	20%	10
4. Performance data are used to do the following (check all that apply)				
A. Determine areas for more analysis or evaluation	0%	70%	30%	10
B. Set priorities and allocate/redirect resources	10%	60%	30%	10
C. Inform policy makers of the observed or potential impact of decisions under their consideration	0%	80%	20%	10
D. Implement QI projects	0%	70%	30%	10
E. Make changes to improve performance and outcomes	10%	60%	30%	10
F. Improve performance	0%	60%	40%	10
5. The group (program, organization, or system) has the capacity to take action to improve performance when needed				
A. Processes exist to manage changes in policies, programs, or infrastructure	0%	40%	60%	10
B. Managers have the authority to make certain changes to improve performance	10%	50%	40%	10
C. Staff has the authority to make certain changes to improve performance	20%	70%	10%	10
6. The organization regularly develops performance improvement or QI plans that specify timelines, actions, and responsible parties	20%	60%	20%	10
7. There is a process or mechanism to coordinate QI efforts among groups that share the same performance targets	20%	70%	10%	10
8. QI training is available to managers and staff	30%	60%	10%	10
9. Personnel and financial resources are allocated to the organization's QI process (e.g., a QI office exists, lead QI staff is appointed)	10%	60%	30%	10
10. QI is practiced widely in the program, organization, or system	10%	50%	40%	10

Appendix 2 continued:

The survey results will help guide the development of ADH's Performance Management Dashboard. The dashboard will represent an overarching scope of ADH's Performance Management System. Other components of the System will include the State Health Assessment, the State Health Improvement Plan, the ADH Strategic Plan, the Quality Improvement Plan, and the Workforce Development Plan. The final component to be added to the system will be Center-based Strategic Work Plans.

The dashboard will be designed to measure internal organizational health, inform management decisions, and facilitate quality improvement. The indicators will focus on internal administrative, business process, and operational indicators. The State Health Assessment will document the health status and needs of Arkansans and will guide the priorities established in the State Health Improvement Plan (SHIP). The ADH Strategic Plan will detail the steps that will be taken to address the public health priorities identified in the SHIP.

The OPMQIE team proceeded with the following assumptions to determine the performance measures.

1. The performance measures selected would reflect areas from all five sections of the Performance Management Self-Assessment Survey, shown in Table 1.
2. Percentages of the three response categories (see below) will be used to select measures so that we could build on our current progress and success as we begin to address challenges.
    i. Never/almost Never,
    ii. Sometimes, and
    iii. Always/Almost Always.
3. Number of performance measures will be limited to 20 (four from each of the five areas) and will be finalized in consultation with area specific ADH managers.

For the selection of specific goal areas, the OPMQIE team analyzed the survey results by section. For each section, the team first considered the survey items that had the highest rate (percentage) in each of the three response categories (mentioned above).

The team considered each goal for inclusion not only based on the feasibility and fitness with the current culture of ADH but also on how the goals relate to other components of the Performance Management System.

In some instances, percentages tied within a category. In other cases, the highest rated item did not pass the feasibility/fit criteria for the agency. At times, the team selected two goal areas rather than one for the ties. When the highest rated item did not pass the feasibility/fit question, the team considered the second highest rated item. The final selection of goal areas appears on the next page. Our next step is to develop performance measures for each of the goal areas, seek final approval, and present them in the ADH Performance Management Dashboard.

Appendix 3: Table 4: Goals Selected Based on the PMSAS Results

Section I: Visible Leadership	Rating Category
Senior management demonstrates commitment to utilizing a performance management system	Sometimes
Performance is actively managed in the following area: Health Status	Always/Almost Always
There are incentives for effective performance management	Never/Almost Never
A process or mechanism exists to align the various components of the performance management system (i.e., performance standards, measures, reports, and improvement processes focus on the same things	Sometimes
Section II: Performance Standards	**Rating Category**
The group regularly reviews standards and targets	Never/Almost Never
Training is available to help staff use performance standards	Never/Almost Never
Personnel and financial resources are assigned to make sure efforts are guided by relevant performance standards and targets	Sometimes
There are defined processes and methods for choosing performance standards, indicators, or targets: Scientific guidelines are used	Always/Almost Always
Section III: Performance	**Rating Category**
Measures are selected in coordination with other programs, divisions, or organizations to avoid duplication in data collection	Never/Almost Never
Training is available to help staff measure performance	Sometimes
There are defined methods and criteria for selecting performance measures: Existing sources of data are used whenever possible	Always/Almost Always
There are defined methods and criteria for selecting performance measures: Measures cover a mix of capacities, processes, and outcomes	Always/Almost Always
Section IV: Reporting Progress	**Rating Category**
A decision has been made on the frequency of analyzing and reporting performance progress for the following types of measures: Workforce Development	Never/Almost Never
Information on progress is regularly made available to the following: Stakeholders or partners	Sometimes
Managers at all levels are held accountable for reporting performance: Reporting progress is part of the strategic plan	Always/Almost Always
Reports on progress are clear, relevant, and current so people can understand and use them for decision-making (e.g., performance management dashboard)	Sometimes
Section V: Quality Improvement	**Rating Category**
One or more processes exists to improve quality or performance: The steps in the QI process are effectively communicated	Always/Almost Always
QI training is available to managers and staff	Never/Almost Never
Performance data are used to do the following: Determine areas for more analysis or evaluation	Sometimes
One or more processes exists to improve quality or performance: There is an entity or person responsible for decision-making based on performance reports (e.g., top management team, governing or advisory board)	Always/Almost Always